POWER DYNAMICS AND PROFESSIONAL EXPERTISE IN THE COMMUNICATION
BETWEEN SPECIALIST NURSES AND DOCTORS IN ACUTE HOSPITAL SETTINGS

MARK THOMAS RADFORD

BSc (Hons), RGN, PGDip (ANP), MA (Med Ed)

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'The sociological imagination enables us to grasp history and biography and the relations between the two within society. That is its task and its promise' - Charles Wright Mills, The Sociological Imagination (1959)

Abstract

Aim. The aim of this PhD thesis is to report the sociological position, power dynamics and expertise in the communication between specialist nurses[1] and doctors within NHS acute hospitals.

Background. Nursing and healthcare have continually evolved, with new nursing roles interfacing professionally at a more advanced level with doctors. Historically the relationship and interactions have been characterised as the 'Doctor-Nurse' game which has been reviewed from many sociological perspectives. However, little has been added to understand the basis of these transactions that take place in the clinical setting between advanced practice nurses and doctors in hospitals.

Methods. The primary methods comprised a critical realist approach ethnography, undertaking: fieldwork observations, follow-up interviews and artefact analysis on teams of specialist nurses and doctors working in three NHS hospitals. Seven specialist teams comprising 30 specialist nurses and 53 doctors of all grades were directly studied, alongside other peripheral members of the healthcare team as they delivered care.

Results. The findings in this study demonstrate that much has changed concerning the role of the specialist nurse: professionally, clinically and sociologically. Four main themes emerged from the research: defining a new relationship between medicine and nursing; social space, development of 'field' in hospital care, division of labour, expertise and a new interaction model. The basis of the relationship has changed through bureaucratic challenges to the medical role which has resulted in changes to nursing power and its application in the clinical field in the new care models. There are a number of new

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[1] It is recognised that there is scholarly debate on the definition, scope and titles of nurses working at advanced levels. This debate is explored in more detail on pages 59 to 66 of the literature review. However, this ethnography represents its participants who defined and recognised themselves by the title 'specialist nurse'. When describing or presenting the participant's experiences, this term will be employed in the context of this thesis to ensure it faithfully represents the voices and lives of those who participated. However, the term advanced practice will be used in the discussion, conclusion and implications of this research to maintain consistency with the wider literature.

strategies employed by both groups in the management of professional role, knowledge base, expertise and clinical work in the field. The communication strategies are more complex with a sophisticated coalition model of organisation. However, some 'doctor-nurse games' are still played out in the clinical setting, based upon traditional divisions of labour and power. This relationship has also created other tensions in the workspace particularly with junior medical staff, nursing staff and administrators.

Key words/ subject of Abstract: nurse; doctor; interaction; communication; clinical decision making; advanced practice; specialist practice; clinical nurse specialist; consultant nurse; ethnography; interview; fieldwork; power; dynamics; expertise; nursing knowledge

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Mark Radford

Mark Radford, September 2012

Contents

List of Appendices

List of Tables

List of Figures

List of Plates

Abbreviations

AHP	Allied Health Professional
ANP	Advanced Nursing Practice
BMA	British Medical Association
CAQDAS	Computer-Assisted Qualitative Data Analysis Software
EWTD	European Working Time Directive
FY1	Foundation Year 1 (doctor)
FY2	Foundation Year 2 (doctor)
GNC	General Nursing Council
GMC	General Medical Council
GUI	Graphic user interface
HO	House Officer (doctor)
LREC	Local Research Ethics Committee
PCT	Primary Care Trust
PDA	Personal Digital Assistant
PDF	Portable Document Format
REC	Research Ethics Committee
R&D	Research and Development
SHO	Senior House Officer (doctor)
SNP	Specialist Nursing Practice
SpR	Specialist Registrar (doctor)
ST (1, 2)	Specialist Trainee (doctor)
NHS	National Health Service
NMC	Nursing Midwifery Council
RCN	Royal College of Nursing
UKCC	United Kingdom Central Council for Nursing and Midwifery

Chapter One – Background to the Study and Organisation of the Thesis

Background to the Study

The purpose of this chapter is to establish the key issues which highlighted the need for the research study and determined the research questions. To do this, the chapter has been constructed in four main topic areas. Firstly, to promote clarity, I have described my own story in advanced practice and how this has led to the study being developed. Secondly, the policy context in the NHS is outlined highlighting the impact this had upon nursing and the development of advanced nursing practice. Thirdly, the scope of the research is identified. Finally, the structure of the thesis is delineated.

Introduction

I started my career in advanced nursing practice in 1998 caring for patients undergoing emergency and trauma surgery. I worked in the operating theatres of a large district general hospital in the NHS where the status quo of the nurse-doctor relationship was largely maintained. Nationally, this was a period of time when medically-led care in surgery and anaesthesia was commonplace. However, a chance conversation occurred in 1996 with a consultant anaesthetist whilst we waited in the operating theatre for a patient requiring an appendicectomy. This conversation centred on the fact that delays for surgery were becoming more frequent. The reduction in junior doctors' hours had left a shortfall in manpower which led to routine jobs such as blood and ECG tests being completed on time - if at all. This sparked an idea between us about how we might improve care by applying the skills and experience of a suitably trained nurse to manage the patient's care from admission through to the operating theatre, plugging the gaps we had identified. Our concept was relatively simple, and our aim was to realise the potential of advanced practice and challenge the traditional professional boundaries to improve emergency and trauma care (Radford, 2000a). The initial reaction to the role was mixed, as nurses and doctors saw this development as a challenge to the traditional order - one senior nurse thought that this was another example of nursing picking up tasks that doctors no longer wished to undertake. However, I worked with a group of clinicians,

nurses and managers who had the foresight and understanding to know that professional background or tradition should not form a barrier to delivering high-quality care for patients. My working relationship with the clinicians was always good, and they took a great deal of time to support and develop my clinical knowledge ensuring they had confidence in my abilities to manage complex patients. I discovered that the move from 'staff nurse' to 'clinical nurse specialist' changed my relationship with doctors - and this was intriguing. How could this simple transfer from one role to another fundamentally affect how I would interact and communicate with the same individuals that I had worked alongside for many years? This initiated an idea that ultimately led to this study. As the role developed and we publicised the results through conferences and journals, we eventually met the NHS Modernisation Agency team and Birmingham Workforce Consortium, which were embarking upon their own workforce development plans to deal with the issue of junior doctors` hours. They provided financial support and access to a range of other people through the Continuous Improvement in Booked Admissions 2 (CIBA2) and Ideal Design of Emergency Access (IDEA) programmes to help others with similar problems. Through workshops and visits to other units, we were able to develop and evaluate a number of similar roles. The resulting impact for patients provided the feedback that Advanced Practice could flourish in an environment not traditionally open to innovation and change, as long as the essential ingredients were in place. The patient and organisational benefits were great (Radford et al., 2001a, b; Radford et al., 2003a, b; Radford, 2000b; Radford, 2003) if this could be achieved.

This personal story is illustrative of a change in the relationship between nursing and medicine during this period. From first-hand experience it was clear that traditional models of interaction would be challenged with the development of advanced practice nursing. Therefore, an investigation into the nature of communication and practice between the emerging advanced practice models and medicine was required in order to determine fully the extent of the changes between the two professions.

Changes in UK healthcare policy and the impact on nursing

Medicine, alongside Law and Religious Orders, has always maintained an important social position in western society. The modern era has seen the continued rise and dominance of the medical profession in the organisation of healthcare which has

influenced health policy and created a division of labour, placing some, such as nurses, in a more subordinate position.

The National Health system in the United Kingdom has been dominated by the medical profession prior to and after the creation of the National Health Service (NHS) in 1948. Its development has hinged on the delicate balance by the state in keeping the medical profession engaged with policy changes to ensure their continued support for the system (Gladstone, et al., 2000; Johnson, 1977).

As indicated in the personal reflection at the beginning of this chapter, a number of drivers were influencing professions within the NHS. Firstly, there was a growing realisation that doctor numbers were declining and there would be a shortfall of specialists in hospitals (National Health Service (NHS) Management Executive, 1991). Secondly, a reduction in junior doctors` hours and rationalisation in training following the introduction of the Calman-Hine system as part of the New Deal created debate within the profession (Department of Health, 1993a; Ham et al., 1998; NHS Management Executive, 1991; Wong, 1995). Thirdly, that nursing truly lacked a positive clinical career structure with no opportunity to remain as a clinical leader (McGee, 2009). Nursing needed development, and the pressures outlined above provided the impetus for nurses to take on enhanced clinical roles (Woods, 1998; Woods, 2002; Schoba & Affara, 2006). Hewison (2009) identifies that the 1990s saw a range of policies which focused on role change for nursing. Key to this were the United Kingdom Central Council for Nursing Midwifery & Health Visiting (UKCC) documents, Scope of Professional Practice (UKCC 1992b) and Code of Professional Conduct (UKCC 1992a), which aimed at changing the focus for nurses where their accountability moved from doctors to themselves. The result was that nurses gradually took on tasks that were previously the domain of medicine through a framework of advanced nursing practice. This was subsequently developed by the government with further policy to establish this (Department of Health, 1993b, 1997, 1999a).

Advanced practice had already been evolving in the United Kingdom since the late 1970s and early 1980s (McGee, 2009). The role and function of many nurses was guided by the Department of Health or professional bodies, such as the British Medical Association (BMA), General Nursing Council (GNC) and Royal College of Nursing (RCN). For example, the Briggs Report (Department of Health and Social Security (DHSS), 1972)

examined those areas where nursing and medicine overlapped, with the recommendation that any medical task to be undertaken by a nurse should be part of their post-registration education and training. The guidelines issued by the Department of Health in 1977 (DHSS, 1977) to health authorities provided the legal and practical framework to perform extended roles. This was given a further boost in 1997, when the Health Secretary for the NHS set about a radical reform programme (Stevens, 2004). With £billions of investment, key reports from the Department of Health (Department of Health, 2000b), NHS Modern and Dependable (Department of Health, 1997), Keeping our NHS local (Department of Health, 2003) and Our Health our Say (Department of Health, 2006b) indicated that significant reconfiguration of health services would be required to offer value for money and deliver choice to patients (Dixon, 2004). The vision set out a primary care led, health promoting service that differed from the hospital-based, illness and disease management approach of the past. This would lead to reconfigured flows of patients and finances, and three key issues emerged. Firstly, a realisation that increasing technology and pharmacology costs in healthcare would continue to rise and services would need to be evaluated on a cost basis. Secondly, power could no longer rest with the professions to decide service provision (Stevens, 2004) and devolvement of power to the patient would drive efficiency through choice (Appleby & Dixon, 2004; Greener, 2003). Thirdly, traditional professional models of care were outdated and the new NHS would require innovative use of staff with adaptability to ensure that the organisations remain competitive. For this to occur it would require changes to the traditional roles and functions of healthcare staff. Politically the government made it clear that the closed market of the NHS would be opened up to competition to provide extra impetus for efficiency gains (Dixon, 2004).

Within this complex policy mix, the most significant challenge for the NHS was the New Deal for doctors training (Department of Health, 1993a), European Working Time Directive (EWTD) (Council Directive, 1993/104/EC) and Modernising Medical (MMC) and Nursing Careers Frameworks (MNC) (Department of Health, 2004a; Department of Health, 2006a). EWTD saw a significant change to the role of the junior medical staff in the NHS. Their hours would be limited to 48 per week, with limitations on their level of service commitment. However, it offered an opportunity for other healthcare practitioners to deliver some of the activities previously the domain of medical staff, including bedside leadership.

It is evident that the NHS has undergone a significant shift in emphasis in the use of its workforce. This approach mirrors some of the economic drivers exhibited in other developed economies, in relation to patient choice, rising costs and technology (Beekun & Ginn, 1993). However, within the NHS there is a strong professional divide between medicine and nursing despite new roles bridging this with greater integration and clinical working. The higher level capability and medicalised skills set has meant that the traditional power relationship of the doctor-nurse has also undergone change and development. Since the earlier work by Stein (1967), Hughes (1988) and Porter (1991) which examined nurse-doctor relationships, much has changed in both healthcare and society as a whole, particularly regarding the role healthcare plays in society. However, little empirical evidence has been added to aid the understanding of current trends and assist in the development of sociological theory from the perspective of the doctor-nurse debate.

Porter (1991) succinctly describes how the understanding of power theories in nurse-doctor relationships can only be extrapolated by comparison of similar studies in different environments. Porter (1991) describes that studies should:

> *'Constitute a triangulation point in the topography of nurse-doctor interaction.' - Porter (1991), page 728*

This study will provide such a triangulation point in the debate and develop a working model of advanced practice - doctor interactions. In addition, the problem addressed by this study is that models of power and communication in the literature are dated in the context of the nurse working at an advanced level in the modern healthcare environment.

The study reported here aimed to enhance the current understanding of the communication and power dynamics in the relationship between doctors and advanced practice nurses in acute hospitals by:

- Exploring the creation, development and division of labour of the advanced nursing role in the contemporary healthcare setting.

- Identifying and examining the use of knowledge and development of expertise in the relationship between doctors and advanced nurses and how this is used in the clinical setting.
- Exploring power within these roles and its wider impact on clinical teams of doctors, nurses and other healthcare staff.
- Understanding how this translates into communication strategies and behaviours between professions in clinical practice.

The scope of the study

The research study was undertaken over a period of four years, from 2005 to 2009. The original intention of the study was to compare two sites, with different systems of clinical practice and organisational cultures so that a true sense of the relationship could be gleaned. During the study, a change of employment by the author required a further site to be added. The additional site proved to be different in its organisation and politics and thus a further stream of evidence could be factored in.

This study reflects upon the relationship, communication strategies and decision making of doctors and advanced practice nurses working in acute hospital settings and therefore cuts across the care they deliver to patients each and every day. Although the patients are part of the scene and an integral part of the transactions that occur, they have not been directly researched as part of this study. They are an important aspect to any healthcare relationship, but the scope of the study was not wide enough to include them and this must remain a future aspect of inquiry.

Organisation of the Thesis

The preliminary review of the literature was undertaken to specifically aid the reader in understanding the current body of evidence. This is discussed in detail in Chapters Two and Three.

This critical realist ethnographic study employing observation, interview and artefact analysis was a suitable methodology with which to explore the research question. It was also an ideal method through which the aims of the study could be met and important synthesis of information and meaning drawn. As these were chiefly exploring the relationship, activity and communication between the doctors (consultant and junior) and those nurses who were working as advanced practitioners, it facilitated the gaining of an interesting perspective on the life and work of the hospital social space. In addition, it developed a contemporary understanding of the lived experience of the specialist practitioner and doctor within the hospital system of the NHS. The research process is described in detail in Chapter Four – Methodology, and Chapter Five - The context of the research. The findings of the study are presented in Chapters Six to Nine, where the main themes to emerge are discussed. The main themes were: the new relationship, the work domain, the division of labour and development of expertise, and interaction in the field of practice. Finally, the thesis concludes by bringing together the findings in a discussion in Chapter Ten - Summative discussion. This is before drawing final conclusions in Chapter Eleven - , including the implications of the study for future practice, research, policy and education.

Chapter Two - Review of Literature (Part I) – Power, knowledge and the healthcare professions

Introduction

There have been a number of changes in UK health policy and society over the last twenty years that have driven a fundamental shift in the balance of power between the state, professions and the patient.

There has been a debate in the nursing and sociological literature on the power relationship between nurses and doctors for decades. The origins of the debate are deeply rooted in the pursuit of a sociological rational model of the wider construction of society, healthcare and individuals who work and interact in these environments. Wright Mills (1959) identifies that concepts of power should look to understand the historical context and nature of power with reference to the individual and their consciousness. It is clear that trying to reduce and distil a single framework of the dynamics and power between nurses and doctors will be challenging.

An iterative search process was completed based upon an adapted form of the Brettle & Grant (2003) spiral search strategy combined with Hart's (1998) literature review process. The initial search was completed between May 2005 and January 2006, with two subsequent reviews following initial analysis of the first phase literature. A second search was completed in June 2008. A final review was undertaken between February and June 2010, with further work undertaken during the initial drafting of the thesis. To ensure that a comprehensive range of literature was available, academic databases were used based upon key word searches as outlined in Appendix 1, page 344 to 352. These included traditional medical, nursing, as well as sociology, management, psychology, economic and thesis databases (Medline, CINHAL, PSychinfo, British Nursing Index, ASSIA, IBBS, SocIndex, ERIC, Socialcare online). In addition, a number of Internet-based searches were completed to ensure that other material such as reports and discussion documents from a variety of government and professional organisations were included.

A structured approach was used in the review of the literature based on Hart (1998) for academic work and an adapted model of policy analysis by Musick (1998). Musick (1998) identified that policy analysis is an important tool for the researcher with two distinct activities: to review and critique the contents of the policy document, and understand the construction and process by which the policy was created. Musick (1998) outlined the key components which examine the conceptual and theoretical basis of the policy and its economic, political, cultural, ideological, historical and legal impact.

In construction of both the literature review and the discussion, the work has been structured specifically in to two main chapters to aid the reader in understanding the author's reduction of the evidence (Figure 1).

Chapter 2 – Section 1 - Understanding Power – a global concept in healthcare

Chapter 2 – Section 2 - The construction of power in healthcare

Chapter 2 – Section 3 - Power, knowledge and the professions

Chapter 3 - Power dynamics in the 'Doctor-Nurse Game' and advanced practice
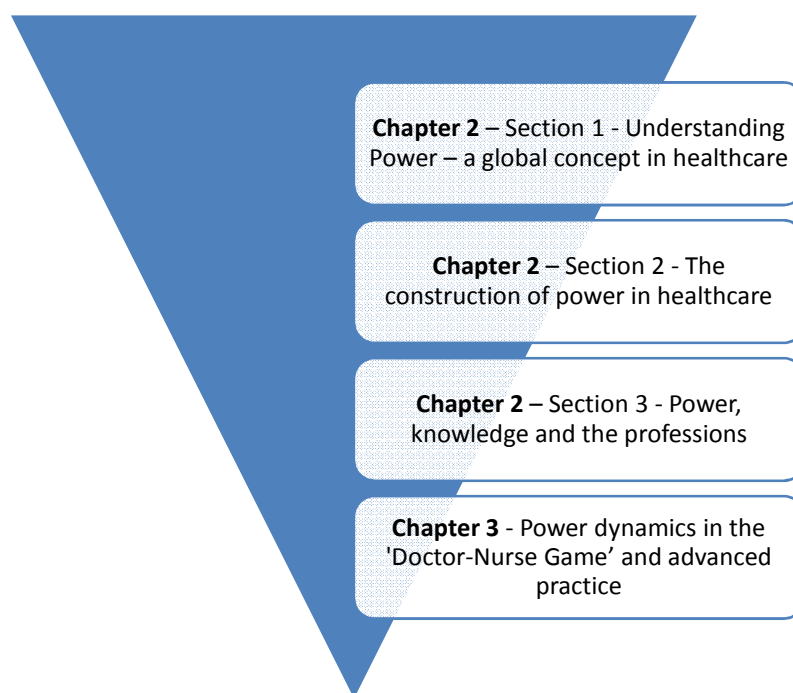
Figure 1 - Structure of the literature review

Chapter 2 - section 1 will explore the concept of power and seek to understand its basis in the sociological literature. Understanding power from this perspective before embarking upon a more detailed look at power in the relationship between doctors and nurses has wider benefits in understanding the research question addressed in this study. This

section will draw from a range of work including Dahl (1957, 1961), Bachrach & Baratz (1962), Lukes (2005), Foucault (1975, 1977) and Bourdieu (1977). This broader view of power will set out the basis of the thread the author aims to weave through the subsequent sections and chapters.

Chapter 2 - section 2 examines how social theory has evolved to understand the complexities of the construction of power in healthcare. Marxist (Navarro, 1978), Parsonian (Parsons & Turner, 1991) and Weberian (Weber, 1968) models are remarkably resilient in health sociology, but this section will also review the feminist perspective and its influence in understanding power. Gender and power will be discussed in more detail including the seminal work on emotional labour by Hochschild (1979, 1983, 1990). Gamarnikow's (1978, 1991) work will be updated with contemporary research from Smith (1992, 1999), Gray (2010) and Theodosius (2008). Goffman's (1959, 1961) view of the ritual and practice of the individual has been applied to healthcare in many papers, but it is useful to re-examine it in the context of this study.

Chapter 2 - section 3 examines the dynamics between the concepts of power, knowledge and the health professions. It will touch upon the key concept of professional power through its control of knowledge and of modern values placed upon knowledge and empowerment. Whilst one is obviously drawn to Michel Foucault (Foucault 1975, Foucault 1977, Foucault 1980), his broad theory needs to be understood in its influence of the professions under study. Freidson (1970, 2000), Antrobus & Kitson (1999) and Kitson (2004) are also influential as they focus on professional power and dominance in healthcare and assist in understanding concepts of professional power and interaction within organisations such as hospitals. In addition, this section specifically focuses on the professions and their work domain, organisation of care, hierarchies, socialisation and networks. This is developed further with particular reference to the influence these have on power dynamics, professional dominance and behaviour. This must include an understanding of the state and role of the patient in creating the structure and rules by which nurses and doctors transact their care and the influence they have on modern practice.

Finally, Chapter Three will review the evidence in relation to the micro interactions and models that exist in nurse-doctor interaction. This section will include a critical analysis of

the classic texts on the subject including Stein (1967, 1990), Hughes (1988), Porter (1991), Mackay (1993), Svenson (1996) and Allen (1997, 2001a). However, little has been added on the subject in recent years, and (in one respect a reason for undertaking this study) it is important to reflect on the direction of travel of current research. More contemporary published accounts have examined the nuances and influences of the relationship in either different settings, such as Snelgrove & Hughes (2000) (Medical wards), Carmel (2006), Coombs & Ersser (2004) (intensive care), Riley & Manias (2002) (operating theatres), or from a particular sociological standpoint, such as Gjerberg & Kjolsrod (2001) with their feminist view. This section will also develop a stronger understanding of the meaning of advanced practice work utilising published work from McGee (2009) as well as theses from Woods (1998) and Ball (2000).

However, power has been addressed from many vantage points (philosophy, sociology, economics and political theory) and it is apparent that they have become blended over time. In reviewing the literature it is not clear where the boundaries and demarcations of power theory exist between philosophy, sociology, economics and political theory. It is inevitable that in developing a literature review it is therefore challenging not to include a number of elements from each of these fields.

Section 1 - Understanding Power: a global concept in healthcare

Power – a definition

The central concept of this thesis is the nature of power and its capacity to shape and define the relationships that exist in the healthcare environment. Few problems in social theory are more complex and perplexing than the concept of power. Power and its influence is not an insignificant problem and as Isaac (1987) states:

> *'A great deal of ink has been spilled debating the meaning of the concepts of power.` - Isaac (1987), page 4.*

Boulding (1989) indicates that power has many meanings, including the ability for it to produce change. He further states that power 'is of great importance to humans and social systems ……. For individual humans beings, power is the ability to get what one wants'.

Etymologically, the word power emerged in the 13th century from the old French *poueir*, from the Latin *posse:* 'be able, have power'. However, power emerged as a concept prior to this. Michael Mann (1986) in his excellent treatise, *Sources of Social Power*, highlights that even in early pre-history, man developed social structures within which had emerged forms of stratification, ranking and power between its members. The evolution of organised societies such as the Mesopotamian, Egyptian and Mesoamerican are well documented hierarchical systems of social organisation based upon powerful elites in both liberal and economic forms. In more formalised classical civilisations, such as Greece and Rome, records emerge describing power through literature, mythologies and histories. Aeschylus's play *Agamemnon* describes Clytaemnestra's powerful rise against her husband Agamemnon whilst he is on expedition to Troy to capture Helen - an enduring Greek mythology of power, love and betrayal. The classics of Virgil, Homer, Aristotle and Herodotus describe the nature of power in these early civilisations through an emerging political system, a ruling elite, economics, knowledge and philosophy. Sun-Tzu defined Chinese militarist power and strategy in the classic, *Art of War* in the 2nd century BC, which is still influential today in political and leadership literature (Beuno de Mesquita, 2002). Early European work on power from Machiavelli (*The Prince*, 1532) and Hobbes (*Leviathan*, 1651) combined elements of political power and philosophy.

The relationship between this early philosophy and emerging discipline of sociology is clear in the 19th century. Marx and Weber, as the architects of social theory, explored relations within society based upon their experiences and empirical work.

Classical Marxism identified power and control expressed through the analysis of the development of industrial capitalism. This placed importance of capitalist power on the private control of the means of production and the oppression of the workers through a class system (Marx, 1974). Although Parkin (1979) challenged this, suggesting that class distinction and boundary were more distinct then, they have become blurred in contemporary social systems making direct application of Marxism more challenging.

Bourdieu also highlighted that 'capital' value in contemporary systems had a broader base than just its economic form. However, from the perspective of medical power, class was more resilient in the professionalised system, and its influence on health and illness was important but not re-evaluated in the literature until the 70s and 80s. Neo-Marxists such as Navarro (1978) and Johnson (1977) explain power and professions more effectively and are discussed as the basis of more contemporary work and debate in the second section.

Weber's (1968) contribution is also significant and centred upon many concepts of social organisation and power. He disaggregated class into subdivisions including social, status and party (which has particular resonance with Bourdieu's (1984) 'tastes' which will be discussed later in the chapter) which were ciphers for the operation, respectively of the market, social esteem (religion, caste) and political influence/power. He also defined the 'state' and its power over agents in the system through political leadership, going on to define their characteristics and ideologies (religious, professional, gender etc.). Weber importantly understood that this social organisation and dominance created an elite through which it managed by the bureaucratisation of society and is:

> 'fundamentally a domination through knowledge'. - Weber (1968) , page 225

These grand theorists have an important influence on the theory of power which has been developed by many contemporary commentators and social theorists and has been woven into the subsequent review with more contemporary analysis. Critically, power itself was recognised as a broader product of these systems, its effects measured and its architecture studied - but it was rarely examined as a singular concept. As Morriss (2002) identified, in understanding concepts and the meaning of power it is vital to answer three main conceptual questions: Firstly, how is power used and shaped to achieve the desired outcome in practical contexts? Secondly, in what moral context does power operate so that we are able to determine the extent of its impact and consequences that affect others? Thirdly, how can we evaluate power to understand the degree to which change occurs between the people in the power relationships?

A revival of interest in the concept of power during the 1950s broadly concentrated upon answering many of these questions. Although literature emerged from the traditional sources of philosophy, sociology, economics and political theory, they had become blended over time. Sociological examples of this include: Wright Mills' (1959) mix of political and social theory, Dahl (1957) and his concept of power using economic, probability and political theory, and Foucault's mix of philosophical and social positions. Most notably from the point of view of theory, in contrast to previous work, the enabling nature of power and the possibility for its ability to transform the lives of those within its influence, rather than oppress, started to be debated. Within this, two main sociological discourses regarding the importance of the role in the structure (socially organised systems that influence or limit choices for individuals) and agency (capacity to act individually) remained.

Both influential theorists, Boulding and Lukes used the terms 'three dimensions/faces of power' to describe their categorisation. Lukes' contemporary view of 'dimensions' neatly encapsulated his conceptual positions (decision making, non-decision making and shaping desires) with the historical development of power theory and the contemporary debate. Lukes appears to bridge the boundary between the traditional discourse and more contemporary notions of power discussed above. Lukes' dimensions conceptually take power forward and provide a theoretical starting point for the discussion of power theory in relation to this study.

The first dimension

One of the first significant contributions to social theory of power was Wright Mills, who described the power elite in North America during the 1950s. Wright Mills (1959) discussed a conceptual shift in the organisation of society from the ruling/upper class (i.e. royalty, hereditary power) to a power elite. Sociologically what characterised the power elite was an individual or group that exerted influence over others through ownership of resources, political influence and proximity to the systems of state. The maintenance of equilibrium of power could be preserved through a system of negotiation and influence that produced influential families and dynasties (Acemoglu & Robinson, 2001; Acemoglu & Robinson, 2006).

In contrast, Robert Dahl (1957) published his *Concept of Power* in 1957. Dahl was influenced by economic and probability theory and concentrated specifically on the interaction model within power situations. He describes his simplified concept of power thus:

> *'My intuitive idea of power then, is something like this: A has power over B to the extent that he can get B to do something that he would not otherwise do.'* – Dahl (1957), page 203

Dahl is clear that power is based upon individual relations and therefore agency, making reference to the basis of power as being inert, passive and therefore to be exploited by the individual for effect. Dahl also indicates three main functional properties of power: a time distance between the actions of A and the response of B, a form of connectedness between A and B and an amount of power, both positively and negatively to be employed in situations. He indicates five factors in power comparability:

- A power differential between A and B
- Differential in the means to use the power
- Difference in the scope of their power
- Differences in the number of responses
- Differences in the change of possibilities.

Fleming & Spicer (2007) regard Robert Dahl's theory as a riposte to Wright Mills` (1957) structuralist view of power. He extended this with an ethnographic study of power in a US city (Dahl, 1961) and further cemented his view above of the bi-directional perspective of power. Both Wright Mills' and Dahl's work have identified a functional description of power relationships, albeit one in the context of a community and the other in mathematical probability. As such they have both created an enduring legacy in the creation of power concepts in social theory although with a differing approach to empirically measuring power. The concept of individual power is critical, as Mann (1986) identifies in the sources of social power. He states that power is intrinsically linked to the creation and maintenance of systems for organising society, be it through ideological, economic, militarist or political means, a viewed shared by Boulding (1989). Mann (1986)

identifies a paradox in that whilst humans are the primary source of power, power itself may not be a human goal at all. It is an emergent need in the course of satisfying some elemental desire, be it affection, wealth, prestige or sexual fulfilment.

A typology of Power

It was during this period that an important perspective on power emerged from psycho-social theory (French & Raven, 1959). Although not a definition of power, it was a typology that has crossed many disciplines to become an orthodox perspective known originally as French & Raven's Five forces of Power. French & Raven (1959) suggested that social power had the potential for influence that stemmed from five different bases - reward, coercion, legitimate, expert and referent.   They added a sixth known as information or persuasion in 1965, and made further subdivisions and additions in later years (Raven, 1992; Raven, 1993) - see Table 1. There are several main points to discuss from French & Raven's typology. Firstly, it is largely individualistic and follows a similar pattern to that of the pluralists. Secondly, there is a significant socio-economic influence from their language (i.e. supervisor) and hint at structure although this is not made explicit. Thirdly, they align with the perspective of Dahl in the context of 'power over' in their use of the supervisor, although they do account for the ability of the subordinate to make choices. In addition, French & Raven are explicit in their original text that:

> 'Our theory of social influence and power is limited to influence on the person, P, produced by a social agent, O, where O can be either another person, a role, a norm, a group, or part of a group.' - French & Raven (1959) , page 346

It flits over the often bureaucratic organisations or systems in which it operates. Finally, even when they are subdivided, no sense of the moral perspective of power is apparent - only the assumption that the supervisor (A) influences the subordinate (B) in a positive or negative way.   Although much fieldwork has validated their work (Podsakoff & Schriesheim, 1985; Matthews et al., 2006; Ryan & Sysko, 2007; Bartos et al., 2008; Canter, 2001), it still remains a typology and does not satisfactorily account for a number of issues in power.

Basis of Power	Further Differentiation
Coercion	Impersonal Coercion Personal Coercion
Reward	Impersonal Reward Personal Reward
Legitimacy	Formal Legitimacy (Position power) Legitimacy of Reciprocity Legitimacy of Equity Legitimacy of Dependence
Expert	Positive Expert Negative Expert
Reference	Positive Referent Negative Referent
Informational	Direct Information Indirect Information

Table 1 - French & Raven's later subdivisions of Power typology

The second dimension

Early theorists were challenged by Peter Bachrach and Morton Baratz (1962) who explored a second face of power. The first face of Mills and Dahl was overt and seen within the communities that it operated. It could be measured and described by the direct impact from one person to another. However, Bachrach and Baratz (1962) described a second face of power which was more covert and hidden and used 'non-decision making' as a tool to control behaviour. They challenged the pluralists on three main issues. Firstly, that there were power structures in which people operated. Secondly, that social systems were inherently unstable unlike the pluralist view of a stable power system. Thirdly, pluralists wrongly equated reputed power with actual power. This development raised the intriguing aspect of a group or societal awareness (or lack of it) of the effect of power on the value and belief systems which maintained order. They described their theory of 'mobilisation of bias', where

> `to the extent that a person or group—consciously or unconsciously— creates or reinforces barriers to the public airing of political conflicts, that person or group has power`. - Bachrach & Baratz (1962), page 949

They created a typology of power labelled coercion, influence, authority, force and manipulation. There were many critics of Bachrach and Baratz's work, led by Stephen Lukes (1974) who challenged a two-dimensional view of power. He states in *Power: A Radical View* (Lukes, 2005) that the second face was incomplete on a number of counts. Firstly, he suggested that the mobilisation of bias is not sustained by a series of individual actions but is shaped and formed by the social structure and cultural patterned behaviours of groups, practices and institutions. Lukes likened this to a romanticised Weberian (Weber, 1968) view that individuals realised their will despite the resistance of others. Secondly, Lukes identified that the first and second faces of power rely on observable conflict even though power play may not continually involve this such as mass media, where power is exerted by controlling information and socialisation.

The third dimension

Lukes proposed a third face, where power to prevent conflict was created by shaping agents` perceptions to accept a social system of control. He defines this element as latent conflict and is a central component of his third perspective, along with the concept that power is dynamic and flows between individuals depending upon situation, timing and interests. He explains this with Dahlian notation:

> *'Power can be exercised by A over B in B's real interests. That is to suppose there is a conflict between the preferences of A and B, but that A's preferences are in B's real interests. To this there are two possible responses: 1. That A might exercise 'short term power' over B (with an observable conflict of interests), but that if and when B recognises his real interests, the power relationship ends. Or 2. That all or most forms of attempted or successful control by A over B, when B objects and resists, constitute a violation of B's autonomy: that B has a real interest in his own autonomy, so that an exercise of power cannot be in B's real interest.' - Lukes (2005), pages 36-37*

Lukes adds a very valuable point, in that, power is dynamic and can be bi-directional and positional. He highlighted that an 'exercise fallacy' exists where power is often seen from the negative viewpoint and as a form of domination, neglecting power that is productive,

transformative and compatible with dignity. Power is invariably viewed from diametrically opposite positions such as male/female and this is common within feminist literature including Beauvoir (1974) and Gamarnikow (1978). This argument is developed by more contemporary feminist writers such as Young (1990 a, b) and Marchand & Parpat (1995) who have recognised that definitions by opposites and domination may add little to theory development and lack recognition of power as a resource for women in modern society. In addition, there are macro and micro consequences of power for the individual or as a collective/social structure. Conflict can precipitate a chain reaction over time where greater knowledge, learning and changes in social structure can erode power.

However, Lukes fails to fully address the issue of the structural perspective of power. Hayward & Lukes (2008) wrote a paper where they debated their different theoretical positions. Hayward challenged Lukes view, with her structuralist perspective:

> *'When agents act, they act within the limits that are set, in part, by the actions of other agents. At the same time they act in contexts that are structured by rules and laws and norms: social boundaries to action, which – not unlike the action of other agents – limit what they can do and what they can be. As agents act and interact within structural limits, they develop expectations about what it is that one does, and what it is that one ought to do, in a particular context. They develop not just the subjective, but also the intersubjective, understanding of the meanings particular actions hold.' – Hayward & Lukes (2008), page 14*

The issue of structure and agency in power was key and required further theorising to take forward.

Foucault and the 'fourth dimension'

Foucault also rejected some of the assertions in the three faces model, putting forward his own theory. Foucault emphasised the emergence of power through relational processes and how this was connected through knowledge. Foucault illustrated this utilising the doctor-patient perspective in *The Birth of the Clinic* (Foucault, 1975). Foucault's main assertion was that power was not held or wielded by individuals or by structures, but had

a more nebulous quality. Agents were constituted *through* power, and their actions (and outcomes) contribute to the operation and organisation of power.

> *'Power is everywhere: not because it embraces everything, but because it comes from everywhere. Power is not an institution, nor a structure or possession. It is the name we give to a complex strategic situation in a particular society.`* – Foucault (1977) , page 93

Appealing to this thesis is the concept that Foucault proposed through knowledge and discourse.   Foucault suggested that power was more dispersed *by* and *within* the social system but it had an essential positive quality. In *Discipline and Punish* (Foucault, 1977) he identified that power was productive and individuals possessed intrinsic power, intention and a consciousness to use it. Foucault also introduced the power/knowledge debate which is an important perspective, and it is described by him as:

> *'Knowledge linked to power, not only assumes the authority of 'the truth' but has the power to make itself true. All knowledge, once applied in the real world, has effects, and in that sense at least, 'becomes true.' Knowledge, once used to regulate the conduct of others, entails constraint, regulation and the disciplining of practice. Thus, 'There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations.'* - Foucault (1977) , page 27.

His theory suggested that a belief system based upon knowledge and access to it can develop into a generalised view of the social system. It was held by those in positions of authority (not necessarily power) and those within the system (Foucault, 1977). Knowledge/power works in a uniform way and constructs a 'Hegemony' or prevailing view/truth of the way the world is seen. In time through discourse, this truth becomes a normalised way of viewing the social system, including the development of laws and social norms. Importantly, it also determines what is wrong, normal and deviant.

Foucault used many metaphors in his work, and an enduring one is the 'Panopticon', which signified this link between knowledge/power through the observation of people.

The Panopticon illustrated that the system had an inherent feedback loop and interconnectedness. Observation creates knowledge and therefore power in a cyclical feedback system defining the 'Medical Gaze' (Foucault, 1975). Foucault described the fact that medicine had a well-developed body of knowledge, which in many western societies was a normalised perspective on the human body. Many would argue, including Foucault, that this has been constructed by medicine to further their professional hegemony. Medical Gaze was a subjectification of the body and extension of control through an intrusive observation method in search of the pathology of illness. Clinical examination was the most overt form which was used by doctors to 'read' the body and classify illness through signs and symptoms of disease. Henderson (1994) suggests that this stripped away the 'human' perspective of the individual both in the physical management by the doctor with the patient, but also on a macro level by medicine on society through the organisation of care.

Crampton & Eldon (2007) discuss the fact that the physical geography is just as important to understand as is the care/medical processes– the Panopticon was as much a metaphor for the process as the structural organisation of power through knowledge. This perspective is helpful in examining medical dominance as it is closely linked to the physical space for caring of the sick, be it hospital or clinic. Rivett (1998) describes the development of hospitals as an important factor in professional power and leadership models of medical dominance, a view shared by Goffman (1961) and Prior (1988). Hospitals became, and still are, symbols of the social power of medicine, and the use of space is an important determinant of power (Prior, 1988).

'Closing the Gap' - Giddens and Bourdieu

There are a number of challenges to Foucault, most notably from Bourdieu (1977) and Giddens (1986). Bourdieu (1977) and Giddens (1986) share a number of concerns in that the structural elements of power are less well defined and aspects of agency such as resistance are not addressed by Foucault. Giddens in his work on structuration theory wished to close the gap between the two camps of Structure and Agency. Giddens first noted this concept in his work, *Central Concepts of Society* (Giddens, 1979) - where a 'Duality of Structure' existed, and he developed this further in *Constitution of Society*. This introduced the concept that whilst there are systems and structures in society, there is the

ability for people to act independently, replicating and intentionally setting up their own power structures. Part of this perspective comes from a rejection of Lukes` view that power and interest are linked although agents may not work in their own best interests (Giddens, 1979).

Giddens introduces to the power debate the concept of resistance. He understood that there are much wider structural systems influencing positive and negative perspectives of power interactions. There is a role for individual/agency behaviour related to power which works against the social system or other individuals who operate within it.   He also addressed the fact that people have tacit knowledge of rules and norms in society, suggesting that individuals and social systems have inbuilt capacity for understanding power. Perez (2008) has criticised Giddens as being too subjectivist, placing a highly optimistic view of the agent in their knowledgeability and reflexivity to control their own existence. In addition, he suggests that he has a loose and limited conception of social structure and other external constraints on the agent, a flaw that is rectified by another theorist, Bourdieu.

Guzzini (2006) calls Bourdieu 'Lukes-plus-Foucault' as he can provide the framework to handle the agency-structure divide and centrally include the performative analysis of power. Bourdieu's perspective on power is a combination of many elements of his thinking which developed into his 'Theory of Practice' (Bourdieu, 1977). Bourdieu himself encapsulated his concept:

[(Habitus) (Capital)] + Field = Practice

(Bourdieu, 1984, page 101)

Although Bourdieu recognised that social hierarchies were important, he rejected the fact that this was created by explicit economic or rational criteria. He suggested that the individuals or agents of the system vied for dominant position within a specific social space (field) through the accumulation/competition of forms of capital. The conflict and the dynamics taking place in the field are the observable forms of power. These can be captured empirically, as Bourdieu (1975) highlights:

> *'The structure of the scientific field at any given moment is defined by the state of power distribution between the protagonists in the struggle (Agents or Institutions), i.e. by the structure of the distribution of the specific capital, the result of previous struggles which is objectified in institutions and dispositions and commands the strategies and objective chances of the different agents or institutions in the present struggle.'* - *Bourdieu (1975), page 35*

The field also defined the physical space and was, therefore, an important representation of power. As Bourdieu (1989) explains:

> *'The objective structures that the sociologist constructs, in the objectivist movement, by setting aside the subjectivist representations of the agent, form the basis of these representations and constitute the structural constraints that bear upon interactions ....these representations must also be taken into account for the daily struggles which purport to transform or to preserve these structures.'* - *Bourdieu (1989), page 15*

Habitus is a set of internalised systems on how an individual understands and evaluates the social world they operate in. It confirms both a sense of awareness on the part of the agent plus unconscious reflexivity. Bourdieu evolved the definition of Habitus, through his interpretation of traditional sociological theory from Durkheim, Mauss and Piagetian theories of psychology (Lizardo, 2004), which he defined as:

> *'Systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them. Objectively `regulated' and `regular' without being in any way the product of obedience to rules, they can be collectively orchestrated without being the product of the organizing action of a conductor.'* - *Bourdieu (1990), page 53*

Habitus is the individual's development of a 'product of histories' (Bourdieu, 1977), and their trajectory though life. Habitus has a distinct Piagetian flavour to it, where schema are developed and over time influence perspectives, not only of the world but also the self (Lizardo, 2004). Through this, agents evolve and develop a sense of balance between the external structures and the internal schema, which he described as Doxa or 'doxic' state.

Forms of capital are arguably one of the most important aspects of Bourdieu's work on power. Bourdieu uses the term capital in a similar fashion to Marx, in that it is part economic, but adds other forms of capital including cultural, social, and symbolic. By doing so, Bourdieu opens the debate on power to include non-economic forms of domination and hierarchy. Much has been written about capital and its influence on and formation of power. Bourdieu (1986) describes capital as:

> *'Accumulated labour which when appropriated on a private basis by agents enables them to appropriate social energy... [it is] a force inscribed in objective or subjective structures, but it is also a lex insita, the principle underlying the immanent regularities of the social world. It is what makes the games of society.' - Bourdieu (1986), page 241*

Cultural capital in the forms outlined by Bourdieu (Bourdieu, 1986) is embodied, objectified and institutionalised. Embodied cultural capital is created through self-improvement and development: embodiment. The critical aspect of the embodied state is the time that is required to achieve it - it cannot be created by external wealth or gift. Objectified cultural capital concerns those objects that convey a sense of social position and authority including works of art, books and technology. This form of capital has an intrinsic value, as it can be traded or transmitted as well as economic capital. In addition, objectified cultural capital highlights the fact that this can occur with a purpose, as Bourdieu states:

> *'However, it should not be forgotten that it [objectified capital] exists as symbolically and materially active, effective capital only in so far as it is appropriated by agents and implemented and invested as a weapon and a stake in the struggles … struggles in which the agents wield strength*

> *and obtain profits proportionate to their mastery of this objectified capital.' – Bourdieu, (Bourdieu, 1986),   page 50*

In addition, institutionalised cultural capital is established though knowledge, skills and qualification, which leads to a status position within the field and social space.   Deeper analysis of Bourdieu's work on cultural capital highlights further aspects influential in the issue of power. Bourdieu (1984) suggests that cultural capital takes on additional forms - the credentials, preferences and behaviours that are conceptualised as 'tastes'. Bourdieu (1984) argued that this development created a further social stratification and potential advantage for agents.   His empirical work understanding French cultural taste in *Distinction* and *The field of cultural production* (Bourdieu, 1984, 1993b) identified distinct class tastes. Upper-class taste was characterised by refined and subtle distinctions, and it places intrinsic value on aesthetic experience.   Bourdieu (1984) created theoretical schema through his research to map out the cultural variants and trajectories of dominant tastes, such as the example in Figure 2.
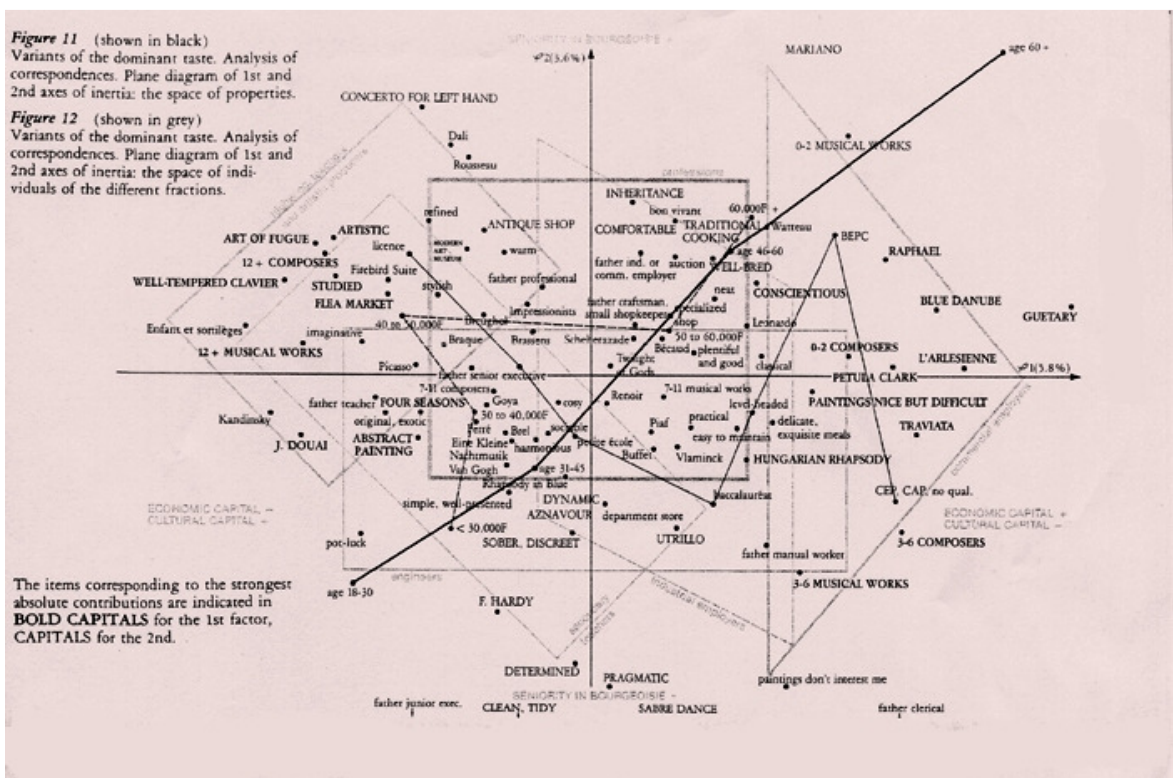
Figure 2 - Bourdieu's (1984) analysis of taste within French culture from *Distinction*, page 259

These schema were developed by Bourdieu using a geometric metaphor to describe the positions of value of various aspects of culture. The distinctions of cultural value are made on the Y axis of total volume of capital, and on the X axis of composition of capital, with more cultural capital being on the left and more economic capital on the right. In addition, Bourdieu added a third dimension on the Z axis; the Z axis is capital *trajectory* and its direction or change over time, the zero coordinate being any present (synchronic) moment of analysis (Figure 3).

Capital Volume (High) – Y Axis

Time - Z Axis

**+ Cultural
- Economic**

**- Cultural
+ Economic**

Capital Volume (low)
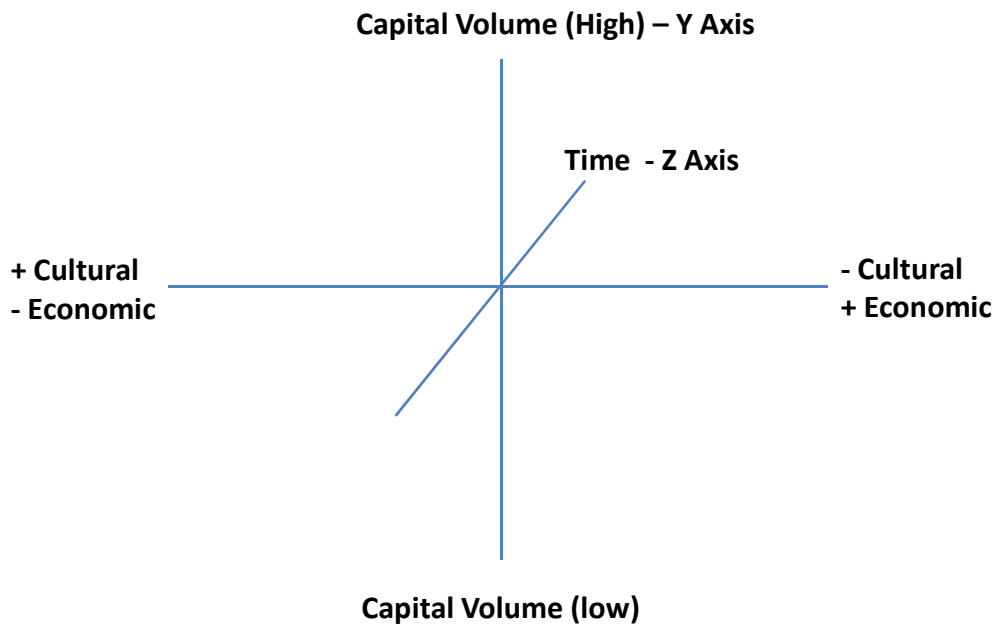
Figure 3 - Bourdieu's geometric schema for the understanding of cultural composition.

Importantly, tastes were acknowledged by other classes who sought to appropriate them as recognised by the society as important markers of high value cultural capital. Significantly, Bourdieu (1984) noted that whilst the middle classes emulated the tastes of the upper class, this was through a desire to recognise power and compete for social status rather than through any real authentic appreciation for aesthetics. The middle classes developed 'cultural goodwill' towards the tastes of the upper class in music, clothes, art, holidays and food. Bourdieu (1984) interestingly used two vignettes of nurses (MMe B., page 325 and Elizabeth F., page 356) to highlight what he called the 'petit-bourgeois':

> *The petit-bourgeois spectators ... can recognise the 'guarantees of quality' offered by their moderately revolutionary taste-makers, who surround themselves with all the institutional signals of cultural authority... Middle brow culture is resolutely against vulgarity.' - Bourdieu (1984), page 324*

The work of Lamont & Lareau (1988) is helpful as they translated some of Bourdieu's early work in schools to form the view that these 'cultural signals' of the dominant class were a marker of status. They describe signals as both material owned goods, knowledge, behaviours and attitudes. Bourdieu highlights that those with an existing cultural capital and higher status in the social space can continue in their dominant position through continued interplay between the accumulation of capital (in all its forms) and their habitus compared to those of lower status.

Bourdieu's Theory of Practice does go a significant way to bridge the Agency/Structure debate on power, although does not finally unify the concept as there are many critiques of his work. Perez (2008) indicates that Bourdieu does lean more towards the structural element of the debate and neglects individual ability to change social circumstance through collective social action. Sullivan (2001) also critiques his work on the premise that it lacks credible empirical support and is too nebulous a theory which ultimately affects its applicability to real social systems. However, Bourdieu has, unsurprisingly given his own work on schools and education, been favoured in the educational research arena (De Graaf et al., 2000; DiMaggio, 1982; Nash, 1990; Zanten, 2005). However, Bourdieu has seen little application in the field of health and medicine (Burri, 2001; Nettleton et al., 2008; Ohl, 2000; Tellioglu, H & Wagner, I, 2001; Lukes, 2003) and less in nursing (Brown et al., 2008; Giddings & Wood, 2003; Rhynas,2005).

Section 2 - The construction of power in healthcare

In section 1, global theories of power and how they relate to the wider agency or structure debate were discussed. This was an important building block to understand how power operates in the healthcare setting. To expand this, it is useful to gain an understanding of

the social structures in which the agents in this study (doctors, nurses) operate. However, this is challenging due to the sheer volume of applicable work in this area and will require specific focus on medical dominance, nursing development, professions and organisational influences.

Medical dominance, power and the social system

A pivotal concept within the dynamics of power in health sociology is the authority that medicine has in society. Turner (1995) suggests that the influence of medicine was not fully explored until the 1970s and 1980s by the neo-Marxist movement who added the further dimension of social power and the political economy. Commentators such as Navarro (1978) developed neo-Marxist ideology of medical power, where the complex relationships existed to improve capitalist accumulation. Navarro (1978) developed four main arguments to illustrate this relationship and the influences it had on the wider context of society as: the positive and negative interventions of the ruling class, the ideological cause and character of illness, the dominance of class and social order in relation to health and the repressive and coercive regimes to reduce conflict with the dominant power. Navarro (1978) and Johnson (1977) felt that the medical profession were the agents of control within this system and manipulated it to maintain their professional dominance.

In contrast to Marxist perspectives, Turner (1995) highlights that others represented medicine as a more liberal profession which was the embodiment of 'institutionalised altruistic values'. The Parsonian features (Parsons & Turner, 1991) of medicine were a developmental enhancement of Durkheim`s (Durkheim, 1964) work. This saw key changes in the approach that individuals had to their own function and their capacity for the creation of stability and order within a community. Turner (1995) describes this as an important alternative to:

'The rational egoism of the capitalist market.' – Turner (1995), page 129

Key to the Parsonian model was that professions shared certain features which looked to functionally control specific tasks such as: creation and restriction in the domain of power, application of impersonal standards and the shared ethic of disinterested service.

The emergence of the feminist perspective has led to contemporary critiques exploring medical power and has important implications for nursing where medicine is largely based upon a male- dominated hierarchy and the category of women is 'hidden'. The Marxist and Weberian perspective focused on domination as a general issue in society, but lacked the ability to distil notions of race, gender and culture. However, Navarro (1978) redirected his thoughts to gender issues and suggested that the economic and social role of the family determines the sexual division of labour. Importantly, Marchand & Parpart (1995) felt that Marxist views disregarded gender, despite making distinctions between work within the home and paid employment. Hirschmann (1995), a Marxist feminist, stresses that the concept of the oppressed worker should not be ignored and that it is important to view this social construction from the oppressed vantage point. Oppression in terms of nursing's relationships to medicine is a useful concept to explore and will be discussed later. Critical feminists such as O'Brien (1981) identify with this and suggest that there has been an orchestrated intellectual oppression of women by the 'malestream', particularly from the view of theory development.

Categorising gender in social theory

The term gender for the purposes of this review should be understood by using the following framework. Firstly, the concept of gender is a relevant and important factor in the creation of power in the development of the nursing profession and its relationship with medicine. Secondly, a great deal of debate in the literature has identified a distinction between sex and gender (West & Zimmerman, 1987). Sociobiologists such as Sydie (1994) identified a biological basis of sex differences compared to the feminist thinkers delivering a transformed category of 'maleness' and `femaleness'. Crabtree's view (1999) is that gender has been embedded in our ordinary language and society, thus opening the way to examine differentials between gender partners – man/woman –

doctor/nurse. Sweet & Norman (1995) identify with this and suggest that such powerful sexual stereotypes are a fundamental aspect of any person's identity. Thirdly, the development of postmodernist theory is influential in the gender debate as Marchand & Parpart (1995) suggest that this has enabled the dismantling of labels in society.

Derrida (1976) believes that western philosophy is based upon opposites such as Truth/Falsity and Man/Woman, where the first term is perceived as superior and the second is measured against it. Foucault (1975) also identified the power relationship in the language used by individuals, particularly in medicine, as a form of social control. Despite nursing sharing a fundamental framework of language with doctors, it does suggest that it is used in a way to exclude and oppress within society and healthwork. Young (1990 a, b) and Marchand & Parpart (1995) highlight that the focus on difference created by postmodernism undermines feminist principles. To examine the intrinsic subject rather than the object is an important distinction in the search for power relationships between nurses and doctors. Butler (1990) links gender and power due to the feminist convergence attitude to biological determinism and social construction. Butler (1990) sees the 'body' emerging through social iteration of 'sex' within the hierarchy of power relations. The practical implication of this is the social exclusion of the female voice from influence. Carli (2001) believes that gender stereotypes are linked to women's role and status in society where men have more influence than women. Carli also notes that males in particular resist influence by women especially if they are highly competent communicators, and can be more successful as influencers if they display perceived feminine qualities, such as communality and warmth.

It is an ideal point in the literature review to examine the work of nursing and medicine and their interconnected development as occupation and profession. Despite what may appear a propensity of feminist literature, this concept must be explored within a social constructionist framework to help understand how doctors and nurses socially construct identities in the healthcare setting. By fully understanding the historical, social and cultural factors in their development, it provides an opportunity to analyse the construction and negotiation of multiple identities by professionals in the field of healthcare based on their professional, cultural, and gender characteristics.

The power of the nurse: patriarchy and sexual division of labour

The development of nursing can be viewed in two distinct phases - pre- and post-organised profession - each dominated by issues surrounding patriarchy, sexual division of labour and emotional labour (Denny, 1999). These are set within stages involving professionalisation, development of the occupation and professional socialisation. This is important as it provides the legacy on which contemporary nursing is based and its subordination to doctors. As McGregor-Robertson states:

> '[A nurse] must begin her work with the idea firmly implanted in her mind that she is only the instrument by whom the doctor gets his instructions carried out; she occupies no independent position in the treatment of the sick person.' McGregor-Robertson (1902), cited in Fagin & Garelick (2004), page 277

Helmstadter (2008) identifies with others including James (1992) and Gamarnikow (1978) that nursing in the late 18th and 19th centuries was largely an unorganised profession. Many nurses were uneducated working-class women whose role was that of domestic servant to the sick with no experience or training. They were supported by the matron whose role was primarily a housekeeper and often came from the lower middle classes (Warren & Harris, 1998). Helmstadter (2008) reviewed 16,000 historical documents on nursing in the early 19th century which identified that nurses faced:

> 'Complex issues of class, gender and the division of society into public and private spheres placed them at a disadvantage when negotiating with male hospital boards.' - Helmstadter (2008), page 11

The advent of the Nightingale Nursing School in 1860 was important but did little to challenge the recruitment from working-class sources. As Baly (1997) suggests, the school produced no significant nursing leaders, a fact largely ignored in the mainstream literature.

The link between class status and nursing has important overtones for nursing today. The classic paper by Gamarnikow (1978) states the 'character' of nursing was largely defined

by the patriarchal position of what a 'women of good character' was, a view supported by Warren & Harris (1998). This position was defined by a division of labour that was gender orientated. The subordination structure of the doctor/nurse/patient triad (Figure 4) was, as Gamarnikow states:

> *'[one] which comes to take on the ideological resonance of power relationships between men and women.'* Gamarnikow (1978) page 97.

As medicine was largely male dominated, men had significant control over the selection process and were unlikely to put in place the potential for a nurse to challenge this orthodox position (Witz, 1992; Hafferty & Mckinley, 1993; Walby et al., 1994). This also included barring entry into medical school (Stacey, 1988).

Doctor / Father

Nurse / Mother   **Patient / Child**
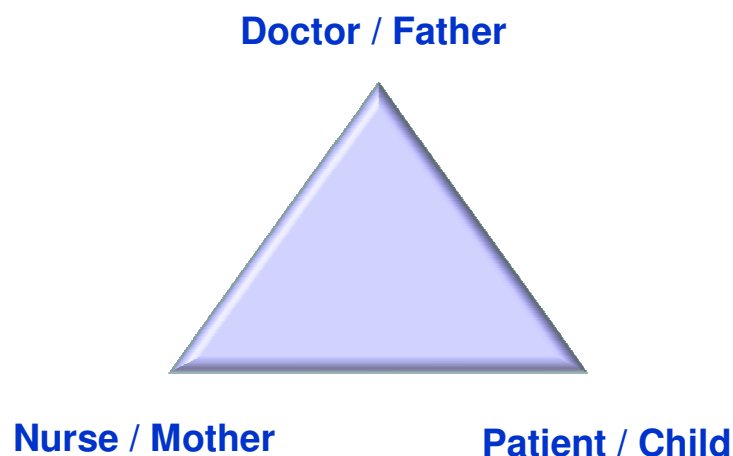
Figure 4 - The Doctor/Nurse/Patient Triad (adapted from work by Gamarnikow, 1978)

Hughes (1951) and Deveraux & Weiner (1950) also linked the emergence of nursing to the role women played within the home, particularly to caring and nurturing. Turner (1995) identifies that this was generated through biological determinism current at the time, but reinforced by figures in nursing history such as Nightingale – 'a good nurse is a good woman'.

Stacey (1988) suggests that central to this ideology is the concept of femininity. Carter (1994) links this inextricably to the patriarchal model that sought to preserve women's

biological femininity and 'natural' order within the home dominated by Victorian values. Such values illustrated as a triad between Father/Doctor – Mother/Nurse – Child/Patient (Figure 4) is a potent parallel that Turner (1995) suggests was made in the 1950s by Schulman (1958).

Garminikow's (1978, 1991) work on patriarchy has been influential in the nursing literature, and has underpinned work in the power and dynamics of nurse-doctor interactions such as Porter (1991) and Hughes (1988). Hartmann (1976), a critical feminist, describes patriarchy as:

> 'A set of social relations which has a material base and in which there are hierarchical relations between men and solidarity among them, which enables them to control women. Patriarchy is thus the system of male oppression of women.' – Hartmann (1976), page 138

Sweet & Norman (1995) agree with the general premise that female nurses were subordinate in the male-dominated medical system, confirming what feminists such as Oakley (1993) had understood for some time. However, Keddy et al. (1986) identified that many women uphold stereotypical gender behaviours for fear of the loss of femininity. Keddy et al. (1986) recognised that this view does not fully explain stereotyping and that social hierarchy and socialisation are important factors in maintaining patriarchy. Sweet & Norman (1995) insist that class domination and patriarchal attitudes are 'remarkably resilient' in the contemporary healthcare scenario despite the feminist movement and increased sexual equality. Female medical graduates increased significantly in the late 20th and early 21st century, with some UK based universities admitting a greater proportion of women than men (Royal College of Physicians, 2009). During the same period, nursing in the UK remained a predominately female profession and male nurse recruitment static at 10%. Showalter (1999) and Heath (2004) believe that examination of women's roles in medicine demonstrates that socialisation and hierarchy restrict female authority and power within the medical workplace. Kvaerner et al. (1999), in a comprehensive Norwegian study, found that even in a progressive society of sexual equality, women in medicine still have to choose between personal commitments and professional power, which mirrors the findings in other studies (McManus, 2001; End et al., 2004; Williams & Cantillon, 2001; Park et al., 2005). The increasing shift of gender

demography in medicine is well recognised, but only relatively recently been addressed (Royal College of Physicians, 2009).

Patriarchy, although an important element to the debate, is too simplistic to explain fully the subtleties in power relationships between nurses and doctors. Turner (1995) suggests that within the traditional western culture, patriarchy is fundamentally flawed in its application, as traditional Victorian domination included male as well as female. Turner (1995) adds that under this regime single males (sons and subordinate workers) were forced into a 'quasi female' status. Within healthcare, male nurses have been of interest to sociologists in the patriarchy and gender debates of doctor-nurse interactions. Savage (1987) found that doctors avoided male nurses due to the threat they posed to the equilibrium of the traditional patriarchal system, or projected qualities on them of assertiveness or confidence that were recognised with equality rather than subordination. However, feminisation and stereotyping of male nurses also appears to occur (Cummings, 1995; Egeland & Brown, 1988; Evans, 1997; Evans, 2004a, b; Williams & Heikes, 1993; Fisher, 2009), highlighting that gender and patriarchal systems in healthcare are complex.

From the previous section a fundamental part of the debate of the sexual division of labour remains the preoccupation with the issue of femininity and how this has been developed by sociological discourse for nurses. As an organised occupation in the 19th century, such delegated work as monitoring and cleaning became known as 'nursing the room' and legitimised the embryonic professional status (Denny, 1999). The 'character' identified previously perpetuated the hierarchical relationships of the home in the workplace. This does suggest that there was an element of self- regulation within nursing in terms of access to the profession, future employment and education. However, Keddy et al. (1986), in a grounded theory study examining the past experiences of nurses, found that medical power extended into nursing as the profession often educated, employed and ultimately defined what a good nurse was. This evidence suggests orthodoxy and structured dominance of nursing by medicine that went beyond gender to issues of socialisation and professionalisation which we will discuss later in the section.

The gendered work of nursing: emotional labour and emotion management

Further to the concepts of patriarchy and caring, Hochschild`s (Hochschild, 1975; Hochschild, 1979; Hochschild, 1983; Hochschild, 1990) seminal work in the airline industry identifies an emotional element given as part of service. There are two main concepts to understand: emotional labour and emotional management. Grandey (2000) described emotional labour as:

> *'A form of emotional regulation wherein workers are expected to display certain emotions as part of their job, and to promote organizational goals. The intended effects of these emotional displays are on other, targeted people, who can be clients, customers, subordinates or co-workers.'* - Grandey (2000), page 95

Hochschild (Hochschild, 1983), defined emotional management as:

> *'The management of feeling to create publically observable facial and body display.'* Hochschild (1983), page 7.

Hochschild (Hochschild, 1983) was heavily influenced by Goffman (1959) who suggested through the metaphor of the theatre, that individuals have the ability to present a view of themselves depending upon the situation and audience. Life was a series of performances in which there was an intention to present both an impression of one`s self and context to another person. Goffman (1959) suggested that humans create impressions through what he determined as *sign vehicles* which includes both verbal and non-verbal cues. Humans create *impressions* by our *expressions.* There are two different kinds of expressions:

1. The expressions we give, primarily the things we say, and the intentional poses, facial expressions (smiles, surprise, etc.) and other controlled body language we emit;

2. The expressions we give off, which are the elements of our expressiveness over which we have less control; the inconsistencies between what we say and what we actually do, the body language which `gives us away` in some situations.

There are many things that we can change to create the *front stage*, such as our clothing, mannerism, language, hair etc., and many reasons why a person may feel the need to do this in public. However, there is a *back stage,* such as our home, where these become less relevant or important to maintain. Hochschild (Hochschild, 1983) found it intriguing in that this more personal area was often exploited by commercial organisations. As emotional labour had economic value in exchange for work, it links with the Marxist feminist view of labour transactions. Hochschild went further by suggesting that this was specifically tied to the work of women in society where they took on roles that emotionally supported and nurtured men. The similarity of this to traditional expectations of women at home meant certain roles were prescribed for women in society, enabling them to extend their role into paid work. In the workplace, the subjugation of women would continue in the roles that gendered organisations gave to them.

Theodosius (2008) highlights that Hochschild never applied the emotional labour concept to nursing work, even though it had particular resonance with the profession. In the early 1990s Smith (1992) used Hochschild's framework to describe student nurses` experiences of emotional management for the benefit of patients. A number of other studies also explored the concept in nursing (Wharton, 1993, 2001, 2009; Wharton & Erikson, 1995; Froggatt, 1998; James, 1989, 1992). Theodosius suggests that Hochschild's original criteria apply to nursing as:

> *'All nursing work involves face to face or voice to voice interaction except in the cases where patients are unconscious. ..... Nursing work also requires nurses to consider the feelings and emotions of their patients (and their relatives), to engender feelings of safety and comfort, caring and protecting their dignity at all times. … The emotional care that nurses give is carefully taught during nurse training and monitored in a variety of ways.' - Theodosius (2008), pages 29 - 30*

Critically, Smith (1992, 1999), Smith & Gray (2001) and Smith & Allan (2010) identified that emotional context of care is taught, role modelled and developed during training forming part of the socialisation and cementing of emotional management in the work of the nurse. Glannon (2005) highlighted that in western healthcare systems this was an important skill to develop for therapeutic value in the complex and challenging delivery of modern nursing. This view is supported by other scholars who highlight its benefits to patients, organisations and the wider nursing profession (Meier, 2005; Gray & Smith, 2009; Smith et al., 2009). From the perspective of this study, emotional labour is often an intrinsic and expected component of the advanced practice nursing role (Waters, 2007; Leary et al., 2008). It has been particularly well developed as an explicit function in those roles that interface in cancer and end of life patients (McPhelim, 2009; Skilbeck, & Payne, S, 2003).

However, others (Merkel, 2002; McCreight, 2005) suggest that whilst it may be an integral part of the nursing role, it is not valued by the whole of the nursing profession. McCreight (2005) suggests that nurses are aware of the personal cost of emotional management, burnout and emotional exhaustion. Smith et al. (2009) suggest that recognising emotional labour at an individual and organisational level by nurse leaders is critical to ensure that the emotional well-being of the workforce (and, ultimately, patients) is maintained.

Lupton (1996) highlights that emotional labour places an element of power over the patient in the hands of the nurse. The nurse-patient relationship is reciprocal in that the patient receives care and gives back gratitude. What was seen and observed as a 'good caring nurse' often translated into a vocational and professional distance, particularly in the respect of demanding patients, death and illness which in turn often translates into gender stereotypes (Gray, 2010). This professional distance and detachment mediated control over the emotional focus created by the intensity of the deeply personal moment for individuals. Such was the attraction of this quality within nursing that it was reinforced within the Nightingale era and is resilient today in nursing and other care work (Taggart, 2011). It is still perceived as a positive quality, yet Warren & Harris (1998) write scathingly of the modern nurse not adhering to such values. They criticise this change in the 'social character of nursing' laying it at the feet of feminism and careerism. It is easy to disregard these views as populist, but they also highlight that informality and a corporate mentality with healthcare have deeply affected the traditional values of nursing.

As Gray (2010) suggests, gender stereotypes in professions and aspects of the gendered organisation are remarkably resilient in healthcare. Classic studies by Kanter (1977) and Acker (1992) offer interesting insights into how organisational cultures reinforce traditional roles through masculinisation of language, artefacts and behaviours. In other service industry sectors such as the airlines (Taylor & Tyler, 2000; Mills & Helms-Hadfield, 1998) and recruitment (Hawkins, 2008), masculinisation occurs through mission statements, branding and recruitment practices. As Hawkins (2008) found in her ethnographic study in recruitment, women in leadership roles had to either play 'games' to be heard, overplay the feminine role or masculinise their behaviours. These are interesting parallels to the health service, where a subsection of the workforce (nursing/cabin crew (female)) are de facto subordinate to (doctor/pilot (male)) role stereotypes (Figure 4, page 33), through the above mechanisms. Acker (1992) identified that organisational processes were gendered, setting up expectation through structures and behaviours that did not allow an alternative view.

On a final note on the debate of patriarchy and division of labour, Turner (1995) claims that despite the ideology of compliance and discipline there is resistance and conflict towards the traditional views of bureaucratic and patriarchal systems. There are a number of changes and challenges faced by nursing as it is becoming increasingly professional and autonomous in the face of rising patient expectation. This is particularly relevant when examining those nurses who transgress the traditional boundaries in advancing nursing practice.

The power of the patient

The relationship between the patient and nurse/doctor is seen in the literature as being a key component of care and well-being and the foundation of nursing practice (Hagerty & Putusky, 2003).

Shattell (2004) suggests that Parsonian (Parson, 1991) features of the sick role are still evident in medical and nursing literature, particularly where nursing is more task orientated and delineated along the biomedical model. As for patients, they accepted a

persona that was of a grateful and passive recipient - giving up their power to the professionals who had expertise and knowledge. Nursing work was delegated by the doctors and the routines of care enabled nurses to regulate their interactions with patients. However, Aranda & Street (1999) noted that a fundamental change occurred in the construction of the relationship during the 1960s, where the patient was reconstituted as a bio-psycho-social being. McQueen (2000) highlighted that the patient was a more complex subject, rather than an object, and as such required a different nursing perspective. This coincided with a time of greater nursing development in research and academic work, coupled with a social movement on issues of gender and human rights. Aranda & Street (1999) in their study noted that this created a challenge for the presentation of the nurse in interactions, similar to that discussed by Goffman (1959). They identified that nurses had two representations of themselves, authentic and chameleon. Authenticity was based upon being genuine in emotion and caring, so that relationship-centred care could develop - although there were limits to this. However, nurses adopted a variety of strategies to be accepted by the patient and their families. This included changing language, voice, body language and personal views - the chameleon aspect. What is not clear from the study is where this expectation was derived from, patient or nurse, or how it was developed. This technique is often used to develop rapport with patients in medical consultations (Clabby & Conner, 2004). Other strategies are used by nurses including deferment, noted by Fulton's (2008) observational study of two wards in the UK. She discovered that where there were specialist nurses, ward nurses would defer emotional support and decision making to them as well as doctors, even though conducting things themselves could potentially improve the relationship.

Ramos (2006) identified that it was a cumulative process that had three qualitatively different levels of attachment and two impasses. Critically, Ramos noted that there was a bi-directional component to the power relationship that challenged the professional authority of the nurse and affected the professional interaction. Ramos also noted that not all nurses achieved these levels, a view supported by Moyle (2003). Shattell's (2004) extensive review of the literature identified that the few studies that examine the patients` perspective in the relationship are mostly centred on the functional aspects of the interaction (i.e. communication strategies used by nurses). These were often described as positive and a number of other studies are in agreement (Cioffi, 2003; Finch, 2004b).

However, Finch's (2004b) study identified that patients noted a range of nursing behaviours towards them, including care and compassion, professionalism and competence. Importantly, they studied the patient reaction to dominance and authority and found that patients rejected nurses` communication perceived in this way.

One important display of power in the nurse-patient relationship is that of compliance with nursing orders. Playe and Keeley (1998), in their analysis of mental health practice, see that the patient norm is of a compliant patient and a passive recipient of healthcare, compared with non-compliance as a negative. This leads to an inherent tendency to attach blame to the patients who do not take advice or challenge the formal knowledge of the healthcare worker. Hewison (1995), in his enlightening grounded theory study of nurse-patient interactions, identified a range of strategies that nurses employed to exert control over patients. He found that the power of language was an important medium of control, which had overt and covert forms. Interestingly, he noted a more nebulous form of control through the management of routines and agenda (the patients identified their response based upon their role in the transaction). He concluded that there was a surface perspective on communicative interaction, but noted within this an element of control. Morse (2007) discovered an interesting reaction from some patients in her study. Patient negotiations took place to a point of equilibrium in the therapeutic relationship where the nurse was fulfilling a professional role and the patient receiving care. If the patient did not receive the care which they perceived they needed, they would use manipulative behaviours to increase nursing input.

The power of the doctor

As indicated in Chapter One medicine has always commanded significant power in many western societies. This evolution came through the consolidation of the power of the professions in many ways, including professional closure in knowledge, recruitment and resources such as hospitals and clinics.   In the UK, hospitals started in the 11th century mainly for the poor, via religious centres and linked to the philanthropic generosity of lay or religious benefactors (Turner, 1995). Rivett (1998) describes hospital development as an important factor in professional power and leadership models of medical dominance, a view shared by Goffman (1961). Hospitals became symbolic of the social power of the

medical profession, consolidated by its role in the training of medical practitioners and the control of space (Prior, 1988).

Rivett (1998) identifies that hospitals commanded respect and privilege, especially to those who worked in them. Edwards & Harrison (1999) state they were often symbolic of civic pride and as a consequence of this, coupled with the economics of charity, they were centred in large cities (Klein, 1995; Stacey, 1988). The creation of the NHS in 1948 was described by Navarro (1978) as the most significant piece of social engineering in the western world. This profound social policy had an enduring legacy on British society as a whole. The NHS became the cornerstone of the UK social care system that remains largely in place fifty years later. However, during its construction, Aneurin Bevan had to maintain the medically dominated system of hierarchical order. Bevan is quoted as saying that he 'choked [the consultants'] mouths with gold', in order to maintain their support for what was perceived by the profession as a controversial path. Their fear, as Luton (1973) describes, is that the plan would involve a 'full-time salaried service' with power of determinism wrested from them. This set out the basis of the relationship between the state and the medical profession for decades. Nursing, however, remained outside the negotiating room - silent and obedient in its traditionally subjugated role. Gerson's (1976) view was that the health system appeared to meet the needs of the medical profession rather than that of the patients.

Stacey (1988) states that during the 1950s and 60s the medical profession continued to exert greater control over the organisation of the health service, although rising costs led to a general call for greater administrative control with the aim of providing accountability and managerial responsibility to the majority of the employees in the service. The NHS in the 1970s was politically a hospital-centric service, with greater consolidation of political power within the hospital consultant body. Attempts at control through bureaucratic means had largely failed. However, Yates (1987, 1995) suggests that during the 1990s a realisation on the part of policymakers identified that the NHS model required a serious overhaul, as mounting costs of new treatments and technology, coupled with a growing elderly population and emergence of chronic disease, became dominant factors. This created a period of significant policy challenge for the UK NHS, described in previous sections, in which medicine continued to exert significant control.

Section 3 - Power, knowledge and the professions

Introduction

Section 3 will provide a more detailed understanding of how power is transacted by the professions. Firstly, an appreciation of the basis of contemporary medical and nursing knowledge is useful in the context of doctor-nurse interactions. The link between knowledge and power is an enduring one in literature and social theory alike. As Herodotus describes:

> 'This is the bitterest pain among men, to have much knowledge but no power.' – Herodotus, Book 9, Ch. 16

Bourdieu (1984) highlighted that historical understanding of the formation of power is essential and from the perspective of this study, we must first determine what medical and nursing knowledge is, and how it is described in the literature.

Medical knowledge and education

Modern UK medical education has been exclusively based in the university sector utilising instructional and didactic teaching of physiology, pharmacology and anatomy in a two year preclinical component. Clinical management and other practical skills have been delivered in the hospital and laboratory environments. Factual retention of knowledge in an outcome-focused assessment model has remained largely unchanged for decades. This led to an apprenticeship model of training in the doctor`s chosen sub-speciality which also required further postgraduate education such as membership or fellowship in a Medical Royal College (e.g. Royal College of Surgeons).

From a contemporary perspective a shift occurred within medical education in the UK following the General Medical Council (General Medical Council) report, 'Tomorrow's Doctors' (General Medical Council, 1993). This made strong recommendations for significant changes to undergraduate medical education, primarily to address the perceived skills deficits that were appearing in newly qualified doctors (Section 2). As Fry (2002) suggests, supported by Hurley & Linsley (2007), this reflects changes in medicine, with a trend towards increasing specialisation that is linked to a growing body of knowledge. This increasing specialisation and diversity were key drivers that shifted the curriculum focus from one based upon knowledge acquisition, to one of education about data evaluation, patient interaction and the development of practical skills (Brian et al., 2007). As a result, medical educators increasingly challenged the traditional structured medical teaching programmes, for those based upon new educational methods that involved compartmentalised programmes concentrating upon holism, body systems and a greater inclusion of social sciences. As Fox & Bennett (1998) found, this was influenced by adult education theory and focused on new skill sets. Dent (2006) suggests that these new skills were not addressed in the traditional undergraduate medical training leaving modern graduates at a disadvantage in an increasingly dynamic healthcare system. New medical schools were turning to other educational philosophical approaches to deliver a curriculum which introduced the expertise of other healthcare practitioners to contribute to the education of new doctors.   Increasingly, the inclusion of other healthcare professionals is being seen in the curriculum planning, delivery and evaluation of pre- and postgraduate medical education programmes (Brian et al., 2007; Dogra, 2005; Vallis et al., 2004).

However, as Toynbee (2002) identified, 'Tomorrow's Doctors' (GMC, 1993) aimed to:

> `… refute all the old complaints about arrogance, out of touch, unfeeling, godlike consultants.'   - Toynbee (2002) , page 719

Indirectly, Toynbee (2002) highlighted that an important aspect of medical education was also professional socialisation and development of status. As others such as Sinclair (1997) have found, medical education was more than just a factual retention of knowledge but also partly a process of professionalisation and entry into a privileged profession. Therefore, entry into the profession was guarded. Dent (2006) has suggested that some

traditional medical schools fought to maintain this dominance and professional status. It is notable that the new medical schools have moved away from this with a more functional competence approach supported by integrated programmes of traditional medical subjects and social science. Dent (2006) adds that this trend away from professionalisation also mirrors the shifting power from the profession to the patients, a view also supported by Toynbee (2002). To a degree, this challenges Freidsons's (1970) initial assumptions that professional change cannot be led by market forces, a view shared by Coburn et al. (1997). However, Freidson (2000, 2001) acknowledged, that whilst medicine's relationship with the public was changing, it still maintained a control over its monopoly. This was against a backdrop of ever increasing bureaucratic-managerial controls over the medical profession and in a society where technology and information availability challenged their complete control of medical knowledge.

Nursing knowledge and education

As nursing was historically a subjugated discipline to medicine, its knowledge base was largely determined on a biomedical basis (Bradshaw, 2000; Cushing, 1994; Herdman, 2001). Mantzoukas & Jasper (2004) put forward three movements of nursing knowledge. In the first movement, nurses` knowledge was largely based upon the biomedical perspective and taught to them by doctors for the purposes of transacting the care they had determined through diagnosis. Nursing developed systems of care that were organised around the practicalities of delivering the doctors` requirements, a view supported by Witz (1992), Hafferty & McKinley (1993) and Walby et al. (1994). The second movement occurred in the 1950s and Fairman (2004) suggests that the Second World War had a profound effect on nursing knowledge. Key figures such as Hildegard Peplau, Virginia Henderson, Lulu Hassenplug and Francis Reiter challenged the orthodox perspective of skills and procedures nursing. They promoted one which had its foundation in psychology, systems theory, sociology and pathophysiology. Rodgers (1991) links this transition to a fuller understanding of the nursing discipline. Carper (1978) suggested that the categorisation of nursing based upon medicine was flawed, and that nursing should look to understand the process by which care is given. The concept of the 'nursing process` dominated the development of a systematic expansion of nursing

knowledge during the 1960s and 1970s, most notably in the US. This was then adopted into UK practice during the 1970 and 1980s. It was often couched in terms of the 'art and science of nursing' which did little to enhance its academic credibility with other professions. Nursing knowledge and development was intrinsically linked to hospital-based practice and still remained under the influence of surgical or medical doctors. However, the ability to apply a different philosophical approach proved enticing. Rodgers (2005) remarked that with this approach came a realisation that nursing adapted knowledge from other professions and disciplines, making it more difficult to understand and generating a unique body of knowledge for itself. The third movement consisted of the global shift towards evidence-based practice as a means for developing care. Mantzoukas & Jasper (2004) state that:

> *'Theorists no longer produce knowledge in the forms of integrative theories, but facilitate practitioners through Reflective Practice (RP) and Evidence Based Practice (EBP) to produce practice relevant knowledge. RP primarily represents subjective, contextual and multiple types of knowledge, whereas EBP primarily represents objective, acontextual and 'true' types of knowledge.'* -   *Mantzoukas & Jasper (2004) , page 319*

Mantzoukas & Jasper (2004) in their ethnographic study of ward-based nurses indicate that five discrete forms of knowledge emerged including: personal practice, theoretical, procedural, ward culture and reflexive. From the perspective of power, three main factors emerge from their work.   Firstly, that clinical and theoretical knowledge based upon normal and abnormal (biomedical) knowledge was gained through academic preparation. This is different from the historical apprenticeship movement of previous iterations of nurse training. Secondly, that procedural aspects of knowledge centre on practical tasks that were once the domain of medical practice, such as Hickman, Peripherally Inserted Catheter (PIC) lines, intravenous drugs etc., and were now normal practice for these nurses. Finally, their concept of the ward culture linked to knowledge suggests a legacy of 'nursing the room' and associated practices of control of space. However, nurses` power still mainly comes in the control of practice and domain rather than control of knowledge itself (Riley & Manias, 2002).

To deliver this change in knowledge acquisition required a significant shift in nurse training. Academic nursing in the UK was limited to few universities during the 1970s and 1980s. Parahoo (1999) identifies that the drive for a more evidence-based profession came following the Briggs report in 1972 (Department of Health and Social Security, 1972), but it took a number of years before this was articulated into practical changes in curriculum planning by nursing (Shields & Watson, 2007). The advent of Project 2000 (United Kingdom Central Council for Nursing & Midwifery, 1986) was an attempt to initiate a process of academic professional development by addressing the perceived lack of academic skill amongst the workforce (Warren & Harris, 1998).

Cooke & Green (2000) suggest that at the same time these curricula were being developed educational leaders were rapidly absorbed into higher education, (namely polytechnics). Burke (2003) argues that there was never a clear statement of intention from the government that this level of integration of healthcare education was intended. However, the fact that it took place without central government involvement was an indication that this direction was one supported by them and by the profession. A year or two later the abolition of the divide between polytechnics and universities rapidly placed nurse tutors in the academic structure as lecturers.

One interesting dynamic posed by the move into higher education was the structural position of academic nursing in the HEIs (Meerabeau 2005). Most local hospital-based nursing schools were affiliated to HEIs. However, more traditional universities had nursing intrinsically tied to medical schools, mirroring the clinical and leadership environment of the NHS - one that Meerabeau (2005) and Miers (2002) felt nursing has fought long and hard to change. In the case of university structures this was perpetuated by the medical schools which controlled entry and regulation of the nursing school via admission criteria. A key example of this was the UK's first nursing degree at Manchester University, which remains to this day within the Medical Faculty, and had in the early 1990s the same A level grade requirements to study nursing as it did medicine.   Whilst on one level, integration would seem a practical solution with regard to shared resources, knowledge and the ideal of developing shared experiences in care and education - it has not been realised. Ginsburg & Tregunno (2005) identify that professional cultures are a macro-barrier to collaboration, even though there is significant evidence to support its beneficial potential. That said, educationally, the lack of academic background to nursing

meant that such a merger was likely even though it sociologically sat at odds with nursing developing as an independent academic profession.

Advanced practice knowledge

The move to HEIs during the 1990s concentrated specifically upon undergraduate programmes although over time ANP courses started to emerge in the UK in the later part of the decade (Gerrish et al., 2003). Most of the academic courses concentrated upon delivery of skills based upon aspects of advanced health assessment, diagnosis, non-medical prescribing and applied pathophysiology (Gerrish et al., 2003). The drive for skills generated through the workforce changes outlined previously concentrated upon getting practitioners with a complement of skills to deliver care at the bedside. From this, Rolfe's (1998) research suggested a typology of advanced practice nursing knowledge, outlined in Table 2.

Knowledge Domain	Theoretical knowledge (knowing that)	Practical knowledge (knowing how)
Scientific knowledge	Things that are known or discovered from books, journals or lectures.	Things that can be carried out or learnt from books, journals, guidelines and protocols.
Experiential Learning	Things that are known or discovered through own experience.	Things that are carried out based upon experience.
Personal knowledge	Things that are known which relate to specific situations or particular people, discovered through own experience.	Things that can be carried out which relate to specific situations or particular people.

Table 2 - Typology of Advanced Nursing Practice (adapted from Rolfe, 1998, page 221)

However, Rolfe's typology may be oversimplified as it does not address a number of issues. Rolfe`s perspective reflects that of Mantzoukas & Jasper (2004) and does not distinguish between knowledge gained as a non-specialist nurse compared with that of the ANP. Personal knowledge is too broad and does not reflect the difference between cultural perspectives of practice and cultural knowledge. Christensen (2009, 2011) also challenges the assertion that some ANP knowledge is advanced and advancing, but does not make the distinction that in some professions what is termed advanced may be basic,

such as basic science physiology in medicine. In the case of ANP, knowledge is often measured against that of the medical profession, although Ruel & Motyka (2009) suggest in their analysis of 300 papers on advanced practice that the distinction between nursing and medical knowledge is indistinct. They go on to say that:

> 'The knowledge that is generated from many sciences is interpreted into practice through nursing science ... There is a consensus that advanced practice nursing has overlap, shifted boundaries, components of care, is likened to, an extension of, or medicalisation of nursing practice in which there is encroachment onto the boundaries of medical practice.' - Ruel & Motyka (2009), page 387

Their view is challenged by Kilpatrick (2008), Herdman (2001) and Georges (2003) who are concerned by this overlap and boundary blurring. Kilpatrick (2008) states that:

> 'This incursion into the medical domain could be viewed as an attempt by nursing to gain greater status and make nursing more acceptable to the dominant medical group.' - Kilpatrick (2008) , page 120

Professions and professionalisation

Bosk (2006) describes the three key ways healthcare is distributed: Firstly, by market forces. Secondly, social organisations in which elaborate rules and structures determine who is entitled to the services of health. Thirdly, determined by the workers with specialised knowledge who do not exploit their exclusive rights to control or distribute because they are driven by a pride in their craft or service to the public. Bosk (2006) wrote this as a legacy of the key theorist, Eliot Freidson (Freidson, 1970; Freidson, 2000; Freidson, 2001), who has studied the role of professions including medicine. Freidson (1960) wrote that:

> 'The nature of medical practice is seen as determined largely by the practitioner's relation to his colleagues and their institutions and by the profession's relation to the state.' - Freidson (1960) , page 374

Freidson utilised the medical dominance of healthcare as a vehicle to discuss professions and professionalisation. One of the key reasons for understanding Freidson`s work is that he recognised that professions developed dominance through control of knowledge. Earlier in this review a number of historical perspectives described how medicine and nursing have developed along professional routes (although there is some contention that nursing is an occupation rather than a profession in the classic definition). It would be impossible to discuss in detail the large body of social theory associated with the profession's development but this review must cover the following: A description of professions and how advanced practice should be classed, professions and the role of the advanced practice, becoming a professional and being professional in practice.

Freidson described a profession as a specific type of occupation that performs work with special characteristics while competing for economic, social and political rewards. Through the application of knowledge a profession develops a closed system of work that leads to a monopoly and a degree of autonomy within a prescribed framework. Medicine has always laid claim to being one of the pre-eminent professions of the western social system (Pellegrino, 2002). Nursing, however, is less well defined and, as previously discussed, can be classically described as an occupation. Freidson (1983) suggested characteristics of a unique body of knowledge, code of ethics, regulating practice, community sanction, socialisation and autonomy defined professional criteria. In these terms nursing is someway short of a profession. Etzioni (1969) classified nursing as a semi-profession although this did only address historical development to the point of his publication. Gerrish et al. (2003) state that the move to degree and Masters education in nursing is a strong social force and a point towards the professionalisation of nursing. Coburn (1988, 1994) proposed an interesting perspective where he aligned the development of the nursing profession in Canada to the proletarianisation of medicine. Coburn was influenced by Freidson and Marx where he viewed proletarianisation as a class mechanism for the movement of wage work and a process of work alienation and fragmentation of medical practice.

The socialisation in professions through ceremony and ritual are still commonplace and important. Graduation and formal qualification form part of the first stages of acceptance, which leads to early socialisation as indicated by Hean et al. (2006), Hind et al. (2003),

Hafferty (2002) and McFadyne (2010). Symbolism in medicine is still prevalent from the medical caudices and the white coat (Antoniou et al., 2010; McSwain, Jr., 2010). White coats became symbolic of the medical position within organisations, but have largely disappeared from hospitals and clinics in the NHS. Infection control is cited as the reason for their demise, but others have a view that this is a rational attempt to make the profession more accessible and less professionally distant (Goldberg, 2008). Paradoxically, patients still require professions to present themselves as professionals (Rehman et al., 2005; Makoul et al., 2007; Wallace et al., 2009; Blumhagen, 1979) linking this with the wearing of the symbolic white coat. Similar issues have arisen in the greater use of first names between doctor and patient (Cooper, 2000; Makoul et al., 2007), although Gledhill (1997) identified that variances arose with the seniority of doctor. Interestingly, Brown et al. (2003) and Russel (2002) noted that the perceived decline in professionalism in the US has resulted in a re-emergence of the 'white coat' ceremony.

There is a perception within medicine that their power is on the wane. Pelligrino (2002), Hafferty et al (1995) and Swick (2000) assert that the 'professed' nature of medical work is still based upon an altruistic desire to help the individual and lament its professional decline. Their romanticised view is of the benevolent doctor ministering to the needy and is reminiscent of the early 19th century perspective and clearly still has a strong hold on the profession.

We have seen in the preceding chapters that through the development of a body of knowledge, the dominance of health policy influencing the state and professionalisation, medicine became the pre-eminent profession in healthwork. Freidson (1970) stresses the importance of power in medicine suggesting that due to occupational closure a monopolistic regime is created so the subordination of paramedical professions, including nursing, continues. This has also been noted by Larkin (1983 1993, 2002) where the pursuit of a 'professional project' may include strategies that involve advancing the goals of professionalisation through control of others, and which are dependent upon access to relevant external power resources such as legislation, regulation and bureaucratic systems of power.

It is clear from the literature that hierarchical relationships based upon gender divisions are perpetuated through cultural and social reinforcement. Keddy et al. (1986) suggest

that within healthcare, gender differences in occupation are encountered within the first years of training. However, there are subtleties in the socialisation of power which fall into three main categories: education, pay and role expectation.

Professionalised organisations and power

It can be asserted that professionalised organisations are intrinsically linked with a power differential when more than one profession works within them. Healthcare has a number of professions, each with their own agenda. Organisational influences on role expectation can be a dominant factor in vertical professional development. In addition, those professions with a hierarchical/political authority and power are able to determine this strategic direction by aligning themselves alongside the power structures to professionalise management. Simpson (1994) identifies that in the UK NHS medicine did this in 1983 following the Sir Roy Griffiths (NHS Management Inquiry, 1983) inquiry into NHS leadership. The introduction of industrial sector management practices in the NHS was aligned to doctors, as he states:

> *'The nearer that the management processes get to the patients, the more important it becomes for doctors to be looked upon as natural managers.'* - (NHS Management Inquiry (Griffiths Report), 1983)

Its impact on the NHS and doctors in their 'natural authority position' meant that they were able to further consolidate control through local, regional and national medical leadership roles. Freidson (2000) identified that medicine has always held a strong position in the management structures of healthcare. In the US, medicine had formalised management roles in the bureaucratic organisation of health systems. Centralisation of medical power has been explored by many commentators who showed that the bureaucratisation of medical care led to a dual system of authority consisting of hospital managers and the largely autonomous professional status of the doctor (Fournier, 2000; Cox, 1991; Boyce et al., 2000). The most important aspect of this was that medical staff enjoyed little interference from administrators when compared with other professions, and

has been identified with leadership across other industries exhibiting the same profile (Kanter 1977; Acker, 1992).

Summary

Many theorists have attempted to provide a reductionist view that will satisfy an explanation of the power differentials in healthcare. It is clear that power dynamics is layered with historical and contemporary sub issues of gender, organisational culture and professions. The literature has highlighted where the occupations of nursing and medicine creates an inherent socialisation that ultimately shapes professional interactions. Hewison (1995) proved correct in his assessment on power being a contested subject. No unified concept exists in social theory but it remains an important component in social interaction. Researching power is often problematic and requires a great deal of focus to determine the major element at work - agency or structure. In healthwork there are many ways that power is contested - both vertically and horizontally - between individuals in organisations such as hospitals. However, hospitals are often structured along bureaucratic lines with many professions working within them – all overlaid with the many social constructs such as gender, ethnicity, class, etc. The role of the advanced practice nurse has challenged the orthodox dynamic between doctor and nurse by virtue of their position within nursing, proximity to the medical structure, use of knowledge and deployment of skills. The most relevant theory from this review to understand power relations in healthwork is presented by Bourdieu with his inclusive theory of the agent behaviour and interaction with the structures that create and maintain power. For the purposes of this thesis, it is important to understand in more detail how power is constructed in relation to advanced practice nurses and doctors by looking in more detail at the empirical evidence of the interaction between the two groups.

Chapter Three - Review of Literature (Part II) - Power dynamics in the 'doctor-nurse game' and advanced practice

Introduction

In terms of nursing's relationship with medicine, power is an important concept. This final section will explore in detail: Firstly, the global perspective on the interaction models of nurses and doctors in acute hospitals. Secondly, an analysis of the empirical evidence of micro doctor-nurse interactions and communication strategies. Finally, it will critically assess literature in relation to the development of advanced practice, and identify what impact this has in understanding power in healthwork.

Global overview of doctor-nurse interaction

The preceding sections identified that interactions between doctors and nurses are complex. The propensity of literature has examined the often challenging nature of the relationship based upon nursing as a subjugated occupation. The work of nursing is largely defined by the dominant role of the doctor and the relationship outlined by the bureaucratic system of the hospital through professionalisation and structures. However, the hospital is also an independent community developing its own cultural perspective on how the agents work within it. Taking a Bourdian perspective, agents work in a unique field and develop habitus that ultimately influences their practice. It is therefore important to understand two main perspectives. Firstly, what are the formal and informal networks that operate in hospitals, and, how do these influence the interactions of the professions?

Griffiths (2003) notes that although much has been written about the social organisation of healthcare it has had little focus in relation to outcomes in health, illness and occupations. For nursing in hospitals the most overt form of social network is the ward or department they work in. The structure and organisation of work in this environment has been developed in collaboration with doctors and the biomedical determinist perspective of the patient's illness, i.e. clinical specialties. Adams & Bond (2000) identified the clinical

specialty of the ward as a significant contributor to the ward ethics, devolved accountability, hierarchy and culture. The implications of such a cultural norm influenced the stability of the ward and standards of clinical care (Adams & Bond., 2003). Adams & Bond (2000)   discovered through a questionnaire study that the interpersonal relationships were a strong determinant of ward cohesion. This included relationships with medical staff, perceptions of their workload and their evaluation of the appropriateness of the system of nursing being practised. This was a view similar to that found in other health systems - Finland (Makinen et al., 2003), United States (Schmalenberg & Kramer, 2008), Australia (Duffield et al., 2009) and Norway (Begat et al., 2005).

However, the above research outlines that the formal and informal relationships linked with working patterns between doctors and nurses were key to satisfaction and clinical outcome. Rafferty et al. (2001) highlighted in her survey of 10,000 nurses in the UK that teamwork and autonomy were closely linked. Although this focused on ward-based nurses, it does have important implications for advanced practice. Tagliaventi & Mattarelli (2006) suggest that this has conceptual links with the 'communities of practice' espoused by Kolb (1984) and Vygotsky (1978). In clinical practice this view is shared by Bleakley (2006) who leans towards a model of learning as a team, as he believes this reflects the reality of the practice domain.

However, formal rules and regulations often prevent the full integration of the team. Protocols and procedures have developed in the UK as part of a drive for evidence-based care and patient safety (Atwal & Caldwell, 2006). Atwal & Caldwell (2006) also noted that there were a number of informal reasons for development of interprofessional working, including perceptions of teamwork effectiveness, assertiveness and confidence of team members and the dominance of medical power that influence team dynamics. Issues such as these form part of the cultural perspective of the organisation and determine how the professional boundaries are managed in the clinical domain (Coleman et al., 2001). Formal networks are supported by the social networks of practice and have been observed in hospital settings. West et al. (1999) noted a significant difference in the extent and depth of social networks and how they were used by doctors and nurses. Although their sample concentrated on senior nurses and doctors, it did highlight some important differences in behaviour and values. Overall, nurses had smaller organisational and professional networks than doctors.   However, they were more central and

interconnected to the network and therefore acted as conduits for knowledge and information which gave them the ability to mediate and control, even in medical networks. Nurses were more likely to work in centralised and hierarchical networks than doctors, supporting conventional wisdom about the difference between the two professions and how they operate in organisations. Doctor's networks were more often related to professional colleagues, social groups and friends. They were egalitarian and centralised, and had the ability to control members` behaviour. Coleman (2001) found these networks extremely influential in deciding upon the approach to evidence-based practice. West et al. (1999) consolidated the view that professional social networks are related to professional socialisation and status.

Contextual issues of nurse-doctor interaction

Stein`s (1967) seminal work on the 'doctor-nurse game' identified the presence of professional socialisation of nurses and doctors, which led to the subordination of nurses, a view supported by Crausmann & Armstrong (1996), Shannon (1997) and Snelgrove & Hughes (2000). Moreover, Stein recognised a paradox in that the doctor needed advice from the nurses to optimise care, leading to internal conflict with their perception of dominance. Although Stein's work has gained orthodoxy in the nursing and medical profession, it has a number of methodological flaws, in that it was based upon anecdotal information gained from his own experiences and those of his colleagues across the US (Sweet & Norman, 1995).

Hughes (1988) made an extensive study of doctor-nurse relationships within a UK casualty department. He produced a contemporary UK contextual research study based upon Stein (1967). Hughes' (1988) results were a complete contrast to the traditional view. He noted that nurses' influence was far greater and more overt than anticipated. One important finding was that nurses' power came from a variety of sources including the ability to control the management of space, patient categorisation and flow. This had transactional elements to it, as the nurses consciously made judgments on the support to provide to doctors in different settings and the organisation of their workload. He also identified environmental factors that promoted power: the number of admissions, clinical

diversity, ambiguity and limited medical staff resources. In contrast to the views of postmodernists such as Friedson (1970), he found that interactions were open but did not form part of a formal organisational system. Hughes noted that his study had its limitations including its single site and that casualty nursing may be a unique identity not characteristic of other areas. In addition to these limitations a number of others are present: Firstly, Hughes' study only partly addressed the issue of duality where the voice of the doctor was not brought to the fore. Secondly, the nurses in this department were not advanced nurses and worked in an era when the traditional division of labour between doctors and nurses was more distinct. Finally, that the wider social space of the organisation was not recognised as an influence on the interactions.

Porter (1991) used a participant observational study based upon symbolic interactionism and examined how the nursing process affected autonomy and decision making. Porter`s (1991) findings supported Hughes (1988) study where subordinate relationships were less frequent than previously described. Porter identified four types of interaction and tested them on a wide range of occupational groups in an intensive care and a medical ward. They were categorised as: unproblematic subordination, informal covert decision making, informal overt decision making and formal decision making. Porter also found linguistic and behavioural diversity in the communication between doctors and nurses that demonstrated attempts at cultural and professional identification. Porter (1991) described in detail the resolution of this conflict via an elaborate interprofessional communication strategy that avoided confrontation. Interestingly for this study, control over diagnosis was a contributing factor that often led to conflict and confrontation. This view is shared by Hughes (1988) who also found that nurses had often made a 'primary diagnosis' before the patient saw the doctor. It has been identified that advanced practice formally challenged these traditional boundaries in terms of complex clinical diagnosis and has established their relationship as one of consultancy - although viewed differently by medical staff. The shortcomings of the work of Porter (1991) and Hughes (1988) are important in the analysis of the APN/doctor dynamic. The two studies concentrated upon methods of power and control over the doctors by nurses. Porter and Hughes do very little to address doctors` reactions to nurses using these strategies. In addition, specialist nurses use consultancy and collaboration in relationships with doctors that demonstrates a dynamic not present in the two studies.

Porter (1991) and Hughes (1988) both share concerns with the validity of Stein`s (1967) work, particularly in relation to his methodology. Stein et al. (1990) revisited his work and concluded that relationships had improved because of a shift in the power balance which he established as being due to decreasing public esteem for doctors, increase in the value of nursing and the shifts in gender distribution within both professions.

Cassell's (1992) study of doctors showed that linguistic and behavioural diversity within medicine was linked to power and authority. Her study of surgeons found their need for hierarchy and identification went far beyond the professional consultations. Linguistic analysis demonstrated differences in professional style with regard to patients, nurses and colleagues which spread to personal linguistics on subjects such as life, hobbies and internal subjects, humour, jokes and sarcasm within working relationships reflecting Bourdieu's 'distinctions/tastes' (Bourdieu, 1984). Although Cassell (1992) did not formally address nurse-doctor interaction, the emphasis of this study examines inter-reactions between like groups and is therefore relevant. It is important to distil contextual issues in this inter-reaction to explore how it is addressed by both groups so the 'rules of engagement' between doctors and nurses is a valid avenue to take. Carter (1994) identifies that it is the presence of these rules that foster patriarchal attitudes. It has been demonstrated by Turner (1995), Porter (1991) and Hughes (1988) that these rules are challenged by various 'modus operandi'. However, in more formal relationships between advanced practice nurses and doctors, do such rules exist? And, if so, by whom are they established?

Mackay's (1993) research using semi-structured interviews focused on the unwillingness and lack of confidence of nurses to collaborate with medical staff. Mackay (1993) highlighted that gender and medical power were important in determining the outcomes of interactions and, in particular, conflict situations between the two professions. Mackay (1993) interviewed all grades of nursing and medical staff highlighting sources of conflict mainly from differences in clinical opinion on treatment plans. This was exacerbated by the experience of nurses and doctors creating an imbalance in the relationship that was a constant source of frustration. Mackay highlighted that some key issues from her study such as conflict scenarios were inevitable, and in certain circumstances an important part of negotiation and challenge. Although a large study in a number of clinical specialities, MacKay's work did not include those nurses working in an advanced nursing capacity.

Further work by Svenson (1996) demonstrated a negotiated order perspective between the nursing and medical boundary. His work in Swedish surgical and medical wards highlighted that a new relationship was emerging that had accelerated during the 1980s. He understood the drivers for this change were in part due to the demographic and gender shifts in medicine - as well as greater education on the part of the nurse through the accumulation of knowledge. This created a change in the clinical model where task-orientated nursing evolved to a more team-based model. This fundamentally changed the interaction model through a continuous process of negotiation. He noted that nurses were still controlling the work of the doctors but were taking a far greater role in determining the division of labour between the two professions. Nurses were more overt in their challenge to doctors, but still had a number of 'silent' strategies to control medicine. Contextually, the research promoted further understanding - although on a limited basis - recognising the medical role in the interactions and the fact that relations were built over time. Unfortunately it was nurse centric and did not address the duality of the medical perspective and is dated in the context of specialist practice.

Allen (1997, 2001a) provided a UK specific analysis of Svenson's work in a NHS hospital. Allen highlighted some important aspects of the negotiated order theory and introduced a number of additional concepts. Firstly, that nursing medical work had changed in the NHS due to a number of drivers including: the introduction of hospital managers and changes to junior doctors` hours. This required nurses to take on tasks previously in the domain of medicine. Secondly, that spatial understanding of the context of work was an important perspective in how nurses and doctors negotiate. This was partly driven by the transient status of the junior medical role within the team. Allen also highlighted that the relationship between the doctor and nurse was rapidly changing, although the negotiated order perspective was not overtly found in the findings, contrasting with the work of Svenson in this regard. For this research, Allen's work is methodologically an important influence in bridging the public (observation) and private (interview) domains of the medical nursing boundary although Allen's work is also dated in respect to specialist nurses.

Snelgrove & Hughes (2000) interviewed 50 nurses and 27 doctors on medical wards in three district hospitals in Wales. Their aim was to add further micro-contextual

information on the roles and where they overlap in the organisation of care. Most notably, Snelgrove & Hughes (2000) highlighted that the nurses and doctors defined their relationship within the traditional division of labour. Doctors, in particular, noted a clear distinction between themselves and the nurses which they emphasised through their control of diagnosis, treatment and prescribing. This led to doctors perceiving themselves in the dominant clinical leadership position through their control of medical knowledge. Nurses highlighted their role in the social understanding of the patient which led to decision making in areas such as discharge planning and rehabilitation. This was 'allowed' by the doctors and mirrored Allen's (1997, 2001a) findings where low status tasks were downloaded to nurses. Interestingly, they identified that nurses` control of 'space' and the 'ecology' of the ward provided a sense of power and control that the doctors did not have. This in turn led to greater specialisation of ward environments (Renal, Haematology) control of tasks and role blurring.

Riley & Manias (2002), in an ethnographic study of operating theatre nurses, added a further dimension of control with the nurse as an encompassing controller and gatekeeper. Their critical ethnographic study identified that nurses in the operating theatre played an integral role in the conduct of surgery by providing service to the surgeon through knowledge of their needs. Although Riley & Manias` study took a postmodern perspective, it also shares elements of development and maintenance of capital from Bourdieu's viewpoint. The interesting issue is the role of the nurses who supported this process, despite being subjugated in their role. This subjugation discounted them from the formal knowledge/power held by the surgeon.

Carmel's (2006) work on intensive care units is also important research. Carmel undertook 280 hours of observations in three intensive care units in the UK NHS to understand how medical dominance worked within such a technical environment. Carmel's results highlighted a less formal relationship between the nurses and doctors linking it to the occupation of space behind closed doors and hidden from public view (a view shared by Coombs (2003). He also identified the lateral conflicts of a modern hospital where management systems sought to control medical work through removing the power to control from a fundamental part of the medical role, i.e. admission and discharge of patients. It was also noted in this study the introduction of the 'outreach nurse' who, as a specialist, extended the role of the ITU outside the physical space and

gave support for junior doctors – although this did not form part of the findings. Methodologically he addressed some of the limitations of previous studies through multisite analysis and included a medical perspective in the findings.

A small-scale qualitative study by Wilkinson (2007) interviewed twenty doctors and nurses with a focus on the EWTD effect on the working relationships of doctors and nurses. It recognised that the policy shifts outlined previously had resulted in a medicalisation of nursing, where new roles were required to deliver the service in the realigned services. This 'upskilling' of nursing had created a number of effects including fragmenting the profession from those with medicalised skills versus those delivering core care, and also doctors offloaded skills to nurses they trusted to a greater degree than the junior doctors. Wilkinson (2007) concludes that the medical profession, therefore, continued to maintain control over nursing by training and determining competence, although, small-scale and interview based, it did highlight some important shifts in clinical practice.

The research highlighted above has provided a nursing and sociological overview in relation to this study. However, this research has taken account of some of the previous limitations, most notably the lack of literature on the power dynamics and interactions between advanced practice nurses and doctors. The interactions described in the studies are also one-directional and appear isolated from one interaction to the next. Communication and negotiation is much more complex and so 'game theory' is more representative of styles of negotiation. 'Game theory' is a form of quantitative economic theory from applied mathematics that established an individual's success in a strategic game. Tarrant et al. (2004) describe game theory as:

> 'Concerned with decisions in which outcomes depend on the actions of two or more decision makers, called players, and where each player has two or more ways of acting, called strategies. Each player is assumed to have clear preferences among the possible outcomes.' - Tarrant et al. (2004), page 462

Mathematical interest in strategies for games emerged in the 18th century, but was extensively developed in the 1950s, influencing a range of disciplines including economics, business, political science, biology, computer science and philosophy (Tarrant

et al., 2004). Game theory has also influenced debate in power theory, with elements appearing in the work of Wright Mills (1959) and Dahl (1957) and has been adapted in sociological work (Bacharach, 2006; Sweberg, 2001; Colman, 1995). However, Petersen (1994) recognises that its quantitative approach lacks the ability to determine aspects of individual preferences and actions as they are primarily social in their origin. Von Neumann & Morgenstern's (1944) and Nash's (1950) seminal work sets out a theory that determined the probability of achieving a successful outcome for the individuals involved within an interaction. It is beyond this thesis to describe the complexity of economic game theory, but a brief description is required.

There are many types of game described within 'game theory', including cooperative/non-cooperative, zero-sum/non-zero-sum, simultaneous/sequential and combinational. In its most basic form, game theory involves players or agents who by definition are an entity with preferences. Players are assumed to be rational, making choices which result in the outcome they prefer most, given what other agents do. In many cases, a player may have two strategies A and B so that, given any combination of strategies of the other players, the outcome resulting from A is better than the outcome resulting from B (see Figure 5).
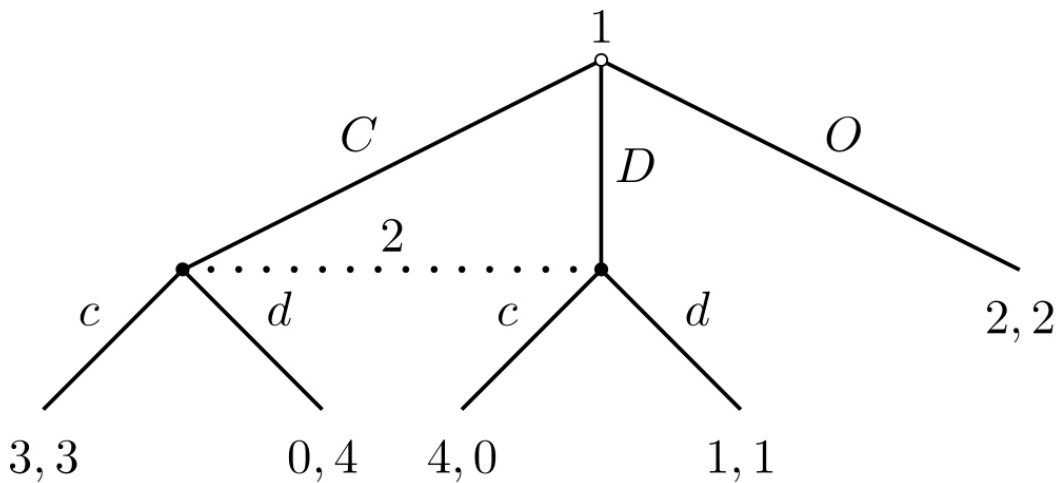
Figure 5 - Mathematical representation of extensive form game from 'Game theory'

Commentators have highlighted that in its basic form game theory remains one-dimensional, constrained by rules and a degree of rationality not seen within social systems (Binmore, 2009; Ginits, 2009). Evolutionary game theory has developed an

elegant solution to this problem where decisions are not chosen by economically rational agents. Instead, agents develop particular strategies through socialisation and genetics to operate within their social system. Successful strategies are defined in terms of their longevity, replication and reproduction by the agents within social systems (Skyrms, 1996, 2004; Ginits, 2009). In this kind of problem setting, the strategies themselves are the players, and individuals who play these strategies are players who receive the cost benefit of the interaction or outcome. Replication and reproduction is then based upon observed successful and non-successful outcomes for individuals and larger social groups.

The general schema of multiple interactions and outcomes is an intriguing one not fully explored in the literature to date and has had limited application within health (Tarrant et al., 2004; Dowd, 2003, 2004). Although game theory is not the main theoretical position of this research, the principles of game types have some influence on negotiation between individuals. The fundamental features of nurse-doctor interaction and their organisational context provide helpful theoretical parallels.

The development of nursing through advanced practice

The introduction of this thesis highlighted a number of drivers for a change in the workforce of the NHS including the development of advanced practice. Hewison (2009) and McGee (2009) identified a number of policy drivers supporting the development of advanced practice nursing in the UK. These changes have placed greater emphasis on productivity and operational outcome. This required the NHS to radically examine its care delivery model and the role of the professions within it. NHS organisations started to utilise their workforce differently and this included breaking down traditional barriers between professions. McGee (2009) identifies that the practical outcome of this has resulted in a greater number of nurses and other Allied Health Professionals (AHPs) taking on roles traditionally the remit of the doctor, including diagnosis, interpreting investigations, prescribing medications and treatment. In understanding advanced practice it is important to highlight its development and evolution both internationally and in the UK.

Advanced practice roles emerged in the US in the early part of the 20th century (Gardner et al., 2007; Schober & Affara, 2006; Spross & Lawson, 2005; Dunn, 1997). Here they developed through market need in managed care environments (Turner et al., 2007). Schober & Affara (2006) highlight that the term specialist practice emerged as postgraduate courses came available in specific areas of practice such as anaesthesia, midwifery and psychiatry. In the 1960s the nurse practitioner movement developed to provide care mostly within rural, isolated and disadvantaged communities (Shober & Affara, 2006; Turner et al., 2007). In such areas, NPs flourished, providing increased family, first contact and emergency care. They were complemented with appropriate skills (diagnosis, prescribing, and minor surgery) and have expanded with marketing and business strategy to extend into such communities. Providing value for money is an important factor in the state system, and improving health outcomes in these communities through health promotion and social care approaches is both high priority and clinically effective. The term 'advanced practice nurse' evolved as an umbrella term to encompass a growing and diverse group of nurses who had moved beyond core clinical nursing practice, either in practice and/or education (Hamric et al., 2009). Although definition, education and models have been debated within the nursing literature, there was a desire and need internationally to develop nursing to function at an advanced level. As a result, the concept and development of advanced practice has been exported to other countries outside the US in many forms including nurse practitioners, clinical nurse specialists, advanced practitioners, nurse consultants and nurse clinicians (Mantazoukas & Watkinson, 2006; Shober & Affara, 2006; Sheer, 2008).

Within the UK context, advanced practice has had a shorter, although some would suggest, a more convoluted development. Advanced practice had already been evolving in the United Kingdom since the late 1970s and early 1980s (McGee, 2009). However, more broadly, the role and function of many nurses was developing guided by the state and professional bodies such as the British Medical Association (BMA), General Nursing Council (GNC) and Royal College of Nursing (RCN). For example, the Briggs Report (Department of Health and Social Security (DHSS), 1972) examined those areas where nursing and medicine overlapped, with the recommendation that any medical task to be undertaken by a nurse should be part of their post- registration education and training. The guidelines issued by the Department of Health in 1977 (Department of Health and

Social Security (DHSS), 1977) to health authorities provided the legal and practical framework to perform extended roles. Hewison (2009) identifies that the 1990s saw a range of policies which focused on role change for nursing. Key to this was the United Kingdom Central Council for Nursing & Midwifery (UKCC) documents, Scope of Professional Practice (UKCC, 1992b) and Code of Professional Conduct (UKCC, 1992a), which aimed at changing the focus for nurses where their accountability moved from doctors to themselves. Critically, the aim was to have a significant number of nurses with advanced skills to fill the gaps in service provision left by changes made to junior doctors` training and hours (National Health Service (NHS) Management Executive, 1991) as part of the New Deal framework (Department of Health, 1993a; Ham et al., 1998) which limited them to 72 hours per week. European law was introduced in 1993 under the working time directive (Council Directive, 1993/104/EC), and challenged by the then UK government (UK v Council of the EU, 1996) to limit this further. Although medicine was initially exempt from this, a further revision of the legislation in 2000 (Directive, 2000/34/EC) included a timetable for incorporating them. For doctors in training, there was an interim limit of an average 58 hour working week from 2004. This was reduced to 56 hours from 2007 and to 48 hours in 2009. Nursing supported this and had for a number of years been developing advanced nursing practice courses with HEIs to ensure that the new practitioner had increased capacity, capability and clinical flexibility (McGee, 2009).

The debate emerging in the literature highlighted a lack of consensus on the types of role that were appearing in clinical practice, their definition, education level and demarcation between titles (Ormond-Walsh & Newham, 2001; Por, 2008). The United Kingdom Central Council for Nursing & Midwifery (UKCC) recognised the need for education beyond registration (UKCC, 1993, 1994) although set out an ambiguous approach to the issue that had significant influence for UK advanced practice development for over a decade (Ball, 2000). The UKCC defined advanced practice as:

> *'…be concerned with adjusting the boundaries for the development of future practice, pioneering and developing new roles responsive to changing needs and, with advancing clinical practice, research and education to enrich professional practice as a whole.' – UKCC (1994), page 5*

Ormond-Walsh & Newham (2001) and Por (2008) highlight that the UKCC was reluctant to set standards or educational level, but did differentiate between specialist nurses and advanced practitioners. Por (2008) suggests that this stemmed from misconception and misunderstanding of the CNS and ANP roles following the adoption of American models and philosophy within the UK.   Therefore, for a short period advanced practice developed along separate tracks (UKCC, 1997a, 1998a) which included the merger of nurse practitioners and clinical nurse specialists within this framework (UKCC, 1997b).   This was complicated by the introduction of the 'nurse consultant' role in the UK NHS in 1998 (National Health Service (NHS) Management Executive, 1999).   This added a further layer to the complexity of existing roles and definitions and promoted significant debate within the profession and within medicine (Coady, 2003; Hayes & Harrison, 2004; Graham & Wallace, 2005).   Following this, the UKCC launched a professional discussion on a 'higher level of practice' which included draft role descriptors (UKCC, 1998b, 1999 a, b, c). This work concluded in 2001 (UKCC, 2001) suggesting that advanced practice remain under a 'higher level of practice' umbrella.

Schober & Affara (2006) highlight that also during this period the International Council of Nurses (ICN) understood that the issue of definition was important globally and took an international lead in finding a consensus. In 2002, the ICN board concluded their survey and collaborative work to issue a position statement on the definition and role of the advanced practitioner (ICN, 2002).   The ICN definition of advanced nursing practice identified the need for the following components:

> `A registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master's degree is recommended for entry level.' (ICN, 2002)

The ICN has further advanced this consensus view with the publication of a scope of practice, standards and competencies (ICN, 2008).

In the UK, continued pressure within the profession and from the state initiated a further review by the Nursing & Midwifery Council (NMC – renamed organisation of the UKCC) in

2004 (Nursing & Midwifery Council, 2004). Following this, the NMC then defined advanced practice as:

> `Advanced nurse practitioners are highly experienced and educated members of the care team who are able to diagnose and treat your healthcare needs or refer you to an appropriate specialist if needed.` – Nursing & Midwifery Council (2005)

The definition also highlighted a range of activities that the advanced practitioner would undertake, including physical assessment, diagnosis, prescribing and use of investigations. In addition, broader skills of education, leadership and autonomy were included. The NMC also worked closely with the Royal College of Nursing (RCN) and Skills for Health (a government body) to further develop the concept, skills and competencies. Skills for Health published a career framework document (Department of Health, 2006a) in which it defined advanced practice as:

> `Experienced clinical professionals who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high-level clinical decisions and will often have their own caseload. Non-clinical staff at Level 7 will typically be managing a number of service areas.` –Department of Health (2006a)

The advanced practice role existed within a continuum from level 1 to level 9, as outlined in Figure 6. It is interesting to note that the lower tier remained the specialist category.

KEY ELEMENTS OF THE CAREER FRAMEWORK

9 — **More Senior Staff - Level 9**
Staff with the ultimate responsibility for clinical caseload decision making and full on-call accountability.

8 — **Consultant Practitioners- Level 8**
Staff working at a very high level of clinical expertise and/or have responsibility for planning of services.

7 — **Advanced Practitioners - Level 7**
Experienced clinical professionals who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high-level clinical decisions and will often have their own caseload. Non-clinical staff at Level 7 will typically be managing a number of service areas.

6 — **Senior Practitioners/Specialist Practitioners - Level 6**
Staff who would have a higher degree of autonomy and responsibility than 'Practitioners' in the clinical environment, or who would be managing one or more service areas in the non-clinical environment.

5 — **Practitioners - Level 5**
Most frequently registered practitioners in their first and second post-registration/ professional qualification jobs.

4 — **Assistant Practitioners/Associate Practitioners - Level 4**
Probably studying for foundation degree, BTEC higher or HND. Some of their remit will involve them in delivering protocol-based clinical care that had previously been in the remit of registered professionals, under the direction and supervision of a state registered practitioner.

3 — **Senior Healthcare Assistants/Technicians - Level 3**
Have a higher level of responsibility than support worker, probably studying for, or have attained NVQ level 3, or Assessment of Prior Experiential Learning (APEL).

2 — **Support Workers - Level 2**
Frequently with the job title of 'Healthcare Assistant' or 'Healthcare Technician' - probably studying for or has attained NVQ Level 2.

1 — **Initial Entry Level Jobs - Level 1**
Such as 'Domestics' or 'Cadets' requiring very little formal education or previous knowledge, skills or experience in delivering, or supporting the delivery of healthcare.

Figure 6 - Skills for Health (Department of Health, 2006a) NHS Career Framework

The RCN has played a significant role in the development although initially supporting the nurse practitioner movement. Working with Skills for Health and NMC, they evolved the nurse practitioner work to blend with the professional coalition that was developing during the mid 2000s. This included a guide to the role, competencies and programme of

education (Royal College of Nursing, 2008).   The Department of Health (England) recognised that roles continued to develop in practice, and a lack of consensus had created confusion and inconsistencies in practice. A position statement was issued in 2010 to clarify its position (Department of Health, 2010) which separated first level (initial registration) and advanced level nursing. It stated that:

> 'advanced level, where the registered nurse is working at a level well beyond initial registration, using their existing knowledge and skills to inform and further develop their practice. … Advanced level practice encompasses aspects of education, research and management but is firmly grounded in direct care provision or clinical work with patients, families and populations.' – Department of Health (2010), page 7

The position statement comprised 28 elements clustered under four themes:

- clinical/direct care practice;
- leadership and collaborative practice;
- improving quality and developing practice; and
- developing self and others.

Many of these elements existed within the models of advanced practice that had been emerging within the literature (Brown, 1998; Ackerman et al., 1996; Micervski et al., 2004; Manley, 1997; Hamric et al., 2009). Within the UK, the devolved Welsh and Scottish governments have also taken different approaches to developing the role.   A helpful descriptor has been articulated in the Welsh Assembly Framework on Advanced Practice (National Health Service Wales, 2010), which recognises that the plethora of titles are unhelpful for the public and the profession, and that distinctions between advanced and specialist practice should be seen as a continuum, as outlined in Figure 7. The Scottish government has developed a range of resources and the use of its toolkit is supported across Scotland (Scottish Government, 2008, 2010 a, b, c)
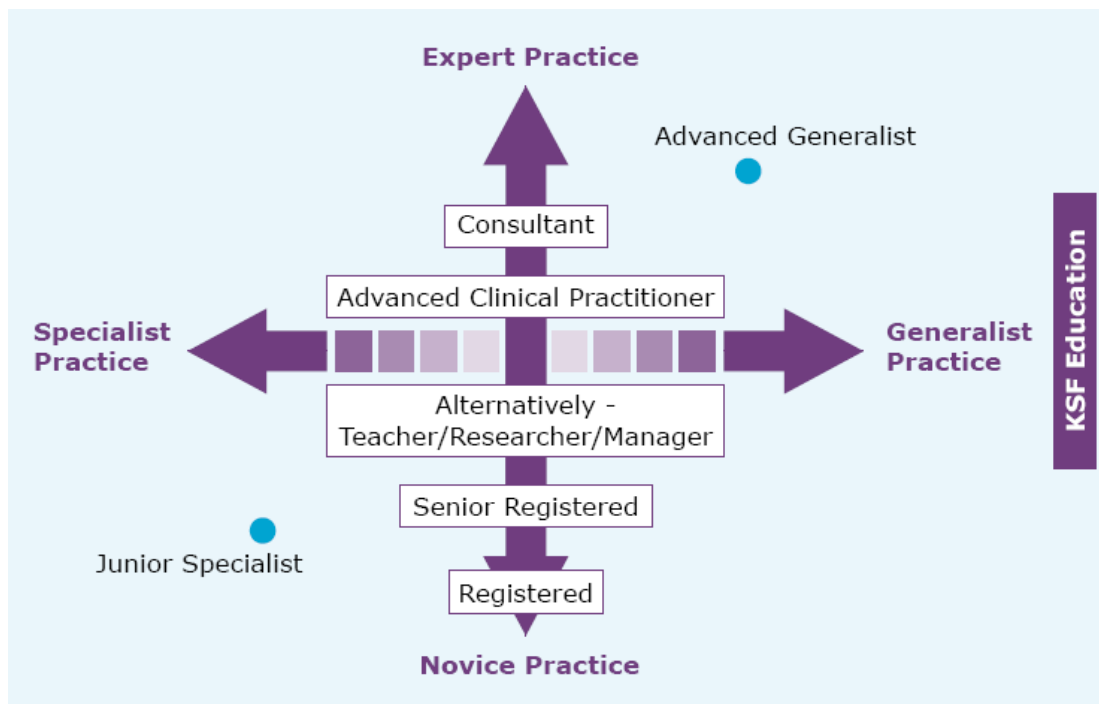
Figure 7 - NHS Wales' framework for Advanced Practice (NHS Wales, 2010)

Achieving a professional consensus has been more difficult and Hewison (2009) notes that there appeared to be a reluctance on the part of the profession to provide clear policy direction fostering periods of uncertainty. The debate centred on the clarification of definitions which Woods (1998) suggests is inevitably fraught with challenges. Whilst debate has continued within the profession, there remains a problematic issue of role type and its deployment in practice compared to the policy and position of the profession. Advanced practice as a concept has evolved and the recent clarification on definition and competency has largely found a consensus view. However, within clinical practice, the embedding of clinical roles and titles has continued where a significant number of roles exist, ranging from nurse practitioner, clinical nurse specialist, advanced practitioner to nurse consultant (Ball, 2005). In addition to this, AHPs have also developed advanced practice models within the NHS (McGee, 2009). The NHS has opened many opportunities for AHPs within the same policy framework that exists for nurses and midwives including physiotherapy, occupational therapy, radiography (Hardy & Snaith, 2007) and pharmacy. The addition of these roles has diversified the advanced practice model where roles are used across professional boundaries, and provided a challenge to nurses` perceived primacy to these developments. The introduction of the physicians`

assistant (PA) roles within the UK, in a range of clinical settings (medicine, surgery, anaesthesia and critical care) (Paniagua & Stewart, 2005) have done this. They have further challenged the nursing advanced practice role as adopted from the US model, where the requirements to directly support the doctor in clinical practice is an important distinction and one that is supported by the medical profession (Parle et al., 2006; Stewart & Cantanzaro, 2005; Hutchinson et al., 2001; Gavin, 2002).

The dynamic national and international situation has assisted in the embedding of advanced practice in the NHS. Nurses have taken on greater clinical influence, knowledge and skill within clinical teams, fundamentally altering the relationship between nursing, the state and other professional groups.

Advanced practice nursing and clinical leadership

The development of advanced practice suggests that nursing has taken a more active part in leadership roles (Hamric et al., 2009; Shober & Affara, 2006). However, there are some complex problems in both the organisation and interpersonal leadership styles of the professions caring for patients. The key question is how a nurse can effectively lead a multidisciplinary team when:

- culturally and professionally they are not expected to fulfil this role
- the organisation of health care is built on a positional hierarchy
- gender roles and stereotypes with medical colleagues develop a power imbalance

Antrobus & Kitson (1999) believe nursing leadership is insular and parochial. The complex nature of political, social and clinical change has often left nursing unable to respond to the leadership demands of a modern health service. In some cases, nurses have been actively held back by others (internally and externally) within the profession from truly realising their potential. Hurley & Linsley (2007) have an interesting viewpoint regarding the impact of what they term a 'neo-corporate environment' on nursing's ability to lead where there are systems and processes designed to control behaviour. They perceive that nursing has for many years been 'done to' in the leadership stakes and has

been on the receiving end of historical autocratic leadership styles. Clinton & Hazelton (2000), in their analysis of mental health nursing leaders, identified that this made them feel undervalued and unable to live out the leadership behaviours because of rigid structures and systems. Nursing leadership, to a large extent, still remains a *position* within the management structure and is delivered through a primarily transactional model. Bondas' (2006) study is a useful example where there is an explicit distinction made between *being* a clinical leader and *entering* clinical leadership. Her study of 68 Finnish nurses found nursing leadership classed as a role into which one entered consciously. Bondas (2006) also found that role models were key, plus educational preparation to undertake the role was important but seriously lacking.

Antrobus & Kitson (1999) state that nursing leadership literature is mainly internally referenced. It concentrates purely on the nature and purpose of leadership, leadership characteristics in nursing and the development needs of those who aspire to be in leadership positions. Whilst the nature of the organisation does go some way to explain nursing leadership behaviours, it does not fully cover why UK nursing leadership has not changed to a more collegiate basis of clinical leadership, as in Sweden and Australia (Shields & Watson, 2007). As Shields & Watson (2007) point out, in these models of healthcare, medicine and nursing are more equal partners. Nurses assert themselves as advocates for the patient from a strong social position backed by a university-based education.   However, what they fail to demonstrate is the different social position that women take in these societies. Scandinavian countries are held up as more socially egalitarian when compared with the UK, and, as Inglehart & Harris (2003) discovered, social policy and cultural behaviour have helped to achieve this. However, Gjerberg & Kjolsrod (2001), supported by Kvaerner et al. (1999), in their ethnographic study of female medical staff, found that gender-centric behaviours in healthcare still persist, most notably between female nurses and female doctors. This translates into fewer female medical leaders in these countries (Kvaerner et al., 1999, Showalter, 1999).

From the literature, we can conclude that organisational structure, culture, behaviours and gender play an important role in healthcare relationships.   The historical literature provides a clear link between 'nurses' character' and their perceived ability. Hean et al. (2006), utilising a questionnaire survey of health and social care students, identified a link with early professional stereotyping. They sought to understand what predetermined

stereotypical profiles students had prior to training and what impact this had on perceptions of leadership role and decision making. Their results demonstrated that doctors were perceived as the strongest leaders, decision makers and highest of all the groups on academic ability. They performed less well on team work and interpersonal skills, being overtaken by nurses and social workers. Nurses and doctors were only matched on professional competence and practical skills. As Hean et al. (2006) point out, this has important implications for team performance, harmony and potential conflict management, a view supported by Rudland et al. (2005). There are some limitations to their study, including a lack of long term follow-up during the course, and whether differences were still evident if they trained together.

A study by Kalisch & Begeny (2006) utilising the 'IOPT' (input-output-processing-template) instrument looked at 578 nurses processing patterns linked to organisational change against a range of other professions including teachers, scientists and managers. Their findings indicate that nurses most closely resemble customer service personnel as they typically refer to approved information sources with step-by-step operational knowledge. However, they were markedly different from other professions such as engineers, where unpatterned information was processed in relation to Relational Innovators (Ideas) and Reactive Stimulator (Decisive action). According to the author, this demonstrates an inability to initiate or accommodate change easily, although there were some minor differences as regards the type of specialty the nurses worked in and the way they adapted to change. However, the paradox was that nurse managers (i.e. those in positions of authority) have similar patterns to those in management in other industries. Kalisch & Begeny (2006) state:

> *'Nurse managers face a challenge in sponsoring and guiding change initiatives. They do not think like the people that report to them. If they follow the 'golden rule' they will do unto staff as they do unto themselves. If they do this the result will fall short of optimal.' - Kalisch & Begeny (2006), page 332*

The limitation of this study is that it did not assess medical staff to identify a different skills set, which would have proved an interesting comparison. Cook and Leathard (2004) offer an alternative perspective in their study, identifying the critical attributes of those followers

of leaders in nursing. Their ethnographic findings highlighted themes as: creative ability, highlighting/signposting, influencing, respecting and supporting. These are interesting when cross-referenced with Goleman's (1998) emotional intelligence five point framework of self-awareness, self-regulation, motivation, empathy, social skills, although there are some similarities and crossover of language. As identified by Shaw (2007) the followers of nursing leaders are looking for something different from that which is offered and what those outside industry appear to need to lead modern empowered organisations. There are two clear issues in this. Firstly, nursing leadership has not evolved significantly from the now outdated hierarchical transactional models built around a figurehead; it still requires positional power to be effective. Secondly, the current nursing leadership development approach may not be delivering the required level of change to fulfil the requirement of clinical roles in the future. A direct model of nurses leading care may be problematic especially when taking into account the literature reviewed in previous chapters.

Hanson & Spross (2009) identify that nursing has increasingly sought to 're-engineer' itself in the modern healthcare environment as technological advances and rising patient expectation increase demand (Rowe, 1996). Woods (1998, 2002) suggests that this re-engineering or reconstruction has been through advanced practice models where autonomy and clinical leadership has been a key component. Clinical leadership appears in a number of frameworks and models (Hamric et al., 2009; Manley, 1997; Department of Health, 2006, 2010; RCN, 2008; Scottish Government, 2008, 2010 a, b, c). Previous research has focused on nurse-doctor interaction within the domain of the professional nurse, traditional environments and medical nursing boundaries. However, advanced practice has transgressed the established normality of hospital practice with little empirical evidence to understand the dynamics of power this creates. As new clinical roles have been introduced, this has led to conflicts which Hanson & Spross (2009) believe is due to differences in ideological framework. Spross & Hanson (2009) suggest this is common when change and challenge of existing practice is made. Hamric & Delgardo (2009) also stated that contests of power occur during conflicts of clinical decision making and ethical discourse. Resolution of such conflicts is important to analyse, particularly looking at the strategies used by nurses. Porter (1991) and Hughes (1988) suggest that these strategies are more overt than previously thought, giving an indication of a power differential between doctors and nurses.

Development of advanced practice centred upon areas of medical specialisation – infection control and surgery, stoma care and colorectal surgeons (McGee, 2009); each was headed by a consultant and the nurse took his or her place within the 'team'. This system perhaps reflects well both the dominant patriarchal system and the bureaucratic enforcement of the negotiated medical model (Svenson, 1996; Allen, 1997). It is important for this study to extrapolate how this order is created and enforced, and to what extent advanced practice has a dynamic in the relationship.

This 'team' concept with its negotiated order ensures that the nurses` requirements of servicing the 'emotional workload' are met (Allen, 2001b). Thibodeu & Hawkins (1994) established that the advanced practitioners apply holism within a traditional medical model, relying mainly on psycho- social information. Larkin (1983, 1993) suggested that although power and authority may have shifted and boundaries been redrawn under such conditions, this has not resulted in the equalisation of power. Larkin further explains that because of the lack of power nurses have, they can only negotiate but not define their competence. Hamric et al. (2009) suggest that because physicians hold these views linked with the hierarchical structures of hospitals, the perception of advanced practice /doctor relationship is one of supervision, although commentators such as Barron & White (2009) see this as a consultative relationship. However, Overton Brown & Anthony (1998) and Duthie et al. (1998) both established the competence of early APN in complex clinical scenarios. More contemporary evidence continues to support this (Jones, 2005; Brooten et al., 2002; Kleinpell et al., 2005; Cunnigham, 2007; Ingersoll et al., 2001; Phillips, 2005; Sears et al., 2007).

Importantly in the power dynamic interface, socialisation and professional attitudes are prevalent as found by Baggs et al. (1997), who looked extensively at the decision-making processes of specialist nurses in a longitudinal descriptive correlation study. They noted that the causative agent for this was the physician's belief that they are the primary decision makers and need not collaborate with others. Cassell (1992) reiterated this with regard to surgeons as they diagnosed, defined treatment and organised the operation time.

Summary

Although Stein's (1967) work has been critiqued by many, his work is still often quoted today. The contemporary evidence highlights a general shift in the micro behaviours in the clinical environments in which doctors and nurses interact. However, beneath this is a remarkable, resilient ordered relationship between the two professions. There has been a significant period of time and opportunity since the creation of the NHS for this relationship (and power) to change and be researched. Little contemporary work has developed an understanding of the relationship, and, sociologically, what this means for power in healthcare and more generally.

Advanced practice research provides an opportunity to take forward this work in a potentially influential way. Woods' (1998) view is that advanced practice has reconstructed the role and perception of nursing in the contemporary healthcare system. To a degree, he is correct that advanced practice has evolved the role of the nurse in healthcare although it can be argued that it is healthcare that has reconstructed nursing in this current form, not nursing. A great deal of evidence has highlighted how the roles have developed with equal resistance from the nursing profession, as this direction of travel takes nursing further way from its traditional role and function.

However, there is little research evidence about the sociological impact of the advanced practice role on the interaction and power dynamics between nurses and doctors. Equally, there is insufficient evidence regarding the medical perspective on these roles, and how they are viewed and incorporated into the healthcare system that is still to a degree modelled on a traditional basis of medical power.

Chapter Four – Methodology

Introduction

The aim of this chapter is to outline the scope and process of the research. This includes a review of ethnography and why a critical realist ethnographic approach was chosen as the appropriate method. The chapter will also review the challenges related to undertaking ethnographic research in a busy healthcare environment and there will be a discussion of the suitability of the specific sites, teams chosen for inclusion in the study and the chosen collection methods. These include participant observation in the peripheral membership role (Adler & Adler, 1987), follow-up interviews and review of the artefacts at the clinical sites. Ethical issues and practical challenges are also discussed. A full and detailed overview of the research process is outlined in Appendix 3 on page 353 and later in this chapter. A substantial amount of information was gathered which required a thorough and systematic approach to cataloguing, maintenance, analysis and management. The final section will examine these aspects in detail, with an analysis of the Computer Assisted Qualitative Data Analysis Software (CAQDAS) used during the study.

Aims and research questions

The study reported here aimed to enhance the current understanding of the communication and power dynamics in the relationship between doctors and advanced practice nurses in acute hospitals by:

- Exploring the creation, development and division of labour of the advanced nursing role in the contemporary healthcare setting.
- Identifying and examining the use of knowledge and the development of expertise in the relationship between doctors and advanced nurses within the clinical setting.
- Exploring power within these roles and its wider impact on clinical teams of doctors, nurses and other healthcare staff.

- Understanding how this translates into communication strategies and behaviours between professions in clinical practice.

This study did not set out to specifically test previous theory on doctor-nurse interaction, but to fully explore the duality of power relationships, capturing the contemporary realities of both professional groups during their clinical work. Through observation and understanding issues of individual agency and social structures, the researcher aimed to truly define the characteristics of the relationship. In addition, a detailed approach was required that sought to examine the thoughts, feelings, values, beliefs and personal experience of all the agents (doctors and nurses alike) and the structures they worked within.

Selecting the methodology

Understanding agency and structure dynamics through research

The theory of Giddens and Bourdieu have taken forward the debate on power to include a rational attempt to bridge one of the fundamental issues within social theory – that of the agency/structure debate. Giddens and Bourdieu offer elegant solutions to this problem, which are discussed in detail on page 22. Bakewell (2010) highlights that there remains a significant debate on the issue as to whether it is concerned about the relationship between micro and macro levels of analysis, voluntarism and determinisms or individuals and society. It is particularly important for this study with advanced practice nurses and doctors in hospital settings for a number of reasons. The literature review on power in healthcare highlights a complex set of agents, structures and relations, yet the majority of research on doctor-nurse interaction focuses on the agency of the individuals in interactions (Hughes, 1988; Porter, 1991; McKay, 1993; Allen, 1997; Snelgrove & Hughes, 2000). Other than gender, they struggle to take account of the broader social structures in shaping or influencing these interactions. In addition, the literature also creates an orthodoxy of the nurse in a subjugated position to medicine, with little understanding of the degree to which this power differential has been maintained and

managed by the agents or the structures. Of theoretical concern is that this orthodoxy has become largely universal, stemming from scholarly work that has focused upon a critical and oppressed 'nurse-centric' viewpoint to this position and not fully taken account of the medical agency nor nurse self-determinism. It is important to understand the degree to which this subjugation is real or not – this cannot be achieved through agent or structural analysis alone. Whilst the literature explores the political, economic and social factors that have developed the nursing role and power, they have not concluded how this has altered the individual or professional power of the nurse.

The literature review highlighted gaps in the research in relation to nurse-doctor interaction and, in particular, the paucity of work related to advanced practice nurses. In addition, a balance has not yet been struck within the scholarly work as to the agency/structure influence on the relations. However, there were a number of key influences from the literature on the study design and these are summarised in Table 3.

Existing literature	Theoretical influence	Study design influence
Power: Bourdieu (1977, 1984, 1990)	The agency/structure dynamic on power relations. Concepts of capital, habitus and field in the development of power.	Naturalistic setting ethnography
Doctor - nurse communication: Porter (1991)	Doctor-nurse communications are complex and subtle. They include overt and covert behaviours.	Participant observation Prolonged observation in the setting
Negotiated order perspective: Allen (1997, 2001a)	Face-to-face inter-occupational negotiations delineate the nursing medical boundary of work in hospitals.	Observer to participant spectrum of role Public (Observation) vs. Private (Interview) Multiple sites Reflexivity of being a nurse Artefact analysis
Incorporation dominance: Carmel (2006)	Medical dominance of nursing is more subtle in complex clinical settings with specialised nursing skills.	Prolonged observation Multiple sites Representation of dual professional perspectives Conversational interviews in the field

Table 3 - The influences of theory from existing literature on the study design

Ethnographic enquiry

Mackenzie (1994) and Bruni (1995) report that ethnography has been developed within the disciplines of anthropology and sociology, where Boas (1928) and Malinowski (1922) have been credited as its founders. Mackenzie (1994) notes that although ethnography shares similar values with other qualitative methodologies, its focus is fundamentally concerned with a person`s experience and actions within a specific culture. Ethnography has been used widely to understand social meaning and the interactions of communities, cultures and individuals. This includes more contemporary analysis of organisations and institutional cultures (Walby, 2005). Brewer (2000) and Reeves et al. (2008) note that ethnography, like many methods, has undergone a conceptual and theoretical regeneration. This has evolved to include many subtypes such as auto-ethnography, meta-ethnography, critical realist and virtual.

Ethnographic enquiry has the ability to understand the perspective of an individual in a cultural context which has given greater flexibility to nursing and social researchers. This includes early nurse researchers such as Dr Madeleine Leininger (1969, 1970) who saw this approach as a challenge to the dominant research paradigm of positive empiricism. Patton (2002) identified that culture is central to ethnography and that research must focus on the culture of the group. Hickey et al. (1999) suggests that nursing and medicine are cultures as notions of hierarchy and power are indicators of cultural identity. Ethnography has therefore been used widely in healthcare settings, and notable examples include – the classic *Boys in White* by Becker et al. (1961) which examined medical school culture, to more contemporary examples including surgical care nursing (Clabo, 2003; Gardezi et al., 2007), emergency care nursing (Purc-Stephenson & Thrasher, 2003; Walsh, 2009), mental health nursing (Allbutt & Masters, 2004), intensive care nursing (Carroll, 2008; Hancock & Easen, 2008; Philpin, 2006), midwifery (Dykes, 2009), and general nursing (Allen, 1997, 2001a; Price, 2009; Smallwood, 2003).

Within the existing literature on doctor-nurse interactions, ethnographic methods have been used extensively (Allen, 1997; Carmel, 2006; Coombs & Ersser, 2004; Hughes, 1988; Porter, 1991; Riley & Manias, 2002) to draw out the specific cultural perspective of the relationship. From the perspective of power studies, Bourdieu was an important proponent of ethnography and used the method extensively (Bourdieu & Wacquant, 2000;

Bourdieu, 2000) to gain an understanding of the elements of 'practice' though his work in Algerian communities. When combined with the concepts of power, the use of ethnography becomes more relevant, but poses some interesting issues. Kuokkanen & Leino-Kilpi (2001) in their study on nursing empowerment, draw one important methodological perspective in that studies of power must seek to understand from the bottom up rather than top down. This is in essence the truth for the discovery of the relatedness discussed by many of the theorists, and is an important perspective of this study.

However, Hammersley (1992) and Atkinson & Hammersley (2000) drew attention to a conceptual and methodological confusion of ethnography in a collection of papers, *'What's wrong with ethnography*?' Hammersley (1992) outlined that whilst ethnography had been broadly accepted as a key research tool for social science it sat between two strands of practice, that of 'naive realism' and 'relativism'. Hammersley outlines that the basic assumption in ethnography is that description itself can generate theory but challenges ethnographers with the fact that they are committed to a reproduction model of research. Hammersley (2000) identifies that ethnography is partially selective as it is tied to the ethnographer and the situational context of the data collection. Hammersley (1992) highlights that truth underdetermines descriptions and that other values and concerns play a role in their production. By accepting this reproduction model, the basis of the research could be flawed. He put forward a 'subtle realism' model that aimed to bridge this gap, where Banfield (2004) notes:

> *'Collapses realism and anti-realism in a kind of smorgasbord approach to the production of theory.' - Banfield (2004), page 55*

Banfield (2004) suggests that this 'smorgasbord subtle realism' has some problems, most notably the point of view of the ethnographer on reactivity and reflexivity in the analysis. More fundamentally, the reality of the agent and its relationship to social structure is only hinted at, rather than definitively explained. To answer the question within this research, an alternative ethnography is required without the methodological and theoretical constraints as outlined above.

Developing a critical realist approach to ethnography and 'digging deep'

Understanding agency and structure within this research is critical to understanding power between doctors and nurses, and the method should seek to do this, although the use of classic or subtle realist options is problematic. Brewer (2000) suggests that a critical realist approach would enable the focus on the 'generative structures and ethnographic imagination' of the issue of human agency and structure. An ethnography using a critical realist approach sets out from the perspective that the subjects' own accounts are the starting point but not the end of the research process. They go beyond the agents' conceptualisation of events and seek to look at social structures, as Brewer states:

> 'Structures are real; their effects can be demonstrated in causal connections in the material world even if such structures also constrain agency. But they also simultaneously enable agency by providing the framework within which people act and such agency reproduces (and occasionally transforms) the structure it occurs within.' Brewer (2000), page 50

The philosophical basis of critical realism has been largely associated with the British philosophers Roy Bhaskar and his mentor Rom Harré, with more recent contributions including the works of Archer (1995), Collier (1994), Danermark et al. (2002), Lawson (1997), Manicas (1987), Outhwaite (1987) and Sayer (1992, 2000). Within a critical realist approach, Bhaskar & Danermark (2006) suggest that social phenomena are seen as a result of a plurality of structures, where human action is conceived as both enabled and constrained by the social structures. In turn, this action can reproduce or transform those structures. Bhaskar & Danermark (2006) have argued convincingly that critical realism is a metatheory, but also a less restrictive methodological approach to be applied in other theories and settings:

> 'It is maximally inclusive as to causally relevant levels of reality and additionally maximally inclusive insofar as it can accommodate the insights of other theoretical perspectives.' - Bhaskar & Danermark (2006), page 294

What sets it apart from other ethnographies is the aim not only to describe events but also explain them with a focus on how agency maintains these structures. Banfield (2004) suggests that this 'digging deep' approach probes domains beyond those that are directly observable. This depth aligns with Bhaskar's (1978) purest transcendental realism theory where he described three interrelated ontological domains (Table 4).

Table 4

	Domain of the Real	Domain of the Actual	Domain of the Empirical
Mechanism	✓		
Events	✓	✓	
Experiences	✓	✓	✓

Table 4 - Ontological domains (Bhaskar, 1978), p 13

Critically, the domain of the Real consists of the underlying structures, mechanisms and relations as well as events, actions and experiences. The Empirical domain consists of simply what is experienced, but is a part of the Realist domain. A realist approach to ethnography requires a recognition of all three domains: that which is experienced by the agents and the researcher; the action and events noted during fieldwork (or not), but reflected upon by the participants; understanding an analysis of the causal level of the embracing mechanism that creates events. While these may not readily be apparent, they can be observed and experienced by their effect, as in Sam Porter's work on racism in the healthcare setting (Porter, 1993). As Bhaskar (1989) notes, people's actions will be influenced by innate psychological mechanisms as well as wider social ones. He goes on to say that:

> 'persistent relations between individuals and groups and with the relations between these relations. Relations such as between capitalist and worker, MP and constituent, student and teacher, husband and wife. Now such relations are general and relatively enduring but they do not involve collective or mass behaviour.' - Bhaskar (1989), page 71

A realist approach recognises that something may be real without it appearing at all, and that social structures may have unexercised causal power. The literature review of power highlighted that in many cases it has a nebulous quality that may or may not elicit action (or inaction) dependent on a range of actors, social systems and context. However, its presence, active or benign, exerts an influence that can be observed and understood. Like theories of power, there are no guarantees that these conditions will create power dynamics. Banfield (2004) highlights that events are not determined by mechanism, and causal laws are not predictions. Houston (2001) argues that Bhaskar's realist approach to research must involve the appropriation of relevant explanatory theory which must assist in understanding the causal mechanism.

Bourdieu has put forward an elegant theory of power that attempts to bridge the fissure between agency and structure although his theoretical alignments are not precise. Bourdieu vacillates between a realist and post-structuralist position, although attempts to interpret Bourdieu as a 'critical realist' have been made (Outhwaite, 1987; Fowler, 1996; Nash, 1999); Robbins (1991) suggests that Bourdieu's 'realism' is actually a form of sociological realpolitik maintained within his commitment to a phenomenological epistemology.

Anspach & Mizrachi (2007) also align this perspective with Bourdieu's concept of the field where fields are arenas in which agents compete for resources in cultural capital. A critical realist ethnography, therefore, works through the small-scale interactions of the agents to build a picture for wider understanding of the social structure in which they operate. By default, it delivers accuracy, credibility and therefore truthfulness in the findings (Lincoln & Guba, 1985). Brewer (2000) takes this a stage further with his concept of 'ethnographic imagination' which describes the leap necessary to recognise the authority of ethnographic findings through openness which he describes through three main principles. Firstly, the belief that the fragments of interviews and observation notes represent the social world, as long as the researcher has been reflexive with the findings. Secondly, micro events have wider common features of a broader social construction. Finally, as highlighted in Bourdieu's (1990) Habitus, people aim to make sense of their world through the meaning of everyday events. The influence of this on the study design is outlined in Table 5.

	Domain of the Real (Bhaskar, 1978)	Study Design	Ethnographic material
Mechanism	✓	Observation Field notes	Analytical field notes Formative Analysis Summative analysis
Events	✓	Interview Artefacts	Interview transcripts Participant feedback on field notes/interview Artefact analysis
Experiences	✓	Observation Interview Reflexivity	Interview transcripts Participant feedback on field notes/interview Reflexivity notes

Table 5 - Realist approach to the study design

A critical realist approach to ethnography and gender

The literature review highlighted that much of the scholarly debate on the power dynamics between doctors and nurses contains much in terms of labelled view such as gender and class. It is important to frame this in the context of the chosen method.

The majority of nurses (ANP or not) are female and the literature has put forward a body of work that projects them as a subjugated profession to a male-dominated medical profession. As Alldred (1998) suggests, there are a number of ethical, methodological and political dilemmas of researching and representing lives of people who are potentially marginalised within and by the domain of public knowledge. This is an important point for consideration when using a critical realist approach ethnography. Bhaskar (1978) himself rejected the pure feminist position due to its focus on biological reductionism. However, gender may be represented in the experiences and events of the participants of this study and the method should be sensitive to these issues. A critical realist approach is well suited to this type of research due to the immersive nature of the process, and the joint experience of the researcher and participants - that is, it seeks to understand the lived experiences of women through narratives and events in the Domain of the Real. In addition, this inquiry takes account of time, environment, social openings and barriers from the real experiences, events and social mechanisms. This creates a sense of the

gender experience and seeks to create an understanding of the role of the advanced practice nurses in contemporary healthcare.

This gender position cannot be ignored as it should be an important perspective on the research design. As Brewer (2000) suggests, the labelling and approach during the research is critical. Women must see the researcher as an equal, with a moralistic need to ensure the emancipatory aims of the research goals rather than the production of knowledge for its own sake. Webb (1993) believes that 'gender centralisation' in research removes objectivity, as amongst others postmodernists reject the very idea of value neutral social science. As the researcher is male, an understanding of this influence is required and undertaken on page 96 .

It is clear that the issue of representation and presentation are important dimensions when conducting critical realist ethnography and researching possible gender issues. It is important that this influences the trustworthiness of the research and the process is open and engages with those whose lives are part of the ethnography (Lincoln & Guba, 1985). Fundamentally, the critical realist approach aims to not only describe the events, but identify the structural influences and how agents can transform them. It therefore provides the opportunity to be participative and transformative when compared to other ethnographies, a view that Swartz (1997) links with Bourdieu's emancipatory aims of sociological knowledge.

Selection of the study settings

The original research proposal was submitted for MPhil degree and concentrated upon a single site. This NHS Trust site (District) was chosen because it had a history of developing advanced practitioners` roles. The researcher had worked there and understood the organisational culture sufficiently to enable easier immersion in the study setting. It was central to the researcher's thinking that access to the study setting and building rapport with the gatekeepers and participants was going to be crucial in understanding the practice domain. In addition, accepting that insider knowledge would need to be addressed within the methodology and discussion (Lincoln & Guba, 1985).

Following the initial work and formative analysis on the District site, it was evident that significant new areas of knowledge in the relationship and interactions between doctors and nurses had started to emerge. A range of interesting findings had been drawn from this one site. It became clear that this study would be enhanced by undertaking further fieldwork in a different organisation. This proposal was submitted to the Faculty Research committee for consideration, and also extension to PhD. Ethics approval was granted due to the fact that no site-specific assessment (SSA) was required in the original ethics notification.

Phase two of this research involved undertaking the further fieldwork with similar teams in another organisation within the scope of the local health economy. An NHS Foundation Trust was identified (Urban site). This organisation was chosen due to its size, Foundation Trust status and what appeared a significantly different culture and ethos to the District site. It was perceived to be a more medically-dominated organisation with fewer advanced practitioners. R&D approval was gained from the Urban site. The additional material would enable further analysis to be undertaken regarding the relationship, but specifically to:

- Test out the applicability of the model in another organisation.
- Study the role of organisational culture on the relationship.
- Understand in more detail, the complex influences upon the nurse-doctor interaction model.
- See how far the changes in status of doctors and nurses are exclusive to this site or more generic across the NHS.
- Assess the applicability of the results to a wider population.

A further four case studies were approached at the Urban site and, where possible, these were matched to the cohorts that had already been reviewed on site one. There are methodological considerations as well as practical concerns using multi-site ethnography. Marcus (1995) notes that multi-site ethnography has been emerging since the 1980s as a direct response to researching 'globalised communities' and 'transnational' trends of capitalism. He states that:

> *'Multi-sited ethnography is intellectually constructed in terms of the specific constructions and discourses appearing within a number of highly self-conscious interdisciplinary arenas that use the diverse high theoretical capital that inspires postmodernism to reconfigure the conditions for the study of contemporary cultures and societies.`* Marcus (1995), page 103

Its use is increasing and with the dynamic working environment of the acute hospital and the agents within it being highly mobile (professionally and clinically), then multisite will enable comparisons to be drawn. Carmel (2006) used this to good effect in his study on doctor-nurse interactions in three intensive care units. However, Marcus suggests that ethnographers must examine the mode of construction in which they will operate, such as 'follow the people', 'follow the thing', 'follow the plot/story/allegory' and 'follow the life' which will be discussed later.

During the research process at the Urban site, (two cohorts had been reviewed), the researcher changed employment to an organisation in a different city. This posed some significant issues for practically completing the data collection and a more fundamental methodological one. Two choices were evident a) continue to collect information at the second site as per original plan b) review the new organisation and identify if any further evidence could be gained from an additional site being added to the study. The new organisation (Metropolitan site) was a far bigger University Hospital, which had a different organisational culture and structure from that of the first two. It was determined that the addition of this site would add to the findings through an additional perspective in the debate. Ethical and R&D approval was granted and two cohorts were approached following permissions being received from the senior leaders of the organisation.

Selection of the cohorts

McGee (2009) indicates that as advanced practitioners are few in number compared to the general nursing workforce, opportunities to research them are often limited. In addition, ambiguity exists over definitions, titles and working practices of the roles in the clinical domain. Judgement sampling was therefore proposed to find appropriate

practitioners for inclusion in this study. Miles and Huberman (1994) and Gerrish & Lacey (2006) believe that qualitative researchers must characteristically think purposefully and conceptually about sampling. Honigmann (1986) agrees with this view, and suggests that in ethnographic study, the deliberate subject selection is best defined as judgement sampling. Therefore a structured approach was taken in the selection of participants (see Appendix 5, page 355) which included detailed preparatory work. From the author's perspective, the selection of participants and immersion were intrinsically linked and dictated the approach taken to understand the organisational structures and hierarchy through formal and informal communication systems. The additional benefit also aids the acceptance of the researcher in the field.   After permission to approach participants had been received from the Directors of Nursing and Medicine (letters of request are included in Appendix 6, page 356 and Appendix 7, page 357), the workforce directory was interrogated to find suitable staff to be included in the study. These roles included titles such as:

- Clinical Nurse Specialist
- Specialist Nurse
- Nurse Practitioner
- Advanced Practitioner
- Advanced Nurse Practitioner
- [Specialty] Nurse/Specialist Nurse, i.e. Cardiac Nurse Specialist or Gynaecology Nurse Specialist

At the District site, a forum for advanced practice existed, headed by a Senior ANP. Permission was sought to attend a meeting to discuss the research in more detail. A similar letter was sent to the lead, and the researcher attended the next meeting to discuss the context of the research and get feedback on potential participants. After this initial meeting, permission was received to approach nurses, and a general communication letter stating the research aims was sent out to them all which included a participant information sheet (Appendix 8, page 358). The initial criteria for inclusion were highlighted and included an analysis of all of those roles that existed in the District site.

A detailed overview of the included cohorts for site one is identified in Figure 8, page 91.

Essential Criterion	Criteria & Rationale
Advanced Practitioner	Role, title, job plan analysis with groups to recognise the spectrum of advanced practice roles.
Working with or alongside doctors	Those teams that shared all or part of their work with medical practitioners, as registered with the GMC
Interest in study	Expressed interest in study
Desirable Criteria	**Criteria & Rationale**
Significant experience as an Advanced Practitioner	The participants had greater than 5 years experience in Advanced Practice
Worked with junior and senior (Consultant) doctors	Worked with a range of doctors in clinical settings so that a full range of interactions could be studied.
Worked within a wider team of Advanced Practitioners	Worked with a team of senior and junior Advanced Practitioners so that the element of experience and work domain could be understood.
Worked in a fixed clinical location.	Worked in a single domain, such as clinic or department, as Burgess (1994) believes that this allows the researcher to focus on the social rhythm, pattern of events and behaviours.

Table 6 - Outline criteria for inclusion

Essential and desirable criteria were established, see Table 6. As a multitude of roles and titles existed for advanced practice, it could only be determined if they were working and operating as such through meetings and discussions with the teams themselves. A number of clinical teams made up of advanced practitioners and doctors were approached (more than was required for the research) and information about the research supplied (participant information sheets can be found in Appendix 10, page 360 and Appendix 11, page 363) After a number of meetings, discussions and informal visits with

the nurses and doctors, three cohorts were identified at the District site. A more detailed description of their work domain is included on page 126.
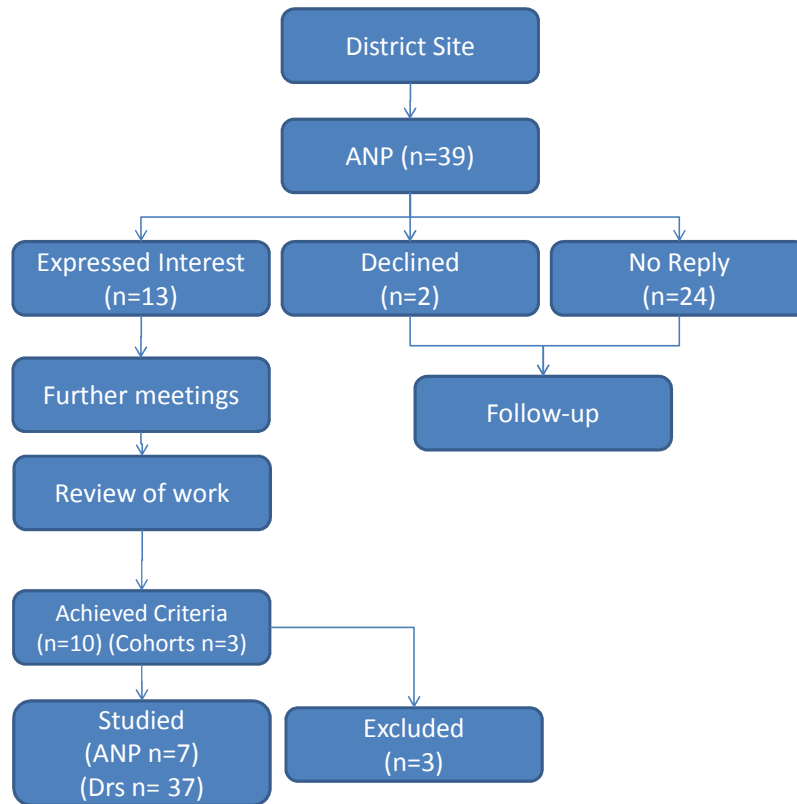
Figure 8 – District site cohort selection process

The same approach strategy was applied to the Urban site, including contact letters, meetings and assessment. Three cohorts were identified, including fourteen specialist nurses. Eleven were studied and one team (ANP n =3) was not included due to the change of employment by the researcher. A detailed overview of site two cohorts is indicated in Figure 9, page 92.
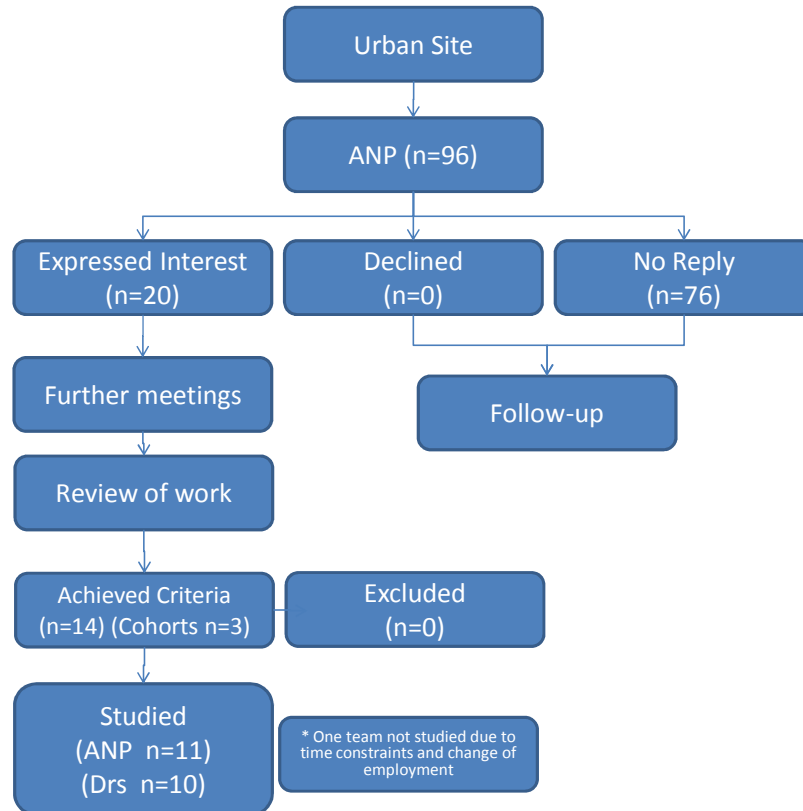
Figure 9 - Urban site cohort selection process

The search strategy for the Metropolitan site was driven by the aims of the research to make a comparison across organisations to identify any themes. It was therefore important that the additional cohorts shared similar work domains or practices. The same permission and approach process was instigated, although two specific cohorts were targeted for cross-site comparison.   The researcher found the process of judgement sampling enhanced and supported the process of immersion and understanding of the study settings. It also enabled a significant dialogue to be developed with the participants and others in the organisation. This also posed some ethical considerations including consent when working in the practice domains, and this will be discussed in more detail on page 112.

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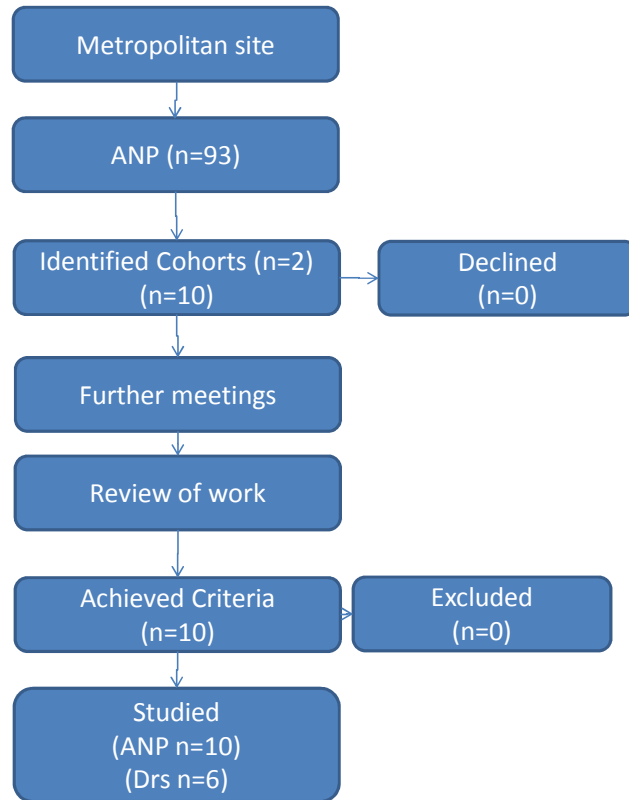
Figure 10 - Metropolitan site cohort selection process

Methods of data collection in the field

The research questions required an approach that took into account the observable behaviours, attitudes and beliefs of the teams under scrutiny. In addition to this, linking the thoughts and feelings of the participants to these events were vitally important.

Within the literature, the structural elements of the power dynamics are influenced by the organisation or social system created by the agents. Dix et al. (2003) suggest that analysis of the artefacts of the organisation can shed some light on this perspective. This approach will enable a triangulation of multiple sources of information and contribute to the trustworthiness (Lincoln & Guba, 1985). This critical ethnographic approach, therefore, uses observation, interview and documentary analysis as its methods, and they are interlinked to enable the researcher to gain the fullest understanding of the domain of

the advanced practitioner and doctors in acute hospital environments. The overview is outlined in Figure 11.

Figure 11 - Overview of the data collection process

These methods and their implications will be discussed in the next section. The total time taken for the fieldwork is outlined in Table 7. A more detailed overview of the data collection methods has been developed into a site-specific matrix in Table 8 on page 95.

	District Site	Urban Site	Metropolitan Site
Cohorts	3	2	2
ANP	7	12	11
Doctors	37	10	6
Informal Visits and Meetings	22 h	22 h 30 m	15 h
Observation	76 h	39 h	27 h
Interviews	5 h 47 m	3h 18m	4 h 2 m
Artefacts	7	77	xx
Time Totals	**103 h 47 m**	**64 h 48 m**	**46 h 2 m**

Table 7 - Outline matrix of fieldwork

Site	District Site			Urban Site		Metropolitan Site	
Informal Site Visits and Meetings (n (hours))	14 (8' 30")			9 (9' 30")		8 (8' 30")	
Gatekeepers	Medical Director, Nursing Director, General Managers, Clinical Directors, Matrons, Lead Nurses, Ward Managers, Administrative Managers			Medical Director, Nursing Director, General Managers, Clinical Directors, Heads of Nursing, Matrons, Lead Nurses, Ward Managers, Administrative Managers		Medical Director, Nursing Director, General Managers, Clinical Directors, Heads of Nursing Matrons, Ward Managers, Administrative Managers	
	Cohort 1	**Cohort 2**	**Cohort 3**	**Cohort 4**	**Cohort 5**	**Cohort 6**	**Cohort 7**
Specialty	Urgent Care	Cancer Surgery	Specialty Surgery	Critical Care Outreach	Acute Pain	Critical Care Outreach	Acute Pain
ANP (n)	1	2	4	7	5	6	4
Doctors (n)	10 Cardiac + 7 ED	11	9	4	6	3	3
Others (n)	4 AHPs & 10 Admin	2 Nurses & 6 Admin	2 Nurses & 7 Admin	5 Nurses & 2 Admin	3 AHPs & 2 Admin	1 Admin	2 Admin
Informal Cohort Visits and Meetings (n (hours))	4 (2')	3 (1' 30")	6 (4')	4 (3' 30")	7 (5')	4 (2')	3 (2')
Observation Episodes	2	5	6	6	2	3	3
Observation	11 hours	32 hours	33 hours	34 hours	5 hours	15 hours	12 hours
Post observation formal Interviews: Role : (hours, min)	CNS (1'05")	Interviews as observation* (CNS & Cons)	CNS (53") CNS (37") CNS (52") CNS (35") Consultant (48") Consultant (57")	CNS (48") CNS (47") CNS (32") AS. Dr (35") FY1 Dr (36")	Interviews as observation* (CNS & Cons)	CNS (42") CNS (32") CNS (30") SpR. Dr (36")	CNS (35") CNS (35") CNS (31")
Interview total	(1'05")		(4'42")	(3'18")		(2'21")	(1'41")
Artefacts (n)	7			77		15	
Follow-up Meetings & discussion	2 (2')	1 (1' 30")	3 (2' 30")	2 (2')	1 (30")	1 (1')	2 (1' 30")

Table 8 - Detailed matrix of fieldwork

As indicated previously in the thesis, the researcher was a qualified nurse who also worked as an advanced practitioner. This is important in the context of conducting the ethnography and raises some important questions regarding the insider/outsider dilemmas for the researcher which will be addressed in the next section.

Insider/Outsider perspective

The insider/outsider dilemma in field research has generated considerable debate and comment within the fields of anthropology, education (Hellawell, 2006), nursing, management, social work, and sociology.

Mercer (2007) identifies two distinct phases in the development of this debate in relation to field research. Early in the 20th century, seminal anthropological research was undertaken by individuals on communities and cultures where it was clear that they, as white outsiders, were distinct from the people they researched (Boas, 1928; Malinwoski, 1922; Mead, 1929). From these studies it is easy to create a distinction between the 'stranger and the native'. The second phase in the later part of the century saw greater focus by anthropologists and sociologists examining more familiar cultures and ones that the researchers were part of, including race, gender, sexual orientation, profession or geography. Mercer (2007) and Hellawell (2006) agree that this created a dichotomy in field research where the researchers were classified in the roles as either an insider or outsider. Merton's (1972) classic description of the insider is:

> 'members of specified groups and collectives, or occupants of specified
> social statuses. Outsiders are non-members' - Merton (1972), page 21

Hellawell (2006) puts greater granularity in this definition by highlighting the fact that whilst the insider may have *a priori* knowledge of the community and its members, it does not necessarily mean being a member of it themselves. The advantages and disadvantages of each viewpoint have continued to be vigorously debated within the literature (Lewis, 1973; Hammersley, 1993; Naples, 2003; Anderson & Taylor, 2005; Samkian, 2007). This debate centres on the ability of the researcher to truly understand the culture they are researching, the crucial point being that as an insider or outsider, the researcher may be able to collect data from different points of view.

However, to address this within this research, it is important that the researcher's personal background is understood so that the implications of the insider/outsider perspective on the methodology can be examined and understood. To frame this, the following section will be written in the first person to make a cognitive connection between the research and the researcher. As discussed previously, I am a qualified graduate male nurse, who has worked in the fields of emergency and perioperative care since 1994. This includes a period of ten years as a clinical nurse specialist in perioperative emergency care (see background to this study, page 2) and as a nurse consultant. I have worked mainly in the NHS at a small number of 'District General Hospitals' but also in the private hospital sector and education at a local university.

Merton (1972) rejected the dichotomy of insider and outsider as a fallacy due to the fact that:

> 'As situations arise, different statuses are activated and the lines of separation shift' - Merton (1972), page 28

It is apparent that my position within the research is indistinct in that I am not an outsider by the fact I share much with the community that I am researching. Alternatively, aspects of my background also exclude me from the true insider position. Further nuances develop when applied to other aspects of my background and the research. From the medical perspective, I am an outsider, but insider to the nurses. From the nurse's perspective, a researcher rather than nurse. From the gender perspective of female nurses and doctors, I am male. Researching an organisation that I had previously worked in makes me an insider, but an outsider at the other sites. Similar perspectives are also apparent when taking into account other dimensions such as gender, ethnicity and age. Labaree (2002) also recognised this limitation within the traditional dichotomy of insider/outsider debate and argued that a researcher can be simultaneously an insider and outsider which can be conceptually identified as multiple continua.

As Mercer (2007) identifies, some issues of identity are fixed as, in my case, gender, ethnicity and profession. Some, such as age, are innate but take on a positional perspective during the research dependent on the observed or interviewee. Other more nebulous issues such as situational context, time, place, personalities and power relationships can all be influencing factors. However, gender is an important issue as highlighted at the beginning of the chapter. As a male researcher, researching a

predominately female professional role can have implications for the research and subsequent analysis. Harding's (1988) view is that if research is completed to understand women's issues, based upon Lather's (1988) idea of empowering a more just society, then it is possible, although Kremmer (1990) stresses the paradox that men who have an appreciation of women's issues should realise their incompatibility with the research. Therefore, if by this definition you have to be a female to do research with women then as a man I may not be in a position to do so (Farrar, 2008). However, if a man can appreciate that women are oppressed from their own experience and challenge this through research, then they can engage in research (Wadsworth, 2001). Webb (1993) believes that ethnography is particularly appropriate for understanding gender, because the immersion in everyday life and development of relationships is key. However, Stacey (1988) suggests that this opens the possibilities for exploitation, in that the ethnographic process involves manipulation, betrayal and misrepresentation to gain information. By choosing a participant as observer methodology, it is hoped that the researcher can overcome some of these limitations and better structure the research.

The consensus view (Naples, 2003; Anderson & Taylor, 2005; Hellawell, 2006; Samkian, 2007) suggests that methodologically these dilemmas must be represented within the research through methodological/reflexivity field notes (see observation design on page 100). An appreciation of the research distance between me and the participants at points in the research must also be represented within the final analysis, which can be found on page 288.   In addition, the research must seek to develop truthfulness through the research design, reactivity and triangulating multiple sources of data, which are discussed on page 109. The reflection on these methodological issues is undertaken in the conclusions chapter on page 276. As will be described within this chapter, the design of the methodology supported this through a five-stage process of approach, immersion, observation, interview and withdrawal framed by a research design influenced by MacKenzie (1994). This includes the use of a number of techniques to ensure truthfulness which is discussed in the subsequent sections.

Approach

The approach phase was an important one for the research. There were two main points to consider. Firstly, the researcher agrees with Barley (1990) that the approach phase is an intensive bureaucratic process that aims to ensure that access to the study setting is

achieved. Devers & Frankel (2000), Barley (1990) and Pope (2005) suggest that this requires a range of skills (and patience) from negotiation, communication, presentation and influencing the myriad of gatekeepers and other agents in complex organisations. This also included a number of wider departmental presentations to discuss the research and its implications, an example of which is included in Appendix 9. Table 8 indicates the number of meetings that took place, and also the gatekeepers that were required to be contacted just to gain access to the participants themselves. Secondly, it is linked to the wider aspects of ethnography such as building trust, credibility and identity of the researcher. Gatekeepers are often hierarchically important personnel whose support can open doors in the study setting, providing additional help to the researcher. However, this does not guarantee access, as it still requires the researcher to take sufficient time to understand the community under study, and this requires a second phase, immersion.

Immersion

To walk into the field and expect to understand the social meaning of the observation setting was unrealistic. Despite the fact that the first site was in a familiar organisation, some of the cues to social meaning may have been particular to the area/specialty under observation. However, as discussed previously, 'insider knowledge' is helpful in terms of geography, organisational awareness and co-worker familiarity. The methodological process dictated that a period of immersion was undertaken to deal with several important issues:

- To reduce confusion amongst the field participants as to the role and function of the researcher.
- To provide a close-up of the immersive experience.
- To reduce the effect of reactivity during observation.
- To support a moral understanding/obligation between researcher and participants.
- To gain understanding of the environmental topography.
- To learn some of the terminology and cultural frameworks.

It is important to recognise that there were many agents in the field of this research who were not under direct observation but were peripherally involved in the setting (i.e. administrative staff, support workers and cleaners). These were important people to take into consideration for cooperation and support to foster a naturalised scene.

Ward/clinical environment meetings were used to talk and discuss the research with them, and an information sheet was provided (Appendix 12). Posters were placed in the clinical environment with a brief synopsis of the research (Appendix 13). The issue of non-participation of these peripheral role members is discussed in more detail in the ethics section on page 112.

Observation

In determining the approach to observation in this research, the work of Aull-Davies (1999) proved helpful when he suggested that good ethnography is not now judged by the proximity of the researcher to the participants but by intensive observation and good analysis. In terms of observation styles, Adler & Adler (1987) proposed three 'membership' roles for fieldwork as outlined in Table 9.

The observation in this research was conducted in a 'peripheral membership role', which is characterised by observing and interacting closely without actually participating in the activities. As the researcher is a nurse, some participation would have been professionally unavoidable, such as helping a distressed patient or assisting in a peripheral task such as checking a non-controlled drug with a nurse. This assisted the researcher in gaining trust and helped access issues, but it was recognised that the move into the active membership role could only be for short periods (see ethics and consent). During the ethical approval process, it was a requirement of the researcher that a list be created of the potential aspects of the clinical work that would be observed and form part of the discussion at the committee meeting. This reflected a wider issue, where the NHS Research & Ethics Committee (REC) had a lack of experience of qualitative methods themselves and ethnography in particular. Although the REC was helpful and considerate with regards to the application, the researcher often had to provide additional information - an experience that was shared by Pope (2005). However, this was ultimately helpful in crystallising an approach that also acted as an aide-memoire (Appendix 15).

Type	Membership/researcher Involvement
Peripheral Membership role	- Observes and participates sufficiently to establish an insider's identity and to gain an insider perspective. - Does not adopt key roles or key functions within the team. - Observes and records, but does not adopt values or goals of the team.
Active Membership role	- Becomes involved in core activities of the group. - Assumes functions and responsibilities that may help the group progress. - Does not adopt values or goals of the team.
Complete Membership role	- Study settings in which they are already members, or chose consciously to become members whilst undertaking the research. - Assumes full functions in the team. - Adopts or already holds to the values and goals of the team.

Table 9 - Adler & Adler (1987) typology of membership roles.

The vantage point of the observation period was identified following discussion with the participants. The teams worked in different environments including wards, clinics, departments, meeting rooms and offices. The observation schedule followed their normal routines and shift patterns, and observations were originally intended to run on consecutive weeks so as to avoid saturating the doctors and nurses whilst providing a reflective period for the researcher. This shares similar elements to other research methods including 'shadowing' (McDonald, 2005b) and 'follow the people' (Marcus, 1995) ethnography. However, this was not often achievable, and through negotiation with the participants a longer period of time was taken. In some cases the participants felt, and articulated, that the 'work' on that day would not involve significant interaction and therefore would be of little use. The participants tried to ensure that the opportunities available to the researcher facilitated understanding of their work.

The overarching field notes structure followed those described by Bryman & Burgess (1994): that is substantive field notes, methodological field notes and partial use of analytical field notes. The substantive notes provided observations, recorded

unstructured interviews as conversations and systematically recorded biographical detail and relationship mapping. The methodological/reflexive field notes allowed the author to keep personal impressions of the research, and therefore a degree of personal involvement and reaction to situational factors, mirroring the current themes of reflexivity in ethnography. The analytical field notes provided inward analysis. Field and reflexivity notes were to be recorded in hardback notebooks (although this changed), which were kept secured in locked storage facility with researcher-only access.

Note taking accuracy is an important factor in field research. From the researcher point of view, there is a need to focus on two main perspectives. Firstly, how they actually take accurate field notes, and secondly, how they select and interpret the information.

In relation to notetaking, Wolfinger (2002) identifies that there are three main considerations:

- That detailed notes made later should be aligned with those taken in the field.
- That the focus of the ethnographer narrows over time, influencing what the notetaker chooses to describe.
- That notetaking may be influenced by the perceived audience.

Wolfinger (2002) goes on to suggest that tacit knowledge is one of the most important considerations to take into account as an influence on the style of notetaking. As the researcher was familiar with the hospitals and also the practice domain, then it was important to ensure that the notes were not selectively based upon his own preconceptions, a view shared by Mullings (1999). To do this, the researcher used the comprehensive note-taking strategy advocated by Emerson et al. (1995) where recording of notes is done systematically to ensure that everything that happened was recorded. To do this, the observation schedule requested by the Ethics committee (Appendix 15) was designed using the Spradley (1980) strategy and used as an aide-memoire in the field. Spradley (1980) suggested nine key elements to ensure comprehensive notes were taken:

1. Space: The physical place or places
2. Actor: The people involved
3. Activity: A set of related acts people do
4. Object: the physical things that are present

5. Act: Single actions that people do
6. Event: A set of related activities that people carry out
7. Time: The sequencing that takes place over time
8. Goal: The things people try to accomplish
9. Feeling: The emotions felt and expressed

An example of the fully transcribed field notes based upon this can be found in Appendix 19.

Practicalities of the observation

There were a number of practical lessons learnt by the researcher in relation to undertaking fieldwork. Firstly, the intention was to record the material in A4 notebooks that were subdivided with the notes on one side and the reflexive account opposite so that the researcher could make a contemporary narrative of the time spent in the field. These books were awkward and cumbersome and ultimately impractical. The researcher converted to reporters` notebooks, which required a rethink on recording and notation. The researcher developed a notation system that would quickly enable material to be recorded, an example of which is shown in Plate 1. Secondly, when recording in the study setting, it was noted on a number of occasions that the taking of the notes produced comment by the participants. This alerted the researcher to the fact that, although trust had been gained, the process of recording could be seen and, potentially, cause anxiety amongst the participants. Therefore, the researcher developed a number of strategies to record notes, in line with others` experiences of conducting ethnographic work in hospital settings (Mulhal, 2002; Pope, 2005). They included taking an opportune 'rest break/going to toilet' to write up, writing when the specialist nurse was writing/on computer, or showing the notes to the nurse and asking if they had captured the event accurately, promoting a sense of ownership and openness.
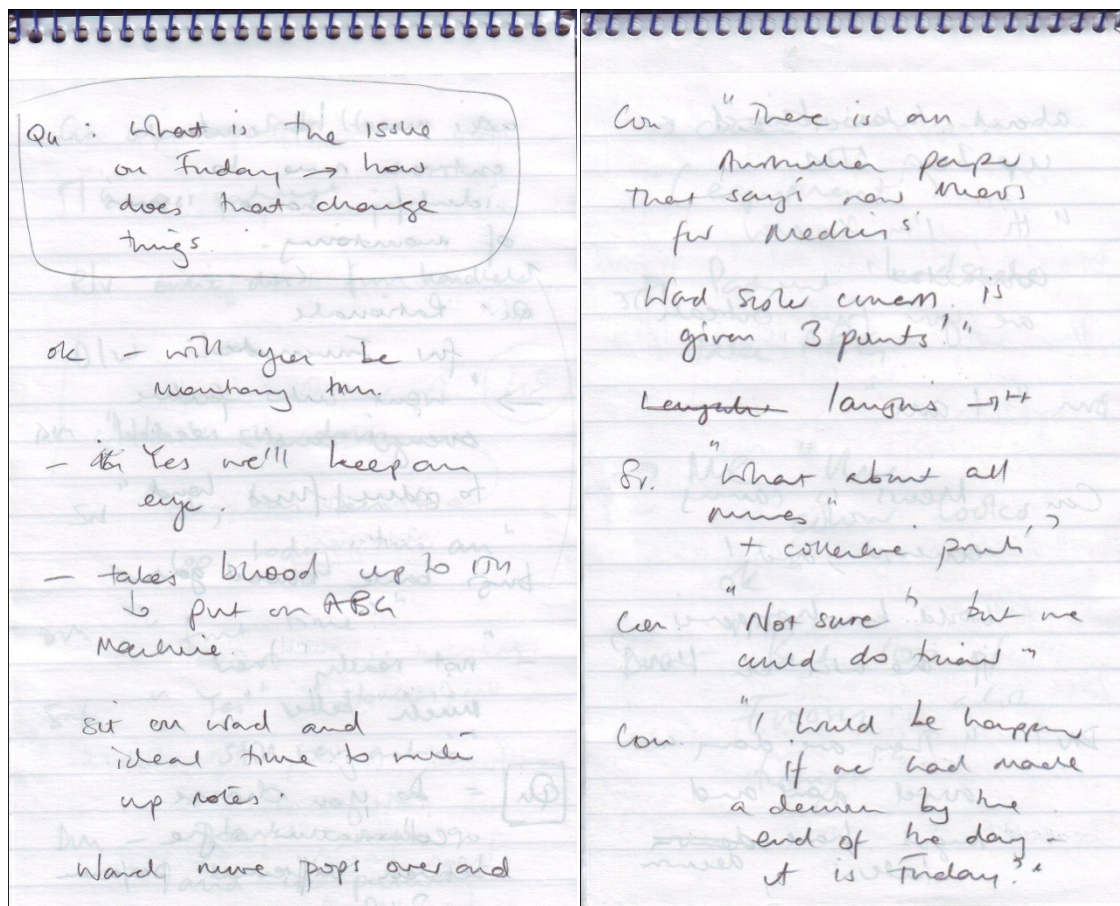
Plate 1 – Extracts from the field notebook

Thirdly, there remained the ability to ensure that the information, such as interviews as observation, was recorded accurately. Notes were taken rapidly during lulls in conversation or when the specialist nurse was attending to patients, computers or paperwork. This often required the researcher to complete the notes fully after the observation session. This posed a number of issues. It was the intention of the researcher to record a narrative of the observation which required the notes to be 'upscaled' with further detail. It was also chronologically written, including reference to the presence of the researcher, reflexive notes and additional comments of the participants after their review. As the researcher was using an IT-based solution (see page 119) to assist in the management of the fieldwork and thematic analysis, the notes had to be word-processed. This needed to be completed immediately after the observation period, to ensure that it remained contemporary (Ehigie & Ehigie, 2005). In order to do this, the researcher dictated the narrative from the notes and then later transcribed these recordings. An example of the narrative and participant review can be found in Appendix 19. Reflexivity notes were also recorded in the context of the narrative noting their

chronological formation. In addition, reflexive notes would also be used to prompt questions to be answered later by the researcher during interview or follow-up. These were identified in yellow boxes, examples of which can be seen in Figure 12.

<div style="border: 1px solid black; padding: 20px;">

Reflexive Note:

The specialist nurse discusses with patient in a confident and open style. She is extremely structured in her approach ensuring that she has been able to give the right level of information at the right tempo and also so it is retained by the patient. She often uses summary discussions at the end of giving each piece of information to ensure that the patient has understood. The specialist nurse is confident and articulate. She demonstrates active listening with the patient.

Reflexive note and question:

Are there different approaches in relation to the grade of junior medical staff and also who is co-located in there, whether or not the presence of a consultant influences the address and approach taken with junior medical staff?

</div>

Figure 12 – Examples of reflexive comment in observational narrative

Following the observation sessions and completion of the narrative transcription, a data management labelling system was employed to ensure integrity of the work. Each document was labelled with the following tags:

YY_Cohort_Session   Eg 09_Cohort 2_Session 3

For security and anonymisation, during the transcription all names were removed from the documents. A security password was applied to each document that was only known to the researcher. Once the narrative had been transcribed and anonymised it was then sent to the participant for comment. In most cases, they changed or removed little but

mostly made additional comments to clarify contextual issues. These were highlighted in red (see Appendix 19)

Interview

The expectation of the researcher was that conversations would be recorded in the field notes. A more formal review of the observation period was designed to elicit a more incisive analysis of the participants` views. As Patton (2002) has described, this allows reflection on experiences prior to the observation period that may have shaped the observed behaviour. They can bring in feelings and thoughts and, more importantly, intentions, thus circumventing some of the limitations described in the literature.

Patton (2002) and Lincoln & Guba (1985) suggest that the inclusion of post-observation interviewing by researchers supports improved trustworthiness. The interview matrix described by Patton (2002) is also a helpful framework to consider assisting the researcher in guiding questions focused on:

- Behaviours/experiences
- Opinions/values
- Feelings/emotions
- Knowledge
- Sensory
- Background

Patton's (2002) description of the hybrid informal conversational interview proved useful for this study. Practically this meant that an unstructured interview utilising the prompts and themes from the observations was undertaken. A time lapse of several days was included between the end of the observation period and the interview.   This was helped by utilising similar skills from 'cognitive interviewing' where the interviewer generates narrative about specific events as well as generalised experiences (Beatty & Willis, 2007). The Willis (2005) model of interviewing identifies verbal probing techniques based upon two main dimensions and two constructions that he places in a matrix (see Table 10). Construction can occur prior to and during the interview, setting up the questioning angle, leaving the interviewer open to probing strategies via proactive and reactive elements of the actual interview itself. The interview was recorded and conducted in an environment

of the participant's choice.   During the ethical approval process, it was a requirement of the researcher that a list be created of the potential topics that could be discussed, and formed part of the discussion at the committee meeting. This acted as an aide-memoire and can be found in Appendix 16.

	Proactive Administration (initiated by the Interviewer/Researcher)	Reactive Administration (triggered by subject behaviour)
Standardised Construction (Constructed prior to the interview)	(1) Anticipated Probes	(2) Conditional Probes
Non-Standardised Construction (Constructed during the interview)	(3) Spontaneous Probes	(4) Emergent Probes

Table 10 – Willis (2005) model of verbal probing techniques in interview

The interviews which took between one and one and half hours were transcribed by the researcher.   A copy of the transcript was forwarded to the participant for review of accuracy and comment.   Once this had been agreed, coding and analysis was then undertaken. Digital interview recordings and document transcripts were digitally secured as outlined in the Confidentiality of data section on page 116.

Practicalities and process

The interviews were conducted in an environment of the participant's choosing; this was often an office or other area away from the clinical environment. The interviews were recorded on a digital dictaphone (Sanyo ICR-150) and extension microphone.   The output file was a proprietary Sanyo® .wav[2] file, which required conversion on a PC to facilitate its use on another computer or standard CD player. The conversion programs

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[2] .wav file is short for **Waveform Audio File Format**, (also, but rarely, named, *Audio for Windows*) and is a Microsoft and IBM audio file format standard for storing an audio bitstream on PCs.

used were Memoscribe ® and Switch Sound Converter ® which enabled the file format to be converted to Windows ® .wma[3] or a Generic.wav.

As the files were digitised, the transcription process was PC based using - Memoscribe ® and Express Scribe ®. The interview audio files were stored electronically on a PC, with encryption and alphanumerical access passwords. No copies could be made, other than those distributed to the participants.   A full list of the IT solutions used in this study and information about the programs can be found in Appendix 2

Withdrawal

Whilst gaining access to the field and the management of the process are important, the researcher was conscious that managing the withdrawal from the field was equally critical. For many participants, the research process is of little value to their work or continuing understanding of their professional or personal role. However, for some, the process may be a more thoughtful one and as such the researcher should ensure that these individuals are not left with any unanswered questions. Feedback to those in the study was given individually whilst ensuring the confidentiality of other participants.   Details or information that could be linked to one individual was not given to any third party in or outside the organisation and no report was made available to managers or senior clinicians. However, once analysis had been completed as part of the dissemination strategy, a brief synopsis of the findings was given to those involved in the study, mostly via presentation to groups of specialist nurses, doctors, research groups, academics and hospital management.   Findings were also presented nationally at research and nursing conferences (Radford et al., 2008; Radford et al., 2009a,b). (Abstracts are included in Appendix 22 to Appendix 24.)

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[3] .wma file is short for **Windows Media Audio** (**WMA**) and is an audio data compression technology developed by Microsoft. It is a proprietary technology that forms part of the Windows Media framework.

Researcher reactivity

From the perspective of this research, participation was unavoidable and therefore the researcher was mindful of his presence and influence on situations. This level of participation was possible because of the researcher's past clinical and management experience which increased his credibility[4]. In addition, participation brought the researcher closer to the experience of the participants. This enabled analysis of the complex processes and practices to discover how they were dealt with by the participants. The researcher spent a great deal of time (see Table 8) with the participants prior to the observation, to ensure they were 'comfortable' with being observed. It is important to note that the presence of the researcher was commented upon by the participants. As Goodwin et al. (Goodwin et al., 2003) highlighted, doing research as a nurse in their own health community can have its negatives as well as positives. In her research in acute care areas, clinical situations arose where she was unsure whether or not to intervene to prevent a problem with a patient. She notes that situational decisions are difficult but believes that ethically one must intervene to prevent harm to a patient. As she was working in her own healthcare community, such action was not recognised by many as unusual. Emerson et al. (1995) indicate that there is a consequential presence by the researcher that is linked to the reactive effects of their involvement. Whilst most notable texts on the subject (Adler & Adler, 1987; Brewer, 2000) emphasise that an observer should influence the scene as little as possible, the process of becoming a full member requires some element of involvement. A challenge for any ethnographer is to achieve the balance of developing a relationship to observe whilst not 'contaminating' the scene. Bosk (2001), Emerson et al. (1995) and Fine (1994) have a relaxed attitude to the reactivity effect, suggesting that unless the researcher is directing events then it is likely to be minimal. Monahan & Fisher (2010) identified that reactivity had a positive impact and would often show important perspectives of individual behaviour. Emerson et al. (1995) suggest that:

> 'rather than view reactivity as a defect to be carefully controlled or
> eliminated in entirety, the ethnographer needs to become sensitive to

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[4] The researcher qualified as a nurse in 1994, and worked in acute, theatre, emergency and critical care nursing before becoming a Nurse Consultant (see Background to the Study, page 15)

and perceptive of how she is seen and treated by others.' Emerson et al. (1995), page 4

Anspach & Mizrachi (2007) argue that the purist must stay out of the field, citing that:

'It is much easier to observe from the sidelines and to rationalise that decision (to step in) as methodologically and ethically scrupulous behaviour than it is to enter the fray.' Anspach & Mizrachi (2007), page 56

The researcher had to be clear with the participants that his role was data collection, although it was important to understand that some aspects of interaction were unavoidable. This occurred in a number of scenarios, including:

- Being directly asked by the participants to help with aspects of care, when two practitioners would be required, i.e. moving and handling a patient.
- Being directly asked by participants for advice on a topic that the researcher was a known expert, i.e. emergency surgery
- Being approached by actors normally outside the field (colleagues, managers and executives), who did not realise research was being undertaken and were asking questions or giving advice regarding a topic that was part of the researcher's daily activities (sites one and three).

Review process

The review of the observation and interview fieldwork by the participants was a helpful stage in terms of verification of the information and gave the participants an opportunity to make additions and corrections. In some cases the participants added additional material as indicated in Appendix 19. It also allowed the participants to understand the nature of the material and information that was being gathered by the researcher. Some participants commented on the detailed nature of the notes and their 'narrative/story-like` nature and this came as a surprise to them. The researcher took a great deal of time to explain the rationale for the narrative style so that the full experience of the role was

understood in context of their working pattern. This was explained to be in contrast to an episodic vignette style, taking the specific interventions and interactions in isolation from the pre- and post-interaction scenarios. None of the participants returned manuscripts or excluded them from the study.

Artefacts

Hammersley & Atkinson (2007) are clear that ethnographers must look to all aspects of the culture they are studying, including those artefacts that exist in the study setting. Dix et al. (2003) suggest that artefacts are a valuable resource, suggesting that:

> *'like the fossil left where the soft parts of the body have decomposed, artefacts act as a residual record of work done and in progress' Dix et al. (2003), page 2.*

It enables the researcher to put aside understanding so as to record the 'visible' phenomena. Mapping and assessment of artefacts is not only related to the objects in the organisation such as posters, off-duty records, memos – obvious artefacts within the culture. It also records the extension to the rules and values, which perpetuate the control of the hierarchy. Dix et al. (2003) suggest a methodology for assessing artefacts within a field setting that run parallel to observation, as outlined in Table 11, page 112.

This poses two main considerations. Firstly, the artefacts are often formal records and can therefore be a sanitised reflection of the organisational history. They should be viewed critically although they do give a perspective of the cultural norms and practices regarding decision making and recording of formal histories. Secondly, the ethical issues of reviewing artefacts and gaining permission for their use. Many of the documents were written and developed by the participants and so requesting permission to use them for analysis was less problematic. However, other records required permission from the author (often more senior within the organisation) to be gained before they could be used. The researcher was careful to ensure that all personal information, such as names and titles, was redacted before analysis was undertaken.

Artefact	Definition	Examples
Artefact as designed	Looking at the ways in which the explicit and implicit knowledge of the designer are exposed in artefacts	Toolkits Procedures Policies Organisational structures
Artefact as used	Looking at the way in which people have appropriated, annotated and located artefacts in their work environment	Meeting minutes Posters Notices Notice boards

Table 11 - Dix et al. (2003) artefact centred analysis approach

Ethical issues

The aim of this study was to undertake an in-depth exploration of communication and power between advanced practice nurses and doctors within the context of three busy hospitals using a critical realist ethnographic approach. This setting alone raises a plethora of ethical questions or issues for the researcher to understand. Methods used to capture these data were participant observation, in-depth interviewing, and artefact analysis. When using these research methods in the environment of hospital settings, there was an increased need for sensitivity, flexibility, and forethought, and thus the ethical concerns commonly associated with these methods were amplified. Murphy & Dingwall (2001) highlight that Beauchamp et al.'s (1982) guiding principles` research ethics of non-maleficence, beneficence, autonomy and justice apply to ethnography as they do to other research techniques, a view that is supported by many other scholars utilising ethnography (Goodwin et al., 2003; Parker, 2009; Atkinson, 2007). These broad principles supported a strong ethical position of the researcher, who was also guided in this study by the Royal College of Nursing (2004) research ethics guidance and Economic & Social Research Council (Economic & Social Research Council (ESRC), 2005) framework which highlighted six key principles as outlined below:

1. Research should be designed, reviewed and undertaken to ensure integrity, quality and transparency.
2. Research staff and participants must normally be informed fully about the purpose, methods and intended possible uses of the research, what their participation in the research entails and what risks, if any, are involved.
3. The confidentiality of information supplied by research participants and the anonymity of respondents must be respected.

4. Research participants must take part voluntarily, free from any coercion.
5. Harm to research participants must be avoided in all instances.
6. The independence of research must be clear, and any conflicts of interest or partiality must be explicit.

With this in mind, the ethical issues that came to the fore for this study were: consent, and enabling informed consent for the participants; consent of peripheral members of the scene; safeguarding patients' interests; safeguarding participants' interests and preservation of their anonymity.

Consent

Moore and Savage (2002) identify that ethics and informed consent are important issues to be addressed in ethnographic research. By utilising an overt peripheral membership role, the researcher aimed to foster the cooperation of the participants in the field. The use of the approach phase was specifically designed to ensure that participants, central and peripheral, have an opportunity to discuss and decide on their involvement in the research. Specifically written consent was obtained from the key participants: advanced practice nurses, key workers (medical and nursing) – see Appendix 20 . This was supported with participant information (Appendix 10 and Appendix 11) Any key workers withholding consent were not included in the study (this did not occur during the research). It was often very challenging to get senior doctors to sign the consent form. Multiple attempts were made prior to the sessions to do this, although they would often brush aside the requests, suggesting that they could continue without it. The researcher continued to insist and it was often immediately before the session commenced. The researcher also made it very clear to the teams that they could ask the researcher to withdraw from the field. This occurred on three occasions where the specialist nurse wished to have a confidential conversation with their patients. An example was giving the patient a new cancer diagnosis. The researcher withdrew as requested.

As identified, the peripheral role members who are not directly under observation should be considered in research, a view shared by Mulhall (2002). No written consent was sought from these individuals. However, during the approach phase, opportunity was given to them as a group to discuss their participation in the research, supported by information (Appendix 12 , page 366). Those individuals who had concerns over participation could approach the researcher before the study started to discuss any

issues. If they did not wish to participate, no notes were collected about their interactions in the field. This did not occur during the approach or observation phase. This approach utilising 'Global Type Consent' is advocated by the American Anthropological Association (American Anthropological Association, 2004) in relation to ethnographic research and is supported by their Code of Ethics (American Anthropological Association, 2009). It is also supported professionally by the Nursing & Midwifery Council Code of Professional Conduct (Nursing & Midwifery Council, 2008b), and the Royal College of Nursing Ethical Research for nurses document (Royal College of Nursing, 2009a).

This research has sought to identify a clear ethical stance by utilising available literature to pre-empt potential ethical issues. However, the field can be an ever-changing ethical landscape and many situations evolved that were managed by the researcher. One example occurred during an observation session with cohort 2 on the district site. Despite detailed preparatory work, the researcher followed one nurse to a meeting with other clinicians (most of whom had given consent) to find an extended Cancer Multidisciplinary Team Meeting (MDT) taking place. There was a large number of additional medical and administrative staff present and it was clear that this would pose some ethical challenges and it was not appropriate for the researcher to interrupt the meeting to discuss consent. The researcher was introduced and this did not draw comment from the assembled people. However, the researcher could not take notes of the meeting for observation purposes as planned and explained this to the nurse after the event.

Safeguarding the patient

The researcher was very aware that whilst the aims of the research focused upon the doctors` and nurses' interaction, this was achieved through their work in the clinical field and the patients for whom they cared. The methodology was designed to be visible and collaborative with the participants and the same approach was taken with the patients who were in the field. The LREC submission, which included references to interaction and decision making related to patients, classified the research as low risk with regard to patients, and concentrated upon the issue of ensuring that access to the domain through the hospital hierarchies was achieved. However, it was important to the researcher that patients were afforded the same rights as the participants of the study. To achieve this, patients were made aware of the researcher's presence in the clinic or the ward by the senior nursing staff during the access phase, which was repeated on the days of the observational fieldwork. As the researcher followed the specialist nurses in their practice,

patients coming into the field were introduced to the researcher, and a brief explanation given as to his role of following the clinical team. It was also explained that the researcher was a nurse and that the patients could ask for them to leave the room/ward bay/clinic if they or the specialist nurse felt it was conducive to their care and interaction[5]. It was important that the specialist nurses had confidence that their role or authority was not in any way challenged or inhibited during the research. The consent process made it explicit that participation would not impair their capacity to conduct their role. This could be initiated by the patient, nurse or researcher and in all circumstances the patients were happy for the research to continue and often contributed to the discussions on the role of the nurse.

Safeguarding the participants

The researcher was cognisant of the methodological considerations of a critical realist perspective and the collaborative nature of the working relationships under scrutiny. In choosing a peripheral membership role (Adler & Adler, 1987) the researcher aimed to ensure that the voices of the participants were heard and included as co-researchers, in line with the view of qualitative research (Heron & Reason, 2006; Kitzinger, 1994; Smith, 1994). Researchers who assume this role, aim to achieve a membership role as it is desirable to gain an accurate appraisal of culture under study. The researcher seeks an insider's perspective on the agents, their activities, and social structure. Adler & Adler, (1987) highlight that the best way to acquire this perspective is through direct, first-hand experience. A researcher in the peripheral membership role would interact closely, significantly, and frequently enough to acquire recognition by members as insiders. They do not, however, interact in the role of central members, refraining from participating in activities that stand at the core of group membership and identification. In addition, the researcher's focus on a collaborative approach extended to shared learning and development of trust in the relationship, aiding the reflexive elements of the work.

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[5] This occurred on a number of occasions. Firstly, a patient was to be given a new diagnosis of cancer in out-patients and the specialist nurse asked the researcher not to be present. Secondly, a patient wanted a private discussion with a nurse about their care and possible complaint. Thirdly, when a patient became visibly upset during a clinical discussion and the researcher thought it appropriate to step away.

As indicated in the approach phase, the researcher took a great deal of time to work with and understand the role of gatekeepers in order to access the study settings. The researcher set out to ensure that the participants and non-participants were informed at each stage of the research. Examples have already been cited where the researcher used a number of preparatory processes (staff meetings, presentations, posters and `one-to-one') to inform and discuss with people in the study settings (see Table 8 and Selection of the cohorts). In addition to this, the confidential nature of the data was an important aspect of the research, and management of this is described in detail in the next section. However, the researcher envisaged that the participants would be safeguarded in the final write-up through the use of pseudonyms.

However, the researcher identified that the research environment was dynamic and from a safeguarding perspective, ever changing. It required thought and reflection on the part of the researcher to ensure that consent, confidentially and the safeguarding of the participants` interests were considered. This was achieved by ensuring that the principles of consent and confidentiality were reiterated at each and every session completed by the researcher.

Confidentiality of data

Confidentiality is critical to the credibility of the study ensuring that participants were able to give their opinions as freely as possible, without cause for concern that their identity could be compromised, during or after their participation. The researcher went to great lengths to create a coding and labelling system to facilitate this.

Firstly, in the observation notes, names were not recorded in the notebooks and pre-assigned labels were given to the participants and used during notetaking. Secondly, the fully typed narratives did not record any names of individuals, buildings or organisations. Finally, the documents were labelled and stored electronically by year of observation, cohort number and observation session. i.e YY_Cohort_Session - 09_Cohort 2_Session 3. From a continuity perspective, the labels for organisations were maintained across all of the cohorts.

Similarly, the interviews were digitally recorded and stored electronically under assigned codes and labels. i.e YY_Cohort_participant ID - 09_cohort 3_Nurse A. The digital audio files were converted as described on page 107. The typed transcripts had all names and

references removed before storage. No typed document remained that included any names or organisational details. For artefacts, an electronic folder was created for each site to act as a repository. File names were only changed if they could identify the author or organisation.

A database was designed in Microsoft Excel 2003 that retained the links between the observational and interview data labels, codes and the participants. The database was encrypted and protected in two ways. Firstly, a multi-alphanumerical password known only by the researcher prevented the database from being opened. The database was locked and was unable to be printed from the computer. Further to this, an increasingly common aspect of research is the storage and control of electronic data. There are a number of ways that data breaches occur including accidental loss of USB drives, email, etc., or more intentional losses such as theft and computer security breaches through viruses. Although national legislation exists on the protection of data through the Data Protection Act (1998),   little is made of preventative measures such as encryption tools. An overview of the security and backup measures are highlighted in Figure 13.
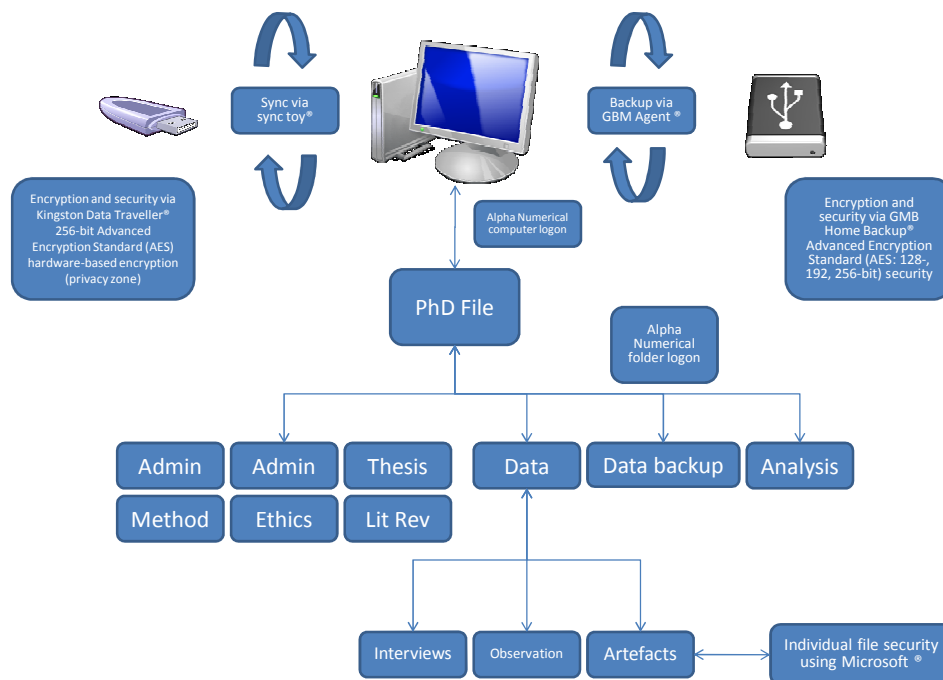
Figure 13 - Security of the data filing system

Thematic analysis strategy

The researcher's analysis approach for this study falls into two distinct phases - formative and summative, and was influenced by the Miles & Huberman (1994) approach to qualitative data analysis. There was a physical and conceptual sequence involved in the processing and analysis of the fieldwork which is outlined in Figure 14. This was adapted from a model illustrated by Morison & Moir (1998) in their study utilising Computer Assisted Qualitative Data Analysis software (CAQDAS). This also links with the practical elements already described in Methods of data collection on page 93.
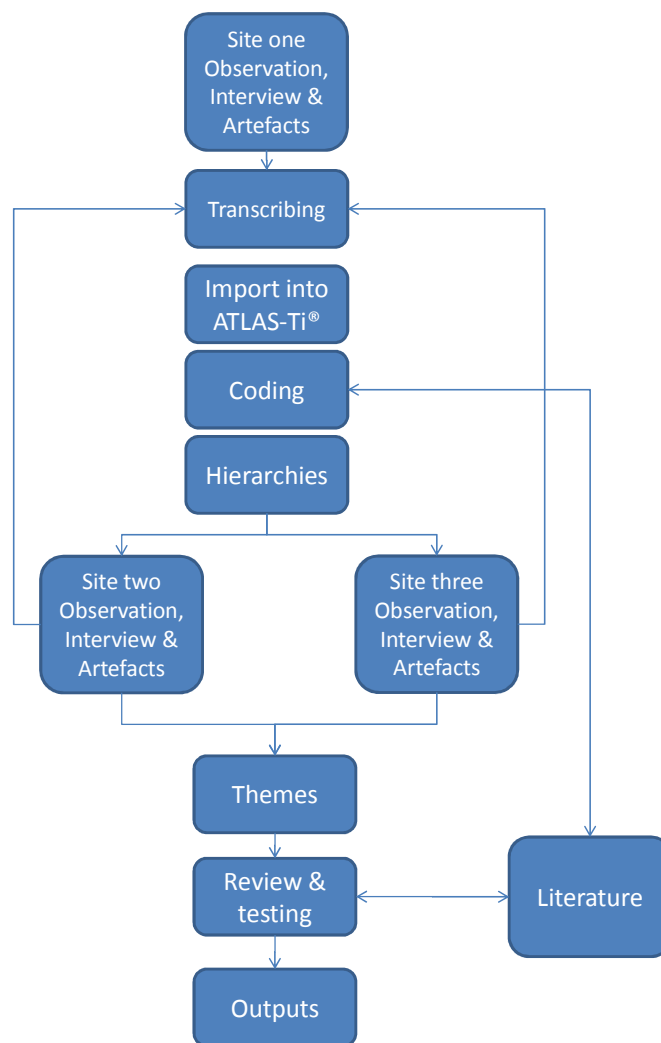
Figure 14 – Diagram indicating the process of data management and analysis

The analysis was assisted with Computer Assisted Qualitative Data Analysis software, which is helpful to describe before review of the thematic analysis strategy.

Computer Assisted Qualitative Data Analysis Software (CAQDAS)

Brewer (2000) notes that:

> *'It was confidently asserted in 1993 that the days of the scissors and paste were over because of the arrival of computers' - Brewer (2000), page 117.*

However, there has been a general debate amongst social scientists on the value and use of computers to support data analysis. Tesch (1990) argued that this stemmed from a user suspicion and a general challenge to the orthodoxy that computers were the tool of the quantitative researcher. Others such as Seidel (1991) warned that the use of computers would distance the researcher from the material, a view shared by St. John & Johnson (2000) and Weitzman (2000). Conversely, Barry (1998) believes that much of this thinking came from a more fundamental perspective of a lack of familiarity with computers. Indeed, Barry suggests that the majority of researchers who lament the use of computers for ethnography have not used the software at all. That said, the early designs lacked intuitiveness, were often complicated and slow, lacking a sufficiently developed graphic user interface (GUI) to ensure that the process was easier than 'scissors and paste'. Indeed, Barry-Lewis (2004b) suggests that tools for the management of qualitative data have now come of age.

The researcher was prompted to examine a CAQDAS system early on in the research process by the supervisory team. Marshall (2002) believes that this is a common scenario and studied five postgraduate research students` decision-making processes utilising the Weitzman & Miles (1995) framework. Bringer et al. (2004) points out that in the field of psychology, the UK Economic & Social Research Council (ESRC) suggests that students are advised to have the skills to use CAQDAS systems for postgraduate research.

There are many systems available in the marketplace, from extended use of simple word-processing tools to more complex software packages. It was evident that a significant amount of data would be generated by the study including word documents, PDFs, pictures and audio, all requiring coding. To do this would require a sophisticated system. The researcher communicated with the research community in web forums to gather opinion and ideas on the tools to use. A review of available literature and internet

searches included some helpful comparisons of the software available (Barry-Lewis, R, 2004a,b; Barry, 1998). Lee & Esterhuizen (2000), Morison & Moir (1998) and Dohan & Sanchez-Jankowski (1998) identify three main forms of the software: Firstly, code and retrieve programs are simple versions which extract and compare segments of text. Secondly, code-based theory building programs, that enabled the code and retrieve element to be built into interrelated conceptual categories. Finally, conceptual network builders, which are visualisation software with the capability of completing code and retrieve, conceptual development and reflexivity memos.

After reviewing and experimenting with demonstration versions of NUDIST®, ETHNOGRAPH® and ATLAS.ti®,the author worked most effectively with ATLAS.ti®. The benefits of ATLAS.ti® were apparent when compared with other software including a more user-friendly GUI, intuitive coding, building of network codes (families), ability to code pictures and Portable Document Formats (PDFs) (see Plate 2).
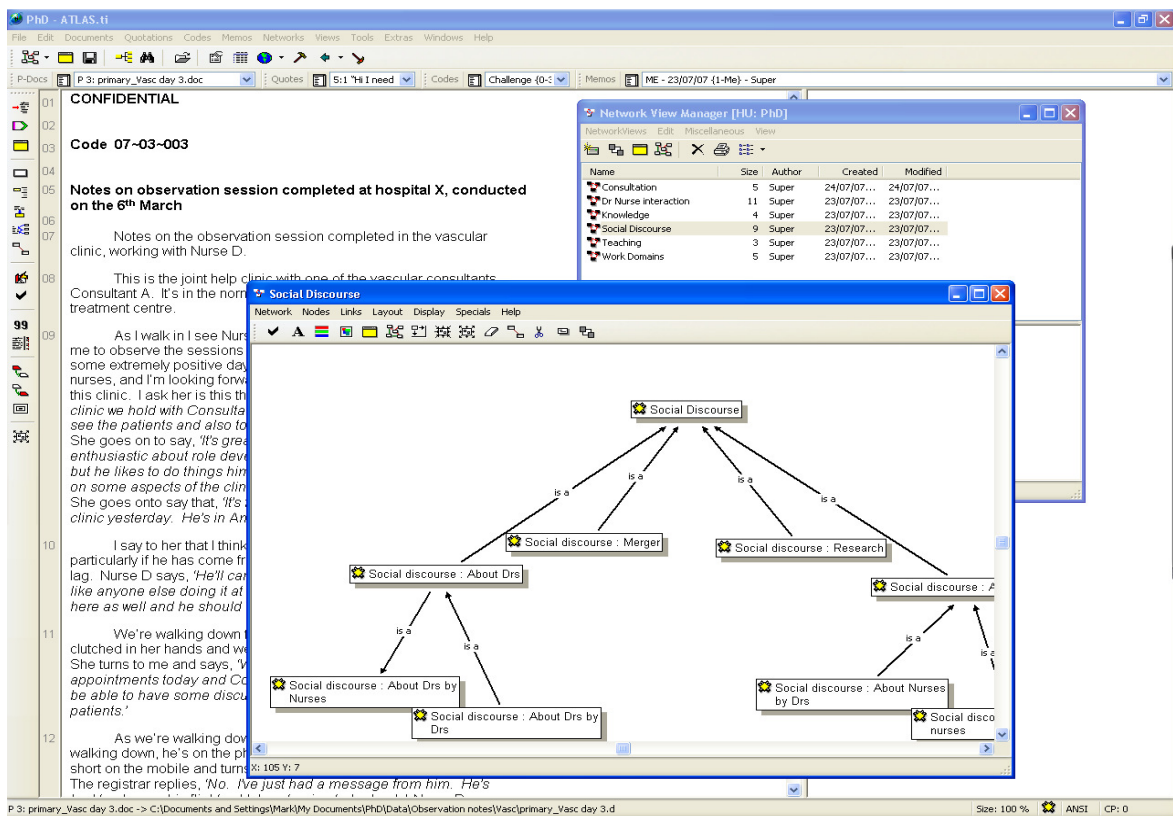
Plate 2 – ATLAS.ti® GUI with codes and network tree

However, any software system still requires decision making on the part of the researcher – or, in the case of analysis making, the coding decisions and identifying themes. ATLAS.ti ®, like many of the CAQDAS systems, is not a new methodological standpoint; it does not replace the ability to make the thematic developments - it is tool to do this.

Formative

This first stage of the analysis occurred during the observation and interview phase. Themes would appear to the researcher and were often recorded during observation or initial writing up of the narrative. Analytical and reflexive notetaking allowed this to take place alongside the observational notes. The participants themselves also offered or identified themes or practices that helped contribute to analysis.

The next stage was to review all the findings, from observation material, interviews and the artefacts. Practically, the large amount of information posed a small but critical problem. As Beck (2003) discovered, the sheer volume of information can often draw a 'blank moment' for the novice qualitative researcher and this occurred. With over 100,000 words of first stage material, the researcher revisited the original research question to determine the primary thematic search strategy. This was achieved by concentrating upon the interactions between the doctors and nurses themselves – identifying their frequency and context.

Once this process had been initiated, the coding flow increased rapidly. The information was open coded, a process that Morison & Moir (1998) postulate as a way of breaking down, examining, comparing, conceptualising and categorising data. In addition to the open coding the researcher also made extensive use of the memo and notes function of ATLAS.ti® to make reflexive comments on the process and data. An example of the open coding structure can be seen in Plate 3, page 103. By re-reading observational notes and transcripts and highlighting relevant information this will include qualitative categories such as approximate timings of interactions, when, where and with whom. More abstract and analytical information identified in the aims and observation schedule include recurrent terminology, phrases, actions or behaviours. The full list of codes and their associated networks generated during the analysis phase can be found in Appendix 21. This review process also provided the researcher with an opportunity to identify themes and information previously not identified. Notes were taken and themes catalogued in an indexing system, where anonymised direct quotes and action could be recorded. The

coding process continued to the point of saturation (Dey, 1993; Ezzy, 2002; Glaser, 1965).
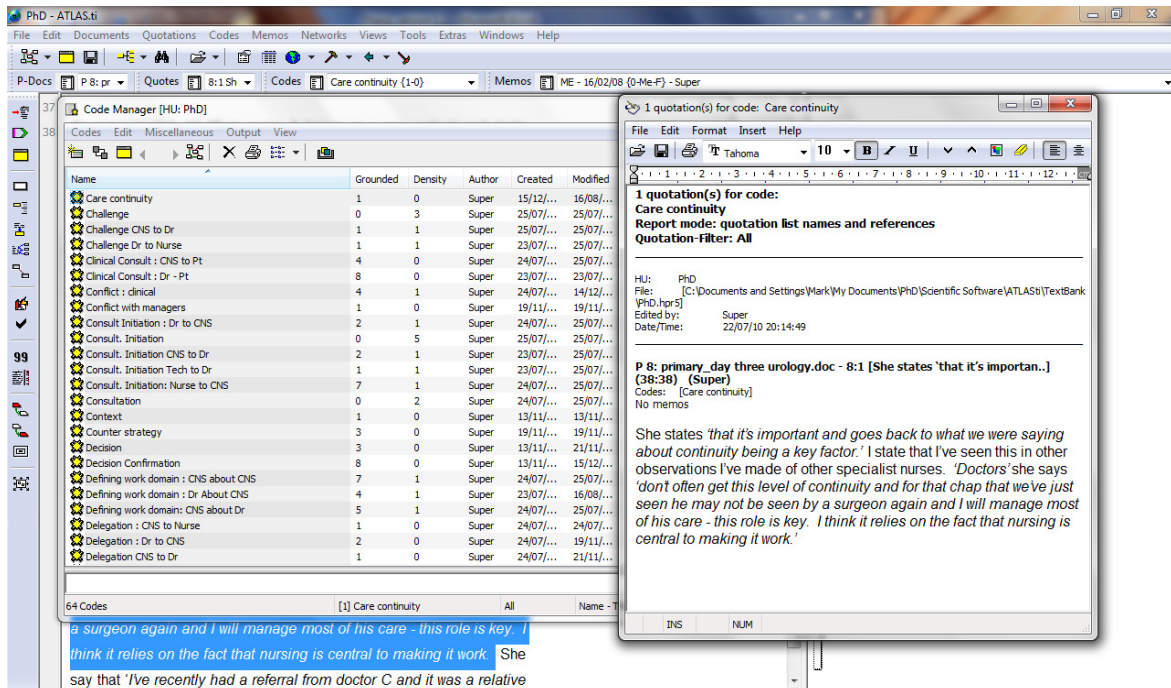
Plate 3 – Open coding in ATLAS.ti®

Summative

The formative task is there to analyse the findings and to find concepts that allow the researcher to make sense of what is happening in the field. The summative stage draws on all this thematic coding and analysis to test the research aims through review, comparison or generating new concepts or typologies. However, Sandelowski (2000) identifies that the researcher must be aware that descriptive accounts of the data are an important first step, where:

> `All inquiry entails description and all description entails interpretation. Knowing any phenomenon (or event or experience) requires, at the very least, knowing the facts about that phenomenon. Yet there are no facts outside the particular context that gives those facts meaning.`
> Sandelowski (2000), page 335

The research required an element of qualitative descriptive account before embarking upon greater synthesis and development of the work.

The summative phase also included the building of a hierarchical indexing system (HIS) or themes, by which the researcher could start to understand and theorise the material. The CAQDAS system Atlas, had a HIS system called families, which demonstrated the approach in Plate 4.
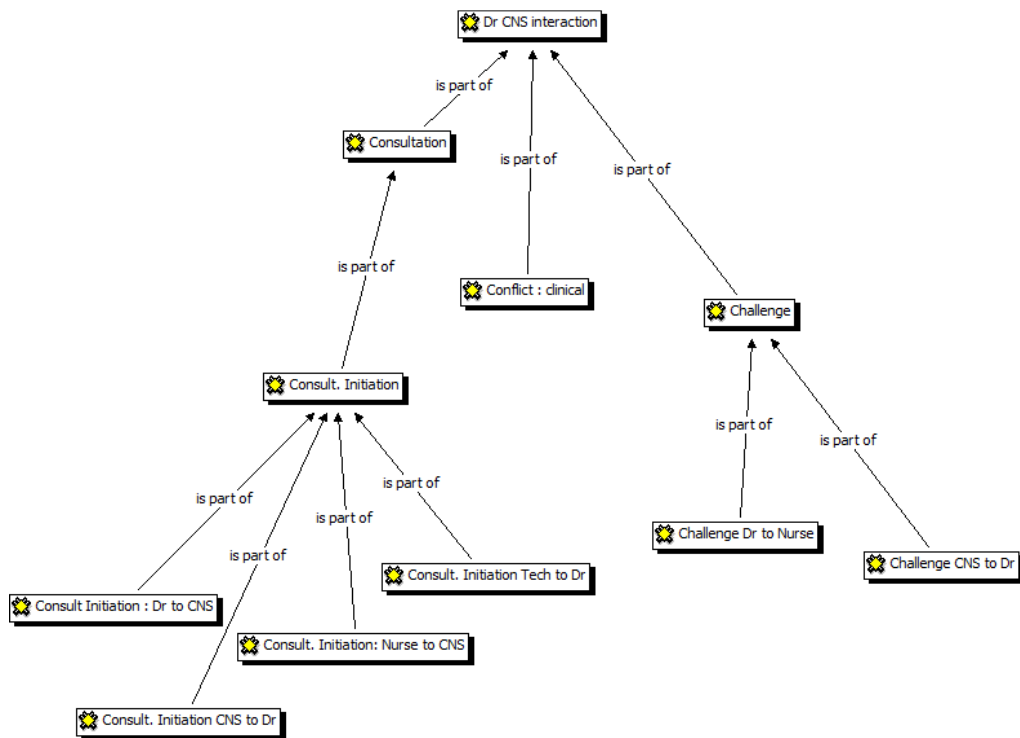
Plate 4 – Developing a Hierarchical Indexing System (Families) in ATLAS.ti®

In addition to the thematic analysis and common trends, there are also often outliers in the findings. Outliers or negative cases are those that do not fit the pattern of others in the findings, but are of interest as they provide a thought-provoking challenge to the existing evidence. Patton (1999), Brewer (2000) and Meadows & Morse (2001) suggested that negative cases` patterns and trends may have been identified by the researcher, and an understanding of patterns and trends is increased by considering the instances and cases that do not fit within the pattern. He states that:

> *'These may be exceptions that prove the rule. They may also broaden the "rule," change the "rule," or cast doubt on the "rule" altogether.' –*
> *Patton (1999), page 1192*

It is entirely reasonable, given the sampling strategy and the seniority of the professional groups under study, that a diverse set of opinions would be available and should be included as part of the analysis. Negative cases have been used in the literature to provide an additional perspective in ethnographic work in a number of research settings (Rizzo et al., 1992; Harry et al., 2001).

Summary

This chapter has set out the researcher's views on the applicability of critical realist ethnography and its value in understanding the culture of specialist nurse and doctor relationships. This has been achieved with an overview of the methods of observation, interview and artefact analysis. The processes involved were found to be complex and required serious consideration being given to data management and the use of a CAQDAS system. It is hoped that this chapter enables understanding of the approach taken by the researcher to reveal the findings discussed in later chapters.

Chapter Five   - The context of the research

Introduction

The aim of this chapter is to provide a contextual account of the study setting including each cohort, the individual sites, their geography, location and makeup. The setting for this study was provided by three acute hospitals within the National Health Service in the United Kingdom which are described below.

District site

Site one was a large District General Hospital NHS trust, serving a population of 500 000 of a mixed rural and urban population with diverse socio-economic areas. The district site had approximately 600 acute beds, providing inpatient services including services such as accident and emergency, high risk obstetrics, surgical specialties (trauma and orthopaedics, general surgery, colorectal, vascular and urology). In addition, it also provided acute medical services including cardiology, gastroenterology, respiratory, endocrine and acute medicine. The hospital employed 2500 staff, of which 1000 were nursing including 100 advanced practice nurses[6] who worked in a range of specialties.

Urban site

Site two was a large district General Hospital NHS Foundation Trust serving a population of just under 1 million. It served a predominantly inner-city population with significant socio-economic challenges including high levels of migrant workers and minority ethnic

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[6] It is recognised that there is scholarly debate on the definition, scope and titles of nurses working at advanced levels. This debate is explored in more detail on pages 59 to 66 of the literature review.   However, this ethnography represents its participants who defined and recognised themselves by the title 'specialist nurse'. When describing or presenting the participant's experiences, this term will be employed in the context of this thesis to ensure it faithfully represents the voices and lives of those who participated. However, the term advanced practice will be used in the discussion, conclusion and implications of this research to maintain consistency with the wider literature.

groups. It provided a full range of acute inpatient services covering three sites, geographically separated by approximately 20 miles. The two main hospital sites provided A&E services and a full range of surgical services (general surgery, trauma and orthopaedics, gynaecology, colorectal, vascular, ENT and emergency surgery). In addition, they provided a range of acute and chronic medical services, including renal, endocrine, respiratory, cardiology, gastro and elderly care services. The organisation included 10 000 staff, of which 3000 were nurses including 100 advanced practice nurses and 5 consultant nurses.

Metropolitan site

Site three was a large university hospital serving a local population of 1 million. It provided a range of regional services to a wider population of 3 million people. The hospital trust had 1200 beds across two hospital sites. The main site was within a large urban centre. Site three was also designated a teaching hospital and was linked with two universities for medical and nurse training. The hospital offered a range of clinical services including surgical specialties (general surgery, colorectal, upper GI, hepaticobiliary, emergency surgery, vascular, head and neck, ENT, ophthalmology). In addition, it provided regional cardiothoracics, neurosurgery and renal transplantation. It also provided acute medical services, including an emergency department, respiratory, gastro, cardiac, endocrine, renal, neurology, elderly care and rehabilitation medicine. The organisation had approximately 5500 staff, of which 2200 were nurses and 90 advanced practice nurses.

Study cohorts

Outlined below are the main study cohorts (clinical teams) included in the study. This section describes their general working arena and relationships using practice charts. The legend is outlined below (Figure 15):

- Medical (blue)[7], Nursing staff (red), Administrative and Management staff (green)
- Grade of staff
- Central field (dark blue circle) which indicates either daily contact and/or close working.
- Peripheral field (light blue circle) which indicates infrequent contact and/or variable working interaction.
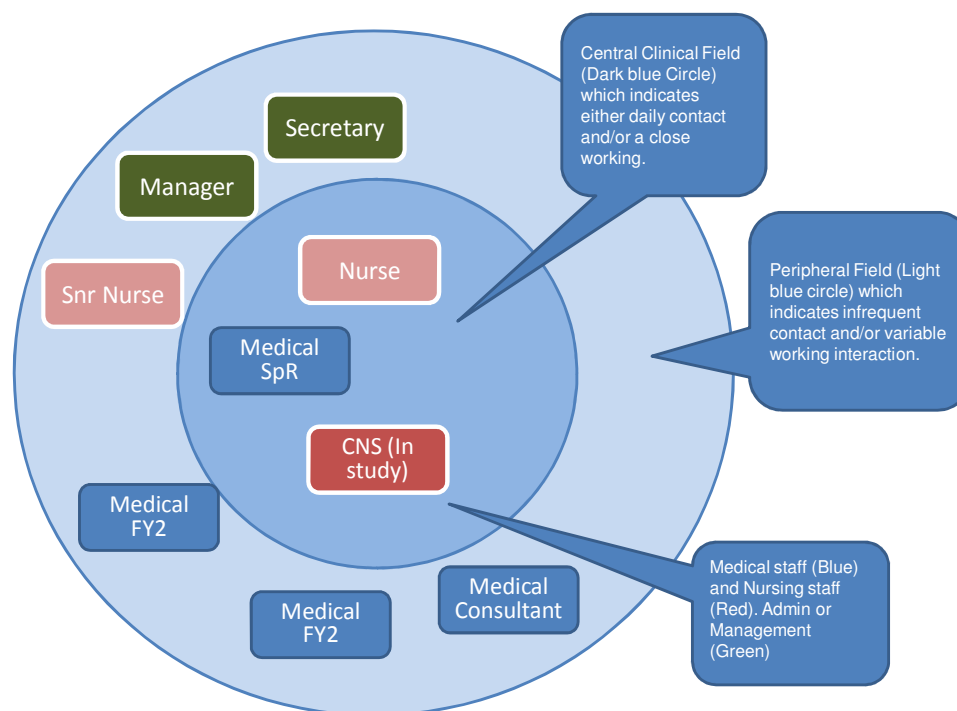
Figure 15 - Practice field chart

Cohort One – Urgent Care

The emergency department and acute medical services were supported single-handedly by a clinical nurse specialist called Reese[8] whose central field was the emergency department, resuscitation room and majors injury cubicles. Reese also worked in the cardiology outpatient facilities to conduct exercise testing and patient follow-up. Reese worked with a range of other clinicians, including four consultant cardiologists, two cardiology registrars, two staff grade and two Foundation Year 2 doctors (Figure 16).
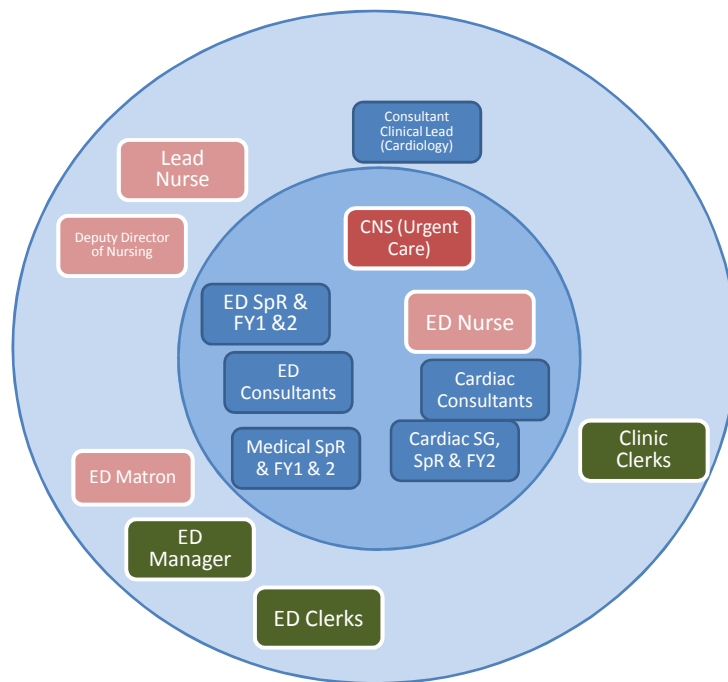
Figure 16 - Practice field and relationships of Cohort One

Reese managed the acute chest pain pathway, thrombolysis and major cardiac problems within the emergency department. He also conducted cardiac assessments, exercise testing and follow-up, following admission through to the emergency area. Reese would manage a caseload each day of approximately 10 to 15 new admissions in the

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8   As discussed in the methods section, all the names used in this thesis are pseudonyms to ensure confidentiality. However, the use of individual names is deliberate to ensure that a human connection is made between the reader and the participants` lived experience of specialist nursing work, as well as the gender context to the research.

emergency department as well as five or six follow-up patients seen within the cardiology outpatient setting.

Cohort Two – Surgical Cancer Care

There were two specialist nurses working within the surgical cancer service, Hannah and Brenda. Hannah was the lead, working part-time within the NHS as well as having other commitments within the university and private sector. Hannah and Brenda worked predominantly in the outpatient setting and the specialty surgical ward. Their peripheral field was working in an outreach clinic within the private hospital.
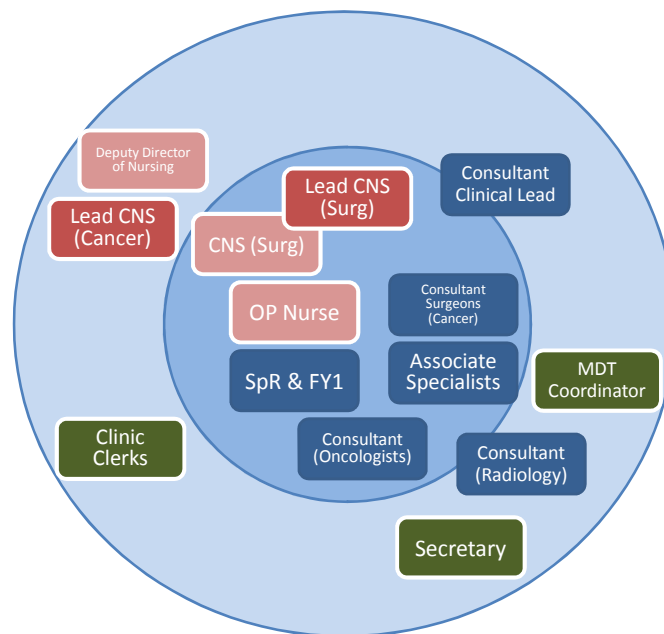
Figure 17 - Practice field and relationships for Cohort Two

They also provided university-based teaching sessions, as well as administrative work within the offices based on the surgical ward. The specialist nurses worked with a range of other healthcare professionals (Figure 17), including four consultant surgeons, Iain, Asan, Arthur and Aadil. In addition, they worked with two clinical oncologists and the radiologist. They were supported by one surgical registrar and two associate specialists. Ward work was predominately completed by a Foundation Year 1 doctor. The team was responsible for both benign and cancer services, which included the management of new

diagnosis, follow-up, treatment and investigation. The majority of the clinics were nurse-led or co-located with a consultant within the patient department.

Cohort Three – Specialist Surgical Care

The specialist surgical nursing service was supported by four specialist nurses on site one called Ora, Robyn, Rachel and Eileen. Their central field was their clinic within the outpatients department which included a treatment area and two offices. This was co-located next door to the technical lab and supported by two technicians. The peripheral field consisted of a research office and the specialty surgical ward. They worked a team rota system to cover outpatients and the ward. They were supported by four consultant surgeons called Ivan, Liam, Deep and Brian, and an associate specialist called Wahid. There was one rotational registrar, one associate specialist supported by two FY2s and one FY1 doctor. However, these staff did not work within the outpatient setting, but cared for patients on the ward (Figure 18). The specialist nurses were responsible for the surgical care pathway from referral by the general practitioner to diagnosis, ongoing treatment and surveillance.
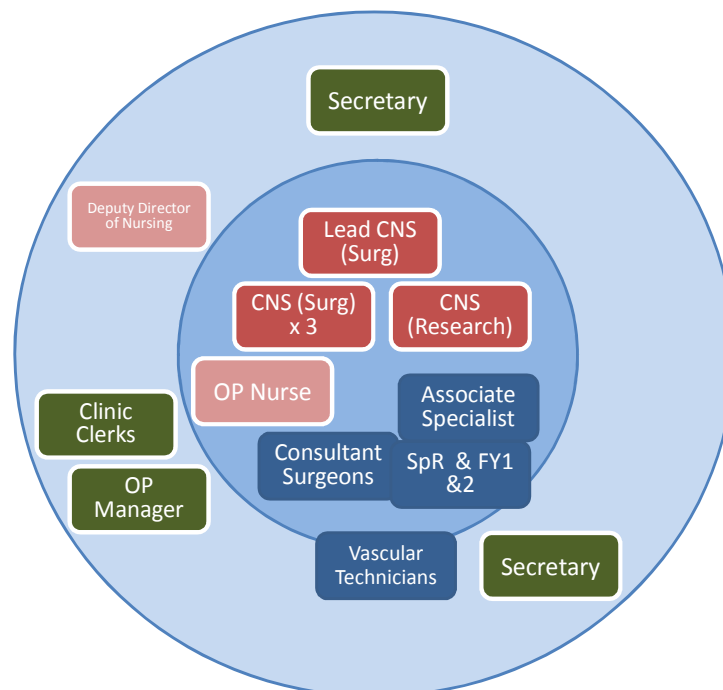
Figure 18 - Practice field and relationships of Cohort Three

This was primarily managed with a telemedicine system linked to several practices and district nursing services. There was limited involvement by the specialist nurses in arterial disease work, including claudication, as this was managed by the surgeons directly.

Cohort Four - Critical Care Outreach

There were seven specialist nurses working in the Critical Care Outreach (CCO) team called Isobel, Eleanor, Abi, Ruth, Naomi, Eloise and Leah. Their central field was the surgical and medical wards. They shared an office with a number of clinicians near the intensive care unit (ITU). They also worked in the emergency department and acute medical unit. They provided a seven-day service via a rotation within the team. The CCO was supported by two part-time consultants, Ralph and James, who were intensive care and anaesthetic consultants. They had one associate specialist, Arun, providing two sessions per week, and a rotational FY1 post (Adel) who was allocated from the intensive care unit. The CCO was primarily responsible for the care of critical care patients outside the intensive care unit.
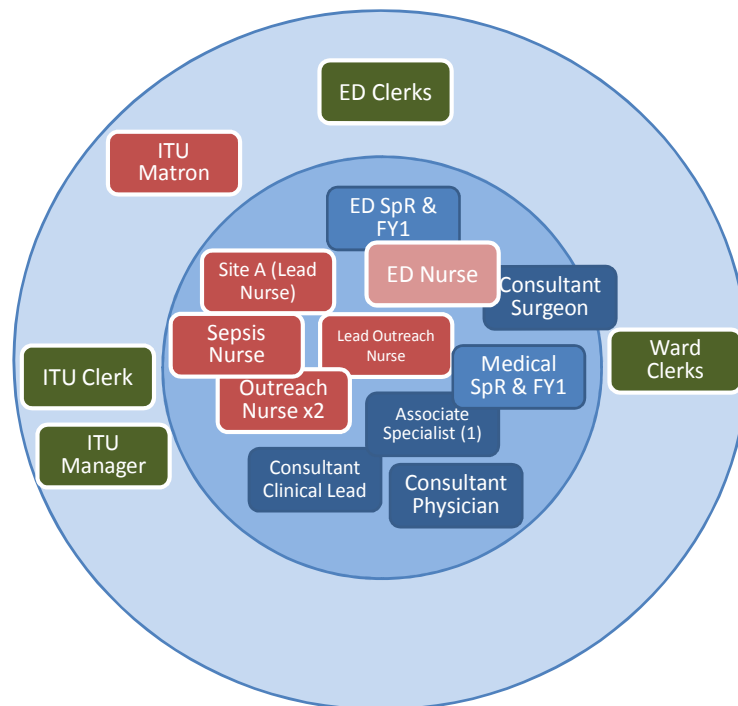
Figure 19 - Practice field and relationships of Cohort Four

They manage patients who have generated a high (> than three) Modified Early Warning Score (MEWS)[9] on the wards and are referred to Critical Outreach for support. The aim of the team is to intervene as early as possible with patients to prevent further deterioration and, therefore, transfer to the intensive care unit. Their role has expanded significantly since the original development of CCO, and now involves managing the sepsis pathway and supporting intensive care. A significant component of their role is the training and education of ward and clinical staff by running several courses on critical care management and awareness.

Cohort Five - Acute Pain Service

The acute pain team consisted of five specialist nurses (Callie is the main participant).

Figure 20- Practice field and relationships of Cohort Five

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[9] Modified early warning score (MEWS) is a simple guide used widely across the NHS to quickly determine the risk of death of a subject. It is based on data derived from four physiological readings (systolic blood pressure, heart rate, respiratory rate, body temperature) and one observation (level of consciousness, AVPU). The resulting observations are compared to a normal range.

Their central field was the surgical wards, with their secondary field a chronic pain clinic and offices within the anaesthetic department The team of five nurses covered three hospital sites from Monday to Friday. They were supported by four consultants, one of whom had a specialist interest in acute pain, while the others had a chronic pain interest; one research fellow and an associate specialist. The team was responsible for managing referrals from ward and department level, from junior doctors and nurses, in relation to pain management, drug therapy, PCA[10] and epidurals. The five nurses in this acute pain team would rotate through the three sites, as well as doing sessions within the chronic pain clinics.

Cohort Six - Critical Care Outreach

The central field of the CCO team was the surgical and medical wards, emergency department, intensive care unit and offices they shared with senior nursing staff within the intensive care unit (ITU).
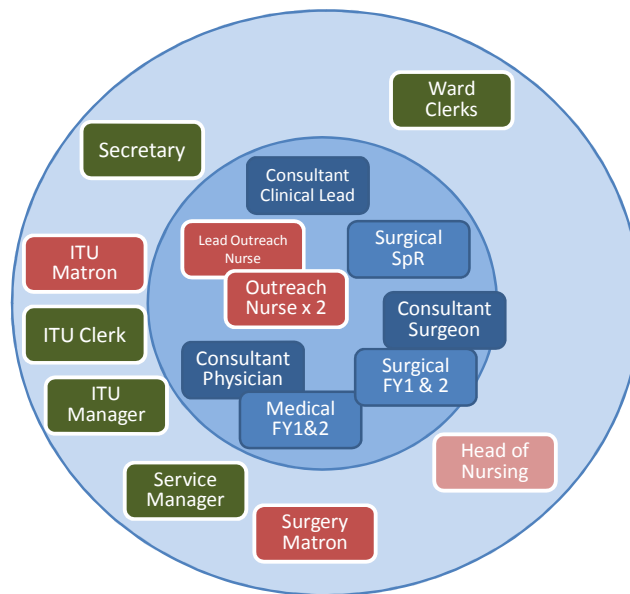
Figure 21 - Practice field and relationships of Cohort Six

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[10] PCA or Patient Controlled Analgesia is a form of self-medication for patients that often involves the use of a medical device that can deliver a set amount of analgesia when required by the patient over a period of time. Often opiate (morphine) based, the PCA is controllable to ensure that the patient is unable to give themselves higher doses of drugs, but faster response times to more traditional nurse-led bolus dosing.

They provided hospital-wide cover six days a week. The service consists of six nurses called Nicky, Sacha, Eila, Erica, Bernie and Sam working a mixture of full and part-time, supported by two main consultants (Maahir and Derrick) who had a special interest in intensive care and CCO. They were also supported by a large anaesthetic and critical care department with a number of research fellows, registrar (Rabani) and junior doctors. They were a nurse-led service and, similar to other cohorts, provided support to the ward for those patients who were clinically deteriorating and required further intervention. They gained a lot of this information from using the VitalPAC system[11], which highlighted those patients who were physiologically deteriorating on the wards. They would also have a responsibility for following up patients who had been discharged from the ITU in the previous few days, to ensure that ongoing care needs were being met on the ward. They would also manage the sepsis pathway, highlighting and identifying those patients developing severe sepsis, and initiating treatment. They also provided education and training, running in-house as well as regional study days in relation to critical care management, sepsis care and outreach skills.

Cohort Seven - Acute Pain Service

The central field of the acute pain service was the surgical and medical wards within site three. They would also support other areas including the emergency department and chronic pain clinic. Their offices were located within the large anaesthetic department. They provided a team of four nurses: Ailsa, Yasmin, Winona and Caroline, Monday to Friday. They were supported by two consultants (Aakarsh and Ahmed) in acute pain who were also anaesthetists and intensivists.

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[11] VitalPAC is a clinical system that uses PDAs and other mobile devices to improve patient safety and quality of care. By performing real-time analysis of haematology, biochemistry and physiology data, VitalPAC identifies deteriorating patients and advises if further escalation is appropriate.
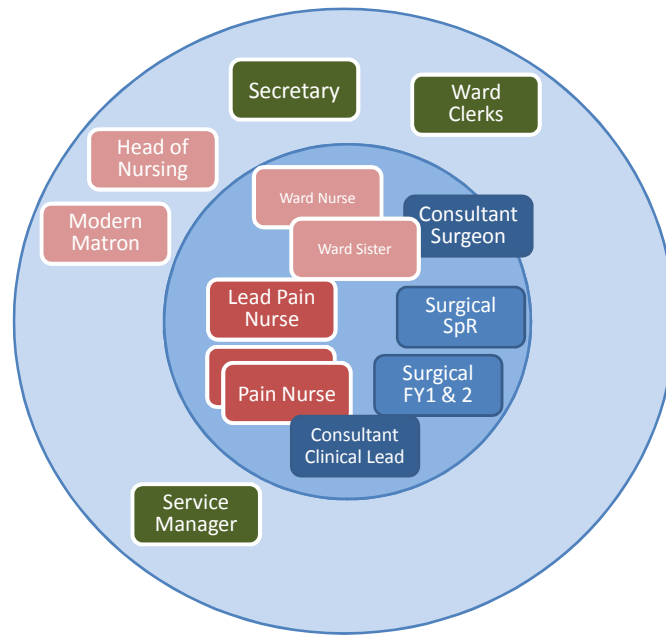
Figure 22- Practice field and relationships of Cohort Seven

There was also a large chronic pain service run by two consultants, but this team only provided limited support. The acute pain service was responsible for following up all those patients` post surgery who had complex pain needs met by PCAs and/or epidurals, as well as new referrals from the wards and departments for those patients who had pain issues. Referrals to the team could be made by medical as well as nursing staff, although they were often very visible on the ward environment, and referrals became quite informal.

Summary

The aim of this chapter was to describe the individual sites, their complexity and the role of the teams that work within them. This chapter prepares the reader for the discussion that arises from the findings in the subsequent chapters. In addition, it provides an initial overview into how the behaviours and practices of the teams are informed by their professional socialisation, organisational culture and shared history. In the following chapters, the findings generated from the study are presented in a logical journey so that

the reader is able to determine the complex nature of specialist nurse-doctor interactions in a modern healthcare system.

The nature of the study, along with the multiple sources of material, generated ethnographic findings of considerable size, volume and complexity. The purpose of utilising the cohorts and an integrative collection of material meant that careful consideration was given to presenting the findings as a cohesive narrative. Emerson et al. (1995) suggest that the primary focus of writing ethnography is representing the particular world under study for those readers who lack acquaintance with the setting. They also suggest that understanding the audience is critical. In most cases ethnography is written for other scholars and must develop ideas which make sense in the conceptual language of the discipline.

Taking these points into account, two main approaches were considered in writing up this ethnographic study: Firstly, a traditional case study approach to the representation of findings. This approach is often presented as a detailed description and narrative of the events found in the original cases. Secondly, a thematic narrative where the findings are organised into themes which are used to describe a coherent story about the life and setting being studied. There were a number of issues in using each cohort under study as a case. Following careful consideration, an adapted form of thematic approach was chosen, which, as Yin (1994) suggests, would provide 'cross case analysis'. Woods (2005) acknowledges that this approach may 'dilute' the unique individual nature of the cohorts to a degree, but is compensated by the ability to examine and compare the nuances between cases as well as determine common themes shared by all groups. This second key point addresses the issues of representation and legitimation examined in the previous chapter.

The findings are therefore presented in terms of four 'grand themes', each with detailed subsets that will illuminate the lived experience and culture of the participants. The themes are:

- The new relationship
- The social space of the field of the hospital
- The division of labour and the development of expertise
- Interaction in the field of practice

The themes will purely outline the findings of the research, and a full discussion chapter will draw together their meaning. While an atypical presentation, it is one that best illustrates the work of the advanced practice nurse and enables the researcher to maximise the synthesis of material into the meaning of power dynamics between them and doctors.

This ethnography represents its participants who defined and recognised themselves by the title 'specialist nurse'. Chapter's six to nine (findings) present the participant's experiences, and this term will be employed to ensure it faithfully represents the voices and lives of those who participated. However, the term advanced practice will be used in the discussion, conclusion and implications of this research to maintain consistency with the wider literature.

Chapter Six – The new relationship

Introduction

One of the key aims of this research was to provide a contemporary account of the relationship of the doctor and specialist nurse. This section uses the research findings to describe the perceived drivers for change, and how this has impacted on the organisation of care, team structure, leadership and professional networks.

Drivers for change

There were a number of perceived macro influences on the changes seen in the NHS. The participants provided a wide range of views on what had driven the changes in the clinical model. Reese, a specialist nurse in emergency care, noted an evolution over his career:

> 'I noticed it when I qualified as an RGN, that would be 1990/'91. That's when I think things turned around and it started to look like people would start to respect nursing opinion … Whereas back in the '80s, you didn't, it was the consultant who made the decisions or the medical team made the decisions. It was rare you would have any real input from nursing.' - Reese (Urgent Care Practitioner), interview

This view was consistent with the medical staff, who also noted a shift in medical and nursing behaviours during the same period. Liam, a consultant surgeon, noted that:

> 'In the early '90s when I qualified there was already push for change and that the nurses were beginning to say there's more to this than just bedpans …….. the nursing structure in the '70s and '80s was still very rigid and I think a lot of intelligent nurses began to ask questions, and when people start questioning, the structure begins to break down.' - Liam (Consultant Surgeon), interview

Liam went on to qualify this by recognising that changes were also occurring in medicine. The growing body of knowledge and technical advances had prompted a rethink on the part of doctors and how they organised care. The impact was a growing sub-specialisation in medicine to counter these developments. Liam goes on to say:

> 'By the '90s there's recognition that one individual clinician could not know everything and, particularly, about some of the more technical aspects, like I say, about imaging or [specialty] surgical management.' - Liam (Consultant Surgeon), interview

The impact for nursing has been profound and is described by Eileen, a surgical specialist nurse, who noted that:

> 'I did my training 21 years ago. I think they (doctors) used to have a perception of what nurses did. But I think it's really changed over the last 20 years and I think obviously nurses are a lot more qualified and more professional these days and they have their own role, separate to doctors but of equal founding. So I think the doctors have appreciated that and they know that nurses are not doctors' handmaidens anymore.'
> - Eileen (Surgical Nurse Specialist), interview

Part of this change was accounted for in the education of nurses and, in particular, the move towards graduate-based programs during the 1990s. Eileen, a specialist surgical nurse, noted that:

> 'I think it's just improved education of nurses to be honest, and improving their roles ….. they've found new roles within the NHS and private sector that have not previously been seen before as being very important but have taken on quite a good importance and have benefited patients.'-
> Eileen (Surgical Nurse Specialist), interview

However, this is not without detractors such as Abi, a critical care outreach nurse, who commented that:

> 'I think they've moved an awful lot to the education - the degrees and things - and sometimes I don't know that it makes any difference. You

*can have a person with a degree who hasn't got an ounce of flaming
common sense! Doesn't know what to do - can't talk to a patient.' - Abi
(Critical Care Outreach ANP), interview*

The macro drivers for change were an interesting combination of policy shifts, technological advances, changes in professional perspective, political, economic and wider social changes. Notably these changes also occurred before 1997 although little evidence could be found in the literature that linked this to the stimulus of health reform of the professions.

NHS policy drivers

It was also identified that a number of other policy drivers during the period of development of advanced practice in the late 1990s and 2000s focused upon productivity and target management within the NHS. The policy drive during this period injected new funding, with a range of targets to improve productivity.   A number of key targets generated an impetus for new roles. For example, Reese, the urgent care practitioner, supported the delivery of two main national targets, including the '4 hour target'[12] in the emergency department , as well as the 'thrombolysis target'[13] for patients with myocardial infarction.   Hannah, the surgical cancer nurse, supported many targets, including the '18 week pathway' [14], '31/62 pathway' and '2 week wait' [15]. An example of the clinical impact was found during observation with the team.

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[12] A four-hour target in emergency departments was introduced by the Department of Health for National Health Service acute hospitals in England. Setting a target that by 2004 at least 98% of patients attending an A&E department must be seen, treated, admitted or discharged in under four hours (Department of Health, 2001b).

[13] The Department of Health through the National Service Framework (NSF) for coronary heart disease introduced in 2000 (Department of Health, 2000c) instituted a target that 75% of patients should receive thrombolysis ("door to needle time") within 30 minutes. This was raised in April 2003 to 75% within 20 minutes.

[14] The standard for delivery of care in the NHS from January 2009 is that no patient should wait longer than 18 weeks from referral to the start of their first definitive treatment. This includes 90% of admitted patients (inpatient and day case), and 95% for non-admitted patients (outpatient)

[15] The NHS Cancer Plan (Department of Health, 2000d) set the targets for the 31/62 day to reduce cancer patient waiting times from referral to treatment. All patients who are diagnosed with a cancer are monitored through the 31 day target and this is irrelevant to where the referral has originated from, e.g. unsuspected diagnosis through radiology, A&E, emergency admission. The

> *Hannah commented, `Asan (Surgeon) is often extremely aggressive in his treatment of these types of cancers, however, insists on his patients being seen by me'. Part of it she felt was related to the cancer standards developed by the Department of Health which insisted on a balanced approach to both information and also consultation, and it was made explicit that in these types of cancer cases patients must be seen by a specialist nurse, a cancer surgeon, as well as an oncologist. – Hannah (Surgical Cancer), observation discussion*

Health policy during this period also influenced the structural organisation of services, which include the introduction of new specialist nursing roles. This is evident in the case of Cohorts Four and Six (Critical Care Outreach). The Audit Commission (1999) introduced the concept that patient management in intensive care could be broadened out to include those who had recently left the ITU and those who could be prevented from deteriorating with ward-based intervention and treatment. This was followed by the Department of Health's 'Comprehensive Critical Care review' (Department of Health, 2000a), which built on the concept of 'critical care without walls'. A key component was the development of the outreach service, which would support ward areas in the management of these patients, introduce MEWS systems and educate nurses and doctors in the management of critical conditions so that patients would not deteriorate and require admission to the ITU. The shortfall in medical manpower required these roles to be taken by nurses. In most cases, these nurses were senior and this had an impact on the areas they came from, as voiced by Ivan, a consultant surgeon:

> *'You're certainly seeing a lot of the senior nurses moving off the wards into these roles, that can be good and bad. Yes, you're losing some senior people off the wards and...their roles have to be fulfilled by more junior people who haven't perhaps got the experience.' – Ivan (Consultant Surgeon), interview*

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62 day target applies to all patients who are referred on the 2 week wait from their GP as an "urgent suspected of cancer". These targets have been introduced to cut the waiting times from referral to diagnosis and diagnosis to treatment.

Productivity was a key component of health policy from 1997, where the targets outlined above focused the health service in a new direction. Productivity of the medical consultant role was a key change in their new contract (Department of Health, 2001a), as Asan explained in a clinic observation:

> *Asan states that, yes, he has great confidence in the system and particularly with Hannah. He states to me, `If it were just her and I we would be able to get through sixty patients in a clinic.` - Clinical observation with Hannah and Asan*

Linked with changes in junior medical doctor training, consultants looked for alternative models to deliver their services. The specialist nurse was intrinsically linked with maintaining the productivity of the clinics or clinical environment. To do this, the organisational model of care required change.

Reorganising the model of care

One of the key changes to affect workforce dynamics was the role of the junior doctor. Since the report 'Tomorrow's Doctors' (General Medical Council, 1993) was published, their role in the NHS has changed dramatically from service providers to an almost complete supervised training focus. This, coupled with the European Working Time Directive (EWTD), has reduced significantly the number of hours available they can give to clinical care. In trying to achieve EWTD compliance, hospitals in the study changed from the traditional 'firm' structure of Consultant, Registrar, Senior House Officer (SHO) and House Officer (HO) (Figure 23) to a shift-based system in parallel to nursing, as outlined by Liam:

> *'On top of that was the whole issue of junior doctors' hours, which necessitated a complete radical change in the way medical teams … well, medical teams broke up. I would say one of our great strengths as deliverers of care was that we worked solidly in teams.' Liam (Consultant Surgeon), interview*
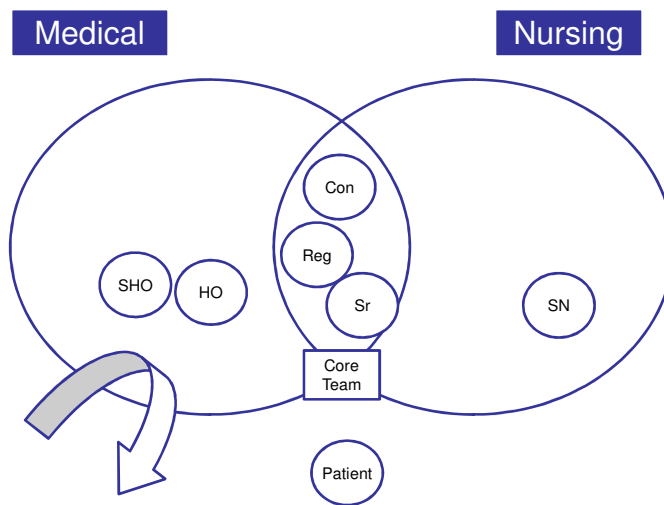
Figure 23 – Traditional medical 'firm' structure

The loss of the 'firm structure' was seen by many in the research as a negative, as Rabani, an anaesthetic registrar, explains:

> 'I don't think it's the right thing for medicine to do; I think certainly the training has deteriorated because of the loss of the firm structure.' – Rabani (Anaesthetic Registrar), interview

These two changes have significantly altered the approach many acute hospital providers have in relation to service delivery, as described by one consultant:

> 'This is where nurse specialists, I think, have really come to the fore in the last ten years, because you're looking for some way of providing that continuity of care to the patient. To get back a team structure, to provide continuity of care and someone who you can invest in, in terms of developing expertise and it isn't the junior doctors anymore. You can't, because they're not there.' – Ivan (Consultant Surgeon), interview

The result of this has altered the relationship between nursing and medicine. Where once the relationship and role boundary was ordered and clear, the introduction and evolution of the specialist nurse to augment teams and services has led to a new model of interaction occurring (Figure 24). The junior medical staff become more transient, less experienced and with limited availability for service commitments, described by one consultant as 'gypsy migrant workers'.
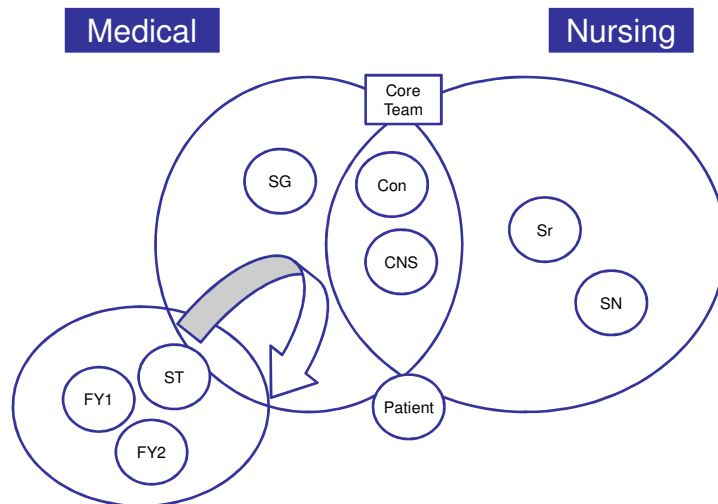
Figure 24 – Contemporary acute hospital structure

What is clear from this new model which is dictated by service delivery, are the boundaries between the professions. The hierarchy within them has changed, as highlighted by a consultant surgeon:

> *'Trainees [Medical] - they're slightly different, they want to get trained. They don't give a **** about your service - pardon me. They don't, they want to suck knowledge out of you and get as much experience as they can of illness and how to manage illness and how to treat it.' – Liam (Consultant Surgeon), interview*

Part of the perceived success of the specialist nursing role is the 'permanency and continuity' that the specialist nursing role has in the new team structure compared with the junior doctor. They often have established social commitments (family, partners and children) in the local area, and are in most cases 'home-grown' around the service or

team and therefore stay for long periods. Liam, a consultant surgeon, saw this as adding value to the workplace:

> 'That's why we've been enthusiastic about them (CNS) over the years because they're generally people who stay within the unit, the people that you can invest time and effort in and, obviously, give something back.' - Liam, (Consultant Surgeon), interview

From the perspective of the nurse, changes in the workload on the wards had also prompted many to consider specialist nursing careers. Many of the specialist nurses recognised that this had a significant impact on the wards, as Rachel, a surgical specialist nurse, explained:

> 'We don't have people breathing down our neck all the time, so we don't have the same pressure as they do on the wards… My worry is that we deskill the ward nurses by visiting just at the drop of a hat. I think they need to be able to do things for themselves before we actually go and see the patients. So I see those as barriers - extra work, and deskilling nurses to what we would do for them.' – Rachel (Surgical Specialist Nurse), interview

This was a view supported by Eloise, a critical care outreach nurse:

> 'When we go on the ward and there's somebody sick, it's amazing how many people run away and just leave you to get on with it, whereas really what ideally should happen is that they should be in there with you.' - Eloise (Critical Care Outreach Nurse), interview

The patient and the reorganised model of care

An important change in this new model concerned the patients themselves. The policy drivers had attempted to give the patient greater control and this is reflected in the representation of them closer to the core team compared to the historical model. The reorganisation of the model of care resulted in an interesting interface between patient expectation and the specialist nursing role.   There were two episodes when the role of

the specialist nurse was noted by patients. This case with Hannah was more interesting as the relative was also involved in the discussion:

> *The patient's relative asks, `Is it normal to see a nurse, what about the doctor, is this new?` Hannah responds, 'No, it's now very, very common for patients to be seen by nurses in clinic rather than doctors.' The patient apologises for her relative being nosey, and says that she's a journalist. She leans forward and says in quite a conspiratorial tone, 'but I understand that you often know more than the doctors.' Hannah is not fazed by this comment and simply suggests, 'This is sometimes the case but we are here more continuously than some of the junior medical staff and therefore work with the consultants on a basis so we are able to get to know more specialist detailed knowledge and provide that to patients.'*
> *– Clinical observation with Hannah (Surgical Cancer Specialist Nurse)*

The patients did not resist or challenge the specialist nurses if they were giving treatment or care even when their perception of the tasks was medical. However, the nurses were conscious of this interaction, as commented by Reese:

> *`I used to turn around and say, "If you'd rather see a doctor, then I'm more than happy". I used to say that when I first started seeing them, but I don't actually add that in any more. I've not had a single patient say they would rather see the doctor.` – Interview as observation with Reese (Urgent Care Practitioner)*

The nurse-patient relationship was different compared with the traditional role of the nurse in their interaction approach, skills and knowledge. Although outside the scope of this research, this is an interesting issue and suggests a shift on the part of public perception. More research would be helpful in this area.

Local drivers and developing the apprentice

In other cases, the drivers for change were more locally specific and related to the availability of a nurse who was interested in developing beyond ward nursing.

'Roy was a teacher on the coronary care course, and on the first day of the module, he saw me coming in to the Uni and he turned around and said, "I've got a job I want you to apply for", because he knew that I had a particular interest in heart patients, cardiology patients. I applied, got the job, and that's where I am now.'- Reese (Urgent Care Practitioner), interview

These individuals were often highlighted by the medical staff, and in some cases developed specifically as a result of a medical manpower issue and recruitment gap in smaller organisations. Reese noted one of the local drivers in his organisation:

'You've only got two registrars in the Trust, in the whole hospital, and both of them are busy, … somebody's got to be able to try and pick up that slack, and I think that's what they're looking at for me now.' Reese (Urgent Care Practitioner), interview

In many cases the specialist nurse was encouraged to apply for the role by the medical staff, as highlighted by Ora:

'They (consultants) were all really, really positive and … in fact it was them that encouraged me to continue to go because they were so keying up the role, how fantastic they think the [surgical] nurses are, how much trust they've got in them, how much further we could take the role, because what I didn't want to do is kind of have a role that I would just sort of stagnate in for years.' Ora (Surgical Specialist Nurse), interview

In the early days of specialist practice, much of the training and education was done via an apprenticeship model alongside the medical staff. There was little or no formal training, as Eloise, a critical care outreach nurse, indicated:

'When I started in Outreach, it was purely a gap came up in the staffing of Outreach and they wanted people that would have a go. So, you know, I went out there with no training or anything.' - Eloise (Critical Care Outreach Nurse), interview

This was common through the research study. Doctors still retained significant influence in the clinical model to have resources diverted to reconstruct the clinical team, as well as manage entry and control training. Analysis of the site artefacts identified that specific criteria were laid down for entry into the role, including qualifications, experience and skills, although these were not often strictly adhered to. In most cases they would be developed when appointed into post. It was evident, even in those teams where national policy initiated the role, that the local doctors maintained an authoritative position. This had important implications in the organisation of the clinical team, division of labour and interactions.

Organising the team and hierarchy

In understanding the team organisation, it is important to make a distinction between the organisational models and the actual day-to-day operational models. As part of the information collection process, the organisation charts of each of the teams were gathered and reviewed. In all cases, the specialist nurses had a hierarchical structure linked to senior nursing such as a Modern Matron[16]. Whilst the medical leads took interest in this, the majority of the management of the specialist nurses was coordinated by other nurses, as Leah outlines:

> 'We've got a medical lead, but there's not that much input from them. I think it comes mostly from nursing.' Leah (Outreach Nurse), observation conversation

There were natural tensions with this system, in that nurses worked in a traditional hierarchy but were expected to have the clinical autonomy to do their roles, supported by

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[16] Modern Matron – Matrons were senior nursing roles in UK hospitals until the 1960s when they were abolished as part of a service reform programme. They were reintroduced during 2001 as a government policy to counter the public perception of deteriorating clinical standards in the NHS. The Modern Matron's role encompassed areas such as cleanliness, infection control and professional standards as well as middle-level management duties (budgets, workforce and monitoring).

the medical staff. The medical view was that nurses operated better within a hierarchy, as indicated by Ivan who linked this to the clinical accountability model:

'I could see how some (nurses) would feel more comfortable in a hierarchical situation because they always know where to go to in the event of… or there's a responsibility issue in terms of, you know, the buck stops with the consultant, type of thing.' Ivan (Consultant Surgeon), interview
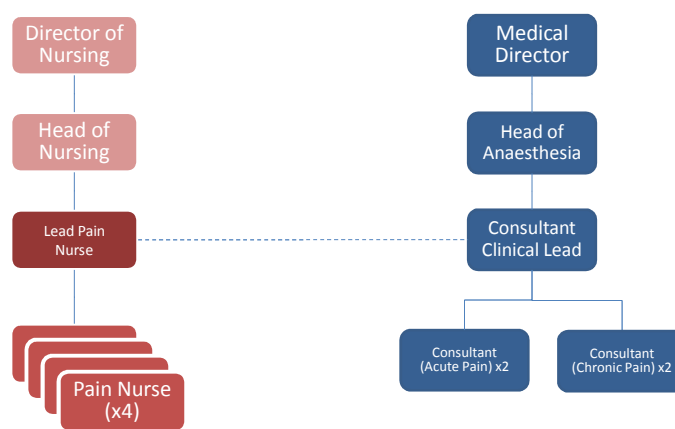
Figure 25 - Organisational chart for Cohort Seven, site three

The key perception was the implicit acceptance of medical dominance and control. This position was largely accepted by the nurses in the formal interactions, who were often complicit in maintaining this position for the patients. This evolved to create a 'medical veto' of their decision making which was a frustration for the nurses due to their perceived autonomy (see Chapter Nine for more detail on the 'medical veto'). In practical terms, clinical autonomy was from the nursing hierarchy with medical oversight.   Robyn discussed her feelings when this occurred:

Robyn: One [Dr] has pulled rank once, yes. But, anyway...
Researcher: How… how did that make you feel?

Robyn: A bit annoyed I think, because there was no need to do that. It's not about rank; it's about the decision making, making sure it's the right thing.

Robyn (Surgical Specialist Nurse), interview

Medical veto as a concept occurred frequently in the decision making of the specialist nurses and will be discussed in more detail later in Chapter Nine. This aspect of oversight and control was also found in the structural procedures of organisations, commonly seen in policy and procedures. In this example related to prescribing practice, the policy stipulated:

'The need for non-medical prescribing must be identified and agreed by the proposed non-medical prescriber, supervising consultant (designated medical practitioner), clinical director and supported by their professional lead. The patient pathway should be reviewed to ensure the effectiveness and links onto patient care and service.' – Artefact 70, Non-Medical Prescribing Policy

This policy outlined that three doctors would have to agree that a specialist nurse would be able to prescribe medications in their field of practice. Formalised medical dominance such as this was common across all three sites, although the degree to which medicine was the dominant professional culture was influenced by the history of nursing in the organisation and the strength of its nursing leadership culture. All sites had a Director of Nursing on the Trust board, but some had more influence than others and as a result nursing was perceived differently. Power of the nursing culture was an interesting finding and related to nursing leadership from a senior level.

On all sites, responsibility was given to the specialist nurses to partly control and manage the workload or clinical pathway. The team exerted an important influence on the division of labour. Continuity for the service was a clear advantage for the specialist nurse over the junior medical staff. This and policy shifts had influenced the clinical model sufficiently for service provision to be a fundamental part of the role, as in this example from Hannah:

'…It goes back to what we were saying about continuity being a key factor.' … 'Doctors,' she says 'don't often get this level of continuity

…… for that chap that we've just seen he may not be seen by a surgeon again and I will manage most of his care - this role is key. I think it relies on the fact that nursing is central to making it work.' Clinical observation with Hannah

This is important for two main reasons. Firstly, the issue of continuity became currency for the specialist nurses over junior medical staff and, with this, brought privileges in terms of conditions of service, power and authority within the team. Secondly, that over time this created a reciprocal relationship built upon trust, which saw greater delegation of responsibility to the nurse of medical tasks and perceived autonomy. Those delegated tasks are discussed in more detail later in Chapter Eight, but presented two distinct issues. This created a tension between the specialist nurses and junior doctors where the division of labour created dissonance between the service role and training of doctors. As a result, the specialist nurses were treated more respectfully than the junior doctors as a result of providing service to the consultant and their specialty. This meant the specialist nurse had to operate in medical and nursing fields, which gave rise to a dependence rather than mutuality. Whilst challenge and debate was tolerated and encouraged, resistance was not. One case was discussed during interview which highlighted the effect of resistance from the specialist nurse in the team model. Liam, a consultant, discussed this:

'It was a problem. A philosophy had not evolved by any sort of collaboration or discussion. It was basically what, I guess, she'd read about. She'd decided in her own mind that it was the right way to go. Some of it was very good, some of it wasn't…she couldn't see that that was an inefficient, inappropriate way to behave for the greater good…We gave her a deadline to set this official launch of the service. "This is when we're going to launch it, this is how we're going to do it and you are going to agree - you are going to head up this service and man clinics on certain days, so that we can feed patients into those clinics in a streamlined way." And that's ultimately, I think, what precipitated her resignation.' Liam (Consultant Surgeon), interview

For the specialist nurse, this led to nurses operating with a complex spatial, clinical and operational hierarchical system (see Figure 26) that saw frequent challenges in maintaining the status quo. In addition to this they also had to maintain links with

administrative levels and this is outlined in more detail in Chapter Seven - on page 159. However, the medical leads recognised the value of their specialist nurses in this reconstructed health team.
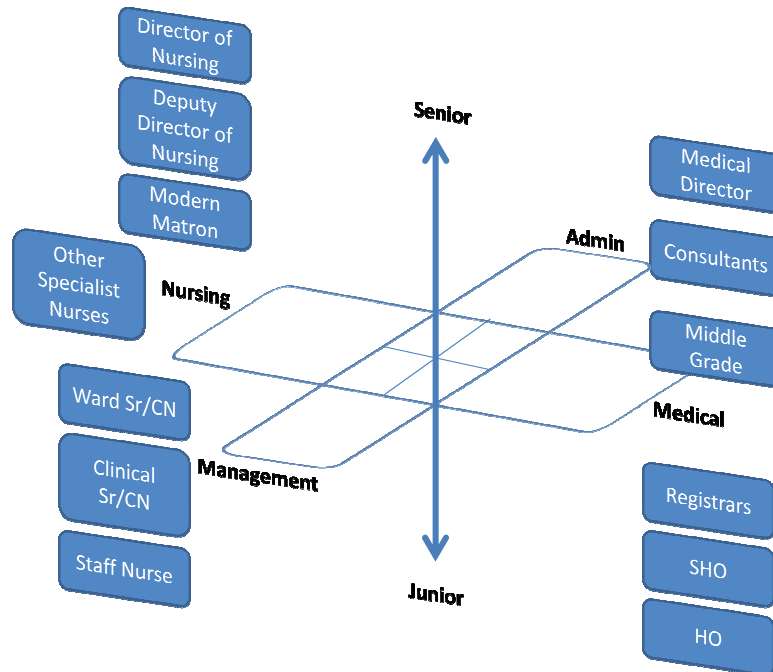
Figure 26 – Clinical hierarchy relationships for the specialist nurse

They understood that the interface could result in conflict, particularly with their junior doctors. It was recognised that this resulted in a change in behaviour or 'allegiance' on the part of the consultant towards the nurse, as outlined by Liam:

> 'I know we had a Reg (Registrar) a few years ago. He really was uncomfortable with the idea, that these nurse specialists knew more than he did. And so they were treated in a more responsible way.'   Liam (Consultant), interview

The impact for the specialist nurse was they had to develop complex networks with a range of systems, professions, departments and individuals to deliver their role. This led to a multitude of influencing strategies that will be discussed in more detail later in chapter nine.

Networks and influence of the specialist nurse

As a result of working in many clinical domains and having to navigate complex hierarchical, professional and organisational systems, specialist nurses developed networks of influence within the wider organisation. Specialist nurses established networks to support their patient care pathway, often with other specialist nurses, as identified by Eileen, a surgical nurse:

> *'The diabetes nurses would know that patient really well. So I would go down there and have a chat to Samantha about a patient, and she sometimes will come to me and get me. "Will you come down and have a look at this patient and we will have a chat about them?" So together we'll look at the patient and we'll not involve the doctor at all.' Clinical observation with Eileen, Surgical Nurse*

A sense of professional isolation of the specialist nurse was observed from other parts of the workforce. They did not 'belong' to medicine in the sense of being part of that professional group by qualification or social capital and they were also just as isolated from ward or clinic nurses, as Nicky stated during interview:

> *'because we're halfway between the nurses and the junior doctors.'*
> *Nicky (Critical Care Outreach), interview*

This had both positive and negative aspects for the specialist nurses, such as 'jurisdiction' when trying to affect change in a professional group's behaviour. With other nurses, they would often leave detailed instructions of care, but in many cases they were not dealt with on the same priority as those of medical staff. In the case of doctors, this would affect the communication strategy, where, for example, they would 'ask and suggest' to a doctor outside their own team when to change a patient's treatments, as outlined by Callie, an acute pain specialist:

> `A lot of them are problems associated with people taking up your advice. You're often asked for it on a number of occasions, particularly to identify if there've been any particular problems. You often come back

sometimes the following day and find out neither the doctors or nurses seem to have followed the advice, and this is mentally frustrating as acute pain seems to be such a fundamental part of what we do within the surgical ward.' Callie, observation with Acute Pain team

Building trust in the clinical team

These changes have some important challenges for medicine and nursing in terms of team genesis, work and leadership. The traditional hierarchical boundaries between the two roles are hard to break, as they are often reinforced by the organisational structures. The specialist nurses implicitly understand or perceive that the final responsibility rests with the consultant even though they may manage the entire care episode.

> *'On the wards you always had the backup, you always had somebody that you could say to: "Do you think this is okay? Do you agree? Should I do this, should I do that?" In this role you don't, and a lot of times you're making decisions on your own back and it's having the confidence to be able to say, "Actually, I'm not happy and I want the consultant."'*
> *Robyn (Surgical Nurse), interview*

The issue of accountability significantly influenced parts of the communication model. This perspective was shared by many of the specialist nurses seen during observation and interviews. They clearly had respect for the consultants they worked with, or, as stated in most cases, 'worked for'. However, the specialist nurses were often taking the lead in clinical situations, as in this observation with Reese:

> *Reese's emergency bleep went off and we were returning straight back to the emergency department, and moved through to the resuscitation area. As soon as Reese came into the room they deferred to him. A brief résumé was given to Reese in relation to the clinical care of this patient who was 67 years old and had arrived with chest pain, with a bundle branch block and bradycardia. Reese immediately took charge of this situation and started prompting treatment decisions and taking over. - Clinical observation with Reese*

This confidence came through the trust and respect given to them through the team and was reciprocated between the two professions. It suggests a sense of protectionism between the consultant and specialist nurse to the exclusion of others in the relationship (managers, junior doctors and ward/clinic nurses). An interview highlighted this:

> *'They are (nurses) pretty much treated as equals, because they've been there a while. They've got tremendous knowledge and experience, often in areas that we don't, so there's this mutual respect.' Liam (Consultant), interview*

This was reflected by Nicky, an outreach nurse:

> *'They (doctors) trust you, you know, because they know how you work and they will trust...if you say, … "I need you to come in and view this patient now", they know that, okay, Nicky said they need you, so they'll come.' Nicky (Critical Care Outreach), interview*

However, trust and respect extended often only to the boundary of the core team, rather than doctors in the whole organisation, as Eloise, an Outreach, identified:

> *'Whereas there's other consultants that might not have ever had dealings with us and find it very difficult to accept advice from a nurse. They might feel a bit, that nurse, doctor thing.' Eloise (Critical Care Outreach), site three*

Although, mutual respect within the team was found across the cohorts, formalised challenge in clinical situations was commonplace, and is discussed in Chapter Nine. Occasionally, disrespectful comments towards doctors were noted in situations that were less formalised and in the presence of colleagues or other members of the team.

> *Ruth looks through the various blood tests … then she turns around, cross-referencing with the drug chart. 'Look - she's had too much. She's now had over 100 mmols in one day. I ask her, 'Why have they (Drs) done that?'... 'I think it's because they are stupid! It's always the same, they either do too much or they do too little, and you end up*

having to sort out both sets of patients.' Observation with Ruth, Critical Care Outreach

This was directed at junior doctors, and it was noted that formal challenges occurred more frequently with this group compared to the consultants.

Summary of evidence

The contemporary relationship is clearly different from the traditional representation in the literature between doctors and nurses (Allen, 1997, 2001a, b; Porter, 1991; Stein et al., 1990; Svensson, 1996). The obvious difference is the genesis and membership of the teams themselves. The critical driver is the role of the junior doctor, rather than the nurse. The findings identified that for the doctors it was the changes to junior medical training that accelerated the developments in the new healthcare team. Whilst they recognised that nurses were requiring more of their role, European Working Time Directive (Council Directive, 1993/104/EC) and Tomorrow's Doctors (General Medical Council, 1993) required a radical and also rapid re-assessment of how the services were to be delivered. It is therefore not surprising that the values the doctors placed upon these new nurses were in essence ones that they required for their services to be continued, factoring in the loss of the junior role. These values were the practical day-to-day management of the patient pathway, whilst they were able to remain as consultants.

The application of the apprenticeship model for the specialist nurse is an interesting finding and one that is a possible expression of cultural capital in the relationship (Bourdieu, 1986). From the findings, the cultural capital of medicine appears to be an important concept in understanding the power of the specialist nurses and doctor. Professional dominance and expressions of power within the healthcare team appear to have evolved with the use and development of capital in all its forms. However, this evolution was largely constructed on the doctor's terms, with an ability to shape and define the practice of the nurses. The specialist nurse largely accepted this state to advance their own position whilst accepting limitations placed on true clinical autonomy. The autonomy given to the specialist nurses was more often about release from the fixed work of the wards and the *possibility* of a degree of flexible practice. This transcended the individual agent behaviour and was ingrained within the organisational culture reflecting the Bourdieu view of organisational habitus (Bourdieu, 1990).

The specialist nurses have an intrinsic level of power in their role which is devolved to them in the majority of cases through their proximity to the medical system and adaptation of medical capital. Critically, doctors can determine the amount of power other agents have in the clinical model through structural controls of their role, such as policy and procedure as observed within the artefacts (Lawton & Parker, 1999). These structural controls are important as they provide system-wide control and direction for the specialist nurse and are an outward projection of medical power. The wider field of the hospital within which the clinicians worked also had a bearing on the operating framework of schema. The hospitals in the study were all well established NHS institutions; they had individual 'professional identities' that represented the dominant clinical culture, a perspective that will discussed in more detail in subsequent chapters.

The profession of medicine has a general veto on the clinical powers of others, despite the specialist nurses` perceived autonomy in the system. This autonomy is granted as part of a process whereby the nurse is recruited, trained and observed in practice by doctors. This bond, through work, developed into a mutual trust and respect between the two professions. However, this contrasted with the negotiated order perspectives (Allen, 1997; Svensson, 1996) where this ultimately settled into a pattern of behaviour determined by different professional, geographic and knowledge domains.

Trust and mutuality of the relationship between the specialist nurses and doctors (both senior and junior) was a key theme and concept that was intrinsically linked into concepts of team, hierarchy and knowledge. Entry control and oversight of the team was provided by the consultants in a professional sense, similar to that of their junior doctors, although managerial responsibility was retained by nursing. The specialist nurses, having been 'chosen` and trained as apprentices by the doctors, maintained loyalty to the team and thus the consultants they 'worked for'. Consultants supported the specialist nurses in their practice with direct access to their knowledge of clinical conditions and treatment. As a result they were treated differently compared with the junior doctors in the team, who in many cases were no longer eligible for team identity due to their transitory role in service provision. Productivity and permanency were valuable commodities in the service model, and delivered primarily by the specialist nurse. However, membership did not automatically bestow trust and this had to be earned over time, the result being that multiple hierarchies existed in teams of specialist nurses even though they may have had similar pay and grades. Gaining trust provided significant benefits within the team, such

as authority and support in conflict scenarios with junior doctors, as well as external credibility within the organisation. The challenge for the specialist nurses is that they had to also maintain credibility and influence in the nursing hierarchy, some of which was given due to proximity to the consultants. As Hayward & Lukes (2008) suggest, time is a critical component in the development of power between agents in a system. If the limits and rules of the operating system are structurally determined in their day-to-day work, it will ultimately shape their actions.

This chapter has highlighted the broader influences on the relationship of the doctor and nurse. The findings also demonstrate that the hospital field is an intriguing avenue of enquiry for understanding power and will be examined in more detail in the next chapter.

Chapter Seven - Social space and field of the hospital

Introduction

The physical space within a hospital is designed to accommodate the functions required to treat and manage patients. Historically, hospitals were designed for the benefit of the professions although modern designs also consider the patients (Carpman et al., 1985; Douglas et al., 2005; Gesler et al., 2004). Sociological commentators such as Foucault (1977), Prior (1988), Lefebvre (1984), Bourdieu (1989) and Giddens (1986) have all argued that space is important in understanding professional power. Lefebvre (1984) described 'l'Espace' (anglicised by Shields (1991) to 'spatialisation') to understand the context of spatial forms that social activities and material things, phenomena or processes take on. The use of space and the sphere of work are an important area to understand, as previous research has highlighted that the practice settings define an important aspect of the relationship (Allen, 1997, 2001a; Carmel, 2006; Hughes, 1988; Porter, 1995). This chapter seeks to determine what role social space has on shaping and defining practice, professionalisation, knowledge, expertise, power and communication methods. This chapter will set out the findings in relation to the physical and sociological space in which they operate.

Spatialisation of the hospital

The hospital itself was a larger community of practice and part of the wider social space of the NHS, healthwork and social community. Within this, the specialist nurses worked in many different environments characterised by patient groups and the division of labour within the hospital. These two elements were influenced by the type of work, specialty and their proximity to medical consultant support. The specialist nurse had central and peripheral fields of practice. The central field was the area, both physical and professional, in which they spent the greatest amount of time - predominantly clinical. The peripheral field was characterised by the additional duties they had - these were often non-clinical areas. Each of these fields was subdivided into a variety of spheres as outlined in Figure 27. They were connected by the specialist nurses and doctors to

ensure continuity of care, and became an important position from which to observe power transactions.
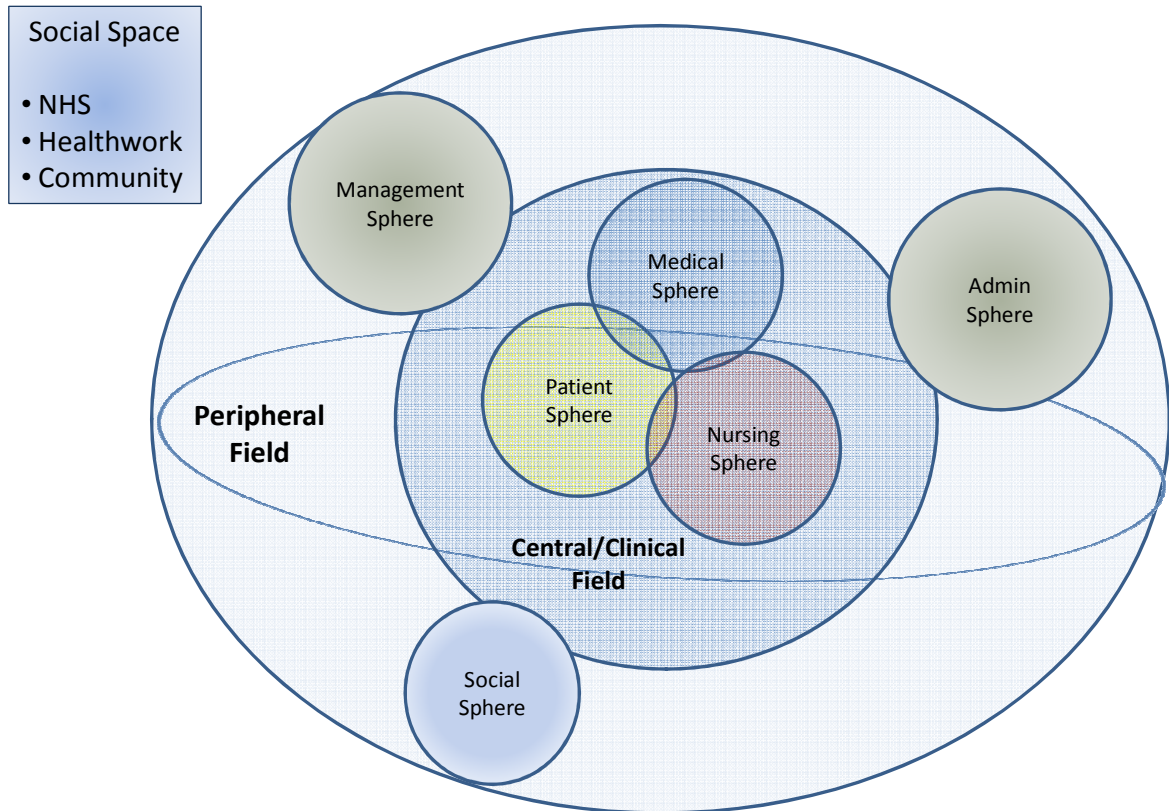
Figure 27 – Spatial diagram of the specialist nurse in the hospital setting

The spheres had an extensive number of artefacts, symbols, characters and tastes that set out their physical and social function (Table 12). The shared clinical fields were also professionalised (socially constructed) providing a key vantage point to see power interactions. For example, the observation of Reese, Urgent Care Practitioner, (on page 154) in the resuscitation room taking control of the situation and the space to transact care. Professionalised space is an important new concept to understand and will be discussed later in this chapter.

Sphere	Descriptor	Symbols and Artefacts
Patient Sphere	Patient spheres were utilised by the patients (i.e. waiting room and corridors). A specific boundary existed between the healthcare practitioners and their clients/patients. They were often waiting rooms, relative rooms, chairs outside clinics, or reception areas.	Signage, seating and environment (potted plants, light and space). Posters and other patient-focused literature such as leaflets.
Nursing Sphere	Nursing spheres were clinically-defined areas, used exclusively by the nurses, such as a clinic room, nurses` station or treatment room. It was also an area that was professionalised by the specialist nurses when conducting assessments or treatment on a patient.	Signage, posters and functional tools, such as machines, used to monitor and assess. Other equipment to signify clinical interactions, such as curtains, gloves, aprons and hand sanitizers.
Medical Sphere	Medical spheres were clinically-defined areas used exclusively by the doctors, such as a clinic room. It is also an area (such as a bed space on a ward) that was professionalised for a period of time by the doctor for the assessment or treatment of a patient.	Signage and artefacts signifying medical practice, such as anatomical models and posters. Prescription pads were laid on the desk, with other forms of documents for the doctors on the desk (X-ray forms, referral documents, etc.).
Management Sphere	Management spheres were areas designated for administrators. They were often separate from the clinical areas.	Management spaces were those areas where the managers worked, and were often segregated from the clinical areas. They often had access controls in place. The offices often had one person in them, with filing cabinets, computers and meeting table and chairs.
Admin Sphere	Administrative spheres had two main subdivisions, those that the specialist nurses had of their own, and those managed by administrative staff such as secretaries.	Administrative spaces were often areas staffed by secretaries and others involved in transacting the business of the managers and consultants. They were shared spaces, with desks, computers, filing cabinets.
Social Sphere	Social spheres were limited in hospitals although coffee and break rooms were available. Social space may also include canteens and other refreshment outlets.	Traditional hospital canteens with serving areas, tables, chairs and vending machines. Smaller local areas away from the patient space with a kettle, coffee, tea-making facilities and notice boards for social events, etc.

Table 12 – Typology of hospital space used by doctors and nurses

The nursing sphere

The nursing sphere was varied although was aligned to their clinical work via the patient pathway and a disease focus. Medical staff had a great deal of control in determining the role of the nurse and this also included the field. For example, Hannah and the specialist surgical nursing team had a fixed clinical space in the clinic as well as providing support to the relevant specialty ward. Reese, the urgent care practitioner, was located in the emergency care areas of the emergency department and medical assessment unit. Providing specialist advice to inpatients required the other specialist nurses to work across the wards of the hospital. This group of specialist nurses was interesting as they were sponsored by the medical teams to support other departments. For example, the outreach and acute pain services worked across all the wards in the hospital but were professionally located in intensive care and anaesthesia departments. This raises the issue of territory as a separate concept to working field as it fundamentally changed the interaction process and outcome.

For those specialist nurses who were predominantly outpatient based, the consultants mainly provided clinical services in the same areas, although they saw different patients from the nurses. Although co-located, they were classed as nurse led:

> *We discuss the fact the processes in this clinic may be slightly different. As it is nurse led there is often little interaction with doctors. The only exception to this is when discussing diagnosis of certain patients with a doctor who is co-located in the treatment centre running a different surgical clinic. - Clinical observation with Hannah*

However, it was frequent for the nurses to use this proximity to resolve issues, including decision making, confirming decisions, knowledge and social interaction, as in this example with Reese in the medical assessment unit:

> *We go through to Anne's (Consultant) office and sit down where Reese then asks her for a prescription. `Can you sign this?` and hands over the prescription sheets. 'Yes`, and signs the form. - Clinical observation with Reese*

The clinical field was also determined by the organisation through job descriptions, job plans and knowledge skills framework documents (KSFs)[17]. These documents link the nurses to the pathway, physical location, role and function. The KSF framework applied to all staff except doctors and also described the knowledge, hierarchy, key relationships as well as space and time as highlighted in this example:

> ***Title*** *:*   *Advanced Clinical Practitioner*
>
> ***Grade*** *:*   *Band 8a*
>
> ***Managerially & Professionally Accountable to:*** *Director of Nursing*
>
> ***Key Working Relationships:*** *Consultant Nurse; Clinical Director; Modern Matron; Director of Nursing; Senior Nurses.*
>
> ***<u>Job Summary:</u>***
>
> *The post holder will be practising autonomously as an advanced practitioner within emergency care to provide patient-centred clinical care. This will encompass the skills of assessment, examination, diagnosis and treatment within an agreed scope of practice throughout the Emergency Department (ED). The post holder will support a new way of working that emphasises a more efficient and patient focused service, and will ensure the safe referral and discharge of patients with undifferentiated and undiagnosed presentations in any area of the ED.*
>
> *The post holder will deliver an 80% clinical component to their role and 20% related to appraisal, clinical audit, teaching, self development and research.*
>
> *-   Artefact 89, Job Description of Advanced Clinical Practitioner*

As the nursing sphere was delineated by the pathway of care, it linked to issues of productivity and continuity which set out where possible interactions that may occur with different grades of doctors, as Adel, the Foundation Year doctor, describes:

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[17] Knowledge Skills Frameworks (KSFs) were introduced in the NHS in 2004 as part of the Agenda for Change pay modernisation programme. KSF defines and describes the knowledge and skills which NHS staff (except doctors and dentists) need to apply in their work in order to deliver quality services. It provides a single, consistent, comprehensive and explicit framework on which review and development of all staff is based.

> `I think they're (specialist nurses) in a particular area and they're involved in clinics and ward stuff … as junior doctors we have very little contact with them.` Adel (Foundation Year 1 doctor), interview

The nursing field was also managed and maintained by the consultants, as indicated by Liam (Consultant Surgeon):

> 'Their [specialist nurses] work then extends on two wards, so they actually probably, I would say, do about 90% of the management of patients on wards as well. So relatively little requirement for input all the time from consultants or even doctors.` Liam (Consultant), interview

This highlights that the clinical field is partly managed by the doctors, who determine the division of labour, in this case to ensure that the consultants` work on the ward or department is minimised, controlled, regulated and observed from a distance. This is noted by the nurses, such as Robyn:

> 'Because our roles on the wards are very different. It's just basically because sometimes they don't want to be bothered to go and see a particular patient with a nasty leg or something. They want us to go, oh yes, we will do the assessment and do all what they don't want to do (laughs).` Robyn (Specialist Surgical Nurse), interview

Robyn goes on to say that the issue of control also extends to managing the time the nurses spend in the field.

> Robyn: I can remember once, I think it was myself and the staff nurse were off on a study day and one consultant rang up for some …to see a patient and he went absolutely berserk, left us a horrible message over the phone, you know.
>
> Researcher: Because you weren't there?

> *Robyn:* `What is it with you girls? You're always off at the same time and we're never off (laughs).` It's just a one-off. So yes, it's different then, they expect you to be there.
> *Robyn (Specialist Surgical Nurse), interview*

The naming process of field was also professionalised, as peripheral members would use the professional title of the doctor to reinforce authority and position, such as 'Dr/Mr X's room', compared to the use of the nurse's forename i.e. 'Hannah's Room'. This informality of the specialist nurse name was also exhibited elsewhere in the hospital and was found across the sites. This reinforced the hierarchy of the clinical team for outsiders and was suggestive of the organisational view of the nurse's power in relation to the doctor. However, the field was often managed by others (ward and clinic managers) and involved complex arrangements for resource allocation. This also opened up a range of other dynamics between the specialist nurse, clinic administrative and nursing staff which affected the vertical and horizontal division of labour. It was observed that rules of service to the clinics were different for the specialist nurses compared to the doctor. They would often have to set up clinic on their own (finding room, setting out desk and notes), with often no staff to support them. They would have to collect their own patients from reception, where the consultant would have patients brought to their room. They would also be expected to undertake 'nursing tasks' such as weighing patients, taking observations, etc. as well as their specialist activities. This engendered a sense of isolation of the specialist nurse from the mainstream nursing workforce, and mirrors research from others where specialist nurses were seen as 'elitist' or 'selling out' (Callaghan, 2008; Elcock, 1996; Scott, 1998; Wallace & Corey, 1983)., as Hannah commented during an interview:

> *Several members of staff are organising three or four different rooms for the consultants. I ask her, 'Do you feel that they sometimes concentrate on others, particularly the doctors?' She says, 'Yes, you often have to do much yourself.`* Interview as observation with Hannah

The specialist nurses also maintained offices and these were spread disparately across the hospital. Offices allocation was a premium resource in all hospitals and this had to be negotiated with managers to secure access. The allocation of resource and its symbolic power will be discussed in more detail in the next section.

Nursing the field

It was evident that whilst the specialist nurses took on a greater level of technical skill and management of patients, they retained many nursing tasks and also behaviours compared to non-specialist nurses. Part of the approach in the management of field was the functional nursing of the field, akin to others who have identified and aligned with nursing the room (Denny, 1999), as Winona highlights in an interview discussing the medical staff`s need to have the team available and also the equipment and skills they bring:

> `And they're [doctors] on a ward and they need all that stuff, so they're very thankful when we wheel our little trolley in, the general doctors and the critical care doctors...` Winona (Outreach Nurse), interview

This aspect of role and how it linked to physical space is important, as it created a number of power differentials. Firstly, it reinforced the hierarchical position of the specialist nurse to the doctor and, by default, the hierarchical position of the ward nurse. The 'invisibility' of the ward nurse was evident, and the specialist nurses often talked of the nurses 'walking away' when they arrived on the ward to see a patient. Secondly, it linked them to the doctor in a technical support role in the clinical field. As with most tasks, the equipment was easily accessible to doctors, but this was more efficiently done by the specialist nurses rather than those on the ward. However, this was not limited to technical tasks and this observation with an acute pain team highlighted a difference in the approach to the space and patient interaction:

> *Aarkash (Consultant) is concentrating, standing at the end of the bed, reading the notes and highlighting a range of health-related problems including hypotension, suggesting concentrating on the fluid management of the patient. Ailsa stands by the patient's bedside holding their hand, running through specific areas in relation to pain control. They finish the discussion and come towards the end of the bed to have a discussion regarding the plan. - Clinical observation with Ailsa and Aarkash (Acute Pain team)*

The connection between the nurse, patient and doctor in the observation is a classic description of the professional expectation within field, and this despite a movement towards clinical autonomy of the specialist nurse.

The medical sphere

There are two main distinctions in the medical sphere of this research, that of the consultant and the junior doctor. The consultant's clinical sphere was much easier to define in the study settings and was linked to their role in the organisations, authority and power. The consultants had a clinical field, such as the operating theatre, intensive care unit or clinic room. Their clinical role determined that they had access to other spatial resources and power:

> *We go down the stairs to a building away from the main hospital. This is one of the main cancer clinics and is set up specifically to have a surgical oncologist, a surgeon and clinical nurse specialist available in the same sphere. We walk into what looks like a busy GP`s surgery setting. There is a waiting room to the right-hand side with clinic rooms to the left and a reception desk at the far end. In one of the clinic rooms we find one of the surgeons. Asan is sitting at a desk in quite a small room writing up some notes about a patient. The medical students sit behind him. – Clinical observation with Hannah (Cancer Surgical Nurse)*

The field was often determined by the need to concentrate resources in a location to ensure efficiency. In the above case, the cancer pathway was aligned to ensure that patients could, if necessary, see all the clinicians in one visit. However, the location and set-up of these was influenced by the medical staff. Patients saw the consultant at set intervals before being passed on to the nurse for further discussion which delineated the division of labour (see Chapter Eight). However, with this came authority, privilege and protection, as highlighted in this observation with Eileen:

> *Eileen then speaks to the patient about his new type of dressing. 'I need to discuss with the doctor, particularly in relation to your plan of care.' She collects a set of notes and we briefly chat with the patient and the carer about car parking and the difficulties they have had as we head into the corridor. Eileen says to me, 'I'm just waiting for the door to open*

to the doctor's room and then I will be able to sneak in.` - Clinical
observation with Eileen (Specialist Surgical Nurse)

The role of the doctor was controlled and protected from interruptions, unlike that of the nurse (see page 169). In addition, consultants also defined the clinical sphere linked to their patients. This observation on an intensive care unit highlights this:

We're interrupted at that point because the surgeons and the team
arrive. There's a general discussion regarding the patient's surgical
procedure and how everything's gone well from that point of view, but his
neurological condition has remained very flat in the last few days. Then
Ailsa turns to the surgeons and says, `So have we been requesting a
head CT?` They actually ignore her at this point and one of the junior
doctors turns to Aarkash (Consultant) and says, `So do you think we
should give him some Flumazanil and try and wake him up a little bit?`
Ailsa then turns around and says, `Well, there's no need to. He shouldn't
have actually had the haloperidol anyway. I think we should have had a
CT scan to see what's going on in his head.` The surgeons say
dismissively, yeah, they think there's something else going on, and what
they'll do is they'll organise a CT for the day. - Clinical observation with
Ailsa and Aarkash (Acute Pain team)

This observation demonstrates the power interplay in the professionalised field during a patient consultation which is led by the doctors. An attempt to discuss and influence by the nurse is ignored. In this observation, the nurse is correct in her assumption of the neurological condition changing and provides a rationale for investigation, but the field no longer belongs to her. This observation also highlights two other important issues. Firstly, is the fact that the junior doctors take a lead from the other doctors and they also ignore the nurse in this setting, whereas in other scenarios they would interact. Secondly, although the researcher's description does not include the ITU nurse in this setting, they did not interact with the team, and stood back physically from the scene, supporting the invisibility of the ward nurse.

Junior doctors had little space although in some cases they had their own rooms to write up notes and access computers. These acted as a meeting place for discussion and were often the busiest parts of the department. Junior doctors required peer support, as

they were often not directly supported in clinical practice by the consultant. This support was often provided by specialist nurses and registrars. This made for an interesting connection between the physical space and knowledge, as in this observation with Reese in the emergency department:

> *The junior doctor walks into the doctors` office in the emergency department with Reese whilst they continue to discuss a case and review a drug chart. Reese advises the junior they should use a statin. Reese turns to one of the more senior registrar doctors and says, `Do you use a Rosuvastatin or Simvastatin?` The senior doctor registrar just replies one word `Simvastatin`. Reese points to the drug chart and says `Simvastatin` and walks out of the room. - Clinical observation with Reese*

The professionalised field

The field could be professionalised for a period of time, and this was particularly evident where doctors and nurses worked in the same location, such as a resuscitation room, intensive care unit, ward or clinic. In the previous chapter we have seen the example of Reese, the urgent care practitioner, and his management and command of the field. However, in other observations, doctors would commandeer the field if being used by nurses, as in this example where the doctors walk into a specialist nurse's clinic room:

> *Just as she starts this examination, one of the consultants walks into the room and goes to see the patient at the other end of the clinic room. Behind him is the surgical registrar, who walks in smiling and says hello to the nurses.*
>
> *Amir (Consultant) then starts to talk to the patient at the other end. The registrar turns to both of the nurses in a friendly way, and says to them, 'Busy?' Ora responds, 'Yes, we've got quite a lot on today.' The registrar seems to nod. This is the end of the conversation and he walks over to be with the consultant who is then discussing with the patient. He simply makes a comment to the patient and relatives, 'We can discharge you now.'*
>
> *On that, they both turn around, walk towards the washbasin and start washing their hands. I expect at this stage some sort of*

communication to take place between the nurses, even if it's some sort of handover in relation to this patient, but nothing happens. Both the consultant and the registrar walk out of the room. - Clinical observation with Ora (Surgical Specialist Nurse)

The request for consultation did not come from the nurses, but their clinic was used by the doctors. It was observed that the consultant did not acknowledge the nurses, yet the registrar did initiate conversation from a social rather than clinical perspective. The field was medicalised and the nurses marginalised. The effect of this was key, particularly when the management of the patient with others (ward nurses and doctors) in the environment was required. In this example, Eleanor (Outreach Nurse) and James (Consultant) had just finished treating a patient on the ward, and had to hand over the plan to the ward team:

Eleanor is talking to the nurses and talking through the treatment and management plan of this patient, and James (Consultant) is talking to the juniors doing exactly the same thing; they must be separated by about 3-4 metres. Nursing staff are by the patient and the doctors are by the desk and the X-ray area. - Clinical observation with Eleanor and James

From this example the professionalised approach taken during handover is delineated along professions` lines, even though the information was the same and the best approach would have been to share it. This connection between knowledge, expertise and the physical location was an intriguing one and will be discussed later in the chapter.

The patient sphere

Although this research has focused on the doctors and specialist nurses, the patient is an integral part of the transactions between them. It is, therefore, useful to define the patient sphere and the implications this has in relation to power. The following observation was noted in a new building designed with patients in mind:

The clinic is in a modern part of hospital X; it is located off a central atrium area, which has high ceilings, glass roof - very different from the rest of the 1960s-built hospital. In this central atrium are the main patient waiting rooms. From this there is a wide corridor leading off to various clinics and examination rooms. At the entrance to the clinic there is a small reception area staffed by members of the administrative staff who greet the patients on arrival and will also bring them through into the clinic. - Clinical observation: Cohort Three

It is clear that the patient sphere is separated from the clinical field with a physical barrier and the parallels with Foucault's description of the Panopticon are intriguing. In most hospital designs, the waiting room is separated physically and professionally. The rooms are often decorated differently and the use of artefacts defining the 'experience' of waiting, such as chairs lined up facing the entrance to the clinical area, with magazines to distract and the use of light and space to create an effect to reduce tension.

Controlling the patient sphere within the field was the role of the administrative staff. The administrative staff provided the transactional mechanism to do this for the doctors and specialist nurses. The power of the administrative staff was significant, as they protected them from additional demands on their time, although this set up interesting transactions between them and the nurse.

It seems that we're still waiting for this first patient so Rachel then picks up the phone and makes a call to the secretary. 'Have we sent the appointment to the patient?' The answer is 'yes'. 'It just seems a bit strange that this patient hasn't arrived.' At this point a clerk then comes through into the room and says that the patient won't be attending for the appointment. Rachel then says, 'Oh well, we'll just crack on with the next over here.` She puts the phone down to the secretary and then picks up another set of notes. - Clinical observation with Rachel (Surgical Specialist Nurse)

In this example the nurses often had to 'chase' the administrative staff for the next case in clinic as they were not afforded the same support as doctors. The patient sphere also extended to the ward environment and the specialist nurses would have some additional

challenges as they were visitors to this area. They would have to introduce themselves to the nurse 'controller' as part of their access, as in this example with Callie:

Callie then goes towards the nurses' station and asks the shift coordinator if there are any patients who need reviewing by the acute pain team. She asks the Sister, `Is there anybody here for me to see?` The Sister replies, not looking up from the desk and the notes that she's reading, `You're going to have to check in each bay. I'm not sure what's going on with each of the patients.` Callie then goes to each of the six bedded areas - there are four on this ward - and asks the nurses working in there if there's anybody to see`. - Observation with Callie (Acute Pain Nurse)

'Trawling for work' was how one nurse described this process and having to deal with controllers, like the ward coordinator – a process that doctors did not have to perform. The referral of work for the specialist nurse was, like the example above, controlled by others such as administrative staff, doctors and other nurses. Providing support to the wards was a critical function of the specialist nurse, but they often had challenges in accessing this part of the field. As identified in Chapter Six, this was not a guarantee of accepting the advice of the specialist.

Territory and boundaries

As discussed, some specialist nurses (critical care outreach and acute pain) provided support to many areas and came up against issues of territory with other nurses and doctors. The outreach nurses were based in the intensive care department and the acute pain team within anaesthesia. However, they were required to support the ward nurses and doctors in managing their patients. This issue of territory was also noted by others, including the doctors, as James (Consultant) indicates:

James continues to write in the notes. He says to me, `You have to be really careful not to tread on people's toes and upset them. I may have come down here and seen a septic patient but the patient has been admitted under somebody else and they can sometimes get a little upset if you start picking up things that should have been managed on initial presentation...` As he was writing the notes the consultant physician in

charge of the case comes over and starts to have a discussion with him and he explains to him what's been happening since his admission and what his initial thoughts are in relation to the cause of the sepsis. They seem to have just a brief discussion in relation to the findings and this is noted down and handed over for the consultant physician to take over.`
Clinical observation with James (Consultant)

The issue of territory could also be a role managed or controlled by one profession within a specific field. In this example, Ivan (Consultant) demonstrated how this can also occur within the team:

As the medical student leaves he turns to me and says, `Well I have got a little vignette about a medical student the other day. I asked her to take a set of notes to follow the process of the patient journey so that they can get an understanding of all the things that go on in relation to getting a patient here into this clinic. The funny thing was the nurse almost wrestled the notes off her and said, "That's my job"'. – Clinical observation with Ivan

Nurses were often territorial with skills they had accrued in their roles as specialists. Analysis of the artefacts demonstrated that many of the extended scope practices, such as taking blood gases, requesting blood tests and initiating treatment, were controlled through protocol and procedure written by the specialist nurses. The requirements set out in the artefacts were often beyond the scope of most ward nurses to achieve and therefore only applicable to other specialists.

The boundaries also extended to issues of access to doctors. This important area of interaction set out a range of power differentials between the specialist nurses and doctors. Within the teams there existed a hierarchy, which ensured access to privileges or advice from the medical staff.   The more senior specialist nurses had greater responsibility and access to the doctors, as highlighted in this interview:

'Right through to now when it is you that's calling the consultant at home saying, "I've got this patient of yours here; I'm concerned about them, you know", and asking for their input. So it has changed tremendously

just culturally and, I think, because of the seniority.' - Isobel (Critical Care
Outreach Nurse), interview

Calling a consultant at home about a clinical case was a privileged position and one that was only afforded to a few people within the team. This would include the senior registrar (doctor), the ward sister or the specialist nurse. The direct telephone numbers of the consultants would be available to the specialist nurses and others, the only alternative being through the switchboard, who would not often pass through calls to consultants without prior notification.

The peripheral field

The peripheral field encompassed a range of other spheres that the nurses and doctors worked in. These were mostly non-clinical and provided additional opportunities for interactions, but often of a different type, frequency and form. The main spheres in the peripheral field were the administrative, management and social.

The administrative sphere

The administrative sphere is an important area to examine, as many of the specialist nurses had taken on additional roles that required greater use of administrative support for communication, i.e. letters and emails. Office space in all the study settings was at a premium, which meant that nurses had to accept what space was available to them.

> *I walk into the Outreach office and there sitting down are Arun (Doctor),*
> *Eleanor and James (Consultant B) all of whom are working on*
> *computers. This is the administrative area of the critical care outreach*
> *team. It is also often used as a research and seminar room by medical*
> *and nursing staff from the intensive care unit, and so they often have to*
> *leave. - Clinical observation, Critical Care Outreach*

They were often shared multifunctional spaces, where they undertook other work such as patient consultations. In this observation, this group of nurses shared the space with the secretaries:

I walked down towards the anaesthetic department and in on the left-hand side just past the main doors is the acute pain office. The office is fairly open plan on the left-hand side with two secretarial desks as well as four desks on the right-hand side where the nurses sit. It is a typical office general environment with administrative folders as well as patient notes on a variety of desks as well as boxes. - Clinical observation, Acute Pain

The administrative sphere is one that provides significant challenges for the role of the specialist nurse. The findings highlighted that this occurred when negotiating or managing the administrative sphere. It was noted in the case of Reese, Hannah and the surgical specialist nurses that they often had to manage patient flow through their clinic, including collecting patients` notes or arranging rooms to conduct their clinic in. In this observation note, Hannah arrives at a clinic to find that it has not been organised:

As we are walking down the corridor we ask several members of staff in which room the clinic is to be held. There does not appear to be a room available for Hannah's clinic. She does not appear ruffled by this and then walks further down the corridor to identify if there is a spare room available. Several members of staff are organising three or four different rooms for consultants. – Clinical observation with Hannah

There was an acceptance that this is normal and the specialist nurses were resigned to 'doing it all' in terms of administrative tasks to perform the role, including diary management, dictation and handling phones calls. Invariably the specialist nursing roles never came with administrative support and this activity evolved as part of the work. In most cases, this work was negotiated on an individual basis between the specialist nurses and the office workers, usually those associated with the medical consultants. The administrative work was therefore added to the secretarial workload, and justified on the basis that it was done for 'their' consultant.

'What I tend to do is I tag the work I do for each consultant so I drop the tapes of consultant X with his secretary so that she is able to get the work done.' – Interview as observation with Hannah

However, this negotiation required 'diplomacy' on the part of the specialist nurse to ensure that the work was done without causing friction with the secretary. The secretary had significant power and access to the consultant, which, as the specialist nurse was aware, could jeopardise their own relationship with the doctor. However, the stresses and strains of maintaining this approach were difficult and challenging. Hannah goes on to say how she dealt with the situation to improve things:

> *Initially we discussed the issues around secretarial support and I asked how she had got to a position where the secretaries were dictating her letters. She stated, 'They would not do the notes and the letters from my clinics and I had to do them myself when I initially started the role, which was incredibly time- consuming.' She stated that when she looked back, she can't believe the things that she used to do to actually get on with her job. She stated, 'When I was new into role, I did not want to rock the boat.' I asked what changed. 'I just dropped the tapes with them one day and asked them to do them. Initially they put other people's work before mine - they're often quite powerful and if you upset them you certainly know about it from the consultant.' I asked if that relationship was a challenging one to maintain. She stated yes, that it was often very, very difficult although she had to be assertive in some cases to ensure that she actually got the work delivered and sorted on time. ` It is an important step because now I would not function without it, but it also is important because it documents my role and also provides a strong element of standard communication to fellow colleagues.' – Interview as observation with Hannah*

Social sphere

The work patterns of the teams often meant that the social sphere was constructed differently for the teams compared to their colleagues in the wards. Ward nurses had defined restrooms, located on the ward or nearby their work area. For the ward nurses to take a break, including lunch, it was negotiated with the senior nurse on duty, and was carefully timed. However, for the specialist nurse, breaks were less well defined and managed around their workload. Frequently the specialist nurse had little time for

organised breaks, as observed with Eleanor, a critical care outreach nurse, who had been working in the resuscitation area of the emergency department:

> *Eleanor turns to me. `What time is it? I just seem to be losing perspective here; we seem to have been down here for ages.` I said it's about a quarter to twelve. She says, `Blimey, I've not even had chance to get breakfast, let alone lunch.` – Observation with Eleanor (Critical Care Outreach)*

The nurses managed their time in the clinical environment, but they were constantly available for service, and were called via phone and bleep, as in this example with Sacha:

> *We head back over towards the Critical Care Outreach Office where we sit down and have coffee. Whilst we are there a bleep comes through from a phone call regarding a patient back on Ward X…Then another bleep goes off, this time we have to go down to one of the surgical wards – Clinical observation with Sacha (Critical Care Outreach)*

Managing the borders and boundaries of space

With multiple spatial areas, there was a requirement to connect them through communication strategies. As identified in this chapter, the clinical field was shared by the specialist nurses and doctors for patient care and interaction. The job plans of the consultants and nurses were often designed to ensure that maximum benefit was achieved through unsupervised working, and the specialist nurse used a range of communication strategies and methods to connect the spaces and ensure continuity with the doctors and the patients, which is discussed in Chapter Nine - . However, physical areas defined for communication were observed, including meetings and clinical multidisciplinary meetings (MDTs) and are discussed here.

Meeting space

There were a number of opportunities for the clinicians and nurses to communicate through formalised meetings, and these were organised around the areas they worked in,

such as intensive care, anaesthesia, emergency department and cancer services. These meetings focused on the bureaucratic functions of the team, and were almost exclusively led by the consultants or managers. They were physically located in meeting rooms and lecture halls in the hospital and they maintained a medicalised focus and were classified as 'Morbidity & Mortality' meetings and Clinical Audit. These were also held in conjunction with managerial meetings that focused on finance, performance and service delivery. In addition to this, the nurses often had separate meetings to discuss other matters specifically focused on nursing and wider hospital issues.

The MDT

For those specialist nurses who shared a common-linked role with a specific consultant team/specialty, such as Hannah in surgical cancer, the multidisciplinary meeting (MDT) was a key part of the care process where clinical information was transacted between doctors (surgical and oncology), specialist nurses and service doctors (radiology and pathology). The MDT connected the space between the clinical, administrative and patient through discussion of care and treatment.

> *In the audience were four surgeons, two visiting clinical oncologists, one consultant radiologist, consultant histopathologist and two medical students; in support was a multidisciplinary team co-ordinator. An oval table in the middle of the room was surrounded by a wide range of technical equipment including a PowerPoint projector which was operated by the MDT co-ordinator. This was linked directly to the hospital computer system for patients` electronic records. The notes of the meeting were typed directly onto the system so they would be accessible immediately following the meeting. The consultant histopathologist had a microscope attached to a video camera system where he had a number of pre-prepared slides associated with cases to be presented that afternoon. The consultant radiologist also had a large flat screen monitor connected to the hospital radiology system to show imaging studies on both plain radiograph, MRI and CT scan. - Clinical observation, Surgical Cancer MDT*

Summary of evidence

The aim of this chapter has been to determine how the physical space of the nurse-doctor interaction may illuminate concepts of power. It is evident from these findings that space is divided and manipulated by the agents themselves as a form of power, as recognised by Bourdieu (1989). The findings demonstrated that those in positions of power in hospitals, such as consultants, hold greater influence in the space design, use and control, reflecting the views of (Gesler et al., 2004; Mroczek et al., 2005). On a simple and practical level, space within hospitals was observed to be a premium resource and therefore a currency on which to transact between key agents, primarily doctors and managers. In terms of capital, space takes on an economic form as well as cultural and symbolic (Bourdieu, 1986). This resource allocation was managed and controlled by the hospital bureaucrats and the findings indicated that nurses had little direct influence. Their position and status in the organisation meant that they were often lower in the order for resources including space and support.   Doctors had more space at their disposal than others, such as administrators and other nurses, and commanded more support in the space to control it (Prior, 1988) In addition, the finding of professionalised space was key to understanding power relations. This new finding of professionalised space importantly demonstrated that power can be fluid and dynamic in clinical situations, reflecting Bourdieu's view of the physical and social dimensions of space and power (Bourdieu, 1989). Professionalised space highlighted that nurses` power has changed. On the one hand they were able to command the space in clinical care as a leader but were also subordinate to doctors becoming a follower. This created a number of scenarios where the nurse was ignored by other doctors dependant on the space. This is similar to the findings of the 'discounting' of nurse practitioners identified by Martin & Hutchinson (1997, 1999) who highlighted the complexity of interaction and behaviours required to counter this. Specialist nurses had complex interactional knowledge to allow this transaction to take place, and know in which circumstances to allow this to occur. They recognised the boundaries and territories of others, including medicine, nursing and administrators, as they went about their work. As they delivered their care, power flowed and evolved to suit the specific context of interaction.

However, specialist nurses had little ownership of physical space outside the clinical field in which they operated and if they did get an administrative space allocation, this was often inferior in quality to that of the medical staff.   The acceptance of this was universal

across the cohorts, and their roles were constructed to be primarily at the clinical interface. In addition their roles came with a significant burden of administrative work, through audit, oversight, management and patient communication, reflecting a mediation of the medical technical boundary (Allen, 1997, 1998; Tjora, 2000). However, specialist nurses did have greater space control through their senior nursing positions and as a result had greater power than others in the system. This influence was partly achieved through the management and control of the clinical pathway, plus their proximity and close working relationship with medical staff. This space came with some interesting power differentials which it created with other agents in the space, including managers, administrators and junior doctors. The most notable power differential was with the administrators, and the findings highlight that the specialist nurses had a number of additional challenges in maintaining and managing the resources given them to deliver their job, including negotiating with administrative staff around work. This highlighted the complex network of interactions that specialist nurses operated within, compared with traditional nursing which often only controlled the space of a ward or department. Whilst 'space' has been a useful tool to aid understanding of the geography of power between doctors and nurses, the division of labour and specialist nursing expertise within this is also an important avenue of enquiry and the findings are discussed in the next chapter.

Chapter Eight - The division of labour and development of expertise

Introduction

One of the key research questions was to determine the division of labour between the doctor and nurse and the development of expertise. The new relationship comes from a predominately dominant medical position within organisations which determines the control of the nurses` field of practice. The aim of this chapter is to ascertain if a division of labour exists within this, and, if so, how it is determined by the agents. To do this, one must examine the division of labour from two points of view, the macro and the micro perspective.

The macro perspective

The macro perspective is concerned with the more structural elements that have influenced the division of labour in the relationship, which have been highlighted in the preceding chapters. There were three main categories of influence, namely the State, Professions and Corporate. The ways in which these impact on the division of labour is highlighted in Figure 28 on page 182. In addition, detailed assessment of the artefacts, observation and interviews from the organisations in the study found a significant amount of material that related to the division of labour for the specialist nurses.

The state

A number of national drivers for the changes seen in the contemporary organisation of clinical care in the NHS have occurred. One of the most significant influences on the division of labour was central policy with its strengthening of the financial controls of NHS expenditure and emphasis on productivity and efficiency. In the last decade new roles in nursing and other professions have developed as a direct result of service development programmes that have fundamentally changed the division of labour in hospitals.
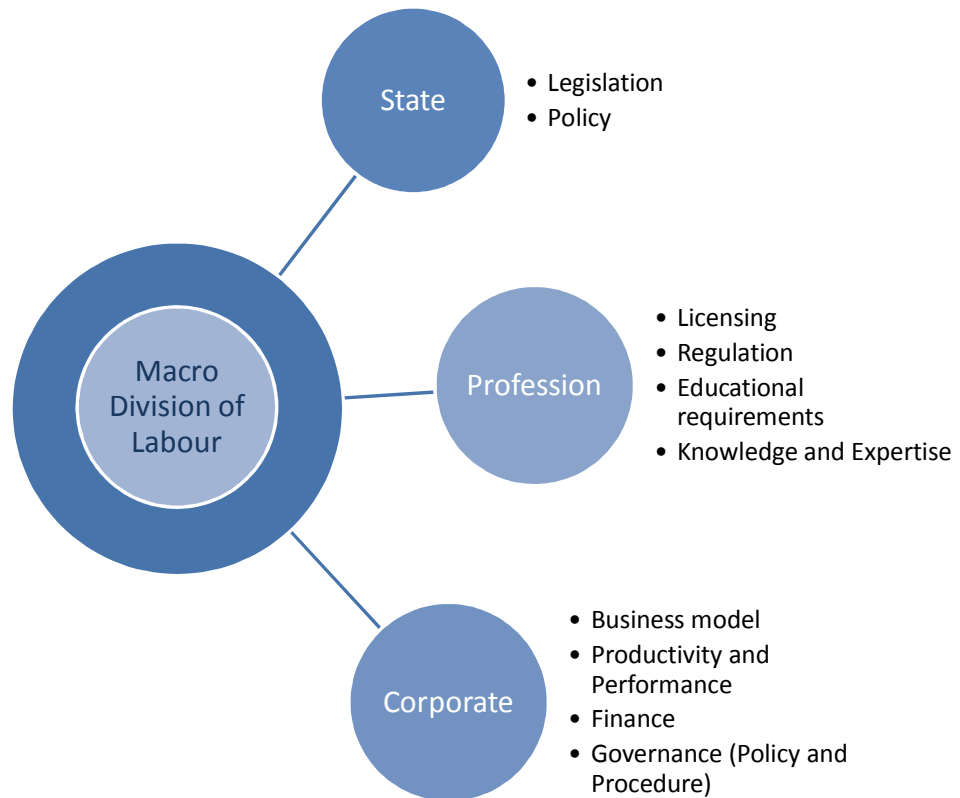
Figure 28 - Findings on the macro influences on division of labour

The professions

The Nursing and Midwifery Council (NMC) and the Royal College of Nursing (RCN) developed guidelines and recommendations for the role of advanced practitioners that were evident in the study artefacts (Royal College of Nursing, 2008; Royal College of Nursing, 2009b; Nursing Midwifery Council, 2005; Nursing Midwifery Council, 2008a). Significantly, the influence on the division of labour was determined by local hospital-based competency systems in addition to those completed on programmes at higher education institutions. The justification is outlined in this report:

> 'However, it is the view of the group that these competencies [NMC] are
> very broad and that they need to be broken down further to provide a

more detailed document, which outlines specific areas of competence that can be more easily demonstrated and measured.

For this reason the group has produced a comprehensive competency framework which underpins the NMC document but makes it much easier for students to demonstrate their achievement.' – Artefact 22, Report into Specialist Practice at Urban Hospital NHS Trust

The practical implication of this was a workforce development strategy focusing on capability and competence rather than the profession-specific activities outlined in professional standard documents. This presented challenges for some of the nurses, as outlined by Eloise:

'I think it'll be more down the medical line and sometimes we do feel that we're being pushed too much that way, even as a team, you know, we're losing a little bit of what we were about and, you know, how the service established itself and it did establish itself ...They [drs] want us to be very medical and, you know, they'll put down a medical model and then we'd be mini doctors and I think that's the way they would guide us which is… shouldn't be what we're looking for, we obviously need that, but we need something more than that, I feel.`   Eloise (Critical Care Outreach), interview

This highlighted the multifaceted influences on the role. In the case of the specialist nurse this would also include medical establishments such as Royal Colleges, as highlighted by Ailsa:

'I think in some hospitals, from what I can gather from talking to other people, they had this remit to get the pain service, because that's what the Royal College [anaesthetists] said.`   Ailsa (Acute Pain Nurse), interview

This influence manifested itself by determining the skills and knowledge required by the specialist nurses. In the case of the specialist nurse this included competency frameworks, supported by medicine that replicated the medical model.

Corporate influence

Willmott (1993 & 2003) aptly describes modern corporate culture through the lens of George Orwell`s book *1984* (Orwell, 2004) and `doublethink'[18]. Willmott's assertion, supported by El-Sawad et al. (2004), is that neo-corporate culture tries to create a system that values the practical, autonomous and independent working of the individual, whilst working within a corporate organisation that controls the modern worker through a range of mechanisms. Changes to the health service have seen the bureaucratisation of their roles through these controls. For specialist nursing this leads to an interesting enquiry in relation to the division of labour and how power and knowledge are used. To achieve the flexibility and autonomy of practice required by the role (and be closer to that of the medical role), the specialist nurses must submit to the limitations and controls by the corporate regimes within which they work.

The controls over service development are often no longer with the consultants, but align with the bureaucratic management structures of the acute hospital. The process of service development can be delayed by corporate management and financial controllers, and may be never agreed without some caveats to controlling medical practice. This has meant that 'cheaper' new roles that deliver the same work as previous medical models are now negotiated from an economic as well as clinical perspective. All organisations in the study had an overarching strategy and development programme for the role of the specialist nurse. Medical influence on this was determined by the organisational culture, size and complexity, with the larger organisations in the study operating with greater bureaucratic controls and processes. For example, in the case of an expansion of advanced practice roles in one organisation, a working party chaired by a doctor was set up, with the following extract taken from the summary:

> *'The Group was established as a sub group of the Hospital steering group following a recommendation from the Senior Nurses. The group was established in November 20XX to give some clarity about Advanced Practice roles with a specific remit to define the role and develop a Trust*

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[18] Doublethink is the act of simultaneously accepting as correct two mutually contradictory beliefs, often in distinct social contexts. Orwell`s classic *1984* describes War is Peace, Slavery is Freedom.

wide competency framework, training programme and effective monitoring, regulation and mentorship framework for Advanced Practice roles by March 20XX… If this approach is to be successful it is essential that the Trust board have confidence in the methods used to develop practitioners. The aim is to produce high calibre advanced practitioners who have achieved the required standard set by the Trust. This will not only ensure that practitioners are safe but also patients and clinical colleagues will be confident in their skills.' – Artefact 22, Report from Working Party

Although the nursing hierarchy had initiated the work, a bureaucratic approach was taken in relation to the mechanism of control. This process was required to assure executives of the safety and efficacy of the role before committing resources to its implementation. This example highlights the changes seen in corporate governance of the healthcare environment but this approach filters down to more practical forms of control, such as job descriptions and person specifications. In determining a division of labour, the roles on all sites were divided up so that they fulfilled the requirements of key stakeholders: nursing, medicine and the corporate managers. Whilst there was some minor variation in the study settings, they had interpreted national drivers to link to practice, as identified in this typical job description:

Key Responsibilities

- *Clinical Practice*
- *Management and Leadership*
- *Education and Training*
- *Audit & Research*
- *Resource management*

Artefact 89, Job Description

In addition to this, the mechanism of control extended to include key experiences, skills and knowledge that the person would require in order to function in the post, as outlined in this example person specification:

'Minimum of 5 years post registration experience in Critical Care or related care setting. Relevant clinical experience with 2 years experience

at G grade in Critical Care. Evidence to support a programme of personal and professional development. Registered 1st level Nurse ENB 100 or equivalent To hold or be working towards a Masters degree in Clinical Practice, incorporating health assessment, or equivalent skills in patient assessment Nurse Prescribing course ALS Provider course APLS Provider course Teaching and Assessing qualification' - Artefact 125, Person Specification for specialist nurse in Critical Care Outreach

What is evident is the significant level of academic accreditation required by the nurse prior to entry into the role. Whilst some of this comes from interpretation of state and professional influences, much was also about the culture and aspirations of the organisation and was at odds with the practical reality of recruitment in the field.

The educational preparation of specialist nurses was limited and an apprenticeship model evolved. This was addressed more recently with developing frameworks of advanced and specialist practice. These were linked to organisation models of service delivery, as explained by Rachel:

> *Rachel says, 'They [hospital management] want us to do claudication patients, not ulcers.' I ask why. 'The main motive is to get us to do the work of other people, because that's what they feel that we should be doing.' She goes on to state that, 'They feel that the tissue viability nurses, they're the ones who should be doing ulcers, not specialty surgical nurses.' - Clinical observation with Rachel (Surgical Specialist Nurse)*

The corporate influence on the role was new and, to a large degree, stronger than the professional influence. Examples emerged where the division of labour was influenced by organisation pressures partly driven by state influence. The lack of a clear professional body giving guidance regarding the roles, often meant that a more organic process of role development occurred, with local regulation of roles, skills and knowledge. This is important considering when the operationalisation of the roles centres on medical skills acquisition to ensure the person can function. Organisations valued the continuity of the workforce and the medical skills these individuals possessed which was largely influenced by doctors.

The findings indicated an emerging dichotomy of the independent, autonomous specialist practitioner compared to one who is constrained by medicalised procedures and structures within the hospital system who perform the functions required of them by the state, organisations and the medical profession.

The micro perspective

The findings demonstrated that the role of the specialist nurse had three distinct dimensions: Practitioner, Teacher and Leader/Follower (see Figure 29). To deliver the role of the specialist nurse, they therefore had to work across many professional and practical boundaries. The specialist nurses used a 'blend' of knowledge and experiences to develop the expertise required to meet the significant expectation of the role in practice. The specialist nurses were 'all things to all people', and this led to a range of interactions and approaches, which will be discussed in more detail in Chapter Nine - .
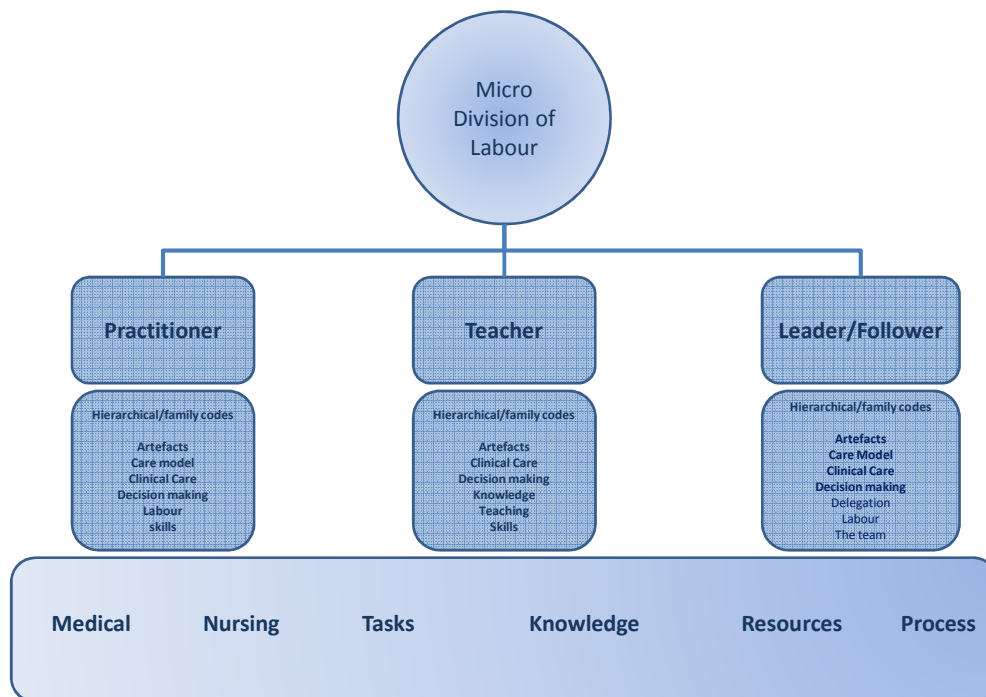
Figure 29 - Divisions of labour in the role of the specialist nurse

Practitioner

The specialist nurses' clinical role was a challenging one. They experienced professional and corporate pressures to take on more medicalised tasks. The traditional division of labour was based upon the definitive practice of the doctor 'to cure', and the nurse to care

(Radcliffe, 2000). The main determinants of the doctor's workload were the ability to gain new work through the referral mechanisms of other doctors and admit them to the institution for whom they worked. 'Admission rights' allowed doctors access to resources and privileges, including hospital beds, diagnostic facilities and the flexibility to undertake their role independently. In addition to this, the doctor was the sole arbiter of determining the cause of the disease that affected the patient, through assessment, examination, investigation and ultimately diagnosis. In the context of medical power it was the doctor who had sole control of these skills and the knowledge which led them to make a diagnosis. Once a diagnosis had been made, the doctor could then decide upon treatment that only they could do, which included prescribing medications or undertaking surgery. The specialist nurse has moved steadily into the blurred territory between the two traditional roles. Traditional medical roles, such as diagnosis, prescription and referral, are now all corporately and strategically sanctioned in training programmes and policy for non-medical staff to perform. This challenged the central tenets of the medical role, and their professional power. This is clearly demonstrated in a specialist nurse job description from the Metropolitan site:

> *'To appropriately assess, examine, investigate, diagnose and treat patients, resulting in the safe management and appropriate referral or discharge of patients with undifferentiated and undiagnosed presentations.`* - *Artefact 89, Job Description from the Metropolitan Hospital*

Examination of the elements of referral, diagnosis and treatment within the specialist nurses` role were helpful when examining the division of labour.

Referral and admission

The referral of patients to the specialist nurses came from a range of practitioners including GPs, consultants, junior doctors, nurses and other health professionals. The majority of the referrals were organised as part of the role, through a variety of pathways and procedures laid down by the organisations and clinical teams. In the case of the inpatient based teams (including CCO and acute pain), referrals were made via phone call and bleep system. Once referrals were made, they were managed, logged, recorded and audited into a variety of paper and IT systems. Few teams had electronic referral systems in place, other than the specialist surgical nurses and the outreach nurses, who

used an electronic MEWS system that emailed referrals. In the case of outpatient-based nurses, they received referrals through their MDT, GPs and other consultants, again using set protocols and procedures. However, the specialist nurse was able to make referrals to other clinicians including consultants to manage care pathways, as outlined in this observation with Hannah:

> *When the patient had left the room I asked Hannah, `Well, what would you do if the blood test result is higher; who would you refer to?` She stated, 'If the blood tests were certainly up again I would refer for chemotherapy. This is based on my own judgement and I would make a refer to Asan (Consultant) but I would also tell Iain (Consultant).' I ask why. 'Not that I need confirmation of my decision but it's really just a courtesy. I still very much see that these patients are Iain's and I need to respect that. He is a very conscientious surgeon and I like to keep him well informed of both my activity and also clinical decisions.' - Interview as observation with Hannah (Cancer Nurse)*

The nurses had access to senior doctors and they would make decisions to bypass the medical hierarchy in order to gain information, make a decision or confirm a decision or treatment plan with the consultant, as in this example from Leah, an outreach nurse:

> *'We do try and go to the registrar first, but quite often if we know which anaesthetist is on the unit on the day and we know they would want to see the patient, then we will go straight to them, or if we want somebody senior involved because of issues with the patient.' Leah (Critical Care Nurse), interview*

This was sanctioned because of the clinical seniority of the nurse and the collegiate nature of the relationship. This aspect was developed over time, through shared working and experiences, reinforcing trust. Working together and building trust have been discussed earlier in this thesis, but cannot be overemphasised.

The referral process from the doctor to the specialist nurse was a boundary of practice that could initiate conflict with GPs. In one case, the referral pathway from GPs to the surgeons had been adjusted to improve efficiency, and the patients sent on to the

specialist nurse. Ivan described what happened when the nurses wrote back to the GP explaining the outcome of the appointment:

> 'So you'd often get a phone call back from the GP saying, "I sent this patient to the hospital to be seen by a doctor and I don't want this …" She (specialist nurse) knows ten times more than you do but, in a sense, that's what you want to say but you have to do it in a diplomatic way.' - Ivan (Consultant Surgeon), interview

In addition to changes in the referral process, the greater involvement of the specialist nurse in decision making led to situations where the traditional roles of admission and discharge were critical to the new pathways. In the study settings, all the nurses had informal and formal admission rights, as in this observation of Eileen:

> The patient says to Eileen, 'Oh, but the pain is so bad'. 'Ok, we're going to need to sort this out today, but you have only been on paracetamol. We need to reserve the big guns for later, for when we see how your legs get on.' She then asks a question: 'You don't fancy a spell in hospital do you?' 'Why?' the patient responds, with a pause. 'Well, we need to get this infection under control and we can also have an opportunity to sort out this pain.' – Clinical observation with Eileen (Surgical Specialist nurse)

The need to have efficiency in the process in urgent care saw Reese having to take on this responsibility, although he recognised that it had only come about through medical trust in his capability:

> `Patients should really be seen by a doctor before being admitted to wards but this does not always happen due to the pressures on the system.` However, Consultant X and Y (Cardiology and A&E) both agree that his experience is crucial and that they trust his ability to be able to admit patients appropriately. Clinical observation with Reese (Urgent Care Practitioner)

In some organisations, these tasks were beyond the remit of junior doctors (see Table 13), setting up interactions between them based upon privileges of practice.

Assessment, examination and diagnosis

Skills in assessment, examination and diagnosis have long been the preserve of medical practice and cemented through the control of medical knowledge. The findings identified that nurses used many of these skills (see Table 13).

Knowledge & Skills	Band 5	Band 6/7	ANP	FY1	FY2	ST1	Cons
History Taking	✖	✖	✔	✔	✔	✔	✔
Auscultation	✖	✖	✔	✔	✔	✔	✔
Phlebotomy	✔	✔	✔	✔	✔	✔	✔
Cannulation	?	✔	✔	✔	✔	✔	✔
Pharmacology	✖	?	✔	✔	✔	✔	✔
Prescribing	✖	✖	SOME	✔	✔	✔	✔
ABG taking	✖	✖	✔	✔	✔	✔	✔
ABG Interpretation	✖	?	✔	✔	✔	✔	✔
ECG recording	✔	✔	✔	✔	✔	✔	✔
ECG Interpretation	✖	?	✔	✔	✔	✔	✔
CXR Ordering	✖	✖	✔	✔	✔	✔	✔
CXR Interpretation	✖	✖	✔	✔	✔	✔	✔
Exercise testing	✖	✖	✔	✖	✔	✔	✔
Echocardiography	✖	✖	✔	✔	✔	✔	✔
CT/MRI	✖	✖	✖	✖	✖	✔	✔
Admission rights	✖	✖	✔	✔	✔	✔	✔
Discharge rights	✖	✖	✔	✔	✔	✔	✔
Referral to Consultant	✖	?	✔	✖	✖	✔	✔
Referal to GP	✖	✖	✔	✖	✔	✔	✔

Table 13 - Comparative skills matrix for inpatient specialist nurses and doctors in hospital settings

These skills were developed through training and competency programmes defined by the organisations and discussed previously. This ultimately led to the specialist nurses making medical diagnoses on a range of patients from minor to complex, although these were always defined in terms of the biomedical model. These were communicated to doctors through clinical discussion, clinical notes, letters and emails. Undertaking this aspect of practice requires a sound knowledge base, as highlighted in this interaction with Ruth:

> *Ruth then says, `Well, I don't think she's coping, her oxygenation seems okay, carbon dioxide is low and she is blowing that off and I think that she's got an underlying metabolic acidosis from a source of infection*

somewhere.` I ask her `Where do you think the sepsis is coming from?`
`It is definitely sepsis but I am not sure where at this stage. The white
cells are normal though but that can often be the case, you often find
that in severe sepsis, you see the white cells reduce and in very severe
sepsis you often find that white cells are completely below the normal
range.` - Clinical observation with Ruth (Critical Care Outreach)

However, the extending of the nursing role into this practice area highlighted some concerns for the doctors which were articulated in terms of their knowledge and breadth of clinical expertise.

'It's the diagnostic thing that's the problem, I think, because naturally
they haven't been through medical school and a bit of basic medical
training where you develop a wide repertoire of disease that could
happen. Some of it's very rare that you can, you might be able to think of
it, or at least be aware of something that could be at the back of your
thinking, whereas they can only think of the common things. So I think
it's really the sort of diagnostic things that I worry about.` – Rabani
(Anaesthetic Registrar)

Treatment

'Certainly when I started training, when I qualified, it was an absolute
clear division of labour. Nursing was wholly aimed at patient care and
patient focused, and the doctors were there to sort out the treatment.' –
Liam (Consultant Surgeon), interview

As Liam identifies in interview, the traditional division of labour between doctor and nurse was overt. The advent of specialist nursing practice had blurred the boundaries and nurses were able to treat and manage patients in most settings and in a range of complex clinical scenarios, as in this example with Ailsa (Acute Pain Nurse).

Just as we leave the room, one of the nurses comes up to Ailsa and
says, `There's a cardio-thoracic patient down there. I think he needs an
epidural review because we're possibly going to be able to remove it.`

Ailsa then pops down to see the patient and has a quick chat with them on how the epidural's working. `No, I think we're going to keep this epidural in and running for a little bit longer, but I do think he could probably do with a little bit more fluid actually. I know he's a difficult patient but, with his venflons, we're going to have to try and get some more fluid down him.` - Clinical observation with Ailsa (Acute Pain Nurse)

In the case of specialist nurses, their role in deciding treatment was far more direct and formalised compared with previous research.

Still being a nurse, still seen as a nurse

In relation to division of labour, other important themes emerged in that specialist nurses saw themselves as nurses and were also still seen as nurses by others in the organisation. The most overt display of this was the uniform that the nurses wore, such as dresses or trousers and tunics. Remaining a nurse was a deeply held value of the nurses, as outlined by Eloise:

'I think we're very nursing. I think you might look at a set of observations on a patient, but you would never do that in isolation, without looking at the entire patient and understanding different aspects of their life. It's not just about a set of obs, it's about that person, so I do think we try our best to look at the whole.' Eloise (Critical Care Outreach), interview

This was also reflected by the doctors who suggested that this was, in essence, a fundamental difference in approach and focus when comparing the two professions. From a secondary point this also related to the time they had to spend with patients and the role and function they performed in relation to medicine, as Rabani explains in her interview:

'I think they're critical to supporting the doctors but also, perhaps more so, supporting the patients, because they've got more time than the doctors or more empathy with the patients, perhaps.` – Rabani (Anaesthetic Registrar)

Rabani's comments highlight the medical perspective on the specialist nursing role in terms of profession outlook and focus on their emotional role. The impact of this when working together led to subtle and unconscious actions that reinforced elements of the division of labour, as noted during this observation with Ailsa:

> *Ailsa then starts to sort out the bed linen and then walks around to where Aarkash (Dr) is writing the notes, takes a few details and taps them into the PDA, and once she's completed this they both walk around the corner into the other part of the intensive care unit to see the next patient. - Clinical observation with Ailsa and Aarkash (Acute Pain)*

In this example, the specialist nurse and doctor are conducting a round together, yet after the consultation, in which the nurse has taken a lead, the doctor writes up the notes whilst the nurse straightens the patient's bed linen. Other examples occurred where the traditional division of labour manifested itself in the dominant medical role, as in this example:

> *James (Consultant) comes off the phone. `Great, we can get an echo and Doctor x is going to see her straightaway. Do you think we can get a T4 done?` Eleanor says (with a hint of sarcasm), `I've done it. Here, I will open the notes for you at the next page for you to write in.` James laughs and says, `Oh, it's just like having a House Officer.` - Clinical observation with Eleanor (Critical Care Outreach)*

Further examination of the findings identified that this nursing role extended to more traditional perspectives, such as the emotional context of care and labour.

The emotional context

Emotional labour as a concept set out by Hochschild (Hochschild, 1975, 1979,1983, 1990) and Smith (1992, 1999) has particular relevance in light of the findings in this research. Emotional labour was a distinct element of the role of the nurse. Emotional labour may be explicit, as in this observation with Hannah, where the doctors refer a patient in an MDT to her:

The senior surgeon referred to the clinical nurse specialist, stating, `Can I refer her to you for you to look at and listen to her concerns about ongoing treatment and management?` To which the clinical nurse specialist replied, `Of course.` – Clinical observation with Hannah (Cancer Nurse)

This observation was followed up later during interview, as Hannah explained:

I ask Hannah, `Do you feel that you pick up the emotional workload for the surgical team?` She responds `Yes, I tend to see a lot of patients either through follow-up following their diagnosis and have to reiterate the information given by the surgeon. However, I do have a very good relationship with the surgical teams and in most cases other than one surgeon, I am also able to give the diagnosis.` She wants to give continuity for the patients. I ask the question, `Is that continuity for the surgeon or is that continuity for the patient?` She states, `That's an interesting question` and I reply that I would like to understand from the surgeon what their perspective was. - Hannah (Cancer Specialist), interview

The explicit element of emotional labour was determined by the support given to the patient and formed part of the service given to the medical care. This exchange of work, surgery (technical) vs. support (emotional), clearly delineated the relationship between them which was throughout reinforced in job descriptions, policy and procedure. Emotional labour could be more implicit in its form, as in this observation in the emergency department with Critical Care Outreach:

Damien (Consultant) states, `We've had this patient for 12 hours and it appears that we actually haven't been able to help her or get things sorted.` Jack (Consultant) turns to Eleanor and says, `What about rels? Have we got any rels here? We need to have a chat with them?` `Yes certainly, the son's here.` She turns around and walks out of the resuscitation bay and there are a couple of relatives waiting just outside in the reception area. Eleanor then starts a discussion with the patient's relatives in relation to the patient`s current clinical condition, particularly the grave and serious nature of the infection the patient has, and the

likelihood that she will need to go to intensive care. - Clinical observation
with Eleanor (Critical Care Outreach)

This is a helpful scenario which demonstrates the emotional expectation of the team is transferred to the nurse; it is the nurse who has responsibility for emotional support given to relatives, even though prior to this, the nurse uses her skills and knowledge to diagnose and manage the patient until they arrive. It is important to note that in all of the observations none of the nurses rejected this element of the role. They expected and asked to perform this function alongside their highly technical capabilities. Eila contextualises this in relation to the workload in the modern hospital:

> `As far as the patient's concerned, quite often no one's actually sat down
> and spoken to them for a while about what's going on, so for them the
> reassurance of having somebody sitting with them for a little while and
> explaining what's happening, what the plan is, you know, is, is
> invaluable.` Eila (Critical Care Outreach), interview

The findings indicate that the role of the specialist has been developed as a result of changes to the medical workforce, and their greater autonomy means that they have more time to spend with patients.

Teacher

A key function of the specialist nurse was to educate and teach other healthcare practitioners, including doctors and nurses, as indicated by Leah:

> 'You are quite often [teaching] in the ward environment; you are teaching
> them [Drs] informally in why you are doing things and maybe blood
> gases and care of central lines. Sometimes we get called to help them
> taking bloods from a central line, things that they have not had
> experience with.' – Leah (Critical Care Outreach Nurse), interview

As identified in the previous section, the role is made explicit in the organisational expectation of the role. The teaching element was both formal and informal and contained three main elements, as outlined in Table 14 .

	Codes	Formal	Informal
Clinical	**Teaching**: CNS to doctors **Artefacts**: Teaching/Developing staff/CNS/AP teaching doctors	Formal clinical teaching could take place at the bedside and consisted of organised 'rounds' or lunchtime MDT meetings where cases would be presented.	Informal clinical teaching took place at the bedside, and consisted of teaching skills, techniques or theory whilst with a patient. This was often 'ad hoc' and arose due to the clinical situation.
Classroom	**Teaching**: CNS to doctors **Artefacts**: Teaching/Developing staff	Many formal courses were available where specialist nurses were on the faculty to develop resources, give lectures and organise. Examples included ALS, ATLS, ALERT and Survive Sepsis[19]	Informal classroom teaching also occurred, with doctors and new starters. Specialist nurses would give talks about their role and give information on the protocols and procedures in their specialty.
Assessment & evaluation	**Teaching** : evaluation of doctors by CNSs **Artefacts**: Teaching/Developing staff/ JD: AP Skills/ CNS/AP teaching doctors	Specialist nurses were involved in the formal recorded assessment of doctors in training through a number of mechanisms, including 360° appraisal and DOPS[20]	Specialist nurses were also expected to make informal assessments of junior doctors to the consultants, which would consist of progress reports on skills, knowledge, adverse events or other aspects

Table 14 – key teaching roles of the specialist nurse

In some isolated cases, this role was extended to teaching medical students, as in the case of Ailsa, who explained what this also did for her role and more widely the specialist nurse:

> *Ailsa also states that they've become quite familiar with the junior doctors coming round because they're actively involved in teaching students that go through university X. This is very helpful because it*

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[19] ALS – Advanced Life Support; ATLS – Advanced Trauma Life Support; ALERT – Acute Life threatening Events: Recognition and Treatment

[20] DOPS – Direct Observation of Clinical Skills.

means that they develop and learn to grow and understand what the
nurses' roles are within the organisation. – Interview as observation with
Ailsa (Acute Pain Nurse)

Specialist nurses perceived their education as inferior to that of the doctor, which highlighted an important tension. Specialist nurses articulated that medical training was no longer producing doctors who were able to work in clinical practice, and this is where their role of practitioner/teacher gained importance. Conversely, they rarely reflected on their own expertise and development. This led to some interesting perspectives, as highlighted in this interview with Isobel:

'[it] quite shocks me sometimes [laughs] but, you know, [doctors] have
been and had seven years medical training and they're asking me how
to do it! [Laughs] How do I write this up and everything, but yeah, I've
found in the last few years particularly, it's getting more and more
noticeable that the junior doctors` inexperience and everything, they are
needing a lot more support.' – Isobel (Critical Care Outreach Nurse),
interview

Leading care within the medical field was represented as giving support and advice. This suggests the role of the nurse in educating doctors is transitory and localised, providing a sense of subordination in the interaction thereby maintaining the power of the doctor. However, the findings demonstrated a wide range of teaching tasks that can be subdivided into task and theoretical subtypes:

Task and theoretical teaching

Nurses have traditionally supported the apprenticeship training of doctors (Brian et al., 2007; Vallis et al., 2004) by teaching skills and practices, more often in the informal setting of the wards. Task teaching is also conducted by specialist nurses and is of a more complex nature than previously seen, as in this observation with Eleanor:

She just turns to the junior doctor: `Well, I think we need this magnesium
written up. Have you done it yet?` He responds, `Yes, but I don't think
I've ever put it up on a patient.` Eleanor responds, `Well, it's simple
enough - I'll do it,` and then goes to pick up the equipment and walks

back towards the patient. – Observation with Eleanor (Critical Care Outreach Nurse)

The idea that nurses are able to teach practical and technical skills is borne out through an understanding on the part of doctors that nurses are more task-orientated in the approach to care, as Liam suggests:

'I think one of the ideas we have … I suppose, to get used to working with nurses as opposed to doctors, is nurses tend to work much … or feel much more comfortable with protocols and guidelines.' – Liam (Consultant Surgeon), interview

However, the study findings point to nurses teaching more complex theoretical and practical subjects to doctors and those require medical knowledge.   This issue of theoretical teaching leads to some interesting issues of credibility and challenge, as discussed by Reese:

'I'll say, "Right, how have you been taught to recognise right bundle block?" Then that little secret which is usually the William Morrow always comes out and you say, "Well, let's start again. Whatever you've been taught forget and we'll start a new one, because that William Morrow doesn't work a hundred percent of the time but this will," and you teach them a better way of doing it, and you'll find they'll walk away and go, "alright, okay, thanks". But you can see that they're thinking, "Mm, I don't know whether to believe him". So the next time you say, "What did I teach you about left bundle branch block and right bundle branch, how to diagnose it?" and they turn around and say, "Erm," and you say "Right, blah, blah, blah", and you go, "Oh right, yeah," and you say, "But yeah, you've took that and you said bundle branch block. The QRS rating is 110 milliseconds, it cannot possibly be a bundle branch block. What can it be? Is it an inter-ventricular conduction defect or a partial right bundle branch block? But you can't write bundle branch block on that ECG because it's clearly not wide enough." And as soon as you start using words like that you start them thinking, "Wow, this person obviously does know more than I think he does", and they start to listen.`Reese (Urgent Care Practitioner), interview

The implications of this are far reaching, and suggest a challenge to the orthodox demarcation between the two professions, as explained by Ivan:

> *'I guess another issue too is where the boundaries between nursing and doctoring are very, very blurred now.' – Ivan (Consultant), interview*

However, this creates an interesting power dynamic in the interaction where the nurse is required to respect the position of the doctor and provide support to them as well as deliver service. This instigates more frequent conflict situations with the junior medical staff. There are many reasons for this conflict, which are discussed in more detail in the next section.

Leader and follower

The findings indicated an interesting tension in the role of the specialist nurse in clinical leadership and practice. It is evident that the nurse takes a leading role in the management of care, but can be assigned the secondary role if the field is professionalised in clinical interaction by doctors. However, the nurse was expected to be both a leader and follower, often making judgements as to which role to take and in which circumstances. In terms of division of labour, this was transacted in the clinical field and operated on a number of levels. This included providing support to others (nurses and doctors in the field) and accepting delegated tasks.

Supporting the ward

Providing support to the wards and nurses was seen as key. Their role and skills were useful to the ward nurses and the shared professional identity meant that they were called upon to pick up these tasks that should be completed by the doctor, as seen in this example with Sacha:

> *`…I feel sorry for the girls on the ward sometimes because they phone the junior doctors and "Yeah, yeah, we're coming, coming", and they*

phone us and say "Oh right, I'll be there with you in five minutes". - Sacha (Critical Care Outreach), interview

This was also observed by the medical staff, who appreciated that specialist nurses provided this support, but recognised that this underlined the difference in professional approach to clinical situations, as highlighted by Rabani:

'Their agenda is to relieve their colleagues, the nurses on the ward, of their pressures, but we wouldn't see that agenda, you know, we'd just come and see whether the patient's sick enough or not and if we don't think they're sick enough, we'll keep them on the ward. We don't necessarily see the bigger picture.` Rabani (Anaesthetic Registrar), interview

Supporting the ward nurses was part of the role, as was the clear expectation of simultaneously supporting the junior doctors.

Supporting the junior doctor

The support provided to the junior doctors was professional, practical and pastoral. Sacha, an outreach nurse, reflects on her experience of new junior doctors:

'I think quite honestly that when they come into medicine, especially when they first start as an FY1 on the wards, they are petrified - absolutely petrified. And when I look at them now they're little boys, aren't they? I mean they, they're just in their 20s. They are. And I think my goodness, the experience that you've not got, bless your heart, it really…it is scary, isn't it?' Sacha (Critical Care Outreach), interview

This was supported by doctors, who accepted that nurses filled this role, which was previously the role of the middle-ranking doctors:

`I've certainly seen outreach nurses who do the hospital at night system basically guiding the house officers, FY1s, through their nights on call when initially...that used to be the role of the senior house officer and the registrar whereas, it's not now...the senior house officers aren't

necessarily there or they're clerking and so is the registrar, and so the house officers are pretty much left on their own.'- Rabani (Anaesthetic Registrar), interview

The change in junior doctors` hours had created a new system of support by using specialist nurses at a similar level of the registrar. But this support often reduced the opportunities for learning on the part of the junior doctor, as pressure of work often meant accepting 'an easier life', as Adel explains:

> `I think palliative care in particular, you sort of rely on them to just do everything and they just write in the notes exactly what medications they would suggest. So you just kind of write it without thinking ... You're just coming in and writing it out, and you're not taking it in rather than if you had to think about it and look things up yourself and talk to patients yourself, you would probably get more experience.` Adel (FY1 doctor), interview*

This working pattern affected the division of labour where work was delegated more formally between the two professions from the senior doctors.

Delegation

Delegation was multi-directional between the consultant, specialist nurse and the junior doctors. In all study settings, the nurses provided oversaw medical care and were given authority through the consultants to manage the care pathway and, thus, manage and delegate accordingly, as in this observation with Reese:

> At 10.45 the medical doctor (SHO) arrives. Reese then describes the three patients that are in the department and identifies, `Can you clerk these patients, as I've got another one to see?` The Doctor (SHO) identifies that this is no problem at all, and she goes off to do the clerking. – Clinical observation with Reese*

Delegation of medicalised tasks from the doctor to the specialist nurse also occurred, and was perceived by the doctors based upon trust and the shared experience of working together, as Arun explains:

> *'There is a certain understanding as to, you know, who can do what, and I would delegate certain tasks to certain teams and they'd be happy with that. …. So it's all based on trust, teamwork and I think it's all because we've grown up together in critical care.` – Arun (Associate Specialist), Critical Care Outreach, interview*

Delegation of medical tasks took on a number of elements, including: redundant medical, technical medical, adapted medical and professional medical. These are summarised in Table 15. The process of delegation was arbitrary and tasks given to the specialist nurse would occur without additional support - despite some resistance from the specialist nurses where they felt that this was beyond their competence. Delegated tasks were often devolved to improve efficiency and access for patients, although this reduced the opportunities for junior doctors to gain experience. This required the specialist nurse to either teach the skills or step back to allow the doctor to learn even though they were not often competent. This is important in relation to the knowledge used and the interactions this precipitated. As a result these challenges in the leader/follower dynamic also created tensions and potential conflict between the two professions.

Delegated Task	Codes	Descriptor	Example
Redundant Medical	**Skills**: technical **Defining work domain**: previous work of the doctor	Redundant tasks were those no longer seen as valuable to the doctor to perform as they were classed as lower order. These were the tasks most often performed by the junior doctors.	Examples include cannulation, venepuncture and catheterisation
Technical Medical	**Skills**: technical **Skills** : competency **Defining work domain**: previous work of the doctor **Artefacts**: crossover of ANP/Dr roles **Clinical care**: doing procedures	Technical tasks were those of a higher skilled nature, and valued by the nurse as they supported their position within the team (compared to junior doctors who were unable to perform them). They were often taught to them by the consultants.	Examples include PIC, CVP, arterial lines, ultrasound scanning.
Adapted Medical	**Skills**: clinical examination **Defining work domain**: previous work of the doctor **Decision making**: use of investigations **Artefacts**: crossover of ANP/Dr roles **Clinical Care**: diagnostics	Adapted medical were broader responsibilities that were conducted by all members of the clinical team. However, they were adapted from traditional medical practice to form a core function of the specialist nurse.	Examples include history taking, examination, diagnosis and ordering tests and investigations such as radiology tests
Professional Medical	**Teaching**: evaluation of doctors by CNSs **Defining work domain**: previous work of the doctor **Decision making**: diagnosis/ treatment **Care model**: referral **Artefacts**: crossover of ANP/Doctor roles/JD: Governance	Professional tasks were those which crossed the traditional professional role.	Examples would include conducting assessments on junior doctors, conducting audit on the medical process or outcomes. Clinically, they would also include elements of care that would be the domain of the doctor-patient relationship, such as giving diagnosis, prognosis and referral.

Table 15 – Delegated responsibility typology

Conflict

At the interface and boundaries of clinical practice between professions, a division of labour was created through the structural changes in the clinical model. However, the practical interface between the two professions created some tensions and potential for conflict.

> '…Yes, conflicts do occur. Decisions are made by me, and some junior doctors do not like it. Others are very good and support both me and my decision.` Observation discussion with Reese

As outlined above, the conflict between the specialist nurses occurred primarily with the junior doctors as their skills crossed over, with the main challenge being that nurses were there to provide service, and the junior doctor to learn, although, as Rabani stated, it was also an issue of hierarchy and authority:

> 'I think with doctors, there is definitely some antagonism there. Some would say you might not want to take orders perhaps from a nurse.' – Rabani (Anaesthetic Registrar)

Conflict between the professions was understood, and an element of professional challenge was recognised on both sides, as highlighted by Eloise:

> 'I think there is an element of threat from some aspects of medicine … like, you know, the doctor should always be uppermost in healthcare. But also I think we're very much welcomed by a lot of aspects of medicine as well, because they realise they can see the future, they can see that problems are going to exist and it shouldn't matter whether it's a nurse or a doctor, there should be somebody there that can provide the experience and the care.' Eloise (Critical Care Outreach), interview

There was recognition in Eloise's statement that a watershed had been crossed, meaning that the role of the nurse had changed forever. The professions would have to negotiate and form a new approach to interaction and this will be discussed in more detail in Chapter Nine - .

Divisions of practice, knowledge and expertise

With the macro and micro division of labour explained, an important research question was the use of knowledge and application in these roles. At a micro level there was a significant diversity in the division of labour, based upon the specialist nurse role, experience, organisation and clinical field which influenced perspective on knowledge. One of the key findings is the perceived professional differences on how knowledge was used in clinical practice. The findings demonstrated that the practice between medicine and nursing is blurred, although the perception of the nurses and doctors was that there were differences in nursing and medical knowledge. The practical implications saw a mixed approach to the use of knowledge and skills, as noted in this observation:

> *It's very clear that these nurses have detailed knowledge of both health promotion and medical knowledge. They use this in quite a structured approach and use holistic assessment, by using a medical model history examination but also a nursing assessment. – Clinical observation note, with specialist surgical nurses*

The nurses still represented knowledge as professionalised in practice, even though they labelled themselves critically in relation to the knowledge, as in this discussion with Isobel:

> *'Though my background is more perhaps of a doctor's model and physiological, I am still a nurse, so I do tend to, sort of, look at the patient as a whole.' Isobel (Critical Care Outreach), interview*

Many other nurses also had a difference with the way they perceived their nursing heritage and medicalised role. They drew the distinction between them and doctors, that it was they who viewed their care as holistic compared to the disease focus of medicine - though they still performed many functional medical tasks. This dichotomy was a clear issue of transaction for the specialist nurse as they navigated within the medical world. The specialist nurses developed their knowledge in three main ways: formal education, experience before entering the role and experience within the role, mirroring that of Rolfe (Rolfe, 1998), as Callie identifies:

> *'Well, a lot of mine [knowledge] was through experience, particularly where I worked in perioperative care and intensive care, but on top of this doing an MSc in pain management. I did this alongside doctors so it was very geared towards medics in understanding the pharmacology as well as also the physiology of pain.`* Callie (Acute Pain Nurse), interview as observation*

Callie's observations are typical in that nurses often worked in the role, developing their knowledge through access to doctors whilst building upon their previous roles in nursing. The value of formal education in specialist nursing was questioned by some, as Reese explained:

> *'I think nursing hierarchy put it in place, but doctors support it and the reason I think doctors support is …if you going to reach that sort of level, when you're going to be making quite big clinical decisions, if you haven't got a masters degree or some sort of qualification that puts you up towards the PhD level, like a doctor, it belittles their role.' – Reese (Urgent Care Practitioner), interview*

The experiential element commanded far greater respect on behalf of the nurses and doctors. They developed detailed and extensive clinical knowledge in their field, and this was driven and supported by the medical staff they worked for, as highlighted by Robyn:

> *'I can make decisions about investigations I have done it today: Health promotion, blood tests, everything like that and certainly claudicants, what medication they should be on, best medical treatment.' Robyn (Specialist Surgical Nurse), interview*

Another important finding was the connection between knowledge and the relationship with doctors, as in this conversation with Yasmin:

> *`Well, if I go out with one of the consultants on an acute pain round, they have knowledge which I don't always have. So that knowledge they can pass on to me, it's as simple as that.` Yasmin, (Acute Pain Nurse), interview as observation*

Doctors were seen by the nurses as those with greater knowledge and therefore a resource to gain access to. Critically, knowledge itself becomes a currency in transactions between the two professions, leading to a perceived power differential.

Levels of knowledge and expertise

Perceptions of the level of knowledge were an important finding. The specialist nurses perceived their knowledge development in two key stages, which, overlaid on Benner`s (Benner, 2001) novice to expert framework, is summarised in Figure 30.
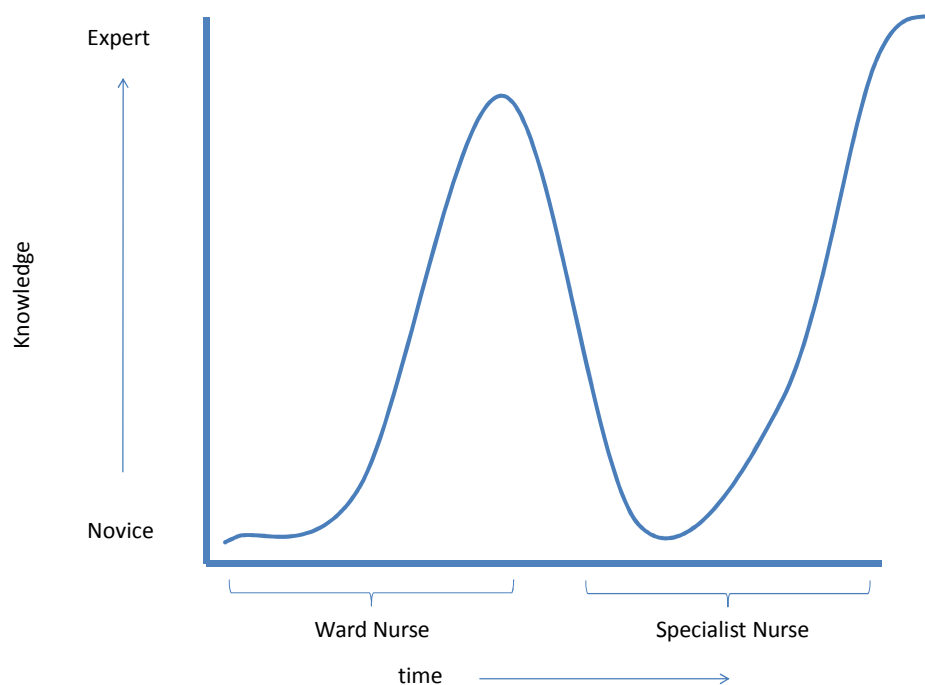
Figure 30 – Nurse perception of knowledge

The transition from ward nurse to that of the specialist nurse was often very challenging, as highlighted by Nicky:

> `I actually found it really difficult, but didn't ever admit to anybody that I found it really [difficult] ...I didn't, I would now, but at that time I had too much pride and so I did find it really difficult to adapt to the role.' Nicky (Critical Care Outreach Nurse), interview*

One of the critical issues discussed by Nicky, which was found with other specialist nurses, is the issue of a public and private confidence related to their knowledge. Many specialist nurses had anxieties in their transition that resulted in the development of communication approaches such as rehearsal. Key to their successful transition was greater confidence through knowledge acquisition, as explained by Yasmin:

> `I think you have to bear that in mind: you gain confidence as you gain knowledge.` Yasmin (Acute Pain Nurse), interview

The transition between the two was signified by moving into the role, where they were able legitimately to use the knowledge in clinical application and, importantly, 'publically' use the knowledge in discourse with doctors. They were guided as an apprentice in the use of the knowledge to support the clinical pathway for the doctor. However, the medical perspective on the specialist nurses` knowledge was very different. Their knowledge was viewed along a linear continuum, where nursing knowledge was a subset of medical knowledge, as highlighted in Figure 31 on page 210. However, the distinction was more narrowly defined when compared to that of general medical training. Ivan discusses this in relation to the junior doctors, and the expertise of the specialist nurses:

> 'I don't use the word power element but I think responsibility and knowledge element. I think the junior doctors clearly don't have the expertise and knowledge of specialist nurses in that particular narrow area. And that can cause problems in both directions because the nurses don't always appreciate that doctors have a very broad experience and wide range of areas, but theirs is a very narrow experience and a very narrow one, so outside that area it's, you know, different to inside.` Ivan (Consultant), interview

This tension was also picked up by the junior medical staff, who noted that this narrow field of knowledge that led to expertise of the nurse was not full medical training. Doctors recognised the expertise, but did not reflect this as superior to their own, as discussed by Adel:

> `I think they definitely have better knowledge in that area, but I think maybe in a broader aspect my sort of knowledge overall may be a bit

more. But they're the ones who would be experienced, so most of the time I do what they suggest.` Adel (FY1), interview
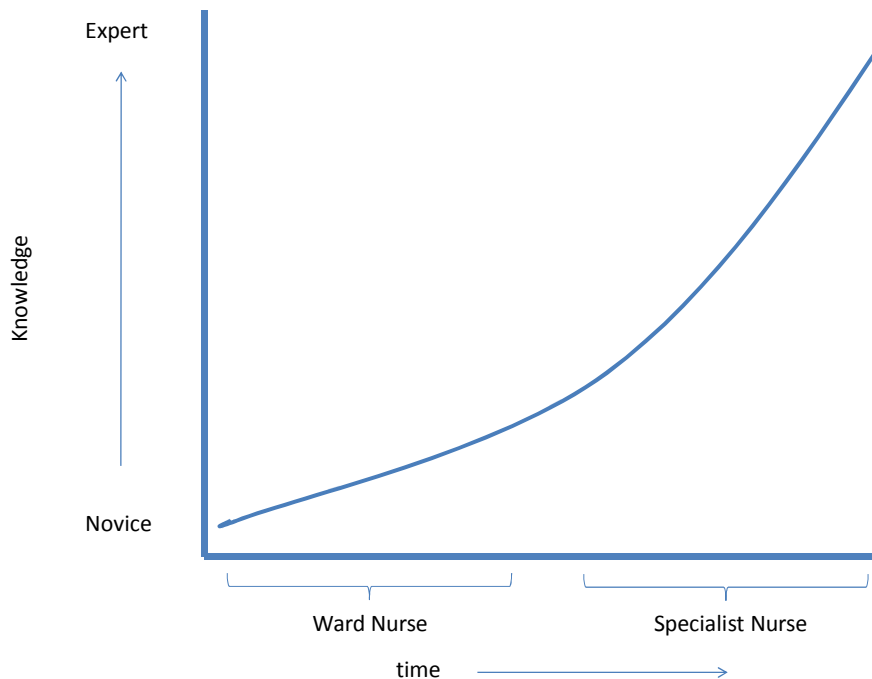
Figure 31 – Medical perception of specialist nurses` knowledge

The issue of levels of knowledge and expertise are also highlighted in how the nurses determine their overall knowledge compared to the medical hierarchy. A constant finding was a view of how knowledge was compared by the specialist nurse, as in this example with Robyn:

> *'Ivan (Con) and Liam (Con) will say [to the Registrar], "Oh go and ask the specialist nurses" …so I suppose I feel on a par with a registrar really.` Robyn (Specialist Surgical Nurse), interview*

The view of the consultants differed from that of the nurses and junior doctors and was referenced to a lower hierarchical position. This example of a clinical observation occurred on a ward with James and Isobel:

> *I ask the question to James (Consultant), `Do you think the outreach nurses are primarily a replacement for the house officers then?` He smiles, and turns to me and says, `Primarily, yes`. To which Isobel*

responds, `Bloody house officer, I think I am more like a registrar.`
Observation with James and Isobel (Critical Care Outreach)

Whilst this was a humorous exchange, it did signify a dichotomy in the perspective of doctors between the practical role the nurses fulfilled and the knowledge they had. This has important implications for the credibility of the specialist nurse, as public and private representation in the field was an important factor in the power dynamics. It was notable that the nurses never represented themselves on a par with the consultant.

Knowledge and credibility

Credibility of the specialist nurse in practice was built upon two main issues: Firstly, their position within the hierarchy of the clinical team. As has been discussed in previous chapters, the position of the nurse, and proximity to the doctors, had important implications for their power base. Secondly, their knowledge, skills and expertise were also an important reference point particularly with the junior medical staff. The junior doctors were transitory members of the clinical team and the specialist nurses were often afforded greater privileges in the team. The issue of knowledge credibility was an interesting finding which had a particular interactional outcome for the nurse. When the junior doctors rotated through the teams, the nurses had to revalidate their knowledge by proving their expertise, as Reese found:

> *'You think to yourself, hang on a minute, he's right. Why the hell do I*
> *have to prove myself to them? ... when actually I've got more knowledge*
> *than they have! [Laughs] But I still do it, but I think it possibly is*
> *because I've no badge that says doctor and unfortunately there are still*
> *people around who actually focus on what's written on your badge.' -*
> *Reese (Urgent Care Practitioner), interview*

Reese highlights that the specialist nurse has to conform to an established pattern of behaviour whilst fulfilling expectations of their position in relation to power and knowledge. This culminated in two effects: Firstly, agents reinforced the structural systems already in place that created this. Secondly, that despite awareness of the contradictory nature of their own expertise through their power/knowledge status, they were still expected to conform.

Summary of evidence

The division of labour clearly demonstrated that power is still weighted towards a medical dominant position, though nursing's power position had changed markedly. The evidence identified that medicine controls the construction of the specialist nursing role through their dominant position within the hospital structure and influence with the bureaucratic systems. The findings also indicated that the division of labour reinforces the traditional aspects of the nurse-doctor relationship, with the former as a subordinate (Gamarnikow, 1978; Gamarnikow, 1991; Sweet & Norman, 1995). However, the nurses proved to have greater intrinsic organisational and professional power compared to their colleagues who worked in the ward environments and used this in practice to influence clinical outcomes for the patient. Whilst the state had constructed a specialist nursing role to fulfil medical needs, the exposure of nursing had improved the overall power and influence of the profession. This had impact locally within organisations and, more widely, with the medical profession in healthcare. Nursing has been able to achieve this by largely augmenting the scope of their practice from nursing to a more medicalised model through the tasks and fundamentals of medical practice, such as diagnosis, prescribing and treatment mirroring the view of others (Gerrish et al., 2003; Rolfe, 1998; Ruel & Motyka, 2009). Success in this sense can be defined in two ways. Firstly, that nurses are able to take on the knowledge and skills (albeit with support from senior doctors) and deliver them in clinical practice. Secondly, that this has been recognised by medicine as a potential threat to their power and position of authority which was most notable with the junior doctors. It was observed that the specialist nurses had developed their practice through the use of medical knowledge, and developing expertise in the pathways within which they operated. This reflects a growing acceptance of the cultural capital of medicine by nursing to increase power within healthcare (Bourdieu, 1986; Kilpatrick, 2008).

The specialist nurses in this study were all clearly at different stages within the expertise continuum. They conformed to the Dreyfus & Dreyfus (1980) definition as being 'able to understand what needs to be achieved, but also how to achieve it'. Power, therefore, links with expertise as it is transacted in a number of ways within this relationship. The specialist nurses have experiential knowledge that far outweighs that of the junior doctors. This aspect of expertise is recognised in the division of labour between them, and impacts on how they interact. The role of the teacher and leader formalises aspects of this

expertise in the relationship between the two professions and is supported by the consultants in both clinically and delegated authority. The junior doctors are perceived by both themselves and the nurses to have greater knowledge in the wider sphere and, by inference, the greater capacity and critical thinking capability which leads to a potential power differential and conflict. The junior doctors define the nurses` knowledge in narrow bands of expertise, and therefore legitimise challenge and conflict through their own command of medical knowledge.

However, it is clear that the perception of expertise within the two professions differs. On a number of occasions nurses benchmarked their combined knowledge and skills with that of the registrar in the medical hierarchy, but never in the realm of the consultant. This reinforced the medical position of dominance in the relationship, although challenging the hierarchical system. This reflects and supports the adaptation of medicalised knowledge to increase power, through the accumulation of capital (Bourdieu, 1986). Conversely, doctors perceived the role much lower in the hierarchy, thereby reinforcing their hierarchical position. The transfer of expectation from the junior doctors to the nurses was evident, although the transfer of power in this circumstance was not. However, nurses are still professionalised as nurses by their prior experience and this they partly retain through their own volition and also by the bureaucratic control of their specialist roles in hospitals. It is important to note that 'still being a nurse, and still seen as a nurse' is commonplace for specialist nurses as they are required to still manage the emotional context of care, which extends their own practice in the medicalised domain in which they operate. The division of labour brought about by structural elements or by agents themselves is evident, although how this is transacted in clinical practice may provide a greater understanding of the concept of power, and this is considered in the next chapter.

Chapter Nine - Interaction in the field of practice

Introduction

The preceding chapters have alluded to a change in the process of communication between the two professions, based upon structural changes in the healthcare environment and how they are operationalised in clinical practice. This chapter seeks to understand how these have impacted on the communication and clinical interaction of specialist nurses and doctors.

High-level interaction model

The findings indicated a more complex model than had been previously identified in the literature, although a number of common features in the model were reminiscent of 'Doctor-Nurse Games' (Figure 32). Whilst the diagram is produced in linear form to aid understanding, the interconnectedness of the elements must be understood, and will be explained in further detail.

The communication model can be subdivided into the pre-, intra- and post- game phases. The pre-game phase was the time prior to the interaction and the findings indicated a number of key elements, including defining the purpose of the interaction and its intention and clarifying the approach method, alongside any pre-game rehearsal required to optimise the interaction. In addition to this, an evaluation of the context would also be required to reveal any other influences. The intra- game phase is the main point of contact or discussion, and could take place via four main transaction types: written, electronic, verbal or non-verbal methods. Around the game were a complex set of rules. The post-game phase is the evaluation and outcome part of the interaction.
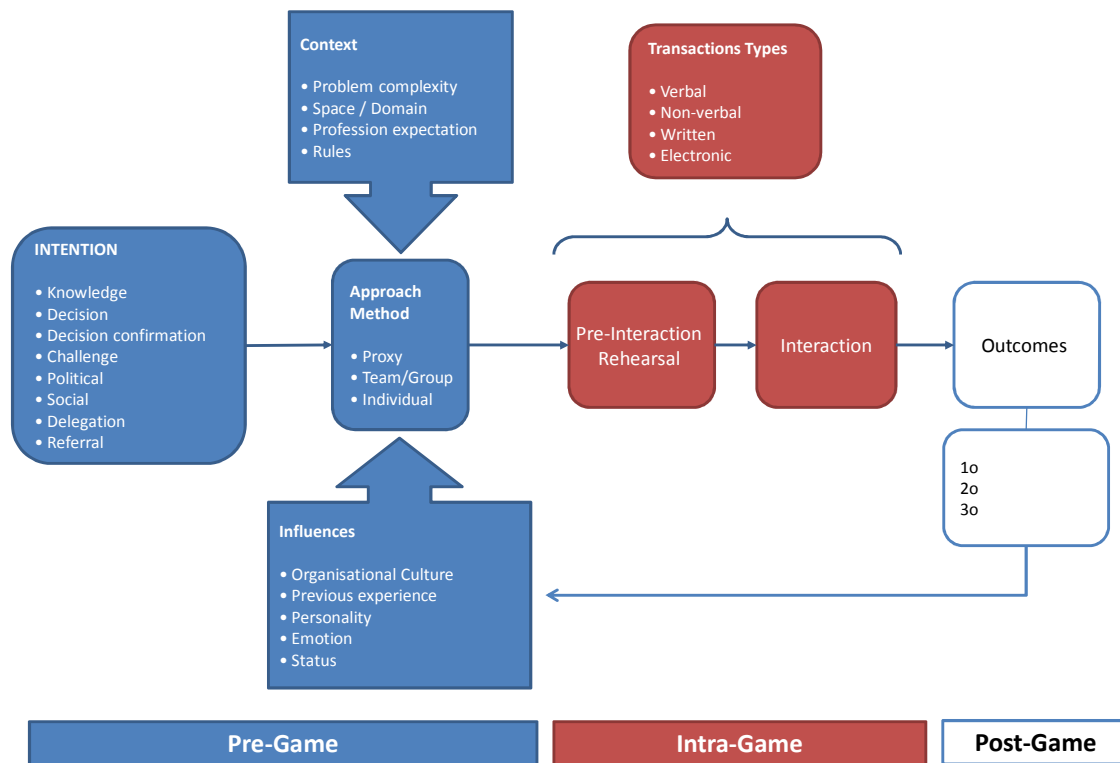
Figure 32 – High-level communication model between doctors and specialist nurses

Pre-game phase

The pre-game element is an important aspect of the interaction between the doctor and the nurse. Pre-game signified a critical decision-making point that can occur in the same field as the clinician or prior to them meeting. It determined a range of possible intervention strategies used by them to achieve an outcome (positive or negative). The first important stage of the pre-game phase is an understanding of the intention to interact.

Intention

The findings indicated that nurses and doctors initiated interaction with each other for a number of reasons, which are summarised with exemplars in Table 16.

	Codes	Descriptor	Example	Code Exemplar
Knowledge	**Knowledge** : CNS about CNS CNS about Dr/CNS revalidating with doctors (juniors)/confidence and trust/intuitive/limitations/multi-professional education/ nursing/medical knowledge/practice vs. education/preventing harm/risks/updating and CPD **Care Model**: boundaries/accountability	A piece of information regarding clinical or operational systems knowledge is required from one to another.	Clinically - How to treat a condition, prescribe an antibiotic. Operationally – A telephone number, contact person or how to access a process for booking a radiology test.	*`If I'm not sure…if I'm looking at an X-ray I'll say to a doctor, "What, what… can you just explain this to me."`* *Sacha (Critical Care Outreach), interview*
Decision	**Hierarchy**: Clinical/medical nursing **Decision making**: Admission/ discharge/ overt/ treatment **Care model**: CNS independence	A decision may be required for which the person will not have the expertise to make a judgement.	A specialist nurse or doctor assesses a patient, identifying their symptoms, initiates investigations but defers to a more senior doctor to determine the diagnosis.	*A phone call is put through to the consultant in charge and a full history and test results are relayed to the consultant. The consultant suggests a diagnosis and management approach. – Clinical observation with Reese*
Decision Confirmation	**Hierarchy**: Clinical/medical nursing **Decision making**: Admission/discharge/confirmation/ escalation/action/treatment/using doctors **Clinical care**: clinical leadership **Care Model**: boundaries/accountability	A decision has been made by the person, but requires validation on the part of someone with more expertise.	A specialist nurse or doctor assesses a patient, identifying the symptoms, initiates investigations and makes a diagnosis. The person will then confirm this diagnosis with a more senior doctor at a later time, i.e. on a ward round	*She said to the patient, 'I have to have a chat with my consultant. I just need to run things by him.' And follows this quickly by saying, 'But I'm not really worried about you and your care.' She takes off her gloves and gown, picks up a set of notes from the side, and then moves out into the corridor. - Clinical observation with Robyn*
Challenge	**Hierarchy**: Clinical/medical nursing **Challenge**: CNS about Dr/CNS to Dr/Dr about Nurse/Poor performance/private covert/within the team **Clinical Care**: Differences of opinion	An agreement is not achieved and the nurse or doctor challenges or initiates discussion with another person.	A specialist nurse disagrees with the approach to care, and challenges the doctor to change approach or justify opinion.	*`Well, we've given her some bicarb,` says the SHO. `You should not have given a patient bicarb.` `Okay,` he says. "Why have you given bicarb? It is only going to correct the numbers and it's going to give her a rebound type potassium increase.` He says, `Okay, I understand.` `She is 94. What do you think we're doing here? What are her gases? Have you done them? ….Look at that Ph. Why are we doing this to her at 94?` She turns to the SHO and says, `Do you agree with me or not? Do you think what we are actually doing is we are prolonging the agony of this lady?" - Clinical observation with Ruth*

	Codes	Descriptor	Example	Code Exemplar
Delegation	**Hierarchy**: Clinical/medical nursing **Decision making**: Delegation **Delegation**: CNS to Dr/CNS to technician/Nurse/Dr to CNS	A task has been identified that can be given to another healthcare professional.	Nurse or doctor has a caseload of patients that require assessment in the ward or department. The workload is directly distributed by the nurse to the junior doctors.	*At 10.45 the medical doctor (SHO) arrives. Reese then describes the three patients that are in the department and identifies, `Can you clerk these patients, as I've got another one to see?` The female doctor (SHO) identifies that this is no problem at all and she goes off to do the clerking. – Clinical observation with Reese*
Referral	**Care model**: referral/referral to other nurses	To pass the care of a patient from one clinician to another, or gain the advice from another specialty.	A nurse clinically assesses a patient who requires the advice of a dermatologist specialty doctor, contacting them directly via phone or letter.	*Ora chips in at this stage, 'Yes I'm going to make a referral and I was also going to get her some support from the dieticians.` She goes on, 'I don't think there are any surgical problems here. She's tried stockings but that doesn't seem to be that effective.' - Clinical observation with Ora*
Political/ Operational	**Hierarchy**: Clinical/medical nursing **The team**: interteam support/not nurse or doctor/the medical firm **Care model**: Oversight and gaze/productivity/team work/supporting ward and junior doctor	An interaction based upon political dynamics within the team, profession or organisation.	A nurse or doctor discusses a political issue regarding the organisation with another.	*Just as we're finishing the conversation one of the bed managers comes in and starts chatting to us about the bed situation, just asking how we're finding things today. There doesn't feel to be any particular bed problems at all and certainly Critical Care Outreach. - Clinical observation with Winona*
Social	**Social discourse** : About Drs/Drs by Drs/About Nurses by Drs/ About Patients	Interaction based upon non work-related issues.	A nurse or doctor discusses with each other family issues or they have coffee together in the cafeteria.	*At that point we see one of the medical registrars again who says 'Hi'. Eleanor and the reg chat for a little bit as the reg is feeling a bit under the weather with a cold. It's mainly just a social chat before we leave the ward again and head up to the ward. - Clinical observation with Eleanor*

Table 16 – Intention of interaction between doctors and nurses

The intentions were predominately clinical, as in knowledge, decision, decision confirmation, delegation and referral. The non-clinical intention findings occurred less frequently, but did form a part of the interactions. In both cases it indicated a bi-directional component to the interactions. However, in determining an approach, there are a number of context issues and influences taken into account by the nurses before determining an interaction strategy.

Context

A number of contextual issues influenced the interactions between doctors and nurses. As identified in previous chapters, context applies to the physical location or field as an influential factor. This space was professionalised by the clinicians working in there, and as Ruth found, required her to think about initiating a challenge interaction:

> *We see there's a ward round taking place, to which Ruth then nods in the direction and says, `Well, that's one of the consultants. I'm not sure whether I should go and front him up about it.' As we walk out of the ward, she stops and talks to the consultant. - Clinical observation with Ruth (Critical Care Outreach)*

This example highlights the complex situations that the nurses find themselves in practice. The situational context is important as well as the professional behaviour that is expected of them. The contextual interpretation was significant, as in this overview given by Isobel:

> *'It depends on the circumstances and the state of the patient. Sometimes you can afford to wait, sometimes you can't and if you can't afford to wait, then you either have to talk to the doctor directly and try and challenge it, or call in favours every now and then, and go and ask somebody who's perhaps a little bit more supportive.' Isobel (Critical Care Outreach)*

These examples highlight a number of issues. Firstly, the complexity of the clinical scenarios and how the nurses had to factor in a number of variables related to initiating

interactions. Secondly, that the field is also a significant factor and in these scenarios nurses would make judgements on which approach to take. Thirdly, it also suggests that where nurses would work through others to resolve issues this can be a predetermined rather than a reactive approach. Finally, the professional context is also important to determine how they should behave and react. Consequently, the outcomes of any interaction were less fixed and ultimately more dynamic, requiring re-evaluation and assessment for the next stage. This suggested that the interactions were less linear and had multiple potential outcomes.

Influences

There were a number of key influences on the chosen approach to communication that centred on more people-related factors. Previous experience of the situation and the people involved were important, as the nurses learnt how they like [doctors] to be approached and managed. As Eloise suggests, it was an expected part of the role:

> 'I think it's very much similar strategies: you get to know individuals and you know what will work and what won't, well most of the time!' – Eloise (Critical Care Outreach), interview

As well as understanding the needs of the consultant and their 'quirky ways', the doctor's specialty was also an influence. Nicky outlines her thoughts on understanding interactions with surgeons:

> 'In some situations it's about standing up for yourself and you know there's certain, say, for certain of the cardiothoracic surgeons that I know, that if you back down, it's lethal. You have to say, "No, I'm sorry", and have an argument.' - Nicky (Critical Care Outreach), interview

Nicky alludes to a number of key influences on communication with doctors. Firstly, that conflict and challenge were expected parts of the role and that skill was required to survive in the role. Secondly, that challenge by doctors could form a situation that had longer-term consequences on their relationship. Finally, that as a nurse you would have to determine which challenges to have and which to avoid. The individual relationship

between a specialist nurse and doctor was important when factoring in the personality of the individuals involved and this could be a key determinant of the approach taken. In this overview by Ora and Robyn, who work in the same team, Ora notes that:

> 'We don't think that he listens to what we're saying and what we want, so he kind of does his own thing with it, so we each have our own strategies to deal with it, and I'm sure Robyn won't mind me saying. Robyn can be very aggressive towards him… but that's not me.' – Ora (Specialist Surgical Nurse), interview

To which Robyn's reflection is:

> 'I tell him that's what I think, again that's because I've got to know them and I don't care (laughs) you know, he doesn't frighten me anymore. Initially he was a bit ….forthright if you like, and I suppose it's scary.' Robyn (Specialist Surgical Nurse), interview

Robyn was more senior than Ora, and had worked in the team for a much longer period. The relationship was established and her personality and style accepted within the team. The communication between her and the doctors was set, compared with Ora who had yet to develop a style. The issue of confidence and developing within the team was important and Ora reflects on her early days in the service and communication with doctors:

> 'I used to absolutely dread it… I never used to sleep day or night when I had a Tuesday clinic for the first perhaps six or seven months because he would constantly question if we go into a patient, why, why have you done that, and I thought it was just him being stroppy, but looking back now I learnt so much from it …what's he going to ask me and what do I need to know before I went in and that is actually …I had a few tears coming out of his room … "Why do you not know that? … Don't come back into this room until you can tell me the answer." You'd come back in and I used to think, "You're so horrible."' Ora (Specialist Surgical Nurse), interview

It was also noted that communication was influenced by the emotional state of the individuals. They all fulfilled highly technical roles in pressured clinical environments, and it was recognised that their own personal perspective could influence and change the course of the interaction, here described by Eloise:

> `I think you have to tailor it to suit, you have to see early on in the conversation, see how the conversation's going and just make a… not a judgement but, obviously speak differently, act differently, depending on where you feel things are. It's hard to explain really.` - Eloise (Critical Care Outreach), interview

Although it was not a commonly expressed view, one influencing factor noted by Reese, the urgent care practitioner, exposed a sense of vulnerability and personal risk in the system of communication and practice. Reese explains:

> 'There's still some part of me ….. probably a very cynical and suspicious part of me that still thinks, are they just waiting for somebody like myself to make a mistake and get bo****ked for it, get hauled through the coals for it? There aren't many, but I've met a couple of consultants who you do get that impression from.` Reese (Urgent Care Practitioner), interview

In such new roles as these, vulnerability could be expected as personnel gained knowledge, confidence and a wider network of support within the organisation.

Rules

The rules of interaction were fluid and dynamic, and few explicit rules were in place other than the medical veto. Medical veto existed in all cohorts in the study, and this can be explicitly stated by either the nurse or the doctor and was expressed in relation to ownership, accountability and responsibility:

> 'I can't override his decision to try and treat that patient in a particular way because at the end of the day we know what we're all told over and

over again, ultimately, that the patient is that consultant's patient, he's not your patient.` Reese (Urgent Care Practitioner), interview

The issue of medical veto was a challenge, as the doctors reflected that using this could provoke difficulties in the relationship. This perspective from the medical staff recognised that using this rule had to be done with discretion and could be played out directly or indirectly. Rabani explains a more direct challenge:

'I still say I think the doctor would have ultimate responsibility and you just have to find the middle ground sometimes. You have to take in the opinions of the specialist nurses and often they've spent more time with the patient than you have.... They certainly can be quite forceful about, you know, what they feel should be done, but sometimes you can go with that and sometimes you can't and have to put your foot down.' Rabani (Anaesthetic Registrar), interview

This is compared to a more indirect approach by Adel:

'I think they're always quite clear and they may write in their notes what they think you should do, but they always… it's up to you whether you follow their advice or not.' Adel (FY1), interview

It is clear that the doctors also understand their role in the game, and have to provide additional strategies to achieve an outcome, whilst also ensuring the relationship is maintained.

Approach style

The approach style taken by the nurses concentrated upon three main forms: individual, team or proxy. We have seen examples previously where the interaction is initiated between an individual specialist nurse and doctor. In addition to that, a group approach between a number of specialist nurses and doctor/s was also observed. However, the findings also suggested that specialist nurses would work indirectly through others to achieve preferred outcomes of the interactions. Termed a proxy approach, this was

characterised by a specialist nurse using another person to support their decision making, and therefore adding credibility or protecting them from challenge or conflict.   The rationale for this was not fully articulated, although as Isobel explains, it was an effective strategy to support decision making when they were not being listened to:

> 'Sometimes you find you've tried the consultant on the ward and they're saying, no, they want all treatment for this patient and you know it's futile and you can't talk them out of it. So then you come up here [ITU] and you talk to consultants here and say, "Look, you really need to come down and see this patient, because I think you'll find that this patient isn't suitable critical care. We can't really do anything ultimately for this patient, it is futile, so, you know, perhaps you'd like to come down and see them." And you know that they'll probably reinforce what you've said and then they'll override the admitting consultant really.' Isobel (Critical Care Outreach), interview

The proxy approach could also involve others in the field such as patients, administrative staff and managers.

> 'What I tend to do is, if the patient is in pain, I might say, an awful lot of pain. So I might use the patient, that's a bit naughty you know. I just try and put the patient within that sentence, the patient wants this and the patient feels this, this and the other, obviously it's for the benefit of the patient I find they respond to that much more quickly and that's a good strategy.' Robyn (Specialist Surgical Nurse), interview

However, being a proxy was noted by Ivan:

> `If a patient's been difficult in terms of behaviour and compliance . . . then they'll tend to refer the [patient] like it's time to discipline the patient. They'd call the consultant a bit like calling daddy in to tell the child off, that happens a bit. … It's almost as if, "If you don't do as you're told, I'll get the consultant in to tell you off".' Ivan (Consultant), interview

The proxy approach emerged as a new and important finding which highlighted the complex clinical and political nature of the field in terms of the interactional approaches used by the specialist nurses to aid communication.

Pre-interaction rehearsal

One interesting perspective identified was a rehearsal stage prior to a planned interaction. In the case of Ora and Reese, this was noted in observation and followed up in interview discussion. Ora discusses the reasons why she rehearses the interaction beforehand:

> 'They [doctors] do sometimes, even now, still make me feel a little bit intimidated. I can do it on the phone but if I'm face to face I'm a bit kind of… … I have to prepare myself to… right go through it logically and go through what it is that the patient's presenting with and what you want them to do and then I'll think, "So what will his response be?" So I'm kind of almost ready to have whatever.' - Ora (Specialist Surgical Nurse), interview

As with Ora, experience and confidence level of the specialist nurse determined whether or not pre-interaction rehearsal was used; Although, it was also noticed with even experienced nurses such as Callie (acute pain), Eila (outreach) and Reese (urgent care). Reese also used this preparatory time to frame the contact and also determine a secondary outcome. In this example he demonstrates that his intervention had improved the experience of the doctor.

> Reese explained that he prepared his handover to doctors and often used a narrative when handing them over, identifying the fact that he may precede discussions with 'I have done the following for you', in some ways legitimising the activities done by him by taking workload away from doctors to ease their workload. Reese (Urgent Care Practitioner), interview

Rehearsal was an interesting concept and one that had not been identified in previous literature. The main issues from this relate to 'getting it right' and presenting a professional image. The specialist nurses perceived the need to present a public face

that was assured and confident. Rehearsal allowed them to fine-tune their presentation and delivery by pre-empting any possible counter discussion strategies that may come from the doctor. Their level of experience and learning from previous encounters significantly influenced the use of this method.

Complexity of problem - Complexity of interaction and outcome

The findings indicate that the pre-game phase is complex and nurses and doctors would take account of a number of situational and contextual factors and interpret them in light of a number of influences. This enabled them to determine the best approach to therefore achieve the desired outcome. This suggests, as was supported in the findings, that outcomes desired for one specific reason may have secondary and/or alternative outcomes. The reason for this was awareness of the game on the part of all the players, including doctors, nurses, administrative staff and managers.   The medical staff also had agendas and strategies which they employed to achieve their preferred outcomes. As Rabani discusses, this can lead to challenge within teams:

> 'They certainly can be quite forceful about what they feel should be done, but sometimes you can go with that and sometimes you can't and have to put your foot down. At the end of the day, if there's no bed on ITU, there's no bed on ITU, and if you can't make a bed on ITU, then the patient is just going to have to be managed on the ward and that might not be the agenda of the critical care nurse...which might have been...to get this patient off the ward.' Rabani (Anaesthetic Registrar), interview

This would lead to a multitude of strategies, interactions and potential outcomes, as schematically identified in Figure 33 . Although previous work from Porter (1991) and Hughes (1988) recognised that strategies were used in interactions, their work highlights a more linear response framework - where the interaction is more defined and the outcome clearer. The findings from this research indicate that, whilst the initial intention may be clear, the interaction and subsequent outcomes are less so. They require a detailed knowledge of people and space to confidently change direction, in order to introduce new information, strategies or responses to ensure that outcomes were achieved.
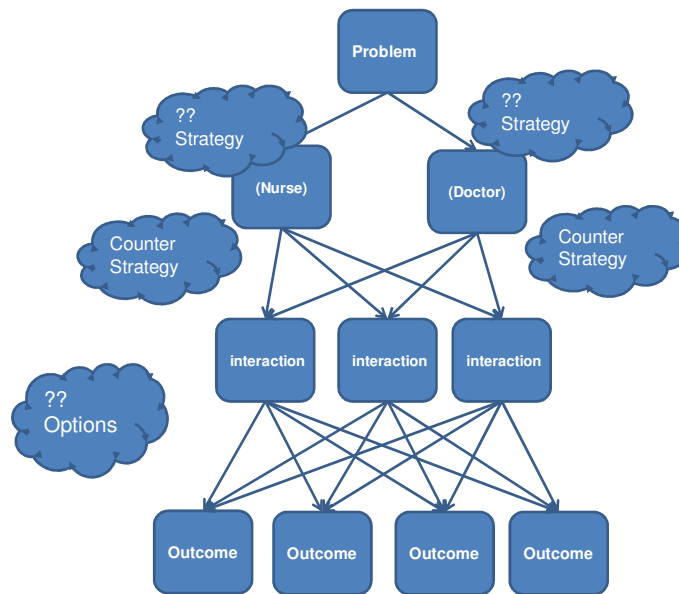
Figure 33 – System complexity and strategies in doctor-nurse communication

Intra-game phase

Much of the existing body of knowledge has concentrated upon this aspect of the interaction between doctors and nurses. It is important to stress that this work differed from previous studies in that it concentrated upon comparing the specialist nursing role versus the traditional role of the nurse compared to previous studies. The preceding chapters have identified that the relationship is constructed differently by the two, and as a result the interactions are altered. This section will start by examining the interaction types, followed by the detail of the game, and the outcomes.

Transaction types

There are four main types of transaction: verbal, non-verbal, written and electronic, which have further subdivisions, as outlined in Figure 34.
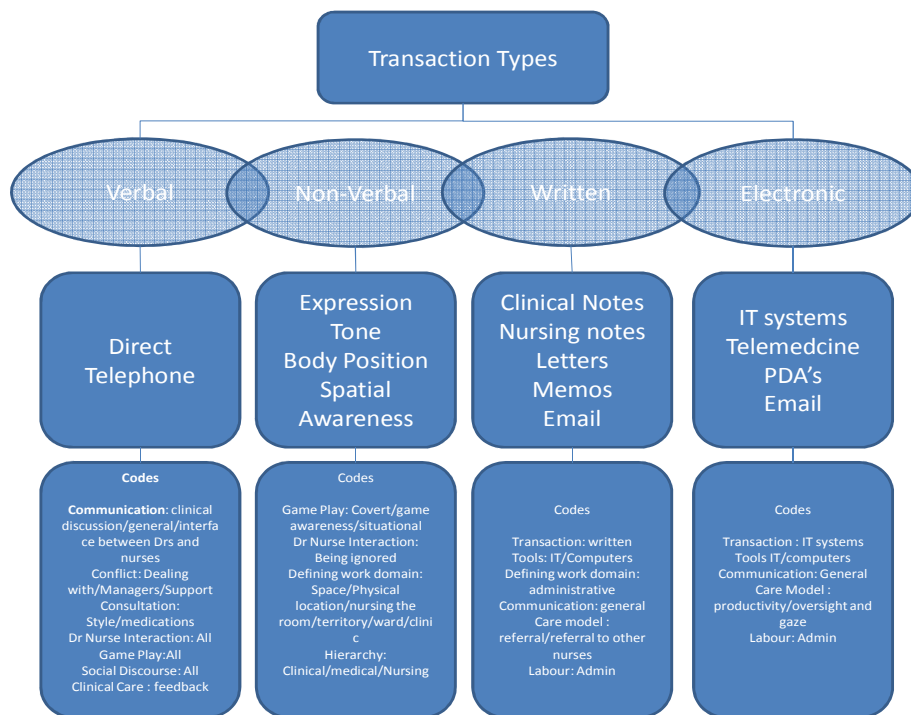
Figure 34 – Transaction types, subtypes and codes in nurse-doctor communication

It was observed that a transaction type was chosen by the nurses for a number of reasons which included expediency, effectiveness and situational factors. However, as has been discussed previously, the advisory element of the role included making recommendations for treatment and action that could or could not be taken up by the doctor. It was observed that verbal communication was more effective in terms of ensuring action was taken against advice, rather than the written communication which could be ignored.

Verbal and non-verbal

Verbal communication types were the most common form of communication between the specialist nurse and junior doctors. The nature of the division of labour and frequency of contact made this the most effective communication strategy and therefore it is focused upon in more detail in the next section. The specialist nurses used written and verbal communication equally with the consultants. Non-verbal interaction was common, as it related to the field of interaction. Two main forms of non-verbal interaction were

observed, overt and covert. Overt non-verbal related to expressions, body language and position in the space displayed with the intention of being noted, as in this example:

> *The doctor asks, `What about the blood gas?` `The machine was at fault and it's not been able to do it.' In the interim time the resuscitation has been abandoned and unfortunately the patient had died and the doctor comments to Reese, `But we still need it` and holds his hands up. Reese says `Why? I'm not putting my hand in a sharps box to do a test that is now irrelevant.` The doctor concedes, `Okay, that's fine` (sarcastically) , raises his eyebrows and looks bemused at the same time towards Reese. – Clinical observation with Reese*

Covert non-verbal were less obvious displays, such as silence and stepping away from the interaction. In this example Eleanor who was actively involved in managing the situation prior to the consultant arriving, had a conflict situation with the registrar, and chose to remain silent:

> *Once he [registrar] had finished his examination they all discuss just outside the patient area by the curtain. The consultant turns and walks out of the resuscitation area into the main part of the A&E department. Eleanor continues to deliver care to the patient at the bedside: she is giving drugs, re-arranging other fluids and giving another fluid – but says nothing. – Clinical observation with Eleanor*

Silence and non-participation as a tool of resistance was a surprising feature of the interactions. However, they highlight and reinforce two main issues - medical dominance in certain scenarios, and the requirement for the nurse to be subordinate.

Written

The clinical notes were still the main source of clinical communication, even with the advances in technology outlined previously. Documentation of clinical intervention has

always been in a separate form between doctors and nurses using medical notes and the nursing kardex[21]. The interesting common factor found in these observations is that the specialist nurses document in the medical notes rather than using nursing notes, which sets up interesting interactions regarding communication processes and field definition. As Eloise noted, decisions were made by the nurses on what to document or plan, and what to escalate for immediate action. This was often centred around skills and knowledge of the specialist nurses as much as the clinical care of the patient and this influenced their approach to communication.

> 'There's just by telephone and by writing… putting a plan in the notes and suggestions in the notes and face to face, you know, or I'll go and seek somebody out, if I feel that leaving messages or speaking on the phone isn't going to be enough to get, you know, the situation resolved. I'll go and actively look for them.' Eloise (Critical Care Outreach), interview

Inevitably this approach was noted by the doctors, specifically by those junior doctors whose mechanism for communication with colleagues and others centred on the notes. Adel, a junior doctor, noted that if the nurses were able to do things they would action straight away and if not, (such as prescribing medication) then these tasks would be left for them to do:

> `Most [specialist nurses] write it down in their notes but it will be, I suggest, the following. I think maybe ... critical care outreach would maybe talk to you more about it, but they would tend to just do stuff rather than leaving it to us, so if they wanted an ABG they'll do it themselves. The only thing they don't do obviously is prescribe with the outreach teams. .... There's a lot of the diabetes nurse specialist they prescribe as well, so they would just do it.` - Adel (Foundation Year 1 Doctor), interview

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[21] Kardex is the proprietary name for a filing system for nursing records that was held centrally on the ward and contained all the nursing details and observations of patients that had been acquired during their stay in hospital. Although this system is no longer used, the term 'kardex' continues to be used generically for certain centrally-held patient record systems.

Written communication methods were used extensively in the form of clinical notes, letters, memos and email which highlighted some interesting differences between the two professions in the communication style as noted by Ivan:

> 'I think they write quite a lot and it's a mixture of feelings and information to back up why they feel that way, rather than this is my opinion, which is… I think it's very reasonable….. [However] it depends on how it's received, if the nurses who that information's sent to are quite comfortable with that style, then it meets the needs, that's fine. It's not for me to say that it isn't the way I'll do it but then that might be because I'm presenting myself as I think a consultant should present themselves, but that might actually not be the way that we're presenting.' Ivan (Consultant)

However, the written communication in certain circumstances was seen as an extension of the consultant's role and work, as in this observation with Hannah and Asan, when discussing clinic letters:

> Hannah then turns to me and says, `That's why it's so difficult to make sure you get what each surgeon wants for each patient`. Asan states, `But Hannah does it so well. An example is if I am reading her letters it is as if I had written them myself.' – Clinical observation with Hannah and Asan

Electronic

Electronic types were common across all the cohorts in the study and were a functional part of communication in a modern hospital. The use of information technology (IT) has increased significantly in recent years and this includes the transfer of information between doctors and nurses. The use of IT was evident by all of the specialist nurses in their daily work and centred on the many hospital systems used to gather, review and collate patient information. The types of systems available included:

- Hospital Patient Administrative System (collating appointments, etc.)

- Patient records
- Pathology systems (blood tests, etc.)
- Picture Archive and Communication System (PACS)
- Audit and evaluation programmes
- Basic computer software packages (Microsoft Word, Excel and PowerPoint)

The majority of the nurses found the technology useful, as it improved communication as part of the care pathway including outside the hospital with a telemedicine system[22]. In some cases, it had reconfigured the division of labour between the hospital and the community, as outlined by Rachel discussing their telemedicine system for ulcer management:

> *Rachel says, 'I really don't know what we would do without this. It's made such a difference to the patients in terms of giving them continuity in relation to their care. It's also enabled us to help train some of the nurses in the community to look after these wounds a little bit better so the patients don't have to come into hospital.' - Clinical observation with Rachel (Surgical Specialist Nurse)*

Interestingly, in the case of the surgical specialist, their work was increasingly designed around its use and factored into the decision-making processes for managing care, as in this discussion with Rachel:

> *'[Researcher] Do you make the decision whether or not the patient should return or not?' Rachel responds, 'Yes, we decide if they come back or we could give them community treatment.' 'How?' I say. 'Well, essentially we use the telemedicine system. We can ask them to be monitored in the community and they can send us regular verbal as well as pictorial updates, but we do have some teams that we're not so sure about their skills, so we often find out which are the patients who live in*

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[22] Telemedicine is an application of clinical medicine where medical information is transferred through interactive audiovisual media for the purpose of consulting, and sometimes remote medical procedures or examinations.

and which team will be looking after them, and make a decision then about whether or not they could go back to the community for monitoring or whether we should bring them back here to be seen.' - Clinical observation with Rachel (Surgical Specialist Nurse)

In some cases they used specific technology to support and assist them, including the use of PDAs[23] to help collect data and manage patient care (see Plate 5). This was the case for Reese (Cohort One), Callie (Cohort Five), Nicky et al. (Cohort Six) and Ailsa et al. (Cohort Six, site three). These devices were carried by the nurses in their routine practice and provided an opportunity to monitor and update interventions made with the patients. Their use was made routine and became a task in itself, such as this observation with Callie:

At this point we chat to the charge nurse at the desk. Whilst we're doing this Callie uses the PDA to start to identify the patient details and what issues need to be addressed this morning by the team…The charge nurse points down towards the bottom of the unit onto the left-hand side, and says to us that there are patients down there that we need to see. - Clinical observation with Callie (Acute Pain)

This information was then downloaded to a central computer, where this would be shared with other members of the team. This information was used in many ways, including auditing the role of the nurse and care issues they found in their practice on the wards. However, not all the nurses found them helpful:

Eleanor is using the PDA, then turns to me. She points to it and says, `Do you have these?` I explain that we've had a trial of them in the past. I make a comment that technology is helpful. Then Eleanor says, `I prefer notes that you can look through, it just takes ages to go through these computer systems at times to get to the right sort of information. It

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[23] PDA – Personal Digital Assistant, also known as a palm top computer, is a mobile device that is used as an information manager. Several brands exist on the market including Palm, iPAQ, Blackberry and iPhone.

is very difficult sometimes to scan this thing.` - Clinical observation with
Eleanor (Critical Care Outreach)

Plate 5 – PDAs used by specialist nurses

Interaction

Two main forms of interaction were identified in the research, direct and indirect. Direct interaction was the most common form and was characterised by formalised discussion where issues, options and plans were openly debated between the specialist nurse and doctor. Direct approaches involved strategies to achieve the outcome, but there remained an open debate and occasional conflict. Indirect approaches occurred less frequently, but were characterised by more subtle influencing strategies, and less conflict. The findings suggested that the indirect approaches were designed to reduce potential conflict situations.

Direct

Direct approaches to interaction were the most common form. They demonstrated an open style of communication, where the nurse took the lead, and opinions were shared

openly. The nurse could direct the conversation, where they state 'I think', which centred control on their decision making to achieve the outcome, as in these examples with Ailsa (Acute Pain):

> *Ailsa then turned to him and says, `Well, I think for this chap he just needs a bit of breakthrough pain analgesia, and they've got him on regular paracetamol. I think we just need to give him something to get on top of things when it becomes a little bit too much, particularly after he's been moving around.` Doctor A then replies, `Yes, that sounds absolutely fine.` - Clinical observation with Ailsa (Acute Pain)*

In this form the nurses provided a prior explanation for the interaction as part of the process, therefore legitimising the request. However, other direct interactions with the doctor were not preceded by an explanation or rationale, as in this observation with Eileen:

> *We go through to Ivan's office and sit down where Eileen then asks him for a prescription. `Can you sign this?` and hands over the prescription sheets. `Yes,` and simply signs the prescription form. – Clinical observation with Eileen (Specialist Surgical Nurse)*

Direct interaction could also involve challenge, through a direct question to a doctor about their decision making, as highlighted by Eleanor in Critical Care Outreach:

> *James (Consultant) précis's the case. 'So we've got a 21-year-old girl who we need to operate on, who potentially may have need for an intensive care bed, so we need to plan for this.' Eleanor then states, `Well should we really be planning to do this operation without an intensive care bed?`…To which Fraser (Consultant) states that he 'entirely agrees'. – Clinical observation with Eleanor, James and Fraser (Critical Care Outreach)*

Other forms of direct interaction included conflict situations:

Ruth turns to both of them and says, `Is Damien (Consultant) coming down?` To which they both reply, `No`. She seems a little exasperated and says to both of them, `Well, she's going to need tubing.` To which the registrar responds, `No, I don't think she's very different [from when the registrar previously saw her].` `Yes she is, her respiratory is now up to 42!` Ruth shakes her head. `Come and have a look at her then … Now!` – Clinical observation with Ruth (Critical Care Outreach)

It was noted that direct interaction was not affected by seniority of the doctor, as many examples across the cohort demonstrated that this occurred through the range of medical hierarchy. The findings indicated that direct interaction, behaviour and language were based on the familiarity and previous experience with the doctors in question. Conflict and challenge was also more likely to occur with this group, and reinforced the findings of familiarity and the concept of team.

Indirect

Indirect interaction occurred less frequently, and involved significantly more influencing techniques, such as positive and negative prompts. This shares similarities with Stein's (1967) original work where interactional strategies created a pretence of unproblematic subordination, but allowed nurses to influence decision making and doctors maintain an authority position. Positive prompts highlight additional activities that could be done for the patient, leaving the decision with the doctor, as outlined in this interaction with Eleanor:

Eleanor turns to one of the doctors. 'So what's the urine output like?' The Registrar turns and says, 'Well, it's okay, but look how much sodium chloride they've given him. I've had to give him about 100mg. of frusemide.' .. Eleanor then says, 'So, do you need another [blood] gas taking?' The Reg says 'Yes, I think it would be really helpful to see if we're improving the situation with fluid management.` …`So what do you think? What about around lunchtime? Well maybe, we could do one now.' – Clinical Observation with Eleanor

And this one with Hannah:

> `I asked Arthur (Consultant) should we be banking sperm. The reason for asking was that I was genuinely unsure and it seemed like a reasonable step. Arthur disagreed and said he did not think it would be an option. However, he came back and said he would bring the patient pack and do this`. … I asked how she felt about this. `Well I got the result I was asking for by sowing the seed and persuading.` - Interview as observation with Hannah (Cancer Nurse)

Nicky highlighted the rationale for this approach in interview:

> 'I always use the technique that I've learned is, like, "And what do you think then we should do?" And then they'll say something and I'll say, "But do you think this could be done as well?" So as I've got older, I've got a little bit more...I don't react in a more heated way. I take a little step back and try and represent it in a different way now than I would have done if I was...even five years ago.' – Nicky (Critical Care Outreach), interview

Opposite to this were negative prompts, that served to highlight actions without specifying them to the doctor, as in this example where Callie who noted some minor pain medication changes that should be adjusted and opted to leave a strategically placed note for the doctor on the drug chart to signpost them:

> Callie then takes a sticky note and puts it onto the front of the drug chart just to remind the doctor to review the medication, and with further instructions to consult the main patient record where her advice is. – Clinical observation with Callie (Acute Pain)

In this case, Ailsa has been discussing the management plan of a patient in a HDU with Aarkash and reviews the plan with him, which prompts a further open question related to her ongoing management:

> Ailsa then turns round to Aarkash and says, `Have you written all this up?` He says `Yes, I've given clear instructions. Everybody knows what

we are going to be doing for her.` `So what have you written then?` He reads out a short list of things discussed including block height and the epidural working. Ailsa then turns to Aarkash. `So what do you reckon then? What next for her?` Henry (Consultant) responds, `Yeah, I think we should send her to the step down unit. Even though it's Friday they should be more than, er, capable of looking after her there. I'll get one of the registrars to go round and review her on Saturday or Sunday.` – Clinical observation with Ailsa and Aarkash (Acute Pain)

This approach, as explained by Leah, is indicative of a choice in these circumstances not to be direct or to challenge, and to maintain the status quo:

'So we quite often say well you know: "Would you like me to refer the patient to the anaesthetist? Shall I give them a ring to come and review the patient now?" and that will sometimes prompt them to look at them more closely and maybe initiate some more treatment before the anaesthetist arrives.' – Leah (Critical Care Outreach), interview

Experience and confidence clearly played a role in understanding which strategy to use in each circumstance. However, indirect approaches were context specific and were also influenced by personality and previous interactions. Although it was expected that gender would be a more prominent aspect of this influencing, Rachel was one of the only nurses who articulated the gender aspect of the strategy:

'You know, that's probably a little bit sex orientated. There's some male doctors that you know who directly challenge them or suggest, let's do this, that the answer would be no. Whereas if you go in a more roundabout way, you know, less confrontational way, you'll get a more positive response.' – Rachel (Specialist Surgical Nurse), interview

Indirect approaches are more conciliatory and project a subordinate nursing role to the doctor, although they offer challenge to medical power through a different method. In the cases highlighted, the nurses clearly have the knowledge and capability to take this approach although the triggers for this are indistinct. However, a key finding is a cognitive proaction on the part of the nurses in both direct and indirect approaches to manage the

relationship by determining a prior strategy. This supports the development and importance of the pre-game phase in power dynamics. This proactive approach, rather than a more reactive approach of the agent within the systems, supports a more independent activity and use of power in the clinical setting.

Post-game phase

There are two main processes operating in the post-game phase: outcomes and a feedback loop. As previously discussed there is a primary outcome from the interaction, which was related to the intention. However, it was also noted that there may be a number of subsidiary outcomes arising from the interaction, including personal, political and interactional such as boundary testing, developing trust and learning the rules. The feedback loop was critical as it established an interconnection with the longitudinal element of the relationship (see Figure 32 and Figure 35).

Outcomes

The outcomes of interactions were both direct and indirect. As indicated, the primary one related to the initiation requirement that is the issue of building trust. Testing this boundary also appeared in the findings as an outcome of interaction, as explained by Reese:

> *'But I still turn around and feel that I need to make sure I've got that backup and that's probably in truth, the biggest single thing that I need from the doctor at the moment. It's that particular backup to make sure that if anything goes wrong, that somebody medical has seen the patient or at least discussed the case with me.' - Reese (Urgent Care Practitioner), interview*

Reese was not isolated in his anxieties related to their role and undertaking decision in an autonomous fashion, hence the feature of decision confirmation as one of the primary intentions of interaction. Whilst this may be related to a specific clinical outcome, there are clearly secondary political and professional outcomes to this which are due to the lack of a formalised feedback system. Performance feedback from the doctors did not exist, and seeking approval was a secondary interaction outcome. Feedback on performance

was not often forthcoming in any cohort and specialist nurses expressed a desire for the feedback and would actively seek it. Interactions would provide one of the few opportunities to do this, as Hannah explains:

> Hannah said, 'I always wanted to learn and continue to learn and wanted to understand more about both how I was doing in my role and also the clinical aspects of surgical cancer.' She goes on to say that 'you get very good at a very specialist group of patients but you need to have broad base of understanding in relation to other clinical problems that are presented by patients, but it's good to get feedback from the doctors that your clinical decisions and judgements are sound…..so no feedback is the clearest indication you get that all is well.' – Interview as observation with Hannah

Feedback system

The interactions between the nurses and doctors should not be seen as isolated events. It was clear from the findings that the longitudinal basis of the relationship between them was key to developing practice through trust and collaborative working. Developing the team ethos and capability could only be achieved through repeated exposure to situations that test boundaries of knowledge, skill and power. A feedback system is therefore required for this learning to be assimilated and new schemas developed for future interactions. Whilst some of this learning was developed through negotiation and pre- and post-interaction (including structural limitations as described in previous chapters), much of this came through inter-agent interactions.

Summary of evidence

It is clear from the findings in this chapter that the interaction model between doctors and nurses is a complex mix of structure and agent behaviour. Prior experience, years of service and situational factors in clinical decision making had already been demonstrated as influential in other studies (Clark et al., 1991; McKinlay et al., 1996; Salem-Schatz et al., 1990; Watson, 1994).

Most notable here is the decision-making process required on the part of the nurse to optimise the outcome (Figure 35). This sets this research apart from the previous work in this area.
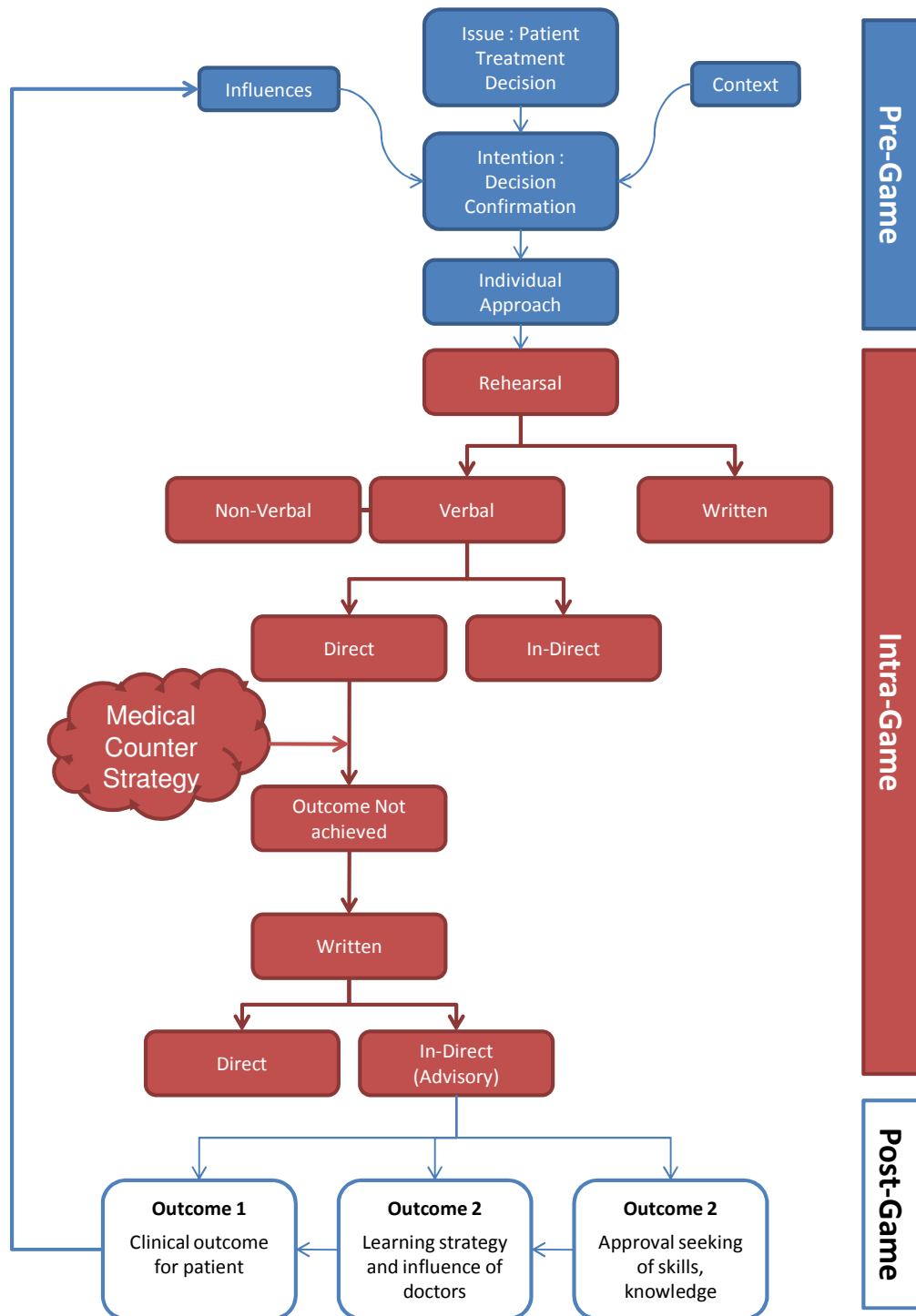
Figure 35 – Exemplar of interaction process

The implication for the interpretation of power was significant. Firstly, the nurses had, through the structures of the organisation and other agent behaviour (doctors, nurses and managers), gained an intrinsic level of power, which they used in clinical practice. This direct power was given to them by the division of labour, and as agents (through proximity) of senior doctors. This power is observed in the direct communication strategies employed by them to effect outcomes. Secondly, nurses can be direct in the power relations, due to the fact that their knowledge (though predominantly medicalised) enables them to directly challenge medical and nursing staff. Thirdly, even in those circumstances where indirect methods were employed, it displays a use of power, although maintaining the position of knowledge owner and allowing the doctor to take a lead. They, in essence, become the follower in this setting, but display a conscious decision whether or not to use overt forms of power. Finally, they also maintain their power base through the control of the system, and knowledge of the organisations. Specialist nurses use their previous nursing experience to exert their positional and professional power to navigate the complex organisational systems, relying upon networks and interaction types to deliver this. However, there appears to be a level of vulnerability on the part of the nurse in this setting, which was expressed as a personal feeling of lack of confidence and cynicism, which had also been found in ward nurses by Fulton (1997). Although professionally they had greater power than many of their colleagues, they were professionally isolated to the point that they had a requirement for approval and support which they sought through interactions.

Chapter Ten - Summative discussion

Introduction

In this chapter, the main findings of the study are discussed within the context of the research questions. The study reported here aims to enhance the current understanding of the communication and power dynamics in the relationship between doctors and advanced practice nurses in acute hospitals by:

- Exploring the creation, development and division of labour of the advanced nursing role in the contemporary healthcare setting.
- Identifying and examining the use of knowledge and development of expertise in the relationship between doctors and advanced nurses and how this is used in the clinical setting.
- Exploring power within these roles and its wider impact on clinical teams of doctors, nurses and other healthcare staff.
- Understanding how this translates into communication strategies and behaviours between professions in clinical practice.

To ensure authenticity this ethnography has represented its participants experiences by using the title 'specialist nurse', part of the spectrum of advanced practice. However, the term advanced practice will be used in the discussion, conclusion and implications of this research to maintain consistency with the literature.

Summative discussion

The aim of this chapter is to examine the evidence from the research that addresses the contemporary relationship between the specialist nurse and the doctor in the acute hospital, and the broader topic of how power is constructed in healthcare. The contemporary relationship of the specialist nurse is an interesting one for medical sociologists and has been the focus of much research. The evidence from this study adds significant contextual understanding to this body of work. It also demonstrates that

the relationship has clearly evolved from that seen in the early literature between doctors and nurses (Allen, 1997; Porter, 1991; Stein et al., 1990; Svensson, 1996). This previous work highlighted the fact that whilst nurses and doctors shared the same clinical space to transact care, they operated with different values, knowledge and expertise. This manifested itself in a set of professionalised behaviours, where the subordinate nature of the nurse was maintained and power transactions could be observed. For Porter, who led on from Stein`s work, the 'Doctor-Nurse Game' became an important sociological position to understand the power of medicine and nursing.   For some (Allen, 1997; Svensson, 1996), this was addressed from a negotiated order perspective, although the degree to which this took place was debatable. The nurses in these studies worked in traditional capacities in emergency departments, intensive care units or wards, whereas this research examined a boarder category of arenas to identify the diversity of power in the contemporary organisation of care. The period in which this work was undertaken was one where the specialist role was still emerging. This current study provides additional evidence as to the impact of this feature of nursing practice on power. In addition, it is important to stress that the methodological approach was selected to capture the dual perspective of power between doctors and nurses in this research and thus provide the additional medical view left untouched by other published work. This would also provide the opportunity to 'close the gap' of two main issues (Giddens, 1986). Firstly, the dual perspective of the agents within the system. Secondly, bridging the debate on power between structure and agency. Creating a duality would also set out the perspective of power between doctors and nurses within a new framework that examined the spectrum of interactions.   The interactions were a visible form of power dynamics and were recorded, reviewed and synthesised into this thesis. What this research highlights is that the role of the specialist nurse is constructed differently by doctors, administrators and the nurses themselves. The findings clearly demonstrate a change in the professional power of the advanced practice nurse and that of the doctor.   The increasing power of the specialist nurse has come through structural influences on the role in the field of nursing, as well as individual agent approaches to organising care in the hospital. Central to this is the use of knowledge and the development of expertise - whilst acknowledging that for the advanced practice nurse this has been adapted from biomedical origins. In addition, the research has demonstrated that power of medicine has also changed markedly. Structural reforms have seen the medical profession realign its power through the bureaucratic mechanism of neo-corporate NHS structures.

Aligning this framework with a single sociological position is fraught with challenges, which reach the heart of the sociological dilemma of the structure agency debate. The work of Lukes (2005), whilst informative, does not fully represent the findings in this study. However, the postmodernist perspective of Foucault and the post-structuralist view of Bourdieu offer an opportunity to present the relationship and its wider sociological implications. Lukes' third face of power readily addressed a number of issues from previous power theories, and understood power in terms of its productive/positive force and its implications for the collective of individual agents. The social form of power was reflected in Foucault's view that power 'connected clusters of relationships' with the use of knowledge. However, neither adequately addressed the interconnectedness of the agents or structures of the workplace. Bourdieu set out in his theory of practice that the combination of Capital (in all its forms), Habitus and Field would bridge this gap. This chapter sets out to examine power between the advanced practice nurse and the doctor through the lens of this theorist.

Construction of the field of doctor-nurse power

There are several aspects of power differential within these findings that have their origins in the structures created and operated in by the agents. It is evident that there are multiple layers of power and, therefore, games within them. Hospitals are a distinct subset of healthcare culture and fill an important part of the social space of the NHS. Within hospitals there are a number of fields in which doctors and nurses operate.

Lukes' (2005) view of power is that it is both dynamic and positional - reflecting the case of the nurse-doctor interactions. It was evident that power was not a fixed and finite source and the researcher therefore rejected the first and second faces of power (Bachrach & Baratz, 1962; Dahl, 1957). The findings of this research suggest that power was a tangible commodity that could be traded, developed and enhanced by the professionalised agents in the hospital field. It was clear that the advanced practice nurses had an intrinsic level of power within their role which was in part devolved to them through their proximity to the medical system (Figure 36 on page 245).

Similarly, Fulton (1997) recognised the intrinsic power in ward nurses, but recognised that the influence of medicine was significant. Independence also proved to be important as this was granted as part of a process whereby the advanced practice nurse is recruited,

trained and observed in practice by doctors. In many cases, the nurse was sought out and 'separated from the herd' for a perceived difference in approach, skill or knowledge which was valued by the doctors. As reflected by Rabani (Anaesthetic Registrar) and Ivan (Consultant), 'getting back the team structure' and the values, attributes and power this previously reflected within their own profession was an important consideration (page 142). Junior doctors were sidelined following the structural reforms that changed the 'medical firm' structure. (This loss is important to the symbolic capital and prestige of the hospital medical role, and is discussed later in the chapter.) Advanced practice nurses were also trained as an apprentice in the ways of the doctors they 'worked for' to ensure continuity and oversight of 'the medical' system through a nursing paradigm. For the advanced practice nurse, this provided a referent power source that has resonance with the referent typology of power described by French & Raven (1959). However, power and control of entry into the role was managed by the medical staff through an understanding of both the capital of the nurse, doctor and the organisations' habitus. The trajectory for the advanced practice nurse in the accumulation of capital and symbolic power was partly developed through the recruitment and selection process. This process moulded and shaped their capital into a form that was recognisable by both professions, and valued by doctors because it shared many similarities with their own selection, apprenticeship and training.
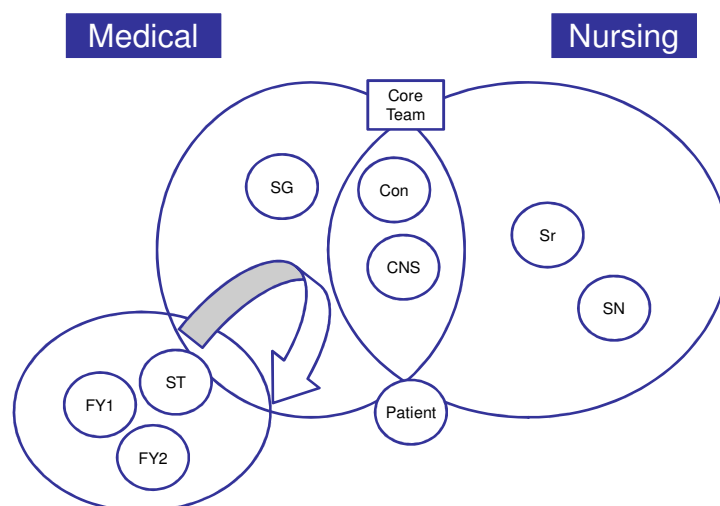
Figure 36 - Contemporary organisation of care in acute hospitals

A key reference point must be the 'topographical position' (Porter, 1991) of the doctor, non-specialist nurse, advanced practice nurse and patient (see Figure 36). The findings indicated that the non-specialist nurse's capital was patently different from that of the doctor and advanced practice nurse – which was reflected in their organisational and professional power. The non-specialist nurse has moved further away from daily contact and interaction with the doctors as the advanced practice nurses took a greater role in care. The non-specialist nurses` 'invisibility' during interactions over their patients (Winona, page 166) and the nurses 'running away' (Eloise, page 145) when the advanced practice nurse arrived highlights three fundamental issues. Firstly, that a key driver for the nursing profession of the advanced and advanced practice role was 'advancing the profession' (Woods, 1998; Woods, 2002). The findings indicate that this appears to be at the expense of core nursing in terms of skills, knowledge and power. This creates horizontal dissonance between them and their nursing colleagues as identified in the findings where there were overt examples such as not helping in clinic, or covert ones such as not completing tasks set by the advanced practice nurses. Secondly, as highlighted by Isobel, 'still being a nurse' and projecting a nursing focus in their language and symbols juxtaposed their accumulation of biomedical knowledge (medical capital) and suggested to the participants that this division of labour moved them away from its core values (page 182). The perceived 'best' of the non-specialist nurses are recruited by doctors and are invested in, in terms of time and resources (in a biomedical framework), reflecting a further devaluing of nursing capital. Thirdly, the organisation of care in the contemporary hospital has reformed some of the gendered hierarchical systems and behaviours in the context of specialist practice between doctors and nurses. This creates a paradox for advanced practice nurses where organisational and professional power is achieved through: the accumulation of medical capital, devaluing core nursing, rejection by their own profession and a new form of gendered hierarchy. To continue this direction will increase their power (although not challenging the medical dominant position) but lose touch with nursing.

It was also clear that the 'flow' of power (Lukes) or nebulous nature of power (Foucault) in the hospital field was ultimately managed by several agents in the system including doctors, nurses, managers, administrative staff, etc. This was noted by Rachel who highlighted that there were many non-clinical agents who were able to influence the advanced practice nursing role where 'they [the managers] wanted us to do … the work of other people'. Each agent had their own interpretation and gauge of power and how it

may be used - which had both positive and negative forms. Power was a visible and productive force in the field that created and reinforced the social structures that employed the nurses and doctors.

Advanced practice nurses in this study were often bound in service to hospitals in terms of their role and function within the social space of their community and families. As parents, spouses and partners they were valued because they stayed within the locality alongside the consultant to provide service rather than move on and progress their own careers, as in the case of doctors. This has particular resonance with Gamarnikow's (1978) view of a patriarchal system in which the role of the nurse and mother/wife were not separated, leading to a gender division of labour with its traditional bond created between them. As suggested by Hayward & Lukes (2008), if the limits and rules of the operating system are structurally determined in their day-to-day work, it will ultimately shape their actions within the field. In this study, the bond through work also developed into a mutual trust and respect between the two professions. However, unlike the negotiated order perspectives (Allen, 1997; Svensson, 1996), this did not ultimately settle into a pattern of behaviour determined by different professional, geographic and knowledge domains. It was more dynamic and characterised by a polarity of observable power behaviours from the collegiate group working on the one hand, to the tensions and conflicts that arise in the field on the other. Time, shaped through shared experience, was a critical component in the development of power between these agents in the system. Structural influences of the doctor-nurse relationship were significant, and will be discussed in more detail later in the chapter.

Professional power of nursing and medicine

Medical power was fluid and dynamic although dominant in the sense that the profession maintained a general veto of the powers of others and this included advanced practice nurses. The evidence demonstrates that doctors still remain in the central clinical power position within organisations even though they are challenged and controlled in their practice through administrators and policy makers/the State. In controlling medical power it is evident that during the research three main influences were at work: policy shifts, technical challenges and the erosion of the societal position of medicine. Firstly, the policy drivers challenged the dominant medical position through contractual changes with a focus on productivity and clinical outcomes (O'Connor & Neumann, 2006). Secondly,

specific workforce developments of nursing, midwives, scientists and other allied health professions challenged traditional practice areas of medicine (Department of Health, 1997; Department of Health, 1999b; Department of Health, 2000b; Department of Health, 2002; Department of Health, 2003; Department of Health, 2004b; Department of Health, 2005a,b; Department of Health, 2006a,b). The findings highlight this where the advanced practice nurses had taken on roles in physical examination, diagnostic interpretation, treatment and discharge (Table 13 on page 191). Stevens (2004) called these 'tectonic shifts' in health policy where a reformist strategy by the NHS gave particular focus on challenging medical dominance. Thirdly, the position of medicine in society had been challenged on a number of fronts. In the UK this had occurred most notably in the Bristol Enquiry in 2001 (Department of Health, 2001c) and the conviction of Dr Harold Shipman, which brought into stark relief the monopolistic and often contradictory regulation of medical practice in the UK. However, this is a view that is supported internationally (Lupton, 1997; McKinlay & Marceau, 2002), and is not unique to the UK.

The following sections will discuss the challenge to medical power in the NHS from a Bourdian perspective. Nurses` organisational power is noted in the findings and is set by a number of factors. Structurally, the role of the nurse had been a source of significant focus by policymakers. This set out a process by which advanced practice nursing models could flourish and develop. Interestingly, the drive for this came from an economic urgency and rebadged the work of the nurse in the same productive capacity of that of the doctor. Although the State separated the remuneration approach between the professions, it clearly aligned healthwork with productivity and economic capital. The hospitals in the study were well-established NHS institutions which had individual 'professional identities'. These identities related to the clinical culture of medical and nursing leadership which influenced the model of doctor-nurse interactions. Historically, nursing leadership was a position in the hierarchy often subordinate to male hospital boards (Helmstadter, 2008). The introduction of hospital Trusts placed executive nurses on the board with the capability to influence organisational strategy and culture. However, evidence suggests that the strength of this leadership was dependent on making their voice heard on medical-dominated boards (Weinberg, 2004). Critically in this research, doctors could determine the amount of power other agents had in the clinical model through structural controls of their role within the bureaucratic organisations of the hospital, a view supported by Freidson (2000). These structural elements are vitally important as they provide system-wide control and direction. However, advanced practice nurses were influential in their organisations and often commanded a level of

respect and authority in the nursing, medicine and bureaucratic hierarchies for the roles they performed and the outcomes they achieved. The findings indicated that advanced practice nurses achieved improved clinical outcomes for patients, improved access to services and a range of hospital performance metrics such as the '4 hour target' (Department of Health, 2001b), cancer waits and treatment times. This reinforced the economic productive capacity of the advanced practice nursing role as it aligned their work to the performance of the organisation, income and clinical care. They maintained a position within the hospital field which was different in terms of the social space they occupied and the power they had compared with their nursing colleagues on the ward. They operated at the boundary of medical and nursing work.

Hospital field, physical space, surveillance and power

The findings from this research highlight an important perspective of power only partly addressed in the previous work of Stein (1967, 1990), Allen (1997), Svenson (1996) and Hughes (1988) in that the use of, allocation and management of physical space in the field was an expression of power. This section will discuss the findings in the context of the following main themes. Firstly, that space was determined by a disease label that the nurses follow for their consultants, and a range of tools have been developed to control and oversee this process. Secondly, there is a public and private space within which they operate, which determines the interaction approach taken by the advanced practice nurses. Thirdly, as Kearns & Joseph (1993) identify, 'space is socially constructed and a physical entity' and is an important issue to understand in the context of healthwork. The findings of this research support the contention that the advanced practice nurse space/power dynamic is controlled and managed by many agents within and by the organisational system. The physicality of the space leads to an interesting debate on the influence this has on the genesis, power and cohesion of teams within the hospital setting.

The evidence from this research supports the view that space used in hospitals is an important representation of power. Bourdieu (1984,1989) highlights that space is both a physical and social construct that is linked to forms of capital used by agents. The differential allocation of physical space between the doctor and advanced practice nurse highlights the power differences between the two professions and defines a form of economic capital and the accumulation of assets in the hospital (Figure 37).

The social construction of space in hospitals is an important distinction created and supported by the attempt to separate and define medical symbolic capital. Prior (1988) highlighted the fact and states:

'Hospital plans are essentially archaeological records which encapsulate and imprison themselves within the genealogy of medical knowledge.' – *Prior (1988), page 93.*
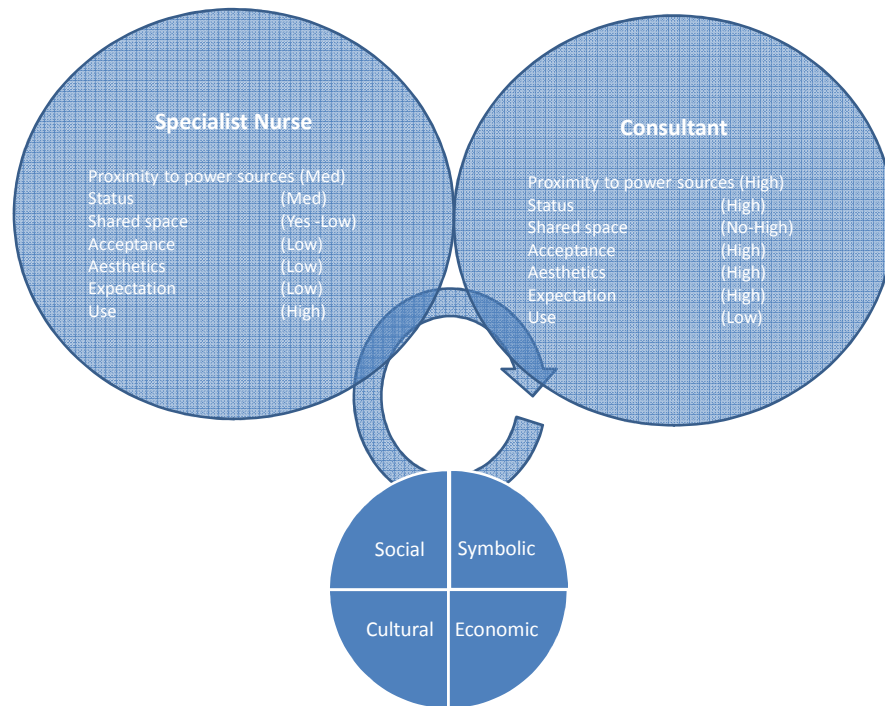
Figure 37 - Construction of space as an expression of power and cultural capital

The modern reality of hospital design supports the continued focus on the disease-defining pathway of the biomedical model and the construction of therapeutic practices of doctors. The findings highlight that the role of the advanced practice nurse is entwined within this space as a controller, supervisor and mediator for the doctor, manifested in their continued role in nursing the room. This was evident in those advanced practice nurses who 'worked for' consultants in clinics taking over the complete management of their patients, whilst the doctors maintained control through the division of labour and oversight of their interventions through traditional and technological means.

The findings highlight the continued separation of space within the hospital field even in the supposed modern designs seen in the research sites. Patients were separated from the clinical field and corralled into spatial design that continued to perpetuate the division

of power. These clinical environments were benign settings despite attempts to bridge the gap between the patient and the professional through therapeutic hospital design (Gesler et al., 2004). However, it is the professionals who are involved in the design rather than the patients (Gesler et al., 2004; Mroczek et al., 2005) and thus reproduce the same systems to see and know the patient, as in Foucault's portrait of the Panopticon. The link between the physical space in the field, organisation of care, and medical knowledge is intriguing and one that Foucault (1975, 1977) explored in detail as a vehicle to demonstrate that by knowing the patient through observation, power was exacted over them. This research pinpointed that the physical design of the hospital is overlaid with biomedical pathways of care that are 'process mapped' to harmonise the journey efficiency and to ensure that the patient gets the least contact with the doctor. The advanced practice surgical and cancer nurses` roles were designed around their ability to take emotional, uninteresting or routinised workload off doctors. This process was described as 'value added' through the language of the industrial redesign techniques adopted in the contemporary healthcare system (Elf et al., 2007; Grove et al., 2010; Waring et al., 2010) where value was placed upon the role of the doctor. This continued to support the power of the medical profession in the decision making of patients` lives and histories. The use of industrial design and the creation of the patient as a productive component on the healthcare assembly line exemplify the objectification of the body to be seen, understood and gazed upon. The efficiency in the assembly line is monitored by the new workers, the advanced practice nurses, who have applied the technology of managing care through IT, which has further expanded the role of the 'Medical Gaze'. Medical gaze was identified in the technical apparatus of clinical practice (PDAs, telemedicine) used by advanced practice nurses as in the case of Reese (Cohort One), Callie (Cohort Five), Nicky et al. (Cohort Six) and Ailsa et al. (Cohort Seven). Medical documentation efficiently archives this personal history with the application of telemedicine, digital photos and information technology, providing an opportunity to visualise the personal histories and the recovery, decline and death of the patient. As Foucault describes:

> 'It is an important mechanism, for it automatizes and disindividualizes power. Power has its principle not so much in a person as in a certain concerted distribution of bodies, surfaces, lights, gazes; in an arrangement whose internal mechanisms produce the relation in which individuals are caught up. The ceremonies, the rituals, the marks by which the sovereign's surplus power was manifested are useless. There

> is machinery that assures dissymmetry, disequilibrium, difference. Consequently, it does not matter who exercises power. Any individual, taken almost at random, can operate the machine: in the absence of the director', - Foucault (1977), pages 470-471

The advanced practice nurses provide the new surveillance of medicine in the clinical field, a view shared by Henderson (1994) and Tjora (2000). The consultants remained distant and powerful in determining the course of patient treatment through the application of the constraints of protocol and procedure that was adhered to by the nurses and identified in the artefacts (policy, procedure and job descriptions). The modern panopticon can be found in the hands of the nurses as PDAs and other devices of control supporting the technical mediation of the nursing medical boundary. Previous work (Allen, 1998) highlights that nursing information was routinely guarded and controlled by nurses. The differences in the collection and management of patient histories were where a distinction could be made between nursing and medicine. This was seen as a central component of the nursing history and signified ownership of the space (clinical and physical) of the ward. Medical notes were disease and outcome focused, providing an opportunity for controlled handover of information from one doctor to the next. However, the advanced practice nurse had to work across this divide and still retain a different style of communication. Their style was interlaced with gendered descriptions of emotional feelings and integral with the public projection of the profession and distinction between the professions, as described by Ivan (Consultant) who commented, 'I'm presenting myself as I think a consultant should present themselves'. The advanced practice nurses have reframed their practice which has resulted in a medicalisation of their work, through assessment, diagnosis and treatment within the biomedical framework. The language and artefacts of the advanced practice nurse demonstrate a willingness to accept this and its accompanying power, through the symbolic and cultural capital of medicine. As Adel (Junior Doctor) notes, the power distinction between themselves and the advanced practice nurses is manifested in a process where they recognise their position by 'suggesting' treatment changes which are at the discretion of the doctor to follow or enact a 'medical veto'.

Foucault (1975) highlights that primary and secondary spacialisation centres on the body of the patient, as medicine classifies and constructs illness in terms of symptoms of disease. However, there is resistance, though privately expressed, in relation to the progress of the nursing profession down this path. Advanced practice nurses saw

themselves as nurses still adhering and ministering to their vocational perspective of service and duty to the patient, through the expression of empathy and compassion. They achieved this through the management of time with the patient but by doing so, they were still seen as nurses by the doctors and the division of labour still had a distinct patriarchal and gender component. In the case of the advanced practice nurse, it is seen that the value of femininity is represented in the classification of their 'nursing' behaviours to patients, through knowledge and artefacts such as uniforms and other symbols of their role. The findings intimate that if you stand in a room of advanced practice nurses and junior doctors, who share much in terms of knowledge and skills, you will spot the nurse easily. The social identity of the advanced practice nurse in the hospital field was a complex mix of modern societal expectations of the category women with a career, education, commitments and service, a view that Bartky (1988) identifies as a Foucauldian perspective of gender which is characterised in the forms of control placed upon the feminine, both physically and in terms of attributes, behaviours and symbols.

It was noted that a multitude of strategies were used by the advanced practice nurses and doctors in their interactions and these were influenced by the social space and the field and occurred in two parts. Firstly, the advanced practice nurse and doctor presented a public self that was distinct and separate in its forms – doctor/nurse – masculine/feminine, which related to the perceived power and authority in certain circumstances. This reflects Bourdieu's (1989) notion of the objective presentation which aims to define to the audience the power and authority of the group. The interesting perspective was that the advanced practice nurses were complicit in supporting the behaviour in public when amongst other nurses and junior doctors. In addition, the advanced practice nurses and doctors adapted the space for the purposes of transaction - the most overt example in the study being the professionalisation of the space to exert power and authority. This critical finding also identifies the individual strategies that advanced practice nurses and doctors employ to present themselves and manipulate/transform the categories of other perceptions of them in the hospital field. In addition, the professionalisation of space to transact care required not only individual agent strategies, shared history and habitus, but wider structural acceptance in the field as it was exhibited on all the sites.

The advanced practice nurses` position, hierarchically and spatially, is a representation of their power. Their role as an individual and within the wider social groups of medicine and nursing highlights some interesting sociological issues. Firstly, the evidence identifies that the perspective of advanced practice nursing as neither belonging to medicine nor to

nursing through the division of labour or the allocation of capital, influences their position within the organisation. Further to this was the tension created in the role of advanced practice nurses as they navigated the complex topography of the social space and field of the hospital. The interactions and 'games' deriving from this suggest a consciousness on the part of both doctor and nurse and an explicit understanding of power. Bourdieu (1985) suggests that a consciousness of position on the part of the agent is borne through their position and accumulation of capital and this is particularly evident in those who sit between poles of power in middle-order positions, a view that was similarly expressed by Mechanic (1962) and Goffman (1990), where 'knowing one's place' is also seen as a presentation to the hospital and with it come a range of expected and agreed behaviours. However, this is not a fixed position as in the case of the advanced practice nurse and junior doctor where both were able to advance their position through accumulation of capital, use of space, resources and representation of their cultural tastes. In *Distinctions,* Bourdieu linked the capital composition of the agents providing an insight into the prevailing 'tastes' of the social space in which they operate. Critically, Bourdieu (1984) highlights that capital is multidimensional, providing an opportunity to map these constructs and their trajectories. The mapping of space and resource for the advanced practice nurse provides an insight into the construction of their power (Figure 38).
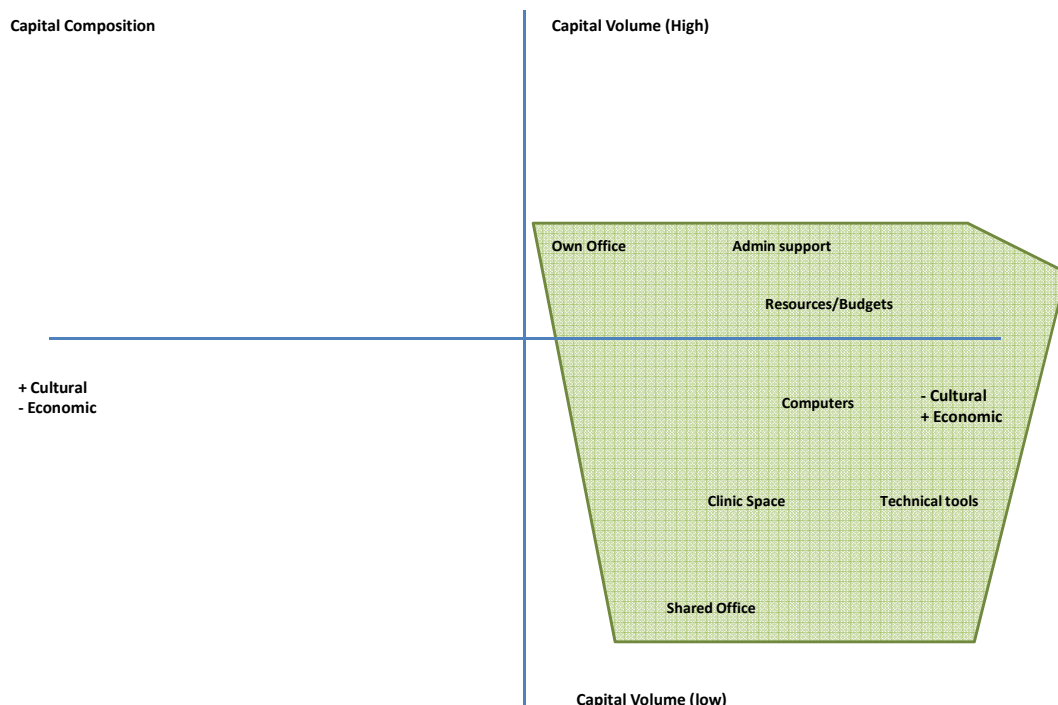
Figure 38 – Cultural composition of space and power for the advanced practice nurse.

As indicated in the findings, the allocation of resources and accrued capital has different economic and cultural significance to other agents in the hospital field. There are agents who distribute resources according to the advanced practice nurses` relative power to doctors and the majority who make judgements on the relative values of each resource. Within this resource evaluation and judgement is a link to the cultural composition and power of the advanced practice nurse. For example, Hannah's discourse on the allocation of clinic rooms, administrative support and distribution of typing identified an observable form of power game in the distribution of capital to her and her relative cultural composition to the doctors. The importance of this is twofold: Firstly, that the agents` actions (doctor, nurse, secretary, manager, etc.) are representations of themselves and their cultural tastes which contribute to the social structures that support the field. Secondly, that social structures and the power relations are socially constructed and that space, cultural capital and power are intrinsically linked.

Forms of capital in nurse-doctor interactions

Capital is used by the agents in their field of practice to maximise their position, in which power is the direct consequence of the interactions (Bourdieu, 1993a). The collection and accumulation of capital by the professions in all its forms (economic, social, cultural and symbolic) is an important aspect of power within the professions found in this study. The findings in this study identify that advanced practice nurses' power is intrinsically linked to the dimensions of their capital and is highlighted in Figure 39 on page 256.

Social capital existed in two distinct forms - individual and collective. The advanced practice nurses in this study had individual social capital in the broad complex networks they developed to function in their role. To do this, they were required to build new networks outside their traditional professional group of non-specialist nurses. The extent of their networks and connectedness within the fields of nursing, medicine and administration was extensive. Their expertise in navigating the complex organisational systems within the field was crucial in developing and embedding them in the reconstructed medical teams and was a valuable form of capital. The experiential knowledge and expertise they displayed bought them power and position within the team, at times at the expense of other agents, namely the junior doctors. Junior doctors for their part could rarely achieve this level of social capital due to their transitory nature within the

team. As a result, the advanced practice nurses had to negotiate the complex boundaries that were created between them, the consultants and junior doctors. This created a number of conflict scenarios between the two groups. In addition to this, they also possessed the advantage of 'continuity and longevity' within the team structure that further supported their role and power. The advanced practice nurses became important to the organisation and doctors for the role they performed in the system, and as part of the system – a finding supported by Woods (1998). They became indispensible, as neither junior doctors nor other nurses could replace them in this role thus supporting the existence of their social capital. To achieve this level of individual social capital required a significant investment in time and energy on the part of the nurse. The findings indicate that nurses 'played the long game' in building the networks, as Bourdieu (1986) wrote:

> 'The network of relationships is the product of the investment strategies, individual and collective, consciously or unconsciously aimed at establishing or reproducing social relationships that are directly usable.' - Bourdieu (1986), page 246
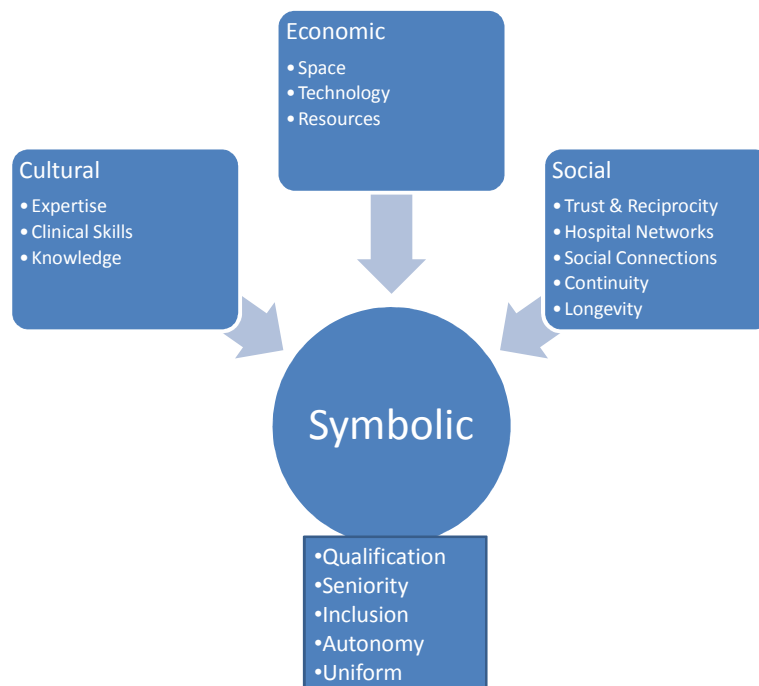
Figure 39 - Dimensions of advanced practice nurses` capital

The individual and collective social capital of advanced practice nurses and doctors

As highlighted in Chapter Nine, the findings indicate that the advanced practice nurse developed a complex range of strategies to determine the optimal approach for interaction to achieve the desired outcomes. Critically these strategies were often decided upon based on personal as well as group impact which ultimately reinforced boundaries and advantage. When coupling this with the longevity of the relationship and the implications for power, it explains the process by which the advanced practice nurse accrued social capital. This was achieved by their choices of where to make investments following analysis of its relative benefit to them and the team. The multiple approach styles employed by the agents including the 'proxy' method by Isobel and Robyn (page 222) evidence this. This came through individual learning and experience, as well as knowledge gained from others in the group or profession in the form of habitus. Key to this was the level of trust given to the advanced practice nurses by the doctors and highlighted by Robyn, Reese, Liam, Nicky and Eloise on page 154. The reciprocal nature of the trust between them indicated that a collective form of social capital existed. Coleman (1990) highlighted that trust and common team value were important parts of collective social capital, which existed in the central domain of the clinical teams in this study. Trust, shared values and beliefs were evident in overt and public forms within the teams although the nurses privately expressed frustrations about doctors` behaviours. This does provide a sense that the two professions protected their accumulated collective social capital. The culture of the team was a significant factor and mirrors work in other areas (Adams et al., 2000; Gifford et al., 2002; Ma et al., 2003; Rosenstein, 2002; Shader et al., 2001). The issue of team identity and loyalty was found to be of prime importance, a finding supported by McDonald (2005a). The trust that forms between the two professions opens the possibility of influence and is discussed in Chapter Nine.

The findings highlight that advanced practice nurses understood that position and authority was granted on their proximity to senior doctors. This created a dichotomous position for the advanced practice nurse where conflict occurred with junior doctors (and others) whilst they supported them in practice. The advanced practice nurse employed strategies to maintain this position and these are discussed in more detail later in the chapter. Likewise, the findings demonstrate that senior doctors became reliant on the

advanced practice nurse to deliver the service in light of changes to junior support to the 'medical firm'. They afforded them protection from overt conflict from junior doctors and others in the hospital such as administrators and senior nurses.

Cultural capital in the institutionalised state, such as formal qualifications, is an important issue. The advanced practice nurse required a level of qualification prior to entry. Their roles as advanced practitioners were influenced by the nursing profession's expectation of advanced practice nursing capital with a drive to Masters level qualification, which would legitimise their role as experts (Manley, 1997). The artefact analysis related to the division of labour (page 182 to 184) highlights this driver towards the academic qualification of the role and its biomedical focus. There was much resistance to this, on the part of the advanced practice nurse who focused on developing expertise through experiential learning and eschewing academia, unless for 'bettering the person' or for terms and conditions. The doctors for their part became 'sponsors' of the nurses as they would a protégé, and supported them through training which focused on aspects of medicalised practice in the shape of history taking, examination, diagnosis and treatment. Reese and Ora (page 146) discussed how entry into the advanced practice nursing role through encouragement by doctors led to further supportive training and social capital. The combination of support, input and the development of trust as outlined in the previous section was a powerful influence on the bond between the teams. This presented a dynamic where the use of power in its transformative capacity created a dependency that mirrored patriarchal relationship outlined by Gamarnikow (1978, 1991). This process reinforced the gendered dynamic through the continued subordination of the nursing role to medicine, although characteristically different from traditional forms seen in the literature (Stein et al., 1990; Stein, 1967), yet it shared a number of similarities with the historical medical control of selection, entry, teaching and practice of nurses (Helmstadter, 2008).

The development of institutionalised capital poses some interesting challenges, as it develops the embodied state of cultural capital. Bourdieu postulated that the embodied state cannot be delegated, as it is gained through investment both in time and resources. In the case of the advanced practice nurse, it is achieved through apprentice-style training, formalised postgraduate qualifications and social capital of the team network. The most intriguing aspect of this adoption of medical capital is the notion that the nurses use this to provide service to the patient and *also to* the doctor. This bi-lateral arrangement indicates a transactional quality to capital and, as the findings suggest, it is

assimilated into advanced practice nursing through delegation. The four forms of delegation (Redundant, Technical, Adapted and Professional) required a significant degree of medical capital to function - such as technical tasks that required higher biomedical knowledge. It is interesting to note that the delegation typology developed from the findings on page 204 was linked by Arun (Associate Specialist) to the themes of trust and longevity of service. However, the advanced practice nurses are seen and see themselves as nurses first, with the learnt biomedical capital of medicine. The findings indicate that advanced practice nurses have, in many ways, adopted and adapted elements of cultural capital from medicine for their own power, namely diagnosis and treatment. Curing is a greater currency than caring in a contemporary consumerist system of health and so the skills that are required are learnt and developed to this end (Radcliffe, 2000). As Liam (Consultant) identified (page 192), this had led to the development of the advanced practice nurse, and as Ivan suggested, the link to the 'boundaries (between medicine and nursing) have become increasingly blurred' (page 200).

Whilst it is legitimised as a service to the patient, biomedical knowledge is a vehicle to power and this is referenced in the changes seen in the power of advanced practice nurses in comparison with the junior doctor. However, this power does not extend to the most senior doctors, the consultants, where the aspect of service is retained through the advanced practice nurses` description of 'working for' rather than 'with' (as described by Hannah and the surgical specialist nurses). This reinforces their position and power within the field. This is coupled with the development of expertise on the part of the advanced practice nurse, which is constructed and delineated separately from medical expertise by descriptions of their knowledge depth and breadth. Medicine constructs advanced practice nurse knowledge as a continuum of medical expertise of a lower order, more narrow, focused, limited and confined to the pathway of disease and division of labour. Skills and knowledge required are passed from doctor to advanced practice nurse through the apprentice system and creates a controlling form of power to their function in the field. This is reinforced through the field by the systematic policies of the medicalised bureaucratic organisation, further limiting their autonomy outside the bounds of medical agreement.

Objectified capital of the doctor is manifested in the materiality of aspects of their role, namely knowledge and the skills to cure, and further highlights the power position of the advanced practice nurse. To determine its impact on power, Bourdian capital

composition is a helpful theoretical schema in determining the relative value of these forms and implications for power (Figure 40). The capital composition map highlights four main dimensions, one of which (space and resources - green) has been discussed earlier. Nursing capital (purple) has lower capital volume and less intrinsic value to the role for both doctors and advanced practice nurses. Medicalised capital (red) has higher cultural volume and greater economic value as its 'mastery' provides opportunity for better pay and influence. Of great cultural and capital importance to both professions are those aspects of the role which provide the continuity and support to the team and the organisation (blue).
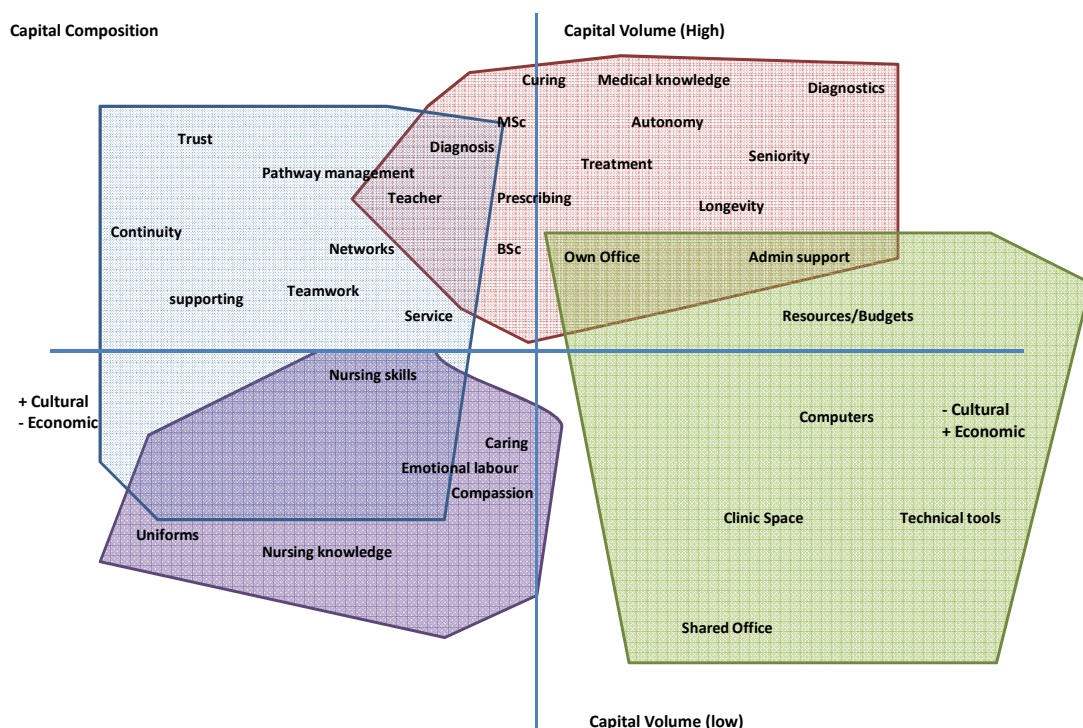
Figure 40 - Capital composition of advanced practice nurses` skills, knowledge and attributes

The findings also highlight that the role of the advanced practice nurse attempts to define itself by 'being all things to all people'. The value placed by the consultants in reconstructing the medical firm is supported through high capital trust and support, which have intrinsic power currency within the field. The advanced practice nurse has to retain some nursing credibility to access and use the networks that ensure they control and

manage the system of care on behalf of the consultants. However, they have taken on medical knowledge and practices which have higher status in the social space, which provides additional power, but also provides challenges and conflict (symbolic violence) with those junior doctors who are also establishing their own cultural capital. These findings also provided an interesting departure from Bourdieu's view of the capital trajectory which would see an evolution of 'taste' leaving behind some aspects of the previous role. However, the advanced practice nurse occupies a place where their skills of nursing continued to be used in their new role, but largely not valued (by others) as a resource of cultural capital.

The findings indicate that the advanced practice nurse has, either by proxy or by individual accumulation, elements of embodied medical capital and retained elements of nursing capital for use in the field. As Bourdieu (1986) highlights, this can lead to struggles in which the agents wield their strength to gain a mastery of objectified capital. The struggle for advanced practice nurses is the power and authority to treat patients autonomously without the influence of doctors. Working autonomously was a key aspect of practice for the nurses in this study, as Rachel highlighted that 'people were not breathing down your neck all the time', although practically meant working independently from direct medical supervision. Although the advanced practice nurses were not directly supervised in practice, the power of medicine over the agents in the system was conditional on compliance with the rules of practice determined by doctors at an individual and collective level. The artefact analysis and observational findings indicate that the advanced practice nurse was required to retain aspects of the nursing role such as service, emotional labour and nursing knowledge, as highlighted in the cultural composition in Figure 40. Conflict and resistance were observed between advanced practice nurses and doctors although this was not often with those they had shared social capital and a co-dependent power relationship. The findings indicate that conflict was often orchestrated on the behalf of consultants during the care of patients with which they and the doctors had a vested interest. These reinforce concepts of team membership and are overt displays of loyalty and surveillance. It was noticeable that indirect methods of communication and influence were often reserved where there was a requirement to maintain the balance of power. Nicky and Leah's (page 235) interviews articulated the rationale for this where the role of the advanced practice nurse was to be subordinate.

Cultural capital and social class of advanced practice nurses and doctors

The findings of this study identify that culturally, whilst the nurses and doctors share similar space and fields, they are socially (using the term in the sense of Bourdieu's tastes) radically different, and this becomes an important aspect of social stratification and power differential between the two professions. The issue of social stratification is fundamental to the concept of power which Bourdieu highlighted through his own empirical examples in the classroom (Bourdieu & Passeron, 1977; Bourdieu & Passeron, 1979). To operate in the field of medical practice, the advanced practice nurse seeks out the credentials in the form of knowledge, competency and qualifications. In addition, they must learn the cultural language, nuances of behaviour and rules to work with doctors. Simply, they must learn the cultural capital of the dominant class. It is the adaptation of cultural capital for the purposes of work. From the findings of this research two main issues can be drawn: Firstly, that there is still a degree of separation between the culture of the nurse and that of the doctor. Socially and economically, they operate in very different cultural worlds reinforcing the works of Denny (1999) and Gamarnikow (1978, 1991) who agreed that social class evoked an important distinction between the professions. Secondly, the cultural capital of nursing prior to specialisation enabled transition to the role of the advanced practice nurse but with two main drawbacks: insufficient capital for admission/acceptance into the medical field and also a rejection from their previous nursing field.

The findings emphasise that advanced practice nurses have a number of challenges in their role and this includes a lack of professional affiliation which led to the feelings of professional and personal isolation, identified in other studies (Bousfield, 1997; Mills et al., 2002; Retsas, 2000). This is common amongst agents who occupy the space between two poles of established power (Mechanic, 1962) which leads to a 'gravitational pull' of power. As indicated previously, this created an internal crisis of representation for the advanced practice nurse. Advanced practice nurses perceive themselves as nurses who came with the expected professional behaviours accrued through previous experience as a non-specialist nurse. On the one hand they are required to be leaders of clinical care and this has been achieved – on the other, sociologically they must also remain subordinate to medicine as a follower. In many situations the latter is reinforced through the hierarchies of professionalised and gendered organisations as well as by wider social perception. The findings support the perspective of Bourdieu, in that, whilst cultural

competencies of the dominant class can be learned, it is very difficult to have the natural familiarity of those who are brought up within it. The issue of medical socialisation is important in that it reinforces the social as well as clinical hierarchy/stratification systems. This is evident in the findings of this work, where the dominant position of medicine within the organisations permeated through the behaviours of doctors. Examples of this were identified including the division of labour, reinforcing both the emotional context of their role, the gender specificity of nursing work and the medical veto in clinical practice. This dominant position is created early in the career of doctors with the social expectation of their authority role prior to entry reinforced further through education (Hean et al., 2006; Rudland & Mires, 2005). Genderisation of the role of the nurse is not a new phenomenon, as previously discussed by Gamarnikow (1978, 1991). A similar genderisation of medicine exists, where career choices (and success) of doctors are affected by their gender (Martin et al., 1988; Miller et al., 2008; Sanfey et al., 2006). It would be natural to assume that this would occur in traditional or patriarchal societies although this has been observed in more equality-based social systems such as Scandinavian (Hamberg et al., 2006; Johansson & Hamberg, 2007; Risberg et al., 2003).

As previously discussed, Bourdieu indicated that cultural capital formed 'tastes' which were also an expression of power with agents. The findings of this research indicate that the consultant had a number of strong cultural signals: for example, the ownership of clinical space, luxury cars, prominent car parking (goods), higher degrees (credentials), expensive hobbies (skiing, yachting) accent and speech patterns (behaviours) as well as expertise (formalised knowledge) (Apker & Eggly, 2004; Cassell, 1992; Hafferty et al., 1995; Hafferty, 1988). It is interesting to note that the number of advanced practice nurses who worked for consultants was also a commodity signal within the hospital. The junior doctor as an apprentice of this system learned to develop medical capital initially through entry from a higher class background. This is common internationally (Jolly, 2008) and in the UK (Grant et al., 2002; Greenhalgh et al., 2004; Seyan et al., 2004) despite policy attempts to widen participation from other social classes (Department of Education and Skills, 2004). The aspirations of junior doctors to attain greater cultural capital and thus the symbolic importance of the medical consultant role, reinforces their subordinate role within the context of hospital work. Critically, the perception of the cultural signals of others (nurses, etc.) reinforces the institutional habitus of the high status doctor, the cultural capital of medicine and structural elements of the field which support continued medical dominance. For doctors, the traditional doctor-nurse

relationship is evident and reinforced through the hierarchy, division of labour and socialisation.

The advanced practice nurse is also a socially constructed role when examined from the vantage points of medicine, nursing and management. Within the findings each profession has their own perspective, cultural and social filter which they apply to the advanced practice nurse role. However, the advanced practice nurses remain culturally different from nursing and emit their own signals as an elitist dominant class. The status of the advanced practice nurse is higher from the perspective of the other nurses, and the signals of clinical space, secretarial support, offices, different uniform (goods), diplomas and degrees (credentials), independence and expertise (formalised knowledge) separated them from traditional nursing capital. They formed a separate and distinct powerful sub-class of nursing and were considered elitist by other nurses (Callaghan, 2008; Elcock, 1996; Scott, 1998; Wallace & Corey, 1983). Previous discussion highlights a number of examples of challenges towards the advanced practice nurse that demonstrated that there was a range of emotions and behaviours directed towards them which included animosity, hostility and opposition as well as elements of approval and aspiration. This tension within the profession is ironic when considering how the whole profession derives power from the development of advanced nursing practice. The findings indicate that ward nurses used the advanced practice nurses to access the resources and skills they would normally gain through doctors to ensure that patients received timely intervention.

Symbolic capital and conflict between doctors and advanced practice nurses

Advanced practice nurses accrued a form of capital within the field and the study highlights the fact that the social hierarchy of the modern hospital has changed from the period studied by Stein (Stein, 1967) and more contemporary analysis by Allan (1997) and Svenson (1996). This hierarchy has been reorganised through the structural changes in the powerbase of medicine and of the advanced practice nurse. The role has positively increased the overall power position of nursing through a more collegiate, but partly co-dependant relationship. However, this has not fully conferred equality in the power stakes, as subordination of the nursing role still exists. Whilst this may be

perceived as a rather pessimistic view of nursing power, the context and methods of subordination have changed markedly and advanced practice nursing does exert more direct power through a complex system of interaction which is explored in more detail further in the text.

In terms of power, the most overt form of realised benefit is symbolic capital. In the case of doctors and advanced practice nurses, symbolic capital through prestige, honour and attention was an evident part of the system. The findings must be framed from the perspective of both professions, as the interplay between them creates boundaries and therefore distinctions between the two groups in their use of symbolic capital. The findings indicate that both professions make overt and presentational distinctions between their role with the patient and the social field of the hospital. The advanced practice nurses are required to present to many different audiences to gain their symbolic capital, including consultants, junior doctors, patients, nurses, executives, bureaucrats and administrators, supporting Goffman`s (Goffman, 1959) sense of presentation. They set out distinction in their role between themselves and ordinary nurses in their use of cultural capital, combined with their access to senior nurses and bureaucrats through proximity to powerful positions within the hierarchical system. The most interesting boundary work and distinction for the advanced practice nurses is with that of the junior doctor. The changes highlighted in the research point to a blurred boundary of work. The 'strata' of their role was often interpreted differently which, from a skills and knowledge sphere, were often seen in the same work perspective as the junior doctor. Their additional symbolic capital came through the support they received from the consultants as part of the system of service to the patient, rather than the juniors who were seen in their educational capacity. As a result, positive attention was given to them by others in the field. However, the conflict and challenge between the junior doctor and advanced practice nurse must be seen as an inevitable consequence of the distribution and accumulation of capital - although for the junior doctor, capital was allocated differently due to their transitory status in the field. Their social capital was limited, as they spent less time in clinical practice and although their cultural capital existed it was not of the same level of their seniors. Symbolic capital of being a doctor was noted to be significant within the hospital setting. Junior doctors had less status and influence which made them more prone to challenge from nurses (Hughes, 1988) and advanced practice nurses, which Bourdieu defined as symbolic violence. Symbolic capital for senior doctors also suggested a shift in their traditional role. The findings indicate that consultants have had to renegotiate their symbolic capital with the neo-bureaucratic systems of health, which

are controlled by managers. The overall authority of the doctors in the study was diminished to a degree, as they themselves became agents of state policy to drive productivity and efficiency in the NHS. Medical work was steered towards a model of economic production, which the advanced practice nurses supported through delegated work from the doctors to fill the gap left by junior doctors. The role of the state, as Bourdieu et al. (1994) identified, is the 'culmination of a process of concentration of different forms of capital' – page 4, and is highlighted in these findings. Whilst the boundaries between medicine and nursing had become blurred, consultants sought symbolic capital from other sources, including further clinical specialisation of their role and by surrounding themselves with artefacts that make them distinct from other professions and in some cases other doctors. Sometimes this was by access to resources such as CT and MRI scans, as well as other tools to demonstrate their professional skills and power (in the operating room, clinic or ward), a view shared by Tellioglu & Wagner (2001) and Burri (2001). In addition to this, senior doctors have accrued symbolic capital through leadership positions within the hospital system such as medical director roles, clinical directors and service leads. As NHS systems became more bureaucratised and economically driven, the traditional symbolic capital of medicine had shifted and changed to reflect the new landscape.

The habitus of doctor-nurse interactions

The research findings contribute to the understanding of power between doctors and nurses through the analysis of the objective field, and the representation of advanced practice nursing within it in the form of capital. Advanced practice nurses had, through their own behaviour, altered and adjusted the boundaries of their practice through interaction with doctors, other nurses and bureaucrats. This behaviour had been shaped by the structures present and continued to mould and shape actions, and affect power through the constant feedback and re-processing of clinical practice in the field. This was achieved both consciously and unconsciously through the shared experience of nursing and medicine`s long history of working in the social space and field of the hospital. The findings highlight the fact that professional norms are resilient - even in the contemporary healthcare systems. This could arguably be explained through the development of capital/outcomes in the field caused by agent behaviour. It is this subjective element that provides the final piece of the jigsaw in understanding the power between doctors and advanced practice nurses and is termed by Bourdieu as Habitus (Figure 41, page 267).
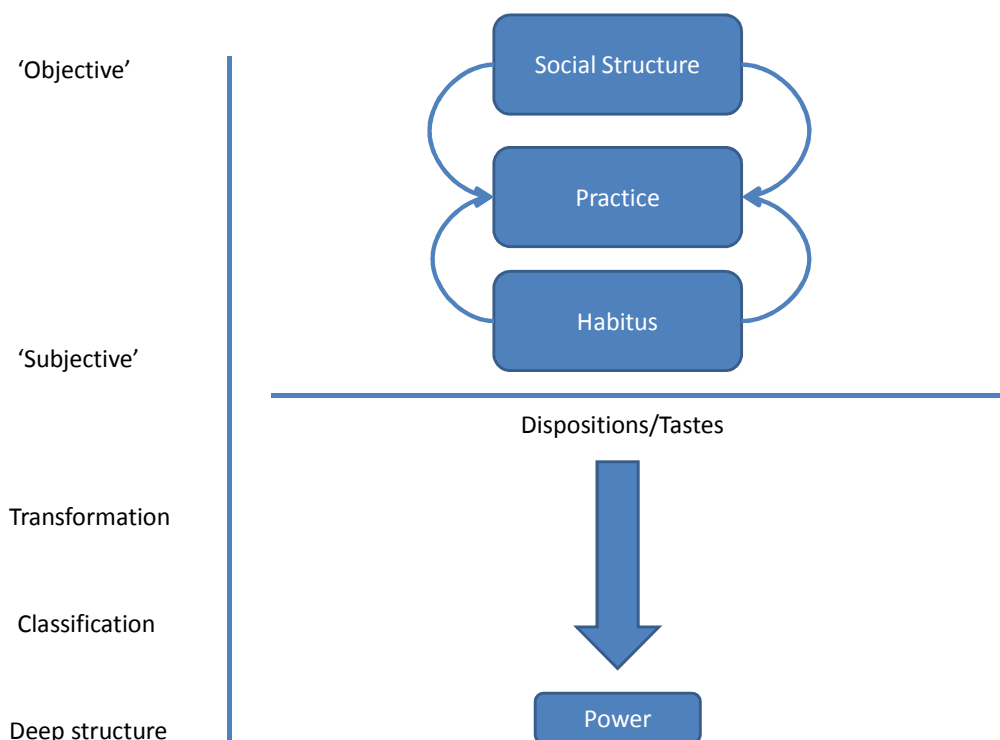
Figure 41 - Diagrammatic representation of Habitus

It is evident that a number of professional systems (including entry into the role, recruitment, training, policy and procedure) shaped and defined the role of the advanced practice nurse through the accumulation of capital. This is critical as advanced practice nurses step out from the general protection of the nursing workforce by working closely with medical staff. They are ultimately aware of the limitations, but choose to work within them to facilitate some degree of autonomy in their work role and gain improved terms and conditions when compared with the ward nurses. This acceptance is critical as it fosters a compliance with the system of rules they operate in and also determines their behaviour and impacts on communication strategies. In order to make sense of the findings of the research in relation to the habitus of doctor-nurse, this must be understood from three main perspectives: Firstly, the hospital or institutional habitus. Secondly, an understanding of the shared space habitus and networks that exist to make the two professions work. This is also an attempt to link the physicality of the fixed field of the hospital to the display of power through working practices. Finally, the habitus of interaction.

The habitus of the hospital

In terms of understanding the institutional habitus of the hospital, it is useful to draw comparisons from the existing literature as most of the previous research was undertaken within the hospital setting. A direct comparison between the work of Stein (1967, 1990) and others who focused on the hospital in the NHS (Hughes, 1988; Porter, 1991; Allan, 1997; Carmel, 2006), highlights some very important transitions in the development of institutional habitus. Although Stein's original paper in 1967 highlighted the subordinate nature of nurses` work in psychiatry, it was still hospital based, and his update in 1990 briefly highlighted the transition in the position of the nurse. However, at this point a significant shift had occurred in psychiatry where the field of practice had relocated from hospitals into the community. As Brimblecoombe (2005) explained, this had ultimately led to new models of care evolving which eroded the psychiatrists` influence on nurses` work. The work of the others is also linked to the period from the late 1980s, in the case of Hughes, to 2006 with Carmel. This provides a number of opportunities to identify the habitus of the institutions in transition - with a contemporary update provided by the work reported in this research. In the period in which Hughes conducted his work, the role of the nurse and doctor was determined by a traditional division of labour, and shared similar experiences with that of Stein. Doctors' hours were long and the social community in the hospital a representation of the NHS at the time. Porter identified a subtle shift as greater challenges on medical hours started to take effect and nurses on wards were encouraged to take a greater role, a view supported by Ensor (2009). Allan further demonstrated a movement in the role of the nurse on the ward, and that policy shifts had made an impact on 'ward turbulence', but that the boundary work between the professions was reordered rather than negotiated. Allan's work also noted that the introduction of the hospital manager appeared in the field and social space. Carmel's (2006) work is of note, in that it reflects on the creation of intensive care in the geography of a hospital, and shows how the development of such a specialised unit had created a new interaction model between the nurses and doctors. A brief review of this work in the context of institutional habitus is helpful, as it highlights the hospital as a living entity - evolving and developing through the structural pressures of the system of healthcare policy and the individual agents that work within it. The limitations of the studies above have been discussed previously, but are worth repeating in the context of this discussion. They focused specifically on the role of the ward or department nurse, but not the emerging role of the advanced practice nurse.

The findings from this work span three very different organisations each with its own cultural identity which influenced habitus. The most notable aspect was the interplay between medicine, nursing and management. The organisation of care was significantly influenced by a number of factors, including the dominance of the medical culture, the strength of nursing leadership and ability, and relationship between the management and doctors, which has been reflected in work by Taylor and Benton (2008). It was noted in the findings that the histories of the organisations were vitally important to the construction of institutional habitus. Each hospital had a unique history centred upon the interaction and outcomes achieved by the professions. The idea of organisational history and habitus is an intriguing one and not discussed by the work outlined previously, although recognised as an influential factor in the strength of professional power in other work (Davies et al., 2001; Davies, 2000; Freidson, 1970; Freidson, 2000). As a result, the structural policy changes on junior doctors that were a key driver in the development of advanced practice nurses resulted in a global effect on NHS institutions, but their organisational habitus had interpreted the most effective way of operationalising this. The important point is that this filtering is based upon the symbolic and cultural capital within the organisations. It is arguable in Bourdieu's view that the institutional habitus defines an effect of the type of agent who will work in them and thus how they will operate. The type of consultant working in a small district hospital compared with a university centre is markedly different with clear links with concepts of capital. The connection between symbolic capital and career choices has been established by Creed (2010) and Newton (2005). In the case of the doctor, greater symbolic capital was achieved through affiliation to a highly performing (financial, clinical and academic) institution.

In the case of advanced practice nurses, they lived locally near the hospital and this element of their social capital was valuable, extending the habitus beyond the walls and into the communities in which they lived. The habitus of the advanced practice nurse was intrinsically linked to the gender aspect of their role. The cultural composition highlighted the value placed upon the networking, emotional labour, communication skills and attributes of the nurses to 'be all things to all people' - providing service and economic reward for gender- based activities. This opens an intriguing issue where the relationship between doctor and advanced practice nurse displays elements of patriarchy. The artefact analysis highlights that the rhetoric of the role for independent practice, expertise, research and teaching was matched with the observational findings of the reality for 'hidden' value roles such as: maintaining the system of care, oversight, networking, mediation, pastoral and support of staff and patients. This was further reinforced by the

biomedical labelling of their role and clinical working along the disease pathways assigned by the doctors, the field and institutional habitus.

There is evidence from these findings that, even taking into account policy changes, the institutional habitus was a significant factor both in terms of the agents that chose to work in them, their expected behaviour, and how they continued to support or create new and developing structures. Institutional habitus, through agent interaction and power, was a constant cycle that became an integral part of the organisation's history, geography and the lives of the agents who worked within them.

The habitus of shared history

Previous sections allude to the observation that team genesis and cohesion is related to a number of influential factors including the use of and distribution of capital. This is furthered by the knowledge that team culture and habitus comprised a guiding principle within the fields of advanced practice nurses and doctors. The issue of team habitus and how it links with the social space, field and networks of social capital is one to explore in more detail. Although the discussion regarding capital may be perceived as a pessimistic assessment of the contemporary role of the advanced practice nurse, it must be seen in the context of role transition. Previous work from Stein, Porter et al. focused specifically on the role of the ward nurse where the social space and field are distinct from that of the doctor. The division of labour recognised the nature of boundary work between the professions in these studies, but was quite distinct from the role of the advanced practice nurse. The role must also be seen in context of a continuum of developing practice, where the role of advanced practice nurses is constantly evolving as their expertise, knowledge and skill develop (National Health Service Wales, 2010). As a result, the interaction between them and the doctors will change. This study recognised that the advanced practice nurses` role was still in a state of transition and likely to continue to influence the relationship between doctors and nurses.

The relationship between them had already evolved and demonstrated far greater aspects of collegiate working than previously demonstrated in the literature. This was highlighted during the observations where they were respected by the doctors within the

team, such as Liam's (Consultant) comments of support for advanced practice nursing when challenging a member of his own profession (General Practitioner). In addition, they were able to use more direct challenges to plans of care or treatment in the clinical environment with junior doctors (Ruth, the outreach nurse) and consultants (Ailsa, Eileen and Eleanor) on pages 233-235. Taking aside the symbolic and cultural capital elements of the relationship, the advanced practice nurse was afforded far greater responsibility and independence than their non-specialist nursing colleagues in the study settings and compared with the previous literature. The defining feature of this was their use of knowledge and the application of higher skills in the field. The ability to operate in this way came through the networks of shared experience that developed with doctors and the trust that built up as a direct consequence of the shared history. Sociologically, there appears to be a need within the literature to make a distinction, and separate the nursing and medical fields. The findings of this research suggest that the social space occupied by the professions is not delineated but functional - although as a clinical group they had overt aspects of shared cultural history. The findings indicate that this was also evolving in light of the interactions and conceptually linked the physical space and cultural identity (Gupta & Ferguson, 1992). In the case of advanced practice nurses, they are in a transitional state both in aspects of space and identity and these can be recognised in the findings by their intrinsic capacity to reproduce aspects of the 'nursing homeland' in their behaviour, such as the symbols of uniform and nursing the space (tidying bed clothes, setting up equipment for doctors and taking notes). This is highlighted in the observations of Ailsa and Arkash (page 167) - where Ailsa holds the patient's hand whilst the doctor writes the notes at the end of the bed, mirroring the visual display of the classic doctor-nurse field. Similarly, Eleanor (Nurse) and James (Dr) (page 170) who feedback the same plan to their own professional group on the ward even though they have seen, assessed and planned the care together at the bedside.

Advanced practice nursing is still finding its way within the field, and this research captures this transitional period. However, as advanced practice nurses struggle for a position within the field, there are times when they looked for inclusiveness and relied on their social capital to provide it. It can come from a variety of sources, most notably within the team itself, junior doctors and, less commonly, colleagues on the wards.

It is recognised that the strata of the team was complex, and remained largely professionalised along the lines of the symbolic capital of the doctor, mirroring work by Fulton (1997). This enabled the advanced practice nurse to wield far greater influence

through direct interaction than in previous research. The reconstruction of the medical firm in the form of the doctor and advanced practice nurse has two important features. Firstly, it came about through shared experience and trust. Secondly, it was constructed very rapidly in the context of an evolving policy within the NHS. The discussion focused upon professional survivability in the face of threat and challenge. The professional 'status quo' in hospitals had been challenged through policy and economic drivers, requiring a rapid reappraisal of the team structure. It was argued, that consciously or unconsciously, the professions combined to form a 'coalition at the bedside' (Barrow et al., 2010) as part of a wider strategy. This explains changes in the use of knowledge and distribution of capital. The alliance and co-dependence is unfolding and developing which, it is argued, could explain the boundary challenges and conflicts that occur as the team habitus. This brings to light an important sociological issue in that Bourdieu's writing does not give much indication as to the process of habitus change and it primarily centres on a sense of conservativism, with the preservation of the defining elite as an important part of its function. Preservation of medical hegemony may, however, require the expansion of control through redistribution of capital and realignment of the expertise within the team.

The habitus of interaction

The role of the advanced practice nurse as an integral component in the care of patients in a modern hospital cannot be overstated. Previous work highlighted that the role of the nurse had evolved and with it the communication methods employed by them to achieve their goals. This is also the case for the advanced practice nurses in this study, where the communication methods employed have changed radically since the early research in this area. The findings of this study identify a range of pre-game intentions which were critical for informing the approach taken by the nurses. This told a greater story of power dynamics where the intentions exposed both a confidence and vulnerability on the part of the advanced practice nurse. Ruth's overt and public challenge or Reese's delegation to a junior doctor (page 217) highlight the growing confidence in the expertise of the advanced practice nurse in the clinical setting. This compares to the seeking of knowledge and support in decision making by Sacha and Robyn (page 217) which highlights a dependency on the part of the nurse to the medical field and habitus. True autonomy remained elusive for them but continued boundary challenge through the accumulation of capital was noted.

The habitus within which they operated influenced the approach taken in communication. It was noted that during interview the advanced practice nurses such as Eloise and Robyn were cognisant of medical power which they adapted to achieve the desired outcome whilst maintaining the status quo with consultants - 'you know what will work and what won't' (Eloise). Even in confident nurses such as Reese, medical power could induce a sense of vulnerability and his acute awareness of the need for their support as 'they are just waiting for someone like myself to make a mistake' led to changes in the communication approach. The habitus and field were complex and the preceding chapters have illuminated why the findings related to communication methods employed were more complex than previously identified. It was argued that nurses have shifted the focus of communication strategies from the covert and informal methods discussed by Porter to more open and direct methods due to the development of the advanced practice nursing role. The advanced practice nurses' proximity to medicine, mastery of biomedical knowledge, development of expertise and gaining trust within the team had created the optimal conditions for more assertive behaviour. They had created power legitimacy through working closely with consultants that allowed them to take greater control and lead care which often drew them into conflict with junior doctors. The open and direct strategies provide the opportunity to examine the power shift that has occurred with the role.

It would be too simplistic to suggest that nurses had abandoned these previous strategies seeing them redundant in light of their visible role in the care of patients. Rather, they had been adapted and incorporated into the new habitus of interaction. The advanced practice nurse has the previous learning from their non-specialist nursing experiences to know which strategies are successful and those that are not - and when to use them, and when not. Their rapidly evolving experiential basis was accentuated due to their proximity to doctors and the public projection of their role within the hospital. Their approach came into stark relief as it is direct, open and visible. They were few in number and were in daily contact with the doctors around the individual patients into which both have invested a commitment.

The key issue proved to be the process of testing and developing new schema in interactions with doctors. The habitus of interaction was shown to be often deeply personal to the agent on the one hand, but it fed into the wider team and organisational structures of power on the other. The communication model described in Chapter Nine reflected the conceptual understanding of the multiplicity of outcomes that can arise out of

a single interaction. It also suggested that this was created by a multitude of players each with their own perspective and opportunity to control and influence. Previous work appears now linear, constrained and mechanistic to the extent that it has overlooked many aspects of interaction that come before and after the observable interaction. The doctors in Hughes and Porter`s work appear unaware of the games compared with the nurses. 'Doctor-Nurse' games are no longer that for the advanced practice nurse: they are multilevel, multiprofessional and multiplayer requiring a different set of rules in which to operate. Social interaction between doctors and advanced practice nurses highlighted an interdependency that required a new perspective to take this into account which has been addressed within this research with a new model of interaction as outlined below.
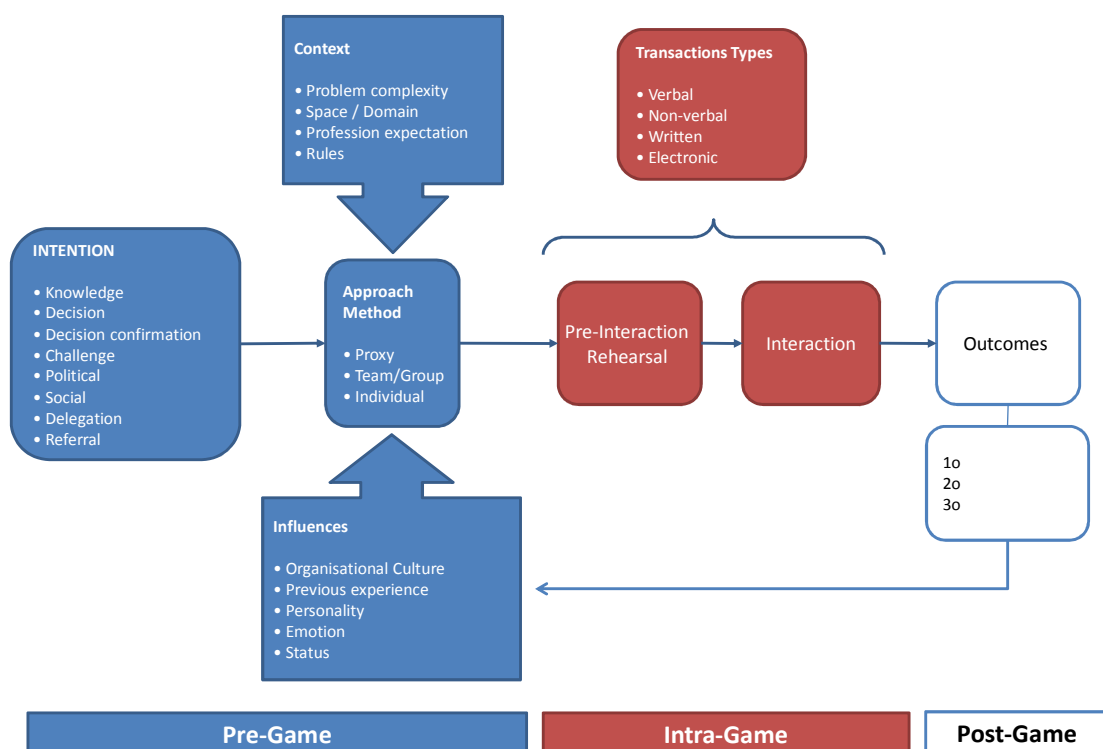
Figure 42 - High Level Communication Model between doctors and advanced practice nurses

The development of advanced practice nursing has in many ways improved communication between the professions, although the complex model outlined in this thesis still largely centred on the professional power of medicine and how nursing must interact with it to be heard. It is interesting to note that the closer working relationship has done little to create a greater professional understanding, as highlighted by Sacha:

> *'I sometimes think that as nurses we're more accepted as professional colleagues by doctors at the clinical interface; that might have been a general perception of nurses. But I'm not entirely sure that it's the general perception of doctors … I think perhaps doctors are more accepting of nursing colleagues than they used to be for different reasons than we actually perceive them to be.'* – Sacha (Critical Care Outreach Nurse)

Sacha has captured an important concept in that a professional distance remains between the nurse and the doctor. This continues to influence the communication strategies employed by the two professions, even with the development of advanced practice enhancing the opportunity for greater collaboration.

In summary, the application of concepts of Bourdieu's Field, Capital and Habitus in the contemporary organisation of hospital work has offered an innovative sociological explanation of the construction of power in this setting. This discussion must logically lead to a conclusion from the findings from this study which are set out in the next chapter.

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Chapter Eleven - Conclusion

This thesis has proposed that the introduction of the advanced practice nurse into the NHS has fundamentally created a new power dynamic between the professions of nursing and medicine, although little structural shift in their orthodox positions. This study has outlined changes in the medical team that initiated a rapid integration of the advanced practice nursing model into clinical care in NHS Hospitals. The drivers for this change were multifaceted and involved State challenges to the dominant position that medicine had gained through the bureaucratic controls of the NHS hospital system. Medicine has reconstructed its symbolic capital within the hospital system by restructuring the clinical team, transferring expectation from the junior doctor to the advanced practice nurse, naturally creating a blurring of the boundary between nursing and medical work (Figure 43).
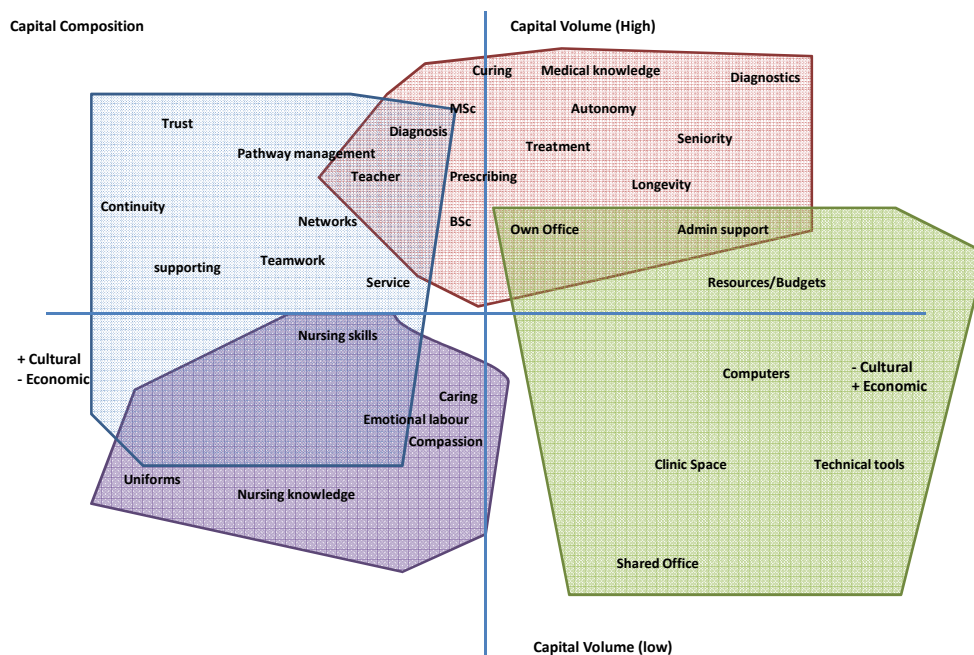
Figure 43 - Cultural composition of the advanced practice nurse in the acute hospital

It is clear that much has changed for nursing with the development of the advanced practice nursing role and the future development of advanced practice. However, this has occurred at a time of an equally profound change in medicine. The findings indicate that structurally little has changed for nursing power with medicine remaining in a

dominant position. In essence, this thesis argues that this has resulted in a fundamental re-balancing of power where advanced practice nursing has appropriated more power at the expense of the junior doctor and non-specialist nurse. The non-specialist nurse appears to have less influence, and examples of their retreat from the focus of decision making between themselves and the doctors typifies this reorganisation of care. The advanced practice nurse has had to develop this through the accumulation of medical capital and alignment of the power base with that of the defining hospital elite, the medical consultant.

Although Bourdian theory suggests that the elite maintain power through an essentially conservative accumulation of capital, the findings of this study highlight a redistribution of capital within healthwork through the role of the advanced practice nurse. The consultants have developed this to counter the continued state challenges to their power, most successfully with the productivity policy agenda of the late 1990s. From the medical perspective two main issues are clear. Firstly, a growing realisation that exclusivity of medical knowledge, and importantly their control of it, has eroded. Secondly, their power role in health had the potential to decline. This has prompted a number of reactions where the professions have attempted to maintain forms of influence and control. The realist perspective highlighted that rhetoric of inclusivity and collegiality from the doctors in the hospitals is tempered with a reality of control and influence through the continued attempts to subordinate other healthworkers. These attempts concentrate upon advancing their own knowledge and specialisation, whilst continuing to control patients. In the case of the advanced practice nurse their inclusion in the health team, influenced by doctors, maintains the positional power authority. Medicine continues to determine the role and function of agents by recreating the sociological division between themselves and others. The recreation of the 'medical firm' with the advanced practice nurse is one strategy employed by them to maintain power and control. The work of the advanced practice nurse was thus defined and influenced by a dominant medical profession within the hospital space with the division of labour constructed along the lines of the medical disease pathway.

This posed some problematic issues for nursing power in that the dispositions and tastes of nursing have fundamentally changed through the advanced practice model and accumulation of medical capital. Two main problems emerged: Firstly, the issue of classification of nursing within the objective and subjective fields. The advanced practice nursing role has altered this significantly as have other healthworkers and administrators.

The implications for nursing philosophy and the wider profession are powerful as the profession struggles to maintain its intrinsic power through its professional identity. This identity continues to be fragmented and thus dilutes the power for nursing. This creates a crisis of identification with the advanced practice nurses themselves who expressed a desire to be seen as nurses, advance their practice and knowledge and continue to care for patients albeit in the biomedical framework. Sociologically, this has consequences for the debate on power in healthcare and representation of the agency/structure dilemma. The process by which advanced practice nurses appropriate biomedical knowledge and execute this in practice requires a change in their habitus and schema. Advanced practice nurses are learning to classify the field in a different (biomedical) way through individual agency and the structural influences of the field. However, the struggle for the advanced practice nurses is that they had to retain enough 'nursing capital' to function in the field. Their roles were created (with medical influence) explicitly to harness this whilst supporting and maintaining a subordinate position. The cultural composition of advanced practice nursing work highlights this in that the broad dimensions are aligned to space, personal attributes/gender, nursing behaviours/skills and medical power sources. Secondly this created a power paradox, where the individual desire to take on more autonomy and power moves them away from the core values of traditional nursing. For nursing as a profession, the development of advanced practice has been seen as an opportunity to develop more power and influence in healthwork but has fundamentally altered the philosophy of nursing. The advanced practice nurse`s role is left with an ambiguous and potentially vulnerable position in the health team where its power is derived by its proximity to medicine and it moves further from its nursing roots. The advanced practice nurse has invested heavily in their development which requires the continued support of its benefactor to function and for them to develop the skills to operate in multiple habitus. Advanced practice nurses continued to struggle with the mastery of practice by establishing their own individual agency where the doctors could determine their progress through the 'apprenticeship'. This realist perspective was an overt form of power and control that defined the dominant medical position and the continued subordination of the nurse.

On many levels the classifications based upon opposites of power exist in contemporary healthwork. The findings of this research highlight that the cultural composition of the advanced practice role, division of labour or the creation of habitus are derived from a source of medical power and its perception of nursing. The dispositions and tastes of the field highlight that power is constructed on four main dimensions; knowledge, gender,

professional identity and philosophy which is represented in the habitus of doctor-nurse interactions (Figure 44).
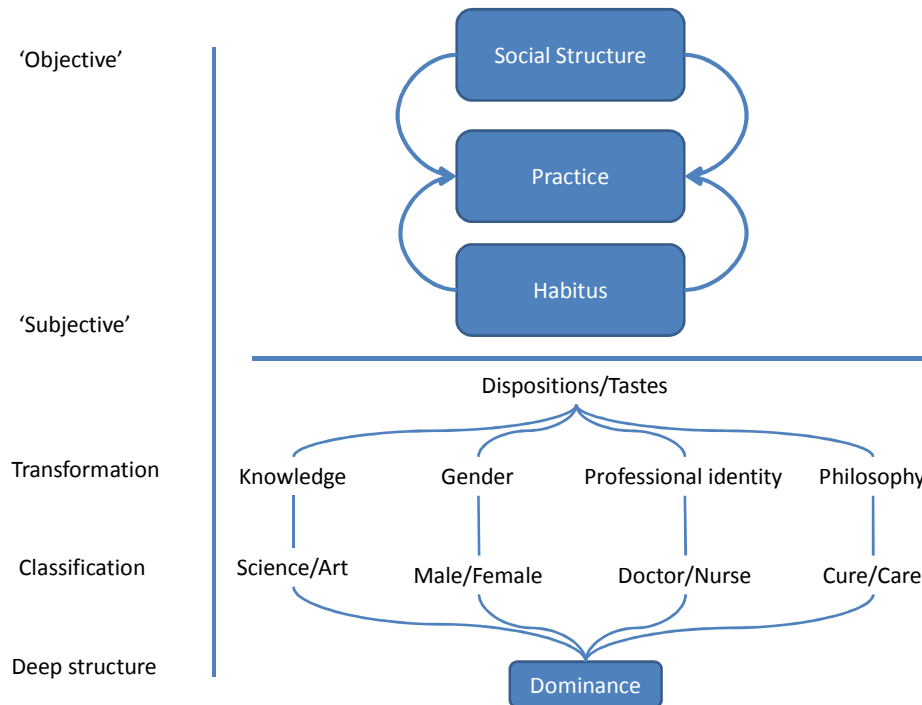
Figure 44 - Habitus of doctor-nurse interactions and power

Sociologically this also represents an important construct of oppositional elements to the power debate, i.e. doctor/nurse, truth/falsity. In line with previous conclusions, little has changed for the perception of nursing where the power model created by medicine still largely represents itself as science/male/doctor/cure, and nursing as art/female/nurse/care. It is argued that although the framework by which nursing is understood in healthwork has shifted, little has changed in the context of power between themselves and doctors. This must remain a frustration for nursing considering the development that the profession has undergone since Stein first wrote his paper in 1967. Gender and its link with the work of nursing played a significant role in the creation of the power differentials between the two professions.

It was clear that the division of labour displayed a constructed gender representation of the advanced practice nursing role. The findings indicate that gender was exhibited in the division of labour in a number of ways which represents a pragmatic shift of power to meet the needs of the medical hierarchy rather than a fundamental shift in power itself.

Although the role of advanced practice nurse has blurred the boundaries between medical and nursing work, the power differential is maintained in a recognisable tripartite form (Doctor - Nurse - Patient). However, nursing continues to evolve and develop, pushing boundaries and attaining more power. Equally, this research highlights that as nursing does this, so do other healthworkers and, importantly, doctors. A power alliance has been realised between medicine and advanced practice nursing - a reconstructed team in a 'bedside coalition'. This has highlighted medicine`s growing dependency on the role of the advanced practice nurse to deliver care in the NHS. This co-dependency was informative of the power of the advanced practice nurse who was observed demonstrating a more collegiate approach to communication and decision making. Growing expertise and confidence in the clinical field characterised a more powerful nurse who was able to challenge medical practice more openly. Unsurprisingly, there was still an undercurrent of traditional values of the nurse-doctor distinction exhibited within the rules and behaviours of the habitus of interaction. However, this created tensions in the organisation of care, and advanced practice nurses faced challenges within a multi-spatial power arena, and conflict with other clinical, administrative and management staff was observed.

The genesis of these new clinical teams had seen greater investment in time, knowledge and resources highlighting the power differential of the role of the advanced practice nurse.   Power was vested in the advanced practice nurse through proximity to the medical symbolic capital and this required them to adopt biomedical knowledge and expertise in order to deliver their role. This was expressed as the spectrum of knowledge of art and science which the findings highlight that advanced practice nurses have difficulty bridging. As hierarchically senior clinical nurses with prior extensive social capital of their own, they were afforded greater power, and this was represented by their clinical independence, allocation of space, resources and their chosen direct communication strategies.

Of equal importance remains a philosophical difference in outlook between the two professions. Critically, it is the legacy of nursing capital which determines this for the advanced practice nurse. The prior social exposure to the structures of their nursing role in which they were subordinate to medicine has a defining influence. In understanding power, the aggregation of capital in the forms outlined in the preceding chapters does not shift the importance on how they are viewed in practice. Doctors cure and nurses care - the adoption of biomedical knowledge and skills of diagnosis and treatment by advanced practice nurses may have increased their quotient of power, but not fundamentally shifted

their positional power with medicine. It is clear that advanced practice nurses have moved into a more powerful position than their colleagues on the wards.

The findings of this study serve to illustrate that the nurse-doctor game has evolved alongside the development of advanced practice models of nursing. Power was constructed in an organic way within the hospital work, supporting the notion of structural influences and individual agent behaviour affecting its creation and development. This study has identified that the doctor-nurse relationship exhibits an interactional model of agent and structural influence on behaviour. The social structure of the hospital, NHS and wider professions affect agent behaviour, but importantly the agents have greater strategic tools through which to influence power. The advanced practice nurse acquires a form of agency associated with the field in which they operate. As outlined previously, this acquisition comes with some major philosophical and professional consequences which nursing will have to reconcile. The political and philosophical impact of this will be profound as advanced practice remains in a transitory state and potentially at risk for changes in policy and internal/external professional influence. Advanced practice models must therefore capitalise on the power and influence they have attained to define a position within nursing and healthwork, or it will continue to migrate towards a paramedical role.

The findings also served to illustrate that the doctor-nurse relationship is a continuum that will evolve and develop over time. Healthcare is a dynamic system and recent policy changes to the NHS are likely to drive the professions to take models of care in new directions, but nurses and doctors will continue to remain key to the provision of care to patients. This research should be seen as part of a continuum of empirical study where others may follow to provide further reflection on this intriguing relationship to discover its implications, for attempting to understand the concept of power.

Originality and key contributions to knowledge

This research has been influenced by a number of other scholars on the subject including Porter (1991), Allan (1997, 2001a), Svenson (1996) and Hughes (1988). Interactions between doctors and nurses as a topic has opened a number of lateral debates in areas such as gender, power, expertise, and communication. Taking this into account, there

are a number of similarities in this work with those described above. There are also many aspects of originality and contribution to knowledge in this study.

Firstly, the other scholars examined the role of nurse-doctor interaction within the traditional confines of the ward or clinic. The advanced practice role is relatively new and from a power perspective had remained little examined in the nursing and sociological literature to date. The evolution of nursing with the development of the advanced practice nurse has redrawn the boundaries between the professions. The findings highlight that whilst a number of traditional doctor-nurse interactions still exist, the power of the nurse has moved forward as a result of this development. The findings demonstrate how the field of practice is a complex habitus created by the doctors, nurses, managers and the organisations they work within. The habitus of institution, space and interaction have significantly added to the knowledge of the advanced practice nurses` power.

The analysis of space and field was helpful in determining the social construction of the clinical relationships within organisations and has enhanced the body of knowledge in this area. This research examined in detail the relationship of physical space to the social constructed clinical work of the advanced practice nurse. This research created a new understanding of how organisations redefined the work of advanced practice nurses as controllers, supervisors and mediators of medicalised pathways of care. This also reflected their developing power within the healthcare team, as they appropriated symbolic and cultural capital compared to others such as junior doctors and ward nurses.

The understanding of cultural and symbolic capital between doctors and nurses also shaped their interactions. The conceptualisation of the interaction model in this thesis produced more detailed findings not previously identified within the literature, such as the 'pre-game' phase and post-game outcome effects. The 'intention' of interaction was a critical new finding, as this highlighted a number of non-clinical initiators of interaction between the professions.   This led to the development of a multiplicity of interactions, strategies, counter strategies and outcomes which was not pinpointed in other work. Importantly, for there to be such complexity, this research recognised that there was awareness on the part of the other agents who complied with the system of rules, behaviours and methods of communication.   This interconnectedness of the conceptual model highlighted that the interactions developed into a general schema and habitus within the field of practice.

Secondly, previous work was often nurse-centric in its analysis. The aim of this research was to draw out the role of the doctor, illuminate their participation and thus understand the duality of any interactions that occurred. Whilst previous work had examined medical perspectives, this research gave granularity to team genesis, cohesion and interactions. This in turn reflected not only the power of the nurse, but the shifting power of the doctor and the profession within the context of the NHS. In addition, as outlined above, the awareness of the 'game' by the doctors was critical to understanding the mechanism by which decisions were made within the team and, thus, how power was transacted during interactions. Without this duality, the ethnographic representation of the modern hospital would have lacked truthfulness and integrity.

Finally, this research used an ethnographic approach to understand the interactions in a complex clinical setting. This has also contributed to knowledge in a number of areas including the use of artefacts, CAQDAS and critical ethnography in a complex health environment.   It was important to address the structural representations of power which were reflected in the use of artefacts in the research to ensure that this aspect was captured within the context of interactions. Other than Allen (1997), artefact analysis was not a tool employed within the existing work on doctor-nurse interactions, and it provided a rich vein of material from the bureaucratic organisations that exist in the NHS. Artefacts were a permanent archaeological record of the topography of the clinical interactions in organisations and represented habitus of many agents including doctors, nurses and administrators. It also helped guide the analysis to the prevailing schema and culture of the organisations within the study.

In addition, the research generated a significant amount of information that required careful organisation using powerful information technology tools. The use of a CAQDAS system was critical, and as asserted by Barry-Lewis (2004b), they had come of age and significantly contributed to this research. Although it has yet to become standard within the field, this thesis will provide an opportunity for others to review its efficacy and applicability to ethnographic work.   Atlas-Ti was an intuitive and powerful CAQDAS system that provided the researcher with the ability to catalogue and analyse multiple sources of data as outlined in the methods. The volume of data generated would not have been manageable with a traditional ethnographer`s 'scissors, paper and glue' for the thematic analysis. Atlas-Ti provided the ability for the researcher to rapidly review, cross-reference and highlight evidence. Recall of information through themes, notation and search capability made the writing-up process easier - extracting quotes to highlight

important concepts was a simple 'copy and paste' process. It also enabled an easily accessible audit and validation trail in the material and how it developed the themes. However, this required the researcher to learn greater technical ability in areas such as digital recording and computer skills in addition to new research skills. Although St. John & Johnson (2000) and Weitzman (2000) cautioned that CAQDAS systems in qualitative research could distance the researcher from the material - this was not the case. Familiarity with the material through transcription and analysis with Atlas-Ti maintained connectivity with the rich nature of the data. The narrative structure to the observation, combined with cross-referenced interviews, reflexivity notes and artefacts ensured that the researcher remained in touch with the experience and environment of those who were part of the research.

Reflections on using critical realist ethnography

This research used critical realist ethnography in a complex healthcare setting. Several aspects of this approach are worthy of mention. Critical realist ethnography was an appropriate method through which to understand the agency structure dynamic of power in the relationship between doctors and nurses. This involved a blended theoretical and methodological approach that aimed to understand the agency and structure of power through the domain of the real. The triangulation of observation, interview and artefact analysis provided the ability to critically review the experience in the clinical environments. Two main realist perspectives emerged. Firstly, it highlighted that whilst advanced practice roles have developed a sense of autonomy and self-determination within the profession, subjugation of the nursing profession to medicine still exists although in more subtle forms. Secondly, the rhetoric of inclusivity and collegiality from the doctors in the hospitals is tempered with a reality of control and influence through the continued attempts to subordinate other healthworkers.

Practically, there were a number of challenges in using this method in a healthcare setting. Firstly, access was a more time-consuming task than first appreciated by the researcher. Although the researcher was known in the first site, the complex hierarchical system required detailed work to gain access to participants. The bureaucratic nature of hospitals and the focus of the research on two professions required twice the effort and time to gain permissions. Once working directly with the participants, many further challenges occurred at local level within the clinical areas. Some of the cohorts worked in multiple areas of the hospital and provided care to patients across professional and

departmental boundaries. Unpicking this and ensuring permission was fully agreed significantly extended the time spent with each cohort prior to undertaking more formalised observations.

Secondly, managing consent with the participants was an interesting process. The 'two tier' consent outlined in the methods of direct participants and global consent worked well. The information leaflets, forms, meetings and posters worked in practice. The procedure outlined in the R&D application was followed but medical participants were often less troubled with the formal process and they discussed many times that verbal or email consent would be appropriate.

Finally, the observation fieldwork provided significant learning for the researcher. The approach and immersion process provided the opportunity to follow participants and meet with the teams prior to the formal observation. This time with the participants was valuable. The researcher got to know the participants` individual personalities and the team dynamics. Although not formally recorded, it provided opportunity to appreciate subtle behaviours and wider social and political issues that influenced their work. Practically it also brought a sense of familiarity with the scene that helped the researcher. It also highlighted the potential for reactivity within the scene, as discussed on page 109. Despite this, when formal observation started, the researcher being part of the scene was noted by the participants. Abi reflected on how this made her feel and the impact this had on the researcher:

> 'A bit nervous. It puts you a wee bit on edge. As much as you try to be normal, and carry on with your daily routine, - it's quite nerve-racking when there's somebody there just eye-balling everything and listening to everything you're saying. And it makes it harder - I think it makes your job quite hard.' – Interview with Abi (Specialist Surgical Nurse)

Ora reflected on the internal conversation that she had being observed, focusing on elements of her performance and outcome:

> 'Did I notice you there? Well, obviously I did notice you there, yes. You were very discreet - you weren't looking at the fact of what we were doing clinically but it was just like, "Oh, is my bandage neat?" and things like that, or are we doing this right, or am I speaking to patient, or is the

patient all right, because a lot of the times you do go into automatic pilot.'
– Interview with Ora (Specialist Surgical Nurse)

Although the presence of the researcher was noted, reactivity was always a consideration of the researcher.

'I think I knew you were there...I wouldn't say that you being there changed the way I work. I didn't like consciously do anything different because you were there, I don't think.' - Nicky

Being part of the research was also enlightening for the participants on one level as in this interview with Eileen, reflecting on the narrative of the observation session:

'That was a little bit weird, seeing it written down what you had said, because that's something that's absolutely not usual, is it? Sort of an interaction with the patient and then seeing somebody else has interpreted it and written it down, because obviously in some cases you think, did I really say that? Why on earth did I say that? And things like that, but obviously that was very unusual, so that was quite interesting to look back on that and ponder on what you had maybe said and what had happened during the day.' – Eileen (Surgical Specialist Nurse)

Whilst conducting the fieldwork, the reflective notes also helped describe some of the methodological challenges of observation, as in this note on the Metropolitan site:

'It is often difficult to know whether to stay within the room, whether the nurse is going to be out for too long. I may be missing some interactions outside on the corridor but it has provided a good opportunity in which to get down further information and write notes'. – Observation notes on the Metropolitan site

This scenario was a common one and getting the balance right was difficult. The need to write notes was a constant challenge to ensure that they remained fresh in the mind. Other situations arose when I had to leave the room with 'ethnographer`s bladder' and hastily scribble the interesting interaction. In other situations a more 'gestalt' moment occurred:

'Need to draw maps of the interconnectedness and space used by the agents in these situations. Managers, doctors, nurses, administrators - So many people all vying for position, space and power!' Reflexive note in observations on the Metropolitan site

This was a point where the partially analytical notes created moments of clarity. In this case, the realisation that power, interactions and space were intrinsically linked. On other occasions, the boundaries between the observer in a participant role were brought into stark relief, as in this example when observing Hannah in clinical practice:

Hannah leaves the room momentarily to pick up another set of notes and the patient turns and talks to me about his diagnosis. I reaffirmed her role and then she would guide them in relation to the decision making. – Observation with Hannah (Specialist Cancer Nurse)

This scenario was particularly difficult, as the patient had been given a serious diagnosis, and as a nurse myself I had done this many times. The desire to reassure and give further information was great, but I was there as a researcher. This boundary between nurse and researcher was more difficult than anticipated. I reconciled the fact that I was not this patient's key worker and had to ensure that he received consistent advice and support of his clinical team. What if I gave false hope, reassurance - or worse - wrong information? The consequences for my interaction were significant. I replied that I did not have enough knowledge to help: it was outside my specialisation. This scenario highlighted the challenge for the researcher with clinical knowledge and experience.

Refocusing on the research after these encounters was often very difficult. The residual lag of this real world role would creep into the consciousness and push out the researcher focus. This highlighted that the focus required during observation was intense and could be disturbed easily. 'Getting your eye in' was a term that I used during this phase to ensure that I was attuned with the setting. By doing this I hoped to be a better researcher.

However, the practical considerations of this must also be balanced with the reflexive nature of the research process as outlined in the insider/outsider discussion on page 96.

Reflexivity on the insider/outsider dynamic

As outlined previously in the methods section, Mercer (2007) and Hellawell (2006) advocated that researchers should recognise and reflect upon their position within the insider/outsider dynamic and the potential issues this may create. As discussed, the researcher was both insider and outsider simultaneously and on many different planes. Both Mercer and Hellawell advocated that researchers keep reflexivity journals, logs or notes to connect themselves and their role to the work.   This was done through reflexive notes alongside the observation narratives and interviews. This integration was done to ensure that the contextual elements of the reflection, such as the trigger or impact, were captured.

My first profound experience on this insider/outsider dynamic came in one of the first direct observation sessions on site one. Prior to starting the observation that day I noted down my feelings at the time:

> *'I think it will be quite useful being an insider to understand some of the*
> *dynamics associated with working patterns and the individuals involved.'*
> *– Reflexive note in observations on the Urban site*

I perceived that this would be a benefit, as I had been nervous about undertaking observation in the setting. Walking into the department and standing by the nurses` station brought a totally unexpected perception and feeling that I recorded:

> *'There seemed to be some anxiety within the department that morning*
> *due to a very difficult weekend, and this had been expressed in relation*
> *to the performance of the four hour target.*
>
> *There were some questions asked around my involvement in the unit at*
> *that time and why I was there. I quickly identified that I was undertaking*
> *research in the department rather than any clinical role. It was interesting*
> *to note that people looked at cause and effect, the difficult weekend/poor*
> *performance and therefore then my presence looking at behaviours*
> *within the department. Despite the fact that I had spent over three*
> *weeks canvassing the department, giving out information, speaking to*

individuals in relation to the study itself, there still seemed to be an understanding that their work was being viewed in the department. However that said, it was quite quick after that, that people seemed to forget my presence.' – Reflexive note in observations on the Urban site

This provided an interesting paradox, in that my insiderness was expected to provide familiarity and understanding, but created the exact opposite. I was an outsider from this group of emergency department nurses – they were initially territorial and defensive about my position in their department. After feeling very much an insider at the start, I was now definitely an outsider to them. This highlighted that the insider/outsider position was fluid and dynamic and was a valuable lesson about the research environment that I was in.

Of course, being a former employee of the organisation was not the only identity that structured these interactions with the participants in the study. Being a nurse and advanced practice nurse also created boundaries of the insider and outsider that often shifted within the context of the fieldwork and interviews. There were a number of examples where the reflexivity notes that I made recognised these scenarios that had advantages, disadvantages and affinity with the participants. I was always introduced as a nurse by the participants, such as Yasmin on the Metropolitan site.

Yasmin then immediately turns to the patient and the relative and says, 'This is Mark. He's one of our nurses and he's following me around today conducting some research on what I do. Is that okay?' - Observation with Yasmin on Metropolitan site

In a number of conversations (observation sessions and interview), the specialist nurses were comfortable in describing their frustrations with doctors and making negative comments about senior medical staff to me. I often reflected on the fact that as a nurse, this professional identity made them feel more comfortable sharing these issues with me, a fellow nurse. As an insider in this scenario, they made me feel that I belonged to their group by sharing. In addition, the advanced practice nurses often discussed their workload and how they wanted to show me what they did in practice. I felt a need from them to demonstrate their value, role and impact to me. As an outsider, my role in some way was to validate what they did. With this came an overwhelming sense of responsibility to ensure that the research was accurate and representative of the

participants. This principle of truthfulness deeply affected me, in that I, as a researcher, had this responsibility.

As nurse and a researcher, interacting with medical staff also created many insider/outsider dynamics. The doctors were very candid and supportive, giving their views both in the field and interviews. In many cases they gave positive anecdotes and comments about the teams of advanced practice nurses. I often considered that they may have done this as I was a nurse myself, an insider to the nursing group but outsider to them. In a similar vein to the advanced practice nurses, the outsider researcher role was valuable to them and would validate their clinical model and approach. There were also some interesting reflections on being researcher and medical staff. Conducting a PhD study was considered by many a notable and worthwhile endeavour; it garnered much cultural and symbolic capital with the doctors. I was recognised by medical staff as an insider, as they themselves had undertaken their own work. However, it elicited a number of interesting and polar views, including discussions about being 'a proper doctor' or 'nurse/doctor'. A similar polarity existed when discussing the study and its sociological basis. Social science has a limited role and credibility within medical practice (Dogra, 2005) and this view was expected.

Although many of my professional nurse insider assumptions were confirmed after spending time in the field, there were some assumptions that were contradicted, thus confirming my insider/outsider continuum status. In particular, as an advanced practice nurse I held an overall positive view of the role`s development, identity and power in the clinical setting. This study highlighted that the generally held view of these roles as autonomous was, in part, contradicted by the critical realist finding of significant medical control of their recruitment, development, and practice in the clinical setting. This control was to a far greater extent than I had considered.

However, by doing a critical realist ethnography of a community and professional role, and being self-reflective as I interacted with the informants in the field, I was able to learn things about the field of practice that another may have overlooked. I was also able to use my own experience in order to examine whether this knowledge would be confirmed or contradicted in these fields. This process, as outlined above, highlighted that there were a number of complex configurations of identity, time and place that would influence not only the collection of data, but its analysis.

Implications of this research

This thesis has produced a significant body of evidence related to the interactions between doctors and advanced practice nurses. From this, a number of implications for practice, policy and research have been identified.

Implications for practice

Implication one – Improving communication between doctors and nurses through teamwork

It was evident that whilst communication was more collegiate in the advanced practice nurse-doctor relationship, there remained some aspects where the voice of the nurse was not heard – thereby reducing the effectiveness of their impact within the health team. As part of the research, the question was directly asked of the participants, 'What could you do to improve communication between doctors and nurses?' The universal response from doctors and advanced practice nurses was 'greater teamwork', which is in keeping with the findings where teamwork built trust and confidence on the part of both professions. This would enable greater dialogue and direct challenge that would support decision making, which has been well established in the literature (Leonard et al., 2001; Sherwood et al., 2002; McKeon et al., 2006, 2009). Several suggestions were made by the participants who felt that this had to start early in the career of nurses and doctors.

Implication two - Organisational support for the development of advanced practitioner roles

This research has highlighted, similar to other scholars (Hewison, 2009; Schober & Affara, 2006), that the development of advanced practice roles is driven by a number of factors. The uptake of these roles within the NHS has been widespread in both acute and primary care sectors (McGee, 2009). However, as Maylor (2005) suggests, despite the successes of advanced roles, as with this research, they are still often implemented as local solutions aligned to traditional medical pathways. As Schober & Affara (2006) highlight, integrating advanced practice into workforce planning of the future is one of the critical challenges for the professions.   This research highlighted that organisational support and networks were critical to the success, but there is little evidence in the

literature to practically support organisations in developing such roles. Woodward et al. (2005) and Willard & Luker (2007) support this view suggesting that organisational support begins at the point the role is first developed.

When developing new advanced practice roles, organisations must begin by defining the needs of the patients and what they require in the clinical pathway (Radford, 2009; Schober & Affara, 2006). As identified in this research, this is often the most challenging stage of role development, as significant operational, financial, political pressures and conflicting priorities will often dictate how the roles are developed. A thorough needs analysis is required as to whether the advanced nurse practice role is the most effective way of delivering the pathway and outcomes. It is also important that the extent to which the advanced nurse practice role will be engaging with the population and other health professionals is also understood. These clinical and economic perspectives must inform robust business planning that defines the role and its function, and has the additional benefit of developing support and understanding with a wide variety of key stakeholders. However, it is imperative that key stakeholders examine areas of practice and support as a part of establishing the role. This should inform the job descriptions and job planning approach, so that they are clear from the outset about what the role is trying to achieve.

Implication three – Role clarity, definition and awareness of advanced practice roles within healthcare organisations

This research identified that the development of advanced practice is a relatively new and challenging process for many organisations. The findings of this work highlighted significant variation in role, skills, knowledge and deployment in acute hospitals. As Schober & Affara (2006) and Jones (2005) suggest, a clear strategy must be in place to communicate the advanced practice concept within organisations to other clinicians and healthcare professionals. Without this clarity about the concept of advanced practice, this can lead to significant personal and political challenges for individual postholders that can leave both the organisation and postholder frustrated. Examples in this research identified that practitioners can feel professionally isolated or, in more extreme cases, open to conflict and challenge from other professionals in their clinical work.

Part of the approach to tackling this is strong nursing leadership and vision within the organisation (Shaw, 2007). This research noted that the strength of nursing leadership

was a significant contributor to the overall influence of nursing within organisations, a view shared by Shaw (2007). This had an effect on the development and support of advanced practice in a number of areas. Firstly, the advanced practitioners in this study interacted with many professional groups, including medical staff, nurses, allied health professions, administrators and managers. As Ball (2005) and Woodward et al. (2005) suggest, these are often very influential but it is ultimately nursing colleagues and nursing management who have the most significant influence on the acceptance of these roles. Secondly, this research supported work of Tye & Ross (2000), Jones (2005) and McKenna et al. (2008) who identified that there are often practical barriers including funding streams for service development and issues about administrative support or office space. The findings of this work noted that this support was often not in place, which required the advanced practitioner to develop strategies to negotiate and placate administrative staff to get their work completed. It is critical, therefore, that advanced practitioners understand the language and politics of leadership. Clinical engagement is vital in a healthcare organisation and this can be enhanced where advanced practitioners are managerially aware; likewise, managers who are clinically aware and knowledgeable of the advanced practice role (Dixon, 2008).

Many challenges can be pre-empted by clarifying the role, communicating it to the organisation, high level political support and also resource investment. A lack of preparation will affect the success or failure of the role (Woodward, 2005; Ball, 2005; Booth et al., 2006; Redfern et al., 2003). Ultimately, a lack of planning may leave the advanced practitioner unable to articulate what the role is about and what objectives it will achieve (Jasper, 2006).

Role clarity and definition will guide the advanced nurse practitioner in the domains of operational and professional performance, but this needs to be supported through effective job planning. This is an area that is often neglected by organisations in supporting their advanced practitioner (Booth et al., 2006). It provides an important opportunity to review workload, balancing internal and external commitments and providing a flexible objective setting for delivery. A robust job plan should include a prospective, focused and relevant review of current policy and the wider healthcare agenda that offers an opportunity for the advanced practitioner to align local developments to this. Balance of workload is vital as the job plan offers and reflects a diversity of skill that is not solely related to clinical expertise but also includes research, leadership and change management. In some cases, without appropriate support, this

large portfolio can lead to a dilution of the advanced practitioner's impact in the organisation.

Implication four - Ongoing organisational support for the advanced practice roles

This research highlighted that there were significant rewards and satisfactions from working as an advanced practitioner in acute hospitals. However, a number of challenges arose from workload, stretched resources and clinical pressures associated with complex work. As discussed previously, a lack of role clarity and the absence of organisational support can leave the advanced practitioner feeling isolated from mainstream nursing which mirrored previous work by Guest et al., 2004. One participant in the Urban site felt the ultimate expression of this would see others aim to discredit the role or themselves. There is an organisational responsibility to ensure that the right support is in place for the advanced practitioner because there is a very real risk of 'burn out' if these challenges remain unchecked (Guest et al., 2004; Jones, 2005; Schober & Affara, 2006; Chen et al., 2007).

One aspect that is often neglected is the personal and professional development of the advanced practitioner. Time must be set aside for educational and professional development. As Maylor (2005) states, a practitioner may take from two to seven years to fully develop. He illustrates this with the Trent Regional Consultant Nurse (TRCN, 2001) framework in which consultants will move from probationary to proficient and towards expert, reflecting the model of Benner (2001). This formalises the clinical and emotional perspective of many practitioners. It is critical that support is given to ensure that the practitioner continues to deliver effectively within the organisation, and has a well-developed network of support through the nursing hierarchy, other advanced practitioners locally, regionally and nationally. As highlighted by Schober & Affara (2006), also keeping updated through conferences and network events is vital for their professional development.

Implication five - Career progression for advanced practitioners

This research highlighted that many of the advanced practitioners had developed their role and remained with the clinical team for many years. In fact, this was exploited by the doctors where longevity and service commitment was highly valued, but provided little opportunity for onward progression. The UK clinical nursing career framework

(Department of Health, 2006) has evolved to include a career progression ladder, with the role of advanced practitioner (Figure 6, page 68). This does give a great deal of flexibility with roles, to enhance clinical freedom, develop services and conduct research and education. The rhetoric versus the reality is very different. As in this research, compared to other scholarly work (Woodward et al., 2005), career progression for advanced practitioners remains problematic.

Traditional models of progression in nursing leave only a few opportunities open for advanced practitioners, such as management, education or research. Most of these require a reduction or complete cessation of activity in some of the advanced domains meaning that clinical expertise can be lost. The Modernising Nursing Careers framework (Department of Health, 2006) highlights future models where there are opportunities for advanced practitioners to continue to move forward allowing lateral moves into and out of clinical practice, shifting the emphasis into academic work, research, corporate or strategic responsibility without any loss of credibility or remuneration (as in the case of medical leaders such as Medical and Clinical Director posts). This leaves open the possibility of hybrid models that draw upon the key domains of advanced practice to flexibly deliver a wider nursing agenda depending on the needs of the population served.

Implication six - Understanding the impact on the other professions and nursing roles

Whilst recent estimates suggest that there are between 3,000 and 5,000 advanced practitioners in the UK, these numbers are small compared with the overall size of the healthcare workforce (Coombes, 2008). Advanced practice has not been a concept that is unique to nursing and has been taken up in many other professional groups including pharmacy, physiotherapy and radiography (McGee, 2009). More recently within the UK, the introduction of Physicians` Assistants has been debated as an alternative for the non-medical workforce (Parle et al., 2006; Stewart & Cantanzaro, 2005; Hutchinson et al., 2001; Gavin, 2002). This role that may be more attractive to the medical professions as it does not aim to be autonomous in clinical practice when compared to advanced practice nursing.

Although advanced practice has been developing over a number of years, it is still a relatively 'new entrant' into the healthcare workforce market and should examine its

position and benefits compared to others to maximise its potential. Brandenburger and Nalebuff (1995) identify that the 'business game' is one where you need to understand not only your own contribution, but all the others who work in the same market. The parallels of the doctor-nurse game are important as they suggest that an understanding of the value of advanced practice is vital to success. The advanced practice 'value net' is diverse, but requires an understanding of the value that advanced practice brings to the health economy (Figure 45).
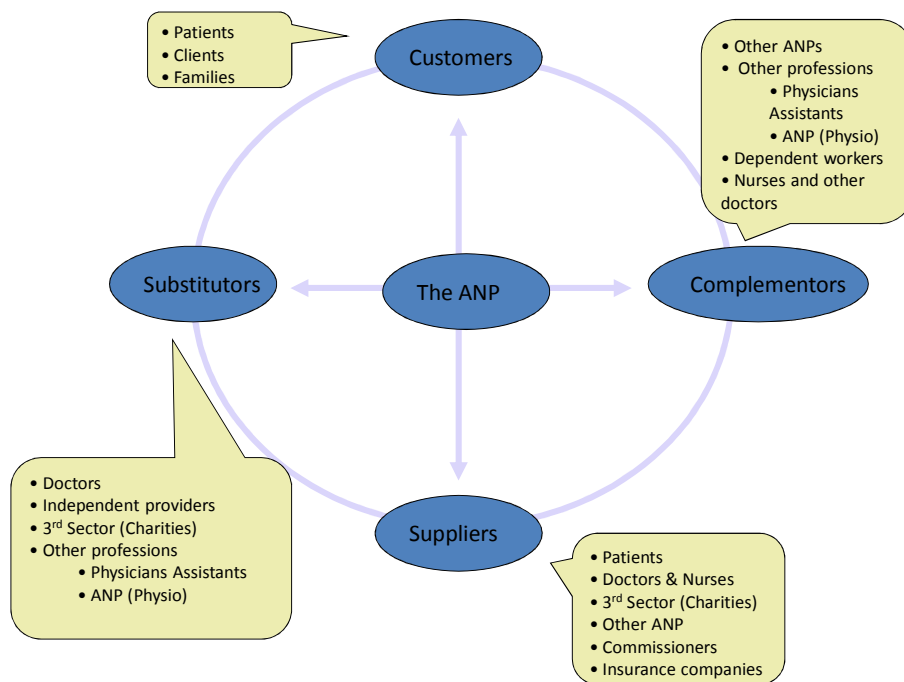
Figure 45 - Conceptual value-net of advanced practice role (adapted from Brandenburger & Nalebuff (1995))

To do this, the advanced practitioner must begin to understand their 'customers' (patients, clients and families), their 'suppliers' (referrers to their service), complimentors (services and practitioners they work with to support their advanced practice role) and substitutors (those who can directly replace them in practice doing the same job).

In addition to understanding challenges in practice for the practitioners themselves, it is also important to understand others who are directly affected in nursing practice. Limited previous work (Tye & Ross, 2000) highlighted this as a potential issue. This research now provides key evidence that the implementation of the advanced practice roles have had two main effects on nursing. Firstly, that the roles have deskilled ward nurses in the

management of more complex patients. This was evident on all sites in the study where nurses no longer participated in some aspects of care. In addition, this reduced some of the contact between the ward nurses and doctors. Secondly, advanced practitioners had been recruited from a pool of nurses in the wards and departments because of skills and ability that would have likely made them the clinical ward leaders of previous generations. The opportunities provided by advanced practice have seen an exodus of able clinical leaders leaving the wards. The sum effect has seen a devaluing of the ward nurse`s role in clinical care, where it now lacks the gravitas that it once did. This is a serious issue for the nursing profession for the long-term stability of core nursing care and leadership of clinical environments. Further work must be undertaken in understanding this impact, and providing suitable professional support for developing core nursing and clinical leadership.

Implication seven – Common training for doctors and nurses

Doctors in the study supported a common training approach with more radical options of 'stem training' where healthcare practitioners all entered the same training and then branched into medicine and nursing, a view supported by Finch (2004a) and D'Armour & Oandasan (2005) . Common training should also extend beyond pre-registration, as junior nurses and doctors should share learning experiences, as a community of practice (Bleakley, 2006; McKimm & Swanwick, 2007), and several examples of inter-professional programmes have been successful (Reeves et al., 2008; Ross & Southgate, 2000).

Implication eight – Improved synchronicity of clinical working

In addition, the participants identified the need for greater synchronicity of the working fields of doctors and nurses as there were too few opportunities in the life of a busy ward or department where shared experience and communication could take place. Tagliaventi & Mattarelli (2006) suggest that such communities of practice and networks also improve knowledge transfer - a perspective that will support other literature in improving outcomes in clinical practice through collaboration (Baggs et al., 1997; Frank, 2009; Rafferty et al., 2001). The erosion of the 'medical firm' and transitory nature of juniors, reduced the frequency of 'grand teaching rounds', and senior nurse presence on ward rounds reduced the opportunity to discuss and plan the care of patients. It was recognised that many would see this as rebuilding the power domain of medicine in the formalised aspects of their professional authority. However, it was suggested that elements of this could be reconstructed with nursing having a greater voice and influence,

with the added benefit of providing opportunity for learning, debate and professional awareness.

Implication nine – Development of clinical feedback systems to improve clinical care

It was evident that the advanced practice nurses lacked any informal or formalised feedback system regarding the care they delivered and the outcomes achieved. All cohorts were directly asked about this issue, and they all responded that this was potentially an important part of their own reflective learning but was sadly lacking in clinical practice. There are many opportunities for doctors and advanced practice nurses to do this if nursing was encouraged to be represented, including professional meetings to enhance professional development such as case presentations, morbidity meetings and journal clubs. It was noticeable that nurses were not formally excluded from such events, and were sometimes participants as observers or, very occasionally, teachers.

Implication ten – Greater formalised role of the advanced practice nurse as an inter-professional educator

 The advanced practice nurse makes a valuable contribution to the education of medical staff, yet their own professional development attracts little or no investment, despite a clear need for the opportunity to develop inter-professional awareness and learning (Radford et al., 2009b). It is recognised that nurses are often anxious about stepping into such environments, due to a lowered perception of their knowledge base and skills. However, as this study has demonstrated, the level of biomedical knowledge they have obtained, coupled with intensive clinical experience, should promote the confidence required to operate successfully in such an arena.

Implication eleven: Increased use of inter-professional clinical training events

Joint training opportunities are increasingly common in UK hospitals, and notable examples are Advanced Life Support, Survive Sepsis and Acute life-threatening events: Recognition and Treatment (ALERT) which have multidisciplinary faculties that include a large number of advanced practice nurses leading the training (Smith et al., 2001). These examples also add value by getting teams of doctors and nurses working together as

clinical teams in scenario-based teaching, and therefore the approach should be actively encouraged both as a teaching method in hospitals and, more broadly, in healthcare.

Implications for policy

It was the intention of this research to initiate debate in relation to several key issues, namely the role of the advanced practice nurse, clinical nursing leadership, organisation of care, and public perception of their care by advanced practice nurses. Each of these policy areas is too sizable and this section too limited to discuss these in detail. Therefore it will focus on policy from the national perspective and that of the profession.

Implication twelve – Continued focus on the role of the advanced practice nurse to deliver the healthcare reform agenda

It was clear from the research that the role of the advanced practice nurse is ingrained within the fabric of the modern NHS hospital. It is important to stress that these roles have in large part been instrumental in the delivery of the NHS radical reform programme which has focused upon patient choice, quality, and rapid and easy access to services (Department of Health, 1997; Department of Health, 2000b; Department of Health, 2003; Department of Health, 2006b). Moreover, in some cases it would not have been possible to achieve the reforms if the government had not realised the potential of the nursing workforce and opened many opportunities for them to deliver care in innovative ways. This enrichment of the profession provided opportunities that were unimaginable at the time when Stein, Porter and Hughes conducted their work. The issue for the profession of nursing is now capitalising on this to ensure that nursing continues to deliver the best care for the patient. To do this, there is a requirement for the greater professional and organisational understanding of the role, definition, competencies and educational standards. Whilst there is a consensus of the advanced practice role emerging in the literature (see page 63), this research highlights that its deployment in practice, titles, education, support, remuneration and power are varied.

Implication thirteen - Greater political activism from the nursing profession to improve patient care

As the findings demonstrate, advanced practice nurses need to fulfil their potential as leaders of care, a view supported by Callaghan (2007). This will go some way to

challenge the perceptions of being '*done to'* as a profession.   Antrobus & Kitson (1999) believe nursing leadership simply has not made the connection that they could actively shape policy, thus bridging the policy/practice divide. Part of the issue for nursing is its lack of political activism (Boswell et al., 2005; Shaw, 2007) which needs to be addressed by its future leaders. However, this can only be achieved by determining what nursing is in the context of contemporary healthcare. This positional change cannot take place where a nurse's intrinsic power base is determined by their proximity to a doctor regarding skills and intellect. Nursing should 'let go of the legacy' which defines itself as the 'martyr' or victim of organisational and political culture, and set about defining itself as the advocate and choice of patients to effectively deliver their care needs.

Political activism can take many forms, and the issues of patients should be paramount. The future focus will centre on choice, access, quality, experience, equity and human rights. Utilising dynamic leadership models such as those of Kellerman (2007) and Shaw (2007) will enable nursing to galvanise the large professional support base of nurses around common themes to deliver change for the patients` good in healthcare, something that to date has eluded nursing to its cost.

Implications for research

The research set out with the specific intention of providing a contemporary update on the relationship between the advanced practice nurse and doctors in acute hospitals. However, during this process a number of other issues arose from the findings, which are highlighted below.

Implication fourteen – Research into the patient perspective of care and treatment by advanced practice nurses

Although the patient per se is part of the scene and part of the transactions that occur, they have not been directly researched as part of this study. They are an important aspect to any healthcare relationship but the scope of the study would have been too large to include this and must remain a future aspect of inquiry. Understanding the patient perspective in relation to the communication between these two groups would also add a useful dimension to the understanding of this new relationship. In addition, it would also be important to undertake further work other than the limited studies (Cooper et al.,

2002; Horrocks et al., 2006; Larrabee et al., 1997; Mundinger et al., 2005) as to the patients` perceptions of being treated and clinically cared for by advanced practice nurses.

Implication fifteen – Continued research into the clinical effectiveness of the roles

As indicated by many commentators (Bryant-Lukosius et al., 2004; Tye, 1997), there still remains a requirement to provide an evidence base on the clinical and operational effectiveness of such roles. Another key issue that requires further work is the ongoing impact of the development of the advanced practice role on the professional role of the ward nurse.

Implication sixteen - Further research should be undertaken into the impact of advanced practice nurses and ward nursing

As outlined in recommendation six, this research highlighted that the development of advanced practice had impact on other professionals in the healthcare team, most notably other nurses. It is important that further work is undertaken to understand three main issues. Firstly, has the development of the advanced practice role deskilled the ward nurse? Evidence in this study pointed to a number of scenarios where nurses no longer undertook aspects of care due to this being taken up by the advanced practice nurses. Secondly, the advanced practice role has intrinsically more power than other nurses, with greater contact with key stakeholders such as doctors and managers. This research highlighted that the ward nurse`s role is often devalued and no longer seen as an end point in the development of a nurse's career. This creates a problem, in that recruitment of advanced practice nurses are taken from a pool of highly experienced, knowledgeable and motivated staff. This creates a vacuum on the wards that is being filled with inexperienced nurses who no longer have the local and visible role model available to support their development.

Implication seventeen – Research into the use and requirements of local competency frameworks for advanced practice nurses

It is evident that some advanced practitioners are undertaking formal qualifications through academic study, and the findings indicate a local use of competency training to augment these. What remains as a research interest is the rationale and use of these

tools. There is a suggestion that the current programmes are providing limited application in the clinical domain and this should be addressed.

Implication eighteen - Further research into aspects of capital in the roles of doctors and nurses

This study has taken a significant step in understanding the forms of capital that determine the roles of doctors and advanced practice nurses. There is very limited work in medicine (Burri, 2001; Nettleton et al., 2008; Ohl, 2000; Tellioglu, H & Wagner, I, 2001; Luke, 2003) and less in nursing (Brown et al., 2008; Giddings & Wood, 2003; Rhynas, 2005). The research has highlighted that capital is a complex problem which requires further work, in particular with non-advanced practice nursing.

Implication nineteen – Use of ethnography in health research

The use of ethnography is critical to understanding culture and was an ideal tool in this study. Critical realist ethnography enabled the discovery of critical findings of power, the allusion of nursing autonomy and the subtle continued subjugation of the nursing role to medicine. However, there were a number of learning points that this research has shared including access and approach to study settings which are complex.   The nature of modern healthcare organisations requires detailed planning and communication by the researcher with a broad group of stakeholders to ensure that access to participants is granted. Consent is a critical part of the process, and the use of direct and global consent has been demonstrated as an effective approach.

As supported by Hellawell (2006) and Mercer (2007), the use of reflexivity during the research added a further dimension to the study. Reflexivity alongside an awareness of insider/outsider dynamic was important to contextualise the role of the researcher within the research. It also provided important analytical support and counterpoint during the observation to ensure that truthfulness and authenticity of the research findings was maintained.

Implication twenty – Use of CAQDAS for data management

The review of CAQDAS on page 119 highlighted that it is still not fully utilised in qualitative research. This research has noted that its use is valuable and enabled the

management of large, complex and multiple forms of data. Although St. John & Johnson (2000) and Weitzman (2000) cautioned that CAQDAS systems in qualitative research could distance the researcher from the material - this was not the case. Familiarity with the material through transcription and analysis with Atlas-Ti maintained a connectivity with the rich nature of the data. The narrative structure to the observation, combined with cross- referenced interviews, reflexivity notes and artefacts ensured that the researcher remained in touch with the experience and environment of those who were part of the research. Postgraduate researchers should be encouraged to use such systems to manage and support their endeavours.

Final comment

In Chapter One I recounted a personal narrative on the path that had led to me to undertake this research and it seems fitting to finally conclude this thesis on this journey. In 1996, the role of the advanced practice nurse was in its infancy in the UK, and being part of that vanguard of nurses at the boundary of nursing was exciting and daunting in equal measure. The development of this project was challenging and immensely hard work. The learning and experience that I have gained cannot be underestimated and will remain with me for my career. However, the research was about the doctors and nurses who kindly allowed me a brief glimpse into their professional lives so that others could learn from their experience. They gave their time and opinion freely so that I could synthesise their world into a framework for future practice. The findings in this thesis are only a part of the material that was gleaned from this enquiry, but they have, nevertheless, highlighted the pragmatic shift in the power dynamics, interactions and professional role of the modern advanced practice nurse. The implications for practice, research and education have been described but it goes beyond this. The link between the role of the nurse and doctor has been used as a sociological tool to understand the power and influence of the medical profession, and this thesis has focused on the practical as well as analytical problems of conducting research in this field.

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Appendices

Government and Policy Searches

- National Health service
- Department of Health
- Royal College of Nursing
- British Medical Association
- National Library for Health
- Health Management
- Knowledge Management
- Public Services Management
- Welsh Office
- Scottish Government
- Cabinet Office
- Canadian School of Public Services Management
- Australian Public Services Commission

Keyword search:

Policy;workforce;organisation;nurse;nursing;care;doctor;physccian;medicine;communicati on;interprofrofeessional;advanced practice; specialist nurse; nurse practitioner; consultant nurse; clinical leadership; leadership; NHS; EWTD; education; training

Research & Academic List of Databases

- Medline
- CINHAL
- Psychinfo
- British Nursing Index
- ASSIA
- IBBS
- Soc Index
- Social Care Online
- British Education Index
- ERIC
- Australian Education Index

Keyword search outputs and strategy are outlined in the schematic diagram on the next page:

AND sub terms
Interaction/s (n= 519)
Relations/relationships (n=1401)
Inter-professional (n=370)
Doctor-Nurse games (n=1)
Collaboration (n=1269)
Teamwork (n=289)
Networks (n=90)

sub terms search
Power (n=105)
IT (n=14)
Delegation (n=0)
Decision making (n=130)

Dr/Physician/Surgeon/Medicine
(N= 571624)

Nurse/RN/Nursing
(N= 549632)

AND policy
(n=1073)

Sub term search
EWTD (n=1)
Workforce (n=55)
Organisation of care (n=1)

AND concepts
Socialisation (n=2)
Power (n=313)
Dynamics (n=84)
Communication (n=1733)
Emotional labour/management (n=147)
Division of labour (n=94)
Leadership (n=506)
Clinical Leadership (n=0)
Decision making (n= 935)

sub terms search for communication
Strategies (n=154)
Conflict (n=45)
Models (n=56)

Sub terms search for decision making
Clinical (n=146)
Models (n=18)

AND Capital
Social Capital (N= 82)
Cultural Capital (n=8)
Symbolic Capital (n=2)

sub terms search
Dr/Physician/Surgeon/Medicine (N= 0)
Power (n=0)

AND Habitus (n=0)

sub terms search
Social/Cultural/Symbolic capital (n=0)
Outcomes (n=1115)
Performance (n=308)
Knowledge (n=907)
Decision making (n=133)
Power (n=61)
Emotional labour/management (n=1)
Education/training (n=8)
Leadership (n=170)
Teamwork (n=17)

Sub term search for knowledge
Biomedical/medical knowledge (n=2)
Nursing/knowledge (n=25)
Inter-professional Education/training (n=5)

AND
ANP (n= 6313)
Specialist Nurse (n=1395)
Clinical Nurse Specialist (n=3243)
Nurse Practitioner (n=8873)
Consultant Nurse (n=100)
Higher Level Practice (n=78)

Sub term search
Nurse/RN/Nursing (n=101)
Dr/Physician/Surgeon/Medicine (n=14)
Power (n=118)
Communication (n=39)
Emotional labour/management (n=0)
Division of labour (n=1)

ethnography
(n=5131)

AND
Critical (n=742)
Critical realism (n=0)

International Political and Health Science Doctoral Research

British Library PhD Database (EtHOS)   **http://ethos.bl.uk/**

The British Library PhD database has over 250,000 theses available. Search strategy included key word search of healthcare related subjects and theoretical concepts associated with this research:

Keyword search

- Professions >>nurse/nursing
    - ANP/SN/NP/CN/CNS
    - Power/Gender
    - Communication/interaction
- Professions >>doctor/physician/surgeon/medicine
    - Power/Gender
    - Communication/interaction
- Healthcare organisation
    - Hospitals/NHS
    - Policy/workforce/nursing/communication/professions

Keyword search for theory and methods

- Power
- Knowledge
- Bourdieu
- Capital >> symbolic/economic/social/cultural
- Gender
- Emotional labour >> Management

- Methods/methodology
    - Ethnography >> critical realism/ realist

Keyword search outputs and strategy are outlined in the schematic diagram on the next two page:
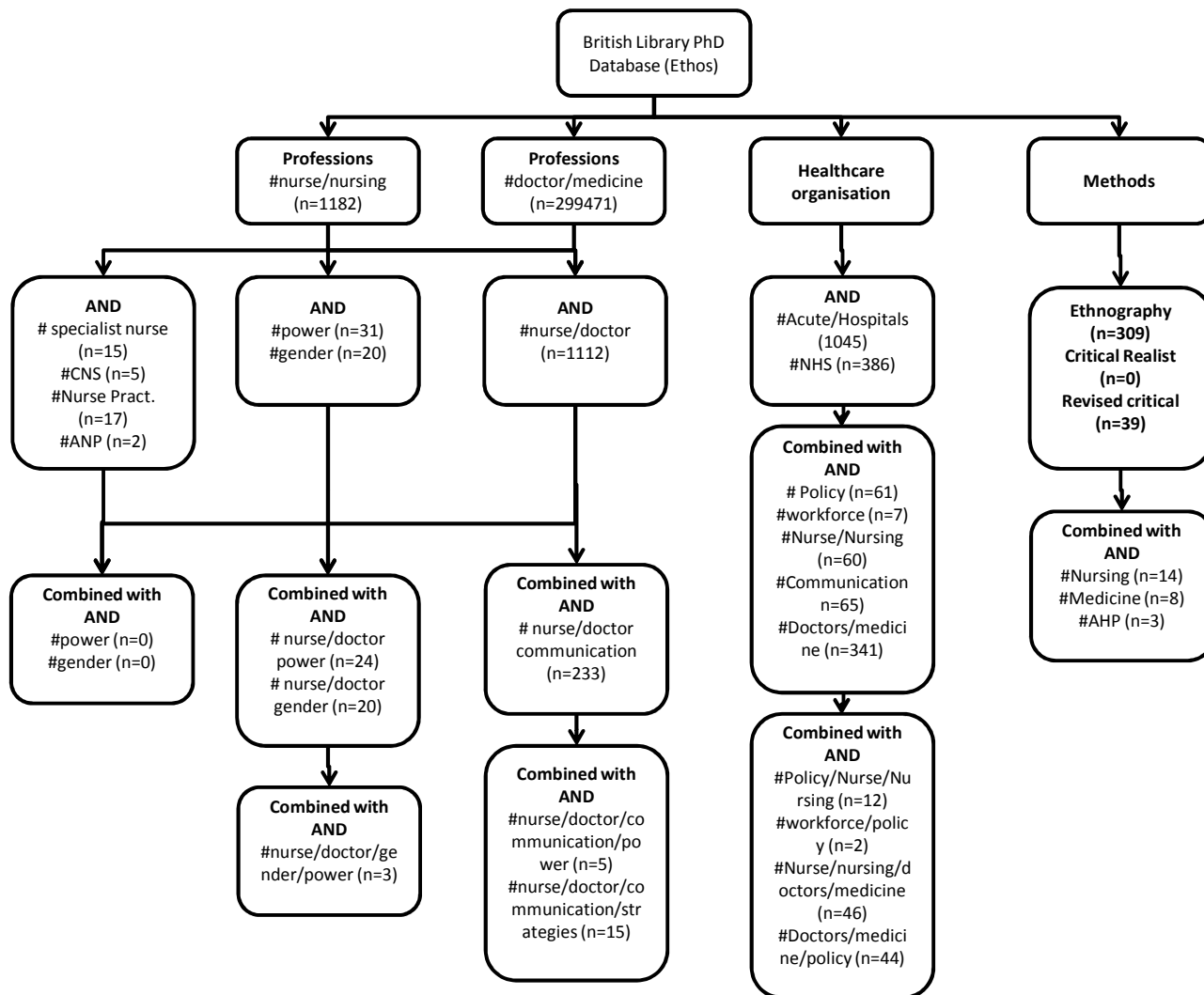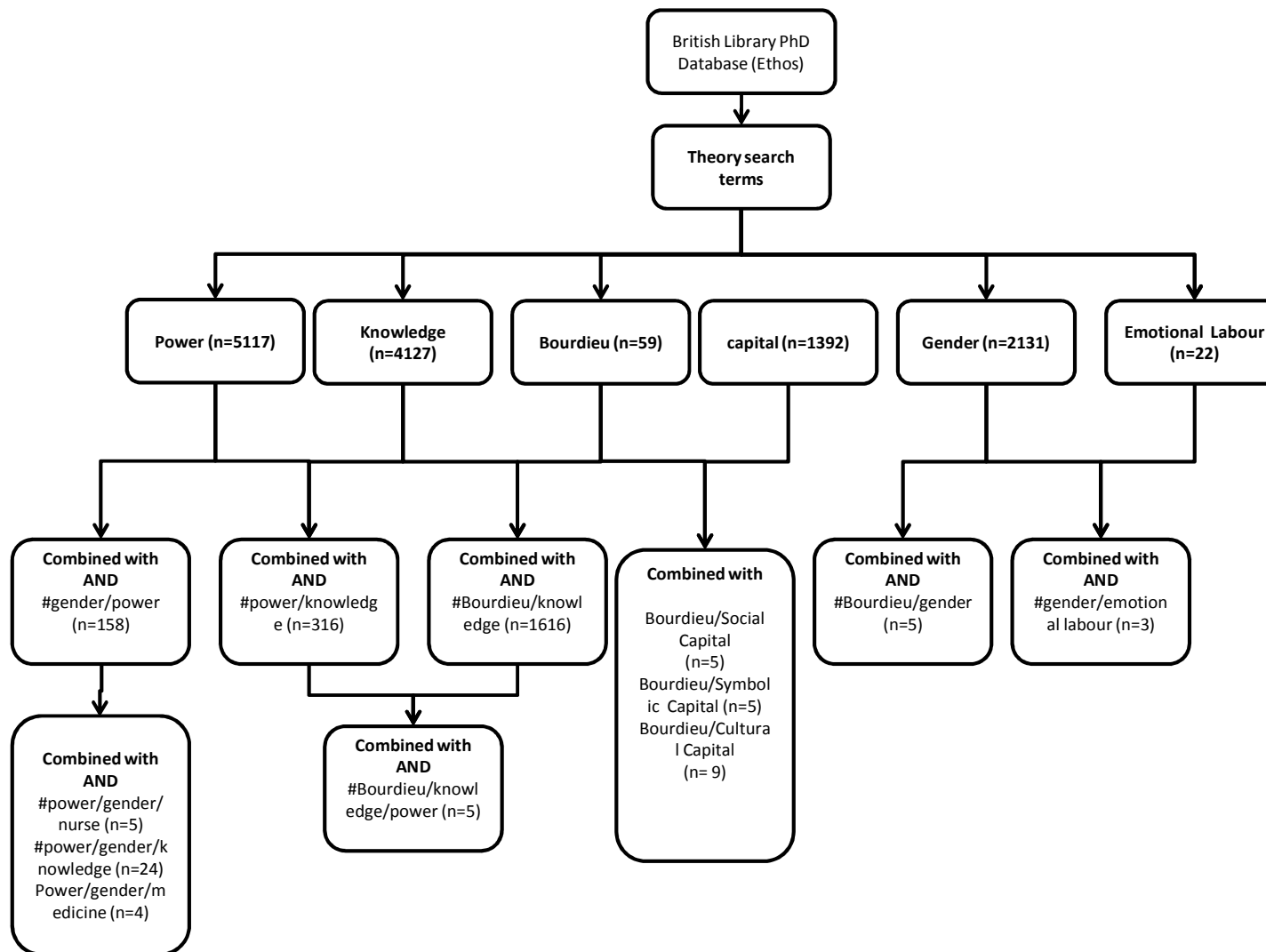
Danish Medical PhD Database **www.dadlnet.dk**

PhDdata.org is a small academic database for doctoral thesis in progress. High level search terms produced following:

- Nurse/Nursing (n=2) - 1 abstracts retained
- Doctor/Medicine (n=3) - none relevant
- Communication/Communication strategies (n=0)
- Power (n=3) - none relevant
- Ethnography (n=0)

PhD Database **www.phddata.org**

PhDdata.org is a small academic database for doctoral thesis in progress. High level search terms produced following:

- Nurse/Nursing (n=3) - 1 abstract retained
- Doctor/Medicine (n=8) - none relevant
- Communication/Communication strategies (n=40) - none relevant
- Power (n=20) - none relevant
- Gender (n=24) - 2 abstracts retained - contact made with one researcher
- Ethnography (n=3) - none relevant

Academic Archive Online **www.diva-portal.org**

Divaportal is a Scandinavian English language database of health related book chapters, journal articles, conference proceedings, Masters and Doctoral thesis.
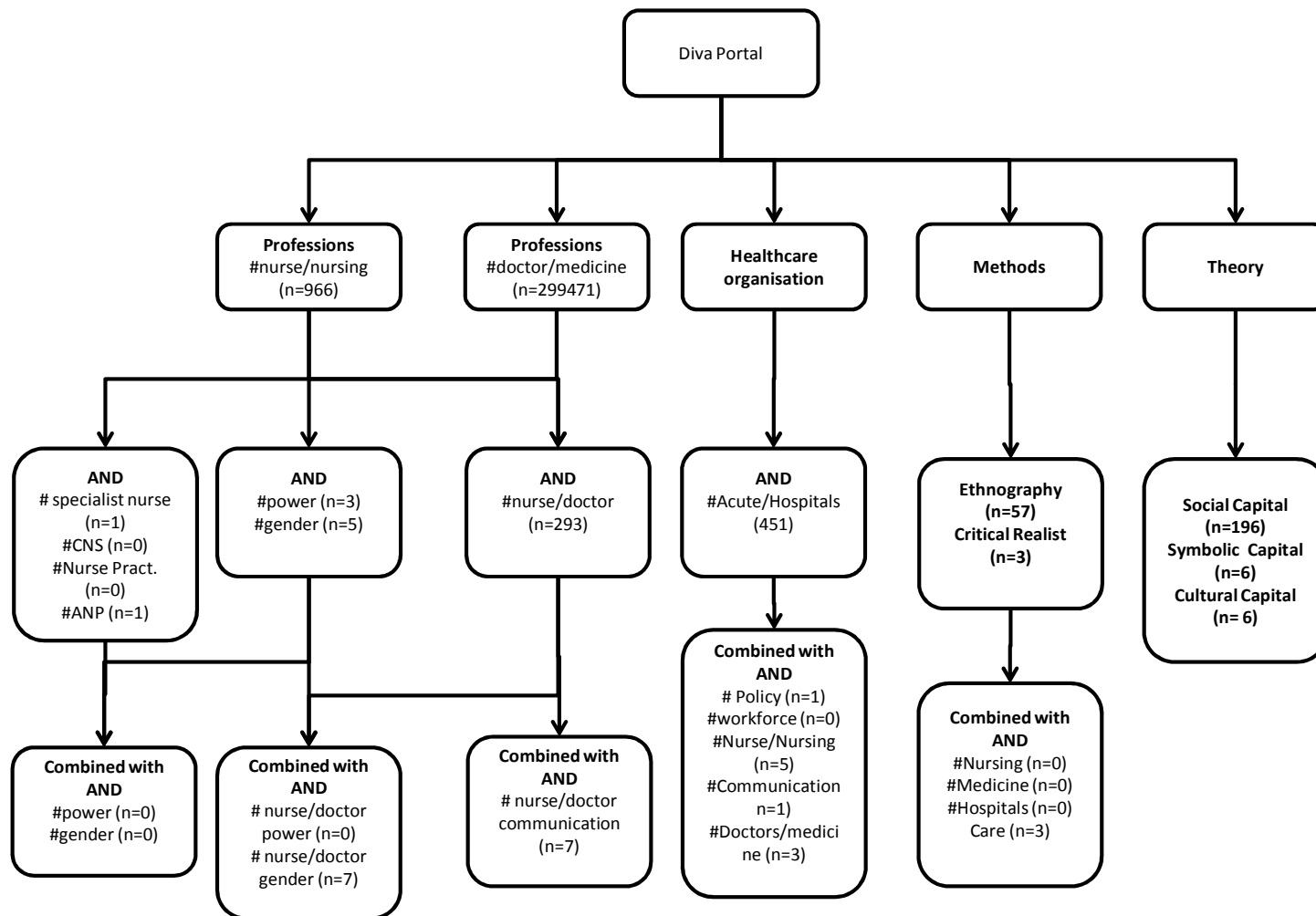
Search Engines

- Google   www.google.co.uk
- Google scholar   www.scholar.google.co.uk
- Academic info   www.academicinfo.net
- Search Engine Colossus   www.searchenginecolossus.com

|	
Atlas Ti	www.atlasti.com
Biblioscape V7	www.biblioscape.com
Kingston Data Traveller	http://www.kingston.com/flash/DTVaultPrivacy.asp
Express scribe	http://www.nch.com.au/scribe/index.html
Sanyo Memoscriber	www.sanyodictation.co.uk
Microsoft Excel 2007	http://office.microsoft.com/en-gb/
Microsoft Word 2007	http://office.microsoft.com/en-gb/
Microsoft PowerPoint 2007	http://office.microsoft.com/en-gb/
Switch Sound Converter	http://www.nch.com.au/switch/index.html
SyncToy	
	http://www.microsoft.com/downloads/en/details.aspx?FamilyID=c26efa36-98e0-4ee9-a7c5-98d0592d8c52
GBM Agent Home Edition	
	http://www.genie9.com/home/genie_backup_manager_home/default.aspx
Adobe Acrobat PDF	http://www.adobe.com/products/acrobat.html

Appendix 3 - the sequence of data collection and analysis

Date	Comment
Nov 2004	Presentation of proposal to Faculty of Health & community Care, UCE
April 2005	Presentation to North Birmingham Research & Ethics Committee
May 2005	Ethical process feedback from North Birmingham Research & Ethics Committee
May 2005	Registered for MPhil at Birmingham City University
July 2005	Approval with North Birmingham Research & Ethics Committee
July 2005	Site I permission received
July - Dec 2005	Site I recruitment and approach
Jan - Feb 2006	Site 1 Cohort 1 - Agreement, initial scoping of study site and consent
March - April 2006	Site 1, Cohort 1 - Data collection
April - Sept 2006	Site 1, Cohort 1 - Transcription and data analysis
Sept - Oct 2006	Site 1, Cohort 2 & 3 - Agreement, initial scoping of study site and consent
Jan - Feb 2007	Site 1, Cohort 2 - Data collection
March - April 2007	Site 1, Cohort 3 - Data collection
May - Sept 2007	Site 1, Cohort 2 & 3 Transcription and data analysis
September 2007	Site 2 - Permissions received
Sept - Oct 2007	Site 2, Cohort 4 - Agreement, initial scoping of study site and consent
Nov 2007 - Feb 2008	Site 2, Cohort 4 - Data collection
Mar - June 2008	Site 2, Cohort 4 - Transcription and data analysis
Feb 2008	Transfer to PhD
Nov - Dec 2008	Site 2, Cohort 5 - Agreement, initial scoping of study site and consent
Jan - Mar 2009	Site 2, Cohort 5 - Data collection
Mar - April 2009	Changed Job role
May 2009	Apply to Site 3, R&D
July 2009	Site 3, R&D approval received
Sept 2009	Site 3 - Permissions Received
Sept 2009	Site 3, Cohort 6 - Agreement, initial scoping of study site and consent
Oct 2009	Site 3, Cohort 6 - Data collection
Oct - Nov 2009	Site 3, Cohort 7 - Data Collection
Dec 2009 - Feb 2010	Site 3, Cohort 6 & 7 - Transcription and data analysis
Feb - June 2010	Initial writing up and further analysis
July 2010 – Jan 2011	Writing 1st Draft
Jan 2001 – March 2011	Review by Supervisory Team
March – May 2011	Amendments and changes to draft
	Submission

Appendix 4 – Medical grade mapping

Year	Old training system (Pre 2004)	New training system (Post 2004)
1	PRHO (House Officer)	Foundation Year 1(FY1)
2	Senior House Officer (SHO) year 1	Foundation Year 2(FY2)
3	Senior House Officer (SHO) year 2	Specialist Registrar (StR)1
4	Specialist Registrar year (SpR)1	Specialist Registrar (StR)2
5	Specialist Registrar year 2	Specialist Registrar (StR)3
6	Specialist Registrar year 3	Specialist Registrar (StR)4
7	Specialist Registrar year 4	Specialist Registrar (StR)5
8	Specialist Registrar year 5	Specialist Registrar (StR)6
9	Consultant (min.7-9 years)	Consultant (8 years)
Optional	Training can be extended by 2-3 years for research purposes.	

Appendix 5 - Research design: Overall subject approach pathway
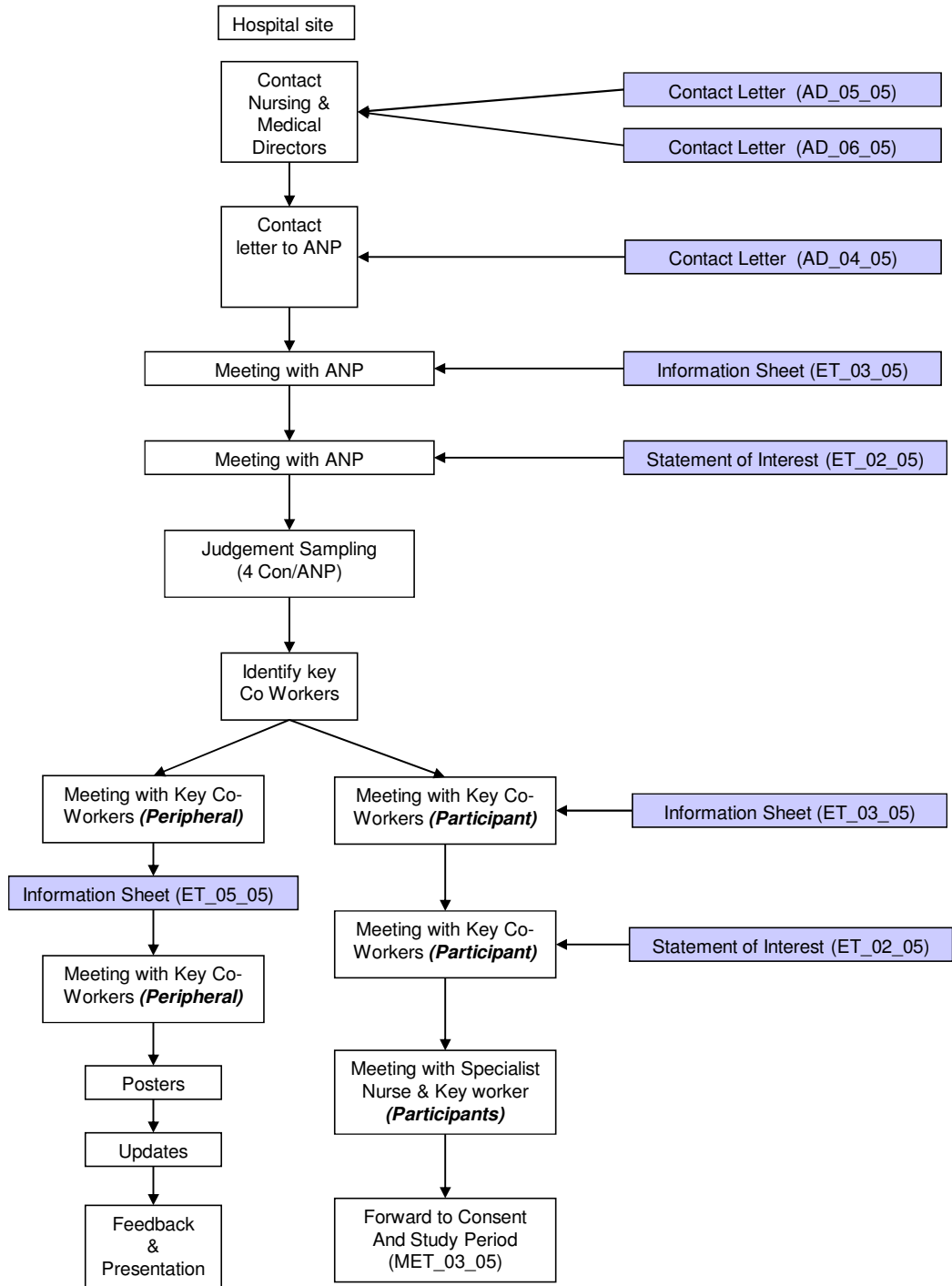
Director of Nursing

XX Hospital NHS Trust

{Sunday, 09 September 2012

Dear XX,

<u>RE: MPhil/PhD study - Power dynamics, knowledge and professional expertise in clinical decision making between specialist nurses and doctors in hospital settings</u>

As part of my MPhil/PhD at the University of Central England in Birmingham I am undertaking a piece of research on the working relationships of specialist nurses and doctors in the clinical setting. The purpose of this letter is asking permission to have access to nursing staff within the Trust to complete the data collection.

As XX Hospital NHS Trust is well advanced with the development of specialist nurses in a wide range of disciplines, it is an ideal area for study.

I am using an ethnographic approach, which will mainly involve close observation for a period of one week during normal working patterns and following this an interview for approximately 1 – 1.5 hours. I have produced an information sheet for participants, to explain further about the project so those individuals are able to make an informed decision about taking part. There will also be a consent form to ensure that all aspects of the study are fully explained (both documents have been included for you to read). I can ensure full confidentiality of the information given by participants, and the Trust in any subsequent writing up.

It is important to point out that this project has been passed by the University research department, and is supervised by three senior lecturers from the post graduate school of nursing. It has also been approved by the North Birmingham Research Ethics Committee (No. 05/Q2704/30) and is registered with the XX Hospital Research and Development Committee (No. RD237).

If you require any further information please do not hesitate to contact me on 0121-xxx-xxxx, Ext. xxxx or mark.radford@xx.nhs.uk.

I very much look forward to hearing from.

With kind regards,
Mark Radford
Consultant Nurse (Perioperative Emergency Care)
XX NHS Trust
&
Research Student
School of Health sciences
University of Central England in Birmingham

Medical Director
XX hospital NHS Trust

[Date]

Dear Dr X

RE: MPhil/PhD study - Power dynamics, knowledge and professional expertise in clinical decision making between specialist nurses and doctors in hospital settings

As part of my MPhil/PhD at the University of Central England in Birmingham I am undertaking a piece of research on the working relationships of specialist nurses and doctors in the clinical setting. The purpose of this letter is asking permission to have access to medical staff within the Trust who work with specialist nurses to complete the data collection.

As XX Hospital NHS Trust is well advanced with the development of specialist nurses in a wide range of disciplines, it is an ideal area for study.

I am using an ethnographic approach, which will mainly involve close observation for a period of one week during normal working patterns and following this an interview for approximately 1 – 1.5 hours. I have produced an information sheet for participants, to explain further about the project so those individuals are able to make an informed decision about taking part. There will also be a consent form to ensure that all aspects of the study are fully explained (both documents have been included for you to read). I can ensure full confidentiality of the information given by participants, and the Trust in any subsequent writing up.

It is important to point out that this project has been passed by the University research department, and is supervised by three senior lecturers from the post graduate school of nursing. It has also been approved by the North Birmingham Research Ethics Committee (No. 05/Q2704/30) and is registered with the XX Hospital Research and Development Committee (No. RD237).

If you require any further information please do not hesitate to contact me on 0121-xxx-xxxx, Ext. xxxx or mark.radford@xxxx.nhs.uk.

With kind regards,

Mark Radford
Consultant Nurse (Perioperative Emergency Care)
xx Hospital NHS Trust
&
Research Student
School of Health sciences
University of Central England in Birmingham

Initial contact letter Consultant or Specialist Nurse

Address

Dear Consultant or Specialist Nurse

RE: MPhil/PhD study - Power dynamics, knowledge and professional expertise in clinical decision making between specialist nurses and doctors in hospital settings

My name is Mark Radford and I am a Consultant Nurse at XX Hospital NHS Trust. As part of my MPhil/PhD at the University of Central England in Birmingham I am undertaking a piece of research on the working relationships of specialist nurses and doctors in the clinical setting.

As XX Hospital NHS Trust is well advanced with the development of specialist nurses in a wide range of disciplines, it is an ideal area for study. This purpose of this letter is asked if you would meet with me to discuss the research project and if you would like to be part of this work.

I am using an ethnographic approach, which will involve mainly close observation for a period of one week during normal working patterns and following this am interview for approximately 1 – 2 hours.. However, as the work of specialist Nurses in the Trust is so varied, it would be best to talk with the you directly about this and this implications if you chose to be a part of this study.

It is important to point out that this project has been passed by the University research department, and is supervised by three senior lecturers from the post graduate school of nursing. It has also been approved by the North Birmingham Research Ethics Committee (No. xx) and is registered with the XX Hospital Research and Development Committee (No. xx).

If you require any further information please do not hesitate to contact me on 0121-XXX-XXXX, Ext. XXXX or mark.Radford@XXXX.nhs.uk.

I very much look forward to hearing from.

With kind regards,

Mark Radford
Consultant Nurse (Perioperative Emergency Care)
XX Hospital NHS Trust
&
Research Student
School of Health sciences
University of Central England in Birmingham

Appendix 9 - Example slides from a presentation given to departments as part of approach process

The Doctor Nurse Game

A study of the interactions during clinical decision making

emergency

Methodology [2]

• Ethnography

– Observation in clinical situation (5 Days)
– Review the observation material with participants
– Follow up interview to discuss interactions and wider issues (1 hour)

emergency

Your involvement

• All material observed or recorded for interview is confidential
• Participation is voluntary

For some;

• You will be observed by a researcher in your normal routine practices.
• The researcher will work with the teams and record issues such as;
  – Cultural systems, use of knowledge, language, networks, role's, rituals &politics

• Followed up by an interview

emergency

RESEARCH INFORMATION SHEET

(For Consultant Nurses/Clinical Nurse Specialists/Advanced Practitioners)

Dear Colleague,
Research Title: Power dynamics, knowledge and professional expertise in clinical decision making between specialist nurses and doctors in hospital settings

You are being invited to take part in a research study as part of my MPhil/PhD at the University of Central England. This information sheet has been produced for you to understand why the research is being done and what it will involve. It will also afford you the opportunity to discuss any issues that concern you and decide whether or not you wish to take part.

What is the purpose of the study?

The purpose of this study is to understand the professional relationships between doctors and nurses in the clinical hospital setting. Specifically those nurses working at a specialist or advanced level, where traditional boundaries have been blurred. As these relationships have changed over the last 10-15 years it is important to understand what strategies are being utilised by doctors and nurses in this area concerning clinical decision making.

What will happen to me if I take part?

The design used for this study is an observational one (termed ethnographic) and it has been designed so that it will be as unobtrusive in your working pattern as possible.

The period of observation will be your working week, approximately 37 – 40 hours. Ideally, this is split over two weeks. I.e. Monday, Tuesday, and Wednesday one week. Thursday Friday the next. (This can be changed to suit you and your work) During this time, I will follow you during your normal working day and record information by note taking. On some occasions I may ask questions related to you work which may be recorded, this will not be done during a clinically or professionally sensitive moment, as I wish in no way to compromise practice in the clinical setting. The researcher is a qualified nurse, and is sensitive to the professional needs of you whilst you do your job.

Following this period of observation, following a couple of days break to allow time for reflection. I will conduct an interview with you for 1 hour and 30 minutes. This interview will be recorded on digital Dictaphone. This interview will remain confidential; the CD recording will be locked in a secure storage facility on the hospital site. Only myself, the researcher, will have access to this, the recording will remain stored for 10 years before being destroyed. A CD copy of this interview will be available to the interviewee.

If at any time during observation or interview you no longer wish to participate, indicate to the researcher who will cease all activity, and provide opportunity to discuss your concerns with the process and your continued involvement.

What do I have to do?

The purpose of the study is to observe normal working relationships between yourself and your medical colleagues, and as such there are no special instructions in your participation.

Will my taking part in this study be kept confidential?

All information received and generated from the study will remain strictly confidential. Names and job details will be changed so as to protect anonymity and all transcripts from tapes and notes will remain securely locked for safe keeping.

What will happen to the results of the research study?

Once all the data has been collected an analysed, you will be asked to review the work so that you are happy with its accuracy of the situations discussed and with the interpretations made in light of the data. You may keep a copy of the data analysis for future reference. This study will then be written up for my MPhil/PhD dissertation at the University of Central England in Birmingham. The material that is generated may add to the body of knowledge surrounding nurse doctor interaction and an overview of the results may be published in the future.

Who is Organising the funding of the research?

As this is part of the MPhil/PhD at the University of Central England, no funding is required for this research project.

Who has reviewed the study?

The study design and background has been reviewed by the MPhil/PhD Post Graduate Research Committee of the School of Health & Social Policy at the University of Central England in Birmingham. This project is being supervised by three supervisors at the University of Central England – Professor Mike Filby, Dr Elaine Denny and Dr Caroline Williams.

The project has also been reviewed by the North Birmingham Research & Ethics Committee, and has been registered with the Research and Development Committee of XX Hospital. If you wish to contact any of these organisations, their details can be supplied.

Thank you in anticipation of your support during the research. If you have any questions, at any time, regarding the project itself, or your participation, please do not hesitate to contact me at;

Mark Radford
Anaesthetic Department
XX Hospital NHS Trust

Tel : 0121xxxxxxx ext xxxx   Email: mark.radford@xxxxx.nhs.uk

Thank you once again.

With every best wish,

Mr. Mark Radford
Consultant Nurse (Perioperative emergency Care) & Research Student
XXX Hospital NHS Trust

RESEARCH INFORMATION SHEET

(For Medical Staff)

Dear Colleague,

Research Title: Power dynamics, knowledge and professional expertise in clinical decision making between specialist nurses and doctors in hospital settings

You are being invited to take part in a research study as part of my MPhil/PhD at the University of Central England. This information sheet has been produced for you to understand why the research is being done and what it will involve. It will also afford you the opportunity to discuss any issues that concern you and decide whether or not you wish to participate.

What is the purpose of the study?

The purpose of this study is to understand the professional relationships between doctors and nurses in the clinical hospital setting, specifically those nurses working at a specialist or advanced level, where traditional boundaries have been blurred. As these relationships have changed over the last 10-15 years it is important to understand what strategies are being utilised by doctors and nurses in this area concerning clinical decision-making.

What will happen to me if I take part?

The design used for this study is an observational one (termed ethnographic) and it has been designed so that it will be as unobtrusive to your working pattern as possible.

The main focus of the observation is the specialist nurse that you work with. The period of observation will be their working week, approximately 37 – 40 hours. They will be followed by me during their normal working day and record information by note taking. As you work closely with the specialist nurse, your work will be observed during this period. On some occasions I may ask questions related to your work which may be recorded, this will not be done during a clinically or professionally sensitive moment, as I wish in no way to compromise professionals in the clinical setting. The researcher is a qualified nurse, and is sensitive to the professional needs of you whilst you do your job.

Following this period of observation, following a couple of days break to allow time for reflection. I will conduct an interview with you for 1 and 1.5 hours long. This interview will remain confidential; the CD recording will be locked in a secure storage facility on the hospital site. Only myself, the researcher, will have access to this, this recording will

remain stored for 10 years before being destroyed. A CD copy of this interview will be available to the interviewee.

If at any time during observation or interview you no longer wish to participate, indicate to the researcher who will cease all activity, and provide an opportunity to discuss your concerns with the process and your continued involvement.

What do I have to do?

The purpose of the study is to observe normal working relationships between yourself and your medical colleagues, and as such there are no special instructions in your participation. You will, however, need to give written consent to my observing you, and I will give you a consent form on your recruitment to the study (or whenever it is)

Will my taking part in this study be kept confidential?

All information received and generated from the study will remain strictly confidential. Names and job details will be changed so as to protect anonymity and all transcripts from tapes and notes will remain securely locked for safe keeping.

What will happen to the results of the research study?

Once all the data has been collected and analysed, you will be asked to review the work so that you are happy with its accuracy of the situations discussed and with the interpretations made in light of the data. You may keep a copy of the data analysis for future reference. This study will then be written up for my MPhil/PhD dissertation at the University of Central England in Birmingham. The material that is generated may add to the body of knowledge surrounding nurse doctor interaction and an overview of the results may be published in the future.

Who is Organising the funding of the research?

As this is part of the MPhil/PhD at the University of Central England, no funding is required for this research project.

Who has reviewed the study?

The study design and background has been reviewed by the MPhil/PhD Post Graduate Research Committee of the School of Health & Social Policy at the University of Central England in Birmingham. This project is being supervised by three supervisors at the University of Central England – Professor Mike Filby, Dr Elaine Denny and Dr Caroline Williams.

The project has also been reviewed by the North Birmingham Research & Ethics Committee, and has been registered with the Research and Development Committee of

Good Hope Hospital. If you wish to contact any of these organisations, their details can be supplied.

Thank you in anticipation of your support during the research. If you have any questions, at any time, regarding the project itself, or your participation, please do not hesitate to contact me at;

Mark Radford
Anaesthetic Department
XX Hospital NHS Trust

Tel : 0121xxxxxxx ext xxxx   Email: mark.radford@xxxxx.nhs.uk

Thank you once again.

With every best wish,

Mr. Mark Radford
Consultant Nurse (Perioperative emergency Care) & Research Student
XXX Hospital NHS Trust

RESEARCH INFORMATION SHEET
(For Ward Staff, AHP and Managers)

Dear Colleague,

Research Title : Power dynamics, knowledge and professional expertise in clinical decision making between specialist nurses and doctors in hospital settings

You are being invited to take part in a research study as part of my PhD at the Birmingham City University. This information sheet has been produced for you to understand why the research is being done and what it will involve. It will also afford you the opportunity to discuss any issues that concern you and decide whether or not you wish to participate.

What is the purpose of the study?

The purpose of this study is to understand the professional relationships between doctors and nurses in the clinical hospital setting, specifically those nurses working at a specialist or advanced level, where traditional boundaries have been blurred. As these relationships have changed over the last 10-15 years it is important to understand what strategies are being utilised by doctors and nurses in this area concerning clinical decision-making.

What will happen to me if I take part?

The design used for this study is an observational one (termed ethnographic) and it has been designed so that it will be as unobtrusive in working patterns as possible.

The researcher will be observing Specialist Nurses and Medical staff in the area that you work. The period of observation will be 5 days or approximately 40 hours. You are not being directly observed as part of this study, however the researcher will be observing the environment you are in. These observations will not compromise your practice in the clinical setting. As the researcher is a qualified nurse, he understands the privacy and dignity of your patients.

If at any time during observation period you do not wish to be observed, indicate to the researcher who will cease all activity, and provide the opportunity to discuss your concerns with the process and your continued involvement.

What do I have to do?

The purpose of the study is to observe normal working relationships between specialist nurses and your medical colleagues, and as such there are no special instructions in your participation.

Will my taking part in this study be kept confidential?

All information received and generated from the study will remain strictly confidential. Names and job details will be changed so as to protect anonymity and all transcripts from tapes and notes will remain securely locked for safe keeping.

What will happen to the results of the research study?

Once all the data has been collected an analysed, there will be an opportunity for the researcher to feed back on the general findings and the research process itself. Feedback will not be given in relation to individuals who have been observed. This study will then be written up for my MPhil/PhD dissertation at the University of Central England in Birmingham. The material that is generated will add to the body of knowledge surrounding nurse doctor interaction and a overview of the results may be published in the future.

Who is Organising the funding of the research?

As this is part of the MPhil/PhD at the University of Central England, no funding is required for this research project.

Who has reviewed the study?

The study design and background has been reviewed by the PhD Post Graduate Research Committee of the School of Health & Social Policy at the Birmingham City University. This project is being supervised by three supervisors at Birmingham City University – Professor Mike Filby, Dr Elaine Denny and Dr Caroline Williams.

The project has also been reviewed by the North Birmingham Research & Ethics Committee, and has been registered with the Research and Development Committee of XX Trust . If you wish to contact any of these organisations, their details can be supplied.

Thank you in anticipation of your support during the research. If you have any questions, at any time, regarding the project itself, or your participation, please do not hesitate to contact me at;

Mark Radford
Anaesthetic Department
XX Hospital NHS Trust

Tel : 0121xxxxxxx ext xxxx   Email: mark.radford@xxxxx.nhs.uk

Thank you once again.

With every best wish,

Mark Radford

Mr. Mark Radford
Consultant Nurse (Perioperative emergency Care) & Research Student
XXX Hospital NHS Trust

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                    ┌──────────────┐           ┌──────────────────────────────┐
                    │   Consent    │◄──────────│   Consent Form (ET_01_05)    │
                    └──────────────┘           └──────────────────────────────┘
                            │
                            ▼
                    ┌──────────────────┐
                    │ Observational    │
                    │ Phase            │
                    └──────────────────┘
                            │
                            ▼
          ┌──────────────────────────────┐     ┌──────────────────────────────────┐
          │ Observational Phase – PART 1  │◄────│ Observation Schedule (MET_04_05)  │
          │                               │     └──────────────────────────────────┘
          │   3 days (8hrs/Day)           │
          └──────────────────────────────┘
                            │
                            ▼
                    ┌──────────────────┐
                    │  Break - 4 days  │
                    └──────────────────┘
                            │
                            ▼
          ┌──────────────────────────────┐     ┌──────────────────────────────────┐
          │ Observational Phase – PART 2  │◄────│ Observation Schedule (MET_04_05)  │
          │                               │     └──────────────────────────────────┘
          │   2 days (8hrs/Day)           │
          └──────────────────────────────┘
                            │
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                    ┌──────────────────┐
                    │  Break - 7 days  │
                    └──────────────────┘
                            │
                            ▼
          ┌──────────────────┐                  ┌──────────────────────────────────┐
          │ Interview Phase  │◄─────────────────│ Interview schedule (MET_05_05)    │
          │ 1 – 2 Hours      │                  └──────────────────────────────────┘
          └──────────────────┘
                            │
                            ▼
                    ┌──────────────────┐
                    │  Transcription   │
                    │  7 Days          │
                    └──────────────────┘
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                            ▼
          ┌──────────────────────────────────┐
          │ Transcription Review Meeting      │
          │ 1 hour                            │
          └──────────────────────────────────┘
                            │
                            ▼
          ┌──────────────────────────────────┐
          │ Individual Feedback Meeting        │
          └──────────────────────────────────┘
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Study Title : Power dynamics, knowledge and professional expertise in clinical decision making between specialist nurses and doctors in hospital settings

The field notes structure will follow those described by Burgess (1994), substantive field notes, methodological field notes and partial use of analytical field notes. The substantive notes will provide observations, record unstructured interviews as conversations and systematic recording of biographical detail and relationship mapping. The methodological field notes will allow the author to keep personal impressions of the research, and therefore a degree of personal involvement and reaction to situational factors, mirroring the current themes of reflexivity in ethnography. The analytical field notes will provide inward analysis . Field notes and reflexivity notes will be recorded in hardback notes books, these will be kept secured in locked storage facility with researcher only access.

Observations

Observation checklist

Space; The physical place
Actor; The people involved
Activity: A set or related acts that people do
Object: The physical things that are present
Act: The single acts people do
Event: A set or related activities that people carry out
Time: The sequencing
Goal: The end result of actions
Feelings: The emotions felt and expressed

Relationship mapping

Produce detailed description of key clinical and managerial relationships.
Line and Professional management structure
Peer support networks
Unofficial support networks

Archive

Job description and organisational charts
Training programs
Other relevant documentation (Letterheads, posters, publications & Presentations)

Rituals, beliefs and rites

Hierarchy order between Nurse and Doctors
Rules of interaction between doctors and nurse
Confrontation (Private/clinical/Organizational)
Team working
Camaraderie
Ordered and 'visible' rituals and rites demonstrated by team. Ward rounds, meetings etc..
Covert systems of challenge to the ritual s and rites

Informal arrangements such as breaks
Personal values
Team/specialty values

Language and discourse

Overt power through orders and delegation
Persuasive & Coercive language
Cultural systems and hierarchy through deference, titles and respect.
The social language of nicknames (private & public), terms of endearment
The social language of 'gossip', underground terminology and referencing
Informal time for discussion; Topics and outcomes
Humor
Trust
Respect

Politics

The political voice of nursing in the organisation
Power base for politics at an individual team level

Networks

Internal and external networks of clinical and professional support
Line and Professional management structure
Peer support networks
Unofficial support networks
Public networks of meetings
Alternative networks

Environment

Resources such as offices, non pay levels
Access to resources and gatekeepers

Icons and symbols

Uniforms/non uniform
Badges/Ties
Professional identity - icons – Professional degrees on wall; posters in office
Personal identity
Letterhead
Posters

Social roles

Gender roles for nurses and doctors
Class differences
Socialization (professional)
Personality; both internal and external view
Organisational integration and socialisation

Clinical knowledge and decision making

Clinical protocols/guidelines and their use
Writing the guidelines and implementation
Visible public decision making on rounds and meetings
Informal decision making
Systems based decision making – how it is integrated?
Autonomy of the nursing staff

Types of decision making subordination; Informal Covert; Informal Overt, Formal overt
Professional conflicts around decision making
Knowledge differences

Interview Schedule

Study Title : Power dynamics, knowledge and professional expertise in clinical decision making between specialist nurses and doctors in hospital settings

Following period of observation, each central participant will be interviewed for one to two hours on aspects of practice. This interview will be tape recorded and transcribed. The interview will be unstructured, but based upon the field notes taken by the researcher.

The interview environment will be agreed by the subject and the researcher prior to the interview. This will take into account needs of the service and privacy.

Opening Comments (MR);

This interview is being conducted by Mark Radford as part of the MPhil/PhD research study into the Power dynamics, knowledge and professional expertise in clinical decision-making between specialist nurses and doctors in hospital settings.

Just for the record you understand the nature of the study and the interview process. Just to reiterate, you are welcome to ask any questions about the research and how it has been conducted. All information that you give in this interview is completely confidential, when transcribed your name and work place will be anonymized. All tape recordings and transcriptions will be locked in a safe area for ten years and only I will have access to these records.

You can at any stage withdraw from this study and request that any information or data collected be destroyed.

Following completion of this interview, I will be the one to transcribe this onto hard copy. Once this has been completed, I will hand to you for review and comment before any analysis is complete.

Are there any questions so far?

This is an unstructured interview

- The first part of the interview will be concerned with a review of the observation data with the participant.
- The interviewer will question the participant on events that occurred during observation. To identify the context issues of normal work patterns and routines between them and their colleagues, including;

  - Time spent with other professional staff (Medical and Specialist Nurse).
  - Tasks undertaken
  - Clinical duties
  - Managerial duties
  - Responsibilities and accountability

- To discuss the participants interpretation of the observed events

- To discuss the participants feelings and emotional reaction to some of the observed events.

- The second part of the interview with discuss with the participant more generic subjects related to working culture of the profession and organisation, including;

  - Rituals, beliefs and rites

    - This may include topics such as cultural differences between the professional groups; Any additional cultural subsets that exist for nurses or doctors working in that specialty. Protocols or ritual that are adhered to remain a member of the professional group or specialty culture. Do the different professional groups share same values?

  - Language and discourse

    - This may include topics such as how professional language is used to communicate between the professional groups to make clinical decisions. What type is most effective, the social, political or professional or organizational language. How is this language developed and are there particular roles for professional groups in this ? Are there any points of conflict in approach to communication. Do the two professional groups

  - Politics

    - This may include topics such as what are the political machinations of the relationship between the two professional groups. How controls the strategic direction of services. How does the rest of the department view the Nurse or Doctors role?

  - Networks

    - This may include topics such as what networks are available for the professional to gain advice regarding clinical decisions. What networks have you developed beyond the traditional to ensure productivity of your role?

  - Environment
    - This may include topics such as the position of the individual in the organization and their access to resources such as offices and equipment.

  - Icons and symbols

    - This may include topics such as role of uniforms, badges and the view of the professional in relation to these.

  - Individual dynamics of the clinical group relationship

    - This may include topics such as what role do personalities play in your team. Does gender play a part in the relationship? Are they're any professional jealously or conflicts over another professional's knowledge or skills.

  - Power bargaining

    - This may include topics such as limitations placed upon professionals practice. By whom and by what strategies have they done this? Is there often an imbalance in relations to decisions and who makes them in the team?

  - Clinical knowledge and how it is used

Are there any other areas of your work that you think are important to this study, that we have not discussed today?

Have you any questions that you wish to ask at this stage?

Thank you for participating in this interview. I will transcribe the information from the tape recording and hand it to you for review and correction.

End of interview

Observation checklist

Space; The physical place
Actor; The people involved
Activity: A set or related acts that people do
Object: The physical things that are present
Act: The single acts people do
Event: A set or related activities that people carry out
Time: The sequencing

Research Design : Key Point Summary

Study Title : Power dynamics, knowledge and professional expertise in clinical decision making between specialist nurses and doctors in hospital settings

Five stage process of Approach, Immersion, observation, interview and withdrawal.

Three Hospital Sites

XX Hospital NHS Trust
XX Hospital NHS Trust
University Hospital XX

Four Specialist or Consultant Nurses from each site .

Approach

Gatekeeper approach to Director of Nursing (Form AD_05_05) and Medical Director (Form AD_06_05)
Contact Letter to Consultant or Specialist Nurse (Form AD_04_05)
Face to face meetings with participants
Information sheet provided (Form ET_03_05)
Reflective time (One week)
Further face to face meeting
Statement of Interest (Form ET_01_05)
Question and Answer
Consent Forms (Form ET_01_05)
One copy for researcher and participant.
Vantage point agreed
Peripheral role members approached
Information sheets provided (Form ET_05_05)
Poster display prior to study beginning (Form AD_03_05)

Immersion

Period of Two days
To reduce effect of the researcher on the environment
Support understanding between participants.
Understand topography of physical environment.
Definitial mapping

Observation

Peripheral membership role
Work/ward environment
Follow shift pattern
Split block observation (Week 1 - Monday, Tuesday, Wednesday – Week 2 – Thursday, Friday)

40 hours of observation, Observation Schedule (Form MET_04_05)
Field & reflective notes kept in hardback book
Note books secured in locked storage facility
Researcher only access

Interview

Interview schedule will be approximately 7 Days after observations have concluded.
Hybrid Informal conversation interview with interview guide (Form MET_05_05)
Tape recorded
Approximately 1 – 1.5 hours in duration
Transcribed by researcher
Transcript viewed by interviewee
Signed off as accurate by interviewee
Tapes and transcripts secured in locked storage facility
Researcher only access

Withdrawal

Individual feedback
Global feedback to the observed area and peripheral role members
Strict confidentiality.

Notes on observation session completed at hospital X, conducted on the 2st March 2007

Observations conducted at hospital x in relation to XX surgery. This clinic was a nurse-led clinic for referrals from district and community hospitals, but running alongside this was a new patient XX clinic that was supported by a consultant and registrar.

Nurse B : We have new patients whether Dr there or not.

We were back in the same clinic room within the treatment centre. I walked into the reception area past the receptionist who noted that I was back, to do some observations and pointed me in the direction of where the nurses were. I wandered round the corner and found the two nurses A and B, looking through the notes and also the computer screen for the inpatient records. As listed by the computer, one of the auxiliaries brings the patient round to the clinic room. Nurse B Note : Not normal to have AN. I move out of the way of the door, as the patient is wheeled in on a wheelchair, being supported by one of the relatives. As soon as the relative arrives at the door the two nurses turn and greet the patient with one of them turning to go and support and help the patient onto the examination couch, which is about two or three yards inside the room. Both Nurse A and B then go back to reading the computer screen and also making an evaluation of the notes for the patient that has just arrived.

Nurse B then comments to me. *'He declined spellchecker on the telemedicine system.'* Both nurses look at each other and smile

Nurse B note : Think that this was nurse A

reflective note, there's clearly some hidden meaning within this that I wish to explore later with these two nurses.

Nurse B then asks Nurse A, *'Do you want to take the history on this patient?'* She responds, *'No problem, I'll do it.'* To which she responds, *'I'll then also get on with the examination.'*

Nurse B then proceeds over to the washbasin, starts washing her hands before putting on a gown. She smiles at the patient and the relative and says, *'I shall be with her in two moments.'*

Nurse B then goes over to the patient, explains to her the process that they'll be going through today. She says that she is going to start taking a history from the patient, and then starts to discuss with her how she has been over the past few months. Nurse B then makes a general comment to Nurse A. *'I'm not entirely sure this is cellulitis. It looks like psoriasis to me.'*

She then asked the patient, *'Have you seen a dermatologist?'* And the patient responds, *'No'*. She then continues to take a detailed health history, particularly in relation to any potential vascular problems. She discusses a lot about symptoms prompting the patient to give her a clear idea as to what's going on.

Whilst I'm observing as she discusses with the patient the other nurse is by the computer screen, and she's calling out some test results that were taken following some photograph of the ulcer the patient had in the previous.

As we're doing this, a new patient is brought into the clinic room by the auxiliary support nurse. There's a second couch at the end of the clinic room and it's a bit of a squeeze as this patient also is in a wheelchair. The patient and the relative is then helped onto the couch by the auxiliary.

CONSENT FORM

Title of Project : Power dynamics, knowledge and professional expertise in clinical decision making between specialist nurses and doctors in hospital settings

Researcher : Mr. Mark Radford
Please initial box

1.   I confirm by signing this document that I give my consent to take part in the above study, by Mark Radford, as part of his research for an MPhil/PhD at the University of Central England in Birmingham. I understand that I will be taking part in a research study examining the relationships between nurses and doctors, specifically looking at decision making and collaborative working styles. This non-funded research project, will be used for his dissertation and it has been explained that at some time in the future all or part of the results may be published.

☐

I understand that I will be observed, and questioned in clinical working environment for a period of 40 hours on the following days.

☐

1.   Following this I will be interviewed for approximately 1 to 1.5 hours. I understand that this interview will be recorded on digital Dictaphone. This interview will remain confidential; the CD recording will be locked in a secure storage facility on the hospital site.   Only myself, the researcher, will have access to this, the recording will remain stored for 10 years before being destroyed. A CD copy of this interview will be available to the interviewee.

☐

2.   I have been recruited into this study because I am working as
………………………………………………….in…………………………
………………………….. at
…………………………………………………Hospital NHS Trust.

☐

3.   I have entered into the study freely, and have been informed that if at any point of the data collection or when I read the results and analysis I may remove myself form the study. If this should occur then Mr. Mark Radford will destroy all notes and transcripts.

☐

4.   I understand that my answers to questions will be in no way communicated to anyone else, and that in the final dissertation my involvement in the study will never identify me in any way.

☐

5.   I understand that I will be allowed full access to the results, and that Mr. Mark Radford will discuss the conclusions will me at a prearranged time convenient to myself.

☐

6.   I have been given the information leaflet and I understand that Mr. Mark Radford is the person to contact if I have any questions about the study or about my rights as a study participant. Mr. Mark Radford can be reached through the following number 0121-xxxxxxx, ext. xxxx.

☐

_____   _____

Date   Participant Signature

_____   _____

Date   Researchers Signature

_____   _____

Date   Witness Signature *(If Applicable)*

Code-Filter: All

_____

HU: PhD
File: [C:\Documents and Settings\Mark\My Documents\PhD\Scientific Software\ATLASti\TextBank\PhD.hpr5]
Edited by:Super
Date/Time: 31/12/2010 14:18:16

_____

Artefacts : Apprentice/Succession planning/Identifying
Artefacts : Benefits of the role
Artefacts : CNS/NP teaching Doctors
Artefacts : competencies of ANP/SNP/CNS
Artefacts : Crossover of ANP/Dr roles
Artefacts : Definition of advanced Practice
Artefacts : drivers for change
Artefacts : gate keeping/control hierarchy for roles
Artefacts : JD : AP skills
Artefacts : JD : External work/national/regional/consultancy
Artefacts : JD : Governance
Artefacts : JD : Leadership
Artefacts : JD : Managing a caseload
Artefacts : JD : management/budget role for CNS/AP
Artefacts : JD : Research
Artefacts : JD : Service Redesign
Artefacts : JD : Teaching/Developing staff
Artefacts : JD : working independently
Artefacts : Law/Statue supporting CNS/ANP
Artefacts : Management control of role agreement
Artefacts : Nursing the process of care
Artefacts : Organisational Medical control/power over CNS/ANP
Artefacts : Qualifacations/Experinece to be ANP/SN/CNS
Artefacts : Rules
Artefacts : Rules/Policy for extending practice
Artefacts: Lack of definition/distinction of ANP roles

Care Model : Access to services/Resources
Care Model : Accountability
Care Model : Boundaries
Care Model : Changes in care standard (Med/Nurse)
Care Model : Changes in roles
Care Model : CNS independence
Care Model : continuity
Care Model : Deskilling Dr/CNS/nurses
Care Model : Differences between Units/Hospitals/Teams
Care Model : Differences between community & Hospital
Care Model : Discharging patients
Care Model : doing the round/being a junior
Care Model : Equality through Seniority of the CNS
Care Model : Health Promotion
Care model : Longevity & familiarity
Care Model : Oversight and Gaze
Care Model : Productivity
Care Model : referral
Care Model : referral to other Nurses
Care model : safety Net/Preventing harm/risk
Care model : Staff Grades/Associate Specialists
Care Model : Support & Development
Care Model : Supporting the Junior Doctor
Care Model : Team work
Care Model : The Apprentice
Care Model : Trawling for work
Care Model : Workload

Challenge (General)
Challenge : Administrative staff
Challenge : CNS about Dr
Challenge : CNS to Dr
Challenge : Dr about Nurse
Challenge : Dr to Nurse
Challenge : Nurse to Nurse
Challenge : Poor performance
Challenge : private covert about drs
Challenge : Professional threat (to Jr Dr.)
Challenge : Within the Team
Challenge : Gender/cultural

Clincal Care : Differences between Dr and Nurse
Clinical care : clinical Leadership
Clinical care : dealing with Relatives
Clinical Care : Diagnostics
Clinical Care : Differences of opinion
Clinical Care : Doing Procedures
Clinical Care : feedback on Care
Clinical care : Improvements in care by CNS
Clinical Care : Inter CNS feedback mechanism
Clinical Care : Legal implications of role
Clinical Care : Motivation to do role
Clinical Care : Self follow up for feedback
Clinical Care : Standardisation
Clinical Care : Supporting Ward/AE/Dept Staff
Clinical Care : Understanding impact

Clinical Consult : CNS to Pt
Clinical Consult : Dr – Pt

Communication : Clinical discussion
Communication : dr about Nurse
Communication : general
Communication : Improving between Drs and Nurses
Communication : Interface between juniors and consultants

Conflict : clinical
Conflict : Dealing with conflict
Conflict : Support for role/Nurse
Conflict with managers

Consult Initiation : Dr to CNS
Consult. Initiation
Consult. Initiation CNS to Dr
Consult. Initiation Tech to Dr
Consult. Initiation: Nurse to CNS
Consultation
Consultation : Initiation with patient
Consultation : Medications
Consultation : Style

Decision making : Admission/Discharge
Decision making : collaboration
Decision Making : Confirmation
decision making : Decision
Decision making : delegation
Decision Making : Diagnosis
Decision making : Differences of opinion
Decision Making : Escalation/Action
Decision Making : General
Decision making : Medical Veto
Decision making : Medication

Decision Making : Overt
Decision making : Protocol & Guidelines
Decision making : treatment
Decision making : Use of investigations
Decision making : Using doctors

Defining work domain : administrative
Defining work domain : Being a specialist Nurse
defining work domain : being busy
Defining work domain : CNS about CNS
Defining work domain : Dr About CNS
Defining work domain : MDT
Defining work domain : Multitasking/ Taking it all on
Defining work domain : Nursing the room
Defining work domain : Previous work of the doctor
Defining work domain : Space; Physical location
Defining Work Domain : Still being a nurse
Defining work domain : Support in clinic
Defining work domain : territory
Defining work domain : Ward
Defining work domain: Clinic
Defining work domain: CNS about Dr
Defining Work Domain: Feedback from Doctors
Defining Work Domains

Delegation : CNS to Nurse/technician
Delegation : Dr to CNS
Delegation CNS to Dr

Dr CNS interaction
Dr Nurse interaction : Being Ignored by dr /Nurse
Dr Nurse Interaction : consultants
Dr Nurse Interaction : general
Dr Nurse Interaction : junior doctors
Dr Nurse interaction : Social
Dr Nurse Relationship : Junior Doctors
Dr Nurse Relationship : Humour
Dr Nurse Relationship : Comment by Nurse
Dr Nurse Relationship : Patient
Dr Nurse Relationship : Shared/Different Clinical values
Dr Nurse Relationships : Comment by Doctor
Dr Nurse Relationships : Frustrations
Dr Nurse relationships : GP's
Dr Nurse relationships : Longevity & familiarity
Dr Nurse Relationships : Making life easier for Drs

Entry into role

Game Play - Keeping head down/ignoring situation
Game Play - Lateral/collateral games
Game Play (General)
Game Play : Advising
Game Play : Anxieties
Game Play : Consultant Differences
Game Play : Context
Game Play : Control
Game Play : Covert
Game Play : Deference to Dr
Game Play : doing deals
Game Play : formal : Overt
Game Play : Gaining access to resources
Game Play : Game Awareness
Game Play : Gender
Game Play : Junior Doctors
Game Play : Learning the rules

Game Play : Political /Backing the team
Game Play : Pre-game strategy
Game Play : Proxy game
Game Play : Situational
Game Play: Counter strategy

Hierarchy : Clinical
Hierarchy : Medical
Hierarchy : Nursing
Hierarchy: Uniforms/Badges/Labels

Influences

Knowledge
Knowledge : CNS about CNS
Knowledge : CNS about Dr
knowledge : CNS revalidating with Drs (Juniors)
knowledge : Confidence & Trust
Knowledge : education BSc/MSc
Knowledge : Intuitive
knowledge : limitations
knowledge : Linked to Grade & Role
knowledge : multiprofessional education
knowledge : Nursing/Medical knowledge
knowledge : Practice vs education
knowledge : Preventing harm/risks
Knowledge : Protocol & Guidelines
Knowledge : Updating & CPD
knowledge background before being a CNS
Knowledge: Dr about Nurse

Label : Consultant
Labels : CNS/Nurse
Labels : culture
labels : doctor
Labels : Gender (female)
Labels : gender (male)

Labour : Admin
Labour : emotional Labour
Labour : Nursing work
Labour : Private Practice
Labour ; Organising
Labour: division of labour

medical support in transitions to being a CNS

Patient

Power : control
Power : Medical

Professions : Historical Perspective/Changes
Professional differences
Professions : Current state of medicine
Professions : Current State of nursing , comment
Professions : Degree education and impact
Professions : Difference between CNS and ward nurse
Professions : Grading
Professions : Uniforms

Research : being part of it (Me)
Research : Interview Comments (Me)
Research : Interview Question
Research : Narrative feedback comments

Research : Nurse Developing their own
Research : Observation Awareness
Research : Observation question
Research : Questions
Research awareness
Research observation feedback

Rules
Rules : Intuitive/Learnt
Rules : Professionally led
Rules : Protocols for CNSs

SD - Pathway Redesign
SD : Drivers for Changes
SD : Initiation of Developments
SD : Junior Doctor experience/hours
SD : Leadership
SD : pay and conditions
SD : Potential of the CNS's
SD : Succession planning
SD: Barriers for change

Skills : Confidence & Trust
skills : clinical examination
Skills : competency
Skills : developing by experience
Skills : Developing skills to be a CNS
Skills : limitations
skills : technical

Social Discourse
Social discourse : About CNS by nurses
Social discourse : About Drs
Social discourse : About Drs by Drs
Social discourse : About Drs by Nurses
Social discourse : About Nurses
Social discourse : About Nurses by Drs
Social discourse : About Patients
Social discourse : Merger
Social discourse : Research

Teaching
Teaching : CNS to doctors
Teaching : CNS to Nurse
Teaching : Dr to CNS
Teaching : Dr to Med Student
Teaching : Evaluation of drs by CNSs
Teaching : Missed opportunities for learning (dr)
Teaching : support/lack of support for teaching
The nurse was not wearing a un..
The team : Inter team Support
The Team : Not a Nurse or Doctor /Isolation
The Team : The medical firm

Tools : computers
Tools ; IT

Transaction - Written
Transaction verbal
Transaction : IT System

'Is the Doctor still in the house?': A Perspective on the contemporary organisation of care in UK acute hospitals

Mark RADFORD[a], Elaine DENNY[b] , Caroline WILLIAMS[c]
& Mike FILBY[b]
[a] Good Hope Hospital, Heart of England FT, [B] Faculty of Health, UCE, [C] QARNNS,
Ministry of Defence

The traditional cornerstone of medical authority in the acute NHS hospital was the 'Firm' of Consultant, Juniors and Medical students. The ordered relationship and power differentials were displayed through rounds, clinics and teaching (Fox ,1993). Other professionals such as nurses took their own power from proximity to these events.   The advent of advanced and specialist practitioners (McGee & Castledine, 2003), has blurred professional boundaries between doctors and other healthcare professionals. This model has also been challenged through the policy agenda of patient choice, competition, centralised control and performance mechanisms and an examination of the working practices of NHS health professionals. Examples such as a change in Medical and Nurse education, coupled with reductions in doctors working hours, new contracts, Modernising Careers frameworks have fundamentally altered the organisation of care in hospitals. The result is a challenge to the traditional clinical power base of Doctors.

This ethnographic study, of fieldwork observations and follow up interviews, was undertaken with three hospital based clinical teams of doctors and specialist nurses. They worked together in specialist areas of surgical, cancer and emergency care.

This paper will focus on the impact of recent developments in health care for the growing band of specialist nurses. Their relative permanence within the team, linked to operational service delivery has resulted in a closer relationship with consultants, and bought challenge from others in the team such as junior doctors, administrative staff and managers. This research also provides a contemporary update on power and gender in healthcare.

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Ethnography of Nurses teaching doctors: implications for classroom practice and educational leadership

Authors

Mark Radford BSc (Hons), RGN, PGDip (ANP), MA (Med Ed.)
Divisional Director of Nursing (Surgery), University Hospitals Coventry & Warwickshire, Coventry, UK and Honorary Lecturer, Birmingham City University, UK

Judy McKimm MBA, MA (Ed), BA (Hons), CertEd, FHEA, FAcadMed
Centre for Medical and Health Sciences Education, University of Auckland, NZ and Visiting Professor, Bedfordshire & Hertfordshire Postgraduate Medical School, University of Bedfordshire , UK

Elaine Denny RGN, BSc, MA, Cert Ed, PhD
Prof of Health Sociology, Faculty of Health, Birmingham City University, UK

Abstract

Background

The philosophy underpinning medical and nursing education now emphasises interprofessional learning, particularly evidenced in the evolution of new advanced level nursing roles. In these roles nurses often take up formal teaching and leadership roles in undergraduate and postgraduate medical education.

Aims and objectives
To explore the experiences, challenges and strategies employed by nurses involved in medical education.

Methods
An ethnographic study of fieldwork observations and follow up interviews was undertaken with four hospital clinical teams of doctors and specialist nurses in a UK acute teaching hospital.

Results
Results indicate a blurred division of labour between nurse and doctor including the use of expertise and education of doctors. This close relationship with doctors challenges the orthodox nurse/doctor perspective. Specialist nurses have formalised roles for clinical and classroom teaching of junior doctors. They have shared anxieties about credibility and knowledge and awareness of potential conflicts in their expertise and the impact this has on junior doctors learning.

Discussion
Medical control over nursing as a profession, as a body of knowledge and in higher education (Denny, 2003; Mundinger, 2002) serves to maintain the view that nursing (and nurses) are seen as 'the other' (Lingard et al, 2002). Socio-structural features underpin the experiences of individual nurses as educators and leaders of doctors where wider social issues, power relations, boundary challenging and professional identity stereotypes

are played out in 'the classroom', 'the boardroom' and the clinical practice arena (Bleakley, 2006).

Conclusion

Our study raises issues for interprofessional education and faculty development as nurses and other health professionals become involved in training, teaching and assessing doctors. The research reflects the findings from others (Lindquist and Reeves, 2007), and offers new insights into some of the strategies that organisations and individuals might adopt to effect nurses' transition into educator and leadership roles.

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An ethnographic study of communication between nurse specialists and doctors in the UK

Mark RADFORD[a], Elaine DENNY[b] , Caroline WILLIAMS[c]
& Mike FILBY[b]
[a] Good Hope Hospital, Heart of England FT, [B] Faculty of Health, UCE, [C] QARNNS,
Ministry of Defence

Background,

Before Stein (1967) first coined the term 'Doctor Nurse game', the relationship between these two groups has been the focus of much research and debate. Stein, followed by Hughes (1998), Porter (1991) and Allan (1997) have sought to understand the complex communication strategies and cultural behaviours of a unique professional relationship. The NHS has evolved with greater specialisation leading to the development of new advanced level nursing roles interfacing professionally and clinically with doctors.

Aim

The aims of this research are to position the role of the specialist nurse in the contemporary healthcare setting and understand the interactions between them and doctors.

Methods

This ethnographic study, of fieldwork observations and follow up interviews, was undertaken with three hospitals based clinical teams of doctors and specialist nurses. They worked together in specialist areas of surgical, cancer and emergency care.

Results & Discussion

A model of communication emerged from the study that was characterised by a relationship developed through shared experience, and long-term interactions. The 'close' nature of the relationship meant that a blurred division of labour existed challenging the orthodox nurse/doctor perspective. Both groups developed overt communication 'styles', depending upon the intended outcome of interaction. Actual communication methods used by the teams, included verbal, written and IT supported by rules and feedback loops. The outcomes were multilayered, often with hidden meaning secondary to the subjects under discussion. Interactions were influenced by individual scenario assessments using a range of professional, organisational and personal values/belief systems. Thus 'Pre-Game' strategies emerged to maximise positive outcomes during transactions.

Conclusions

A contemporary collegiate model of interaction is emerging, although 'doctor/nurse games' are still played out in the clinical setting. However, traditional models of interaction and communication based upon the orthodoxy of a subjugated profession will need to be revised in the light of new evidence.

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