ROLE TRANSITION AND THE NURSE PRACTITIONER: AN INVESTIGATION INTO THE EXPERIENCE OF PROFESSIONAL AUTONOMY

ANDREW MICHAEL MERCER

A thesis submitted in partial fulfilment of the requirements of Bournemouth University for the degree Doctor of Philosophy

November 2007

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Abstract

This research project explores nurse practitioners' experiences of role transition and professional autonomy, aiming to gain a new understanding of how nurse practitioners experience their role, and seeking new insight into the potential of the nurse practitioner role in the ever changing arena of health care delivery. The study addresses the concept of professional autonomy, and the boundaries of professional practice, and links this to the legal, ethical and epistemological foundations of nursing practice in general, and more specifically to the professional role of the nurse practitioner. Amongst specialist nursing roles, the position of the nurse practitioner is of particular interest, because nurse practitioners have evolved within an interprofessional philosophy of care, and therefore have complex issues relating to the scope of their professional practice, their individual and professional identity, and their professional autonomy.

The research was conducted using a phenomenological hermeneutic approach inspired by Ricoeur (1976, 1981), and placed a significant emphasis on the meaning of the lived experience of the participant nurse practitioners within their professional role. Narrative interviews with fourteen nurse practitioners were transcribed to create a series of texts for subsequent analysis. Data analysis provided a progressive exploration of the meaning of the experience of professional autonomy for the participants in the study, and incorporated a descriptive analysis and an interpretive account of the phenomenon. From this hermeneutic analysis a new interpreted sense emerged, and a comprehensive understanding of the meaning of the phenomenon under review could be formulated.

The findings reflect a generally positive view of practice on the part of nurse practitioners, but highlight a number of barriers to the development of their professional autonomy. Professional relationships are central to the experience of professional autonomy, and the future development of the nurse practitioner role. The findings reinforce the need for clearer definition of the nurse practitioner role, and suggest that further reflection on the nature of advanced practice, and the relationship between nurse practitioners and the wider profession of nursing might help in this regard.

Contents

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Chapter 1: Introduction

The aim of this study is to explore nurse practitioners' experiences of role transition and professional autonomy, to achieve a new understanding of how they experience their role, and gain new insight into the potential of the nurse practitioner role in the ever changing arena of health care delivery.

Nurse practitioners are a relatively recent addition to the range of professionals engaged in the delivery of health care, and are of particular interest because they are at the forefront of new advanced practice roles, and as such have contributed to the diversification of nursing practice and the blurring of intraprofessional and interprofessional boundaries in healthcare (Abbott 2007). In exploring the experience of professional autonomy nurse practitioners provide an ideal professional group: they inevitably have experience of role transition because to date all have previously worked in a registered nurse role, and have experience of increasing professional autonomy, afforded to them in varying degrees by the very nature of the nurse practitioner role.

My ideas are derived from different aspects of my personal experience. My interest in this area originates from my practice as a nurse, working primarily in the field of mental health where I had first hand experience of changing interprofessional relationships within mental health services. Changes in the patterns of delivery of care, and in the knowledge and skills of practitioners working in the field have led to increasing opportunities for mental health nurses to work autonomously in

planning and implementing programs of care, particularly in community settings.

A second influence on my interest in this field has been my engagement with nursing philosophy, and philosophical aspects of health care. The close relationship between human science as a paradigm for nursing, as articulated in the work of Neuman (1986, 1990), Paterson & Zderad (1988), Watson (2008) and particularly Parse (1981, 1988), and the underpinning philosophical writings of the pioneers of human science, notably Dilthey (1976), provides a way of understanding nursing that focuses on lived experience of nurses and patients. The focus on human science, as opposed to natural science, provides an approach to care that establishes a unique place for nursing within health care, and reasserts the position of nurses as autonomous practitioners. Nursing care is complementary to medical care, but is at the same time predicated on a different philosophical basis.

The key research questions addressed within this study ask about nurse practitioners experiences of professional autonomy, and the boundaries of professional practice. In the discussion generated by the participants' responses, this is linked to the legal, ethical and epistemological foundations of nursing practice in general, and more specifically to the professional role of the nurse practitioner.

Amongst specialist nursing roles, the position of the nurse practitioner is of particular interest, because nurse practitioners have evolved within an interprofessional philosophy of care, and therefore have complex issues relating to the scope of their professional practice, their individual and professional identity, and their professional autonomy. My decision to

focus this study on nurse practitioners was taken following extensive contact with nurse practitioner students during their degree programme, and the issues they raised in relation to legal and ethical standards in anticipation of their new role.

This study was therefore designed to explore how nurse practitioners experience the professional autonomy afforded to them in their clinical role, and consider how the experience of autonomy impacts on their practice. A number of studies have explored the concept of autonomy and the exercise of professional autonomy in nursing, one or two focusing specifically on nurse practitioners. In addition, several studies have looked at role transitions and nurse practitioners. There is however little research exploring nurse practitioners' experience of professional autonomy, an area of topical interest and potential importance given the ongoing moves towards nurse led services in a range of clinical specialities.

The early part of the study provides a review of autonomy and nursing, and includes a theoretical exploration of the nature of autonomy, and a review of the relationship between professionalisation and autonomy in practice, with particular reference to nursing. This is followed by a chapter exploring the background to the nurse practitioner role, including the definition of a nurse practitioner, the development of the role in the US and the UK with specific reference to regulation, and consideration of different ways in which nurse practitioners have been deployed in practice.

Following this methodological issues are explored. In keeping with a human science approach to nursing, the philosophical approach adopted

for the study is based on phenomenology; the object of qualitative research is to focus on the human aspect of behaviour in context, in this case seeking to highlight the personal, professional and organisational aspects of the research question through narratives.

The research was conducted using a phenomenological hermeneutic approach inspired by Ricoeur (1981), and placed a significant emphasis on the meaning of the lived experience of the participant nurse practitioners within their professional role. Data collection was carried out through semi-structured narrative interviews, which were transcribed verbatim, and provided the texts for subsequent analysis. Data analysis was completed in three stages. First the texts were subject to a first (or 'naïve') reading, designed to achieve a broad impression of the scope of the narrative accounts and the common themes evident within them. This was followed by a process of structural analysis, based on the reading and re-reading of the texts to uncover thematic patterns within the data, and the creation of a descriptive account of the emergent themes. The third stage was designed to achieve a deeper comprehensive understanding of the phenomenon, via an appropriation of the meaning of the texts, combined with a reflection on the interpretation in context, and reference to thematic descriptions and other evidence in published sources. From this hermeneutic analysis a new interpreted sense emerged, and a comprehensive understanding of the meaning of the phenomenon under review could be formulated.

The findings reflect a generally positive view of practice on the part of nurse practitioners. They believe that they have the potential to work in an autonomous way, within the context of their defined role, but recognise that their role is complementary within the health care team.

Nurse practitioners can therefore work independently, but not in isolation. Participants were able to identify a number of issues that they see as frustrating their development, and impact on their opportunity to maximise both their autonomy in practice, and their clinical effectiveness, and these provide some pointers to the changes necessary to improve the effective deployment of nurse practitioners.

Participants believe that nurse practitioner roles should be located firmly within nursing; they were adamant that they occupy an advanced practice nursing role, and articulated a reluctance to accept any reconfiguration of roles that placed them in a more generic role as a substitute for a junior doctor.

Nurse practitioners are proud of their achievements, but exploration of the appropriated meanings within the narratives showed evidence of significant doubt regarding their potential for increased autonomy, particularly given the seemingly intractable dominant professional structures within health care. Frustrations associated with bureaucratic controls such as guidelines, protocols and statutory restrictions compound this, and evidence of a submissive attitude underpinning nurse practitioners' self-worth leaves many nurse practitioners unsure of whether they should be promoting themselves as an alternative to other disciplines, such as medicine, or consolidating a position as a senior nurse, accepting that others will then view them as a part of the wider nursing group.

Several key implications emerge from the study. The findings reinforce the need for clearer definition of the nurse practitioner role, backed by statutory control. While this may reduce the number of nurses eligible to

make claim to the title, it will help clarify nurse practitioners position within the health care team, and allow others to have more uniform expectations of the role. It might also promote further reflection on the nature of advanced practice, and the relationship between nurse practitioners and the wider profession of nursing.

PART ONE: BACKGROUND

Chapter 2:

Autonomy, nurses and professionalisation.

2.1 Introduction

Autonomy is by definition synonymous with freedom, independence and self determination. The term has its origins in ancient Greece, where it defined the system of self rule afforded to city-states (Dworkin 1988), but its modern usage derives from the work of Kant (1998) who explored the concept of autonomy in relation to self rule at the level of the individual. Kant saw autonomy as a human capacity, the ability to take action that is outside the control of others, free from coercion, duress, undue influence or manipulation. (O'Neill 1990; Childress & Fletcher 1994). In recent years autonomy, or more specifically respect for autonomy, has become widely recognised as a key ethical principle, particularly relevant to healthcare because of the close correlation between respect for autonomy and respect for the person exercising that autonomy.

2.2 Autonomy and professional practice

In health care settings autonomy has been described as the foundation of respect for others, and conversely the condition upon which respect is based (Hanssen 2004); respect for others is therefore seen as a fundamental principle guiding human relationships, but in practice only

those with the capacity to exercise autonomy see their decisions upheld and their actions respected by others. As Beauchamp and Childress (2001) point out, choosing autonomously is not the same thing as being respected as an autonomous agent. In the context of professional practice this is an important observation; nurses have often been regarded as subservient to other health care providers, and have not therefore been in a position to exercise autonomy in their practice. Nurse practitioners may be able to meet the pre-conditions required for autonomous action, but if others fail to recognise their potential it is unlikely that they will achieve the professional recognition that is necessary for them to work independently.

In his discussion of professional practice Hall (1968) describes autonomy as both a structural and an attitudinal attribute, evident in the professional socialisation of nurses and the values that underpin professional practice. Professional autonomy encompasses both the structural and the attitudinal aspects of Hall's seminal paper. In defining nursing autonomy, Batey & Lewis (1982) suggest that 'freedom to make discretionary and binding decisions consistent with one's own scope of practice and freedom to act on those decisions' are the necessary components, a view in keeping with Keenan (1999), and Wade (2004), who suggests that nurses' professional autonomy is progressive, and is dependent on the specific role of the nurse or nurses in question. This corresponds with the views of Wood et al (1986), who define autonomy as 'the amount of discretionary control the individual has over the performance of actions in the course of practice', this discretion deriving in part from the individual nurse's beliefs, and in part from the

experience of role socialisation and the organisation and management of the practice setting.

Hall's (1968) reference to attitudinal and structural aspects of autonomy is in keeping with the work of Gillon (1985), who describes three subdivisions of autonomy: autonomy of thought, autonomy of will, and autonomy of action. Autonomy of thought is defined as the opportunity to make decisions, to hold beliefs, and to possess preferences. Autonomy of will is a logical development of this idea, and allows individuals to make decisions regarding their behaviour freely, according to their own volition. This is the essence of the view of autonomy espoused by Kant, who saw free will as the heart not only of autonomy, but also of morality (Sullivan 1989). Autonomy of action, Gillon's third aspect of autonomy, suggests that the ability to carry out decisions is essential to the exercise of full autonomy, and within nursing practice the freedom to make clinical choices has been seen by some as the pinnacle of both professional and autonomous practice. It has been suggested (Schutzenhofer & Musser 1994) that there is a positive relationship between the highest levels of nurse education and autonomy, however others have suggested that it is not the most highly technically skilled nurses who have the greatest opportunity to exercise autonomy in their practice. Several studies have indicated that community public health nurses and psychiatric nurses have greater autonomy than critical care nurses, despite the popular perception that critical care and other hospital based nurses have greater opportunities to demonstrate higher levels of practice than those in primary care settings (Wood et al 1986; Adams & Miller 2001). This is perhaps because nurses in primary care settings practice as part of a nursing team, where leadership and

professional supervision is provided by other nurses, rather than professionals from other disciplines, and where there is an emphasis on caseload management. This position is supported by Mrayyan (2004) whose study of nurses' autonomy and the impact that management has on professional autonomy concluded that autocratic management, together with the influence of medical practitioners on nurses' workloads, were the most important inhibiting factors; strong nurse management impacts positively on nurses' (self) perceived autonomy.

Finn (2001) echoes the view that medical practitioners can affect nursing autonomy, and describes nursing as still suffering the effects of "patriarchal dominance" by the medical profession. This view is backed by the observation that in certain circumstances nurse managers adopt a rigid controlling management style not dissimilar to that associated with the controlling, paternalistic tradition of medical dominance in health care, in which nurses were viewed as servants of the hospital, or servants of the physician, but rarely as independent practitioners (Bullough 1980). This tradition is described by Duffy (1995) as a significant impediment to autonomous nursing practice; the view that strong nurse management enhances nurses' autonomy is entirely dependent on the management style in question. Nurses have long been perceived as lacking the power necessary to influence others, whether they be senior managers within nursing of other professionals within the wider health care system. This in turn leads to an inability to achieve professional goals, and increasing frustration (Raatikainen 1994). Where nurse managers empower and motivate their staff through transformational leadership autonomy is likely to be an inevitable consequence (Lindholm, Sivberg & Uden 2000; Murphy 2005).

Some observers (Englehardt 1985, Baumann et al 1998) have suggested that professional power is derived from those enabling functions that are backed by statutory licences, and that certain defining characteristics, such as prescriptive authority, and the practice of surgery, have been guarded by medicine in a way that might constitute restraint of trade (Sage et al 2003). Others would argue that the development of nursing autonomy should not be dependent on extended roles that encompass tasks formerly the exclusive province of other disciplines, most notably medicine (Watson 1985; Parse 1998, Bryant et al 2004).

The view that professional autonomy can be defined through professional function, or more precisely the idea that this view of autonomy can be applied to nursing practice, has been criticised because it promotes logic and reason as central to decision making processes, placing rationality in decision making above other influences (Paley 2002). This emphasis on rational thought denies, or at least minimises, the influence of the context of action on decision making processes, and the impact of the community within which a given action is set. Kant's dependence on reciprocity is seen as incongruent with the ethics of caring, as espoused by a range of theorists working in the field of caring, both within nursing (Gilligan 1993; Watson 1985; Parse 1998), and allied fields, such as education (Noddings 1985), or social work (Freedberg 1993). In the context of nursing, the emotional component is central to practice (Benner 1996) and the notion of caring science is predicated on the relationships that emerge within the therapeutic milieu.

Despite this nursing has increasingly claimed that autonomous practice is central to both nursing care (Silva 1983; Budge et al 2003), and to the development of advanced practice nursing roles, particularly that of the nurse practitioner (Brown & Drayne 2003). Indeed Schutzenhofer (1987) suggests that the achievement of autonomy is the key to full professional status, and that it is a failure to achieve true professional autonomy that for many years denied nursing appropriate professional recognition. Although autonomy is regularly identified as a key to professional status (Freidson 1994;) several observers have noted that the nurse is a person in his or her own right, with all the qualities inherent in a person (Wood et al 1986), and that independence of thought and action are integral to the individual accountability of the practitioner. While some aspects of accountable, independent decision making within nursing are influenced by professional codes and universal professional values, individual morality makes a significant contribution to the attributes of every practitioner. Liaschenko & Peter (2004) suggest that professional codes of ethics are of limited use in the everyday morality of practitioners and their work.

This is in accord with the views of Mill (1859), who saw liberty of thought and discussion as a prerequisite of individuality; through the development of individuality man could achieve 'essential well being', something which can only be maximised through action. The limits placed on this freedom of action are those which comply with general utilitarian theory, autonomous action is justified only if it maximises autonomy and does not impair the opportunity for autonomous action in others. For Mill, therefore, autonomy is one of the component parts of liberty, and relates to individual freedom to act. This freedom exists

within the boundaries of Mill's wider theory: people are responsible for maximising their own autonomy, and at the same time must ensure that other people have the same freedom to act autonomously. Everyone is bound to act to promote freedom both in themselves and in others at every opportunity. This is the basis of the biomedical ethical principle of respect for autonomy (Beauchamp & Childress 2001), a position which has over the past twenty years become the acknowledged standard for practitioner patient relationships within western medicine (Woodward 1998, Hanssen 2004), and forms the basis for therapeutic relationships across a range of healthcare disciplines.

Supporting the rights of patients to exercise autonomy is not the same as acting autonomously in a professional role, however. In this context medicine has been accused of ignoring patient autonomy and acting out of beneficent paternalism (Childress 1982), while nursing has lacked the opportunity to take direct action in support of patient autonomy because of inequalities in professional relationships. In recent years the development of advanced practice roles has promoted greater professional autonomy within nursing (Thompson & Watson 2003, Clarke 2006), a development that has coincided with the general acceptance of patient autonomy as the key ethical principle guiding practitioner/patient relationships in healthcare. These changes have combined to strengthen the potential for the further development of professional autonomy in nursing, as nurses have the opportunity to manage care without automatic reference to other disciplines.

2.3 Concepts of autonomy

Mill's position on autonomy has been described as 'soft determinist' (Viney & Crosby 1994), acknowledging the influence that past experience can have on present decision making processes, and recognising that antecedent events impact on free will. Where antecedent conditions are consistent, individual exercise of autonomy will be consistent. Within professional practice elements such as education and role socialisation form an important part of these 'antecedents', and might support the view that professional autonomy is not synonymous with individual autonomy, and is only intelligible within the context of practice, governed as it is by professional codes and statutory regulation (Porcher 1996, Husted & Husted 2004).

This view of autonomy has been adapted in modern liberal theory; for example Scanlon (1972) suggests that the powers retained by the state should be restricted, and only those which allow the citizens of the state to consider themselves 'equal, autonomous rational agents' are justifiable. The relationship between state and citizen is not dissimilar to the relationship between professional regulator and practitioner, where professional autonomy is seen as a legitimate goal for advancing practice, but must always be developed within the context of statutory authority and professional codes.

An alternative perspective on autonomy was provided by Kant (1998), who was concerned less with autonomous action and more with autonomous thought. He considered the real nature of autonomy to exist in the exercise of free will, the precursor of free thinking. In making

autonomous decisions the individual is able to deliberate autonomously; the exercise of autonomy is therefore something which precedes action. In Kant's view autonomy is seen not as a right, but as a duty (Sullivan 1989). It is essential that all men are autonomous, because autonomy of thought is the basis for all moral behaviour. This position is echoed in the work of John Rawls; his *A Theory of Justice* (1971) emphasises the idea that freedom and equality are essential for the development of a just society, but suggests that rational thought leads people to accept public principles of justice and fairness as constraints which facilitate autonomy. Professionalism, and therefore professionalisation within nursing, a discipline founded on caring principles which include justice and fairness as central tenets, might be viewed as conforming to underpinning beliefs that promote autonomy as a social good.

Many modern authors have combined the principles of liberty and duty into a single concept of autonomy, which encompasses both the functional ability to deliberate rationally and the physical opportunity to act on decisions (Childress 1982, Faulder 1985, Beauchamp & Childress 2001). Linking freedom of thought and liberty of action within a general definition of autonomy, which combines the three elements described by Gillon, and incorporates both deontological and teleological concepts, has provided health care with an all encompassing ideal, but gives rise to further questions. How should the parallel concepts of autonomy of thought and autonomy of action be utilised in defining ethical practice, particularly where the essential aspect of the practitioner/patient relationship is about respect rather than autonomy per se? How do nurses and other health care professionals demonstrate autonomy of thought if 'full' autonomy is dependent on actions which in turn are only

possible within the boundaries established by codes of practice, and contracts of employment?

Benson (1983) sets out to question the exercise of autonomy. His often quoted article 'Who is the Autonomous Man?' reaches the somewhat problematic conclusion that there can be no unique concept of autonomy; rather autonomy must exist within the personal schema of the individual concerned. Like Childress (1982), Benson considers the definition of autonomy to incorporate both will and intellect. He is, however, concerned about the traditional view of autonomy existing only within the intellectual and analytic aspects of human experience, which might be seen as limiting the potential range of autonomous behaviour to those who possess specific life situations and abilities. In the context of nurses' professional autonomy these limitations are determined by professional registration; only those who hold professional registration can claim the right to exercise professional autonomy.

The concept of autonomy might therefore be described in several different ways, and each has implications for the way in which health care both seeks to promote and respect the autonomy of patients and potential patients, and regulate the professional behaviour of practitioners. Benson believes that there is a difference between 'intellectual autonomy', in which the person concerned takes responsibility for 'first hand' investigation of the knowledge element in the decision making process, and an alternative which might be termed testimonial autonomy, in which there is an acceptance of information supplied by others in a process described as 'truth directed enquiry'

(Benson 1983). If Benson is correct in proposing that autonomy is consistent with the acceptance of others' knowledge, thus creating a situation in which independent decision making, or the exercise of free will, is possible, then his criteria for autonomy are met. It is not true to suggest that these criteria constitute autonomy, however. For full autonomy to exist the individual concerned must go beyond understanding and resolution, and take autonomous action. A distinction can be drawn between those people for whom each action is autonomously chosen, following an analysis of facts and a deliberated decision, and those people who are subservient to a greater power but have still exercised individual autonomy in choosing to accept the external power over and above their individual decisions. Childress (1982) suggests that those whose judgements and decisions are taken on their behalf should be described as heteronomous, that is ruled by others. Much of what is considered to be professional autonomy would fall into Childress' heteronomy, given the degree of regulation implicit in practice. Individual decisions are inevitable taken in the context of statutory and professional regulation, and for this reason practitioners are only free to take (autonomous) decisions in the context of their professional regulatory frameworks.

Dworkin (1988) proposes that a distinction is made between 'first order' and 'second order' autonomy. First order autonomy refers to situations in which the individual makes a free and informed choice, and acts upon that choice. Second order autonomy would describe the relative freedom of an individual who has previously made a 'first order' choice to live by a given set of rules or principles, such as the laws of a state or the teachings of a religion. If the person abides by the rule of the institution

their freedom to act in any given situation would be minimal, all action being determined by the parent organisation, but they would be exercising second order autonomy provided they continued to subscribe to the broad values of their chosen order. This view is similar to the notion of autonomy as 'relational and practical' expounded by Meyers (1989), and further developed by Atkins (2006), who distinguishes between choices that reflect internalised social norms, and those that are critical choices made at an individual level within the scope of social norms. Again this is in keeping with the restraints placed on practitioners by statutory and professional standards. Autonomy, characterised by self regulation and freedom to practice are among the defining characteristics of a profession, and adherence to professional standards provides status and power in public life.

2.4 Professionalisation and nursing

Over the past century nursing has aspired to professional status and professional recognition, particularly as the delivery of health care becomes increasingly the province of a multi-professional system, and individual contributions are in part dependant on professional status. For much of the past century however sociologists have classified nursing as an emerging profession, or a marginal profession, and this despite the progress made in research, education, and regulation during that period (White & Begun 1996; Keogh 1997; Thupayagale & Dithole 2005).

The characteristics of a profession were first defined by Flexner (1915) early in the last century, although there had been a number of earlier references to professional status in writings on the history of medicine

(Burnham 1996). Flexner's work was based on his observation of medicine, alongside two other long established professional groups, law and the priesthood, and sought to define the basis for full professional status by listing the characteristics shared by those who were in his view 'established professions'. Flexner's 'characteristics of a profession' include intellectual challenge; the existence of an underlying body of knowledge; work that is developed through education discipline but is practical rather than theoretical; internal organisational structures, such as professional memberships or registration; and practitioners who are motivated by altruism.

Flexner's work was modified and further developed by Bixler & Bixler (1945) in the middle of last century. The Bixlers' work was based on observations of nursing in the US, and coincided with a significant change in the education and deployment of nurses which had itself prompted a renewed interest in the professional status of nursing. The Bixlers built on Flexner's 'characteristics', by adding a reference to the importance of a code of conduct, and specifying the need for professional autonomy and internal regulation. The paper by Bixler and Bixler was influential at the time of publication, and has formed the basis for several other observers' definitions of professional status, notably the work of Pavalko (1988). However, definitions based on a listing of characteristics might be seen as reductionist, and have been criticised for creating a monopoly of services within cultures dominated by scientific credibility, hierarchical order and power (Baines 1991).

Given this type of criticism, it is not surprising that the debate on how best to define a profession has perhaps run its course with no real

consensus by way of conclusion. Within healthcare changing patterns of decision making, with critical decisions made at organisational level on the basis of available funding the potential for the exercise of professional autonomy has diminished for all disciplines, including medicine (Chambliss 1996; Liaschenko & Peter 2004). Despite this, achieving autonomy in practice, as a precondition for accountability (Leddy et al 2005), is seen by nurses as one of the most important contributory factors in maximising job satisfaction (Finn 2001). In the ongoing debate over how professional status might be defined, recent discussions within sociology have focused more on how occupations gain (or claim) professional status (Freidson 1994). Several observers, notably Pavalko (1988), have looked to identify disciplines on a continuum from occupation to profession, a move away from a rigidly defined set of criteria for the definition of a profession, towards a recognition that professions are never static, and cannot be categorised over time. This view reflects the process of professionalisation as more important than a simple definition of professional status, and encourages aspiratory claims from some sectors. The proliferation of 'professions' led some to make a distinction between the so called 'status professions' of medicine, law and the clergy, and the 'occupational professions' that have emerged from a desire among a number of occupational groups to achieve a certain status within society (Elliott 1972, Freidson 1994). Professions are seen as having high social status, but this recognition must come from society at large; in other words public perception is one determining factor in the establishment of professional status. Generally the public like nurses, but many people perceive nursing to be of inferior status to other healthcare disciplines, notably medicine (Thupayagale & Dithole 2005).

The overall number of nurses, the wide variation in their practice, and their diverse education, training and skills militates against their recognition as a homogenous grouping. Moreover the tradition of altruistic service is seen by many as a further inhibiting factor; altruism fits well with the foundation of nursing as a caring science, but may not create the preconditions necessary for professional recognition. This view has been prevalent in feminist literature, where the belief that patriarchal oppression in society is mirrored in the relationship between the male dominated medical profession, and the predominantly female world of nursing (Chinn & Wheeler 1985; Campbell & Bunting 1991). Wuest (1994) goes further, suggesting that it is the patriarchal nature of professionalism per se that has constrained the development of nursing knowledge, and marginalised nursing within the health care sector.

The historical relationship between medicine and nursing cannot be ignored in any analysis of the professional status of nursing. Nursing emerged from an apprenticeship model of training dating back to Florence Nightingale and beyond, in which order, discipline and hard work were the foundation for success, and day to day practice was based on a sense of duty, built around the need to carry out medical orders. Bradshaw (2000) cites one early (1898) guide produced for aspiring nurses at the London Hospital in which 'self-discipline, personal responsibility for learning, truthfulness, obedience, punctuality, loyalty and the kindliness of genuine compassion' are the essential qualities of a nurse. Contrast this with the development of medical education, where an emphasis on scientific knowledge traditionally preceded any patient contact, and provided a basis for the designation of high level components of care, such as diagnosis, drug prescription and most

notably surgery as the exclusive province of the medical doctor. Arkosar (1985) suggests that this enables doctors to feel that they have mastery over their practice, and by structuring their work around individual patients and time limited contacts doctors can organise a range of interventions that they will not personally be directly involved in administering. Nurses by contrast take a more task orientated view of practice, responding to directions given by others and therefore lacking any sense of personal control over working practice.

Nursing knowledge was for many years seen as a simplified version of medical knowledge. Nurses were typically taught about anatomy, physiology and disease processes in order to understand something of their patients' conditions. Within training schools the majority of lectures were delivered by doctors, and most 'nursing' text books were written by doctors. Nursing competence was judged in terms of the practical skills of the bedside nurse, skills primarily developed to ensure effective ministration to the sick, backed by a strong sense of vocational duty and deference to the medical management of care.

While it might be argued that a failure to adequately develop a knowledge base founded in *nursing* theory has contributed significantly to the view that nursing sits somewhere in the middle of the continuum between occupation and profession, other factors have combined to bring about changes in the nature of nursing care, and the professional status of nursing. Since the 1970s nurses have taken on increasingly complex tasks, such as intravenous cannulation and the administration of intravenous antibiotics, catheterisation, the administration (although not, typically the interpretation) of ECGs, and venepuncture. In the UK these extended

roles were typically subject to local hospital certification, with varying degrees of assessment of competence required before nurses were permitted to practice with some degree of independence.

2.5 Developing advanced practice nursing

In 1992 the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) published a new guideline detailing transferable arrangements for the extension of nursing practice into new roles. The policy, entitled *The Scope of Professional Practice* (UKCC 1982) created a situation in which doctors could give up much of what they considered to be menial, low level tasks to nurses. Nurses, on the other hand were undecided about the implications of changing roles. There were some perceived advantages in providing holistic, seamless care, but some were concerned that there would be too little time for 'hands-on' care of patients, while at least one author has suggested that this 'gradual professionalisation' has clouded the purpose of nursing (Bradshaw 2000). Certainly changing the scope of nursing practice paved the way for a significant increase in the deployment of healthcare assistants, and similar lower grade workers. Bradshaw (2000) suggests that this is a retrograde step in the provision of practical bedside nursing, and has been introduced contrary to the wishes of the majority of nurses, because it moves nursing away from its vocational roots and central position in the delivery of care. Bradshaw describes 'confusion and paradox' arising from the 'mutation' of nursing into new advanced practice roles, and concludes that the value of nursing care is undermined by the introduction of assistant grades.

Others have offered a more positive analysis of developing nursing roles and the coherence of advancing practice. Svensson (1996) and Allen (1997) note the development of new nursing roles, but suggest that this is a natural consequence of changing patterns of morbidity amongst the patient population, with an increasing prevalence of chronic illness changing the focus of care towards managing ongoing conditions rather than effecting a cure. This in turn requires an increased 'social' component in a holistic approach to patient management, bringing nursing, with its broad orientation to the fore, and allowing nurses involved in managed care to draw on a range of inputs, including healthcare assistants working under the supervision of a registered nurse.

While this analysis might help to explain how nursing retained and re-established its professional credentials during a period of role blurring and organisational turbulence, it does not address the key question of whether nursing has a sufficiently developed knowledge base to warrant professional recognition. The view that nursing theory is insufficiently developed amongst registered nurses, and indeed within programmes of education leading to professional registration, has been echoed by a number of key nursing theorists, including Watson (1979) and Parse (1998). Both would argue that nursing scholarship has generated underpinning philosophies that could and should shape practice, but that there is no coherence to the way in which diverse theory is translated into principles that guide practitioners, or consensus over definitions and shared ideology. Fawcett (1984) noted variation in the context and degree of generalisation applied to the very term nursing, and Conway (1985) suggested that the science of nursing has to be distinguished from the practice of nursing because social relevance and societal need impact on

practice, while the development of nursing science towards a paradigm, or a metaparadigm, requires a degree of abstraction that is not always reconcilable with practical application.

To counter this dilemma Watson (1985) has developed a science of caring that she believes represents the core of nursing, aspects that are integral to the nurse patient relationship. This view is echoed and further developed by Parse (1988), whose focus on human becoming necessarily denies the division of the philosophical underpinnings of nursing from the personal interaction inherent in a nursing relationship. Parse's philosophical background is in phenomenology, and her view of relationships founded on 'true presence' is consistent with the exploration of the person's lived experience of health. This view is echoed in the later work of Ricoeur (1992), whose notion of the 'ethical self' emerges from similar philosophical roots, and involves 'living the good life with and for others in just institutions'. This view has been promoted as a philosophical basis for advancing nursing practice without reference to extending roles or role blurring, and was referred to as alterity, a term associated with the work of Levinas, by Cameron (2006), who advocated that nurses should adopt the perspective of the 'other', having recognised that no one theoretical perspective can ever govern the diversity of patient presentations or the nursing response.

The changing relationship between doctors and nurses has been one key to understanding the development of the professional role of nursing within health care systems, and specifically the ongoing development of the advanced practice nurses role.

Gillis (1996) asserts that the development of autonomy is a prerequisite for the successful deployment of nurse practitioners in practice, but recognises that the complex nature of advanced practice roles gives rise to a range of issues, including the crucial question of professional relationships. This is echoed by Baer (1993), who in considering the authority of primary care nurses identifies the boundary between nursing and medicine as crucial to an understanding of changing roles. Baer cites the work of Goode (1960) with reference to the notion of encroachment, defined as claiming authority over an area previously claimed by another group, and here central to the debate on role transition in nursing.

The rise of the advanced practice nurse has been a significant feature of the development of healthcare systems over the past twenty years, and has contributed significantly to the debate over professionalisation, and role transition within a new health care order. Understanding the deployment and of advanced practice nurses, and their position within healthcare delivery is one key to understanding how the professional autonomy of nurses is changing as new roles emerge. The following chapter explores the development and deployment of nurse practitioners in more detail.

Chapter 3: Nurse Practitioners

3.1 Background

The nurse practitioner is a relatively recent addition to the range of professionals engaged in the delivery of health care, and is of particular interest because nurse practitioners are at the forefront of new advanced practice roles, and as such have contributed to the diversification of nursing practice and the blurring of intraprofessional and interprofessional boundaries in healthcare (Nancarrow & Borthwick 2005; Abbott 2007).

Fifteen years ago the then professional body for nursing, the United Kingdom Central Council for Nursing Midwifery & Health Visiting published a document entitled 'The Scope of Professional Practice' (UKCC 1992). This brief publication represented a significant milestone in the development of a more independent, autonomous role for nurses, in that it permitted and encouraged nurses to expand their practice to respond to patient care demands, and placed a greater emphasis on individual accountability than had previously been the case. This represented a significant change in the philosophical basis of nursing practice; previously nurses had taken on so called 'extended roles' following specific training (and often local certification of competence) in an exclusively task specific way. The Scope of Professional Practice placed the onus on individual nurses to work to a professional standard, in an accountable way, exercising their own professional judgement in respect of their practice, and paved the way for a number of subsequent developments including the expansion of specialist practice and specific roles such as nurse prescribing.

The 1990s were also a period in which the increasing cost of delivering 'free at point of use' health care under the National Health Service was putting the allocated budgets under severe pressure. Modernisation in response to cost pressures led to significant changes to health care delivery during the latter years of the 20th century, and significant among these changes was the move towards primary care as the preferred location for the majority of services. Alongside these policy developments there was increasing interest in promoting nursing as a solution to the ever increasing demand for health care. The rise of the nurse practitioner appears, in retrospect to be a tailor made solution to a particular set of circumstances. The US had, however, seen a similar set of circumstances combine to encourage the development of the nurse practitioner role in a number of states within the US some years previously (Joel 2004).

3.2 Definition

A single definition of the term nurse practitioner is difficult, but several authors have looked to define a nurse practitioner in terms of their skills, or their preparation for the role. For example Witney (1990) refers to a nurse who has undertaken a course of study that includes 'principles of health assessment, management of acute and chronic illnesses, health promotion, prevention of disease and illness, community based nursing care, and advanced practice nursing roles'.

The American Nurses Association (1996) describes the nurse practitioner as 'a skilled health care provider who uses critical judgements in the performance of comprehensive health assessments, differential diagnosis,

and prescribing of treatments in direct management of acute and chronic illness and disease'. Nurse practitioners share with other advanced practice nurses an educational preparation at advanced level, typically masters' level, and 'substantive autonomy, and independence resulting in a high level of accountability' (*National Council of State Boards of Nursing;* Keane & Becker 2004).

The focus on autonomy within the description of the nurse practitioner role is a consistent factor in a range of different definitions. Sitwell's widely quoted definition suggests that nurse practitioners are professionally autonomous because they 'receive clients with undifferentiated and undiagnosed problems' (Sitwell 1985). Bowling & Sitwell (1988) focused on the philosophy of autonomous nursing practice as the underpinning for a range of activities carried out under the nurse practitioner umbrella. Dolan's definition of the nurse practitioner role in emergency care highlighted that nurse practitioners have sole responsibility for their professionally autonomous decisions (Dolan 2000). An alternative approach to the definition of the nurse practitioner role has been to specify the key behaviours or activities performed by nurse practitioners (Hicks & Hennessey 1998; Fawcett-Hensey 1991). This has the advantage of making clear to those who may be unaware of the potential of the role the range of activities that might be undertaken by nurse practitioner; however as an approach it necessarily marginalises the potential for truly autonomous practice in which the nurse practitioner is free to make decisions without reference to a preordained set of behaviours.

In the UK successive professional regulatory bodies have failed to acknowledge and define the nurse practitioner role, or indeed other advanced practice nursing roles, despite ongoing discussion, lengthy but inconclusive consultations, and some interim guidance on issues such as advancing practice (UKCC 1996; UKCC 1999). It has been left to the Royal College of Nursing, who were instrumental in identifying and establishing the nurse practitioner role in this country to collate the defining characteristics of the nurse practitioner role.

The Royal College of Nursing (RCN) established the earliest nurse practitioner programme in the UK through the RCN Institute, with the first formally accredited nurse practitioners graduating in 1992. At the same time the RCN provided the first UK specific role definition for the nurse practitioner, and this provided a foundation for both the development of a more comprehensive definition of the role, and the designation of nurse practitioner competencies. The competencies were in turn important in ensuring that new nurse practitioner courses developed under RCN approved franchise arrangements at a number of British Universities complied with transferable standards against which nurse practitioners' knowledge and skills could be judged.

The initial RCN definition of the nurse practitioner role included five main elements that distinguish the role of the nurse practitioner from that of the registered nurse. The Royal College of Nursing (1996, 2002) suggest that nurse practitioners see people with undifferentiated and undiagnosed health problems, are autonomous in identifying problems and taking clinical decisions, use advanced nursing skills, including interpersonal skills and skills in health promotion in the delivery of care

to patients, have the power to admit and discharge patients, and the right to refer patients to appropriate services, and finally provide leadership, support and advice to other nurses.

The current RCN definition (RCN 2005) builds on earlier versions, and defines the nurse practitioner role as

A registered nurse who has undertaken a specific course of study of at least first degree (Honours) level and who:

- *Makes professionally autonomous decisions, for which he or she is accountable*
- *Receives patients with undifferentiated and undiagnosed problems and makes an assessment of their health care needs, based on highly developed nursing knowledge and skills, including skills not usually exercised by nurses, such as physical examination*
- *Screens patients for disease risk factors and early signs of illness*
- *Makes differential diagnosis using decision making and problem solving skills*
- *Develops with the patient an ongoing nursing care plan for health, with an emphasis on preventative measures*
- *Orders necessary investigations and provides treatment and care both individually, as part of the team, and through referral to other agencies*
- *Has a supportive role in helping people to manage and live with illness*
(RCN 2005)

This definition retains the key features of the earlier definition, such as professional autonomy, highly developed nursing knowledge and skills, and interprofessional team working. It supplements these key features with a greater emphasis on aspects of professional practice that have increasing importance in the current health care delivery system, such as risk assessment, patient involvement in care, and health promotion and the prevention of illness.

3.3 Nurse Practitioner Competencies

It is perhaps an anomaly that a role championed as being autonomous is further defined by a lengthy and detailed set of competencies. Again it is the Royal College of Nursing who have published the definitive listing of competences for nurse practitioners (RCN 2005), and while they have no formal standing they do provide the benchmark by which nurse practitioner courses are judged, and provide a starting point for the role specifications and job descriptions created by those seeking to employ nurse practitioners.

The RCN competencies were based on core competencies for nurse practitioners established in the United States during the early 1990s (Joel 2004). These core competencies were designed to describe the generic practice required of all nurse practitioners on qualification, and were published, in a slightly revised form, by the National Organization of Nurse Practitioner Faculties (NONPF 2001). The RCN suggest that detailed competencies help to develop a standard for nurse practitioners clinical practice, and that this standard will not only help healthcare providers feel confident about the quality of care offered by nurse practitioners, but will also form the basis for regulation of the nurse practitioner title in the future.

The RCN competencies are structured within seven domains of practice; again these domains have been developed from the U.S. model established by the National Organization of Nurse Practitioner Faculties, but have been adapted to ensure that language and some aspects of practice readily reflect the UK Healthcare delivery system. The first domain relates to the management of patients health and illness, and

includes competencies relating to health promotion and the prevention of illness, and the management of patient illness. The second domain seeks to define the relationship between the nurse practitioner and the patient, and includes competencies relating to interpersonal skills as well as consideration of underpinning ethical values. The third domain covers the teaching–coaching function of the nurse practitioner, detailing processes designed to help patients interpret their own health needs and plan health related activities to maintain and improve health status.

The fourth domain is of particular importance within this study, because it lists the competencies associated with the professional role of the nurse practitioner. These are grouped under three subheadings. The first is about the development and implementation of the role, and requires the use of underlying theory and research within the role, but also lists a number of role dimensions and requires nurse practitioners to 'interpret and market' the role to interested parties including the public, policy makers and colleagues. The second is about the direction of care and lists required skills in areas such as coordination, prioritisation, referral, consultation and advocacy. The final subheading covers requirements in the area of leadership, and includes engagement with the development of nurse practitioners and the promotion of the nurse practitioner role to a range of external agencies.

The fifth domain incorporates competencies in managing and negotiating care within the Health Care delivery system, and the sixth domain covers the maintenance and promotion of quality in practice. The final domain is titled cultural competence and includes reference to both cultural and spiritual awareness. Competencies have been mapped against

dimensions of the NHS Knowledge & Skills Framework (KSF) (DoH 2004), to ensure that the basis of nurse practitioners preparation and practice is congruous with the knowledge and skills demanded by the NHS.

In total there are 115 competencies listed under the seven domains of practice, significantly more than are required of a registered nurse seeking initial entry to the professional register. This focus on a detailed listing of competencies to be incorporated in approved nurse practitioner courses, and subsequently forming the basis of practice, does not appear to be in keeping with the aspirations of nurse practitioners to be regarded as autonomous professionals. The nature of professional autonomy is explored elsewhere, but one key characteristic of professional status relates to higher learning and individual accountability; specifying the actions required of a nurse practitioner to the extent that the RCN competencies do may not be in keeping with the aspirant professional status of the nurse practitioner, particularly because the RCN framework creates a requirement for competence assessment within programmes of preparation, and may thus limit clinical decisions to those 'authorised' by the competencies.

Despite this the Royal College of Nursing have made attempts to formalise and standardise the nurse practitioner role, through role definition, the specification of competencies, and an accreditation system for franchised courses. However the professional body, the Nursing & Midwifery Council, continue to prevaricate over the status of the advanced practice nurse. The long drawn out discussions about how best to manage advanced practice are considered later in this chapter.

3.4 Development of the nurse practitioner role in the US

The origins of the nurse practitioner role lie in the US, where the first nurse practitioners were established nearly 50 years ago. Nurse practitioners are one example of an advanced practice role in nursing; others have a longer history, but all share some common characteristics. The various advanced practice roles are based on sound nursing principles, and incorporate advanced theoretical knowledge and practical skills, combined with significant experience. They are distinguished from other nursing roles by their autonomy in decision making (Hamric 2005), and by their direct accountability to patients. The American Nurses Association recognises four advanced practice roles: nurse practitioner, nurse anaesthetist, clinical nurse specialist and nurse midwife (American Nurses Association 1996).

Advanced practice nursing roles share several key elements; they are all clearly located within the clinical domain (Ketefian et al 2001), and all involve advanced preparation, at graduate level or above, preparing the advanced practice nurse for expanded, evidence based interventions. Advanced practice nursing roles are predicated on enhanced decision making and greater professional autonomy than is traditionally associated with the role of the registered nurse (Hamric 2005). The earliest specialist roles for nurses were in nurse midwifery and nurse anaesthetics, although they were not commonly recognised as advanced practice nursing roles until the 1990s.

Midwifery has a long history dating back many centuries, and has been regulated in the UK and parts of Europe since the beginning of the last century. UK midwives not only enjoy significant professional autonomy

backed by statutory control, but are the attending professional at a high proportion of births in the UK. In the US, however, nurse-midwives have struggled to assert their independence and still attend a relatively small proportion of births, in part due to ongoing legislation in some states requiring a physician to be present during childbirth, or to act as supervisor to midwives (Joel 2004).

Nurse anaesthetists also have a long history in the US, and share some of the background associated with other advanced practice roles in that they initially came to prominence to fill a gap in the available health care provision. In the case of nurse anaesthetists this gap was caused by a shortage of interns, or junior doctors, in poorer hospitals (Bigbee & Amidi-Nouri 2000). Later nurse anaesthetists came to prominence in wartime, particularly in field hospitals where emergency surgery placed significant demands on services. Nurse anaesthetists played a significant role in field hospitals in both World Wars, and later in Korea and Vietnam. Nurse anaesthetists, like nurse midwives are described by Bigbee & Amidi-Nouri (2000) as 'estranged' from mainstream nursing in that their clinical responsibilities have developed in isolation from that of the registered nurse. The same cannot be said of the nurse practitioner, or the clinical nurse specialist.

Clinical nurse specialists were perhaps the most natural and comprehensible diversion from the generic registered nurse role, in that specialisation is an inevitable consequence of defined roles in specific areas of practice. As Joel (2004) points out, for many years registered nurses worked predominantly in a hospital system that is based on certain types of patients being grouped together for the convenience of

the medical consultant. Among the first clinical nurse specialists were those who developed expertise in areas that were unpopular or underserved, such as the care of people with tuberculosis, or sexually transmitted disease. Later the clinical nurse specialist role became the focus for increasing links between higher level post registration education, and specialist practice. For example the development of clinical nurse specialists in mental health was made possible by the pioneering work of Hildegard Peplau (1965), who linked graduate level studies with direct patient care to close the perceived gap between theory and practice.

The clinical nurse specialist role was further developed through the latter decades of the 20th century. This was the result of a number of factors, including advancing technology, greater diversification amongst medical practitioners and greater educational opportunities for nurses, all underpinned by the need to care for a growing number of patients with increasingly complex health needs. By the 1970s the American Nurses' Association sought to limit the title clinical nurse specialist to those who had gained a masters degree with a 'concentration in specific areas of clinical nursing'. This was the first time that the level of educational preparation had been specified for an advanced practice role, previous role definitions tending to focus on knowledge and competencies rather than an academic standard (Dunphy, Youngkin & Smith 2004). Clinical nurse specialist roles have been threatened by recent developments in health care, however, with many hospital-based clinical nurse specialists having to rethink their role as changes in the structure and delivery of health care create a situation in which patients are discharged to the community earlier than they were 20 years ago. If this change has

impacted negatively on clinical nurse specialists it has had the opposite effect on the employment of nurse practitioners; one definition of the nurse practitioner role suggests that it is about 'providing a full range of primary health care services using the appropriate knowledge base' (Keane & Becker 2004), and the emergence of community care as the primary focus of healthcare delivery has heightened the need for an increasing number of practitioners who can provide broad primary care services to a diverse population.

The nurse practitioner role originated in the US during the 1960s, thanks to pioneering work by nurses such as Loretta Ford (Ford 1967, 1975, 1991). Ford, in conjunction with a paediatrician named Henry Silver established the world's first nurse practitioner programme, at the University of Colorado in 1965. Their primary concern was the health of underserved populations, initially in rural settings. Ford established three key principles underpinning the nurse practitioner role: first, enhanced patient care is the primary aim; second, the role is predicated on interprofessional working, involving nurses with medical colleagues, and third, nurse practitioners should have a graduate level preparation for the role.

Nurse practitioner roles expanded rapidly in the US. Ford & Silver's initiative in the field of paediatric practice was followed by a similar paediatric nurse practitioner programme in Boston, Massachusetts, but following the establishment of a nurse practitioner programme focusing on family practice at the University of Washington in 1971 the nurse practitioner role expanded into several other fields. By the end of the 1970s, in addition to paediatric and family care settings nurse

practitioners were working in mental health, adult health, women's health and geriatrics, and other primary care fields (Gray 2001)

The development of the nurse practitioner role may have been a response to the shortage of medical practitioners in some parts of the US, primarily poor rural areas and inner city areas with predominantly immigrant populations. However as Reedy (1978) points out, there were a number of well educated, ambitious nurses who quickly embraced the opportunity to adopt a new role that superficially at least provided some form of parity with medicine, on both an organisational and an intellectual basis.

The nurse practitioner role in the US has been significantly strengthened by changes to the process for reimbursement for nurse practitioner practice. Under the Balanced Budget Act (1997) direct payment for nurse practitioner services became possible. While there has been some reluctance on the part of insurers to recognise nurse practitioners, or to reimburse nurse practitioners at an appropriate level, there has been an increasing demand for places on nurse practitioner programmes as a result of new opportunities to enter (private) practice. These opportunities come at a price, however, and in future nurse practitioners in the US will have to hold a master's degree and appropriate nationally recognised certification before they can practice. By 1990 over 90% of all US nurse practitioner programmes were at masters level (Pulcini & Wagner 2001); at the time of writing the UK are still awaiting a final decision from the Nursing & Midwifery Council regarding the required academic level for nurse practitioner programmes, but it appears likely that the UK will also require masters level preparation for all nurse practitioners in the future.

3.5 Development of the nurse practitioner role in the UK

The development of the nurse practitioner role in the UK has a number of parallels with the US experience, despite the more recent timeframe. The 1980s saw a very significant change in health care delivery in the UK, following the introduction of an 'internal market' for health care as part of the Conservative government's reform of the NHS. The subsequent development of variations on a 'purchaser/provider' approach, in which commissioners purchase packets of health care from provider organisations, has created a financially driven NHS in which commissioners' specify the services to be provided and the agreed price. This was intended as a mechanism under which money would follow patients to efficient providers (West 1998), but has led to provider organisations seeking cost savings wherever possible, and has impacted on the professional autonomy of lead clinicians, whose freedom to select interventions under an umbrella of clinical freedom has been curtailed by financial restrictions and internal competition for limited resources (Cairney 2002).

Some observers have suggested that while the purchaser provider split in the NHS may have introduced a new approach to financial management and budgetary allocation within UK health care, the recent reforms have failed to challenge the autonomy of the medical profession. Although the financial model has changed professional hierarchies remain entrenched, and doctors continue to be the dominant powerful professional grouping in health care (Klein 1995). This is reminiscent of the situation at the inception of the NHS, where medical interests shaped a healthcare system that set doctors apart from other disciplines in their power and status (Ham 2004), and has perhaps perpetuated a power imbalance

between the medical profession and other practitioners within the NHS. Despite this, the cumulative effects of change have opened up new opportunities for other disciplines, particularly nursing, for whom the last fifteen years have been a period of rapid development.

Central to the development of the nurse practitioner role was the shift of emphasis from a hospital-based National Health Service to a primary care led service. Following the Primary Care Act (1997) the shift of services from secondary to primary care led to a significant increase in the clinical caseloads in primary care, and an urgent need to reconsider the roles and responsibilities of practitioners working within primary care. The potential for nurse practitioners to make a meaningful contribution in general practice was identified by the pioneering work of Stillwell (1982) in her work in Birmingham, and during the late 1980s and early 1990s several reports encouraged the development of specialist nursing roles in primary care. The Cumberledge report (DoH 1986) recommended that community nurses should develop skills in health promotion and the diagnosis and treatment of illness in order to practice more effectively in primary care settings, albeit under the supervision of a medical practitioner. In 1987 the government white paper 'Promoting Better Health' (DHSS 1987) outlined the intention to focus health care delivery within primary care, and to look again at the skill mix across the interprofessional team. This message was again central to the white paper 'Primary Care: Delivering the Future' (DoH 1996) which stressed the importance of three key areas, better team working, developing professional roles and the need for partnerships within primary care. (Galvin et al 1999)

During the same period the National Health Service Management Executive responded to reports criticising the number of hours worked by trainee doctors within hospital-based services (McKee & Black 1992) by announcing a planned reduction in the number of hours worked by junior doctors, in an attempt to both improve patient care and enhance the working lives of junior doctors while at the same time maintaining the standard of medical training (Jagsia & Surender 2004). These changes, referred to as the 'New Deal' (DoH 1991) were not as extensive as those introduced through EU working time directives in more recent years, but did reduce the number of hours that junior doctors could work in a week to 72 hours of 'on call', with a maximum of 56 hours of 'hands-on' working. The implications of these changes necessitated a review of the way in which health care was delivered. In effect, reducing the amount that junior doctors could do created new opportunities for other disciplines to reconsider their contribution to the delivery of healthcare, and realign their scope of practice accordingly. This was particularly true of nurses, more specifically advanced practice nurses, including nurse practitioners.

The NHS Plan (2000) envisaged the development of a more integrated system of interprofessional care, placing greater emphasis on collaboration and designed to ensure a more speedy response to patient need. The plan specifically included an intention to empower appropriately qualified nurses to undertake a number of new clinical roles, including the management of clinics, the admission and discharge of patients, the ordering of diagnostic tests and a significant increase in prescriptive authority. These powers were detailed in the 10 key roles for nurses set out by the chief nursing officer as an adjunct to the NHS plan.

The close correlation between these planned developments in the scope of nursing practice and the competences of the nurse practitioner placed nurse practitioners in a key position in the implementation of new services (Marsden, Dolan & Holt 2003).

Nurse practitioners were seen as having broad potential to provide a new service that was not simply a replacement for the input of medical practitioners, but represented a different approach to the care of diverse client groups who were increasingly demanding a more comprehensive service from the healthcare system. This was true both in primary care, where nurse practitioners were deployed to assist in the management of an increased demand resulting in part from the realignment of health services, and in secondary care where a reappraisal of roles and responsibilities created opportunities for nurse practitioners to offer an alternative to the services necessary curtailed by the reduction in junior doctor hours.

3.6 Regulation

The regulation of nurse practitioners in both the US and the UK is a complex issue, and while both countries recognise the need for robust systems to ensure competence in practice neither has, for various reasons, been able to establish a comprehensive and consistent approach to regulation. In both countries the early initiatives towards standardisation of both the nurse practitioner role and the nurse practitioner qualification were taken by a representative body rather than a regulatory body. In the US it was the American Nurses Association (ANA) who introduced the first certification examinations for nurse practitioners, the so called 'credentialing examinations' in 1975. At the time the Council of State

Boards of Nursing were considering the implications of the nurse

practitioner role in the context of the Nurse Practice Acts, which provide

the legal basis for registered nurses to practice within individual states.

By 1995 credentialing via the professional organisation was a

requirement in order to practice as a nurse practitioner in the majority of

states. (Goodyear 2000)

Various additional safeguards help to ensure that the nurse practitioner

qualification is consistent across the US. Nurse practitioner programmes

are set at master's level, and in order to enter the programme applicants

must be registered nurses with a bachelor's degree. The programmes

themselves are based on curriculum guidelines developed by the

National Organization of Nurse Practitioner Faculties (NONPF),

although individual states may stipulate additional local requirements

for nurse practitioners; each State Board is charged with the

responsibility of ensuring that nurse practitioners, and indeed other

nurses, are safe and competent and that the public are not placed at risk.

In the UK the regulation of nurse practitioners has been ongoing for

several years, and has involved a lengthy process of consultation, several

position papers, and eventual inaction. Several authors have suggested

that the United Kingdom Central Council for Nursing Midwifery and

Health Visiting (UKCC), the professional body responsible for the

regulation of nursing from its inception in 1979 until it was superseded

by the Nursing and Midwifery Council (NMC) in 2002, could and should

have done more to formally establish the nurse practitioner role. (Reveley

1999)

The publication of the 'Scope of Professional Practice' (UKCC 1992) was an important milestone in establishing the potential for nurses to move into new and expanded roles. Prior to the introduction of the 'Scope of Professional Practice' provisions any change to the traditional role of the registered nurse was through extended practice, the specific addition of a defined task that was typically sanctioned and carried out under the supervision of a doctor (DHSS 1977). The subtle distinction between an extended role and an expansion of clinical practice is significant, in that the type of expansion envisaged by the 'Scope of Professional Practice' placed the onus on nurses to take individual accountability for their own competence, and created new opportunities for the exercise of professional autonomy. These new opportunities were not, however formalised in regulations, and advanced practice remained a somewhat ambiguous concept.

During the early 1990s, when nurse practitioners were growing in number and being deployed in a variety of settings, the UKCC adopted a policy of consultation on advance practice roles, and looked to research into the effectiveness of the nurse practitioner to provide a justification for the role before it could be formally adopted. Increasing evidence for the effectiveness of the role (Touche Ross 1994; Coopers & Lybrand 1996) did not provoke any clear action on the part of the professional body, and by the time the UKCC handed over to the new registrant body, the NMC, little progress appeared to have been made.

Reveley (1999) suggested that the ongoing prevarication regarding formal recognition and regulation of the nurse practitioner role arose from three key factors; first, the variety of practice roles adopted by nurse

practitioners made it difficult to establish clearly defined criteria; second, longstanding confusion over the nomenclature of advanced practice mitigated against clear definitions; and third, the significant differences in the educational preparation of nurse practitioners made standardisation difficult. In addition some people have challenged the use of the nurse practitioner title; for example Castledine (1993) argued that every nurse is a practitioner and therefore the title 'nurse practitioner' is confusing, while Lloyd Jones (2004) suggested that the diversity of advance practice generates a degree of role ambiguity for specific roles, including that of the nurse practitioner.

In 1994 UKCC identified eight areas of specialist practice in community settings, and specified a number of core competences shared by all specialist community nurses. They did however maintain separate titles for various of the traditional community based nursing specialities including district nursing, health visiting, community mental health nursing and school nursing. Some observers have suggested (Walsh et al 1999) that the failure to adopt a generic community nurse practitioner title in place of these longstanding nursing roles was a response to political pressure from various groups within nursing, and contributed to ongoing confusion with regard to the definition and status of the nurse practitioner, and indeed other advanced practice roles.

Following the inception of the NMC in 2002 a number of nursing organisations, particularly the Royal College of Nursing, maintained the pressure previously directed at UKCC for a clearer definition of advanced nursing practice. The profession recognised that the best interests of nurses and indeed patients were not being served by ongoing

confusion about roles and responsibilities within nursing beyond initial registration. In 2004 the NMC announced a process of consultation on advanced nursing practice, with the expressed intention of reporting to the full Nursing & Midwifery Council during 2005. The report on the consultation was considered by the Council in June 2005 and a number of changes requested, including greater clarity of role definition, the alignment of relevant competencies with the knowledge and skills framework, and the inclusion of a process to accommodate existing practitioners. The council agreed that what they termed the 'advanced nurse practitioner' should become a registrable qualification, and indicated their intention to seek the relevant approvals for the creation of a further sub-part to the nurses' part of the register.

By December 2005 the Council had agreed the revisions included at their request, and proposed a five year transition period in order to facilitate the inclusion of existing practitioners who wanted to register as advanced nurse practitioners. The Council included a detailed definition of an advanced nurse practitioner, mirroring the competency framework developed by the Royal College of Nursing, and indicated that only those nurses who had achieved the competences set by the NMC would be entitled to register as an advanced nurse practitioner, and refer to themselves as nurse practitioners.

Following the Nursing & Midwifery Council's endorsement of the revised specification approval was sought from the Privy Council, who ultimately must sanction the proposed changes. In January 2006 NMC indicated that it may take up to six months for the Privy Council to conclude their discussions with the Department of Health and oversee

the drafting of new legislation. During this period NMC were in contact with the Association of Advanced Nurse Practice Educators (AANPE), an organisation representing the universities who provide nurse practitioner programmes, with regard to the implementation of new requirements and the implications for nurse practitioner education.

By the summer of 2006 NMC indicated that some progress was being made, but envisaged a further six month delay during which the legislation would be drafted. In the summer of 2007 NMC issued a further statement expressing regret that new standards had not yet been implemented. The statement went on to suggest that NMC were optimistic about bringing matters to a speedy conclusion following the publication of the White Paper 'Trust, Assurance and Safety - the Regulation of Health Professionals in the 21st Century' (2007). This White Paper, however, does not appear to include the detail that advanced practice nurses have been waiting for, in that it sets out more extensive and general provisions for the reform of the regulation of health professionals in the United Kingdom, rather than focusing on the regulation of advanced practice nursing. The NMC have interpreted the section of the White Paper that promises greater freedom to regulatory bodies as their license to implement the proposals; the White Paper suggests that the Council for Healthcare Regulatory Excellence (CHRE) will liaise with regulators to develop standards for higher levels of practice in a number of health care professions, including nursing.

While NMC appear to be 'very enthusiastic' about this development others have speculated on the additional delay that a more comprehensive review of regulatory function across a variety of

healthcare disciplines might cause. A report in the journal 'Independent Nurse' (June 2007) suggested that the working party set up to consider the implications of the White Paper would not report until late in 2008, meaning that any changes made to the structure of the nursing register, in order to permit the registration of nurse practitioners could not happen before 2009. Unusually NMC issued a statement in the form of a response to the journal refuting this assertion, but failed to provide any detail beyond the opinion that it is 'neither helpful nor possible to speculate on the likely timescale'. Fifteen years after the publication of the 'Scope of Professional Practice' document and the initial consultation on the regulation and registration of nurse practitioners the profession is still awaiting a final outcome.

3.7 The role of the nurse practitioner

Chambers (1998) outlined a number of different models of practice indicating how the nurse practitioner might be viewed, or deployed, in different settings. Nurse practitioners combine their function as nurses working in an expanded role with their specific expertise in health assessment, diagnosis and care management to bring a new perspective to the holistic care of patients; this however has not been universally accepted as an improvement to the overall provision of healthcare, and in some cases there has been significant resistance to the introduction of nurse practitioners.

Barbara Stilwell's pioneering work in Birmingham in the 1980s established her as one of the best known nurse practitioners in the UK, and presented one example of how a nurse practitioner might contribute

to the delivery of primary care (Stilwell 1991). Stilwell worked alongside general practitioners providing a range of primary care interventions, including examination, diagnosis and treatment. She proved to be particularly effective in the provision of advice, preventative practice and the management of chronic conditions, and was popular with female patients. Stilwell, reflecting on her experiences in a role where she had very few UK peers, saw the nurse practitioner as an autonomous case manager, and rejected the idea that her practice could be defined by reference to the tasks that she undertook. (Stilwell 1991)

An alternative model of nurse practitioner engagement in healthcare was provided by another pioneer in the role, Barbara Burke-Masters, who worked as an independent practitioner with homeless men in London, again during the early 1980s. Burke-Masters' practice is very much in keeping with many of the early nurse practitioners in the United States, who tended to work with the underserved population, generally adopting an 'outreach' approach to maximise compliance. Unlike Stilwell, Burke-Masters saw her role as substituting for medical involvement in the care of this particular client group (Chambers 1998), and encountered opposition from the medical profession and from the RCN, both of whom believed her to be working beyond her scope of practice.

Roles are characterised as positions within a social structure, and are often defined in terms of the behaviour expected of an individual within a specific role. These expectations of individuals within a role are shaped by pre-existing norms, and reinforced by ongoing role differentiation (Hindin 2007). The roles of nurses have been defined in structural terms,

and in organisational terms; these approaches to the definition of the role relate to the parallel observation that nurses tend to work in a predictable and consistent manner, based on collective values, and that they also work in a controlled, managed way within their employing organisation. These two approaches to describing the role of the registered nurse help to explain why nurses tend to define their work in terms of nursing values, while others perceive nurses in terms of their contribution to the health care team, incorporating traditional organisational structures and hierarchies.

Hierarchies have existed for many years, both within nursing and more widely across health care disciplines. Nursing hierarchies have traditionally been defined in terms of grade, or salary, with senior staff such as matrons and ward sisters at the top. The development of advanced practice roles within nursing have made the situation more complex, and the relative status of senior nurses is increasingly dependent on the criteria used to judge status and seniority. The introduction of a revised clinical grading structure (Agenda for Change, Department of Health 2004) which is based on an assessment of the required skills and inherent responsibilities within a role has further complicated this situation, and ongoing confusion about the relative position of nurse practitioners in relation to clinical nurse specialists, modern matrons, consultant nurses and specialist practitioners makes the new nursing hierarchy less important in determining power. In place of received status based on a job title, professional recognition is increasingly a product of respect for individual ability.

Whitehead (2003) is one of several observers who have suggested that nursing's position within the wider hierarchy of health care professions is explained by the predominantly female workforce within nursing; this contrasts with the predominantly male tradition within medicine and helps to define the relationship between the two professions. Certain key functions within medicine, some of which (such as the right to make a diagnosis, and prescriptive authority) are backed by statutory authority, have helped to maintain a power imbalance between medicine and nursing that perpetuates the gender divide. This is compounded by the central values that drive each profession: the curative intention within medicine as opposed to the caring function at the heart of nursing. Some of these traditional power imbalances are being challenged in the development of advance practice nursing roles, particularly that of the nurse practitioner, but this can only occur in circumstances where the advanced practice nurse is deployed in a position that affords a degree of independence, and only where the right to practice autonomously is respected by others.

Chambers (1998) describes four different models within which nurse practitioners have been deployed; these are as doctor substitute, as assistant to the doctor, as a complement to medical care, and as an alternative first point of contact for patients.

Doctor substitute

The earliest model of practice adopted by nurse practitioners was as a 'doctor substitute', in which the nurse practitioner sought to provide medical intervention in situations where no doctor was available. This

model predates the advent of the nurse practitioner, and fits the practice adopted by missionary nurses and others working in remote situations with populations who would otherwise receive no medical care at all. Many of the pioneer nurse practitioners in the US adopted this model, working in isolated communities, typically in rural settings, and providing care to patients who were unable to access traditional medical care. In the UK Barbara Burke-Masters' work with the homeless in London followed a similar model. Some examples of successful nurse practitioner deployment are fundamentally doctor substitute roles, for example the use of nurse practitioners in minor injuries clinics has facilitated the rationalisation of accident and emergency units in district general hospitals while maintaining some provision in local hospitals through nurse led services. The reduction in junior doctor hours following successive policy and legislative change, including the European working time directive, has led some to propose advance practice nurses as potential replacements for doctors in secondary care.

An assistant to the doctor

A number of nurse practitioner roles have been developed as an assistant to a medical practitioner, undertaking a number of extended nursing roles with the defined group of patients, often within a speciality and with patients referred by the doctor. This is largely the model within which practice nurses work, providing specialist care for people with conditions such as asthma and diabetes, and is also the model adopted by a number of specialist nurses in hospitals who work with a clearly defined patient group, for example in stroke rehabilitation. These examples highlight dilemmas over the definition of advanced practice

nursing roles, because while both practice nursing and clinical nurse specialists share a number of features with the nurse practitioner they may not meet all of the criteria for employment as a nurse practitioner. Despite this a number of nurses working within practice nursing and clinical nurse specialist roles are ostensibly employed as nurse practitioners, and hold that job title (Lorentzon & Hooker 2006).

Complementing medical care

This model sees nurse practitioners as partners in the provision of medical care, focusing on those aspects of care which fall outside the remit of the doctor. Chambers (1998) describes this as the 'illness care: health care dyad', in which the doctor concentrates on the management of illness, while the nurse focuses on preventative work, screening, and health promotion. This model can be seen operating clearly in the relationship between medical practitioners and midwives in obstetric care, and may reflect the differing underpinning philosophy in medicine and nursing.

An alternative first point of contact

The final model proposes that the nurse practitioner can provide a useful alternative first point of contact for patients who have a specific need, or who require urgent attention. The model is well established in community midwifery, and to a certain extent amongst mental health nurses working in community settings, particularly in the UK and in Australia, where mental health nurse practitioners are well established (McCann & Baker 2003; Wortans et al 2006). It is also evident in the acute

care and triage functions carried out by nurse practitioners within accident and emergency units (Norris & Melby 2006).

These alternative models highlight the variety of roles and functions undertaken by nurse practitioners, and reinforce some of the difficulties in defining the role in a way that might permit some standardisation in advance of professional registration. As nurse practitioners have become more and more established as part of the healthcare delivery team they have grown in professional confidence, and many nurse practitioners have suggested that adherence to an underpinning nursing philosophy is the only way to enhance professional identity; promoting nurse practitioners as substitutes for medical practitioners is therefore an inappropriate way forward. (Brush & Capezuti 1997)

For many nurse practitioners the quest for autonomy in practice is the most important issue, because the authority to practice in a way that is free from significant restriction and without intrusive medical supervision is the key to ensuring that nurse practitioners have an independent future, regulated by nursing, thus ensuring that the scope of nurse practitioners' practice is determined by the nursing profession rather than outside agencies. (Pruitt et al 2002)

Turner et al (2007) suggest that opportunities for nurse practitioners to work in an autonomous manner are determined by the ways in which they are viewed both within nursing, and externally by other healthcare professionals, and by patients, families and society. The way in which nurse practitioners are deployed has an impact on how they are perceived by others, and contributes to their own sense of self worth.

Rafferty et al (2001) noted the positive correlation between nurses' exercise of autonomy and effective interprofessional working, reinforcing the view that external recognition of the potential inherent in autonomous nursing roles will not only support the professional development of nursing, but will also enhance patient care. This is particularly true of advanced practice roles, where external recognition is often dependent on the precise nature of individual roles and contributions.

Benner (1988) developed established models of skill acquisition (Dreyfus & Dreyfus 1977) to explain the stages through which nurses progress in achieving expertise. The transition from registered nurse to nurse practitioner is about more than skill acquisition, however, despite the significant emphasis placed on advanced practice skills in the preparation of nurse practitioners. Nurse practitioner roles are diverse, both in terms of clinical speciality and patterns of deployment, but all involve the individual practitioner in a transition from a role as a registered nurse to a nurse practitioner position.

Role transitions in nursing have been of interest to a number of observers, who have considered a wide range of examples within nursing, including health care assistant to registered nurse (Gould et al 2006); staff nurse to clinical nurse specialist (Glen & Waddington 1998) and in-patient care to community nursing (Zurmehly 2007). Studies focusing on role transitions and nurse practitioners fall into two groups; those that consider initial entry to the nurse practitioner role, and those that reflect changes to a specific aspect of an existing nurse practitioner role. In the first group studies have considered a range of specific clinical areas, including acute

care (Chang et al 2006), neonatal care (Nicholson et al 2005), and primary care (Heitz et al 2004); in every case the research suggests that new nurse practitioners reinforce the view that their success in achieving re-socialisation within the workplace is central to their progress, and their overall effectiveness. Immediately before embarking on an advanced practice role nurse practitioners are typically employed as respected senior nurses, but having qualified as nurse practitioners they return to the workplace as neophytes with all the inherent uncertainty that this entails. In situations where they are readily accepted within the health care team their confidence in their own ability remains high, and they are able to make an effective contribution to the team. Where the opposite is true nurse practitioners describe feelings of limbo, and can take up to a year to feel comfortable and work effectively in their new role.

This is less true of transitions that involve nurse practitioners taking on new activities within an established nurse practitioner role. Examples of this include the introduction of new prescriptive authority for nurse practitioners (Kaplan & Brown 2007), the deployment of mental health nurse practitioners in an accident & emergency department (Wand 2005), the development of new ICU liaison procedures (Green & Edmonds 2004), and new approaches to the care of adolescents with specific health needs (Betz & Redcay 2005). In these examples nurse practitioners were deployed in new ways because those involved in delineating the new role recognised the potential contribution that nurse practitioners could make to patient care, and the nurse practitioners concerned did not therefore need to establish their professional standing within the team.

Several observers (Brykczynski 2000; Joel 2004) confirm the view that newly qualified nurse practitioners experience significant conflict and anxiety during the transitional period. This is often explained by the nurse practitioners themselves through reference to a perceived lack of clinical skills and underpinning knowledge (Murray 1998), but may also be a product of role stress arising from increased responsibility and accountability; anticipatory anxiety generated by the increased autonomy afforded by, and expected of those occupying an independent role.

This follows the pattern of role transition described by Bridges (2004), who described three stages to role transition. The process starts with the ending of the 'old' role, and the relinquishing of the values and self image associated with the role. Next comes an interim period of uncertainty and anticipation, where the person concerned is preparing for the new role. Finally they achieve a 'new beginning' in which working within a new role allows the development of a new self image, new values and new working practices. This final stage is significant for nurse practitioners for two reasons; unlike some role transitions the transition from registered nurse to nurse practitioner does not involve an entirely new set of knowledge, skills and values, leaving the novice nurse practitioner in a situation where much of their new world is familiar, but has to be viewed in a different way if their transition is to be effective. In addition, nurse practitioners are often expected to move directly from the protected, supervised world of their preparatory period into an independent role where the nurse practitioner may not be a familiar part of the heath care team, and their philosophical approach to care may prove to be unfamiliar to other disciplines, particularly those who are grounded in a positivist world of health and illness (Dzurec 1999).

Kaplan & Brown (2007) see this transition as a transition to full autonomy which requires the integration of a new scope of practice and a new professional identity within nurse practitioners working lives. They identify this as a paradigm shift, and cite Kuhn (1970) in describing a new set of commitments that provide a new basis for practice, and inevitably create a period of 'disequilibrium' as the new professional paradigm becomes established. Achieving autonomy within a new role is key in assuring the success of the transition.

This observation provides the key to this research. The central phenomenon under investigation was role transition from registered nurse to nurse practitioner, and the specific research question asked participants about their experience of professional autonomy in their nurse practitioner role.

Chapter 4: Methodology

4.1 Phenomenology and nursing

In recent years phenomenological research has become increasingly accepted within nursing. Extensive and prolonged interaction with a small number of individuals, a characteristic of phenomenological research, allows the researcher to focus on the meaning of a particular lived experience for the participant. Dialogue, reflection and writing provide an approach within which meaning can be constructed and conveyed; the essence of the experience of illness, for example, can be captured in a way that allows nurses who have typically been schooled in a positivist tradition to better understand the world of their patients. Description, interpretation, and critical self reflection on what Van Manen (1997) describes as 'the world as world' of the participants can provide nurses with rich insight into the experience of others, and thus allow a broader view of the nature of caring to develop.

Links between the ontology and epistemology of nursing and qualitative approaches to nursing research have reinforced this focus on the nature of caring as an important underpinning to effective practice. Kiikkala & Munnukka (1994) suggest that the epistemological basis of nursing, embodied in nursing theory, is derived from subjective human experience. Holistic nursing as an entity delivers more than the sum of its parts, and as such cannot be subdivided for research purposes. Phenomenology and similar qualitative approaches to research allow the object of the study to remain in context, ensuring that research findings are based in the life world of the participants.

This is important to any study that seeks to explore the lived experience of nurses or their patients. Corben (1999) suggests that traditional approaches to nursing research were primarily empirical and reductionist; this is seen as a consequence of the influence of medical hegemony on the development of nursing (Playle 1995). In recent years nursing research has sought to explore and explain the nature of nursing, with reference to the distinct knowledge base emerging from the work of nursing theorists. This knowledge base goes beyond practical knowledge, and incorporates Gadamer's notion of 'techne', a term borrowed from Aristotle, which describes the acquired skills of the expert (Gadamer 1989). In combination practical knowledge and expert skills allow nurses to make competent and autonomous clinical decisions. The knowledge base that allows this is a 'unique form of science 'which must by definition arise from practice (Bishop & Scudder 1990). The recent trend towards evidence based practice in nursing (Messecar & Tanner 2004) acknowledges the need for a sound research base, and reinforces the unique position of nursing within the healthcare system.

Nursing research is no longer exclusively about seeking answers to the questions that are commonly asked within medical research: the causes of disease, the reliability of diagnosis, the cost effectiveness of interventions, or quantifiable indicators of health. The philosophical foundations of nursing, based in an holistic and interactive approach to caring for people, are not compatible with approaches to scientific inquiry based on logical positivism (Ray 1990; Beck 1994; Munhall 2001; Whall et al 2006). Indeed caring has been seen as the core of nursing by a number of theorists, notably Jean Watson (1985), whose work is predicated on a science of caring. Watson's theory promotes a humanistic perspective,

and she argues that traditional scientific methods may not be a suitable means through which to validate a science of caring. Watson sees caring as central to nursing, but does not always clearly distinguish between caring as a set of skills, and caring as a value (Conway 1985). Her philosophical approach to nursing, and by definition caring, is derived from existentialist phenomenology, focusing on lived experiences, and an underpinning spirituality derived from both Catholic and Bhuddist philosophy (Sarter 1998; Watson 2005).

Watson's philosophical approach shares its phenomenological roots with the theory of Rosemary Parse, who also developed her exploration of nursing within an existential phenomenology. Parse, however was also influenced by the work of Martha Rogers (1970), and made explicit use of Rogerian principles in developing her ideas, notably the notion of unitary human beings. Parse's notion of nursing is derived from shared experience, and a heightened form of caring termed 'true presence', in which nurses are able to understand the life world of the patient (Parse 1981).

Lawler (1998) believes that nurse researchers are often seeking insight into the experience of uncertainty; nurses who are seeking an understanding of the lived experience of illness must recognise the unpredictability of human morbidity, and the diverse ways in which patients cope with this phenomenon. Lawler (1998) goes on to suggest that nursing, a discipline that is seeking to explain human experience, should turn to human science to conduct its research. Within nursing practice the complex array of influences on the knowledge, skills and values of the clinical nurse precludes the adoption of one single

'scientific' approach. Academic nursing faces similar concerns, "straddling multiple paradigms and methodologies; diverse and rapidly expanding knowledge bases; and research questions which may have no established trails to guide us." (Lawler 1991 p18)

In the circumstances it is perhaps unsurprising that qualitative approaches to research, in particular grounded theory and phenomenology (and in some cases the combination of the two, often termed 'method slurring' (Baker, Wuest, & Stern 1992) have become increasingly widespread within nursing. It has been suggested (Baker 1997) that Patricia Benner's (1984) work on expertise in nursing practice was a turning point because it provided the first extensive piece of nursing research based within a qualitative methodology. From the outset Benner adopted an interpretive approach which she has subsequently refined and explicated (Benner 1994a; Benner 1994b; Benner, Tanner, & Chesla 1996); she has however been criticised for a perceived weakness in the application of the 'pure' interpretive method. Geanellos (1998) suggests that Benner fails to adequately challenge and qualify preconceptions and presuppositions, leading to a value orientation which distorts the findings. Geanellos proposes that these distortions, termed 'forestructures' by Heidegger (1962), should be acknowledged and addressed within an interpretive research report. This view is shared by Koch (1995), who argues that Benner's work fails to reflect any dynamic movement on the part of the researcher, who remains apart from the process. Corben (1999) further criticises Benner for failing to describe the participants view of the phenomenon under investigation; Benner's work on expertise (1984, 1996), for example,

concentrates on the participants experience of expertise but does not describe their potentially contrasting view of what constitutes expertise.

These comments capture part of the current debate about the validity of phenomenological approaches within nursing research. There are those, such as Crotty (1996) and Paley (1997) who believe that the dilution of the pure philosophical foundation of phenomenology as it is applied within human science research negates the validity of the method. There are others (Giorgi 1985; Van Manen 1997) who see 'scientific phenomenology' as a research method to be distinguished from the philosophical origins of 'life world' studies. For many nurse researchers the challenge is to derive a meaningful, consistent and valid research method from a philosophical position which was not originally written with research practice in mind.

4.2 Phenomenological research

Phenomenology as an approach to research includes a range of different theoretical standpoints, and a diversity of applications. The roots of phenomenology are in philosophy, and the concept of phenomenology as a philosophy has been distinguished from phenomenology as an approach to social research, termed scientific phenomenology by a number of authors, notably Giorgi (1985). Researchers in the field of human science have adopted and adapted the principles of phenomenological philosophy in developing an alternative to the approaches characteristic of the traditions of natural scientific research. Giorgi's 'scientific phenomenology' was derived directly from the work of Husserl and Merleau-Ponty, but has developed its own

phenomenological research methodology, a discipline that is different from philosophy. The underlying principles described by the pioneers of philosophical phenomenology, such as description, reduction, and the identification of essences are incorporated within Giorgi's scientific method, but he does not claim that in this context they represent a philosophical discipline (Giorgi 1985). Giorgi was seeking to develop a phenomenological research method for psychology, his own discipline, but he recognised the potential applicability of the approach within other human sciences. The scientific phenomenological method described by Giorgi (1997) involves the researcher in the tasks of description, reduction, and the identification of essential structures; this, Giorgi claims is both a phenomenological method and a scientific method. It is phenomenological because it builds on the "Husserlian" view of life world, and it is scientific because it generates knowledge that is methodical, critical and systematic. Moreover it is possible to replicate scientific phenomenological studies using existing data, or through new descriptions of the same phenomenon.

Giorgi's defence of his scientific phenomenological method was developed in response to a number of papers criticising the application of phenomenological approaches within nursing research, notably from Crotty (1996) and Paley (1997; 1998). Crotty (1996) suggests that nurse researchers who claim to be using phenomenological approaches do not adequately incorporate the philosophical basis of phenomenology within their work. He is critical of nurse researchers who use a descriptive approach to phenomenology and claim that their work is based on the work of Husserl, on several grounds. A failure to distinguish between 'phenomena' and 'experience' has led, Crotty claims, to confusion over

both the subject and the object of the research. Too often research findings suggest that the phenomenon under discussion is the product of the subjects' experiences, rather than the primary focus of the investigation. Crotty is equally critical of nurse researchers who claim to be using interpretative methodologies based on the work of Heidegger. He suggests that Heidegger's quest for the meaning of 'being', which is presented as the central tenet of Heideggerian philosophy is neglected within nursing research in favour of a search for commonalities generated from an interpreted view of subjects' embodied experiences.

Giorgi (2000a) refutes this criticism through the suggestion that nurse researchers (and indeed other researchers working in the field of human sciences) are not trying to 'do phenomenological philosophy'. Rather they are using the principles of scientific phenomenology to investigate subjective human experience, an approach that Giorgi believes to be the primary task of phenomenological research in the human sciences. This theme is echoed in the critique of Crotty offered by Darbyshire, Diekelmann, & Diekelmann (2000), who suggest that Crotty has misunderstood the nature of interpretive nursing scholarship. This view is presented as an adjunct to the main theme of the paper, which argues that Crotty has adopted a narrow and ill-informed view of Heidegger's work, and that this shortcoming has contributed significantly to what Derbyshire et al suggest is Crotty's flawed critique of interpretive research within nursing.

Paley (1997; 1998) has also been critical of nurse researchers who claim to be using a phenomenological method. He has commented on what he believes to be a tenuous links between Husserl's philosophy and

'phenomenological' research within nursing, and has also suggested that Heidegger has been misinterpreted by nurse researchers adopting an interpretive or hermeneutic approach (Paley 1998). In both papers his criticism is based on the idea that nurse researchers have failed to understand the philosophical foundation of phenomenology, and should not therefore be citing Husserl or Heidegger as the ontological basis for their research method. Giorgi (2000b) refutes Paley's views in the same way as he refutes Crotty: he suggests that nurse researchers are not engaged in philosophical phenomenology, and that Paley has failed to distinguish scientific phenomenology as a legitimate *research* method derived from the philosophical foundation from philosophical phenomenology per se.

Giorgi's distinction between philosophical phenomenology and scientific phenomenology has parallels in the work of other researchers who have developed approaches to understanding human sciences that are rooted in phenomenology. Van Manen (1990) describes the philosophical underpinnings of his own approach to phenomenological research, but makes clear that his position is derived from the application of principles in the exploration of 'life worlds', and not from the more abstract orientation to 'lived experience' that is characteristic of a philosophical approach to phenomenology. Van Manen believes that researchers approach human science research with a legitimate prior interest, often derived from professional training in teaching, nursing, psychology or rather similar professions. In order to make use of the principles underpinning phenomenology researchers must engage in the human scientific study in question. Van Manen's approach, which is essentially hermeneutic, in that it demands an interpretation of phenomena as

described by participants, does not claim to be philosophy, but is described as 'human science', a term which Van Manen uses interchangeably with phenomenology and hermeneutics to describe his own approach to researching the lived experience of others.

Moustakas (1994) draws a similar distinction in his approach to human science research, which he calls transcendental phenomenological research. The methods and procedures which he suggests are required elements in the development of an organised, disciplined and systematic research study are derived from the philosophical background, but the research methodology is seen for what it is, and not as an integral part of the conceptual framework. For Moustakas, the origins of his transcendental phenomenology derive from the work of Husserl, but he draws a distinction between the philosophical processes that underpin the methodology and the procedures to be adopted by researchers following his method. Moustakas' describes three 'core processes' essential to effective phenomenological inquiry. These three core processes are described as:

- The *epoche*, a Greek word used here to describe an approach to investigation in which the phenomena being studied are viewed non-judgementally, presuppositions are set-aside, and only observed phenomena are described.

- The *transcendental phenomenological reduction*, in which the subject under investigation is perceived as if for the first time, and each experience is considered in isolation. This necessitates a full description of the components of the experience, the meanings and essences of the phenomenon.

- The *imaginative variation*, an intuitive structural description of the experience overall. This final stage allows the identification of

structural essences, building on the textural essences of the transcendental phenomenological reduction stage of the 'core process.

Moustakas, like Giorgi and Van Manen, recognises that the application of philosophical phenomenology in the field of human science research requires a scientific methodology that builds on the philosophical foundation. Within Moustakas' approach, this means translating the core processes of the philosophy into a series of procedures that permit an organised and systematic study to be conducted. These are summarised under the headings methods of preparation, methods of collecting data, and methods of organising and analysing data.

For Moustakas, for Giorgi, and for Van Manen phenomenology as human science research has a clear methodological basis that builds on the philosophical origins of phenomenology to provide a practical approach to understanding the life experience of a defined subject or group. Texts detailing appropriate research methods for nursing have followed a similar approach; as phenomenology has become increasingly accepted within nursing research an increasing numbers of text books have included a description of the phenomenological method. The diversity of approaches within phenomenology has led to a diversity of recommended methods, although the vast majority of these texts share one common feature, in that they tend to detail the procedures involved in a phenomenological study rather than attempting to offer an extensive philosophical basis for the approach (Polit & Beck 2004; Parahoo 2006).

Indeed it might be argued that the philosophical foundations of phenomenology are based in approaches to the practice of the discipline, predicated on the description of phenomena as evident to the subject. An

understanding of the phenomenon under consideration is vital before any form of explanation can be formulated. Husserl (1913) says that phenomenology is a 'descriptive psychology' which must satisfy the principle of 'freedom from presuppositions', and focus on description of the life world, or lived experience. The 'life world' has been described as the 'prereflexive' or 'preobjective' world (Sadala & Adorno 2002), in which description of lived experience allows what Husserl calls the 'actions of consciousness' to emerge. A phenomenon can only be studied when there is a description based on a lived experience of the said phenomenon. Experience is unique, in that different people exposed to the same phenomenon will experience it differently, despite the sharing of the situation or stimulus. Husserl describes two experiential foci for lived experience; the 'noematic', focusing on the situation or stimulus shared by the participants in the experience, and the 'noetic' focus, in which descriptions of the experience are tempered by individuals cultural, cognitive and affective background, which can consciously or unconsciously add to the meaning of experience for the individual (Ihde 1977; Spinelli 1989). Husserl believes that it is necessary to seek a pure description of conscious experience, achieved through intuition, and separated from theoretical assumptions and reflection.

Heidegger's work took this notion of the 'life world', and sought to explain the human condition through reference to the context in which people exist. This notion of 'being in the world', or *dasein,* suggests that an understanding of people is only possible if we understand their situation, background and culture, and that these elements are an inescapable element of the 'hermeneutic circle' (Heidegger 1962). The hermeneutic circle, a concept later developed and refined by Ricoeur and

Gadamer, among others, refers to the notion of circularity of understanding (Packer & Addison 1999), and is, in Heidegger's view, an essential opportunity to gain an increased appreciation of being in the world. The researcher does not gain new knowledge, but seeks to interpret an existing understanding of the participants' world. This is context driven, and can only develop from a given and inescapable set of 'fore-structures', an a priori world that cannot be 'bracketed' or eliminated (Koch 1995; Annells 1996).

The hermeneutic 'turn' adds depth to phenomenology, and allows a degree of reflexivity in the inquiry process (Todres & Wheeler 2000). The existentialist basis of Heidegger's work, focusing on human existence and the search for meaning in human lives allows for multiple interpretations to emerge from one set of data, and provides a basis for hermeneutic research. It also provides a philosophical context for caring, in which Heideggerian constructs such as being-in-the-world-with-others have direct parallels with concepts such as caring presence (Nelmes 1996) or true presence (Parse 1998) in nursing.

4.3 Hermeneutic approaches

Heidegger's interpretive hermeneutic element acknowledges the constantly changing nature of lived experience, something that was reflected in his notion of 'historicity'; the importance of past experience, present understanding and future expectations in helping to describe lived experience (Conroy 2003). Hermeneutic phenomenology provides researchers with an opportunity to explore lived ethics, by understanding peoples' experience of ethically sensitive situations. The significant

advantage of the hermeneutic phenomenological approach is that the data collection phase requires participants to recount personal experiences of the phenomena under investigation, and the subsequent hermeneutic interpretation allows the researcher to consider the narrative and clarify the ethical underpinning.

This approach has gained significant popularity among nurse researchers over the past ten years. The work of Geanellos (2000), Van der Zalm & Bergum (2000) and Lindseth & Norberg (2004) has looked to formulate a research method based on hermeneutic approaches to research interviewing and textual analysis. Central to this approach is the philosophical theory of interpretation developed by Ricoeur (1981, 1988), an approach which provides opportunities to understand narratives as a product of their constituent parts.

Ricoeur's early work was firmly rooted in the tradition of existential phenomenology, but as he developed his philosophy he argued that phenomenology was not merely enhanced by interpretation, but that phenomenological understanding is not possible without a hermeneutic component (Moran & Mooney 2002). In *Hermeneutics and the Human Sciences* (1981) Ricoeur first explores the central tenets of Husserl's phenomenology, described by Ricoeur as 'idealism', and proceeds to argue that the limits inherent in seeking understanding through description can be extended if understanding is mediated by an interpretation.

Interpretation uses language, and more specifically texts, as the starting point for the development of understanding. Ricoeur says that people are

"in the world....affected by situations" and therefore have "something to say .... experience to bring to language". (Ricoeur 1976). The process of interpretation is achieved in two stages, first through the understanding of narrative accounts, and second through an explanation of understanding to a putative third party. Narratives involve the recounting of an incident, or story, within which multiple elements are synthesised into a coherent plot, a process described by Polkinghorne (1997) as 'emplotment'. Polkinghorne suggests that the recounting of a coherent narrative is a reflective process, involving the coalescence of elements of experience in a time limited, conscious account that has a recognisable format and a considered conclusion.

Narratives are by necessity 'languaged' accounts of experience, and as such cannot be free from symbolic meaning; the textual account of an experience can never be identical to the lived experience. Ricoeur, however suggests that language has a capacity to incorporate aspects of experience that might not be apparent through observation, and that literal description can provide a starting point for others to understand lived experience. He also suggests that interpretation is the route to understanding, as the meaning of experience becomes public through discourse (Ricoeur 1976, 1991). This view is in keeping with Heidegger's assertion that no-one can have a view of the world that is atemporal and ahistorical (Leonard 1989), and that interpretation occurs within a set of shared cultural norms and mutual insight.

Validity is dependent on overcoming elements of ambiguity inherent in narrative accounts. Chomsky (1968) refers to 'linguistic competence', a command of the meaning structures of language. This, when combined

with common cultural understanding, allows semantic interpretation to take place in context, a phenomenon described by Habermas (1970) as the intersubjectivity of mutual understanding. Gadamer saw this background of practice, language, and values as the 'tradition', the preunderstanding of prejudice and prejudgement that put new understanding in context (Thompson 1985).

Merlau-Ponty (1962) suggests that 'our effective involvement in the world is precisely what has to be understood and made amenable to conceptualisation'. Researchers have an inherent understanding of meaning through language, and this preunderstanding has to be acknowledged in any subsequent analysis of the lived experience of others. For Husserl, and descriptive phenomenologists such as Giorgi (1985) this is achieved through bracketing, the setting aside of prior knowledge of the area under investigation.

For Heidegger and the existential phenomenologists lived experience is part of a circular process, symbolising the interface between the biases and presuppositions of the reader and the biases and presuppositions of the text. This view, which is implicit in the conception of the hermeneutic circle, is further enforced by Heidegger's notion of co-constitution (Heidegger 1962; Koch 1995), in which an individual both influences (or constitutes) his world and is influenced or constituted by it. Co-constitution is evident in nursing theories influenced by Heidegger, notably Roger's 'Science of Unitary Human Beings' (1970), and Parse's 'Theory of Human Becoming' (1998) which incorporates the principle of co-creating in Parse's exploration of the rhythmic nature of relationships.

The hermeneutic philosophical orientation of Ricoeur (1981, 1992) has allowed the development of an interpretive linguistic perspective in which narratives permit insight into the first-hand experiences of others. Through an interpretation of a narrative account the life world of an individual can be cast in a new light, and new meanings can be formulated. Ricoeur (1991) regards the narrative account as an expression of the (lived) experience of the narrator, and any subsequent transcription into a text as a symbolic representation of the spoken word. Together speech and transcribed words form the discourse, which Ricoeur suggests has given characteristics. Discourse is framed in the present, even though events recounted may lie in the past. This in turn ensures that discourse refers exclusively to the participant and his or her personal experience, in the context of the life world. Finally discourse is addressed to another person, and is necessarily influenced by the interviewer, whose role in the creation of the discourse can never be neutral.

Transcribed research interviews provide the text for analysis and interpretation, a central feature of Ricoeur's hermeneutic method. Ricoeur (2004) suggests that a transcript can only provide a description of an event, but through hermeneutic interpretive processes it is possible to 'appropriate' intention. Achieving a deeper understanding of a text, to understand something of the motivation, or intention of the participant, is the essence of the hermeneutic transition from the descriptive to the interpretive.

The narrative method thus allows an interpreted view of the phenomena under investigation to emerge, retaining individual participants' choices and their responses to situations described in the narrative account. The

approach allows the phenomenological tradition of Husserl, as formulated and described by Giorgi (1985, 1997) to guide aspects of data collection, and the initial descriptive stage of the data analysis; and the interpretive hermeneutic approach of Ricoeur, as formulated by Norberg and others (see, for example, Soderberg 1999; Lindseth & Norberg 2004) to provide the means to formulate a comprehensive understanding of the phenomenon through interpretation.

Ricoeur proposed that the interpretation of narrative accounts, presented in the form of texts, is the primary aim of hermeneutics, and sought to explain how an understanding of narrative accounts can be achieved. He saw a relationship between the meaning of a text and the process that a reader has to undertake to uncover that meaning; through this relationship the researcher is able to understand the experience of the participant, but cannot 'live' the experience. The experience remains private, but the interpreted narrative forms the basis of a new shared understanding. In his later work Ricoeur links hermeneutic phenomenology to philosophical ethics, and asserts that ethics should form the basis of an accomplished life. Ethics, according to Ricoeur, differs from morality, because morality merely reflects norms and expectations within a society, while ethics provides personal understanding. When viewed in the context of healthcare, ethics provides the basis for positive relationships between practitioner and patient. The contribution that ethics makes to the lived experience of practitioners is significant, but may not be directly reported. Interpretation of texts, such as narrative accounts of lived experience (Talseth, Jacobsson, & Norberg 2000) or transcripts of therapeutic interactions (Fredriksson & Eriksson 2003) are one way in which the ethical basis of practice can be revealed.

Ricoeur's philosophy has inspired a number of researchers working in the field of health and social care, particularly nurses, to make use of narratives in seeking an understanding of the lived experience of nurses, patients and their carers. The suggestion that individuals make sense of their own life experience by recounting their personal stories has been proposed by many authors, notably Bailey & Tilley (2002), and provides a foundation for the development of phenomenological hermeneutics as a research method. This development has been particularly associated with work at a number of Scandinavian Universities, including the University of Tromsö, Norway, and Umeå University in Sweden (Soderberg 1999; Lindseth & Norberg 2004).

Over time a number of studies have been completed using a hermeneutic phenomenological approach based on Ricoeur; as more researchers have adopted the methodological approach some standardisation has occurred. The approach is founded on a fundamental commitment to try to understand the world from the point of view of the participant, knowing that their personal experience is unique, but working towards an understanding of the meaning of the experience through interpretation.

Several phases are adopted within the process of understanding and explaining narratives. These phases are not, however, entirely sequential, and the process of hermeneutic interpretation may require movement between phases in order to achieve understanding. The first phase, naive understanding, aims to achieve a broad understanding of the entire text. Some observers, notably Frid, Ohlen, & Bergbom (2000), have suggested

that this phase should not constrain subsequent analysis of the text; the purpose is to acquire a sense of the potential within the text, not to limit the range of interpretations that might emerge from the entire interpretive process. The subsequent phases seek to provide a structural analysis of the narrative, through an examination of the integration of different parts of the text. These structural analyses involve an examination of narrative structures within the text, and the identification of meaning units in order to develop a thematic analysis of the text. The final phase, the presentation of an interpreted whole, a reflexive and contextual summary based on hermeneutic understanding of the phenomenon under investigation.

These phases in the research process form a cycle, a hermeneutic circle within which the researcher seeks to understand the lived experiences of the participant. The researcher naturally has a number of personal experiences and prior understanding of the phenomenon. This prior knowledge, termed 'foreknowledge' by Gadamer (1989), and recognised by Husserl and the descriptive phenomenologists in the concept of bracketing (Moran 2000), is acknowledged by Ricoeur (1981) as something that cannot be ignored, but at the same time cannot be escaped. Ricoeur sees pre-understanding of the phenomenon as part of the 'vital relation' of the researcher to the phenomenon described in the text. The researcher is only ever aware of part of their understanding, but the influence of intangible, unconscious elements of pre-understanding, such as culture, creates the potential for subjectivity in interpretation and demands adherence to the research method in order to maintain the validity of the narrative.

Ricoeur referred to this in his concept of distanciation, the act of 'putting something at a distance' (Geanellos 2000). Ricoeur describes four principle elements to distanciation; the transcription of speech, in which meaning has greater significance than the specific words used, the use of verbatim transcripts, which leaves the text open to new interpretation, the freeing of the text from the cultural and political bias of the researcher, a process referred to by Ricoeur (1981) as 'decontextualisation', and the removal of the interpersonal aspect of face to face speech. Together, these elements allow transcribed narratives to remain true to the meaning of the participant, and preserve some distance between narrator and researcher.

Distanciation is a process that allows the text to remain free from the researchers interpretations. However, a hermeneutic methodology requires interpretation, and Ricoeur sees the stage that follows distanciation, termed appropriation, as the point at which the researcher derives meaning from the text, and provides new knowledge through the 'actualisation' of meaning (Geanellos 2000). This appropriation 'discloses possible ways of being in the world' (Wiklund, Lindholm, & Lindström 2002), and allows the researcher to see new perspectives on the world of the participant.

Ricoeur's principles are readily applicable to different situations, including caring science (Wiklund, Lindholm & Lindström 2002), nursing practice (Lindseth & Norberg 2004; Frid, Öhlén & Bergbom 2000), nursing ethics (Sørlie, Kihlgren, & Kihlgren 2005), patient decision making (McCormack 2002), patient experience of illness (Lindhahl, Sandman, &

Rasmussen 2003), and the experience of carers (Hellzen et al. 1999;

Hellzen & Asplund 2002).

Chapter 5: Method

5.1 Introduction

Hermeneutic phenomenology has been utilised by nurses in a number of contexts, including practice development (Benner & Wrubel 1989) and research (Geanellos 1998). However Geanellos points out that an identification with hermeneutic phenomenology only provides a philosophical foundation for further study, and suggests that researchers planning to adopt the broad approach need to consider how the detail of their research process can be derived from the underpinning philosophy, in order to ensure that there is 'congruence between philosophy, methodology and method'. Methodological considerations have been explored elsewhere, but the translation of the philosophical principles that provide the basis of the methodology into a coherent and workable research method presents its own challenge.

This study was designed to explore the experience of role transition and the meaning of professional autonomy for nurse practitioners. In considering an appropriate research method for an exploration of nurse practitioners' experience of role transition several factors were taken into account. The object of qualitative research is to focus on the human aspect of behaviour in context, in this case seeking to highlight the personal, professional and organisational aspects of the research question. Human participants have their own view of their life situation, or 'lifeworld', and inevitably the research process itself becomes a part of the participants' experience. Indeed, confronting participants and exploring lived experience requires emotional engagement with the topic under investigation on the part of the participant, and any contribution to

qualitative research will involve them in the selection, editing and interpretation of lived experience, whether consciously or unconsciously, as part of the framing of responses within an interview.

Having determined that a qualitative approach was appropriate, a decision had to be made about the detailed approach to the research method. An exploration of the philosophical bases of qualitative research led to an interest in phenomenology, because of the central focus on lived experience, and hermeneutics, because the opportunity to synthesise diverse experiences into a new understanding of a phenomenon, through interpretive processes, appeared to present an appropriate structure for the project. Further background reading led to the realisation that the exploration and interpretation of narrative accounts, based on the philosophical approaches adopted by Gadamer and Ricoeur in particular, would provide a consistent philosophical basis for the project design.

5.2 Narrative approaches

The use of a narrative method was felt to offer several potential benefits to the research study. In a narrative account the participants are encouraged to express their personal engagement with a given set of circumstances, and in recounting their stories will incorporate personal opinion, and will also offer their personal interpretation of the experience through reflection on the antecedent events, the actions of other players, and the consequences. For Ricoeur (1984; 1992) narratives are fixed in the present time but draw on past events, because they are based on individuals' memories of lived experiences. Narratives therefore offer an opportunity to anyone who engages with the narrative to understand the present, be they speaker, listener, or reader. In this way narrative studies

can make use of the past to help shape the future; Ricoeur (1992) describes this as a 'double gaze', looking backwards to the 'practical field' and ahead toward what he describes as the 'ethical field'.

The ethical field refers to Ricoeur's (1992) assertion that self esteem is an important component of 'aiming at the good life', which Ricoeur saw as the fundamental motivating factor in life, and gave rise to the 'reciprocal benevolence' that charactersied his view of interpersonal relationships. For Ricoeur, the pursuit of self esteem has an ethical foundation, because the interpretation of lived experience must include consideration of the ethical dimension. This is pertinent at the level of self interpretation within narratives, where the narrator reflects on experiences, and evaluates decisions and actions in unfolding the story. It is also important within research as an acknowledged part of the hermeneutic appropriation of meaning from texts; recognising the potential ethical implication of using past events to shape future understanding is important, and reinforces Ricoeur's declaration that narratives can never be 'ethically neutral'.

This study has its basis in professional ethics, exploring nurse practitioners experience of professional autonomy, and is therefore dependent on participants' self interpretation of clinical decisions and professional relationships, as recounted within their narrative accounts. Actions undertaken within clinical practice are shaped by nurse practitioners own perception of their autonomy, and by the respect that patients, families and other professionals have for their role and status within the health care team.

Ricoeur's philosophy has inspired a particular approach to qualitative research, rooted in hermeneutic phenomenology, in which the transcription of narrated experience provides a text that can be interpreted. However as Wiklund, Lindholm & Lindström (2003) point out, Ricoeur's is a 'theory concerning interpretation, rather than a method describing how to interpret'. For this reason it was necessary to determine how the principles derived from the philosophical underpinnings could be translated into a research method. This involved advance specification of the requisite stages in the research process, to ensure a coherent route from initial contact with the participants to an interpreted account of their experiences, synthesising their narrative accounts into a valid and coherent conclusion to the research question.

The research method adopted for this study therefore uses hermeneutic principles to provide a basis for the interpretation of narratives, and is derived from the theory of interpretation developed by Ricoeur. The method has been adapted and modified for use in this research along similar lines to those adopted by several researchers working within the caring science field, notably Wiklund, Lindholm and Lindstrom (2002), and a number of researchers associated with work initially carried out at several Scandinavian Universities, including the University of Tromsö, Norway (Lindseth et al 1994; Lindseth & Norberg 2004) and Umeå University Sweden (Soderberg 1999). The approach is based on the premise that within a caring science paradigm experiences can be recounted as narratives, translated into texts through a process of transcription, and reinterpreted so that the sense of the text can be understood, and hidden meaning incorporated in the interpreted whole.

Ricoeur views the interpretation of a text as a means to understanding the text itself, rather than the meaning intended by the author of the text, or in the case of transcribed interviews the narrator of the experience. He recognizes, through the concept of 'distanciation', that reading a transcribed text is a different experience to listening to a speaker. Distanciation is the process through which a text separates and distinguishes the message fixed within a transcript from the spoken account, the 'literal event' of speech (Ricoeur 2004); the process of transcription itself represents the transformation of the message from a 'finite horizon' into a permanent form, open to a wide audience.

Ricoeur describes four processes that together help to achieve distanciation, and allow narratives to remain true to the meaning of the participant. First is the transcription of speech, a process which focuses attention on the meaning of the words used, rather than the 'speech-act'. Second is the use of verbatim transcripts, which isolates the direct link between the speaker and the researcher and creates a text that stands alone, open to new interpretation. Third is the opportunity to review the narrative account on multiple occasions, an option that is clearly available to the researcher once the transcript has been created, and finally the text is able to address all readers, unlike the narrative account which is necessarily confined to the interview situation and is therefore specifically directed at the researcher. Distanciation makes it possible for the researcher to read the text in an open and objective way, a process referred to by Ricoeur (1981) as 'decontextualisation', in which the interpersonal aspect of face to face speech is minimised. Transcribed narratives thus nullify the relationship between narrator and researcher, and remain true to the meaning of the participant.

For Ricoeur, understanding of a narrative account can only happen when the reader can go beyond understanding of the description contained in the text and seek an understanding of the underpinning meaning, the human condition evident in the lifeworld of the participant. In this study the narrative interviews were designed to allow participants to describe experiences of working as a nurse practitioner; these transcribed narratives provided the texts from which new meaning, drawing on a hermeneutic understanding of the world of the nurse practitioner could be appropriated.

Hermeneutic approaches to research require that the researcher is an active participant in both data collection and interpretation. Researchers cannot, however, be entirely free of their existing knowledge and experience of the phenomena under consideration. This pre-existing awareness is termed 'pre-understanding' by Heidegger (1962), and is an important element of hermeneutic research for two reasons. First, because understanding is always governed by pre-understanding, it is pre-understanding that provides the context for interpretation; and second, the recognition that pre-understanding is an inescapable element of the world of the researcher in turn requires that a strict method of interpretation is adopted in order to negate any subjectivity on the part of the researcher (Ricoeur 1976).

The approach to interpretation adopted within this research is outlined below; prior to embarking on the initial stages of data analysis I used the period during which I was exploring the background to the nurse practitioner role to reflect on my pre-understanding relating to this field.

A reflective account was compiled, for personal consideration, and this provided a point of reference during the subsequent data analysis.

5.2.1 The context of the study

Research designs based on narratives allow the personal experiences of the participants to be studied across time and situation, something that was important to this enquiry. Within this research the transition from registered nurse to nurse practitioner was the principal phenomenon under investigation, but this transition could only be explored within the context of the prevailing health care system. Nurse practitioners' lived experiences are individual experiences, interpreted and recounted during the course of the purposeful discussion generated within a qualitative interview. However the professional context within which nurse practitioners and fellow health care professionals practice has an impact on everyone working in the field, and individual experience is naturally augmented by professional considerations and inter-professional relationships. The lived experience of nurse practitioners is inextricably linked with both their patients and their colleagues, and the special circumstances within which health care is delivered demands that providers demonstrate an ethical awareness that is specific to their practice and context.

5.2.2 Narratives as a means to explore ethical issues

Narratives are powerful vehicles for the exploration of ethical issues, because they allow the participant to explore past experience and present feelings, personal explanation and understanding, and both objective and subjective aspects of experience within a single discourse. Within a

narrative personal interpretation provides the focus of the participant's particular experience, and this will, implicitly or explicitly incorporate personal (and in the case this instance, professional) values. Personal interpretation thus provides internal coherence to the narrative, in accordance with the participants' ethical standards. Ricoeur (2004) proposes that 'remembering is a moral duty', because anyone describing an experience involving other people has an obligation to ensure appropriate representation of 'the other' in their account. In presenting narratives from the health care arena, there will also be an inescapable professional duty, generated by professional codes as well as individual conscience. Ricoeur goes on to suggest that recounting a lived experience brings 'the past into the present to shape the future', and this potential to gain new understanding from an interpretation of lived experience means that 'a narrative is never ethically neutral' (Ricoeur 1992).

The use of narratives has been of interest to qualitative researchers working in the field of health care related research for some years, but the term has not always been used in a precise way. Frid, Öhlén & Bergbom (2000) suggest that narratives are different from story telling in that narratives relate the personal experience of the author, while story telling recounts the experiences of third parties. This view is not shared by many other observers, who see the terms 'story' and 'narrative' as capable of being used interchangeably. Ollerershaw & Cresswell (2002), for example discuss what they call a narrative project in which the data comprises the 'stories' told by the participants. Paley & Eva (2005) propose a scale of 'narrativeness', in which stories are categorised as high level narratives, involving plots and characters rather than a simple recounting of a sequence of events, as might be seen in low level narratives.

Within this study the interviews conducted were designed in a way that sought low level narratives as the basis of the text, with 'high level' interjections in the form of illustrative stories interspersed within the main text. Participants were asked to recount specific incidents to indicate how actions are derived from defined principles within their working practice.

Frid, Öhlén & Bergbom (2000) further argue that recent interest in narratives has not always demonstrated a coherent approach to interpretation as a means to new understanding. This view at least is echoed by Paley & Eva (2005), who suggest that use of the term 'narrative' in health care research has been inconsistent, and that a tendency to 'romanticise' narratives, promoting them to what Bury (2001) described as the 'authentic voice of the ... underdog' creates the need for 'narrative vigilance' ensure that powerful emotional storytelling is not allowed to marginalise accuracy and objectivity. Ricoeur (1986) sees a story as a way of expressing an individuals 'pre-understanding' of life, providing a dialectic between factual description, subjective experience and personal meaning.

Hermeneutics has been described as the "philosophy of understanding and the science of textual interpretation" (Wiklund, Lindholm & Lindström 2002). Ricoeur (2004) suggests that any written document can be a text and therefore suitable for the interpretive process. Narratives are most often the source of texts for analysis in health care research, because they provide the opportunity to move beyond a descriptive recounting of the content, and undertake an analysis of the structure and meaning of the experience contributed by the respondent. Structured interpretation

provides an opportunity to seek an understanding of the meaning of lived experience in context; this new understanding can reveal 'hidden' meaning through interpretation. This is the 'hermeneutic circle' described by Heidegger (1962) linking self understanding with understanding of the world, and implicit in Ricoeur's assertion that phenomenology is the essential foundation of hermeneutics, and that hermeneutics presupposes phenomenology: the two are inevitably interdependent (Spiegelberg 1982). Narratives are, however open to a number of different interpretations, and any one story might be the subject of multiple understandings, a situation referred to as plurivocity (Brown 2006). While this might not in itself be problematic and could be construed as a positive indictment of the power of narratives, it is important for the researcher to be aware of the issue, and to ensure that any interpretation derived from the transcribed texts is authentic and trustworthy. These issues are explored in more detail later.

5.3 Ethical considerations

Following the identification of the research question, and a firm decision regarding the methodology to be adopted, the process of gaining ethical approval began. The research proposal indicated that the empirical stage of the research would be carried out through a series of interviews with nurse practitioners drawn from a number of specialities and geographical locations. Following extensive consultation with supervisors and with the Central Office for Research Ethics Committees (COREC) it was determined that this particular project would require multi-centre (MREC) ethical approval, because a majority of participants would be employees of the National Health Service, and would be drawn from more than one Strategic Health Authority. The actual process for ethical

approval was fraught with difficulty, and following an abortive attempt to meet with the Birmingham MREC the proposal was eventually considered by the Cambridgeshire MREC. The panel appeared bemused by the application, and struggled with both the methodology and what was perceived as a lack of precision in the proposal – for example my suggestion that the final number of interviews to be conducted would only be determined later in the process. The MREC meeting thus provided me with an unexpected opportunity to defend the methodology, and explain the research design to an audience who were entirely grounded in quantitative approaches. The meeting was open and productive, and ultimately successful, because following some minor additions to the requisite paperwork formal ethical approval was granted, and the empirical research could begin.

Once ethical approval for the project was confirmed, the potential participants were identified. Sampling in qualitative research varies slightly according to the specific approach adopted; typically in hermeneutic phenomenological studies the basis of sampling is that participants are willing and able to recount their experiences (Van Manen 1997; de Witt & Poleg 2006). The selection of participants is dependent on their having lived experience of the research topic; there is no requirement for the sample to be representative, or for their individual experiences to be typical of the sample, or the wider group as a whole. However in keeping with the notion of 'maximum variation sampling' (Polkinghorne 1989; Langridge 2007) participants shared a common professional background, but were otherwise a diverse group, working in different countries, in different specialities and in different settings.

In this case I approached a purposeful sample of nurse practitioners, by telephone or Email, and invited to participate in the study. All those participating in the interview programme were accredited nurse practitioners, having followed a recognised programme of study in the UK or the US. Although nurse practitioners from both countries participated in the study the data collected were not analysed with a view to making comparisons between the two groups; early in the process it was clear that despite some minor linguistic anomalies participants were describing experiences of the same phenomenon, and could therefore contribute to a single thematic analysis. All had experience of practice in their specific field; specialities were not important to the study, but participants came from a range of backgrounds, including primary/community care, paediatrics, mental health, women's health, learning disability and acute care. The purpose of the research and the general principles underpinning the research method were explained, and provided those approached were willing to meet with the researcher, an appointment was confirmed.

In addition to the common ethical considerations associated with qualitative research the particular approach within phenomenological studies suggests that an additional set of ethical considerations be considered by the researcher, because of the nature of the relationship between researcher and participant. Smith (1998) suggests a range of strategies for ensuring ethical integrity in the research relationship, including the development of a trusting relationship, mutual self disclosure, accurate empathy, use of self, genuineness and remedial action if necessary.

In negotiating to meet with participants certain guarantees were offered, in accordance with established ethical principles for the conduct of qualitative research. Participants were given assurances that their anonymity and confidentiality would be protected, and were offered written information about the research project and the storage and use of data. The information sheet specified the process for recording and transcribing interviews, and made clear that identifying characteristics (such as names of individuals and specific practice locations) would be edited to preserve confidentiality. Furthermore, the participants were offered the opportunity to withdraw from the study at any point. A copy of the information provided to potential participants, and a copy of the consent form completed prior to their participation are included in an appendix to the study.

Bok (1988) describes four justifications for maintaining confidentiality, all of them relevant to the research situation. The predominant reason for confidentiality in any human relationship is the respect customarily given to personal information that is disclosed for a particular purpose. This is a facet of individual autonomy; everyone has the right to disclose or withhold information from others unless particular circumstances demand otherwise. In a research interview the contribution that the participant makes is a response to an agreed, planned process, and the data collected should only be used in support of that process. Two other grounds for maintaining confidentiality develop this notion of respect in human relationships; Bok advocates that maintaining confidentiality is further justified because it helps to strengthen the relationship between the parties concerned, and because assurances given at the outset of a relationship should be maintained. Bok's final justification for

confidentiality is specific to 'managed' situations, and is best described as a 'professional' obligation to maintain confidentiality. In the case of research this relates to the ethical codes and controls within which researchers are obliged to work, for example adherence to a University's code of practice, or working in accordance with approvals given by an ethical committee. This is a powerful justification, in that the publication of research findings is often difficult if ethical codes have not been strictly adhered to.

In this case the information sheet given to participants and the consent form offered guarantees regarding the standard of confidentiality to be adopted during the study; I also raised this during the preliminaries to the interviews, so that participants could be reassured regarding the anonymity of the data, and had an opportunity to ask any questions that they might have. The process is in accordance with the requirements of my ethical approval, but more importantly allows participants to see that I am aware of the potential sensitivity of the data, and understand both the principles underpinning confidentiality and the practical steps required to assure anonymity.

5.4 Data collection

Interviews have become the predominant vehicle for the collection of data within qualitative research, and as such have been the subject of a good deal of discussion. The various approaches to qualitative research each demand data in a specific form, and therefore require a different approach to the interview and a different internal structure to the process, although there is considerable overlap. Ongoing refinement of technique, described by Nunkoosing (2005) as the 'precise technology of

interviewing', has to be seen in conjunction with the interpersonal impact of the relationship necessarily engendered by the interview situation.

The qualitative research interview, according to Kvale (1996), allows the researcher to 'gather descriptions of the life world of the interviewee'. Van Manen (1997) describes two specific desirable outcomes of the interview within hermeneutic phenomenological research: it can be used to explore narrative material which subsequently helps the research to develop a rich understanding of a phenomenon, and it can be used to develop the meaning of an experience through conversation

The phenomenological research interview is typically based on a semi-structured or unstructured format, in which open-ended questions are used to establish a dialogue with the participant as a way of evoking life experiences. It is the nature of the participant's experience that is central to the development of a phenomenological study, and the interview should be designed in a way which allows the participant to give examples of the phenomena under discussion from their own life experience. This was achieved by focusing on key areas, particularly the one key area of professional autonomy, and inviting participants to recount their own stories during the course of the conversation.

Becker (1992) suggests that phenomenological research interviews are unique experiences for both researcher and interviewee, and their course cannot be predetermined. She recommends that interview should be based on one single open-ended question, with subsequent questions being developed from the response. This is a similar strategy to that forwarded by Kvale (1996) although he describes a semi-structured

approach to interviews, and lists a range of different types of questions that can be employed to progress the interview beyond the initial response. In this case semi-structured narrative interviews were conducted, in which I introduced key areas and invited participants to reflect on their experiences of the phenomenon under investigation. This format has been described as 'narrative interviewing' (Green 2004), because the interviewers expressed intention is to facilitate the participant in telling their story, exploring their lived experience of the phenomenon under investigation, and looking to achieve an understanding of the interviewee's underlying beliefs.

Language is an important consideration in any interview conducted as a means of data collection within qualitative research; in a phenomenological study based on narratives this is particularly true, because the texts generated through the transcription of the research interviews provide the sole source of material for subsequent analysis. Several authors (Denzin & Lincoln 2000; Green 2004) highlight the need to ensure that the language used within interviews is accessible to the participant, particularly where there are social or cultural differences within the interview relationship. In this study the participants were made aware of my status and background prior to the interview. The fact that there was significant similarity between my professional background and that of the participants led to a degree of mutual understanding around language; participants tended to use technical language, nursing argot and medical abbreviations in their narratives, having assumed that this was appropriate to a peer discussion of their experiences in relation to role transition. This sense of affinity, generated through mutual recognition of professional status and experience, helped to establish a

level of respect and collaboration that was conducive to a productive interview process, and provided me with opportunities to confirm meaning, and where appropriate seek further explanations and ask for more detail of participants' experiences, both during and subsequent to the interview.

Sorrell & Redmond (1995) see the interviewer as the 'instrument' through which data collection takes place. They recommend that a tentative scheme is prepared in advance of an interview, but recognise the importance of flexibility, allowing the interviewer to respond to the direction of the discussion, focusing on issues that seem to be important to the individual participant. Qualitative interviews are intimate occasions, established to encourage disclosure, and it is important to ensure effective rapport built on trust between interviewer and participant.

Kvale (1996) describes the different types of questions that are available to phenomenological interviewers; in combination he believes that they provide the best opportunity to elicit details of participants' life experience in relation to the research question. Interviews open with what Kvale calls 'introducing questions', designed to provide the participant with an opportunity to give an initial account of their experience of the phenomenon under investigation. This in turn provides the researcher with an indication of how best to further develop the interview. Kvale (2004) describes a variety of interpersonal skills, commonly used in counselling, as appropriate to the development of the interview. These include reflection, summarising, probing and

rephrasing, all used to help the interviewer clarify the experiences described by the participant.

In this case the 'introducing' questions asked participants to describe their transition to the nurse practitioner role, and to give me examples from their experience of ways in which they are able to exercise professional autonomy. While I had some further prompts to guide the narrative should it prove necessary, the general tone of the interviews was of a conversation between two experienced nurses discussing an issue of mutual interest. I assumed the role of the facilitator, using principles of active listening to draw out the narratives, and where necessary prompting the participant to illustrate their experiences in relation to the phenomenon under investigation by recounting specific incidents from their own professional practice.

In the first stage of the interview process eight interviews were conducted, divided between UK based and US based nurse practitioners, over a four month period. Interviews were audio taped, and transcribed in full, providing a verbatim record of the conversation for subsequent analysis.

5.4.1 Transcription

Interviews were transcribed from the original tape recordings directly into a Microsoft Word file. Transcribing is a very time consuming process, but is vitally important because the texts created from participants' narrative accounts of experience are an essential part of the method used. The transcripts were created by the researcher, a process that was felt to be of significant importance, because creating transcripts

'first hand' allows ongoing immersion in the data, and provides the researcher with a first opportunity to see common threads in the narratives as a first stage in the formulation of a naïve understanding of the data (Gilham 2005). Accurate transcription is seen as essential to the validity and reliability of qualitative research (Easton et al 2000), and in support of accuracy recordings were transcribed as soon as was practicable following the interview, and once complete were reviewed to check their consistency and coherence. On occasions it was necessary to return to the recording to verify specific sections of a transcribed interview; where the coherence of the narrative was compromised by the interviewee's failure to present a clear story the transcript was allowed to stand, but on occasions revisions were necessary to take account of transcriber error and ensure that a true record of the narratives offered by the participants was the starting point for subsequent analysis.

During the repeated listening necessary to produce an accurate interview transcript, it became apparent that certain key issues were consistently mentioned in a number of narratives. This gradual emergence of particular themes allowed the beginning of naïve understanding to be developed alongside the lengthy process of transcription.

Once the first set of interviews had been transcribed a more detailed reading was undertaken, to begin the process of data analysis (see detail below). It became clear at an early stage that additional data would help to assure the consistency of the emerging themes, and therefore a further set of six interviews (again divided between UK and US based nurse practitioners) was undertaken, and transcribed in exactly the same manner. Re-reading the entire set of transcripts provided greater

assurance that the emerging meaning units and themes were valid, and that no new generalisable data would emerge from further interviewing.

Morse et al (2002) use the terms significance and relevance in preference to reliability and validity when discussing qualitative research; this is a continuance of a debate instigated by Guba & Lincoln (1989), who wanted to avoid borrowing terms from quantitative research and redefining them in an attempt to make them relevant to qualitative studies; they used the term 'trustworthiness' to capture the principle that qualitative studies should be credible, transferable, dependable, and capable of confirmation. Morse et al (2002) prefer the terms significance, relevance, impact, and utility as their criteria for evaluating qualitative studies, but the general principles are similar. Yardley (2000) points out that the diversity of qualitative methodologies, and the emergent nature of many qualitative approaches explains the lack of concordance in determining how validity should be judged.

At the level of the individual interview, researchers have a duty to ensure, as far as is possible, that the data is 'authentic', that is representative of the participant's personal view of the world. Within this study participants were encouraged to be open and honest about their experiences, and reflect on their personal lifeworld in an authentic manner. This was facilitated through assurances of confidentiality and anonymity in advance of the interview, and through mutual respect and facilitative interaction during the interview, supported by the shared background enjoyed by researcher and participant.

At the level of the structural analysis the phenomenological account must achieve a consistency that allows readers to accept the integrity of the findings. This standard has been described as trustworthiness (Guba & Lincoln 1989), significance and relevance (Morse et al 2002) and validity and reliability (Searle & Silverman 1997). In effect the differences are largely semantic, in that in each case the authors have the integrity of the research at the heart of their concern, and are looking to establish processes by which qualitative studies can be seen to generate legitimate findings that are of interest in a wider context than the study itself.

In this research study these principles were addressed throughout the structural analysis, and subsequent interpretive appropriation of meaning. Using principles outlined by Searle & Silverman (1997), several strategies were adopted. Meticulous transcription ensured that a full and faithful text was available to the researcher. Issues that were common to a number of participants were identified within transcripts, and a rough count was carried out to confirm that the experiences quoted in support of the developing thematic account were not isolated anecdotes, but did reflect a more general view. The mechanics of the data analysis, discussed in more detail below, were carried out using a computer programme, to ensure that every meaning unit identified during the first structural analysis was available for systematic evaluation and comparison. Key meanings within narratives were checked as far as possible with participants, to ensure that their words were being read in the way that they intended.

5.4.2 Interpretation and understanding

Ricoeur views the interpretation of texts as a way of understanding the meaning of the text, rather than the meaning intended by the author of the text. In this sense the hermeneutic interpretation of interview transcripts, or texts, is intended to explore the meaning of the transcript, rather than the participant.

For Ricoeur, understanding of a narrative account can only happen when the reader can go beyond understanding of the description contained in the text to an understanding of the underpinning meaning, the human condition evident in the lifeworld of the participant. The research interview creates a narrative between the participants, focused on the phenomenon of interest and the topics introduced to the conversation. The transcript provides a verbatim record of this conversation, and is the source material for the data analysis. In accordance with Ricoeur's (1992) view, it is the transcript that is important to the researcher, and any new understanding gained through a descriptive account of the phenomenon, or via an interpretative exercise, must be derived from the text created by researcher and participant rather than from a direct interpretation of the interviewee's intention. Within the human science paradigm it is important to recognise that history, social structures and comparative cases all impact on the readers understanding of the phenomena (Green 2004), and therefore researchers need a broad perspective that incorporates the context of the participants' experience as well as the narrative account.

In preparing for the data analysis several steps were taken to ensure that the research focused on the text, and not on my shared experience of the

interview. Interviews were transcribed during the first listening, and the tapes were immediately discarded; this ensured that the aural record of the interview was only reviewed once, and all subsequent re-examination of the narrative was based on the text. Field notes were incorporated in the transcript where appropriate, and similarly discarded. Names, locations and other identifying features were removed from the texts during transcription, and pseudonymous initials assigned to each transcript. Together these steps were designed to ensure that there was minimal association in my mind between my memory of the interview, and the texts created for purposes of analysis. This in turn helped to ensure that my engagement was with the text and not directly with the participant.

Transcripts were first created in Microsoft Word, as verbatim accounts of the interview, the only distinguishing marks within the texts were formatting changes to make my own contributions to the interview dialogues clear. Texts were then reformatted as ASCII files in order to import them into Winmax, a software programme designed to assist qualitative data analysis. Winmax was originally developed as a 'code and retrieve' tool for use specifically in research using a grounded theory methodology (Kuckartz 1998), but later versions of the software provide an effective tool for various types of textual analysis. In this case the transcripts were read and re-read within the Winmax programme, and as meaning units, sub-themes and themes were identified the relevant text was marked. Winmax allows the same passage to be marked for different purposes, and also provides the opportunity to annotate segments of text for purposes of cross referencing.

Once all the texts had been read, analysed, the key passages marked and the required annotation added Winmax provided me with the capacity to retrieve collated extracts from the texts relating to a specific theme or sub-theme, quickly find highlighted key contributions from specific, selected participants, and the opportunity to search the texts for an identified keyword, according to the exact focus of the analysis being undertaken at the time. This proved to be an invaluable facility, allowing me to move quickly through the many thousands of words of narrative to see the frequency with which specific experiences arose, and to find key examples to illustrate the developing argument. This in turn helped to ensure that the data were systematically checked to maintain the focus of the research, and confirm the unfolding analysis. This process, termed verification by Morse et al (2002) helps the researcher to maintain the integrity of the research while moving between perspectives in order to synthesise the data.

In hermeneutic phenomenological research the intention is to gain a new understanding of the world of the participant(s) in relation to the identified phenomenon. This requires personal engagement on the part of the researcher, and this clearly cannot be achieved by a computer. In using a software programme to assist in the management of the data it is important to recognise the limitations of the software, and ensure that it is used appropriately. In this study the software provided a vehicle that allowed meaning units to be highlighted, and emergent themes collated.

5.5 Data analysis

Introduction

Data analysis was carried out in three phases, the initial stage within which key themes are identified, the structural analysis, which develops a descriptive account of the phenomena under investigation, and a hermeneutic appropriation, or interpretation, which allows hidden meanings within the text to be explored and developed with reference to the researchers pre-understanding, and external resources such as published literature. The phenomenological analysis thus moves between understanding and explanation, first gaining a sense of the whole, then de-contextualising the narratives to formulate a descriptive account, and finally placing the narratives back in context to move from a semantic to an interpretive account of the phenomenon; identifying the hermeneutic possibilities opened by the text.

This three stage process is similar to the procedure described by Wiklund, Lindholm & Lindström (2003), and by Lindseth & Norberg (2004), who developed a modification of Ricoeur's hermeneutic approach in order to ensure that the hermeneutic interpretation is clearly located within the context of the participants' world. They recognised that an interpretation situated entirely within the text cannot reflect the context of the participants' experience. In 'caring science' the professional and clinical context is an essential element of the experience, and if the research is to achieve a full understanding of the phenomena under investigation the text cannot be separated from the context.

5.5.1 Stage 1: Naïve interpretation

The first stage in data analysis is designed to achieve a preliminary or 'naïve' understanding of the main themes within the texts, and thus achieve a sense of the world of the nurse practitioner. This naïve interpretation serves two purposes; first it allows the researcher to begin to identify key themes within the narratives, and provide some direction for the more detailed structural analyses that follow. The second element that naive interpretation contributes to the overall research project is that it permits the researcher to begin to recognise how a pre-understanding of the subject matter under investigation might influence the interpretation of the texts. This is the distanciation stage described by Ricoeur, during which the text becomes the focus of the researcher's attention, rather than his or her participation in the interview process.

Naïve interpretation allows the researcher to consider the range of experiences recounted within the narratives under consideration, and make what Fagerberg (2004) refers to as 'guesses and speculations' about the content. Repeated reading of the narrative transcripts, to gain an impression of the material in its entirety allows the researcher to engage with the data as a whole, and start to develop an awareness of similarities between participants' experiences. Ricoeur (1981) also refers to this process as 'guessing', by which he means validating the credibility of naïve interpretations by reflecting on the text. Some key issues arise within this process. The 'sense of the whole' achieved through repeated reading of the transcripts, or as Conroy (2003) terms it, 'immersion in the transcripts' provides the basis for the detailed examination of the text during the subsequent structural analysis. This is achieved through the constant comparison of the narratives, noting the various components of

reflective accounts of the lifeworld. These might include the relation of past experience to present circumstances, contextualising experience through reference to external influences, and speculation about the future implications of current actions, termed forward reflection by Conroy (2003).

The naïve interpretation of the interview transcripts provided a number of 'guesses and speculations' about the data. Given that the hermeneutic interpretive process is not a linear progression, but rather a dynamic movement between phases the initial impressions formed during the earliest stages of analysis were not always borne out during the more detailed reading of the texts that followed. Naïve interpretation provides a first view of the world as lived by the participant, and opens the 'world in front of the text' (Ricoeur 1981), but it needs to be validated within the subsequent structural analysis.

5.5.2 Stage 2: Descriptive structural analysis

Once the researcher has achieved a naïve understanding of the overall range and complexity of the narrative accounts, a structural analysis of the texts is undertaken. This involves a meticulous scrutiny of the transcribed narratives, to elicit the central issues arising within the experiences recounted by participants, and to identify patterns and consistencies that can provide a basis for the thematic presentation of the phenomenon under investigation.

The structural analysis is designed first to identify meaning units, a comment, sentence or paragraph identifiable as conveying a particular experience, delineated by a subtle shift in the content of the narrative.

These meaning units were then marked to begin to identify commonly occurring examples of responses to specific experiences. Often these are unique individual experiences, but incorporate certain qualities that allow them to be grouped together in a way that allows the researcher to identify sub-themes and themes within the texts. It is these sub-themes and themes that provide a structure for the subsequent description and interpretation of the research findings, and present the points of reference from which a new understanding of the phenomenon can be developed. Themes are the essential meanings within the storyline, evident in meaning units, and are formulated as what Lindseth & Norberg (2004) term 'condensed descriptions', rather than as abstract concepts.

Ricoeur (1981) described the identification of meaning units as the beginning of the 'search for metaphors'; reflecting the dialectic movement between the identified meaning units and the text as a whole, and the ultimate intention to formulate a hermeneutic account of the possibilities revealed through interpretation of the texts.

The identification of sub themes and themes allows the researcher to interact with the transcribed narratives and present a thematic structural analysis. This presentation incorporates the researcher's pre-understanding of the phenomenon under investigation, and allows the meaning units identified earlier to be integrated into a new narrative account of the phenomenon as a whole. The thematic structural analysis is compiled in two stages; first a descriptive analysis, in which themes are explored through direct reference to the experiences of participants, and second an interpreted reflective account, re-examining the established themes, seeking metaphors within the meaning units associated with the

themes, and incorporating reference to literature in support of an interpreted whole.

The descriptive analysis was compiled following principles well established in descriptive phenomenology (Giorgi 1985; 1997). Once meaning units had been identified within the texts, individual structural annotations based on each participant's narrative were created, and these were then compared and contrasted in order to identify aspects of experience that were constant across a number of texts. These shared experiences were grouped into the identified sub themes and themes, which provided the basis for the general structural description of the phenomena. An example of the way in which the participants' experience was derived from identified meaning units, and the consequent formulation of sub-themes and themes is incorporated in the appendices. During this process meaning units were considered in isolation from their context within the narrative text where they occur. Some meaning units contribute to the development of more than one theme within the descriptive analysis.

5.5.3 Stage 3: Comprehensive understanding

The final stage in the data analysis was achieved via a re-examination of the narratives, organised within the structure established by the descriptive analysis, to seek a new comprehensive understanding through interpretation and reflection. This involved reading the transcripts alongside the descriptive analysis, identifying hidden meaning in metaphor, analogy, and implicit sentiment within participants' narratives. Once identified, these inherent meanings could be linked together and reviewed in the light of published literature, to

ensure consistency and begin to reveal new insight into the world of the nurse practitioner.

This interpretive phase was described by Ricoeur (1981) as 'appropriation', a way in which the researcher can seek to gain an understanding of the world of the participant through the explication of meaning. Ricoeur sees a dialectical tension between explaining and understanding; a text, or a descriptive account of a text can readily explain the narrator's experiences, but in order to understand the hidden meaning within the narrative account the researcher needs to see beyond the surface meaning through a hermeneutic interpretation of the text.

The search for hidden meanings within a text is for Ricoeur fundamental to achieving understanding. This is in accord with a number of other authors, including Dilthey (1976) who saw 'explanation' as the task of the natural sciences, and 'understanding' as the goal of human science (Gonzales 2006). For Ricoeur however, understanding cannot be achieved through a simple interpretation; the process of explication incorporates elements of pre-understanding combined with a validated, personal understanding focusing on the narrative account: the meaning of the text, rather than the intention of the narrator.

Langridge (2007) suggests that understanding meaning is about uncovering the essence buried within the anecdotal level of the text, through the identification of what Ricoeur terms the empathic and the suspicious. The empathic element, or demythologising, is a process in which the researcher uses their own world view, including their pre-understanding, in their engagement with the text. The suspicious

element, also referred to as demystifying, is where the researcher looks to uncover hidden meaning, including the unconscious motivation revealed in language.

Lindseth & Norberg (2004) describe the interpretive stage in hermeneutic phenomenology as 'nonmethodic', because it is not possible during this stage of analysis to follow strict methodological rules. The researcher's task is to focus on the possibilities generated by the text, and consider them in the context of the researcher's pre-understanding, and perspectives gained from relevant literature.

In a practical sense this search for hidden meaning, or appropriation involved revisiting the interview transcripts to look for metaphors, imagery and other allegorical or symbolic elements within the texts. Insights gained in this way were considered in the light of the researchers pre-understanding, to formulate an interpreted meaning, a synthesis of the narrative intended to generate a new understanding of the topic under consideration. These new insights were then considered in the light of published literature, and a new referenced account of the meaning of the texts was prepared.

PART TWO: FINDINGS

Chapter 6: Results

The central phenomenon under investigation within the study was nurse practitioners' experience of role transition and professional autonomy. To explore this key area, participants were asked to describe their experiences of moving from a registered nurse role into an advanced practice role, as a nurse practitioner, and reflect on the implications for independent autonomous practice, and their professional relationships.

The results are presented in three parts, to reflect the three stages in the data analysis. This chapter includes a brief reflection on the naïve interpretation, the initial stage of the research, and concludes with a formulated 'naïve interpretation' produced prior to the detailed structural analysis. The subsequent chapter explores the narrative texts in detail, using the identified themes to present a structural analysis of the data. The penultimate chapter presents the final stage of the data analysis, and incorporates an interpreted account of the narratives and a discussion of the findings, which together provide a comprehensive understanding of the world of the participants. The final concluding chapter summarises the findings, and considers the implications for the future deployment of nurse practitioners.

Naïve interpretation

The initial 'naïve interpretation' represents the first stage in the analysis of the data, and provides the researcher with both a broad understanding of the overall structure of the narratives, and an opportunity to identify

common threads within the texts. This in turn allows the researcher to begin to identify the emergent themes, typically evident in several different narratives, in advance of the systematic review required as part of the structural analysis of the data. Naive interpretation also allows the researcher to begin to recognise how a pre-understanding of the subject matter under investigation might influence the subsequent analysis of the texts.

The research process is explored in detail elsewhere; in this initial stage repeated reading of the narratives, first as an essential part of the transcribing process, and later in their transcribed form, allowed the researcher to highlight key themes. In this study naïve interpretation offered an initial understanding of the world of the nurse practitioner that encompassed several broad contextual issues. The initial impression was that participants discussed their experience of autonomy with reference to inspiration, self approbation, regulation, frustration, and optimism, and these areas provided an initial outline upon which a more detailed examination of the texts could be developed.

These were refined and elaborated during the subsequent structural analysis, as sub themes were added and the individual experience embellished through association with others' similar experiences. The key themes however remained constant: one encompassing experiences in relation to role transition, a second exploring participants' experiences of the exercise of autonomy in their nurse practitioner role, and a third bringing together experiences of changing professional relationships, including nurse practitioners' interprofessional relationships and their relationship with patients and families. Finally, participants reflected on their current role, and offered some speculative thoughts on the future of

the nurse practitioner role, based on their experience, and providing an interesting conclusion to the narratives.

The formulated naïve understanding was summarised in the following terms: nurse practitioners are comfortable in their role, and believe they are autonomous practitioners who offer a high standard of care to their patients. They do however feel some frustration in their day to day work within interprofessional teams because of their unequal relationship with medical colleagues, and the way in which care is organised and regulated, which together interfere with their ability to maximise their effectiveness.

Chapter 7: Descriptive structural analysis

The descriptive structural analysis represents the second stage of the research process; it is predicated on a preliminary examination of the research data, the naïve interpretation, designed to allow the researcher to develop an overall sense of the scope and scale of the work in progress. Once the overall range and complexity of the narrative accounts had been ascertained, and key themes had been tentatively determined through a constant comparison of the narratives, a structural analysis of the texts was undertaken. The transcribed texts were broken into meaning units, and these meaning units were grouped within sub themes relating to the identified key themes. This was achieved through a meticulous scrutiny of the transcribed narratives, focusing on the experiences recounted by participants, and the patterns and consistencies that allow the thematic presentation of the phenomenon under investigation to be developed. Additional areas, such as a theme exploring nurse practitioners reflection on their skills, and their debt to nursing as the foundation of their practice were added as they emerged from a more exhaustive examination of the texts.

Eventually six themes were identified, each incorporating a number of sub themes. These were headed role transition, exercising autonomy, professional relationships, nurse practitioner-patient relationships, nurse practitioner's skills, and the future of the nurse practitioner. The conduct of the structural analysis is detailed in the 'method' chapter, and an indication of how the themes and sub themes were formulated from identified meaning units is included as an appendix.

7.1 Nurse practitioners: role transition

7.1.1 Introduction

The first theme identified during the initial phases of data analysis explores nurse practitioners experiences of role transition. This aspect is fundamental to the phenomenon under review, and encompasses several distinct aspects of participants' experience, but analysis of the collated texts reveals some significant consensus within the descriptive accounts.

In the exploration of this theme several sub-themes describing barriers to role transition emerged, particularly relating to other professionals' misunderstanding of the nurse practitioner role. Participants also reflected on their motivation to move into a nurse practitioner role, a sub-theme that offered some insight into participants' prior expectations of the role, and how well they were borne out once they achieved nurse practitioner status.

7.1.2 Experiences of role transition

Participants discussed their experience of change, beginning with their preparation for the role. They were in general agreement that the best preparation for the transition to a nurse practitioner role was experience, but that some additional elements are an essential part of any nurse practitioner preparation.

There is no preparation like experience, but in truth in our curriculum, we talked about our role, our standards of care, our legal scope of practice, our prescription writing. (ND)

One participant described her experience in a primary care practice, where as a practice nurse she was asked to take on more and more complex tasks, to the point where she felt that she needed the comprehensive knowledge and professional confidence that a nurse practitioner preparation offered.

They did want me to develop and take on more, so that's how I ended up going on the course. (CD)

Others reflected on their transition to the nurse practitioner role in more personal terms; one participant realised soon after taking up her first post that the nurse practitioner role is different in terms of responsibility and accountability to that of the registered nurse.

I think that was one of the real sort of ... the point where by I thought hey, this is going to be perhaps more than I anticipated. (FH)

This realisation that as a nurse practitioner the level of autonomy associated with the role creates additional responsibilities led several participants to describe the stress associated with the role.

When you actually have to make the decision, you see the patient, you make the diagnosis, you often do the treatment and then you dismiss, discharge them, that's when you don't sleep at night. (CD)

This particular participant described her response to the stresses of the role, which involved a supervisory session on a regular basis providing her with feedback on her performance.

I did used to find it stressful, and I used to go over it, saying I was worried about this, and this happened and that happened, and they would talk to me about the work, a reflective session really, at the end, and that was very useful. The more competent I got the less that was needed, and in fact it got to the point where I would request... (CD)

The use of clinical supervision signifies a different relationship between supervisor and supervisee, in this case doctor and nurse practitioner, to the hierarchical 'management control' reported by many in a registered nurse role. This increase in professional autonomy is also reflected in the diminished use of (or adherence to) protocols reported by nurse practitioners, and the lessening requirement to have decisions sanctioned by someone perceived as being in authority.

When I was doing practice nursing I found that I was doing a lot of stuff to protocols, to the guidelines and if anything was outside that I wished to phone up the doctor, and it would always take that responsibility away from me. (WM)

I think what was different were some of the decisions I could make as a nurse practitioner versus the decisions I could make as a nurse. You know, you get to a certain point where you just can't make any more decisions. You have to pass it by somebody who either a nurse practitioner or a physician (MU)

Increasing independence is a precursor to the exercise of professional autonomy, and some participants found that independent practice brings its own challenges; for one nurse practitioner time management became an issue when there was no-one to tell her how to structure her working day.

A big learning curve from being a health visitor to being a nurse practitioner has been the time management aspect. (TK)

7.1.3 Barriers to role transition

All of the participants had experienced barriers in making the transition to a nurse practitioner role; many of these relate to professional boundaries, and are considered elsewhere in this study, but some were less predictable. A number of negative experiences related to the complex

relationships between nurse practitioners and medical colleagues. Several participants felt that they had had some difficulties making the transition to their new role because of resistance from doctors, particularly at a time when nurse practitioners were gaining new statutory authority in areas such as referral and prescribing.

The physicians looked at our stepping in on their territory, they were concerned about that. They felt threatened because they had owned prescriptive privileges (TW)

One participant acknowledged the possibility that doctors may well see nurse practitioners as a threat, and in common with others identified the likelihood that nurse practitioners skills and knowledge may be brought into question, particularly where the nurse practitioner's responsibilities are very similar to those of the doctor.

I have to accept that doctors are going to be very defensive about nurses taking on more autonomy within their practice, and they're going to question and query the training that we've had, and they are going to feel very threatened. (FH)

There was a view, however, that doctors need not feel threatened. The vast majority of nurse practitioners have no desire to become doctors, and see themselves as firmly part of the nursing profession, an issue explored in more detail later in this chapter. One participant described an experience where she needed the skills of her medical colleagues in order to establish the cause of the patient's presenting problem, and summarised a view common amongst nurse practitioners regarding the need to work collaboratively with medical colleagues.

(I need the medics on my side) when a patients condition is very complicated. You know again I'm not a doctor so I wasn't trained in ... advanced pathophysiology. (RM)

Another participant described her colleagues' experience of referring patients to hospital consultants; in this case the GPs concerned were supportive of the nurse practitioner, but old prejudices created a particular barrier.

> *One of the consultants has requested that he no longer receives referrals from this particular person. Now the GPs in that instance, her employers, are saying hey, hang on, this is ridiculous, these are the reasons that we fully support this nurse in her role and we ... so it's ongoing, it isn't sorted yet. Because in fact, you know there was this whole spiel about I'm not taking referrals from nurses, (FH)*

Relationships with doctors were also cited as the root of a further barrier to role transition. Even where doctors were welcoming, certain policy issues have tended to militate against nurse practitioners achieving their full potential. The greater potential independence of a doctor when compared with a nurse practitioner, even where the nurse practitioner has achieved significant independence and autonomy in practice, has led to some participants feeling that they might be overlooked when financial constraints force employment choices.

> *If it became a choice between - even though we do things a little differently - the nurse practitioner and physician, the physician would say they've got to go, you know we can only hire one position, and this physician can practise independently. (TW)*

Another barrier related to the writing of protocols. Protocols have become more common over recent years, ostensibly as a means to achieve consistency in response to a given set of circumstances. Several participants felt that their professional autonomy was limited not only by the requirement to follow predetermined protocols, but also by the

common requirement that nurse practitioners' protocols are drawn up by, or approved by physicians.

Nurse practitioners are perfectly capable of writing the protocols, we have an advanced training, we know how to look things up on the Internet, how to look things up in a text, but in most institutions it's a joint collaborative effort with the physicians. (ND)

It was not only doctors who presented barriers to nurse practitioners as they moved into new roles. Several participants commented on their experience of a general reluctance on the part of pharmacists to accept nurse practitioners as prescribers.

Another group of professionals, pharmacists, who ... felt threatened again by the fact that we were prescribing, and how were we going to do that, how were we going to give out samples, was that dispensing without a licence... (TW)

More commonly nurse practitioners recounted issues arising from their relationship with fellow registered nurses as presenting barriers to their role transition. Registered nurses who had perhaps felt undervalued in the health care system, and who were struggling to establish their professional credentials in an increasingly competitive world, saw nurse practitioners as another professional grouping to compete with. One participant summed up their frustration, which does not appear to endorse the nurse practitioners' view that they are all part of 'nursing'.

I think that nurses who don't feel as working with them collaboratively, but view it as one more power struggle - not only do we have to work against physicians now; we have to work against these nurse practitioners. (LC)

This view was echoed in others experiences, where lack of support and a reluctance to take directions from nurse practitioners were mentioned as evidence of a rift.

Fellow nurses have not been as quick to come around and support the role. (LC)

I know nurses were uncomfortable, and didn't want to take orders from nurse practitioners. (CL)

The assumption that independent practice is desirable was not borne out by one participant, who also reflected on the lack of interaction with registered nurses, and identified that increased autonomy can come at a price in circumstances where peer support is absent.

I came in working completely - totally in isolation, there was nobody around in terms of peer support or anything from nurse practitioners, I was completely on my own within the Trust working completely independently, and all off into a tangent, and all experiencing different problems with different aspects of their roles, whether it was ordering investigations or whatever it was. (FN)

Other barriers to the smooth integration of the nurse practitioner related to organisational issues. The management of primary care practice was highlighted by several participants working in the field, who had particular concerns about the way in which appointments are handled. One participant had experienced some problems in her relationship with receptionists, who she claimed held significant power to manage her appointment schedule.

Sometimes I have to remind them that I'm not a doctor, because they send me some of their more troublesome patients when I have a slot, and the physician might not, and I say you know this is really stressing me out and this one really truly needs (a doctor). (ND)

This was echoed in another comment, which noted the problem of inappropriate referrals but acknowledged the reality of time pressures on busy clinics.

Theoretically, and in a perfect world, you would ask people have you had other medical problems, this that and everything, but quite frankly sure the doctors are booked much more in advance so they are too busy if someone's really sick and needs urgent attention. It's sort of how we get them through the doors - give them to the nurse practitioner (LC)

The pressure of time was mentioned by the majority of participants, particularly those working in primary care settings. Managing appointments within predetermined slots might help get patients through the surgery, but it presents a significant barrier to nurse practitioners who are looking to adhere to their philosophy of holistic care and health promotion through patient education. As one participant observed, time limitations drives practice toward task orientated care.

Sometimes it's a function of time. You know, we have 20 minutes visits; that's a travesty. And sometimes it's like OK, come on, let's go, 20 minutes, what you need, just you know trying to be more task orientated. When the time allows it really allows you to be more process orientated, and of course I'm always trying to be compassionate - yes I know the visit is a bit short, yes I know you have a lot of things, yes I know it's hard for you to come back. (ND)

Given that nurse practitioners see similar patients to those seen by medical practitioners in similar settings, they are open to similar measures of cost effectiveness as their medical colleagues. It appears that it is the more time consuming elements of the role that are most vulnerable to simple efficiency studies.

So much for our model about teaching - that takes time and it's not cost-effective - that's the first thing they cut. When you've condensed everyone into doing 20 minute visits there's not so much time for prevention. (LC)

Salary differentials might however mean that nurse practitioners can work differently, or as one participant put it, 'bring something different to the role'.

I think that what we bring to the position is just as important. You know, my boss will always say, you're just as important as any other doctor here, and in most ways she does treat me that way, but in other ways she does not. Salary is one of them, you know she'll say, you know, you guys make an awful lot of money, and I'm like, are you suggesting that we not make that money. Are you telling me I'm not worth it, because I see the most patients up there. You know, I do see the most patients of any other provider, including a doctor. Does that mean, you know, I should be getting paid more money or less money, you know, I think it's a little sticky, that area. (RM)

One participant felt that her preparation had left her unprepared for the reality of professional practice. She described her experiences of being new to the role, and found that while her clinical skills were appropriate to the demands of her patients, she felt under confident in decision making because she did not have a history of autonomous professional practice.

I don't think we really had sufficient training. I think we touched on ... certainly we undertook a module called 'professional issues for nurse practitioners', and we looked at autonomy, and the ethics of extended practice, the scope of practice. (FH)

Despite this the majority of participants were optimistic about the future, and could see the remaining barriers to autonomous practice being overcome in the near future. One was awaiting clearer guidance on independent prescribing.

... the transcribing issue, which is hopefully going to be resolved. That is probably the only thing that I would need in the context of what I do it would be the only thing that I need to be able to actually do my totally eventually independent role. (FN)

However others sounded warnings about the degree of control that nurse practitioners are likely to have over their own practice in the future.

I think there's a lot of extraneous forces that are creating the conditions - when you adhere to the philosophy.... I am not sure that we're driving the boat. (ND)

The adherence to nursing roots is a strong guiding force, however, and for some this represents the best, perhaps the only way to ensure the future status of nurse practitioners.

I've always felt that as an advance practice nurse there's a major difference in the way that you look at yourself and how you function. There were some nurse practitioners that do consider themselves, that happily consider themselves as second-class medical type people, versus first class nurses. (LC)

For those who are independent in their practice setting, managing the infrastructure in order to be able to work effectively was a challenge, one that had to be faced in order to establish the role, particularly where there was no history of employing nurse practitioners.

...actually getting all the policies and procedures and everything else on board through that completely different culture was really really hard, and it took me up to a year to actually do... it was the bureaucracy of it. It wasn't a bad thing, because it meant that I did things actually in... probably more to the book really. It was a real policy driven Trust, and I do feel that in retrospect that probably was a better way of actually doing things and setting things up (FN)

Two key challenges that need to be addressed if nurse practitioners are to thrive in the future were identified. The first relates to financial restraints, which might prevent large numbers of registered nurses from undertaking training to equip them with some of the fundamental skills of the nurse practitioner.

I suppose the biggest frustrations are in terms of ... they are probably financial actually now, in terms of wanting to expand the service If I had the ideal situation I would want to develop other nurses to be able to do the same, and to build up follow up clinics and things like that, which we don't have the time or the money to do. (FN)

The second is about the defining features of the role, and how the relationship between various members of the health care team ought to be.

What we are struggling with is what's the role of the psychiatrist, what's the role of the paediatrician and what's the role of the nurse practitioner. And how do all three of those enhance each other. (MU)

7.1.4 Other disciplines' misunderstanding of the nurse practitioner role

Speculation over the future development of the nurse practitioner role indicates some of the variety of opinion evident among those who are actively engaged in nurse practitioner practice. This diversity is perhaps understandable, given the range of practice settings within which nurse practitioners are employed, and the different specific skills required in each, but it does not help others to understand the unique aspects of the nurse practitioner role. The majority of participants described situations in which others failed to understand their practice, and how their contribution might therefore be used to greatest effect.

Some of this misunderstanding has arisen because many of the participants think of themselves as pioneers, having established their practice in areas where nurse practitioners had not previously been deployed. In these circumstances it is important to establish competence and thus credibility as quickly as possible, to persuade others that the role is valid and useful.

When you're stepping in on well-defined traditional territories that you need to prove that you have been educated to provide those services, that you know what you're doing, and indeed then that you're safe to do that (TW)

One participant described the need to assure colleagues that she had been adequately prepared for her role, and that what she was proposing to do within the role had been appropriately sanctioned.

Within the trust where there weren't any nurse practitioners and it was a real uphill struggle trying to convince people that this was safe practice and that it was within my job description and that the Trust knew about it and all those things that go with your accountability. (WM)

For her, this dilemma was interesting because she had moved from a Trust where nurse practitioners were an accepted part of the health care team to an area where there was no previous experience of the nurse practitioner role, and significant suspicion of nurses who were adopting new working practices.

...it did really highlight the difference between working for somewhere that was safe, and they know what you did, and they were familiar with it to somewhere that was completely alien, it was like nurses do not do that, they are not covered to do that, and dealing with all those sort of issues. (WM)

The experience of 'trailblazing', being the first nurse practitioner to be employed in a particular area, was seen as both a threat, because of potential misunderstanding, and an opportunity, in that it helped to establish the role of the nurse practitioner as different to that of the registered nurse. One participant described her attempts to ensure that colleagues had every opportunity to understand her role, and how it differs from the work of from other equally well educated nurses who might have previously been deployed in the same clinical area. Establishing herself in her role was seen as paving the way for other

nurse practitioners to enter practice without the same need to persuade others of their potential.

I need to do something about this and make the pathway easier for nurse practitioners coming after me ... because it was a complete mess, and people were coming on the nurse practitioner course from there sent by these particular people and they had no idea of what they were sending me for. They were used to people coming perhaps here, doing a nursing degree, it didn't impact on.... well it did, obviously, but it didn't really impact on their practice like the nurse practitioners role does. (FN)

This is not a once only exercise, however, and other participants described similar battles to establish nurse practitioners as part of the care delivery team, particularly where the reorganisation of patient care demands new working practices, and therefore the establishment of new working relationships.

I think where we're struggling right now is we're changing our care model in in-patient psychiatry from kind of an ambulatory practice based model to a hospitalist practice based model, and the physician who is in charge of the hospitalist has never worked with nurse practitioners before. So he doesn't understand the collaboration and the support that a nurse practitioner needs from a physician colleague in order to be able to carry out their day to day work. (MU)

Patients' misunderstanding of the nurse practitioner role is an issue that is explored later in this chapter, but participants recounted two additional experiences which help to explain why patients misunderstand the various roles within the health care team, and who is actually responsible for their treatment. One American nurse practitioner pointed to the potential for confusion among immigrant populations whose first language is not English, and who are not used to Anglo-American health care systems.

Well, in this place they think I am a doctor, and they're shocked when I say you need to see the doctor. But you're my doctor - I'm not a doctor, and the language is part of the problem, and also the cultural aspect. In Brazil there are no nurse practitioners; nurses there are not well-trained, so to have a nurse who treats me like a doctor, that's one cultural concept. They're usually shocked and say 'but you are my doctor' and then there's a little drama you know. Like no, I'm your nurse, your infirmamatica magica, your medical speciality nurse. (ND)

Another nurse practitioner discussed her experience of wearing a nurse's uniform, and how patients cannot distinguish her from a registered nurse because of the way in which she is dressed. This contrasts with some of her nurse practitioner colleagues who choose not to wear a conventional nursing uniform, and who consequently struggle to persuade patients that they are anything other than a doctor.

I know of colleagues who don't wear a nurses uniform, maybe wear a white coat or their own clothes, and even though they have said to the patients, my name is so-and-so, I'm a nurse practitioner, blah blah blah, if you want to see the doctor, all the sort of stuff that you say, gone through their consultation, done all the bits and pieces, then the patients have gone out and as they go out they say thank you very much doctor. (FN)

More significant for the development of the nurse practitioner role were circumstances in which the very presence of a nurse practitioner was mistakenly seen as detrimental to the development of medical practitioners.

It was not easy to function as a nurse practitioner back then, nobody knew what the role was, there were very few places ... When I would ask if I could work in an out-patient clinic or an office as a nurse practitioner the usual reply was 'well if we let you do that how will we teach' (junior doctors)? (CL)

Nurse practitioners challenging relationship with medical practitioners was referred to regularly by participants in a number of contexts, and is explored in detail later in the chapter. In considering the potential for

misunderstanding the nurse practitioner role several participants suggested that the problems they encountered in seeking to establish their practice alongside doctors has been as much to do with protectionism as genuine misunderstanding of the role. This same phenomenon was reported by several participants while describing their experiences of working with other disciplines, including other registered nurses. Nursery nurses and school nurses were among those mentioned specifically.

> *A lot of nurse practitioners have a practice where they go in and see the new borns in the nursery, and a lot of the nursery nurses were really kind of threatened I think by not understanding what the nurse practitioner role was. (CL)*

> *In some of the school settings, where the traditional school nurse wasn't sure if he or she was going to be taken out of the role, and not have a role, because they didn't see the difference. (CL)*

While a potential conflict of this type is perhaps understandable in a situation where one party feels threatened, it is less easy to see how senior staff could misunderstand the nurse practitioner role. One participant described the difficulties she encountered in establishing herself in her new role, a situation that she felt was created through ignorance on the part of nursing management within her Trust.

> *...it was mainly the high level nursing management structure. And that was, I would say, the crux of that was that they did not understand what a nurse practitioner was. (FN)*

Some saw registered nurses as having a superficial awareness of the role, but equating it with a junior doctor's job.

> *Nurses... they generally... generally there is quite a good acceptance. There is always an element there of people who don't really understand the role,*

however much you try to explain to them, and you do hear people saying you're just like one of the junior doctors, or you just do, you know, that's just what a doctor does isn't it. (FN)

Misunderstanding is not a one way phenomenon, however. One participant described how his fellow nurse practitioners failed to appreciate the sensitivities inherent in the relationship with registered nurses, and the best way to handle the professional boundaries explored in more detail elsewhere.

I think where I struggled, and still continue to struggle sometimes is with the nurse practitioners that haven't worked with registered nurses for a number of years, and, you know, an example would be in the practice I was in, the paediatric practice I was in the nurse practitioners not being willing to give a shot, or not being willing to call in prescriptions for patients because that quote unquote wasn't part of their role. (MU)

Nurse practitioners are critical of the professional regulatory body for not making clearer decisions about registration, and the protection of the nurse practitioner title, suggesting that ongoing vacillation has contributed to confusion and misunderstanding.

There is a huge debate about what is the nurse practitioner any way, and I'm critical really of the UKCC & NMC for not recognising earlier the name, because it has led to greater confusion. (FH)

Nurse practitioners are keen to stress their nursing roots at all times, and several made clear their affiliation to nursing as the defining aspect of their work.

I wear a uniform, I wear a nurses uniform. That's a silly debate, I don't know, but I wear a dress, I wear a nurses uniform with (my name) and nurse practitioner on, and I think immediately patients know that I am a nurse because that is how I am dressed. (WM)

I constantly find that I have to qualify what I do, and let them know that I am a nurse, and I'll always be a nurse (FN)

The potential for misunderstanding the nurse practitioner role is significant, and a number of participants commented on the challenges of working with colleagues, often well meaning but ignorant of the potential contribution that nurse practitioners could make, and the need to ensure that systems and processes are robust in order to minimise potential difficulties.

...it was quite a difficult transition, I suppose, a real learning curve in terms of everything... What it did was make me more geared towards making sure that the background is all watertight. If you are going to set up a role you need to have done x, y and z, you need to have the policies in place, you need to completely cover every avenue that could lead to a problem. (FN)

7.1.5 Motivation to move into a nurse practitioner role

Nurse practitioners' motivation to make the transition to their new role was derived from a number of different experiences. For some, there was a general feeling that the registered nurse role was not providing the sort of challenge they wanted in their working life.

It just wasn't enough, you are always striving to do something more (CD)

I was a staff nurse for four years, and I got a little tired of the sort of day-to-day being a nurse, having everybody go to lunch, and you know. I just needed something more than that, intellectually. (RM)

Others referred back to some of the frustrations associated with role transition described earlier; for many the lack of professional autonomy in the registered nurse role, particularly the requirement that clinical decisions are ratified by someone else, provided the strongest motivation to move into a more independent role.

I think what was different were some of the decisions I could make as a nurse practitioner versus the decisions I could make as a nurse. You know, you get to a certain point where you just can't make any more decisions. You have to pass it by somebody who is either a nurse practitioner or a physician. You know you can't call in medication without an order from a physician, you can't go ahead and give an immunisation without an order from a physician, but as an advanced practice nurse I can. (MU)

One participant described how she came to be a nurse practitioner, a process that was as much about her circumstances at the time as her personal motivation, although she did appreciate that a better educational preparation would enhance patient care.

I had health visited a long time and wanted something else to do really... My boss then offered to pay for me to do the nurse practitioner course. So that's what happened, and that's how I went to do it. I was quite ambivalent about doing it, wondering whether... it was at a time when nurse practitioners weren't really very well recognised or accepted, particularly by doctors... the advent of skill mix and things like that meant that we could evolve different roles really. I was seeing more and more patients and thinking I need to back this up really with a bit of education, or quite a lot of education, because the more you see the more you realise what you don't know. (TK)

Several participants described how becoming a nurse practitioner was the culmination of a number of other activities, and how the nurse practitioner role was the vehicle through which the potential developed during the early part of their careers could be realised in an integrated autonomous way.

I undertook integrated training as an RGN/RSCN, and then I trained as a midwife, and worked in general practice after that. I did a couple of practice nurse courses, I did a family planning course, a teaching and assessing course. I was building up this catalogue really, of certificates, and at that time they had just launched the nurse practitioner course at the Royal College, and so I went off to do that which was great for me - that really consolidated everything. (FH)

Improving patient care was the prime motivating factor for many; the opportunity to fill deficits in the service, to take on additional responsibilities or to provide a service that had not previously been available to patients spurred participants to move towards nurse practitioner roles.

I became involved as part of a group who did pre assessment as well as working on the ward... the nurse practitioner route in terms of pre assessment for those patients seemed to be a good move forward, because we never had an SHO who could ... they were always not there for some reason or another, so it was a way of improving patient care and improving the service really... and assessing patients properly. That was my first impetus for doing the nurse practitioner course, I may have had a vague awareness that something wasn't quite right, but I wouldn't have been able to put my finger on why it wasn't right. (FN)

One practice said, look we are looking to have nurses assess same day patients, would you be interested in that? And I was, I thought, oh yes, that sounds all right, you know, because as a practice nurse I was pretty experienced (CD)

Career advancement was also a strong motivating factor, with many participants undertaking a nurse practitioner qualification having realised that they not only needed the requisite skills to extend the scope of their nursing practice, but also needed the authority and security that a formal recognised qualification offers, both in terms of self confidence and employability.

I won't get further than I am now unless I can get some core skills which I feel I'm using because I know somebody has taught me that from a, you know, reputable place. (CD)

I think (my nurse practitioner programme) gave me a decent foundation, but a lot of what I learned was on the job training, a lot of it. And a lot of study on my own. (RM)

Several participants recounted experiences of meeting established nurse practitioners, and being so inspired by their example that the nurse

practitioner route became a career aspiration from an early stage in their nursing development. For one, it was the factor that decided her career choice.

I was debating whether to go into medicine or nursing, and my very first year I heard a nurse practitioner come and speak. I was very impressed with this woman that was talking about hanging up her (uniform), having her own practice, and really doing the types of nursing that I was interested in. Promotion, prevention, but also management of common diseases and illnesses, and gee I really liked this nurse practitioner idea. (LC)

Another participant made the decision that she wanted to be a nurse practitioner as the result of an experience during her student nurse training.

I did my paediatrics with a paediatric nurse practitioner, the first one I had ever seen, and I was so impressed. I remember seeing a rash from an allergic reaction, and she was dealing with all these common illnesses and complex problems, and she was so autonomous, I said this is the kind of nurse I want to be... I knew I wanted to be a nurse practitioner. (BM)

Several participants acknowledged their debt to nursing, a topic discussed in more detail later in this chapter, as part of their motivation within the nurse practitioner role. 'Being the best' was how one nurse practitioner described nurse practitioners.

I would say that in my career one of the reasons I became more successful than some of my colleagues was that I always considered myself a nurse foremost. My doctorate is in nursing. I always wanted to be ... if I was going to be a nurse I was going to be the best nurse, (LC)

For some, the nurse practitioner role was a fitting position because it provided opportunities to work within their preferred area of practice, and to be able to complete the care process rather than having to involve other disciplines.

I went back into general practice, and really that's my passion if you like, being a nurse practitioner in general practice. It was the challenge, the job satisfaction (FH)

(I was working in primary care), and doing my clinical, and being around patients on an outpatient basis, and seeing how much autonomy I could have, that's when I really knew that that's what I wanted to do. (RM)

You have got the skills to actually think, so from that perspective... you know it's nice to be able to finish it off really instead of having to send them to a GP. (FN)

Most agreed that nurse practitioners need significant personal motivation to succeed; as a nurse practitioner the comfort afforded by the hierarchical system of workplace organisation typical amongst registered nurses is removed, and individual accountability is emphasised. Nurse practitioners, at least the first generation of nurse practitioners, are by virtue of being in their role 'pioneers', prepared to break new ground and face the challenges of uncertainty, and do therefore need to be comfortable with their independence and autonomy.

That is a kind of symptom of what nurse practitioners are about, constantly striving (CD)

Nurse led services have been a part of the health care system for some years, in name at least, but the rise of key advanced practice roles has provided an opportunity to put rhetoric into practice. Authority and autonomy create the independence that allows nurses, in the form of nurse practitioners, to manage the entirety of the care process. This does have implications for the practitioners involved, and participants recognised this.

...a nurse led, or nurse practitioner led pre assessments unit, and that led on to doing a follow up clinic as well, for patients who had been pre assessed through

the clinic, so it was covering the whole spectrum really, from pre admission through to discharge. It was quite a difficult transition, I suppose, a real learning curve in terms of everything. I suppose it made me think about the real implications of what I was doing. (WM)

You then suddenly start to realise that this decision that I make could mean that the patient is put under more risk, under an anaesthetic, and it?s quite a scary decision to make, and you have to learn to cope with those patients (FN)

I was trying to cover myself, making sure that I had really robust policies and procedures and competencies and things that I felt met what was required. I had lots of documentation that was specific to what I was doing, wrote up everything that I was doing for patients and that sort of thing,
it did really highlight the difference between working for somewhere that was safe, and they know what you did, and they were familiar with it to somewhere that was completely alien, it was like nurses do not do that, they are not covered to do that, and dealing with all those sort of issues. (WM)

7.2 Exercising autonomy

7.2.1 Introduction

The second key theme identified during the naïve understanding phase was the central theme of participants' experience of autonomy, and how nurse practitioners are able to exercise autonomy in practice. Professional autonomy was a key topic of discussion during the interviews, although participants commonly described experiences that impact on the potential for autonomous practice in ways that did not explicitly refer to autonomy per se. The theme encompassed a number of sub-themes, reflecting the commonly held view among participants that extraneous factors have a significant impact on their opportunity to practice independently, and therefore their experience of professional autonomy in practice.

The sub-themes identified within the texts as having implications for the exercise of autonomy included nurse practitioners' confidence in their professional role, something that participants felt created conditions within which they could demonstrate the 'professional' assertiveness that is an essential foundation for autonomous practice. While this represented a positive affirmation of the potential for autonomy, participants also explored the frustration that they have experienced in situations where they felt that their opportunity to maximise their autonomy was limited by external factors, including working practices, policy initiatives and legal restrictions.

7.2.2 The exercise of autonomy in practice

Given the definitions of autonomy explored earlier, and the way that autonomy is understood within professional nursing practice, nurse practitioners feel that their role is autonomous, with some reservations.

I would say that I have complete autonomy except for those areas that I choose not to have complete autonomy (LC)

I would say that my role is as autonomous as it can get ... I mean I do see patients and close whole episodes ... so it probably is (CD)

Several participants were keen to stress that their experience of professional autonomy is always in the context of the heath care team.

I would say my role would be viewed as autonomous, yes, but I would like to think that it's collaborative (CD)

This view of collaboration is interesting, because although nurse practitioners appear to see themselves as having a very different set of professional relationships from those experienced by registered nurses,

they cite their professional relationships as a key indicator of the success or otherwise of the role. For some it is a key source of frustration, while for others part of the satisfaction afforded by the nurse practitioner role derives for positive experiences of interprofessional working.

In many cases nurse practitioners have medical supervisors with varying degrees of statutory and organisational authority over the nurse practitioners' professional practice, particularly in areas that might be seen as extending the scope of practice of the registered nurse. The idea that autonomy can only be seen in its pure sense, as absolute freedom of will if it is considered in the abstract naturally leads to an abstract understanding of autonomy. As soon as autonomy is part of lived experience, in a real context, it can be seen as relational and practical, and subject to the effects of a variety of oppressive forms of inter-professional socialisation that impact on patterns of decision making in practice. Not all the participants see their supervisory arrangements as oppressive, but some do reflect on limitations on their potential for a fully autonomous role. For some the notion of collaboration is entirely in keeping with their view of interprofessional working

I don't think we could ever be completely autonomous, no. I don't think you would want to be. I think it is a bit unrealistic to think that you are, why should you need to be, really. (LC)

In some cases the contribution made by the nurse practitioner is judged according to their patients' perception of the professional relationship, and consequently their professional role and their autonomy within that role is defined by patient satisfaction.

...some patients come in, and they say I always come and see you first, because if you can sort it out you will, and if you can't then I know that you can make me an appointment or whatever (LC)

For others, their own satisfaction with the degree of independence afforded them by the way in which nurse practitioners are able to practice is the key factor in determining their autonomy. In this respect there was a clear division between those nurse practitioners who work in primary care settings, where autonomous practice is more clearly identified as a key component of the role, and those who work in secondary care, where close contact with other professionals was much more likely to be part of the nurse practitioners' everyday working life, and was reflected in their views on autonomous practice.

(I work) in primary care, so that's probably where I feel the most autonomous because I have my own panel of patients who only come to see me, they don't need to check with anyone else, and I am essentially seeing all those patients on my own. (RM)

...the clients have direct access to my services, that I offer them an holistic package of care if you like, and then I can actually discharge them from the health care arena, hopefully empowered to, or equipped with the skills and the knowledge to deal with their health problems for which they originally consulted me (GH)

In both cases the professional context within which the nurse practitioners were employed allowed a degree of independence in practice. Contrast this with the feelings of a nurse practitioner employed in secondary care

I work in a hospital environment, there's always going to be doctors, physios, there's always going to be all those people around you (FN)

This mutual respect for the skills and contribution of others was particularly evident in situations where a teamworking approach was

part of the practice culture, however a number of participants felt that their autonomy was most evident when they were not obliged to engage with others, and were given the opportunity to complete patient care episodes without reference to others

...from that perspective... you know it's nice to be able to finish it off really instead of having to send them to a GP (MW)

7.2.3 Developing self-confidence within the nurse practitioner role

For the majority of participants, the key to recognising the autonomy afforded to them as nurse practitioners was confidence in the role. This was vital to their ability to practice effectively; as one participant put it

There's nobody here telling me what to do (ND)

Because of the degree of independence expected of a nurse practitioner, their own confidence in their ability to work effectively is something that is developed from an early stage in their transition to the role.

...we had seminars that run through the entire one or two years of preparation, and those seminars address the development of the professional role of the student, in being able to see how they develop their autonomy, how they can define themselves, how they can go out and educate the public, and proceed to share that role, and explain that role, and grow with that role professionally for the rest of their life (TW)

The professional role, and the responsibilities inherent in adopting and developing the role, was seen as key to being able to practice autonomously. Confidence in the role was a natural progression from the staff nurse, or registered nurse role for some

I've done pretty much everything I wanted to do in nursing, because I have a pretty broad background and I think that's what contributes to having confidence in my decisions at this level of practice (ND)

This feeling was further emphasised by those who see the nurse practitioner role as having a distinct and separate identity from that of the medical practitioner, despite there being identified parallels and overlaps between the roles. For some, there is little difference in reality

In terms of who sees who, there is really little differentiation between the NPs and the doctors (ND)

For others an understanding of nursing theory, and the clinical experience as a registered nurse that is implicit in the background of every nurse practitioner is a key to defining their practice, and to providing nurse practitioners with the confidence to exercise their autonomy in practice

My college education prepared me to be a nurse, you know, and that's why I've never felt that I was in a medical role, or a second class medical person...

Nurse practitioners, are first class nurses, not second-class medics (LC)

Recognising the 'nursing' basis of the nurse practitioner role was for many the key to their confidence in practice, and to the development of their professional autonomy. A professional role derives from a professional foundation, and participants saw the central place of nursing as the basis of their professional autonomy. Collaboration with colleagues was seen as an essential factor if nurse practitioners are to work effectively, and being able to access information provided many with the reassurance that they could maintain their professional responsibilities and perform to a high standard.

...why do I do what I do. I think it really boils down to two things: it boils down to what do you know, and what you feel comfortable with. What do you know that you don't know, is sometimes more important, to recognise oh no,

nothing in my training has prepared me for this; and also when and who to go to, and do you trust that advice (LC)

I'm accountable for the decisions that I make... so it's important to do it right. I trust my decision making, I trust that I'm logical, I trust that I'm thorough, but part of that thoroughness is consulting other people that have more experience, like the infectious disease person (or) the emergency room person. (ND)

The question of referrals, as part of the interprofessional process was seen as an essential part of the nurse practitioner role, and where referrals were accepted without question this reinforced the autonomous role of the nurse practitioner; the ability to communicate with colleagues from other disciplines, and to feel that as a nurse practitioner they were respected as skilled and knowledgeable members of the health care team enhanced personal confidence in the role.

I have the ability to refer on, and I see that as part of my autonomy: people consult me with a problem, and I see this very much in a collaborative way. Autonomy for me isn't just me being able to fix it, it's having the ability to utilise other services, and be able to refer. (FH)
...doctors treat you differently because they know that you have got some of the knowledge that they have got. The power base, I think, changes, but I also think that is something about levels of confidence, my confidence as well. (FN)

Feeling confident in their role helps nurse practitioners to work effectively, and to exercise a degree of assertiveness in their dealings with other disciplines

I've been on the phone to a ... wanting to refer somebody I'd seen with a sebaceous cyst which needed incision and drainage, tried to refer to the surgical team - just ring up and refer - and had an SHO on the phone who'd obviously had a telling off by the registrar, consultant, whatever. He just said, well he said, well why isn't the GP making the phone call. I said, well actually, the patient consulted me today, and you know, I've made the decision. Well, don't you think the GP better have a look at him; no, no, no I don't for these reasons.

I think once you start, once you have the ability to give them a good informed structured history, and you can articulate exactly what is going on ... I said look, and he sort of then said okay, that's fine, it sounds all right to me. (FH)

As nurse practitioners have developed their role, to a point where they feel confident in their ability to provide comprehensive care to the client group some believe that their clinical involvement is equal to, or better than that provided by other disciplines. This is in part a product of individual differences, but also emerges from nurse practitioners perceptions of the effectiveness of their specific approach to patient care.

...you don't need to go to medical school to be a good primary care provider, and that's true. I think that in some ways I'm better at providing care than some of the doctors that I work with, because I've seen their practice, I've read their notes. I see how their patients aren't taught about their own health, and I think that's reality, that's life. You know, there are going to be better nurses than others, there's going to be better doctors than others (RM)

If I just take what I actually do personally the junior doctors rotate on a three to six monthly basis, they are in training, they are learning. I've been in the field of practice for ten, fifteen years and I would say I have got a lot more knowledge about the patients. Not necessarily about the disease processes or about the operations, but actually about the patients who present with those problems and need that care. I've got a much better understanding of that really (FH)

Further evidence of the confidence with which nurse practitioners approach their role emerges from their dealings with patients and their families, whose attitude and trust generates feelings of respect, and allows the nurse practitioner to see themselves as making a significant contribution to care.

...if you take the time to explain to them how the roles are very similar, and what our training is, and what we can do for them I've found families to be very receptive (MA)

This receptiveness might be explained by a degree of misunderstanding about the role; in some cases patients and families mistake nurse practitioners for doctors, although in others they appear to be commenting on the outcome of care, and suggesting that they are just as satisfied with the ministrations of a nurse practitioner as they would be if attended to by a doctor.

I'll say to them Hi, I'm a nurse practitioner; I'm going to be taking care of your child. Oh, okay, hi doctor, thank you so much.

I think people still think of me as a doctor, an even some patients say, I know you're a nurse practitioner, but you're still my kids doctor. (RM)

Most nurse practitioners have encountered patients who insist on seeing a doctor, but these instances appear to be rare, particularly in settings where nurse practitioners are established, and their role is understood.

Once in while but rarely, rarely you have people that only want to see a doctor, and yes we do have some like that but generally speaking, people have problems and if you can attend the problems, and you are courteous to them, they think you are a doctor (ND)

...what we find now is that fewer and fewer people refuse to see me, and more and more come back, and actually request to see me. So that's great, that's nice. (FH)

Confidence in the role is further compounded by the realisation that nurse practitioners have established themselves as an integral part of the healthcare team, providing an essential service. For many, the realisation that nurse practitioners are no longer looking to justify their existence, or at least their employment, helps them to feel comfortable in re-evaluating their contribution and participating in service development from a position of strength.

...at the end of the day, GPs are pressurised, you know they really are, stressed due to excessive workload, and at the practice where I now work ... they had a terrible problem where one of the GPs was off sick, one had just died, there were places being run by locums, and there was identified need. Their waiting room at twelve o'clock was still full of 20 patients waiting to be seen. So I was able to step in, and it was very fortuitous for me, because it very quickly showed that nurses could step in and see those patients whom traditionally saw a GP. They could very effectively be seen by a nurse practitioner. (GH)

...first of all, we are not going anywhere, we are not going to disappear, I have every confidence in that. I think there are enough people that believe in us, and who admire us, and who like us as their ... provider that that won't happen. (RM)

7.2.4 Experiencing frustration

Establishing a clear role for the nurse practitioner in a variety of healthcare settings may have helped them to feel confident in their role, but the system within which most nurse practitioners are required to work generates a number of areas where they find practices frustrating. For many, the potential for autonomous practice is limited by restrictions on their freedom to work independently.

Frustration arising from restrictions on the potential to work autonomously appears to be derived from a number of different issues. High on the list is the relationship that nurse practitioners have with other professionals, who often do not appear to understand the role, and undermine the autonomous role of the nurse practitioner by questioning their authority or their competence. The relationship with doctors is often set out in statutory regulation, and for this reason perhaps gives rise to fewer frustrations. Other disciplines, however, are often cited as a cause of some disquiet.

...x-ray, that's the one stumbling block, with the radiographers is that you... you're not taught to interpret x-ray results, and therefore you shouldn't authorise them

I have had problems with pharmacists, well, my prescription has been taken to... I think there was a notorious pharmacist in (xxxx) I don't know which pharmacy, who will never actually give any prescriptions which isn't from a doctor, so this poor patient had to come all the way back again to get it (WM)

Doctors are not immune, but typically those who work most closely with nurse practitioners do understand their role and contribution. Referring patients to other specialities, however, presents greater problems

I don't refer to any hospital doctors at all, because it's such hard work and the risk is that you'll get a letter back saying get the doctor to refer to me. (WM)

...one of the consultants has requested that he no longer receives referrals from this particular person. Now the GPs in that instance, her employers, are saying hey, hang on, this is ridiculous, these are the reasons that we fully support this nurse in her role and we ... so it's ongoing, it isn't sorted yet. Because in fact, you know there was this whole spiel about I'm not taking referrals from nurses (FH)

Indeed nurse practitioners appear to believe that their referrals compare favourably with those from junior doctors

What I thought I might do is actually go to the clinical directorate at the local hospital, and look at inappropriate referral rates. You know, I wouldn't mind, I'll stand up and say well okay, you can scrutinise the referrals that I make, but let's see data alongside that looks at your inappropriate referrals, to see if junior doctors are doing it more often (FH)

Working practices also give rise to frustration, with many nurse practitioners finding that guidelines and protocols limit their ability to make clinical decisions. The delegation of aspects of patient care to a nurse practitioner has often been done following the establishment of a protocol to guide decision making, leaving the nurse practitioner

concerned unable to exercise autonomy in clinical decision making. Typically protocols are written by the medical staff who are authorising the delegation, or by a combination of medical and nursing staff. In either case the protocol determines the appropriate response, rather than a considered decision taken by the nurse practitioner in response to the presenting symptoms.

Generally the facility agrees upon what they going to use as a group; where this differs is that a physician for example can just decide to give urinary tract infections superfloxacin, and that may not be the wisest decision medically, but they have the licencensure to do that. For me, as a practitioner, I need to follow a certain protocol, the first line drug which might be bactrim, if the person or allergic we would go to the second line drug, if they had extenuating circumstances - they had been resistant to bactrim, resistant to all these things, then you could go to the superfloxacin. There's more clearly spelt out guidelines, it's not the whim of the day, and it's not the independent decision, it's really a decision in collaboration with the pre-set guidelines. If something in my own training or my own experience tells me that the patient is not going to be well suited to what's already on the protocol it's my obligation legally to seek the consultation and document that I did so. (ND)

...there was always controversy, no one really wanted to get into guidelines versus cookbook medicine... the protocol became a running joke, because no one ever was agreed with them, they never could get them signed off, and us as we set them up, new meds would come out, new procedures, new policies, and it became, since they were becoming outdated, that we were more concerned about the legal liability of having outdated protocols on the books. (LC)

Several nurse practitioners commented on their frustration at the way in which they were deployed within their workplace; this was of interest because it reflects a degree of acceptance, but indicates that reliance on nurse practitioners to the point at which they are obliged to work in a way that is contrary to their training and their inclination can also limit the opportunities for autonomous practice.

A lot of it is being driven by insurance companies, in terms of reimbursement, and what they will reimburse. Volumes are set by administrators, and so you can be the most compassionate and well diagnosing person, but what the administration is looking for is cheap and fast, high volumes, in MDs and in NPs. So much for our model about teaching - that takes time and it's not cost-effective - that's the first thing they cut. When you've condensed everyone into doing 20 minute visits there's not so much time for prevention. (ND)

...you're not a doctor and you're not a nurse. So sometimes they just put you in this grey zone. There was one day, I felt like I was totally overworked, and I said to one of my friends who works upstairs, you know what, I'm not a doctor and I'm not a nurse; I feel like a slave. Like that day, I just felt like... you know because I think they do rely on the nurse practitioners here to do much more of the clinical work. (RM)

Linked to this frustration around working practice is an underpinning issue about payscales; several nurse practitioners commented on the fact that their pay did not reflect their level of responsibility and their overall contribution to the health care team.

I think that what we bring to the position is just as important. You know, my boss will always say, you're just as important as any other doctor here, and in most ways she does treat me that way, but in other ways she does not. Salary is one of them, you know she'll say, you know, you guys make an awful lot of money, and I'm like, are you suggesting that we not make that money. Are you telling me I'm not worth it, because I see the most patients up there? You know, I do see the most patients of any other provider, including a doctor. Does that mean, you know, I should be getting paid more money or less money, you know, I think it's a little sticky, that area. (RM)

I think as long as we work like doctors and get paid like nurses it will be a very popular role (among employers) (LC)

Our health care is in a crisis, you know. Working like a doctor and being paid like a nurse, I don't think that is really a solution for anybody.(ND)

7.2.5 Legal Restrictions on practice

Some respondents suggested that their perceived autonomy was limited by certain legal restrictions on their practice, most commonly associated with their prescriptive authority, and the varying local requirements for medical supervision of nurses' prescriptions. For some, this is a cause of some frustration

I'm an extended nurse prescriber, but there are things we can't prescribe (WM)

There's still some kind of restrictions on what you prescribe for, and who you prescribe for even though it might be the same drug, which is a frustration, which is I think going to be ironed out, well it will be anyway with this new legislation. (CD)

Others see this as an administrative process that impacts on theirs and others perception of their professional autonomy, but in reality makes little difference to their clinical practice

I write my own prescriptions. We have a regulation… that says we are supposed to be supervised by a physician, or have a supervising physician as a partner, but in truth the reality is I write my own prescriptions and nobody really looks over my shoulder or checks them. (CL)

…instead of prescriptions, we used in-patient hospital forms for orders, in triplicate, and the rule was that it had to be within a certain period of time it would be co-signed by the physician. I could tell you that the majority of times I was there people didn't even read my orders, they just signed them, blindly. (LC)

One nurse practitioner commented on the changing relationship with medical practitioners in respect of supervision; as nurse practitioners have developed their role and gained greater authority within practice so physicians have been less willing to be associated with the nurse practitioners' clinical decisions.

...there were some nurse practitioners where people would read every word. That became an issue of ability, credibility, as well as expertise, but no, prior to ... I always thought it was interesting, because when a physician co signs your order without reading it I thought they were being totally liable, but then physicians became resistant and we could order things under our own name and they wouldn't be liable at all. (LC)

There were several comments about a less obvious but equally restrictive form of supervision, in the form of protocols, or written directives that specify action to be taken in any given situation, thus restricting the nurse practitioners freedom to make their own independent clinical decisions. This is seen as another impediment to the exercise of professional autonomy in the role.

Having protocols guided your practice, having a formulary that said what you could prescribe and what you couldn't (TW)

there was always controversy, no one really wanted to get into... cookbook medicine (LC)

...there are legal limits. You know as a registered nurse you're really not supposed to go to the point... you can make some decisions, but they need to be based on an algorithm of care, or they need to be based on a professional understanding that you have with the physicians you work with. (MU)

we have medicine prescribing - prescription protocols about things that we do on our own because they fall within the protocol. Things that don't fall in that protocol it's not left to you randomly to make decisions, it's up to you to and know where to look for the information and who to consult (ND)

Protocols might specify what action is to be taken in a given circumstance but nurse practitioners recognise that they are accountable for their practice, and therefore should not follow a protocol that suggests a very different course of action to that suggested by their own clinical judgement.

if something in my own training or my own experience tells me that the patient is not going to be well suited to what's already on the protocol it's my obligation legally to seek the consultation and document that I did so. (ND)

They also recognize that restrictions imposed by shared protocols, developed by the health care team as an agreed best response to a particular patient presentation places an equal restriction on the clinical freedom of others involved in patient care, and in some cases appear to resent the fact that protocols are developed in consultation with others rather than by the nurse practitioners themselves.

if you had sheer protocols that were co-signed then it put the burden on the physician to follow the same protocol for common illnesses or whatever. (LC)

Nurse practitioners are perfectly capable of writing the protocols, we have an advanced training, we know how to look things up on the Internet, how to look things up in a text, but in most institutions it's a joint collaborative effort with the physicians. (ND)

The question of the nurse practitioners relationship with colleagues, particularly doctors, was a recurring issue for many, and is considered in more detail later in the study.

7.3 Nurse practitioners' professional relationships

7.3.1 Introduction

In their explorations of the nurse practitioner role and role transition participants were keen to explore the ways in which nurse practitioners fit into the health care delivery system, and the particular perspective that they can offer in support of patient care. This theme provided a rich source of stories from their practice experience, illustrating the participants' conviction that they occupy a nursing role, albeit an

advanced practice nursing role. Emergent sub-themes developed the notion of a unique 'nurse practitioner' perspective on care, derived from nursing theory and rooted in caring philosophy, but also explored professional boundaries and some of the controlling influences on autonomous practice, notably nurse practitioners' relationships with other professionals.

7.3.2 A unique perspective

All the nurse practitioners who participated in the study talked about how they felt that their skill set brought a unique perspective to the care of their patients, and in many cases suggested that their approach to patient care offered a better overall experience for patients than traditional approaches. They felt competent to deal with the vast majority of cases, and felt that in many areas their potential has not yet been fully realised.

The overriding feeling is that nurse practitioners have advanced nursing skills, and that despite the similarity in many respects between the focus of the nurse practitioner role and that of the medical practitioner employed in the same setting, nurse practitioners still feel that their fundamental skills are those of the nurse.

... your origins are with nursing, that's really why the nursing is there, because nurses are nurse practitioners, and nurse practitioners are nurses, that's right, because we started from that point, and I think we do bring something different from other practitioners who are developing their roles (WM)

Several participants explained that their nursing background allows them to take a holistic view of their patients. One described the nurse practitioner role as

> ... the ability actually to perform a full holistic nursing health assessment on somebody with an undifferentiated problems, and to actually form a working diagnosis and offer treatment (FH)

For some the key is about ensuring that patient care incorporates all aspects of their wider health status, including an educational component.

> I think that a lot of what I do is make people feel very comfortable, try and educate them as to what's going on, try and help them agree with if not make decisions about their own care, and go back out there and take care of themselves, and learn how to be more independent in their care.

> I find that talking with parents, if their baby has a fever or if their child has a fever, we'll talk about what they've done and one way I like to help them is reassure them that they have done all of the right things. And that the next time when this happens they can continue to do that, and maybe we can just talk on the phone without having them come in, if they're comfortable doing that. (CL)

The ability to offer holistic, family centered care that incorporates the wider health context is valued above a focus on tasks, which are seen as reductionist and less demanding and therefore less worthwhile.

> I think nurses, anybody intelligent, can learn how to do anything, tasks, anything. But I think if we give up our base of nursing, which is understanding that person, doing a total assessment, doing some disease prevention, doing some health maintenance, and putting it in the context of this - the tasks that they do.

> We have paede nurse practitioners at children's hospitals who take care of kids with cancer, so they call themselves oncology nurse practitioners. They're really primary care, that the programme they went through, and they can do bone marrow aspirations, they can do LPs, and they can be taught how to do that because they are clever intelligent people. But that's not where their

expertise lies. Their expertise lies in taking care of that child in the context of the family (CL)

Many nurse practitioners see themselves as engaged with a similar caseload to their medical colleagues, and working to achieve similar goals. They recognise the differences between the role of the registered nurse and that of the advanced practice nurse, but sill feel that their foundation in nursing is central to their role.

I've always felt that as an advance practice nurse there's a major difference in the way that you look at yourself and how you function. There were some nurse practitioners that do consider themselves, that happily consider themselves as second-class medical type people, versus first class nurses.

I think that with all the advances that we have made, we've made ourselves a little more threatening. We need to be really together, and we really need to I think maintain that edge which is that nursing approach that we bring to the healthcare market, and that we're not substitute, mid-level ... I hate that word ... true nurse practitioners hate being called mid-level anything. I say ... we're not mid-level, we are advanced practice nurses (LC)

For one nurse practitioner, at least, personal feeling helped define the role

I think I always feel like a nurse because I never wanted to be a doctor (RM)

The majority of the nurse practitioners who participated in the study commented on their skills, highlighting the nursing influences on their practice, but also reflected on the relationship between skills and knowledge.

If they're coming in for a medical problem I still think about how it impacts on the family, how it impacts on the child -- how it impacts on them developmentally, and hopefully every good nurse practitioner and doctor would do that. I'm still not convinced that doctors are trained to think that way. So whenever I teach medical students, I encourage them to think that way because that to me is what's real about it, and that's what makes it fun. (RM)

Some nurse practitioners accept that they have a less comprehensive knowledge base than that required of their medical colleagues, but given their conviction that the typical approach taken by the nurse practitioner provides a different and more effective option to that provided by a medical practitioner this is not seen as a significant issue.

I do think to back up to the difference between physicians and nurses is that physicians, because their learning and their education really focuses on pathology, and really looks at medical kinds of things, and they are great at diagnosis and treating. And we on the other hand look at the entire person to try and see where this fits, and look at normal kinds of growth and development with respect to kids, and even with adults and older adults.

I see physicians medicalise things much more than nurse practitioners. Right now there's this great debate about should women take birth control pills all of their life so they never have a period - well that medicalises a normal occurrence in a female's life. And what's the point, you know? (CL)

Most recognise, however that their professional status requires them to be aware of their scope of practice, and work collaboratively with colleagues from other disciplines where there are gaps in their knowledge, or where they feel the need for a further opinion.

... nurse practitioners are trained beyond what we actually do in the office, so that we can recognise unusual diseases - not that we are necessarily going to be treating them, but our training is thus that we would recognise them and refer people appropriately, and also recognise when we might be in beyond our scope of practice.

What do you know that you don't know, is sometimes more important, to recognise oh no, nothing in my training has prepared me for this; and also when and who to go to, and do you trust that advice. (ND)

(The patient) was my responsibility, but the way I handled it was I called the infectious disease chief of medicine, and I called the emergency room because they have some experience in dealing with this regimen, and so collaboratively we worked out a plan for his care. Sometimes even though you collaborate there's information that falls through the cracks, and you have to know where

to look and you have to trust your ability to make a good decision, as good as anyone else in your shoes.

I'm accountable for the decisions that I make... so it's important to do it right. I trust my decision making, I trust that I'm logical, I trust that I'm thorough, but part of that thoroughness is consulting other people that have more experience, like the infectious disease person and the emergency room person. (ND)

For most nurse practitioners the relationship with medical colleagues was central to their experience of professional autonomy. The legal requirements for supervision vary between countries, but very few nurse practitioners work in isolation, and most recognise the need for interprofessional collaboration to achieve the best possible patient care outcomes. Not all were entirely convinced of their medical colleagues' range of skills, however.

... there are some doctors that I work with who also see families the same exact way. They'd make great nurses -- as doctors. Then there are other doctors who aren't as good at that, aren't as good with communication, with teaching.(RM)

In terms of how you treat people I think that that is nursing philosophy and I have to say that here, in this clinic the line is very blurred, because the doctors are not your typical kind of in house hospital doctors, they're very kind. (ND)

One participant even questioned junior doctors' clinical skills

I read something in one of the latest paediatric journals where they are looking at paediatric preassessment. Nurse practitioners assessing children to ensure they're fit for theatre. They did a comparative study, and in about ... I think the nurses were faultless -- a senior anaesthetist found that every nurse may be good judgement, but only 43 percent of the SHOs were actually making good judgements. So the data is coming through, I think, to support nurses. But it doesn't add ... it doesn't ease the defensive behaviour of the GPs. (FH)

The experience of putting nurse practitioner skills into practice is recognised as a daunting step, one that does lead to some reflection on the role.

I hadn't realised how much I relied on probably subconsciously being able to say to the patients, never mind, go and see the doctor. When you actually have to make the decision, you see the patient, you make the diagnosis, you often do the treatment and then you dismiss, discharge them, that's when you don't sleep at night. (In) the nurse practitioner role I know my job is to actually make the decisions and not just to discuss things with the doctor, particularly. I had to be brave enough, if you like, to actually use my training and use my skills and make decisions, and be prepared to be accountable for those decisions. (WM)

I learnt very early on never to make a decision that was going to worry me. I went home one night worrying that the child wasn't going to be there in the morning, and I thought this isn't what this is about. And you only do it once. You take a risk with everything you do, every anti-biotic you prescribe might kill somebody, you know, you just don't know. I can work like that. It's just being aware, really, where your competence ends (WM)

7.3.3 Professional boundaries

The transition into the nurse practitioner role impacted on the relationship with other disciplines experienced by the participants. One aspect of this perceived change related to professional boundaries, and way in which the nurse practitioners changing scope of practice was viewed by others.

The nurse practitioners felt that some physicians saw this development as a threat, despite the regulatory controls on nurse practitioners practice described earlier.

... the physicians looked at our stepping in on their territory, they were concerned about that. They felt threatened because they had owned prescriptive privileges (TW)

However many nurse practitioners disagreed; they felt that their skills were different from those of physicians, even thought they were working in an autonomous way with a similar patient population.

... we don't see ourselves competing with physicians, we see ourselves complementing the healthcare team (TW)

This view was enhanced by the feeling that the developing role of the nurse practitioner has allowed medical practitioners to change the way in which they work; one consequence of changes to the scope of nursing practice is that doctors have new opportunities to work differently.

... the physicians became more of the consultants, and the nurse practitioners were really the main primary care provider, the main representative of the health care provider on the team (ND)

Nurse practitioners recognise the potential for competition, particularly in the US, where reimbursement issues have highlighted circumstances in which nurse practitioners might be a more cost effective provider of health care, particularly in the primary care sector.

I do think there still is that socialised, general power conflict between nurse practitioners ... actually I think there is more so now, with reimbursement coming our way, and third party reimbursement that we're more respected. And we as nurse practitioners have gained a more legitimate, credible role, we've become ... and primary care has become the national goal versus specialisation, then we're back in that competitive mode with physicians that we weren't in for a long period of time (LC)

In the US nurse practitioners are very aware, however that competition is not just a one-way phenomenon. The first nurse practitioners were often employed to care for under served populations, typically poor communities with a high proportion of migrants and people from ethnic minority groups. As medicine has discovered that there are not always

sufficient openings at consultant level in 'traditional' specialities, some doctors have looked to move into areas of work that they may not previously have considered.

...when you get into adult practice and adult care now there's more of a competition, because we find physicians are struggling where there identity is. Everyone cannot be, you know, an ear nose and throat specialist, a cardiologist, they're cutting back on that type of role, so they are now competing for populations that physicians did not want take care of (LC)

However one consistent theme amongst the participants was the feeling that they are nurses, with no aspirations to move into a 'medical' career pathway.

...nurse practitioners are first class nurses, not second-class medics (LC)

This did not, however detract from the quality of care offered to the patient. The idea that nurse practitioners offer a different approach to the same population, particularly in the delivery of primary care, is a consistent theme. For one nurse practitioner, at least, the quality of care was as much down to the individual as to their discipline.

...you don't need to go to medical school to be a good primary care provider, and that's true. I think that in some ways I'm better at providing care than some of the doctors that I work with, because I've seen their practice, I've read their notes. I see how their patients aren't taught about their own health, and I think that's reality, that's life. You know, there are going to be better nurses than others, there's going to be better doctors than others (RM)

Most nurse practitioners recognised the limitations to their scope of practice and the need to work collaboratively in areas such as prescribing and referrals, although for some this is a source of some frustration. The recognition that the transition to the nurse practitioner role has implications for professional boundaries is not confined to the relationship between nurse practitioners and doctors, however. For many

nurse practitioners an awareness of the changing relationship with other disciplines, including registered nurses has also been a significant part of their experience in the role.

She comes and asks me if she is unsure, the district nurse, and the practice nurses, and the health visitors often ask me to see babies that they are worried about. It works well now. (WM)

I like doing the nursing part as well, and I always do whatever I have to do my role, I never treat nurses as subservient because that's so contrary. (LC)

Most were positive about what they perceived to be a blurring of professional boundaries, because of the potential released by the change

I think if anything the excitement is that the advanced practice role has facilitated registered nurses in being able to do more of what they were educated to do. (TW)

7.3.4 Controlling influences

Despite some enthusiasm for the potential afforded by the nurse practitioner role there was clear recognition that controls were still in place, through the relationship established with medical practitioners. Local regulations vary slightly, but most nurse practitioners indicated that aspects of their work were supervised to a greater or lesser extent by a medical practitioner.

The nurse practitioner practices interdependently, (but) must still be associated with a physician. (TW)

For some, this was about ensuring that they had their supervisors on their side.

Discussed with Dr. so-and-so, even if it's my idea, right dose, right medicine, and a lot of physicians love you if you practice like that, they have confidence in

your abilities. Your ability can go beyond your licence, but to stay legal you've got to stand within the scope of practice. (ND)

For others, the supervisory relationship felt like a paper exercise, something that was seen as a necessary formality to be observed but something that did not significantly alter clinical decisions and treatment plans.

...instead of prescriptions, we used in-patient hospital forms for orders, in triplicate, and the rule was that it had to be within a certain period of time it would be co-signed by the physician. I could tell you that the majority of times I was there people didn't even read my orders, they just signed them, blindly. (LC)

The nurse practitioners recognised that doctors were in a supervisory role, despite what they often perceived to be a cursory level of scrutiny, but for some the notion of partnership still dominated their views on how control was exercised

I thought that if I documented, and was careful that would be OK. But you did, you still did rely upon your partner - I always consider the physician my partner versus supervisor - to be credible, and support you because there still was that final say. (LC)

The question of protocols, pre-determined responses to given patient presentations or clinical situations were also cited as influential in controlling the scope of the nurse practitioners responses in practice. Protocols were seen as more useful if they were based on an interprofessional response, and incorporated nursing interventions as well as 'medical' responses. Compliance with protocols, however, presented a problem for doctors. Where a protocol specifies the preferred response to a given issue, based on evidence, it is a natural assumption that any practitioner faced with the specified presenting problem will follow the approved guideline. A protocol designed to ensure that nurse

practitioners respond to a situation in a predetermined way will naturally limit the clinical freedom of other disciplines if it is universally applied.

> *...the concern was that nurse practitioners were supposed to have protocols, but the physicians didn't want anything to do with protocols. If you had sheer protocols that were co-signed then it put the burden on the physician to follow the same protocol for common illnesses or whatever. (LC)*

7.3.5 Professional Relationships

Nurse practitioners experience of professional relationships was, as demonstrated, varied and must be considered in the context of the issues already highlighted as significant by the participants. The majority of the experiences recounted above refer to relationships with doctors, but a variety of health care disciplines were also mentioned, some in a more positive light than others. In addition, nurse practitioners discussed their experience of organisational change across professional boundaries, something that impacts on their working practice and their perception of their position within the interprofessional team.

The relationship between the nurse practitioner and the patients they engage with also has a very significant impact on the nurse practitioner role, their potential for autonomous practice and their personal job satisfaction.

7.4 Nurse practitioner-patient relationships

7.4.1 Introduction

During the structural analysis it became clear that participants' relationships with the patients and families that they work with are of paramount importance, and hold a significant place in nurse practitioners' affective response to their role. A great deal of satisfaction is derived from the positive relationships established with the client group, and within the sub-themes derived from this grouping the analysis was able to focus on attitudes to patients and participants' role satisfaction. The theme also gave rise to sub-themes that explored patient misunderstanding of the nurse practitioner role, and the effect that patients' reluctance to accept care from a nurse practitioner had on participants.

7.4.2 Nurse practitioners' attitudes to patients

For the majority of nurse practitioners one fundamental aspect of the transition from their registered nurse role to that of the nurse practitioner is the changing relationship with patients. The nurse patient relationship is a cornerstone of nursing, something that is at the heart of most nurses' education and experience, a part of the essence of what it is to be a nurse.

The decision to move into a nurse practitioner role is seen by many nurses as a natural career progression, but for many it comes with the realisation that the nurse practitioner's relationship with the patients they treat can never be the same as that enjoyed by the registered nurse. This is in part a consequence of the changing relationships with other members of the healthcare team, but also arises because patients and

families see the nurse practitioner differently from the registered nurse, and therefore have different expectations, and make different demands of them.

Some nurse practitioners experienced an initial reluctance to make use of their service, because of ignorance among the patient population.

...there hadn't been any nurse practitioners in (this area) three years ago, it was a totally new concept, and so there was a lot of hesitation (FH)

Overcoming this initial hesitancy was seen as an essential step towards acceptance in the role. One nurse practitioner suggested that patient satisfaction is the key to ensuring acceptance, and that this can quickly be established provided the nurse practitioner has access to the patients.

...we have always just said, let us just see them once (TW)

Others approached the need for acceptance from a more logical position, seeking to use explanation and persuasion to gain the trust of patients and families.

If you take the time to explain to them how the roles are very similar, and what our training is, and what we can do for them I've found families to be very receptive (MU)

I do a lot of things like the doctor but I don't go up to the hospital, and when things are complicated it's good for you to have two people taking care of you (ND)

The role of the nurse practitioner is described in very different terms from that of the registered nurse by participants, who stressed the autonomy inherent in the primary care provider role enjoyed by some nurse practitioners, particularly in the United States. The independent management of a caseload in primary care places the nurse practitioner

in a position of some authority, although in many cases this is tempered by various checks, balances and regulatory bureaucracy, however from the patient's point of view it makes the nurse practitioner their first point of contact in the healthcare system.

...they are my own caseload, they don't see another doctor, or another nurse practitioner. Of course if they're sick, and I'm not here they might see someone else, but everything, for the most part, is done pretty autonomously, as far as ordering medications, vaccinations, writing prescriptions, making decisions about their management (RM)

Not everyone was quite so ready to assert their engagement in the full range of primary care interventions. For many nurse practitioners the acquisition of a caseload is achieved through a differential process in which the skills of the nurse practitioner are matched to the needs of the patient. This often appears to draw on the holistic nature of the nurse practitioners' role, and has in turn reinforced a belief in the partnership between practitioner and patients. This 'partnership' view, which puts patients in a position where they retain some responsibility for their own health status is perhaps closer to the traditions of nurture that are fundamental to the registered nurse role, and has helped some nurse practitioners to define the relationship between them and their patients.

So long as you have done what you need to do then that patient is responsible as well for their own health, and they will come back if they need you, they know the service is here. It takes quite a lot of getting used to, recognising the patient has that ability if you like, because nurses tend to be very nurturing and doing and you know, always taking the responsibility from the patient (CD)

In some specific areas of practice gender was an important issue in shaping nurse practitioners attitudes to their relationships with patients; in gynaecology, for example, the preponderance of male doctors meant

that the nurse practitioner could bring a different perspective to the care of patients.

With gynae, because they have particularly sensitive needs there was something I would say around having a female to female contact in terms of understanding their problems, helping them to deal with that sort of thing (FN)

7.4.3 Experiencing 'role satisfaction' through patient care

Several participants commented on the satisfaction that they get from their relationship with patients, and the factors that create this fulfilment. The opportunity to develop the relationship with their patients is a recurring theme, with some participants suggesting that this is something that nurse practitioners are particularly adept at. Some do, however, acknowledge that medical colleagues also have skills in this area, although this does not detract from the supportive nature of the nurse practitioner role.

I would like to think that they get great quality of care from everyone. I think from a nurse practitioners point of view they probably get more of a relationship, more of an equal relationship, and that we do take some time to build that relationship, although many of the physicians that I work with of very good - so they're giving good quality care too (CL)

Others saw the opportunity for continuity of care as a source of satisfaction, providing opportunities to work consistently with patients over a period of time.

...there is scope there for good continuity of care, which is very satisfying. Being able to see someone through from start to finish that is quite satisfying, definitely (FN)

...for the most part when you're in chronic care there's something of a luxury because you have continuity of time, so if you don't convince people the first time, you have time (ND)

One participant revealed that the task orientation derided by most and seen be many as the preferred approach among the majority of medical practitioners was easy to adopt when times became more difficult and pressurised.

If I'm rested and I'm running on time, I'm the most compassionate healthcare provider, but if I'm not, I'm as task oriented as the rest (ND)

For another participant the satisfaction derived from a successful and effective working relationship with a patient and her family was diminished by the family's misunderstanding of the nurse practitioner role.

I think I'd been a nurse practitioner about 10 years; I'd been dealing with this family who had a young daughter that had very severe mental retardation, had congenital rubella syndrome, and cardiac problems, and diabetes - uncontrolled diabetes. And they actually trusted me with their daughter's life, the whole thing. I remember being at a big meeting, and the father said to me, M, you are a really good nurse, you really need to think about going back to school, and stop being a practice nurse, and becoming a real nurse. They thought nurse practitioner meant I was a practice nurse, but I wasn't a real nurse, and they had no clue, after 10 years (LC)

7.4.4 Patients' misunderstanding of the nurse practitioner role

The majority of participants described situations in which they were either mistaken for doctors, or seen as occupying a role synonymous with that of the doctor. While fellow professionals are frequently sensitive to the status and powers of the nurse practitioner, it appears that patients and their families are often completely oblivious to certain professional boundaries.

I'll say to them Hi, I'm R, I'm a nurse practitioner, I'm going to be taking care of your child. Oh, okay, hi doctor, thank you so much (RM)

In some cases this misunderstanding originated in cultural differences compounded by linguistic complications. One participant, who works extensively with immigrant populations in the United States, described her experiences.

Well, in this place they think I am a doctor, and they're shocked when I say you need to see the doctor. But you're my doctor - I'm not a doctor, and the language is part of the problem, and also the cultural aspect. In Brazil there are no nurse practitioners; nurses there are not well-trained, so to have a nurse who treats me like a doctor, that's one cultural concept. They're usually shocked and say 'but you are my doctor' and then there's a little drama you know. Like no, I'm your nurse, your infirmamatica magica, your medical speciality nurse. (ND)

In other cases, however, patients are very clear about the nurse practitioner role but still persist in regarding the nurse practitioner as a doctor. One nurse practitioner described how she always reminds patients of her status, and checks their understanding, so that she is secure in the knowledge that they retain the opportunity to choose their healthcare provider.

So I think that knowing they have the choice is really ... or making sure that they've told me that they know I'm not a doctor. Which is fine, because when I introduced myself I introduce myself as a nurse practitioner, which doesn't mean that I'm not called Dr L. often, and that I don't point out that I'm not a doctor (CL)

Once patients accept the nurse practitioner for what he or she is, and are able to confirm in conversation their understanding of the situation, some nurse practitioners appear to be happy to be referred to as a doctor.

I think people still think of me as a doctor, an even some patients say, I know you're a nurse practitioner, the you're still my kids doctor (RM)

...one patient, one of my teenage patients said to me I know, I know, I know, but you're my doctor. You take care of me (CL)

7.4.5 Reluctance to see the nurse practitioner

Not every patient is willing or able to see the nurse practitioner as synonymous with the doctor, or equal in authority or competence. Many participants described situations in which patients or families questioned their position, and refused to see them, although for most this was a rare occurrence.

Why can't I see a doctor today, why have I got to speak to a nurse first? (TK)

I've only had a couple instances where families have said I don't want to see a nurse practitioner I want to see a physician, or I want to see an attending physician (MU)

For some, this was a situation that needs to be handled with respect and courtesy to the patient. Several participants suggested that competence in clinical practice can overcome patients' misgivings.

Once in while but rarely, rarely you have people that only want to see a doctor, and yes we do have some like that but generally speaking, people have problems and if you can attend the problems, and you are courteous to them, they think you are (a doctor) (ND)

For others, patients always have the right to see a doctor, and appropriate arrangements are always made for patients who insist that only a doctor will do. One nurse practitioner suggested that they would not try to persuade a patient that they could provide a similar service.

I can only remember a few occasions when someone would say to me, oh, I'm not going to see the doctor? And I'd say, no, you're going to see me, but if you want to see the doctor that's perfectly all right, and we can make those arrangements (CL)

I just wouldn't argue, we don't want the trouble (TK)

One nurse practitioner described the process in her primary care practice, where all patients are assessed by the nurse practitioner in the first instance. She recognised, however, that for some patients this was not acceptable, and did not feel that was inappropriate, or in any way undermined her position within the primary care team.

What the GPs had intended to do was try to direct all the on the day appointments to come through me; I might have acted in a triage type role. And so the receptionists were saying like our nurse practitioners is here this morning, would you like an appointment with her, she is seeing the extras today. Now, the majority of people said, that's fine. But there were one or two people, and excuse me, that's fine as well, patients' choice, you know they don't have to see me at all (FH)

Many nurse practitioners recognised that patients will often want a medical opinion in situations where they present with complex or threatening conditions. These may be medical emergencies, or situations where patients or families were under extreme stress.

...when you get into ... or pre surgical type things - somebody might have a stricture, an oesophageal stricture and might need to be going in - I'm thinking of ... and they'll say, you know, I want to talk to the physician. I want to talk personally to the physician (LC)

The stress experienced by families is particularly acute where children are concerned, and one nurse practitioner recognised that contact with the doctor might in itself be reassuring, despite their perceived lack of personal involvement in many of the cases they oversee.

...in situations of extreme anxiety, or where they felt that there was still that ultimate 'he's the physician' - 'she's the physician'. Even though they knew that the physician never really knew who their child was, or what they did. (LC)

Several participants commented on the attitudes of medical colleagues towards patients who are reluctant to make use of appointments with the nurse practitioner. One described a situation in which the doctor concerned reminded the patient that the nurse practitioner was a legitimate part of the primary care team, and that her advice was appropriate and correct.

...there was no need for you to come and see me today because you saw (the nurse practitioner) yesterday and she told you that (TK)

For some, reluctance on the patient's part became an issue for the doctor to deal with, indicating perhaps an impression of where the nurse practitioner concerned believes the power to determine the pattern of service delivery lies.

I don't get many who say they don't want to see me, but if they say no, I'm not seeing a nurse, I want to see a doctor, I say fine, I'll write it on the computer and it's up to the doctors to take it up with them if they don't think it's appropriate (TK)

Ultimately nurse practitioners see their service as increasingly an accepted part of care delivery. One nurse practitioner, working in a specialist service established with nurse practitioners working alongside medical practitioners had encountered no resistance from patients. The status of the practitioner appeared to be immaterial.

...that doesn't really matter to them, I've never had anybody say, I don't want to see you, I want to see the doctor. Never (RM)

Systematic evaluation of nurse practitioner services appears to some to be providing evidence to justify the role, and the willingness of patients to return having experienced care by a nurse practitioner is one cause for satisfaction, suggesting patient acceptance is increasingly common.

The clinic that I set up I did as a pilot project, and I evaluated it as I went along because I wanted to prove to them that this was an effective service, and that is what came out of that audit - that patients were satisfied with it. There wasn't one patient that said I would rather have been seen by a doctor, or nurse, or anything like that. It was all... and we audited the consultants and the staff on the ward and people like that, and it all came out positive, there was very little resistance to any of it (FN)

...the patients can now choose to see me if they want to, they have these appointments that they can book, and my surgeries are full (TK)

...what we find now is that fewer and fewer people refuse to see me, and more and more come back, and actually request to see me. So that's great, that's nice (FH)

In conclusion nurse practitioners feel that their relationships with patients are generally good, and despite some initial reluctance of the part of patients and their families to consult a nurse practitioner these instances are rare, and becoming rarer, as patients become more familiar with the role. For some nurse practitioners the increasing acceptance by patients of their position as the primary provider of care has reminded them of their professional responsibility, and the autonomous position in which they are now established. As more patients are included in their managed caseload, there is an increasing awareness of the accountability associated with the role, and the diminishing opportunity to assume that medical colleagues carry ultimate responsibility for the overall delivery of care.

...the responsibility I've taken on board. I actually felt, if you can, much more accountable because I suppose I was doing holistic care, which I thought I was doing before, but actually had been reneging on my responsibilities in a certain way because I hadn't grasped it by the throat or anything, I'd been kind of half doing it, thinking I was doing it but actually allowing the doctors to take responsibility (CD)

7.5 Nurse practitioners' skills

7.5.1 Introduction

This theme explored the participants' experiences in practice with particular reference to the skills that they deploy in the care of patients and families.

Nurse practitioners were consistent in their acknowledgement of their nursing background, and firmly believed that their experiences as registered nurses provided the defining features of their nurse practitioner role. This was true in spite of the skills and responsibilities demanded of them in practice, where several participants described their work as being similar in scope and level to that of a physician, particularly in primary care settings. One nurse practitioner, who had been in practice for several years, commented on the debt that she owed to the nurse theorists who were instrumental in shaping her approach to patient care.

I am providing physician type services and I am held to a physician type medical knowledge to practice on, and that is the truth, and (nursing theory) is kind of where I go to deal with the uncertainty. Dorothea Orem was actually the theory that we used... and I was a nurse that was really into nursing theory, and a practitioner that was considered fairly confident. That connection of having a theoretical framework... and assessing people's responsibilities within the Orem model (ND)

Others were less forthright about their link back to key theorists, but acknowledged the contribution that nursing theory made to their general philosophy of care.

You know I don't think of, you know, Betty Neuman when I'm making every move, but, you know I do think of the family as an entire whole for me, I don't look at just one aspect of the child's care. (RM)

This view was reinforced by one participant, who commented on the often expressed view that nurse practitioners were really substitutes for junior doctors, adopting an identical role albeit via a different preparatory route.

...that bothers me. You don't want to start off by being substitutes for physicians, you want to start off by saying this is a nursing role, and I use you know Florence Nightingale or Lillian Wald... the first school nurse, as nurses that really were comprehensive and holistic in their approach. (LC)

In making the transition to the nurse practitioner role registered nurses often do need to reappraise their skills. One participant found that concepts she had dismissed as irrelevant in her previous practice became central to her new role.

It fits with holistic nursing, emphasising relationships. But how difficult to try and explain that to experienced nurses. I remember being resentful, I did a (course) called therapeutic communication, and we looked at (various theorists) and I just remember being defensive and thinking well there is absolutely no way I need to do this; you know, I've been nursing far too long to think about how I'm going to ... my opening skills, and my closing skills, and the boundaries to this. And you know, actually, it's really crucial, really crucial. (FH)

One participant drew a distinction between those aspects of an individual's performance that are learnt, as tasks to be completed, and those that are part of the philosophy underpinning their performance in

the role. This underpinning was regarded as the 'nursing' base, providing a foundation for the addition of specific tasks required in any given role.

I think nurses, anybody intelligent, can learn how to do anything, tasks, anything. But I think if we give up our base of nursing, which is understanding that person, doing a total assessment, doing some disease prevention, doing some health maintenance, and putting it in the context of this - the tasks that they do. (CL)

7.5.2 Nurse practitioners' use of nursing skills

Confidence in practice is an essential part of the nurse practitioner role, and not every aspect of care delivery can be dismissed as a task to be learnt and performed as required. Nurse practitioners see their new skill set as encompassing traditional nursing values and skills, combined with new skills that were often the province of other disciplines prior to the development of advanced practice roles. New responsibilities in areas such as diagnosis, using skills of physical examination have allowed nurse practitioners to feel that they are an equal part of the healthcare team, rather than a discipline working in a subservient role.

Nursing is helping people to provide that care, and historically it was under the diagnosis that was given and the dictates of someone else, now it's from around diagnosis, from working collaboratively, it's more fused with other health care providers. (TW)

We are expected to deal with those front-line things, to listen to chests, and as nurses we're not taught those basic skills of physical examination. We have to have that, it's a skill that is not just in the domain of doctors, this is something we have to take and do competently. (FH)

Specific skills are seen as important to patient care in any given area of practice, but the core skills of the nurse practitioner are still seen as the defining feature of the role.

We have paede nurse practitioners at children's hospitals who take care of kids with cancer, so they call themselves oncology nurse practitioners. They're really primary care, that's the programme they went through, and they can do bone marrow aspirations, they can do (lumbar punctures), and they can be taught how to do that because they are clever intelligent people. But that's not where their expertise lies. Their expertise lies in taking care of that child in the context of the family (CL)

Some participants reflected on how their move into a nurse practitioner position had led them to reappraise their previous role as a registered nurse; one described her realisation that despite having significant responsibility in her registered nurse role she had not fully understood certain vital aspects of patient care prior to undertaking her nurse practitioner qualification.

For the last 20 years I have been administering medicines to patients without a clear understanding of what I have done. I didn't have that deeper knowledge that I have gained through the nurse practitioner role. (FN)

Despite this, several participants recognised that in many ways registered nurses often have better knowledge of narrow or specific aspects of care than nurse practitioners, who tend to be more generalist in their knowledge base, particularly in the primary care field.

I work with five practice nurses and they all have specialist skills to a much greater depth than I would. (CD)

(the registered nurses' role) is narrower, but they probably know a whole lot more about one thing than I probably know, you know, a lot more about a lot of things but in much less depth. (TK)

Nurse practitioners see their practice as being founded on nursing values, and one participant commented on how her medical colleagues demonstrated what she saw as 'her' values in their dealings with patients.

In terms of how you treat people I think that that is nursing philosophy and I have to say that here, in this clinic the line is very blurred, because the doctors are not your typical kind of (junior) doctors, they're very kind. I tease them sometimes, I say 'you guys were nurses in your past life', because they treat people with the same kind of courtesy, but I think that I spend maybe more time trying to talk to people about how your disease works, why are you taking this medicine. (ND)

Several participants acknowledged that nursing does not hold a monopoly on caring and compassion, but do believe that an inherent respect for people, and the ability to listen, is valued by patients and respected by other disciplines.

It's just basic human compassion, I'm not sure that that comes from any one discipline. I think we like to think that we own it in nursing, but I'll tell you the truth (laughs) - no we don't. It's human, and you have it, or you don't have it, and some days you have it more than others. (ND)

Because I can talk to people, people find it easy to express their ideas and fears, and so many times people will sit down and say, you know, I really feel I haven't wasted your time, and thank you for listening -- so fundamentally, nursing. I think it is, I really cling on to that. And sometimes GPs have sat in with me, and you know, one of them has said, do you know I've really got that you really listen to people, you really respect them, and it doesn't matter if they come in with an in growing toenail, or you know, headaches for five days. It's still a very real problem to that person. (FH)

This adherence to the fundamental skills of the registered nurse as a basis for their practice as a nurse practitioner was described in some way by the majority of participants. Some were explicit in describing how they feel that they are nurses, because of their underlying values.

I feel that I am in a nursing role. I think that a lot of what I do is make people feel very comfortable, try and educate them as to what's going on, try and help them agree with if not make decisions about their own care, and go back out there and take care of themselves, and learn how to be more independent in their care. (CL)

(I feel like a nurse) because I'm still looking at the whole picture, not just parts, not just the intestines, not just the skin. I'm really looking at the whole family. If they're coming in for a medical problem I still think about how it impacts on the family, how it impacts on the child -- how it impacts on them developmentally, and hopefully every good nurse practitioner and doctor would do that. (RM)

One participant even went as far as to suggest that she believed her adherence to nursing values had allowed her to progress her career more quickly that some of her nurse practitioner colleagues who saw themselves as 'medical' practitioners.

I would say that in my career one of the reasons I became more successful than some of my colleagues was that I always considered myself a nurse... my college education prepared me to be a nurse, you know, and that's why I've never felt that I was in a medical role, or a second class medical person. I've always felt that as an advance practice nurse there's a major difference in the way that you look at yourself and how you function. There were some nurse practitioners that do consider themselves, that happily consider themselves as second-class medical type people, versus first class nurses. Nurse practitioners, are first class nurses, not second-class medics. (LC)

For doctors, the primary focus is on the presenting problem, while for nurse practitioners the focus is the person with a problem.

I would say the training for medics is very often ... it's not centred on the person, is it, it's centred on the presenting problem and how you're going to manage that. I think the slant for nurses, and how I emphasise our nurse practitioner course, is that you're dealing with a person who has a problem. (FH)

Once the person becomes the focus of care, skills of engagement come to the fore. One participant expressed this very clearly, seeing the additional skills of the nurse practitioner as secondary to the fundamentals of nursing.

Within my own practice that is what comes first, definitely. Building a therapeutic relationship, I would say, with the patients as a starting point for the things that you do to them. If you talk about the main concepts of the nurse practitioner, roles, such as phys exam and history taking and that sort of thing, I think those things come secondary to the things I do as a nurse really. (WM)

For all the participants nursing remained the essential defining characteristic of their work. One was very clear about her allegiance.

I think I always feel like a nurse because I never wanted to be a doctor (RM)

Another commented on the changing nature of the nurse practitioner role in relation to management, with an increasing emphasis on advanced practice in nursing fitting into a nursing continuum

What I've noticed is that the advanced practice nurses have gone from being primarily responsible to physicians to now also being responsible to the department of nursing. (MU)

Most appeared to concur with one participant who summarised her debt to her background in nursing succinctly.

I couldn't have done this job 20 years ago without the experience I've got now. Well, not dot it and enjoy it, and do it as competently as I do now (TK)

7.6 Reflections on the nurse practitioner role

Towards the end of each interview participants were asked to reflect on their role, and what it means to them, as part of their exploration of professional autonomy. Nurse practitioners' professional self identity is important in exploring their experience of practice; the impact of a relatively new role within the healthcare team, combined with inconsistencies in how their professional and legal status is defined, and a degree of uncertainty regarding how the role might develop in the future

provide a background for further consideration of how nurse practitioners impact on health care delivery.

One long serving nurse practitioner reflected on how her current role is different from the role that she was originally prepared for, because like all nurse practitioners her role now demands expertise in direct patient care. Her understanding of the origins of the role is that it was much more closely allied with care management and coordination, rather than clinical care.

Originally nurse practitioners, part of their definition in primary care was to co-ordinate care, so that somebody needed to co-ordinate that with reference to working with all the disciplines from the physicians to the other kinds of participants in their multi-disciplinary teams (TW)

Several participants recounted experiences that they saw as contributing to a justification of the role, providing them with an opportunity to prove that nurse practitioners could make a viable and valuable input to patient care.

There were about a hundred nurse practitioners throughout that area that were followed, for three years. They kept records and sent them in, they had interviews with clients before and after, and that convinced the health care populace, the physicians, that we could do it, we could provide quality care that was safe (TW)

I approached to the health authority with a business plan. They went with it, gave us money for a year's funding, and we went off and did this project, where the health authority paid for us to go into general practices on a sessional basis if they had shown an interest in working alongside, or having a nurse practitioner come into their general practice, and just seeing what happened (FH)

Others saw the nurse practitioner role as valuable because of the volume of patients nurse practitioners can typically manage, and because the

skills of the nurse practitioner are more closely aligned with the needs of the majority of patients, at least within primary care.

> *...it comes down to supply and demand, and here when you look at the fact that nurse practitioners practise differently from physicians, we're really educated take care of maybe 80 per cent of the primary care that comes in and out of a private practice door (TW)*

The skills of the nurse practitioner are integral to any discussion of the role, and participants realise that in current practice, particularly in primary care, it is not sufficient to merely suggest that a skill set that is different from that of the medical practitioner. To work effectively nurse practitioners are expected to be able to offer a range of services to the patient, from assessment and diagnosis to intervention and referral. This requires more than the skills and values that they bring with them from their registered nurse roles, it requires enhanced knowledge to ensure competence in practice.

> *...they are expected to deal with those front-line things, to listen to chests, and as nurses we're not taught those basic skills of physical examination. We have to have that, it's a skill that is not just in the domain of doctors, this is something we have to take and do competently (FH)*

One participant noted the difficulties encountered by nurse practitioners whose previous registered nurse experience was typically in acute, highly technical services when they are faced with a range of relatively minor conditions. Given the way in which many nurse practitioners have been deployed, this provides a different focus for new learning in support of the transition to the nurse practitioner role.

> *...the walk ins have a load of diseases - it's awful - that they have to be competent at assessing, through flu type symptoms, cold symptoms, sore throat, pyrexias in children. Ear syringing, for some strange reason... they haven't had the minor ailments, they've never been exposed to that before, you*

know people don't go to A&E and say I've got a sore throat. You know, and so these nurses have predominantly been drawn from A&E and have no knowledge of these minor ailments (FH)

The holistic philosophy espoused by many nurse practitioners forms a basis for practice that is based on education for health as well as a measured response to ill health, and this is what many believe makes the nurse practitioner role unique.

...helping them to understand how to be responsible for their own health care, to be responsible for that for the rest of their lives, preventatively identify risks, to keep themselves healthier and promote their health, as well as deal with their illnesses (TW)

Some participants, however, take a more pragmatic stance alongside the idealism reflected in the underlying philosophy of care, and recognise that the ready availability of nurse practitioners has played a significant part in establishing the role in some areas of practice.

...the nurse practitioner route in terms of pre assessment for those patients seemed to be a good move forward, because we never had an SHO who could... they were always not there for some reason or another, so it was a way of improving patient care and improving the service really, and assessing patients properly (FN)

Once established as part of the team the opportunity to provide continuity of care further enhances the nurse practitioner role, although one participant reflected on the impact that the availability of enhanced roles, such as that of the nurse practitioner, has on community based services. Specialist skills and knowledge among community based practitioners allow earlier discharge from hospital, helping health authorities to meet various targets, but explaining the assertion that patients go home "quicker and sicker" as expertise in home care grows.

...a nurse led, or nurse practitioner led pre assessments unit, and that led on to doing a follow up clinic as well, for patients who had been pre assessed through the clinic, so it was covering the whole spectrum really, from pre admission through to discharge (FN)

...where nursing was providing the education, and teaching the clients, providing the hands-on kind of care. As we are more into the community now then hospitals, you know you're going home quicker and sicker in this country (TW)

Increasing acceptance of the role has helped nurse practitioners to feel that they do not constantly need to explain their position and potential contribution, although one participant suggested that acceptance was as much about individual personality as the nurse practitioner role in itself.

I think most of what happens now is more of a personality than a professional issue. Someone either likes you or not, and they're going to get along with you or they are not, kind of thing (CL)

For others, the divide between primary care, where typically nurse practitioners work independently with a defined caseload, and secondary care where many perceive the nurse practitioner role as more regimented and controlled by hierarchies within the team is a key distinction, with implications in several areas, including professional regulation and autonomous practice.

...there's nurse practitioners working in secondary care who might not have undergone that degree or that level of training. I don't belittle the role that they are doing but whether that fits with my concept of a nurse practitioner ... I'm sure there's going to be you know debate about this, but I would think that the NMC should take a leading role in this, and they haven't done that (FH)

For one nurse practitioner working in secondary care this view was familiar, but was countered by the assertion that the policies and procedures were in place for her own protection, rather than as a limit to professional autonomy. This issue did give rise to further questions about

skills and working practices, and was encapsulated in the discussion regarding the position of nursing within the traditional hierarchy of health care professions.

I was trying to cover myself, making sure that I had really robust policies and procedures and competencies and things that I felt met what was required (FN)

7.6.1 Future prospects for nurse practitioners

The opportunity to reflect on their role led many participants to speculate on the potential for further development of nurse practitioners, in new areas, and to criticise some recent initiatives that are seen as compromising the integrity of the role. Many participants were grounded in primary care, and most see primary care as the natural home of the nurse practitioner, and the essential foundation upon which other specialist skills and knowledge can be built.

Primary care is the first step and the first layer, and that we should build on that. And then if they want to be acute care, if they want to be speciality practice, whether its psych, whether its oncology, whether it's cardiovascular, they should build on that. Or school, or whatever, you know there's always some other things they can learn once they have their base of nursing knowledge and nursing practice. (CL)

One participant suggested that the increasing number of nurse practitioners now working in secondary care settings is in part a result of clinical nurse specialists comparing their role with that of the nurse practitioner in primary care, and finding sufficient similarities to adopt the nurse practitioner title.

We're seeing nurse practitioners move into what we call the critical care hospital role. Some of that is the result of I think personally the fact that we had clinical nurse specialists who were masters prepared that did work in hospital,

and did consulting work with the families and the nurses who were taking care at the bedside (CL)

Many recognised that the nurse practitioner role is now diverse and in many respects ill defined, and as a consequence nurse practitioners as a group need to ensure that they retain sufficient integrity and esteem to maintain and develop their status in the health care system.

I think that we are at a cross roads, and right now with many of the advances that we've had I think are putting us in a competitive market, and we need to really be kind of savvy about where we're going. (LC)

Nurse practitioners were consistent in their adherence to an underpinning philosophy that they see as central to their particular approach to healthcare. Many recognised, however that the requirements of the system leave them faced with roles and tasks for which they may not adequately be prepared. Much of the discussion about the future of nurse practitioner roles has focused on the relationship between us practitioners and medical colleagues, and the potential for substitution; in reality however it appears the some nurse practitioners at least feel that their preparation does not always fit the role demanded of them.

I think in some ways we are trained with certain philosophies and goals, and we are shoved out onto the stage really not knowing our lines at all for this play. (ND)

When nurse practitioners are required to substitute for junior doctors, a key issue in the light of new European working time directives (and equivalent legislation in the US) some participants expressed concern that their work might become 'medicalised', thus marginalising underpinning philosophies, and that nurse practitioners' jobs might be vulnerable to future policy change.

We are developing these educational programmes that will target nurses who want to be critical care nurses in hospital. I'm a little concerned about that because I don't think we want to medicalise what the nurse does, we want to retain our nursing status. Also, I see us filling in behind residents because there's fewer of them. What will happen later on if there happen to be more of them the nurse practitioner's going to be kicked out? Or, more to the point, these nurse practitioners will get very quickly burned out. (CL)

Despite these concerns one participant at least saw a positive future for nurse practitioners in this country, based on her experience of the nurse practitioner movement in the US, but noted the ongoing dependence on medical supervision in practice, something that militates against further development of autonomous practice for nurse practitioners.

Having spent that time in the States at the beginning of the year, I go over there and I see nurse practitioners working ... you know they are 30 years down the line, they are running clinics that are like GP practices, and still every single script that they sign themselves, there is a protocol which has been signed by a medical director. And they have to adhere very very strictly to that. It's no different from the potential for us right now, you know, we are in this position. (FH)

The future of the nurse practitioner role is naturally of great interest to nurse practitioners, as well as the wider health community, but there was considerable variation in the speculation engaged in by participants. One American nurse practitioner sees her role and that of her colleagues as increasingly shaped by financial concerns rather than subtle variations in working practice between disciplines.

A lot of it is being driven by insurance companies, in terms of reimbursement, and what they will reimburse. Volumes are set by administrators, and so you can be the most compassionate and well diagnosing person, but what the administration is looking for is cheap and fast, high volumes, in MDs and in NPs. (ND)

Several others, while not focusing specifically on the potential financial advantages of employing nurse practitioners in the gaps created by reduced working hours among junior doctors, recognised this as the primary reason for the significant increase in nurse practitioner numbers over recent years.

> *I think the only reason nurse practitioners are taking off really is through a lack of doctors because it is much more of a medical model, and also, certainly in general practice it is general, and so you have a generalised knowledge. (WM)*

> *It's interesting in the way that they're utilising nurse practitioners more to kind of bridge the gap with our new residency training rules, you know, the residents can only be there for eight hours at the time. (SU)*

An alternative view, presenting a slightly more positive vision of the future suggests that nurse practitioners and medical practitioners complement each other, and that the future will require effective collaboration rather than competition.

> *So many people see nurse practitioners as trying to replace what doctors do, and I think that if we work together for the benefit of the families ... We are not going to push doctors out, and doctors won't push us out. We need very articulate spokes people on our behalf, to convey what we do and that ... you know we want to work with people, not against people. We will not try to replace anybody. (RM)*

This view, reinforcing the philosophical basis of nurse practitioner practice and highlighting the contribution that nurse practitioners can make to the holistic care of families is however dependent on maintaining effective practice, where the key indicators for effectiveness are those by which medical practitioners are judged.

> *So much for our model about teaching - that takes time and it's not cost-effective - that's the first thing they cut... it's going to be determined not by*

the great job we do in prevention and teaching, but by cost effectiveness, diagnostic acumen and all the things that the MDs are guided on. (ND)

All were agreed that the consolidation and further development of the nurse practitioner role requires careful management, and positive outcomes cannot be assumed or assured.

I think we need to be careful about the language that we use too, to people. You know, language, meaning, you know again that we are here to work with people not against people, we're not here to push doctors out of their jobs, we're not saying we can do it better. (RM)

Consolidation was seen as challenging, in the light of current policy, and several participants highlighted the potential for nurse practitioners to be exploited by the healthcare system. For some, this was reflected in increasingly complex workloads without commensurate financial reward.

I think as long as we work like doctors and get paid like nurses it will be a very popular role (ND)

For others the increasing intensity of the nurse practitioner role, particularly in secondary care settings, combined with the changing balance within the healthcare team is seen as an area of vulnerability. Nurses, particularly nurse practitioners, will be expected to take on more and more of the organisation and delivery of care. This is seen as falling within the scope of the well prepared nurse practitioner, but without adequate education and training might prove significantly stressful, and without adequate resource might be seen as exploitative of nurse practitioners.

They're going to be in intense kinds of roles, over a period of time, and they will get used. And I'm concerned about that. I mean we've seen that in primary care and we've tried to move a little bit beyond that, and I'm afraid

that that is going to happen even more so in a hospital because it's so much more intense. You know when you're dealing with intense things, and families that are in acute crises, I mean that's going to be tough. (CL)

I think it will become much more... because we haven't got the doctors, have we. I mean the doctors are working less hours, the junior hospital doctors are working less hours, more and more is going to be done by nurses, and can be done by nurses, I believe, provided they are properly trained. (TK)

Cost is recognised as central to the dilemma; participants were aware of the arguments about pay and conditions, but still see the potential for their role to develop in a way that might increase pressure on individuals, and leave nurse practitioners feeling undervalued, overworked, and defensive about their future roles.

Our health care is in a crisis, you know. Working like a doctor and being paid like a nurse, I don't think that is really a solution for anybody. In office practice you're doing almost 80 per cent similar. So you know the difference in pay is really for the education, and the responsibility, added levels of responsibility. (ND)

The government will see this as a very nice cheap option for health care and he's worried by that, he has great concerns about that. And so I think ... I must say it's not only doctors who get defensive (FH)

This defensiveness is already evident in a number of ways. One participant criticised the ambition of pharmacists, in a way that is reminiscent of the defensiveness demonstrated by medical practitioners who feel that nurse practitioners are encroaching on their territory.

In recent years there's this new issue of pharmacists wanting to have prescription authority. But they don't have the educational background for management of illness - they know a lot of pharmacology background, so that's somewhat ... around the country that's been a huge controversy. (LC)

Another participant commented on the trend for clinical nurse specialists to seek nurse practitioner status, on the grounds that their role is similar.

This reinforces the 'nursing' foundation of advanced nursing practice, but does again highlight the ongoing confusion over the delineation of the nurse practitioner and other specialist nursing roles.

When nurse practitioners evolved and started to get some very good power bases, and very good authority on their own, with prescriptions and other kinds of practices the clinical nurse specialist sort of thought hmm, me to, I should have that. We saw a lot of clinical nurse specialists come back to get retooled as nurse practitioners. Now they became primary care, but they used a lot of their good patient health education information, good disease prevention information, good health maintenance information that I think is the essence of nursing, and brought that back with them to the hospital. (CL)

One interesting aspect of the defensiveness evident among nurse practitioners relates to a perceived threat to a core area of their practice, in primary care. Several participants noted that the early development of nurse practitioners was in part a response to a lack of provision in primary care. As policy change reshapes the pattern of healthcare delivery, primary care has become a more important element of overall provision, and other disciplines have again become interested in the field.

The role evolved because so few people were interested in actually providing primary care to patients that now there is sort of this pendulum swinging back now, where doctors are realising that that's actually where the need is. There isn't so much of an emphasis on subspecialty care; that's where people want to be now, it's really weird, it's fun, it's where you really connect with families. (RM)

Ultimately, nurse practitioners' confidence in their abilities, and the degree of satisfaction evident among their patients, will help to determine their future.

First of all, we are not going anywhere, we are not going to disappear, I have every confidence in that. I think there are enough people that believe in us, and who admire us, and who like us as their children's provider that that won't happen. (RM)

Speculation on possible future development of the nurse practitioner role provided a number of potential scenarios, ranging from increasing generalisation to increasing specialisation, and several combinations of the two.

I think there is a place for nurse practitioners who can be very generalist, and could assess a wide range of cases whatever they might be. I also think there is a case for nurse practitioners in specialist areas, (FN)

There is a case for combining the classical specialist nurse type roles with what we would view as being a nurse practitioner, so that you've got the kind of support from psychological point of view as well as someone who is actually able to provide some sort of hands on clinical care as well. (FN)

For some, more registered nurses need to develop nurse practitioner skills, even if they do not become nurse practitioners: future nursing roles are likely to demand greater clinical acumen and the basis of the nurse practitioner role is seen as a template for nursing as a whole.

If I had the ideal situation I would want to develop other nurses to be able to do the same, and to build up follow up clinics and things like that, which we don't have the time or the money to do. (WM)

I think it's the future of nursing for the ambulatory setting, because there is? because when you look at the way the patient mix has changed in-patient, and how that has affected patient mix in the ambulatory setting, and the fact that the kids are coming out of the hospital sicker, sooner (SU)

Not everyone was positive about the future, however. On an individual level one participant, at least, reflected on her feeling about the role, and suggested that competence can breed a degree of complacency, leaving her considering a new challenge.

You reach a point where you think well, this is great, I'm quite good at this, and there must be something else. I think the same with my nurse practitioner

in that I have reached a point where I thought this is great, I'm doing my job, I'm meeting the needs of the practice but I'm not really being fulfilled, whereas all through my training and probably the first couple of years I was. (WM)

A more general comment on the trend towards a more autonomous, medical role, driven by the need to substitute for junior doctors was perhaps more telling, and may not support the direction that the nurse practitioner role appears to be taking.

I'm not sure this is what we as a profession want, and I'm not sure that's what's best for patients. (ND)

7.7 Summary

The structural analysis provided a rich source of descriptive material exploring the participant nurse practitioners' transition from registered nurse, and their experience of professional autonomy. Within the collated experiences of the participants there is sufficient consensus to reflect on the phenomena, revisit the questions raised by the research, and seek some conclusions. Nurse practitioners appear to believe that they have the potential to work in an autonomous way, within the context of their defined role. However in many cases it is felt to be neither desirable nor possible to work without reference to other health care professionals, many of whom are acknowledged to have a different skill set from that possessed by the nurse practitioner, and some of whom have much greater knowledge and skill in specific areas of practice. Moreover participants were able to recount numerous barriers and obstructions that frustrate their development, and impact on their opportunity to maximise both their autonomy in practice, and their clinical effectiveness, issues that were seen as complementary by participants.

In exploring the transition from registered nurse to nurse practitioner participants painted a positive view of both the impact that nurse practitioners have had on patient care, and the potential for future role expansion. The development of the nurse practitioner role to date, and any continuing evolution in the future must however be located firmly within nursing; participants were adamant that they occupy an advanced practice nursing role, and indicated that they would be resistive to any reconfiguration of roles that placed them in a more generic role as a substitute for a junior doctor. The success of the nurse practitioner role has only been possible because nursing principles have underpinned nurse practitioner practice, a factor that has both defined the role, and contributed to the high levels of patient satisfaction recounted in the narrative accounts.

The future is positive, although not assured, particularly given the pace of change in health care. Despite this nurse practitioners believe that they are here to stay, and with the right support, backed by complementary legislative, regulatory and policy change, can offer a key contribution to the care of patients and families.

Chapter 8: Interpretation and discussion

8.1 Introduction

The final stage in the data analysis involved revisiting the narratives to seek a new understanding of the world of the nurse practitioner through an interpretation of the collated data. Transcripts were reviewed in the light of the descriptive account, and hidden meaning in metaphor, analogy, and emotive responses were highlighted in order to begin to appropriate the meaning of the phenomena. These highlighted passages were linked together to establish patterns within the texts, and avoid the possibility of what Silverman (2001) described as anecdotalism, the selection of a single telling example of an experience to illustrate a point, ignoring alternative or contradictory examples that might lessen the argument.

These emergent meanings were then reviewed in the light of published literature and in full awareness of the researchers pre-understanding. This process allowed connections to be made between the interpreted meaning of the texts, and the context within which the respondents live and work. This in turn helps to ensure consistency, and begins to explore ways in which new insight into the lived experience of the participants in the study can be consolidated and enhanced, taking into account external evidence.

This interpretive phase was described by Ricoeur (1981) as 'appropriation', a way in which the researcher can seek to gain an understanding of the world of the participant through the explication of

meaning. Understanding cannot be achieved through a simple interpretation; the process of explication incorporates elements of pre-understanding combined with a validated, personal understanding focusing on the narrative account: the meaning of the text, rather than the intention of the narrator. Researchers use their own world view, including their pre-understanding, in their engagement with the text, in order to uncover hidden meaning, including the unconscious motivation revealed in language. This involved revisiting the interview transcripts, to formulate an interpreted meaning, which was then considered in the light of the descriptive analysis and published literature, and a new, hermeneutic account of the meaning of the texts was prepared.

8.2 Exercising autonomy

One key theme established during the descriptive analysis of the data was titled 'exercising autonomy'. Here nurse practitioners described their experiences of autonomous practice, celebrating the opportunities afforded by a more autonomous role while at the same time reflecting on the barriers they encounter in a number of aspects of their day to day work. These barriers are diverse, and include the impact of bureaucratic controls on their practice including some of the legal restrictions placed on nurse practitioners, and the significant effect that interprofessional relationships have on complex models of healthcare delivery.

8.2.1 Feelings of pride, self-esteem

Under the broad theme of exercising autonomy the first interpreted consideration to emerge from a reappraisal of the data was the pride that nurse practitioners have in their role. Participants consistently

demonstrate their satisfaction with the nurse practitioner role; on an individual basis they indicate a sense of fulfilment in achieving a status that they see as a significant position for a nurse; on a 'professional' basis they take pride in the net contribution that nurse practitioners make to the overall care of patients, and the achievement of what many believe to be a recognised, respected and responsible position within the health care team. For several participants achieving a status in which they are respected as autonomous professionals, no longer having to defer to others in the day to day exercise of their clinical duties is something to be proud of, at both a personal and a professional level.

This sense of achievement is evident in many of the comments within the narratives. While participants generally maintained a professional attitude within the interview situation, reflecting on experiences without seeking to elaborate or embellish their role within the healthcare team, there was sufficient indication of an underlying satisfaction with their position, particularly in relation to the independence afforded to practitioners whose former role, as registered nurses was traditionally subservient to others (Timmins & McCabe 2005). The idea that nurses have not asserted themselves within the health care team is explained by Farrell (2001) as a consequence of the 'dual oppression' of gender and medical domination, however the participants in the study believed that their role allowed them, at least in part, to break free from medical control, exercise their own professional autonomy in the workplace and through their skilled intervention, make a difference to patient care.

....on occasion... I will be the only paediatric provider...so to that point I'm very autonomous. I make all of my own decisions about patient care (CL)

I have my own panel of patients who only come to see me, they don't need to check with anyone else, and I am essentially seeing all those patients on my own. They are my own caseload, they don't see another doctor or another nurse practitioner (RM)

There is increasing evidence that nurse practitioners enjoy high levels of job satisfaction, and that much of this is derived from the sense of achievement inherent in progressing to an advanced practice role, and the key characteristics that define the parameters of their working lives. Kacel, Miller & Norris (2005) suggest that achievement, recognition, responsibility, and advancement are the key motivators contributing to job satisfaction, while Kleinpell (1997) lists autonomy, time spent in direct patient care, challenge, and sense of accomplishment as the primary indicators. This listing is similar to the conclusions reached by Misener & Cox (2001), whose work on job satisfaction amongst nurse practitioners was based on a quantitative survey using the Misener Nurse Practitioner Job Satisfaction Scale, an instrument developed specifically for the task. The outcome of their study suggested that nurse practitioners are most satisfied if they can maximise certain key features, which Meisener & Cox suggest are the percentage of time spent in direct patient care, the challenge presented by the workload, the sense of accomplishment derived from the role, the ability to deliver quality care, and ease of access to preceptors. Interestingly studies consistently suggest that it is extrinsic factors that militate against job satisfaction; these include remuneration and opportunities for career advancement (Öhlén & Segesten 1998), and is clearly reflected here in participants' comments regarding their employment; one summed the situation up as 'working as a doctor and being paid as a nurse', while other feel that they have reached a plateau and cannot see any further potential for career development.

Kangas, Kee, & McKee-Waddle (1999) reached a similar conclusion in their survey of nurse practitioners; they too concluded that lack of career opportunities, including the opportunity to participate in research, was a significant frustration for nurse practitioners. They highlighted the positive impact of a supportive working environment with well developed interprofessional collaboration, and noted that patients expressed higher levels of satisfaction with their healthcare in situations where the professionals concerned were themselves experiencing positive job satisfaction. Job satisfaction also has a positive impact on the commitment and adherence of nurses to key principles, such as respect for others and organisational values, which in turn enhance their relationship with patients and colleagues alike. (Wild, Parsons & Dietz 2006)

The nurse practitioners who participated in the study were here reflecting more on the pride they feel in achieving their status and providing effective care for their patients. There is however a correlation between job satisfaction and individual positive affirmation and enhanced personal identity; Mills & Blaesing (2000) suggested that nurses' satisfaction is associated with a strong sense of professional status and pride. This view is similar to that reached by Öhlén & Segesten (1998), who suggest that professional development is important in promoting self esteem amongst nurses, and that factors such as self awareness, professional knowledge and confidence in one's own abilities are characteristics that are often more evident in nurses who achieve significant professional development. Nurse practitioners typically fit this

category, and the pride they feel in their achievements derives from personal confidence and role satisfaction.

I started doing my clinical rotation, and said, wow, this is fantastic, the best of both worlds, the nurse thing, the patients and the teaching, and all incorporated into the one... So, these are the types of patients that I am seeing, this is one that I need to refer, this is one I need to consult, these are the references that I will use, this is the treatment that I will use. So as far as practice itself, we are pretty much autonomous. (FK)

Participants were consistently keen to indicate the scope of their practice, and to provide examples of the range of activities that they engage in on a regular basis. The majority recounted experiences that they considered to be beyond the scope of practice of the registered nurse; these included individual consultations, referrals, diagnostic tests and prescribing. While on the surface these would appear to be merely a list of clinical activities performed by nurse practitioners there was a clear satisfaction in the way that these have been internalised within their day to day working lives.

(Patients) will phone up here, I need to see a doctor, and the receptionist or the PAs will say you can see one, but is it something the (nurse practitioner) can deal with. (CD)

To be sharing an office with one of the consultants, and to be quite high profile and demonstrating the whole time this ability to communicate with patients. We're actually running a specialist asthma clinic together now, which is great (FN)

This final comment is interesting because it not only reflects the participants satisfaction in having achieved what she perceives to be significant status in the delivery of specialist care to patients with asthma, it also begins to acknowledge the possibility of an equal partnership between nurse practitioner and doctor. To be sharing an office is seen as worthy of reporting, over and above the sharing of a clinic, which

perhaps reflects the nurses traditional view of the power relationship between themselves and the medical profession.

8.2.2 Evidence of doubt regarding potential for autonomy

This pride in the achievements of nurse practitioners is however tempered by an underlying feeling that nurse practitioners are not able to exercise their autonomy to the full. These doubts over the potential for a fully autonomous nurse practitioner role are evident in a number of different contributions offered by the participants in the study, and arise from disparate observations on experiences in practice. Controlling influences arising from statutory controls and organisational restrictions account for some of these perceived limitations, but a more covert area of misgiving is evident in the ongoing tendency of nurse practitioners to defer to others, particularly doctors, in their reflections on working practices.

8.2.3 Controlling influences, legal restrictions, and prescribing

Participants discussed the legal restrictions on their practice at length, but much of the narrative was non-specific, and merely hinted at statutory restrictions on their ability to practice in a fully autonomous manner. There are a number of statutory restrictions on nurse practitioners' clinical practice. Clearly these vary from country to country, but in most cases they are viewed by nurse practitioners as bureaucratic mechanisms that interfere with effective care delivery. All relate in some way to the scope of practice, which is more closely defined within the US than it is in the UK, in certain states at least, and it appears that prescriptive authority

is the biggest single issue arising out of statutory restrictions on the scope of practice.

I'm an extended nurse prescriber, but there are things we can't prescribe (WM)

There's still some kind of restrictions on what you prescribe for, and who you prescribe for even though it might be the same drug, which is a frustration (CD)

Independent prescribing by nurses working in advanced practice has been promoted as an integral part of the role (Latter et al 2007), and certainly the participants in the study viewed it as a requirement if their practice is to be regarded as truly autonomous. This is in accord with some of the early deliberations of the Nursing & Midwifery Council on the nature of advanced practice (NMC 2005); they also identified the ability to prescribe as a defining feature of advanced nursing practice, although as has been highlighted earlier in this study the profession is still awaiting a statutory definition of advanced nursing practice.

Nurse prescribing has been an area of rapid development since the government first promoted the idea in earnest as part of the Cumberledge Report in the mid 1980s (Department of Health and Social Security 1986). The primary reason for ongoing and increasing interest in expanding the role of the nurse to include prescriptive authority is cost; the need to maintain clinical standards in the light of ever increasing budgetary demands has fuelled changes in legislation to permit nurse prescribing, and more recently prescribing by other non medical healthcare professionals.

There are however other acknowledged benefits to nurse prescribing beyond the need to control costs. The Crown Report (1989) suggested the

nurse prescribing would lead to improvements in patient care by permitting consistency of professional involvement and promoting better communication within the interprofessional team. Buchan & Calman (2004) further suggest the nurse prescribing permits more effective use of time and resources, and has a positive impact on professional roles. For medical staff the deployment of nurse prescribers helps to reduce demand on the doctor's time, while for nursing the legitimation of prescribing within the nurses' scope of practice enhances the standing of the profession.

Certain nurses, primarily community based staff, have been able to prescribe from a limited formulary which included a range of dressings and appliances since the late 1990s. Since then independent prescribing has been extended to a wider range of practitioners and the range of items available within the independent prescribers' formulary has been significantly enhanced. Government guidelines have specified how independent prescribing should be implemented, and have defined the practitioners for whom independent prescribing is appropriate. Independent prescribers should be practitioners who are 'responsible and accountable for the assessment of patients with undiagnosed and diagnosed conditions and for decisions about the clinical management required, including prescribing' (DoH 2006). This definition is uncannily similar to the Royal College of Nursing definition of a nurse practitioner, with the addition of prescriptive authority, something that nurse practitioners clearly feel is an essential element of their role if they are to maximize their autonomy.

...they are going to allow nurses to prescribe antibiotics at walk-ins, and I just hope that ... well I'm confident that by hell or high water I will be able to prescribe at some point in future (FN)

Questions about the range of drugs that nurse prescribers can prescribe independently have largely been answered through a succession of extensions to the available formulary; from May 2006 qualified nurse prescribers can prescribe the vast majority of licensed medicines, including 'prescription only medicines', the only exclusions being some controlled drugs.

Guidance produced by the Nursing & Midwifery Council (2006) specifies the standards of proficiency required of nurse prescribers. The standards include the ability to undertake a thorough patient assessment, in addition to specific competences relating to the prescription and monitoring of medication. Nurse prescribing should be part of and complement advanced practice, and the more generic preparation for the advance practice roles should include skills in diagnosis and physical examination. Employers are responsible for ensuring that staff who are trained for a prescribing role possess the requisite skills in advanced practice.

Several participants described situations in which they had to secure a doctor's signature, or counter signature, on a prescription written to validate a clinical decision that the nurse practitioner had ostensibly made independently. This has implications for their own self worth, given that the authority to work in a completely autonomous way is still limited by procedural requirements, but one participant was keen to point out it also has implications for patients, because the nurse practitioner is obliged to seek out a doctor in order to complete the

consultation. This has repercussions both for the patient who the nurse practitioner is seeing, and will inevitably interrupt the doctor's working day.

If I'm at the doctors I don't terribly like being interrupted, and you know you like to try and respect that, but come May or whenever it is that we can prescribe everything then that may change, and I may have to look to see more patients in less time (TK)

8.2.4 Organisational structures

Participants also reflected on the way in which organisational structures within the workplace militate against the development of full professional autonomy. In some cases these arise from processes required of nurse practitioners that might be seen as the legacy of their nursing origins; the progressive extension of prescriptive authority for example, has not always been matched by parallel changes in pharmacies' processes to ensure that nurse practitioners prescriptions are dispensed without a request for a doctor's confirmation or counter-signature. Some nurse managers, ignorant of the potential within the nurse practitioner role or indeed the competences achieved during nurse practitioner education, have prevented participants from undertaking the very roles for which they were prepared and employed. While participants acknowledge that as the number of nurse practitioners has grown other disciplines' awareness of nurse practitioners' abilities and responsibilities has also grown, but this does not wholly avert the ongoing feeling amongst participants that their professional autonomy is limited by others perceptions of their potential.

8.2.5 Protocols, guidelines and clinical pathways

If professional autonomy incorporates the freedom to make clinical decisions without reference to others, any practice which is limited by preordained guidance necessarily curtails the autonomy of the individual. The use of protocols in one form or another has become increasingly common in the delivery of care, particularly nursing care, in recent years. It has been suggested (Flynn & Sinclair 2005) that nurses tend to adapt clinical protocols as they see fit; Flynn & Sinclair see this as evidence that nurses place significant importance on their own professional judgement and autonomy. The very fact that someone has seen fit to write a protocol undermines the notion of clinical freedom. It is interesting to note the comments of one participant (LC) who highlighted the fact that creating a protocol for use within an interprofessional team placed an obligation on everyone within the team to follow the agreed protocol in the situation, something that medical practitioners were not used to, and had not considered as applicable to them when the protocols were created.

...if you had sheer protocols that were co-signed then it put the burden on the physician to follow the same protocol for common illnesses or whatever. (LC)

This observation raises an issue addressed by research carried out by Manias & Street (2000), who looked at the use of policies and protocols in practice. They concluded that policies and protocols helped to legitimise nurses' knowledge in the delivery of care to patients, but were largely rejected by doctors who preferred to rely on their personal knowledge and experience to guide their clinical care. The balance between the use of a prescribed response to any given clinical scenario with the aim of ensuring the quality and the consistency of the intervention, and

sanctioning of adequate flexibility to ensure that the complexities of patient care can be managed on an individual basis is at the root of this division.

For nurse practitioners, the regular references to protocols and the frustrations that from time to time they feel when care pathways are predetermined by others, are undermined by the tacit acceptance of the need for consistency, and an apparent agreement with the principle of generating guidelines for practice that are shared across the team.

There's more clearly spelt out guidelines, it's not the whim of the day, and it's not (an) independent decision, it's really a decision in collaboration with the pre-set guidelines. (ND)

While participants' acknowledged that the very existence of a 'recipe' for intervention in any given situation might detract from the quality of clinical care, it was interesting to note that the term 'protocol' appears to have a negative connotations, with several participants commenting on the advent of critical pathways, or guidelines, which appeared to be more acceptable. In terms of their impact on professional autonomy there may be very little difference; indeed the critical pathway might be seen as a euphemism for a protocol. However some participants clearly saw the use of the term guideline as less binding and therefore more respectful of their professional status and autonomy.

There was always controversy, no one really wanted to get into ... cookbook medicine. (In place of protocols we now have) published guidelines that aren't step-by-step protocols, and actually within our prescription authority and scope of practice that has been accepted... now we're seeing critical pathways, which are similar to guidelines or algorithms of care. (LC)

Dilemmas around the use of protocols go beyond the question of whether they are equally binding for every profession, and whether they limit the professional autonomy of the practitioner who is obliged to work to a given protocol. One participant pointed out the potential risks of protocols that had to be formally approved given the speed of change within certain areas of practice. Part of the professional responsibility of the nurse practitioner, in common with other independent and autonomous healthcare workers, is to ensure that their knowledge and skills are up to date. The implications of an outdated protocol are significant, and present a real dilemma for anyone required to follow a course of action has been discredited or revised within the evidence base for practice.

The protocol became a running joke, because no one ever agreed with them, they never could get them signed off, and as we set them up, new meds would come out, new procedures, new policies, and it became, since they were becoming outdated, that we were more concerned about the legal liability of having outdated protocols on the books. (LC)

It appears that clinical guidelines, whether they are called protocols or not, are regarded with some suspicion by nurse practitioners. Participants in the research appeared to recognise both the need for consistency and the limitations imposed by predetermined responses. Reflecting on the earlier observation that nurses use protocols as a way of legitimising clinical action while doctors tend rely on the knowledge and experience gleaned from years of practice, it appears that nurse practitioners are reflecting the view expressed by doctors when considering the impact of protocols and clinical pathways on their own practice. Experience attained in a registered nurse role is an essential prerequisite for a nurse practitioner, and provides a foundation for clinical decision-making; the value added by formal nurse practitioner preparation should permit a

degree of professional autonomy that goes beyond blind adherence to protocols.

For one participant, at least, the requirement to produce protocols was reduced to a 'lip service' response in which the texts that inform nurse practitioners' preparation for practice have been designated as the clinical guidelines governing practice.

But we're supposed to have protocols and guidelines but what we have done is taken textbooks that are designed for primary care practitioners, nurse practitioners and have delegated those as our protocols. (CL)

Another was dismissive about both the use of protocols and their development, suggesting that the writing of a protocol is a straightforward process that could be managed very easily by the practitioners themselves.

Nurse practitioners are perfectly capable of writing the protocols, we have an advanced training, we know how to look things up on the Internet, how to look things up in a text (ND)

In reality healthcare professionals have long accepted that clinical guidelines can make a significant contribution to patient care; the development of evidence based practice has led to a significant increase in the number of research papers disseminating best practice, and the work of bodies such as the National Institute for Clinical Excellence, and the Cochrane library has reinforced the need for practitioners to ensure that the care they offer to patients is of the highest quality. This might on the surface be seen as presenting a dilemma for practitioners; on the one hand the development of practice guidelines and critical pathways have been viewed as a significant contributory factors in developing the professional status of nursing, however others have criticised this

developing trend in which protocols are given greater importance than the 'clinical and relational' knowledge that is acquired through reflective practice (Smithbattle & Diekemper 2001).

8.2.6 External factors limiting the potential for autonomous practice.

The sense that external controls are undermining the further development of nurse practitioners' professional autonomy is borne out by several studies. Management structures and governance processes are highlighted as significant factors (Mraryan 2004; Norris & Melby 2006), with 'nominal' autonomy being effectively limited by guidelines and supervisory processes.

Increasing autonomy is one of the factors cited by Miller (2007) as contributing to the increasing number of malpractice claims made against nurse practitioners in the US; other identified factors are closely related to this primary cause, and include wider independent prescriptive authority and decreasing supervision by medical practitioners. The claims made by nurse practitioners that they are hampered in developing their autonomy by archaic supervisory requirements appear to have some justification, but conversely the very bureaucratic processes at the heart of the issue might be protecting them from direct criticism and the threat of litigation. Nurse practitioners have been forced to revise their professional indemnity insurance arrangements in recent years, and if the US experience is repeated in the UK, nurse practitioners may need to reassess their practice, paying particular attention to the management of risk.

Several participants in the study recognised the link between autonomy, accountability and liability, and appeared to understand that further development of the autonomous role of the nurse practitioner brings new considerations in relation to civil law and professional standards. It is interesting that this was not, however, a common theme within the texts, despite participants' extensive discussion of professional autonomy, clinical authority (including prescribing rights), and role substitution. Those that did touch on legal implications were almost exclusively US based nurse practitioners who had well defined working practices, and had received advice, mostly solicited but on at least one occasion unsolicited, about liability and indemnity. Given that the UK government has recently announced that it intends to introduce compulsory indemnity cover as a condition of registration for each health profession, this issue may be of greater interest to nurse practitioners in the future.

A second recent phenomenon contributing to the potential for professional autonomy relates to the 'surveillance' of practice in order to monitor progress against targets within the revised primary care contracts. This is impacting on nurses, including nurse practitioners, and doctors alike, but it is the nurse practitioners who feel that their autonomy is being eroded by the controlling impact of performance monitoring (McDonald et al 2007).

8.2.7 Feelings of inferiority, deference to others

A more interesting observation concerns the consistent underlying feeling that nurse practitioners are inclined to defer to the authority of others who are perceived as more senior, or more authoritative within the traditional hierarchy of professional relationships within health care.

Participants in the study were keen to explore the meaning of professional autonomy in the context of their clinical practice, and the degree of autonomy enjoyed by nurse practitioners is one of the key messages of the descriptive analysis explored earlier. However within the celebratory reporting of the significant autonomy inherent in the nurse practitioner role two hidden messages are evident from a more detailed examination of the texts.

The first is that nurse practitioners are seen by themselves and by others as having reached a pinnacle within nursing. For this reason their reflections on the experience of autonomy may not be readily comparable with theoretical accounts of what it is to be an autonomous professional, or with the experiences of practitioners from other professional groups within healthcare. Nurse practitioners have all previously worked as registered nurses, a role that is subject to a range of factors that militate against the development of autonomy. These come both from within nursing, where hierarchical structures have limited the potential for individual decision-making, and from outside nursing, in that other disciplines, notably medicine, have historically had a significant controlling influence over the work of nurses.

This does not in any way negate the validity of the nurse practitioners' reflections on their role, but does place in context some of the comments regarding limitations on their freedom to practice in accordance with their preparation. While the participants were confident that they had achieved significant autonomy within their nurse practitioner role their

reported clinical freedom might be best considered in comparison with that available in their former roles.

Participants did describe a number of limitations to their professional autonomy, the majority deriving from interprofessional relationships and bureaucratic structures. However within the texts there is evidence that in some contexts nurse practitioners do see themselves as subservient to others within the healthcare system, predominantly the medical colleagues who, despite all the changes in professional roles and interprofessional practice in recent years, still retain a degree of authority over the nurse practitioner.

The impression that nurse practitioners have some doubt about their autonomous role within practice is not a conclusion derived entirely from participants' explicit experiences of workplace systems, even though these systems do frequently require medical supervision of aspects of the nurse practitioner role. Nurse practitioners' doubts over their autonomy are also borne out by the implicit references to seniority, hierarchy and other disciplines' perceived superior knowledge and skill contained within the texts. This inference should be seen in context; nurse practitioners believe that in certain circumstances the care that they offer represents the very best care available to the patient, but within the interprofessional team they appear to find it difficult to view themselves as having equal standing with medical practitioners. Even where they do feel they have equal status and authority they believe that the rest of the world fails to regard them in that way.

For some participants the idea of complete autonomy was unrealistic; indeed one participant stated that she could not see why a nurse practitioner would need to be 'completely autonomous'. This raises several questions: what does 'completely autonomous' mean, and which if any health care practitioners expect complete autonomy in their practice. The participant concerned went on to explain that she did not need to be completely autonomous' in her practice because she worked in a hospital and there were always doctors and other healthcare professionals on duty. The implied message is that it may be important for other people to be able to exercise autonomy but for nurse practitioners this was not always necessary, at least in the secondary care environment. Again the implication is that nurse practitioners (limited) autonomy is supportive of their developing status, but cannot be compared to the professional freedom exercised in medical practice.

I don't think we could ever be completely autonomous, no. I don't think you would want to be. I think it is a bit unrealistic to think that you are, why should you need to be, really. (LC)

Another interesting comment came from a participant who in describing her own experience of professional autonomy suggested that the physicians she works with expect nurse practitioners to be autonomous, but added the rider that they should always 'ask if they need help!' She had previously reflected on a somewhat patronising acceptance of the autonomous' role of the nurse practitioner by physicians within her practice.

The physicians who work with nurse practitioners expect them to be autonomous and responsible, and ask if they need help. (CL)

The reported experiences of participants' everyday relationships with medical colleagues contain a number of references that provide insight into the nature of the perceived autonomy of nurse practitioners. The recognition that doctors do from time to time use nurse practitioners to fill gaps in the service clearly has an impact on their self esteem, and appears to hint at inherent doubts over their autonomous role. Nurse practitioners would like to be seen as competent in their own right, and not merely more available to see patients than the doctors and 'safe' – that is meeting a minimum requirement in terms of competence.

The doctors, if they have been on call at night they have actually said to the person, look we'll see if you can see (the nurse practitioner) tomorrow morning. I think mainly because they know that I've got appointments and they know that I'm safe, (WM)

I hadn't realised how much I relied on probably subconsciously being able to say to the patients, never mind, go and see the doctor (CD)

Even in the primary care field, where the majority of participants seem to indicate that the potential for nurse practitioners to adopt an autonomous role is at its highest there are still relationship issues that militate against the full exercise of autonomy, and evidence that nurse practitioners still see themselves within a hierarchy that limits their true autonomy.

I did as much as I could and then got the GP to see her. I said to him afterwards what did you do, and he said I gave her (indistinct) and gave her an injection. I said did you send her home, and he said yes, but I did say come back if it didn't get better. I said, oh well, that was your prerogative, I wasn't prepared to do that. (TK)

Some participants recognise that there are gaps in the knowledge base and that their professional duty to the patient requires them to seek advice before proceeding, or refer the patient to another practitioner. In reality this means consulting a (supervising) doctor, which may not in

itself be contrary to the principles of autonomous' practice to, but does detract from independent working.

I work with a cardiologist who's wonderful, she is a great teacher and mentor also, but of course because I'm not a cardiologist. I would never ever feel comfortable seeing patients on my own. So they're really done in consultation with her, but I get all the histories, and I do physicals on those patients, and do a lot of teaching. And that for me is a nice diversion, so even though it is not as autonomous (RM)

...(it) is sometimes more important, to recognise oh no, nothing in my training has prepared me for this (ND)

We all see patients, you know but we didn't go to medical school, we don't have the huge base of knowledge that they have. Do we necessarily need that to be a nurse practitioner? Probably not (RM)

There was an interesting interplay at work in participants' reflection on their knowledge base. Participants recognise that there are certain circumstances in which medical knowledge acquired through a conventional medical training is vitally important in providing high quality care to patients. This is thought by some participants to detract from their potential for autonomy in the nurse practitioner role, because they lack the requisite knowledge to manage these patients independently, and this in turn reinforces the idea that nurse practitioners inevitably defer to doctors within the interprofessional team in certain given situations. However this must be seen in context; for many participants the knowledge base required of doctors is not an essential component of their nurse practitioner role. Their celebration of the perceived success of the nurse practitioner role tends to focus on the development and refinement of essential nursing skills, and the progression to an advanced practice role within nursing. This is something the nurse practitioners appear keen to promote. Whether they

recognise the persistent power relationships within interprofessional teams, perpetuated in part by variations in the depth and scope of the knowledge and skills brought to the practice arena by different professional groups is debatable. The nature of the power relationship between medicine and nursing was discussed by several participants in relation to skill mix, and is discussed in more detail below.

8.3 Nurse practitioner skills

Another key area identified during the descriptive phase of the structural analysis concerned nurse practitioners' skills, and the complex relationship between the acknowledged role of the nurse practitioner and the origins of the role within nursing. Every nurse practitioner inevitably began their career as a registered nurse, and the role socialisation experienced by nurses has a significant impact on the knowledge, skills and values inherent to the nurse practitioner role.

8.3.1 Promoting the nurse practitioner role

The fact that the origins of the nurse practitioner role are entirely within nursing appears to have an impact on nurse practitioners perceived status within the health care team, particularly in respect of their professional autonomy, and their relationship with medical colleagues. This issue has been explored elsewhere. However the very history of the nursing professions' relationship with medicine has perhaps influenced nurse practitioners to seek to promote their particular status within nursing, with a view to ensuring public recognition and professional acceptance. Nurse practitioners see themselves as a new breed of professional who can make a significant contribution to patient care in a

way that nurses have not previously been prepared or authorised to do. This is a significant factor in creating the pride that nurse practitioners demonstrate in respect of their role and status, an issue that is explored above, but also gives rise to the perceived need among nurse practitioners to promote their role at every opportunity, something that is in keeping with the fourth domain of the Royal College of Nursing competencies for nurse practitioners (RCN 2005).

This desire for professional recognition is evident in many of the comments made by the participants in the study, who in reflecting on their professional autonomy were consistently keen to include some comments on both their scope of practice and their effectiveness.

I have the ability to refer on, and I see that as part of my autonomy: people consult me with a problem, and I see this very much in a collaborative way. Autonomy for me isn't just me being able to fix it, it's having the ability to utilise other services, and be able to refer. There's a lot of scepticism at the moment about nurses undertaking that direct referral pattern (FN)

Nurse practitioners recognise that they are in a sense pioneers in a new role, and many described experiences in which others failed to recognise their potential because they were unfamiliar with the concept of a nurse practitioner. This sense of adventure which is evident in many of the narratives gives rise to a noteworthy underlying aspect of participants' experience, the need, or desire, to be respected as autonomous practitioners occupying a different role from that of the registered nurse.

Within the trust where there weren't any nurse practitioners, and it was a real uphill struggle trying to convince people that this was safe practice and that it was within my job description and that the Trust knew about it and all those things that go with your accountability (WM)

Elston & Holloway (2001) point to the impact that power, status and gender can have on the development of effective interprofessional working; Nolan's (1995) view of interprofessional working as the 'blurring' of professional boundaries, predicated on 'trust, tolerance and a willingness to share responsibility' does not always conform with the predominant view of medical practitioners, who more commonly see the interprofessional team as adjuncts to medicine, particularly in primary care (Dean et al 2004), or see care provided by anyone other than a medical practitioner as being of questionable value or doubtful quality. Cooper & Stoflet (2004) make this clear in their discussion of the maintenance of quality in a multidisciplinary workforce; that medical care is of high quality is taken as read, and their concern is how the quality of other diverse 'non physician clinicians' can be assured.

Nurse practitioners' championing of a holistic approach to care focusing on prevention, promotion and education as adjuncts to the management of ill health has been questioned by a number of authors (Fagin and Garelick 2004), and there have been suggestions (Radcliffe 2000) that nurses' desire to mimic doctors has led to nurses reinventing themselves as nurse practitioners in order to elevate the status of their profession. While nurse practitioners would not deny their desire for greater recognition most would dispute the suggestion that they are seeking to mimic doctors in the development of their role. The majority of participants in the study were adamant that they had no desire to become 'doctors', and believed passionately in the potential of their advanced practice nursing role.

I think I always feel like a nurse because I never wanted to be a doctor (RM)

This often expressed conviction that nursing is at the centre of the nurse practitioner role is key to understanding the transition from nurse to nurse practitioner, and indeed the movement of certain functions from medical practitioner to nurse practitioner. The question of skill mix within the NHS is central to a number of changes that have taken place in the delivery of healthcare in recent years, and the question of role substitution in a number of areas, including the interchange between doctors and advance practice nurses is important in understanding the development of the nurse practitioner role.

Skill mix has been a significant issue in the organisation and delivery of health care for many years, and strategic planning within the NHS has both driven and conversely responded to the changing skill mix within the healthcare workforce (Sibbald et al 2004). Traditional definitions of role substitution assume the replacement of a service provided by one group, for example doctors, by another group, such as nurse practitioners, and further assume that the 'substitute' service is consistent in approach and quality. This is different from complementary provision, in which one discipline, such as nursing works alongside another, such as medicine to provide a more comprehensive service to patients. Participants in the study were keen to promote the nurse practitioner role as different again, providing an approach to patient care that is not designed to be complementary to medial care, and at the same time does not substitute for medical care in a traditional sense, because it is based on a different philosophical approach and a develops a broader relationship with the patient and the family. Participants were confident that they could work effectively in a collaborative manner with other disciplines, including medicine, and were convinced that their approach

to patient care offered a high quality service, in many cases equal or better than that offered by others when evaluated in terms of patient outcome, overall cost and satisfaction measures.

While nurse practitioners see the development of their role as having positive benefits for patients, others have been less willing to accept nurse practitioners without some clarification of responsibilities and reassurances about professional boundaries. Participants were generally keen to extol the virtues of the nurse practitioner, pointing to specific attributes that generate alternative or additional opportunities for patients as they engage with the health care system. Participants felt, however, that other disciplines, notably doctors were more reluctant to embrace the nurse practitioner without some qualification of role boundaries, and have drawn into question nurse practitioners skills and experience, as well as invoking their own understanding of their ultimate responsibility for certain aspects of patient care.

> *The physicians looked at our stepping in on their territory, they were concerned about that. They felt threatened (TW)*

> *They double check everything which may be arrogance on my part, you know, well, have you done this and have you done this (CD)*

> *Every now and then you do hear the odd cynical doctor who says ... doctors go to medical school for six years, why do you think you can come out and do all the same things that we do (WH)*

8.3.2 Power and relationships

This dismissive attitude towards the knowledge and skills of nurse practitioners was not something that all participants had experienced in quite such a direct way, however within the narratives there was a

general impression of a continuing power conflict between nurse practitioners moving into new roles and medical practitioners who had traditionally carried out many of the functions now being undertaken by nurse practitioners within a reorganised service. The complex issues that have established and sustained medical dominance within healthcare have been touched on elsewhere, but the experience of nurse practitioners suggests that medical attitudes are among the most intractable among the interprofessional team, and that it may take more than the challenges presented by the first generation of advance practice nurses to alter entrenched attitudes that are still a part of the socialised role of the doctor.

I do think there still is that socialised, general power conflict between nurse practitioners (LC)

This power conflict, in which questions of authority and accountability lead some medical practitioners to believe that they have an ongoing responsibility to manage the interprofessional team, and medical hegemony demands that other practitioners work within a system where the dominant processes and language have been shaped by medical practice militates against the establishment of fully autonomous alternatives to the medical model. That said, a number of participants believe that they are in a position to challenge medical supremacy. This belief emerges from two distinct lines of reasoning; nurse practitioners have established a niche amongst underserved populations, particularly in the US, a fact that places the nurse practitioner in the dominant position and leaves medicine in the unusual position of challenging another discipline for a market share.

We as nurse practitioners have gained a more legitimate, credible role, we've become ... and primary care has become the national goal versus specialisation, then we're back in that competitive mode with physicians that we weren't in for a long period of time. (LC)

More importantly perhaps nurse practitioners believe that they have an effective alternative to medical care, an alternative that can provide a high quality service to a significant number of patients in both primary and secondary care. Participants were very keen to establish through their critical reflection on their role and their experiences of working with patients and families the essential elements of their practice. These essential elements combine the competencies required for practice with the intrinsic philosophical underpinning based on holism, education and family engagement.

8.3.3 Holistic care, better care

One striking message emerging from the narratives was the confidence demonstrated by participants that they are able to provide an alternative approach to that traditionally offered by doctors, and that this more holistic approach was of potential benefit to a significant proportion of patients.

I think from a nurse practitioners point of view they probably get more of a relationship, more of an equal relationship. And that we do take some time to build that relationship (CL)

...helping them to understand how to be responsible for their own health care, to be responsible for that for the rest of their lives, preventatively identify risks, to keep themselves healthier and promote their health, as well as deal with their illnesses (TW)

...this ability actually to perform a full holistic nursing health assessment on somebody with an undifferentiated problem, and to actually form a working diagnosis and offer treatment (FN)

On the surface the competencies required of a nurse practitioner appear to equip the nurse practitioner to work in a very similar way to a medical practitioner, particularly in primary care. The Royal College of Nursing (RCN 1996, 2002) include in their definition of the nurse practitioner role several criteria that would apply equally to the primary care role long established for doctors: the assessment of people with undifferentiated and undiagnosed health problems, autonomy in identifying problems and taking clinical decisions, the power to admit and discharge patients, and the right to refer patients to appropriate services. However the RCN also highlight in their definition the use of advanced nursing skills, including interpersonal skills and skills in health promotion in the delivery of care to patients, and it is this focus on nursing skills that participants are keen to draw attention to, and believe provide the foundation of the enhanced service that they are able to offer to patients. It is acknowledged that the nursing focus will inevitably give rise to some variation in the processes associated with assessment and, on occasions, the clinical decisions made in response to a diagnosis.

The rapid progress towards full prescriptive authority for nurse practitioners has helped to ensure that a full range of interventions are possible, but most participants still see their approach as different to that of doctors despite having increasing opportunities to work in a very similar way to their medical colleagues. Prescriptive authority appears to be important to nurse practitioners in part because it helps to establish the credibility of their role as primary providers of care, but participants believe that it will not in itself produce a change in the underlying philosophical principles upon which nurse practitioners' care is predicated.

I don't think we want to medicalise what the nurse does, we want to retain our nursing status (CL)

I think I have borrowed from both disciplines what I thought were the strengths and tried to integrate it in a way that makes sense (ND)

The theoretical or philosophical approach adopted by nurse practitioners, based on human science and holistic approaches to patient care reflects their background in the caring, nurturing world of nursing, a world dominated by feminine stereotypes and feminist responses. Participants did not explicitly discuss gender differences, but the relationship between nurse practitioners and doctors does perpetuate some aspects of the old order, and in some narratives the experience of being 'watched over' by medical colleagues is described in a way that has more to do with concern for the nurse practitioner as vulnerable junior member of staff than any accepted process of clinical supervision.

Wuest (1994) has suggested that patriarchal oppression in society is mirrored in the relationship between the male dominated medical profession and nursing, and it is interesting that the relatively few male participants in the study recounted similar experiences to their nurse practitioner colleagues in respect of their relationships with doctors. This is in keeping with the work of Alliot (2006), who looked at gender differences and relationships between men and women working in health care roles, and concluded that the power differential is based more on the professional background of the people concerned that their gender; female doctors tended to think and behave like doctors, while male nurses conformed to a nursing standard. While this may be a generalisation it is interesting to consider whether nurse practitioners, who appear keen to stress the centrality of nursing within their role,

perpetuate the status quo through their very adherence to their professional roots.

Further to this observation several participants commented favourably on the abilities of their medical colleagues in developing therapeutic relationships with patients; these were seen as skills that were not part of the core of medical practice, and one participant suggested that the development of advanced communication skills, including empathy, allows doctors to practice in a way which is much more similar to the approach that is integral to nurse practitioners as a result of their background, training and philosophical values.

> *I tease them sometimes, I say 'you guys were nurses in your past life', because they treat people with the same kind of courtesy, but I think that I spend maybe more time trying to talk to people about how your disease works, why are you taking this medicine. (ND)*

The recognition that doctors can practice within the principles that are central to the world of the nurse practitioner is here qualified by the assertion that the participant is still able to spend more time with the patient than the doctor might in explaining the illness and the clinical response.

> *There are some doctors that I work with who also see families the same exact way. They'd make great nurses - as doctors. Then there are other doctors who aren't as good at that, aren't as good with communication, with teaching. (RM)*

One other implicit observation reaffirms the nature of nurse practitioners clinical engagement, and highlights another potential difference between the nurse practitioner and the medical practitioner. The focus on the person, rather than an identified condition, leads the nurse practitioner to

regard every presenting problem as having a significant implication for the patient; if it is worth a patient making the effort to see a healthcare professional then their condition should not be ignored or trivialised. Respecting people is seen as important, as a precursor to any more focused clinical assessment and intervention.

Sometimes GPs have sat in with me, and you know, one of them has said, do you know I've really got that you really listen to people, you really respect them, and it doesn't matter if they come in with an ingrowing toenail, or you know, headaches for five days. It's still a very real problem to that person (FN)

8.3.4 Implementing care: knowledge and skills for practice

Nurse practitioners were willing to acknowledge the potential implication of the knowledge gap between themselves and medical practitioners in a number of areas, deferring to doctors' specific knowledge in areas such as anatomy and physiology in areas of diagnostics and specialist prescribing. However they were also critical of medical colleagues, particularly junior doctors who were perceived as lacking experience in patient care, something that nurse practitioners felt they had in abundance because of their long period of practice in a registered nurse role.

One participant summarised the feelings of many, in recounting her experience of working with junior doctors in a secondary care setting. The observation that junior doctors are generally engaged in specific practice areas for a limited period, typically six months, as part of a training rotation, is the source of some resentment among specialist nurses with many years of experience. This is compounded by the supervisory relationship that consultants have with junior doctors, leaving many nurse practitioners feeling marginalised within their own

area of specialist practice, and doubting the abilities of the (junior) medical staff who are often regarded, by patients at least, as above them in the professional hierarchy.

> *If I just take what I actually do personally the junior doctors rotate on a three to six monthly basis, they are in training, they are learning. I've been in the field of practice for ten, fifteen years and I would say I have got a lot more knowledge about the patients (WM)*

Others criticise doctors for failing to focus attention on aspects of care that are important to the patients. One participant recounted her experience in relation to asthma care. She recognised the vital importance of a correct clinical decision regarding medication, something that could be achieved by the doctor or the nurse practitioner. However she went on to describe her additional input, planned to ensure that the patient understood the difference between her inhalers, and how best to use them. This is particularly important in asthma care, where self management of medication is the norm. The nurse practitioner was critical of medical colleagues' reluctance to take time to provide additional support, and saw this as another example of how nurse practitioners are regarded as supplementary to the doctor, undertaking tasks that are lower level, or more time consuming. This is the cause of some underlying resentment and is evident in a number of narratives.

> *Like this woman with her inhalers, I went over this one is for the emergency, this one is to help smooth things out in your lungs. I'm sure that they (the doctors) mention it but I don't think that they really approach it from a teaching perspective. I would say OK, what does this do, what does that do, no no no, let's go over that one more time. I think I have more of a focus on teaching patients, but I think that came from nursing (ND)*

Some were more palpable in their resentment, based on the conviction that not every medical practitioner is necessarily providing a high quality

service, and the value added by a holistic approach might be preferable to a traditional medical approach to care

> ....you don't need to go to medical school to be a good primary care provider, and that's true. I think that in some ways I'm better at providing care than some of the doctors that I work with, because I've seen their practice, I've read their notes. I'm still looking at the whole picture, not just parts, not just the intestines, not just the skin. I'm really looking at the whole family (RM)

8.3.5 Reflections on the effectiveness of the nurse practitioner role

Participants' confidence in the contribution that they make, and their value to the healthcare team, is backed in research literature. Since the 1970s there have been a significant number of research studies that demonstrate the effectiveness of nurse practitioners; early studies tended to be individual reports detailing the deployment of nurse practitioners in specific situations, typically in primary care. More recent studies have confirmed the effectiveness of nurse practitioners in a range of situations and working with a variety of patients and families.

Considine et al (2006), in their study of nurse practitioners in emergency care concluded that nurse practitioners provide effective care for specific patient groups, but that the role could be extended if changes to the legal limitations on nurse practitioners' scope of practice were relaxed, allowing them greater independence in the overall management of care. Nurse practitioners were seen as having significant potential in managing increasing demands on services, but some observers (Haynor et al 2004) have cautioned against reducing what is essentially a nursing role to a task oriented response to specific isolated care needs. This reflects the narratives provided by participants, who saw medical practice as

predominantly an 'illness response' based on tasks, and less integrated than the interventions typically offered by nurse practitioners.

Studies designed to compare the work of nurse practitioners with that of medical practitioners have suggested that nurse practitioners provide a comparable standard of care in areas such as diagnostic accuracy and clinical outcome (Horrocks et al 2002), but that nurse practitioners are evaluated more favourably than doctors in areas such as patient satisfaction, due to the high quality of the patient education provided by nurse practitioners, and their ability to communicate effectively with patients and families (Bryant et al 2004). These outcomes relating to communication and education are echoed in research carried out in different countries, and have considered a number of specific areas where nurse practitioners and other advanced practice nurses are deployed, for example in primary care (Kinnersley et al 2000), in critical care (Ball & Cox 2003), in surgery (Basnyat et al 2002), in learning disabilities (Jones et al 2007), in cardiac care (Perry & Bennett 2006), in the care of older people (Allen & Fabri 2005), and in mental health (Wortans et al 2006).

Woods (2006) offers a similar conclusion in her study of nurse practitioners in paediatric care, but suggests that while neonatal nurse practitioners perform to a safe, acceptable standard they may not always achieve the same level of clinical care that is achieved by medical colleagues. This is not an empirical finding, but a reflection on how difficult it is to ascertain the relative contribution of different disciplines in situations where several practitioners are involved in care, as is invariably the case in neonatal care. This is perhaps a more pertinent observation in relation to secondary care than primary care, because of

the nature of care delivery in in-patient settings, where practitioners rarely work in isolation, and supervisory relationships are well defined. Weingart et al (2002) in their study of differences between doctors and nurses clinical judgements in secondary care settings, make a similar point regarding the problems inherent in evaluating individual contributions to team working. They also highlight the retrospective nature of the majority of evaluative studies, where there is a tendency to locate evidence that is collected retrospectively within conventional structures, such as established inter and intra-professional hierarchies.

Some studies, such as Marsh and Dawes (1995) confirm the effectiveness of nurse practitioners in managing the vast majority of patients (in their study nurse practitioners managed 85% of the total caseload) within primary care. However Marsh & Dawes state that the volume of care provided by nurse practitioners has 'freed the doctor to see patients with more serious problems'. This could be interpreted as a product of effective teamwork and the appropriate use of the available resource, but might at the same time be construed as confirmation that there are material differences between the care provided by nurse practitioners and medical practitioners, and that doctors will always take charge of the more complex cases. This tallies with the comments of one participant, who referred to the nurse practitioner caseload in her practice as 'the trivia', thus perpetuating a hierarchy that is incompatible with the notion of full professional autonomy for nurse practitioners, but is perhaps understandable and acceptable in the context of high quality care for differentiated patients. Participants were generally respecting of medical colleagues abilities in specific situations, and recognised that there are always circumstances in which nurse practitioners cannot provide the

requisite intervention. This view, however cannot be generalised to include every patient care episode, and for this reason participants were constantly seeking ways in which the high quality care provided by nurse practitioners could be brought to wider attention, and consolidated in the eyes of colleagues, patients and the public at large.

8.3.6 Collaborative working - nurse practitioners' relationship with other disciplines

The feeling that nurse practitioners still need to convince a wide range of colleagues of their worth was a consistent theme, and behind the narrative descriptions of nurse practitioners' professional relationships with a variety of disciplines lies some frustration over the way in which they are regarded. Several discussed problems with pharmacists arising from increasing prescriptive authority, which participants believe arose in part because pharmacists are unconvinced by the quality of nurse practitioners' knowledge of pharmacology, and the underlying feeling that pharmacists themselves believe they would be safer and more effective prescribers than nurses.

When we first got prescriptive authority that some of the nurse practitioners had difficulty with pharmacists (CL)

Since May 2006 pharmacists have been eligible to undertake the same range and level of independent and supplementary prescribing as nurses, provided they have completed an accredited programme of preparation (DoH 2006). Participants were ambivalent about this development, but did see some resentment among pharmacists who were used to working exclusively with doctors, and were felt to be over inclined to challenge, question or ignore nurses' prescribing decisions. Grindrod et al (2006), writing from the pharmacists' perspective, were concerned that

pharmacists' contribution to prescribing activity among other health care professionals has little impact, and that advice offered by pharmacists has as much to do with cost containment as clinical effectiveness. This tallies with participants' experience of pharmacists' perceived equivocal attitude to nurse practitioners in relation to prescribing.

Another common experience amongst participants was the experience of resentment by registered nurses. Participants in the study saw their nursing background as the single most important factor in the formulation of their role, and most recognised the need to work collaboratively across disciplines. This clearly included nursing, where most participants had not envisaged that there might be difficulties in establishing a productive working relationship, and found the experience of conflict both uncomfortable and unexpected.

For many nurse practitioners, their own pride in achieving an advanced practice role, with the attendant respect, responsibility and autonomy, to say nothing of quantifiable esteem measures such as salary, provide a model for other nurses to follow. Participants see their status as both an indication of what the nursing profession has achieved and a goal for all nurses with career aspirations, so were surprised to discover some reluctance on the part of the wider nursing profession to celebrate their achievements, or on occasions accept their judgements.

I know nurses were uncomfortable, and didn't want to take orders from nurse practitioners (CL)

I don't necessarily see that my relationship with my nursing colleagues has changed. I worked really hard to make sure that it didn't. (MU)

Participants variously described registered nurses who felt uncomfortable with the addition of a nurse practitioner to their team. This is perhaps a product of nurses' traditional working patterns, in which the chain of command is very clear, at least within nursing. Nurse practitioners do not fit precisely into a nursing hierarchy, and are therefore regarded as sitting outside the core nursing team, but they remain sufficiently close to have an impact on nursing practice. This potential confusion appears to underpin registered nurses suspicion, a feeling that is compounded by the perception that nurse practitioners are striving to distance themselves from nursing practice by adopting an increasing number of roles that were previously the province of the (junior) doctor. Nurse practitioners are themselves clear that this transition provides an opportunity to adopt new practices, underpinned by a nursing philosophy, rather than replicating the work of doctors. Registered nurse colleagues, however are thought by participants to have misinterpreted this, leading to what is seen by nurse practitioners as misguided antipathy.

This view is reflected in the literature; Leonard (1999) speaks of 'conflict and disharmony in the workplace' as a consequence of the introduction of advanced practice roles within nursing, citing registered nurses' fears that an increase in responsibility inevitably means a decrease in direct patient care, the implication being that those remaining in roles that have not been subject to expansion will be left with increased workloads. Van Offenbeeg & Knip (2004) highlight the fragmentation that can occur as the interprofessional team becomes more diverse, and the need to manage the complex interdependencies generated by 'augmented differentiation'. Registered nurses report that part of their job satisfaction

derives from what they consider to be 'high level' tasks, and worry that nurse practitioners will take these on as part of their core competencies, leaving registered nurses responsible for the routine work that no-one else wants to do.

Participants reported this view, but dismissed it as mistaken; they did however recognise the need to contend with the potential implications of disharmonious relationships, particularly when these arise with their peers. Nurse practitioners contend that the development of their role has allowed registered nurses to work to their own role competencies, something that participants clearly believe to be true, but at the same time realise that registered nurses do not necessarily recognise for themselves.

I think if anything the excitement is that the advanced practice role has facilitated registered nurses in being able to do more of what they were educated to do (TW)

One or two participants felt some responsibility for the nursing staff in their clinical area, despite their explicit wish to establish themselves as 'new' practitioners, working to competencies that are significantly different from those of the registered nurse. This implies that even advanced practice nurses find it difficult to avoid considering themselves as a part of a nursing hierarchy, and means that their relationship with junior nurses is inevitably different from that with other professions. Registered nurses, however, have often asserted that nurse practitioners are adopting medical roles, and by taking on tasks that appear to be unwanted by medical colleagues, are in effect renouncing nursing in favour of a hybrid role that marginalises core nursing principles in favour of dilute medical practice.

Isolation and poor support networks, particularly in relation to a lack of peer support, were highlighted by Bousfield (1997) as key factors contributing to ineffective advanced practice roles in nursing; in order to achieve success advanced practice nurses need support both in the direct delivery of care to patients, and in achieving confidence in their role through professional socialisation. What participants were describing when reflecting on their relationship with registered nurses fits closely with the state of 'anomie' described by Farrell et al (2001), in which ambiguity, confusion, and alienation lead to a lack of consensus about the way in which routine procedures should be managed, and the precise role of various players within a team.

8.3.7 Responses to being mistaken for a doctor

This suspicion on the part of colleagues regarding the nurse practitioner role, or more precisely the implications of the current and future development of the nurse practitioner role, led to a number of participants indicating some defensiveness about their skills and the skill mix within health care in their narratives. This was inherent in their desire to persuade others of their value. For some, as discussed above, this was about reasserting the nursing tradition and the 'value added' by their preparation as nurse practitioners. For others, however there was an implied satisfaction in being mistaken for a doctor, or acknowledged by patients and their families as having equivalence with a doctor, to the extent that some people have come to regard doctors and nurse practitioners as interchangeable. This finding undermines the persistent claims that nurse practitioners are specialist nurses first and foremost,

and may reflect a different set of covert aspirations on the part of some nurse practitioners, at least.

This is evident in the tone of some contributions within participants narratives, and is backed by reports of nurses' willingness to adopt medical roles, or more accurately medical tasks (West 2006), and findings confirming that patients' primary concern is that they receive high quality care and that they are happy to accept care from a range of health care practitioners (Williams & Jones 2005). It is more prevalent in the tone of the contributions made by participants based in the US, particularly those working as primary care providers in poor communities who are managing undifferentiated caseloads, where families may not have access to alternative healthcare providers. These nurse practitioners are deployed in a way that is indistinguishable from their general medical practitioner colleagues, and they therefore have a different perception of their role within primary care to the majority of nurse practitioners who participated in the study. While this observation cannot be generalised, it does highlight one potential area for future monitoring.

8.4 Role definition and role transition

During the descriptive structural analysis this theme drew together a number of meaning units relating to role definition and role transition. On the surface this was an area in which nurse practitioners were very positive about their increasing acceptance as an integral part of health care provision across a number of practice areas, in both primary care and secondary care. Participants described their experience of role transition at length, and in the narratives explored the ongoing development of their role and their respective careers in optimistic terms.

The surface message was one of confidence, growth and a robust outlook for the nurse practitioner within an interprofessional health care system.

8.4.1 Uncertainty about the future

Underlying these positive reflections, however, was evidence of uncertainty about the future. This insecurity appears to arise from the realisation that the establishment of a role that is recognised and accepted by others leaves the nurse practitioner vulnerable to the vagaries of a competitive health care system in which employment is increasingly determined by financial considerations (Barr 2003). In the US these financial considerations are generally related to reimbursement (Robinson 2004), while in the UK they care more closely related to cost benefit or cost effectiveness studies (Curtis & Netten 2007).

In addition to financial and budgetary concerns, standards are subject to constant monitoring by increasingly litigious consumers. Nurse practitioners in independent roles are subject to the same legal risks as any practitioner working with undifferentiated cases as a primary care provider, and despite nurse practitioners' claims that they represent a cheaper option in many situations, some analysts have refuted this when long term considerations are factored into the cost benefit equation.

Horrocks et al (2002) comment on the paucity of quantitative data regarding employment costs, but do point out that nurse practitioners typically have shorter working lives than doctors, based on full time years of service following qualification; this is confirmed by the work of Curtis & Netten (2007), whose study attempts to place a monetary value on nurse practitioners' and doctors' practice, and concludes that nurse

practitioners do not represent the sort of long term cost saving that might be suggested by a mere comparison of salaries. Their analysis recognises the nature of nursing work is often part time and that nurses often do not achieve nurse practitioner status until comparatively late in their working lives.

Participants recognised that financial considerations could in time militate against the development of the full potential of the nurse practitioner. Cost benefit analysis is only one part of the overall picture; participants also recognised that during a period of financial austerity, where there are no guarantees of permanent employment, other disciplines may try to establish themselves, or in the case of doctors re-establish themselves, in the very area where nurse practitioners see their role as being most effective.

When you get into adult practice and adult care now there's more of a competition, because we find physicians are struggling where there identity is. Everyone cannot be, you know, an ear nose and throat specialist, a cardiologist, they're cutting back on that type of role, so they are now competing for populations that physicians did not want to take care of (LC)

If it became a choice between the nurse practitioner and physician, the physician would say they've got to go, you know we can only hire one (person), and this physician can practice independently (TW)

Where nurse practitioners are central to the provision of care the quality of that care may be threatened by external controls, imposed in the form of targets or revised protocols and designed to achieve cost savings.

So much for our model about teaching - that takes time and it's not cost-effective - that's the first thing they cut. When you've condensed everyone into doing 20 minute visits there's not so much time for prevention (ND)

In addition, current unease concerning the level of unemployment among junior doctors have opened debates about skill mix and role substitution, which may present a further threat to the continuing development of the nurse practitioner, on this occasion generated by political considerations rather than issues of quality of care or cost effectiveness. Dynamic changes in disciplinary boundaries have been identified as a potential challenge to professional monopolies in healthcare (Nancarrow & Borthwick 2005), but participants in this study recognise the threat inherent in rapid change in the system of health care delivery for emerging disciplines such as the nurse practitioner. There is a perceived vulnerability associated with being a new professional group, compounded by the fact that nurse practitioners are somewhat detached from the main body of the nursing profession, to the extent that some nursing colleagues regard nurse practitioners with suspicion. This vulnerability is clearly seen as a threat, but at the same time appears to be a catalyst for solidarity, and a motivator in the celebration of success, particularly where this is backed by research.

8.4.2 Optimism

The final message emerging from the narratives provided by the participants is a positive note for the future. Nurse practitioners were consistent in their view that the achievements of the pioneer nurse practitioners have set a standard for other advanced practice nurses to emulate, and furthermore the achievements of nurse practitioners in adopting independent roles within a range of care settings have confirmed the potential within nursing as a whole to move from the traditional subservient position of the registered nurse to a more independent, accountable role in which specific knowledge and

professional autonomy combine to establish nursing as an equal player in the delivery of high quality care.

This is evident in the underlying optimism regarding the future that pervades the narratives, both at a personal level and for the nurse practitioner movement in general, and augers well for the future. West (2006) suggests that further development of the nurse practitioner role will only come about if nurse practitioners are proactive in asserting their position within the healthcare team. Farrell (2001) suggested that assertive behaviour in the workplace is inconsistent with the nursing traditions of caring and nurturing; nurses see assertiveness as evidence of uncaring behaviour, so avoid confrontation, and reflect the public view that nurses are 'nice' by failing to challenge conventional hierarchies. However the advent of advanced practice roles, in which power derived from knowledge and authority is for the first time a defining characteristic of a nursing role, may play a part in redressing this imbalance, particularly as more and more advanced practice nurses, predominantly but not exclusively nurse practitioners, challenge the established status of other professional groups in the workplace. The optimism regarding the future invoked by participants in this study provides a foundation for the further development of a new order.

8.5 Summary

While the central themes remain consistent, the appropriated meaning evident within the hermeneutic interpretive account reflects a different understanding of the experiences of the nurse practitioner in relation to role transition and professional autonomy. While certain elements remain

constant, the interpreted account demonstrates extremes of feeling more clearly than the descriptive account, particularly in relation to the highs and lows of practice.

The first key meaning derived from a comprehensive understanding of the texts was the positive affirmation evident in the pride felt by participants, and their optimistic view of the future, which here presents a slightly different perspective to the parallel sections of the structural analysis. It is evident that the appropriated meaning has transcended the professional stance inherent in earlier description, and allowed a more personal view to emerge. That nurse practitioners are proud of their achievement is very evident, and the extrapolation of personal feelings to reflect participants' pride in the nurse practitioner movement offers some justification for the optimism demonstrated within participants' speculation on the future of the nurse practitioner role.

A second key understanding relates to nurse practitioners' diffidence regarding the potential for full autonomy within their role. The findings emerging within this section provide additional insight into the exercise of autonomy within participants' clinical practice, and together offer a more cautious message than that evident in the descriptive account. In some respects the interpreted meaning undermines some aspects of the positive experiences recounted in the narratives. Evidence of significant doubt regarding the potential for increased autonomy, particularly given the seemingly intractable dominant professional structures within health care, presents a less confident picture of independent practice than appeared to be the case, and the frustration associated with bureaucratic controls such as guidelines, protocols and statutory restrictions comes

through even more strongly in the interpreted account. This is compounded by the feelings of inferiority in interprofessional contexts apparent within many of the narratives, although it is not clear whether these feelings of inferiority are perceived by participants to be the cause their diminished opportunities to maximise professional autonomy, or whether it is their lack of autonomy that generates this supposed inferiority.

A third key area of understanding relates to nurse practitioners' position within the health care team. The question of power and professional relationships is interesting, and ongoing evidence of a submissive attitude underpinning nurse practitioners' self-worth confirms the perception of the status of the nurse practitioner evident in the narratives. It also reflects the traditional position of nursing within the hierarchy of health care professions. Fears about having to compete for jobs, or status, in an open market against other disciplines are understandable in the light of this observation, and might further undermine the emergent professional confidence of a relatively new sub-discipline in the health care arena. What is perhaps revealing in this context is the suggestion that some nurse practitioners revel in patients' misunderstanding of their role, and are happy to be seen as doctors and behave like doctors, despite an apparent consensus regarding the nursing basis of the nurse practitioner role. This may reflect a covert desire among nurse practitioners to distance themselves from registered nurses; in other contexts nurse practitioners have seen themselves as responsible for overseeing the work of the registered nurse, while the registered nurse has in turn viewed the nurse practitioner with suspicion, perceiving a threat to their own prospects for future career development.

Despite this there are a number of positives emerging within the appropriated account. The conviction that the care offered by nurse practitioners is of high quality, and represents the best available care for a majority of patients is the final key meaning established within the comprehensive understanding. This is a powerful advertisement for the nurse practitioner, and given the range of supporting evidence backing this assertion, should help to consolidate the nurse practitioner role, particularly in areas such as primary care where the evidence is particularly persuasive (Horrocks et al 2002; Williams & Jones 2006).

Chapter 9: Conclusions

This study has explored nurse practitioners' experiences of role transition and professional autonomy. The participants' narratives have offered a new understanding of how they experience their role, and subsequent interpretation of the research texts has provided new insight into the potential of the nurse practitioner role in the ever changing arena of health care delivery.

Traditional approaches to the determination of professional autonomy have tended to focus on an evaluation of the role in question, using the parameters of the job description to predict the level of autonomy likely to be available to the post holder. This is in keeping with the most common approaches to assessing patient autonomy, which typically use competencies to assess the individual's potential for autonomous thought and action. These competencies normally include reference to knowledge, understanding, and freedom of thought and action in determining potential. While this approach may have applications in the assessment of professional autonomy it will necessarily draw conclusions at the level of the professional group under consideration; nurse practitioners within a specific speciality will for example all be assumed to exercise autonomy in an identical manner.

This research allows an alternative view of professional autonomy to emerge, a view that is based on the individual experiences of nurse practitioners, and which reflects a view from the life world of those who are exercising professional autonomy, rather than a view from external observers.

The first stage of the analysis provided rich descriptive material that facilitated an exploration of participants' transition from registered nurse to nurse practitioner, and their experience of professional autonomy within the nurse practitioner role. The various experiences described by the participants demonstrate some significant areas of consensus, allowing key themes to be identified, explored and reflected upon within the context of the research question.

Nurse practitioners consistently assert that they have the potential to work in an autonomous way, within the parameters of their defined role. However many participants were clear that do not want to work in a completely independent manner. They recognise the need for effective interprofessional collaboration in care, and feel that it is neither desirable, nor indeed possible to work independently, without being part of a multidisciplinary team. They acknowledge the wide range of knowledge and skills brought to the team by other professional groups, and recognise that their preparation cannot replicate characteristics that other disciplines have spent many years developing and refining.

Nurse practitioners do however want to be recognised for their own unique knowledge and skill, and respected as equals. Maximising autonomy has long been regarded as a key indicator of professional status, but here participants appear to regard professional recognition as the most important factor in establishing professional status. In absolute terms, autonomy defined as complete freedom of action is not seen as a realistic goal. In relative terms, however, increasing autonomy, through the acquisition of greater freedom to implement the care for which they

are responsible without interference and hindrance from outside agencies is seen as an important step towards clinical effectiveness and role satisfaction.

Participants were able to describe numerous barriers and obstructions that frustrate this development, and impact negatively on their opportunity to maximise both their relative autonomy in practice, and their clinical effectiveness, two aspects that are seen as complementary.

Nurse practitioners believe that their role is readily accepted by patients and families, and that their involvement in patient care has had a positive impact on clinical outcomes. Participants believe that the success of the nurse practitioner role has been achieved through an adherence to nursing values in formulating nurse practitioners' working practices. The nurse practitioner role is an advanced practice nursing role, and the positive acclaim achieved by nurse practitioners is seen as a vindication of their frame of reference, in which holistic care extends their involvement beyond the identified condition. The care offered by nurse practitioners typically encompasses a wide range of physical and psychosocial factors, including health education and health promotion, and practical and psychological support for the families of identified patients. These principles were thought to be defining principles in any exploration of the nurse practitioner role, and if widely adopted would appear to exclude nurse practitioners from taking on junior doctor roles as 'substitute professional'. It may not preclude nurse practitioners from taking on junior doctors' areas of responsibility, however, and adopting an approach based on holistic care underpinned by nursing values. This would position the nurse practitioner as complementary to aspects of

medical care, providing an alternative first point of contact for patients and families in certain defined circumstances.

Nurse practitioners are generally confident about their future, both on a personal level and as an emerging professional group, or sub-group. They recognise the barriers to further development, and can see how the current professional and political initiatives are likely to lead to the legislative, regulatory and policy changes necessary to enhance their autonomous role.

The interpretive stage of the research echoed the central themes established within the descriptive analysis, but the findings offer a slightly different understanding of the experiences of nurse practitioners in relation to role transition and professional autonomy. Within the appropriated meaning the texts reveal participants' affective responses to the realities of their lived experience in practice. This is perhaps to be expected given the research methodology, and is in part a vindication of the approach, with the descriptive element providing concrete examples of particular experiences, and the hermeneutic interpretive stage revealing aspects of participants' motivation to engage with the phenomenon, and emotional responses to the experiences recounted within narratives.

The findings reveal a number of positive aspects of nurse practitioners' experience. One overriding feature of the narratives was the pride that the participants feel in relation to their personal achievements and the development and status of the nurse practitioner role in general.

In this particular area the appropriated meaning has transcended the professional stance inherent in earlier description, and allowed a more personal view to emerge. This sense of achievement provides some justification for the optimism demonstrated within participants' speculation on the future of the nurse practitioner role. Pride in existing achievements does not necessarily guarantee future success, and there was some evidence within the interpreted account of incongruity between the sense of achievement generated by nurse practitioners current status, and their feelings of self-worth in relation to interprofessional relationships and the ongoing external restrictions on their practice.

The interpreted meaning challenges some of the positive experiences evident in the descriptive accounts. There is evidence of doubt amongst participants concerning the potential for further increasing their current levels of autonomy in practice, and this uncertainty stems from several observations regarding the nature of nurse practitioners' role and status. There is still a clear divide between the professional power and influence of nurses, including nurse practitioners, and other professional groups, primarily doctors but including disciplines such as pharmacy and physiotherapy in certain contexts. This power divide is evident within the interpreted account and is manifest in two different responses among nurse practitioners. First is the frustration associated with bureaucratic controls such as guidelines, protocols and statutory restrictions, which come through even more strongly in the interpreted account than in the narrative description. Participants feel that many of the bureaucratic controls on their practice are imposed by other disciplines, who do not fully understand the nature of nursing, and furthermore believe that

controls are unilateral, in that doctors faced with similar clinical situations are free to make an informed choice based on individual need, rather than follow the pre-ordained course of action required of the nurse practitioner.

This frustration is compounded by evidence of feelings of inferiority in interprofessional contexts that emerge in the interpretation of many of the narratives. There is ongoing evidence of a submissive attitude underpinning nurse practitioners' self-worth, which perhaps reflects the traditional position of nursing within the hierarchy of health care professions. The pride in achievement referred to above might be more accurately described as pride in achieving an enhanced status within nursing, rather than challenging traditional interprofessional hierarchies.

The evidence that nurse practitioners still feel a degree of professional inferiority in interprofessional contexts is clear; what is not clear is whether these feelings of inferiority are perceived by participants to be the cause of their diminished opportunities to maximise professional autonomy, or whether it is their lack of autonomy that generates this supposed inferiority. Confidence overall is clearly a factor, with many accounts of specific experiences demonstrating confidence at the level of individual patient encounters, but less confidence in the wider context of multi-disciplinary care delivery. Fears about having to compete for jobs, or status, in an open market against other disciplines are understandable in the light of this observation, and might further undermine the emergent professional confidence of a relatively new sub-discipline in the health care arena.

The question of power and professional relationships is interesting, and what is perhaps revealing in this context is the suggestion that some nurse practitioners revel in patients' misunderstanding of their role, and are happy to be seen as doctors and behave like doctors, despite an apparent consensus regarding the nursing basis of the nurse practitioner role. This may reflect a covert desire among nurse practitioners to distance themselves from registered nurses; in other contexts nurse practitioners have seen themselves as responsible for overseeing the work of the registered nurse, while the registered nurse has in turn viewed the nurse practitioner with suspicion, perceiving a threat to their own prospects for future career development.

Despite these uncertainties there are a number of positive messages emerging from an interpreted understanding of the narratives. The clear conviction that the care offered by nurse practitioners is of high quality, and represents the best care available for a significant number of patients is a powerful advertisement for the nurse practitioner, and given the range of supporting evidence backing this assertion, should help to consolidate the nurse practitioner role, particularly in areas where they are well established such as in primary care. Nurse practitioners are autonomous, and have the potential to increase their professional autonomy, but given the nature of modern healthcare delivery their autonomy will always be relational, and must be seen in the context of collaborative interprofessional structures within health and social care.

9.1 Limitations of the study

This study was designed to explore nurse practitioners experience of professional autonomy following their transition from a registered nurse role. The research design, based on hermeneutic phenomenology, focuses on human experience and is concerned with understanding the meaning of experience in context. While the findings embody the descriptive accounts evident in the narratives, and provide a hermeneutic interpretive account of the meaning appropriated from the interview texts, they are not necessarily representative of nurse practitioners as a whole. The new understanding offered within the study provides some indication of how this particular group of nurse practitioners experience professional autonomy, and while it is reasonable to expect others to have had similar experiences, given the defined nature of the professional role, this cannot be assumed.

The fourteen participants who took part in the study were selected on the basis of their having experience of the phenomenon under investigation, and although they came from diverse clinical settings no attempts were made to balance the sample in any way. This is in keeping with the methodological approach, but clearly gives rise to a situation in which participants were all nurse practitioners who were willing to discuss their experiences, and may have had specific reason to volunteer for the study.

Data collection was carried out using interviews as the sole means of eliciting participants' experience; again this is in keeping with the research methodology, but might be seen as a limitation of this particular approach to research. Similarly the position of the researcher cannot be ignored, and although steps were taken to eliminate bias within the

study, it is accepted that the researcher is an active participant in hermeneutic phenomenology, and as such becomes part of the narrative account and subsequent analysis.

A phenomenological study achieves its general aim when a reader is able to gain an understanding of the ways in which the participants experience the phenomenon under investigation. It is not designed to achieve generalisable findings in the same way that a quantitative research project might do.

9.2 Implications for practice

In keeping with the nature of a hermeneutic phenomenological study the findings do not provide, nor are they designed to provide, specific generalisable indications of key implications for practice. However the descriptive and interpreted accounts generated from the narrative texts provide some new ways of understanding nurse practitioners experiences of professional autonomy, and from this some issues that may have wider implications can be identified. These can be considered under four headings.

First, the confidence that nurse practitioners have in their ability to offer care to patients that is holistic, evidence based and effective should enhance the status of the nurse practitioner, and lead to their wider deployment in a range of practice settings. This is however dependent on nurse practitioners finding an assertive voice through which they can promote their role and their success in providing holistic care to diverse patient groups.

Second, ongoing uncertainty regarding statutory regulation of nurse practitioners, and continuing variation in their precise role definition have implications for maximising the potential evident in existing nurse practitioner roles. Professional autonomy cannot be achieved merely through the establishment of statutory roles, but regulatory clarity would help to define the parameters of nurse practitioners' clinical practice, which might in turn help to achieve the professional recognition that nurse practitioners believe is essential if they are to enhance their opportunities for autonomous practice.

Third, the potential for nurse practitioners to work autonomously is dependent on their relationships with fellow professionals, particularly doctors. Evidence from this study and elsewhere suggests that where nurse practitioners are well accepted as equals within the health care team their role transition is easier, and their contribution to patient care is more effective than in situations where they encounter barriers. Greater awareness of the nurse practitioner role, and more effective planning within multi-disciplinary teams prior to the introduction of a nurse practitioner might help to facilitate this transition, and enhance positive professional relationships.

Finally, nurse practitioners demonstrate evidence of ongoing uncertainty, or at least ongoing dissonance with regard to their position within the profession of nursing. The adherence to nursing values provides a clear philosophical basis for nurse practitioners' claim to offer a unique approach to specialised care, and nursing is consistently cited as the basis of practice. However the close observance of nursing traditions appears to include submissive feelings of inferiority in professional relationships,

particularly with doctors. Nurse practitioners who define their role as materially different from that of the registered nurse are criticised for compromising their professional roots, but evidence from this study suggests that some nurse practitioners at least regard the emulation of medical roles as a way of enhancing their status and achieving greater autonomy.

Taken together, these observations suggest that a more robust definition of the nurse practitioner role, enshrined in statutory regulation, might pave the way for a philosophical debate about the future of advanced practice roles. To achieve maximal autonomy in practice settings, nurse practitioners may have to dissociate themselves further from the wider nursing profession. This may provide the best opportunity for nurse practitioners to realise the external recognition that they appear to believe is vital to their further professional development.

Appendices

Appendix 1: Example of the interview process

Interviews were arranged by telephone and/or Email, at a mutually convenient time for the researcher and the participant. All the interviews were conducted in a private environment, to assure confidentiality, either within the University, or in a practice setting. On arrival I introduced myself to the participant, and introduced the project, allowing an opportunity for participants to ask any questions they might have about the research process. I discussed specific issues relating to confidentiality, anonymity and the storage of information. I also provided written information in summary format, and asked that participants signed a consent form before commencing the taped interview (see appendix 2).

I began each interview with an 'introducing' question that asked participants to describe their transition to the nurse practitioner role, and to give me examples from their experience of ways in which they are able to exercise professional autonomy. I had some further prompts to guide the narrative whenever it proved necessary, using a variety of interpersonal skills commonly used in counselling, as appropriate to the development of the interview. These included reflection, summarising, probing and rephrasing.

The general tone of the interviews was of a conversation between two experienced nurses discussing an issue of mutual interest. I assumed the role of the facilitator, using principles of active listening to draw out the narratives, and where necessary prompting the participant to illustrate their experiences in relation to the phenomenon under investigation by recounting specific incidents from their own professional practice. The following transcript indicates the pattern of a typical interview.

Sample interview transcript

First, can you give me a bit of background, and tell me how you became a nurse practitioner

I worked on a gynae ward, a main gynae surgical ward as a staff nurse, and I got involved in setting up a pre assessment clinic, and I became involved as part of a group who did pre assessment as well as working on

the ward, and from that .... I suppose it was looking at what we were doing in practice, and the nurse practitioner route in terms of pre assessment for those patients seemed to be a good move forward, because we never had an SHO who could .... they were always not there for some reason or another, so it was a way of improving patient care and improving the service really .... and assessing patients properly. That was my first impetus for doing the nurse practitioner course, and through the course that is what I developed – a nurse led, or nurse practitioner led pre assessments unit, and that led on to doing a follow up clinic as well, for patients who had been pre assessed through the clinic, so it was covering the whole spectrum really, from pre admission through to discharge.

Were there specific cases that lent themselves to this model?

Particularly with women, and particularly with gynae, because they have particularly sensitive needs there was something I would say around having a female to female contact in terms of understanding their problems, helping them to deal with that sort of thing. What worked really really well was actually was being able to pre assess certain patients, like hysterectomy patients, patients who were having vaginal repairs, because they have got very sensitive problems and issues, and building up a relationship with somebody like myself as a nurse practitioner was great because I would see them in pre-admissions, sometimes I would see them on the ward as well, because I worked on the ward, and then that group of patients I would actually ...would be my follow up patients. I knew them really well, so the first thing the post operative lead wants, easy, so they know that I'd built up a good rapport so from a pre operative sensitive bit. From that point of view it wasn't a trauma for the patients really so it was good for them.

And there was continuity

Good continuity yes.

Can you tell me something of your experiences of working as a nurse practitioner, examples that might illustrate that, and your general feelings about nurse practitioner roles.

I've probably got quite a good example, because I built all that with the nurse practitioner clinic, in one trust, and I did it while I was developing through the course, so I learnt my examination skills and I was able to put those into practice, in a safe environments, with good support from

clinicians, and people like that. I felt comfortable in what I was doing. In terms of consenting, because I consented patients as well, that was something that I put together in terms of having consent competencies, and lots of trips to theatre, liaising with the gynaecologist so they knew exactly what I was doing. I worked in an environment where surgical nurse practitioners were the norm, really, and were doing similar things. They were pre clerking patients, they were consenting them, and they were transcribing medications. It was actually a familiar environment that they were working, so from a legal point of view, and from the Trusts point of view I was working to something that they were familiar with, I suppose you could say. It was safe practice, because they has never had any issues with nurse practitioners, and any complaints I suppose or litigation or anything like that, so they had been going on for a number of years, in a safe manner, really.

I then moved to a different Trust, and as part of my role, I mean my role changed quite significantly, but as part of my role I wanted to maintain that same (*indistinct*)....Within the trust where there weren't any nurse practitioners, and it was a real uphill struggle trying to convince people that this was safe practice and that it was within my job description and that the Trust knew about it and all those things that go with your accountability. So it was quite a difficult transition, I suppose, a real learning curve in terms of everything was safe and fine and they were happy for me to carry on there, and I suppose it made me think about the real implications of what I was doing. I was doing that anyway, I was trying to cover myself, making sure that I had really robust policies and procedures and competencies and things that I felt met what was required really. I had lots of documentation that was specific to what I was doing, wrote up everything that I was doing for patients and that sort of thing, but it did really highlight the difference between working for somewhere that was safe, and they know what you did, and they were familiar with it to somewhere that was completely alien, it was like nurses do not do that, they are not covered to do that, and dealing with all those sort of issues. And then actually getting all the policies and procedures and everything else on board through that completely different culture was really really hard, and it took me up to a year to actually do that.

That was with really good support from the clinicians and from my manager, but it was the bureaucracy of it. It wasn't a bad thing, because it meant that I did things actually in probably .... more to the book really. Maybe there had been a little bit of leaving me to my own devices in the other Trust but this time it was a real policy driven Trust, and I do feel that

in retrospect that probably was a better way of actually doing things and setting things up and what have you.

Were there particular people who were particularly resistive to the new role?

Yes

Do you want to say a bit more about that? Was it particular professional groups?

It was nursing management at a high level. The consultants that I was actually working with were fine, absolutely fine, couldn't wait for it all to happen, and were really supportive. The anaesthetists were as well. My immediate nurse manager was, and I think that was something around her knowing me, and what I was capable of, that I wouldn't do anything above my limitations. Ward staff were fine, pre-assessment staff were fine; it was mainly the high level nursing management structure. And that was, I would say, the crux of that was that they did not understand what a nurse practitioner was. It led on to all sorts of things in terms of putting a strategy together within the Trust, because I identified that I'm not going to be the only one who is going to be working here as a nurse practitioner. I need to do something about this and make the pathway easier for nurse practitioners coming after me – because it was a complete mess, and people were coming on the nurse practitioner course from there sent by these particular people and they had no idea of what they were sending me for.

Well they weren't employed as nurse practitioners generally. These are people who either were sent on the course, or there was this 'oh you go and do your degree, go and do a course' and I suppose they were used to people coming perhaps here, doing a nursing degree, it didn't impact on .... well it did, obviously, but it didn't really impact on their practice like the nurse practitioners role does. They were coming, doing the course and going back obviously better off for it, from a clinical point of view, but that it is not obvious when it is other nursing courses that people do.

So has that led you to reappraise the nurse practitioner role: your role, or the role in general?

I think what it did was make me more geared towards making sure that the background is all watertight. If you are going to set up a role you need to have done x, y and z, you need to have the policies in place, you need to

completely cover every avenue that could lead to a problem. I suppose that's what it helped me to do.

Have you got examples of specific situations when that might have been the case?

In terms of patients?

Yes. Or processes

I have to say in terms of the patients that I have actually looked after I've never had …. I've never run into a problem where I made the wrong decisions.

I was thinking more about patient examples that help you to define roles or processes.

In terms of how I interacted with patients?

You were saying that as a result of some resistance you were obliged to think again about how you operated.

I didn't change the way I operated at all. My practice didn't change, because I knew that I was working to the RCN nurse practitioner competencies, which are the gold standard really. As far as that goes, that is what I was doing.

So it was more about persuading senior management that what you were doing was appropriate, and that there was quality in the care of the patients.

Yes. The clinic that I set up I did as a pilot project, and I evaluated it as I went along because I wanted to prove to them that this was an effective service, and that is what came out of that audit – that patients were satisfied with it. There wasn't one patient that said I would rather have been seen by a doctor, or nurse, or anything like that. It was all …. and we audited the consultants and the staff on the ward and people like that, and it all came out positive, there was very little resistance to any of it.

So have you more recently come across further resistance to the role?

No. In fact it has moved forward I would say. As more nurse practitioners have pitched up at that Trust, they have been more effective, and we have

had … we've got a good mechanism now for helping them to tackle the different problems.

What sort of mechanisms do you have?

Well, we set up … this is what I did for my project actually – we set up a nurse practitioner group, because there was nothing, and that's I think the crux of it. I came in working completely - totally in isolation, there was nobody around in terms of peer support or anything from nurse practitioners, I was completely on my own, and because of my role here obviously I was in contact with nurse practitioner students who were all within the Trust working completely independently, and all off into a tangent, and all experiencing different problems with different aspects of their roles, whether it was ordering investigations or whatever it was. It was a way of actually one helping them set up and develop roles in a sensible way, I guess really, like I had to do, using me as a kind of example – this is the best way for getting through all these different processes. I've already written this policy and procedure – use this, you know it has been approved so you use the same template, all that sort of stuff. We did that in such a way that we set up a nurse practitioner support group, the development group we called it, so all student nurse practitioners and qualified nurse practitioners were invited to and still are invited to the group that we hold once every six weeks. I guess it is like a group supervision for the group. There is lots of peer support, there is nobody else in it, just the nurse practitioners so for people coming in new, and for students, and for qualified for getting peer support it is ideal. It's a forum for them to bring incidents that have happened, or just, you know, how do I do this? Where do I go about finding this?

What sort of things would they be bringing along? Can you think of issues, without breaching any confidences?

Ordering investigations was quite a key one at one point, because there was resistance from the radiology department in terms of ordering x-rays. That was quite a big thing, (*the 'wrong' signature on the form*), so that was a big issue, that is resolving. And that was something, because it came from the group and not from that one individual, there was strength in that, I think really. The other one is around …. this is an ongoing problem about the use of PG Dip Ds and transcribing and prescribing issues, and again that is going to be a big thing going on really.

And that world is changing anyway…

Absolutely

With new formularies available

That's right. Various elements of that have come up. There has also just been things around how on earth do I convince my manager that I should be doing this aspect or that aspect, so other people were able to give their experiences of how they had done something. One girl was setting up .... she had set up a follow up clinic actually for her group of patients so was able to use stuff that I had done for my follow up patients. They are some of the examples.

Good. You talked about other professionals and their acceptance or non acceptance of the role. What about patients? Directly, your patients you say were very accepting.

Yes

Have there been any who have been suspicious?

Of me personally? No

Or perhaps of the role?

Certainly from what other people have said there have been. I think ... mine ... one, I wear a uniform, I wear a nurses uniform. That's a silly debate, I don't know, but I wear a dress, I wear a nurses uniform with (*indistinct*) with nurse practitioner on, and I think immediately patients know that I am a nurse because that is how I am dressed. Whereas I know of colleagues who don't wear a nurses uniform, maybe wear a white coat or their own clothes, and even though they have said to the patients, my name is so-and-so, I'm a nurse practitioner, blah blah blah, if you want to see the doctor, all the sort of stuff that you say, gone through their consultation, done all the bits and pieces, then the patients have gone out and as they go out they say thank you very much doctor. That has actually come up on a number of occasions actually, its patient perception of the role really, or of the person, I don't know what it is. I've never had that, and yet I'm doing exactly the same as they would do.

Do they say to you, thank you nurse?

Yes, they will do. Yes, definitely.

Is the role then based on nursing skills? Are you a nurse?

I would say I am a nurse, definitely. That is another perception; I think other people see it differently as well. For me within my own practice that is what comes first, definitely. Building a therapeutic relationship, I would say, with the patients as a starting point for the things that you do to them. If you talk about the main concepts of the nurse practitioner, roles, such as phys exam and history taking and that sort of thing, I think those things come secondary to the things I do as a nurse really.

It is interesting, thank you. Can you give me any examples of things that you now do differently from the way that you might have done them in your previous life as a registered nurse without nurse practitioner skills.

Oh, loads of things. Just assessing a patient, really ... what would I have done as a staff nurse, I would have probably gone and done their obs, and looked at them and thought oh yes he doesn't look very well, you know, and get someone in to have a look at him, whereas as soon as you start to look at those physical examination skills and things you look at patients in a different way. Definitely, most definitely, and because you have got the skills to actually think, he's got a bit of a *(indistinct)* to his chest and go ahead and do that. Then with pharmacology, I find hugely beneficial, with that it was around ... you know for the last 20 years I have been administering medicines to patients without a clear understanding of what I have done. You know, basic stuff to pass my drug assessment, and things like that, and I knew what drugs were for, but I didn't have that deeper knowledge that I have gained through the nurse practitioner role. So I'm able to say to patients if I see a drug history, what they are on and things, you know you are taking that for that. I think I am much better able to discuss what patients are taking and how they might be interrupting *(indistinct)*.

So do you have prescribing in your repertoire?

No. I don't need to be able to prescribe. I do need to be able to transcribe patients own drugs, but that is going through, hopefully. It is basically copying, it is not changing any medication. I don't need to be able to do that in my particular role, but obviously other people ...

So it is more about understanding the implications of their medication history

Yes, definitely

Are there still areas of frustration, things that you are not allowed to do, or things that might be of benefit to your patients if you were able to extend further and take on additional responsibilities?

I guess so. It is difficult because my role is not purely nurse practitioner now, I do other things as well, and I suppose the biggest frustrations are in terms of ... they are probably financial actually now, in terms of wanting to expand the service, succession planning, in terms of what I do I feel that there should be other people who do the same as what I do. It is from a service provision point of view really. If I had the ideal situation I would want to develop other nurses to be able to do the same, and to build up follow up clinics and things like that, which we don't have the time or the money to do. So it probably is financial. From a personal point of view, probably not, other than the transcribing issue which is hopefully going to be resolved. That is probably the only thing that I would need in the context of what I do it would be the only thing that I need to be able to actually do my totally eventually independent role.

Are there examples of how your relationship with other professional groupings has changed? I know you talked about acceptance, but what sort of evidence is there for acceptance?

Probably almost from the start when I think back to as I went through the course and as I developed some skills that were perhaps more medically focussed I think that doctors treat you differently because they know that you have got some of the knowledge that they have got. The power base, I think, changes, but I also think that is something about levels of confidence, my confidence as well. But definitely, yes, there is definitely change.

And what about other disciplines?

... doctors ... that is the major one, I would say probably. And the others .. probably the only people I would have any particular ... is perhaps physios in terms of...we I am doing some work with a physio, writing, and whether it is because I am a nurse practitioner rather than purely a registered nurse, but perhaps I was on more of a par with her as well.

You mean she was more accepting...

Probably, yes.

And what about other nurses?

They generally ... generally there is quite a good acceptance. There is always an element there of people who don't really understand the role, however much you try to explain to them, and you do hear people saying you're just like one of the junior doctors, or you just do, you know, that's just what a doctor does isn't it. I constantly find that I have to qualify what I do, and let them know that I am a nurse, and I'll always be a nurse and that sort of thing really. And then every now and then you do hear the odd cynical doctor who says – it hasn't been in relation to me, I have to say, but other people who have said it, doctors go to medical school for six years, why do you think you can come out and do all the same things that we do. We say back to them, well, actually, we are experienced nurses, you can't chuck out 20 years of experience as a nurse, and this course and that course.

But even the need to justify it might be frustrating

It is a challenge actually.

Are there examples of how you can use your increased autonomy in the nurse practitioner role? If you can give me examples, patient case histories...

Probably the biggest one would be in terms of the level of knowledge and things that I had and a few patients who have ... on pre-assessing I've taken a history from them, we've discussed what they re going to have done and I feel that I was able to say to them, stop here. The operation that you are having is not the right operation for the symptoms that you have actually got. I would say that was probably gained through better knowledge and understanding of the systems approach that you do through the nurse practitioner course. I mean perhaps before I may have had a vague awareness that something wasn't quite right, but I wouldn't have been able to put my finger on why it wasn't right. I feel that I have got the authority now to be able to say to them, these symptoms are far more likely to be such and such, you need to not go ahead with this, you need to go back and see the consultant again, and again that doesn't seem to have been a problem. I've been able to ring the consultant and say, this lady has come in with symptoms that don't match what she has come in

for. He's taken my word for it, I suppose, because he has got confidence in what I do, and I've been able to refer them back, really.

So are you making an alternative judgement, or merely reflecting a discrepancy between presenting symptoms and diagnosis?

Possibly...the consultant had probably had a ten minute consultation with that patient and hadn't been able to...I mean I'm not saying there is no...I'm not doctor bashing at all, but he probably hasn't had the time to go through a proper assessment of that patient, whereas I've got more time, I'm homing in on specifics really and can see that there is perhaps something wrong, or something has changed, as well, that's the other thing that's happening, something's changed.

The superficial evidence might point in one direction...

Yes

...and in 80% of cases it will be correct, but it is the others that you are uncovering.

Yes, and I suppose another example would be in terms of referrals to other agencies, or other professions. I don't know if this is the case, but if I phoned a haematologist or a cardiologist and said I need some advice on this patient, whose come in and I've picked such and such up, can I get them...make an appointment for them to see you. I don't know if they would stick with it, but I've never had any problems with doing that, a direct referral, but I don't know if I'd been a staff nurse on a ward doing the same they would have accepted it in the same way. I don't know if they would have done, but I have, possibly, reservations that they might have queried it.

Is that because of you, as an individual, or because of the role?

I think it is both. I think you do build up an air of confidence about what you are talking about, and the way that you put things across.

And a personal reputation?

No, because it would be people that I didn't actually know, so I don't know if it was the role, or whether it was the way I put it across, I don't know.

But one or the other was effective – perhaps a combination of the two?

Yes

The final area I am interested in is whether you think the nurse practitioner role is a specialist role for a few people, or whether we should all be nurse practitioners, because the skills clearly are making a difference to patient care.

That's a difficult one. There is potential for lots of different models, really, because I think there is a place for nurse practitioners who can be very generalist, and could assess a wide range of cases whatever they might be. I also think there is a case for nurse practitioners in specialist areas, say like where I am; and I also think there is a case for combining the classical specialist nurse type roles with what we would view as being a nurse practitioner, so that you've got the kind of support from psychological point of view as well as someone who is actually able to provide some sort of hands on clinical care as well. Do I think everyone should be a nurse practitioner …possibly some of the skills would be well used by other people. My reservation would be that as a registered nurse you go through three years of training and education, and you come out as a registered nurse, and if you came out with all the skills that you come out with as a nurse practitioner …I'm not sure. The danger is that because they haven't got the experience behind them they wouldn't utilise the skills in the right manner. I mean that's my personal …I mean I'm not sure that that …I would just have reservations about that, I think it is something that you need to have the experience and then move it to …I'm not sure that everybody need to be a nurse practitioner, or would want to be particularly. You might put off an awful lot of your ward based nurses who are quite happy to do that, or people who want to go into different roles, you know you don't want to lose that nursing, that classical nursing inheritance at all.

Is it a satisfying role?

Yes, definitely.

Why? How do you feel about your role?

I think what is nice about it is that you can actually see someone in a holistic manner. It might be a bit clichéd, but I do think it is nice. I mean before you sort of do half the job, and if I think just about in pre assessment you know I do x, y & z, and stop, and someone else will take over, but

doing the whole thing you get such a good picture of the patient and if you are able to give them the information that they need and things like that it is nice and rounded, and there is scope there for good continuity of care, which is very satisfying. Being able to see someone through from start to finish that is quite satisfying, definitely.

Do you think your service to the patient as a nurse practitioner is different from the junior doctor? You said earlier that people say you are just like a junior doctor, but is there something qualitatively different about what you offer?

Yes, definitely. If I just take what I actually do personally the junior doctors rotate on a three to six monthly basis, they are in training, they are learning. I've been in the field of practice for ten, fifteen years and I would say I have got a lot more knowledge about the patients. Not necessarily about the disease processes or about the operations, but actually about the patients who present with those problems and need that care. I've got a much better understanding of that really ...and they find it boring, they hate pre-op assessment, they think it is just ...they come in, they check the patient over and they go out, and that is the general feeling about pre-op assessment. Every time the change they say I can't stand doing it, they don't ...and there's a push push push for the time, and they are always doing other things, whereas I've got the luxury of going to my patients, and that is what I'm going to do today, whereas they get bleeped here and there so from a time point of view it is much better.

It sounds like a strong endorsement for the nurse practitioner role.

Yes. I think so!

Is it an autonomous role?

I think so, but I think it is also very much a ...I don't think we could ever be completely autonomous, no. I don't think you would want to be. I think it is a bit unrealistic to think that you are, why should you need to be, really. I work in a hospital environment, there's always going to be doctors, physios, there's always going to be all those people around you. You should be working in a team and not to do that is denying the patients a complete package of care really.

I suppose I was thinking more about your opportunities to make those decisions that you have been prepared to make independently.

I suppose to a certain extent if I look again at my practice before now, yes, I make a lot more clinical decisions, and certainly you notice it from when you've done your OSCE and you think you are marvellous at examining patients but actually that is the start of your learning. You then suddenly start to realise that this decision that I make could mean that the patient is put under more risk, under an anaesthetic, and it's quite a scary decision to make, and you have to learn to cope with those patients really. So that's where I would, and maybe I'm a bit cautious, but I always make sure that I do liaise closely with the anaesthetist and the consultant, even if they just take my word for it I always talk to them about, you know, any complex patients, to make sure that there is that team look.

Do they treat you in the same way, would they come to you and say, here is an interesting case; do you have an opinion on that?

No, not to me, no. I'm sure it does happen in other people's practice. I suppose because I see the patients on m own, and they are not involved in that part ... *that might make a difference*

Thank you

Appendix 2: Information to participants, consent.

Participants were given a summary of the research project prior to their interview, and were asked to sign a consent form to confirm that they were willing to participate. The summary, and a copy of the consent form, are reproduced here

Role Transition and the Nurse Practitioner: An Investigation into the Experience of Professional Autonomy

The project

This research project is designed to investigate the role of nurse practitioners, with particular reference to their experiences of autonomy following the transition to a nurse practitioner role. The study will address the concept of professional autonomy, and the boundaries of professional practice, and link this to the legal, ethical and epistemological foundations of nursing practice in general, and more specifically to the professional role of the nurse practitioner.

Amongst specialist nursing roles, the position of the nurse practitioner is of particular interest, because nurse practitioners have evolved within an interprofessional philosophy of care, and therefore have complex issues relating to the scope of their professional practice and their own individual professional autonomy.

This study is designed to investigate how nurse practitioners perceive the professional autonomy afforded to them in their clinical role, and explore with nurse practitioners how the theoretical foundations of their clinical practice, and the realities of care delivery contribute to their experience..

Methodology

The study is to be conducted using a phenomenological hermeneutic approach inspired by Ricoeur (1981; 2004), placing a significant emphasis on the meaning of the lived experience of nurse practitioners within their professional role. Data will be collected through tape recorded narrative interviews with the participants; in depth interviews are the preferred method of data collection, because open dialogue and questions can maintain a focus on the participants' experience, and allow the researcher to engage with the participants. This helps to achieve a richness in the

participants' disclosure, and allows the researcher to feel the lived experience of the participants, thus helping the authentic representation of the participants reflections within the study. Verbatim transcripts of research interviews will be interpreted using a hermeneutic approach based on the work of Ricoeur and adapted by Lindseth & Norberg (2004), in which the text of the transcripts are analysed through a first (or 'naïve') reading, followed by a process of structural analysis aimed at validating or refuting the initial understanding. This involves the interpretation of research interview transcripts to uncover thematic aspects within the data through an understanding of the narrative, the appropriation of the intention of the participant, reflection on the interpretation in context, and the incorporation of thematic descriptions from published sources. From this analysis meaning units, sub-themes and themes can be identified, a holistic interpretation, or comprehensive understanding, can be formulated, and the phenomenological account developed

Ethical approval

The study has been granted full ethical approval via the NHS Central Office for Research Ethics Committees (COREC), who determined that this study should be categorized as a multi centre study. It was considered by the Eastern Multi-centre Research Ethics Committee, sitting at Papworth Hospital in Cambridgeshire who gave detailed consideration to the proposal, and granted formal ethical approval for the study.

Ethical considerations

Written consent will be obtained from each participant by the researcher. Written information will be provided explaining the nature and purpose of the research.

Audio tapes of interviews will be coded to ensure that participant details do not appear on the recording, or on the box. Interviews will be transcribed as soon as is practical, using the assigned code, and original recordings destroyed. In the interim period, tapes will be stored in a locked compartment. Transcripts will be held in a password protected area of a University computer system, to which only the primary researcher has access. The key to the identity of participants will be

stored on a different part of the system, to avoid accidental disclosure of participants' identities.

Quotations used in the text of the research will be anonomysed, although the participants broad area of practice will be identified if it is essential to understanding the issue under discussion.

Research participants will be offered copies of the transcript of their interview; in addition they will be notified if interim publications derived from the ongoing study are accepted. They will be informed of the dissemination of research findings following completion.

References

Lindseth, A. & Norberg, A. 2004, "A phenomenological hermeneutic method for researching lived experience", *Scandinavian Journal of Caring Science*, vol. 18, pp. 145-153.

Ricoeur, P. 1981, *Hermeneutics and the Human Sciences* Cambridge University Press, Canbridge.

Ricoeur, P. 2004, *The Conflict of Interpretations: Essays in Hermeneutics* Continuum, London.

Role Transition and the Nurse Practitioner: An Investigation into the Experience of Professional Autonomy

Andrew Mercer

Thank you for agreeing to be interviewed as part of my research project, which is designed to investigate the professional autonomy of nurse practitioners.

I am a nurse educator working in Bournemouth University, and I am undertaking this study for my doctorate. I am registered at Bournemouth University. I am a registered nurse, and my clinical background is in mental health nursing.

I would like to record an interview, lasting approximately 45 minutes, during which I will ask you to describe your experience of working as a nurse practitioner, and ways in which you have been able to exercise autonomy in the role. Following the interview I will transcribe the dialogue, and make use of the text in my thesis. The interview will be transcribed verbatim, but identifying characteristics (such as names of individuals and specific practice locations) will be edited to preserve confidentiality. I will be undertaking the transcription, and tapes will be wiped once the transcript is complete. Texts will be identified by code numbers, no names will appear on interview transcripts, and pseudonyms will be used within the thesis.

I will provide participants with a copy of their transcript. If for any reason and at any time you wish to withdraw from the research, I will delete your interview from the data set and remove all references from the text. If you wish to amend the transcript, either for purposes of clarification, or to remove sensitive material, I will make the amendments, and delete the relevant passages from the data set and the text.

Please sign below, to indicate your willingness to participate in this study.

NAME... SIGNATURE...

In order to send transcripts, and/or to follow up any issues I need to be able to get in touch with you. Please indicate

a) If you are willing to allow me to make further contact if necessary   YES / NO

b) Your contact details:

Telephone..

Email..

Address..

Appendix 3: Sample descriptive analysis

Example of original text: sample meaning unit(s)	Summary description of meaning unit(s)	Participants' experience	Sub theme	Theme
When you actually have to make the decision, you see the patient, you make the diagnosis, you often do the treatment and then you dismiss, discharge them, that's when you don't sleep at night. I think what was different were some of the decisions I could make as a nurse practitioner versus the decisions I could make as a nurse. You know, you get to a certain point where you just can't make any more decisions.	I quickly realised that the nurse practitioner role is a very different role from that of the registered nurse	Experiencing change	Experiences of role transition	*Role transition*
I have to accept that doctors are going to be very defensive about nurses taking on more autonomy within their practice, and they're going to question and query the training that we've had, and they are going to feel very threatened. I think there's a lot of extraneous forces that are creating the conditions - when you adhere to the philosophy.... I am not sure that we're driving the boat.	My transition to the nurse practitioner role was not easy, because other disciplines were suspicious of nurse practitioners, and employers seemed to place bureaucratic hurdles in the way	Being thwarted	Barriers to role transition	
Within the trust where there weren't any nurse practitioners and it was a real uphill struggle trying to convince people that this was safe practice and that it was within my job description and that the Trust knew about it and all those things that go with your accountability. I constantly find that I have to qualify what I do	I had to explain to colleagues what my role involved, and 'prove' my competence before they would accept me	Being misunderstood	Other disciplines' misunderstanding of the nurse practitioner role	
It was the challenge, the job satisfaction You have got the skills to actually think, so from that perspective... you know it's nice to be able to finish it off really instead of having to send them to a GP.	I needed a new challenge, one that allowed me to feel fulfilled in my role	Feeling inspired	Motivation to move into a nurse practitioner role	

Appendix 3: Sample descriptive analysis

Example of original text: sample meaning unit(s)	Summary description of meaning unit(s)	Participants' experience	Sub theme	Theme
I have my own panel of patients who only come to see me, they don't need to check with anyone else, and I am essentially seeing all those patients on my own. ...the clients have direct access to my services, that I offer them an holistic package of care if you like, and then I can actually discharge them from the health care arena, hopefully empowered to, or equipped with the skills and the knowledge to deal with their health problems for which they originally consulted me	I have responsibility for a defined caseload in my practice	Working autonomously	The exercise of autonomy in practice	*Exercising autonomy*
There's nobody here telling me what to do I have a pretty broad background and I think that's what contributes to having confidence in my decisions at this level of practice Nurse practitioners, are first class nurses, not second-class medics	My background in nursing has given me confidence in my ability to work with patients in an independent, autonomous nursing role	Feeling confident	Developing self-confidence within the nurse practitioner role	
I don't refer to any hospital doctors at all, because it's such hard work and the risk is that you'll get a letter back saying get the doctor to refer to me. I'm not a doctor and I'm not a nurse; I feel like a slave. Like that day, I just felt like... you know because I think they do rely on the nurse practitioners here to do much more of the clinical work.	I find it hard to overcome some problems in practice – other disciplines make life hard at times, and I feel that the nurse practitioner is given all the work that no-one else wants	Feeling frustrated	Experiencing frustration	
I'm an extended nurse prescriber, but there are things we can't prescribe you can make some decisions, but they need to be based on an algorithm of care,	Ongoing issues regarding prescribing and clinical guidelines reduce my potential for autonomy in practice	Facing legal limits	Legal Restrictions on practice	

Appendix 3: Sample descriptive analysis

Example of original text: sample meaning unit(s)	Summary description of meaning unit(s)	Participants' experience	Sub theme	Theme
I think that a lot of what I do is make people feel very comfortable, try and educate them as to what's going on, try and help them agree with if not make decisions about their own care, and go back out there and take care of themselves, and learn how to be more independent in their care I think we do bring something different from other practitioners ... the ability actually to perform a full holistic nursing health assessment on somebody with an undifferentiated problems, and to actually form a working diagnosis and offer treatment	As a nurse practitioner I can offer a different perspective from other practitioners, based on a holistic approach which incorporates diagnosis and treatment for the patient, as well as support, education, and advice for the patient and the family	Celebrating the role	A unique perspective	*Professional Relationships*
I do think there still is that socialised, general power conflict between nurse practitioners ...the physicians looked at our stepping in on their territory, they were concerned about that. They felt threatened	I still feel that we are fighting to establish our role. Boundaries do change, but slowly	Feeling uncertain about professional relationships	Professional boundaries	
they double check everything which may be arrogance on my part, you know, well, have you done this and have you done this doctors are really struggling with what is the role of the nurse practitioner, and how do we develop a relationship with them as advanced practice nurses and also make sure that they develop a relationship with the registered nurses	I feel that medical colleagues still feel they are in charge of my practice, and want to check up on me at all times	Experiencing control	Controlling influences	

Appendix 3: Sample descriptive analysis

Example of original text: sample meaning unit(s)	Summary description of meaning unit(s)	Participants' experience	Sub theme	Theme
...they are my own caseload, they don't see another doctor, or another nurse practitioner. Of course if they're sick, and I'm not here they might see someone else, but everything, for the most part, is done pretty autonomously, as far as ordering medications, vaccinations, writing prescriptions, making decisions about their management So long as you have done what you need to do then that patient is responsible as well for their own health, and they will come back if they need you, they know the service is here. It takes quite a lot of getting used to, recognising the patient has that ability if you like, because nurses tend to be very nurturing and doing and you know, always taking the responsibility from the patient	I deal with undifferentiated cases, but need to remind families that I work differently from a doctor, and they have some responsibility for their own health	Wanting to be accepted by patients	Nurse practitioners' attitudes to patients	*Nurse practitioner-patient relationships*
...there is scope there for good continuity of care, which is very satisfying. Being able to see someone through from start to finish that is quite satisfying, definitely	I find the relationship with patients and families provides them with good quality care and me with a high level of job satisfaction	Feeling useful	Experiencing 'role satisfaction' through patient care	
Well, in this place they think I am a doctor I think people still think of me as a doctor, an even some patients say, I know you're a nurse practitioner, the you're still my kids doctor	I tell patients I am a nurse practitioner, but they still see me as a doctor	Being misunderstood - again	Patients' misunderstanding of the nurse practitioner role	
I don't get many who say they don't want to see me, but if they say no, I'm not seeing a nurse, I want to see a doctor I just wouldn't argue, we don't want the trouble	I do have patients who refuse to see me, but I recognise that they have the right to refuse	Risking rejection	Reluctance to see the nurse practitioner	

Appendix 3: Sample descriptive analysis

Example of original text: sample meaning unit(s)	Summary description of meaning unit(s)	Participants' experience	Sub theme	Theme
You know I don't think of, you know, Betty Neuman when I'm making every move, but, you know I do think of the family as an entire whole for me, I don't look at just one aspect of the child's care You don't want to start off by being substitutes for physicians, you want to start off by saying this is a nursing role	I am a nurse first and foremost, and my practice is based on nursing skills	Being a nurse	Nurse practitioners' skills	*Nurse practitioners' skills*
(I feel like a nurse) because I'm still looking at the whole picture, not just parts, not just the intestines, not just the skin. I'm really looking at the whole family. If they're coming in for a medical problem I still think about how it impacts on the family	As I nurse I use holistic principles to care for the whole family	Working holistically with the whole family	Nurse practitioners' use of nursing skills	
...helping patients to understand how to be responsible for their own health care, to be responsible for that for the rest of their lives, preventatively identify risks, to keep themselves healthier and promote their health, as well as deal with their illnesses covering the whole spectrum really, from pre admission through to discharge	In the future I expect to be providing broad care to patients and families, from initial diagnosis to discharge from the caseload	Reflecting on the future	Reflections on the nurse practitioner role	*The future*
I think that we are at a cross roads, and right now with many of the advances that we've had I think are putting us in a competitive market, and we need to really be kind of savvy about where we're going I don't think we want to medicalise what the nurse does, we want to retain our nursing status I think there is a place for nurse practitioners who can be very generalist, and could assess a wide range of cases whatever they might be. I also think there is a case for nurse practitioners in specialist areas	Nurse practitioners need to ensure that we position ourselves appropriately, retaining nursing principles and clarifying role definitions and degrees of specialisation within the role. Given that, the future is bright!	Feeling positive	Future prospects for nurse practitioners	

Appendix 4: Glossary of terms

Advanced practice, advanced practice nurse

A generic term to indicate a level of practice beyond initial registration. In the US advanced practice incorporates four distinct roles: nurse practitioner, clinical nurse specialist, nurse anaesthetist and nurse midwife. In the UK the term has been used by successive regulatory bodies (UKCC, NMC) to indicate practice beyond first registration in their various consultations about future regulation, but to date no formal standards for advanced practice have been set.

Clinical nurse specialist

Also known as nurse specialists. A registered nurse with additional education and training who is a clinical expert in theory-based and/or research-based nursing practice working with a defined population or within a speciality area. As with nurse practitioners, no formal regulation of clinical nurse specialists currently exists in the UK.

Nurse

A protected title describing an individual who is regulated by a professional body (the Nursing & Midwifery Council for UK registered nurses), and is held legally responsible and accountable for their practice (*see registered nurse*)

Nurse anaesthetist

A category of advanced practice nursing (US only).

Nurse consultant

Nurse consultant is a job title unique to the UK; consultant nurses are very experienced registered nurses, typically clinical nurse specialists who work in a particular field of healthcare. They spend 50% of their time working directly with patients, they are responsible for developing practice through involvement in research and evaluation, and also contribute to education, training and development in their specialist area.

Nurse midwife

A category of advanced practice nursing (US only).

Nurse practitioner

"A registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded

practice." (ICN 2002)[1] Nurse practitioners are typically prepared at postgraduate level, and have skills in advanced health assessment, diagnosis, clinical decision-making, and may also have the authority to order investigations, prescribe medication and treatment, refer clients to other professionals, and admit patients to hospital. In the US nurse practitioners are often licensed by State Boards; in the UK no such system currently exists, and any nurse can refer to themselves as a nurse practitioner. Nurse practitioners prepared through RCN accredited programmes are generally recognised to have achieved a defined standard, and formal regulation of nurse practitioners is likely in the near future.

Nursing
'The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death' (RCN 2003)[2]

Registered nurse
A nurse who has successfully completed a period (typically three years) of professional education at a minimum of diploma level, and whose name appears on the live register of nurses held by the professional body (the Nursing & Midwifery Council for UK registered nurses).

Role, role transition
Role is defined as the position or purpose that someone or something has in a situation, organization, society or relationship .4 Within this study the term role is used to describe the position of the practitioner and his or her practice responsibilities in the context of the delivery of care. Role transition refers to the changing behavioural characteristics displayed by participants in response to changes in individual responsibilities and the context of care delivery. This is a key experience for registered nurses moving into a nurse practitioner role, and is one of the key themes explored within this study.

Specialist practice
Specialist practice was defined in the UK by UKCC[3] as 'the exercising of higher levels of judgement, discretion and decision making in clinical care'. It incorporates higher levels of clinical decision making and the

[1] International Council of Nurses 2002 *Nurse Practitioner/Advanced Practice: Definition and Characteristics of the Role* ICN Geneva
[2] Royal College of Nursing 2003 *Defining Nursing* RCN London
[3] UKCC 2001 *Standards for specialist education and practice* UKCC London

monitoring and improving of standards of care through supervision of practice, clinical audit, research, teaching and the support of professional colleagues, and the provision of skilled professional leadership. Community Specialist Practice included eight specialities, district nursing, practice nursing, community mental health nursing, community children's nursing, community learning disabilities nursing, occupational health nursing, school nursing and health visiting. In 2004 the new NMC register introduced a new category of registration for specialist community public health nurses, a category that includes occupational health nursing, school nursing and health visiting.

Pre-thesis

Areas of prior interest:

Nursing, professional status,
Advanced practice, new roles,

Interprofessional practice

Philosophy & health care
Autonomy

Consideration of research focus

Nurse practitioners
Professional autonomy
Role transition

Setting up the research

Initial proposal
Registration, funding

Ethical considerations

Detailed discussion of methodology

Phenomenology (Husserl, Giorgi)
Hermeneutics (Heidegger, Van Manen)

Narratives, interpretation (Ricoeur)

Consideration of methodology

Aimed at capturing personal experience

Qualitative approach

Literature review

Autonomy, nurses, professionalisation
Advancing practice

Nurse practitioners
Development, regulation, role

Philosophy, background, values

Ethical aspects

Local (University) approval; MREC approval

Information to participants, consent

Confidentiality, management of data
Ethical integrity, research relationships

Method, Data Collection

Derived from Ricoeur

Narrative interviews
Recordings transcribed to create texts

Data Analysis

Three phases:
Naïve interpretation
Structural (descriptive) analysis
Hermeneutic interpretation

Sampling

Purposeful sample: accredited NPs
Mix of UK & US registered, all with experience of topic
Diversity of clinical experience (Maximum variation sampling)

NPs were approached by Email/phone and invited to participate
Information and consent managed as per ethical approval

Preparation of texts to aid
analysis (MS Word, WimMax)

Revisit literature
to inform interpretation

Naïve interpretation

First reading of texts
Preliminary Identification of key themes
"Guesses and speculations" about content
A 'sense of the whole'

Descriptive structural analysis

Line by line scrutiny of texts
Identification of meaning units,
sub themes and themes
Creation of descriptive account of phenomenon,
Drawing on participants experience

Hermeneutic Interpretation

Re-examination of the texts to seek new
understanding, via appropriated meaning
Metaphor, analogy and emotion
Emergent meaning linked to literature

Thesis
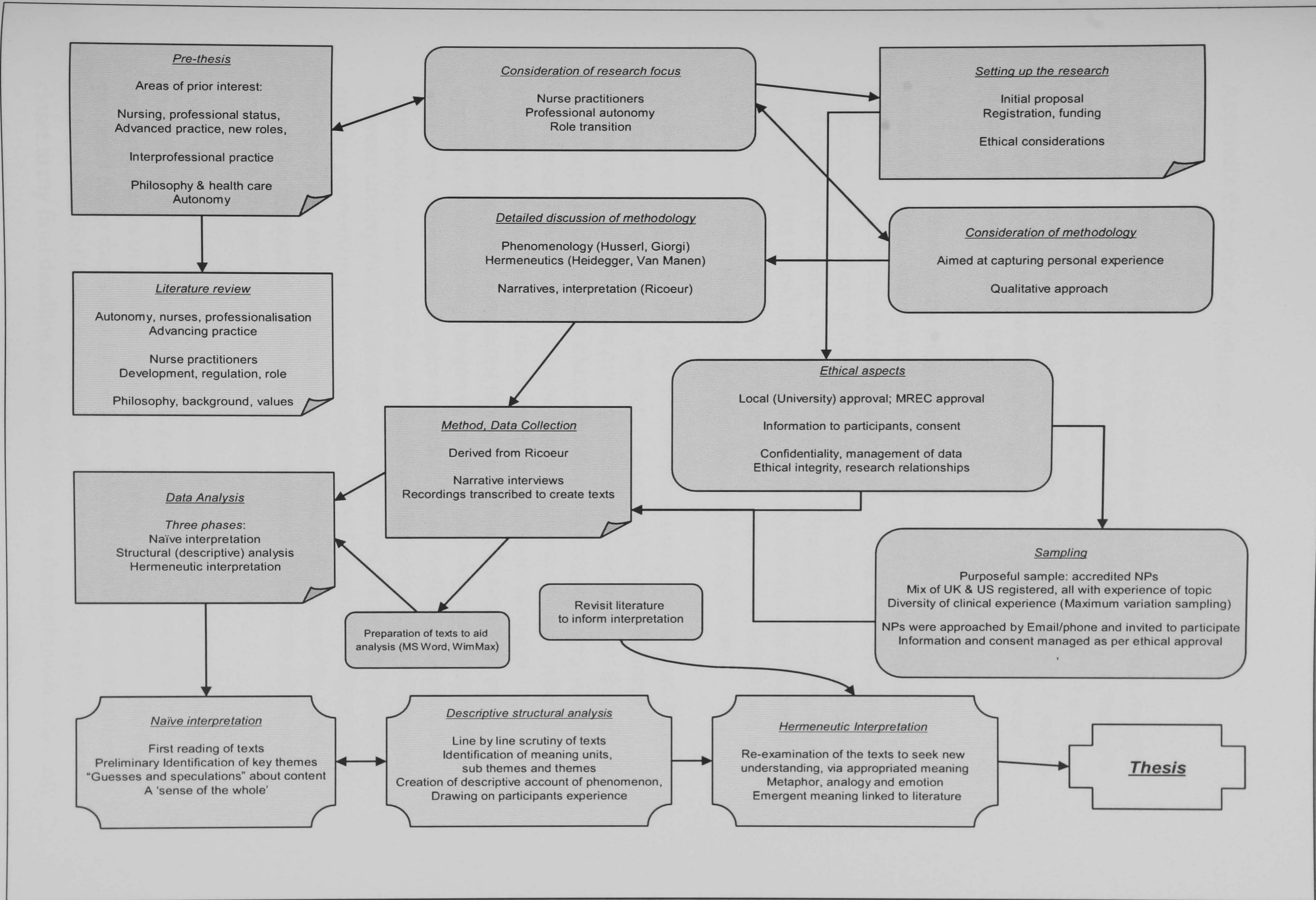
Appendix 6: Personal reflection

The development of this thesis has been a long and sometimes fraught experience, during which I have learned a lot about nurse practitioners and their roles, and about the conduct of qualitative research, but my most significant learning has perhaps been in relation to myself and my response to the demands of balancing doctoral study with full time employment and family life.

My initial interest in the subject and the encouragement offered by several insightful colleagues led me to register my interest in studying for a PhD. During the succeeding years my resolve was tested on several occasions, by conflicting workplace pressures, bereavement, job changes and the need to retain a work-life balance. Ultimately everything fell into place, and I am thankful that I was eventually able to reserve enough time to complete the study, despite those periods when I could not see how I would ever reach the point of successful completion.

My interest in philosophy led me to explore a range of methodological approaches to qualitative research; this in turn led me into some extensive discussions with my supervisors and others about the relative advantages of descriptive phenomenology as a means to explore personal experience. It was a year or more into the process, at a time when I was engaged in my review of the background literature on nurse practitioners, when I revisited the work of Paul Ricoeur, and my approach to the research began to fall into place. My supervisory team were very supportive, despite the lack of other studies using a similar methodology, and helped me to clarify my thoughts on the relationship between underpinning philosophical approaches, the research method, and the phenomenon under investigation. As I began the process of data collection and analysis I had to consider how each phase of the research should be conducted, evaluated, and recounted to generate a coherent account of the participants' experiences.

I was very grateful to all those people who participated in the study, and to all those who encouraged and supported me in my sometimes sporadic bursts of activity. After several years of engagement with the process I had a thesis that I felt was worthy of examination; my major problem was that it was not committed to paper, and I was getting ever closer to my final deadline. Six months from the final submission date my

supervisors questioned whether it was too late to complete in time, but I was determined to make a final effort, and they retained faith in my ability to write coherently and quickly. The final three months, during which the majority of the thesis was assembled, was a time of intense pressure, but I believe this helped me to maintain consistency in my writing and develop a text that I hope has integrity and coherence.

With little time for revisions and extensive editing, my study was submitted on the final available day, and I resumed my day job while arrangements for my viva-voce examination were put in place. When the appointed day eventually arrived, the examination was almost an enjoyable experience, made so by the positive, professional and supportive approach adopted by my examiners.

The outcome generated feelings of joy, relief, pride and a sense of achievement that only now, several months later, I can begin to appreciate in the wider context of my working life. I have learned that I can manage a large scale project to successful completion, and I understand something of qualitative research processes, and more about the conduct of hermeneutic studies. I appreciate the world of the nurse practitioner better than I did before I embarked on the study, and have developed my personal understanding of how professional roles and interprofessional relationships impact on the delivery of health care. Finally, throughout the process I have been gratified by the exceptional co-operation and support I have received from a whole range of people, including the nurse practitioners who participated in the research, my supervisors, university colleagues, external supporters and friends and family members, without whom I would not have been able to achieve my goal.

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