

A SPECIALIST NURSE: AN IDENTIFIED PROFESSIONAL ROLE OR A PERSONAL AGENDA?

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JANE A HUNT
Senior Nurse for Research and Development
King's College Hospital NHS Trust
Denmark Hill
London SE5 9RS

Tel: 020.7346.1694 (Work)
020.8693.8804 (Home)
Fax: 020.7346.1699 (Work)
020.8693.8804 (Home)
Email: Janeahunt@hotmail.com

INTRODUCTION

For the first half of the 20th century the term 'specialist' denoted a nurse with extensive experience in a particular area of nursing and in North America nurses have been deemed 'specialist' since 1910 (Hamric, 1989). However, 'specialist' nurses such as 'Sister Dora', who became famous during the 1870s for her specialized nursing treatment of machinery accident victims in Walsall (Manton, 1971), have existed within the United Kingdom (UK) since the Nightingale era. Castledine (1994) argues that the creation of specialist nursing practice began during this period with both the establishment of the Florence Nightingale School of Nursing and with the publication of her second version of *Notes on Nursing*. These two initiatives, he suggests, identify and link nursing as a profession with that of a speciality in which two classes of nurse are described: the amateur and the professionally prepared hospital nurse.

In the history of nursing, however, it is more generally considered that the clinical nurse specialist (CNS) first emerged in North America, reaching the UK during the early 1970s. Storr (1988) suggested that 'specialists' in clinical nursing evolved when the term 'nurse clinician' was first adopted in 1943. Others have considered that the CNS title dates back to 1938 (Peplau, 1965). Elsewhere some confusion reigns as to the origins of the title (Hamric 1989). It is agreed nonetheless that the title's beginnings arose in North America, during the late 1930s or early 1940s. More commonly, the label CNS began to appear in the 1960s when, in North America, much of the early literature focused on the justification for master's level education for advanced clinical practice (Storr, 1988, Hamric & Spross, 1989, Fenton, 1992).

The rise in specialist nurses within the UK occurred in response to an increase in public demand for services, an expansion of knowledge and skills, both in medicine and in nursing and particularly in technological interventions, and a desire on the part of nurses for a more varied career structure

(Castledine 1982, 1983, 1994). Early CNSs within the UK sometimes took on tasks previously undertaken by doctors, whilst others developed new skills to cope with new patient problems (Castledine, 1994). During the 1990s similar theories were assigned to the emergence of the advanced nurse practitioner (United Kingdom Central Council for nursing, midwifery and health visiting (UKCC) 1994, Cassidy 1996, Chan 1996, Dowling *et al.* 1996, Caballero 1998). The emergence of the advanced nurse practitioner (ANP) in the UK, compounded the continuing confusion regarding the CNS role and delineation between the two roles remains indistinct (e.g. Castledine 1996, Castledine *et al.* 1996, Coyne 1996, McGee *et al.* 1996, Mills 1996, Wilson-Barnett *et al.* 2000).

In his earliest study of CNSs, Castledine (1982, 1983) identified 11 key aspects of the CNS role which no single CNS fully encompassed. These comprised: direct involvement in care, responsibility and accountability for nursing actions, to be highly educated, a researcher, an educator, a co-ordinator of care, an expert in both clinical assessment of patients and in her field, to be autonomous, to be a writer and to form a liaison between the community and the hospital. This multiplicity of roles is reflected in a later survey conducted by the Daphne Heald Research Unit of the Royal College of Nursing (RCN) in which it was reported that 1016 CNSs nationally held 82 differing job titles (Wade & Moyer, 1989). Debating this confusion Steele and Fenton (1988 p.45) wrote:

Even though the role of the clinical nurse specialist (CNS) has been described in educational criteria, standards and the literature, some confusion still exists about the essential clinical practice skills needed for this advanced role. This situation may be due to the wide diversity of roles that CNSs assume in health care settings. In one institution a clinical nurse specialist may be involved primarily as an educator, in another as a consultant, and in another as an administrator or researcher or some combination of these roles.

A review of the literature undertaken during the mid 1990s in Britain, reflecting an earlier study (Storr 1988), suggested six major components to CNS roles to which many health care professional still subscribe. These comprise: clinical expert, resource consultant, educator, change agent, researcher and advocate (Miller, 1995). Many of these components have recently been ascribed to nurse consultants (NHSE 1999) and this new role will inevitably further cloud boundaries between higher level practitioners (Cox 2000, Hesketh 2000).

It has been recognized in the UK since the 1980s that nurse specialists: 'are prepared beyond the level of registration' (RCN 1988 p.6). However, in contrast to North America and despite support from the UKCC (UKCC 1999), distinctive criteria regarding educational attainments of CNSs remain unspecified. Moreover, educational accomplishments of all higher level practitioners, including CNSs have varied and, despite recommendations to the contrary (Wilson-Barnett *et al.* 2000), jobs have frequently been developed around the experiences of individuals (Smith, 1990). Whilst the UKCC recommended that nurses entering a speciality (as distinct from becoming a specialist, i.e. 'expert') be appropriately trained (UKCC, 1996), there remain limited stipulations for attaining 'specialist' status.

Implicit within examinations of specialist nurses over the years is an assumption that a high degree of 'specialist' knowledge is acquired. Despite continuing confusion surrounding CNSs, ANPs and more recently nurse consultants, including both a lack of a clear definition of their roles and explicit educational criteria in the UK, 'specialist' knowledge pertaining to all higher level practitioners, has for many years, been grounded in 'specialist', post-basic education. It is, however, also embedded within extensive clinical experience (Castledine 1982, 1983, Benner 1984, RCN 1988, Hamric 1992, Lipman & Deatrick 1994, MacLeod 1996, Wilson-Barnett *et al.* 2000).

This chapter draws on data from a study, undertaken during the 1990s, which examined the relationships between hospital- and community-based health care professionals and a group of specialist nurses collectively known as Paediatric Oncology Outreach Nurse Specialists (POONSs). It suggests that, despite nursing's continuing attempts to establish a professional agenda concerning the 'specialist' knowledge status of CNSs, health care professionals working with POONSs commonly disregarded professional agendas and conferred 'specialist' status on POONSs according to their own personal agendas and experiences. The chapter therefore offers some new insights into defining 'specialist' practice. Firstly, it provides multidisciplinary rather than nursing-specific definitions of 'specialist', through the perceived value of POONSs. Secondly, it proffers informal as opposed to formal definitions of 'specialist' which are not wholly enshrined in measurable criteria, which have to be met, such as qualifications. Thirdly, it tenders insight into the influence of work settings on the definitions of 'specialist' practice.

THE NURSING SPECIALITY OF POONSs

POONSs emerged as a nursing speciality during the mid 1980s as a result of perceived gaps in services both by families caring for children with malignant disease and by health care professionals in regional paediatric oncology units. They arose predominantly to support both families and carers through a child's terminal illness, at home. The successes of early posts led to a nationwide expansion of services, incorporating care through all stages of a child's illness and enhancing the philosophy of 'shared care' (Bacon 1989, Orton 1994, Bennett *et al.* 1994, Hooker & Williams 1996, Patel *et al.* 1997, Gibson & Williams 1997, Hunt 1998a, Greener 1998, Jones 1998). POONSs act as main contact persons to families in their own homes during periods of treatment and post-treatment, enabling them to feel more secure (Bignold *et al.* 1994). In so doing they provide links between primary, secondary and tertiary care, offering local services information and support.

The degree to which POONSSs fulfil the role of CNS, as identified within the literature, varies and is influenced by the different organizations associated with funding their work (Hunt 1994, 1995, 1996, 1998a) and, during the period in which this study was undertaken, POONSSs were either located within children's departments at district general hospital trusts or within specialist paediatric oncology units at tertiary referral centres. The funding arrangements and work location of POONSSs in turn influenced service structure and POONSSs either worked alone or in teams (Hunt 1994, 1996, 1998a). The impact that differing work locations had on health care professionals' perceptions of 'specialist' are highlighted in this chapter.

THE STUDY

This chapter draws on qualitative interview data from the second stage of a large two-part study which explored the impact of funding arrangements on the professional relationships between POONSSs and other health care professionals (Hunt 1996, 1998a). The first stage was designed to understand better the structure, organization and working practices of POONSSs. Interviews were conducted with all POONSSs in post in the UK and the Republic of Ireland during 1993, using a semi-structured interview schedule (n=43). Findings from the first stage of the study have been reported elsewhere (Hunt 1995, 1996, 1998a).

The second stage was designed to examine the perceptions and experiences of health care professionals working with POONSSs. It comprised case studies at three locations in England (two regional, Southern Regional Hospital and Northern City Children's Hospital, and one district, Westlands District Hospital), consisting of focused interviews with a broad cross-section of community and hospital-based health care professionals. These included senior and junior medical and nursing staff, specialist social workers, general practitioners (GPs), health visitors (HVs) and district nurses (DNs).

Sixty-five interviews took place between October 1994 and April 1995. The participants are summarized in Table 1.

During the period in which the study was undertaken no ethical approval was required since interviewees of both stages of the research were consenting health care professionals. Ethical considerations, however, mean that hospitals and individual practitioners have been allocated pseudonyms to maintain their anonymity.

Analysis

Issues with analysing qualitative data are not concerned with generalizability or 'sample to population' representativeness but with establishing theoretical links within each case and developing new theories (Brannen 1992, Miles & Huberman 1994). In this study, analysis of the interviews with health care professionals was conducted through the development of a conceptual framework which was generated using a data reduction, display and verification model (Miles & Huberman 1994). Four major themes emerged from within the conceptual framework. These included: teamwork, relationships between POONSSs and other nurses, relationships between POONSSs and doctors, and specialist knowledge. Only data pertaining to the theme of 'specialist knowledge' are drawn upon in this chapter. Other findings have been reported elsewhere (Hunt 1996, 1998a, 1998b, 2000).

CONFERRING SPECIALIST STATUS ON POONSSs

Disregarding nursing's professional agenda to ensure that specialist nurses be highly educated and experienced in their field, this study indicated that, in general, health care professionals conferred 'specialist' status to POONSSs according to their own experiences and agendas. Perceptions of 'specialist' knowledge appeared to be contingent upon the level of experience health care professionals had themselves gained in the speciality in question, the hospital location and the professional

background of the POONSs they worked with. When 'specialist' status was conferred to POONSs, 'specialist' knowledge was seen to be derived from a combination of: formal qualifications, hands-on technical skills, previous 'specialist' work experience, in-depth 'medical' knowledge and/or insight into families' dynamics. The relative contribution each of these made towards constructing a 'specialist', primarily depended upon the regional or district location of POONSs (Figure 1.) Different emphasis was placed on each conferred component of specialist knowledge, depending on the agendas of individual health care professionals working with POONSs. Here, examples of two personal agendas are described: (1) 'needs-driven agendas' and (2) 'peer-driven' agendas.

Needs-driven agendas

Some health care professionals who worked with POONSs had professional needs, either concerning caring for children with malignant disease, or helping them to pursue their own careers. This led to the identification of four personal 'needs-driven agendas' which contribute to health care professionals conferring 'specialist' knowledge and status on POONSs: (1) a knowledge gap, (2) resolving anxieties, (3) pursuing 'specialist' nursing careers, and (4) knowing families.

A knowledge gap

Primary health care professionals' experience of working with children with malignancy, although different, are extremely limited (Halliday 1990, Pinkerton 1993, Hunt 1996, 1998a, 1998b). These limited experiences are epitomized by one GP from this study who said:

This particular patient was the first one... in general practice. I've not had anyone that's had a terminal illness. Yes, yes, I've not had anyone else.

(GP5, Northern City Children's area)

The personal 'needs-driven agendas' of primary health care professionals relate to these limited experiences – primary health care professionals need to understand how to care for sick children and their families before comprehending the more 'specialist' problems associated with paediatric oncology. In this scenario emphasis is placed on two components of conferred 'specialist' knowledge hands-on technical skills and 'specialist' work experience (Figure 1). The definition of 'specialist' work experience depends not only on the past experiences of individual primary health care professionals, but also on where the POONS with whom they worked was located. At one level, all POONSs achieved 'specialist' status since all had 'specialist' paediatric experience relative to primary health care professionals' needs. As one district nurse (DN) suggested: '(POONSs) are used to actually dealing with children' (DN9, Southern Regional area). Hence nursing sick children, irrespective of the disease: 'needs somebody who's got experience of looking after children' (DN2, Northern City area).

At a second level, however, work experience takes on a 'specialist' perspective. A basic cognizance of paediatrics was seen as essential by all primary health care professionals. In contrast to those working with a POONS at a district general hospital trust, many primary health care professionals working with regional POONSs considered 'specialist' working practice to be derived specifically from paediatric oncology nursing experience. As one DN involved in the care of a newly diagnosed child commented: 'she's a specialist and I can't possibly keep up with the (cytotoxic) drugs, you know, the current ones' (DN15, Southern Regional area).

Resolving anxieties

A second 'needs-driven agenda' whereby 'specialist' knowledge was conferred on POONSs, concerns resolving anxieties. District nurses, unused to nursing sick children, experience a great deal of anxiety when faced with caring for a child with malignant disease (Hunt 1998a, 1998b). In this situation,

anxieties may be resolved through the availability of 'specialists' with hands-on technical skills and previous work experience (Figure 1), which they lacked.

For junior staff nurses (SNs) on a general paediatric ward, used to nursing sick children but less familiar with malignant disease, anxiety also arises when caring for children with cancer or leukaemia and their families. The perceived 'specialist' status of POONSs, arising from SNs' anxieties, similarly draws on 'specialist' work experience and hands-on technical skills. It may also draw on formal training. 'Specialist' knowledge as identified by SNs is epitomized thus:

I wouldn't be able to cope with the bereavement side of things – I just feel very inadequate and I'd need a lot of training in that direction I think, with parents, with knowing what to say and then saying it.

(SN8, Westlands District Hospital)

Hence 'specialist' status was granted to POONSs through the 'needs-driven agendas' of both DNs and SNs at district hospitals, to resolve their anxieties. However, the stresses endured by these two groups of nurses, both inexperienced in paediatric oncology, arise from different baseline perspectives. Whilst DNs and SNs at district general hospitals conferred 'specialist' status on POONSs because of their 'specialist' work experience and hands-on nursing skills, their definitions differed. For DNs, these skills pertain to paediatric nursing, whilst the hands-on skills and work experience demanded by junior SNs at Westlands were specific to the needs of children with malignant disease.

Pursuing 'specialist' nursing careers

A third 'needs-driven agenda' in which 'specialist' status was accorded to POONSs concerns SNs pursuing careers – becoming a POONS is one option which was open to them. Contemplating future career pathways affected all junior SNs similarly, regardless of the environment in which they worked;

work experience and further formal qualifications assist SNs up the ladder of seniority and to attaining 'specialist' status. 'Specialist' status was conferred upon POONSs according to the perceived deficits in SNs' own knowledge which they would have required before undertaking the work of a POONS (thereby becoming a 'specialist') themselves. It was this perceived need of SNs to rectify shortfalls in their own knowledge before attaining 'specialist' status, which contributes to this 'needs-driven agenda'. However, 'specialist' knowledge was constructed differently according to the environments in which SNs worked, the formal training and experiences of the POONSs they worked with and, for those at regional centres, professional agendas concerning the professional and academic qualifications of CNSs. Furthermore, formal qualifications demanded by SNs to achieve the 'specialist' status of POONSs differed between regional centres and Westlands District Hospital.

Staff nurses at the district hospital overlooked professional agendas which attempt to dictate the formal post-registration training undertaken to attain 'specialist' status. Instead, reflecting the background of the POONS they worked with and their own working environment, they generally beheld 'specialists' as having extensive work experience and hands-on technical skills. In contrast, in addition to 'specialist' work experience, SNs at regional centres, mindful of the professional demands nursing places upon itself to achieve 'specialists' status, also emphasized the importance of formal post-basic qualifications.

Junior SNs at the district hospital considered that 'specialist knowledge' is gained through extensive work experience following the attainment of the Registered Sick Children's Nurse/ Registered Nurse (part 15 UKCC registration, Child). It comprised 'specialist' hands-on nursing tasks (Figure 1) such as handling central venous access devices and administering intravenous drugs. It may, for a limited number of SNs, have comprised formal post-basic training attained through a National Board Certificate in paediatric oncology nursing. One SN commented:

You've got to have an overall paediatric knowledge...learning and knowing about oncology problems, of treatments...

(SN7 Westlands District Hospital)

In contrast, SNs at regional centres envisaged that 'specialist' knowledge of POONSSs comprised both formal post-basic community nurse training and 'specialist' experience in this field. Taking the premise that formal training and lengthy experience in both paediatrics and oncology was accomplished by all senior nurses working within the field of paediatric oncology, it was the community nursing experience and formal training in this area of work which was seen to separate POONSSs from other senior nursing staff:

You have to have a community qualification to be in the community, I mean that's a criterion to be a community nurse, you can't otherwise do it.

(SN11, Southern Regional Hospital)

Knowing families

POONSSs are seen to develop especially close relationships with families (Bignold *et al.* 1994, 1995a, 1995b, Hunt 1998a). This arises through POONSSs' abilities to 'boundary hop' between hospital and the community. However, unique to the paediatric consultants at the district hospital, the in-depth knowledge of families' dynamics brought about through 'befriending' (Bignold *et al.* 1995b) families, was seen as a skill of POONSSs to be drawn upon (Figure 1). This gave rise to a fourth 'needs-driven' agenda in which consultants depend upon this knowledge to assist them in making treatment-related decisions about patients. The reason consultants at Westlands District Hospital depended on this knowledge were unclear, but may lie in consultants' frequent provision of hands-on care to children, both in hospital and at home (Hunt 1998a). In this situation, consultants were reliant on POONSSs to teach them specialist technical 'nursing' skills such as accessing central venous access devices. To

undertake such tasks required 'befriending' the child with malignant disease and his/her family in order to gain their trust. Consequently, in this 'needs-driven' agenda, consultants not only confer 'specialist' knowledge on POONSSs through POONSSs' relationships with families, they also draw upon their 'specialist' hands-on skills.

In summary, in this study 'needs-driven agendas' were derived from four perspectives: knowledge gaps of primary health care professionals, anxieties of some groups of nurses, career pathways of SNs and POONSSs' knowledge of families. 'Needs-driven agendas' which drove health care professionals to confer 'specialist' status on POONSSs were not only influenced by individuals' experiences and agendas. They differed predominantly according to the hospital location and the background of the POONSSs they worked with.

Peer-driven agendas

A second type of personal agenda existed where 'specialist' knowledge was conferred by health care professionals who did not 'need' to draw on POONSSs' knowledge. These personal agendas are referred to as 'peer-driven agendas', and two types are discussed here: (1) distinguishing between specialists, and (2) the professional status of POONSSs. In the main, these existed for senior, hospital-based health care professionals at regional centres, who, in the absence of POONSSs, could (and previously did) provide a skeleton outreach service to children being cared for locally. In this scenario, 'specialist' was denoted by the attributes which distinguished one 'specialist' from another. However, 'peer-driven agendas' also existed for senior medical staff, regardless of their work location, whose concerns included the professional status of POONSSs.

Distinguishing between 'specialists'

A major characteristic of 'peer-driven agendas' concerned distinguishing between 'specialists'. This arose from two perspectives: firstly it occurred when senior hospital-based health care professionals at regional centres distinguished the 'specialist' nature of POONSS' work from either their own, or that of other senior hospital staff. Secondly, it transpired when health care professionals across both community and acute hospital settings distinguished the 'specialist' nature of POONSS' knowledge from that of community children's nurses.

Senior health care professionals at regional paediatric oncology centres achieve their own 'specialist' status such that both consultants and sisters develop their own 'specialist' areas of practice, including bone marrow transplantation, long-term follow-up, adolescence and disease-specific areas such as brain tumours. In this situation 'specialist' knowledge was constructed amongst peers of POONSSs as that which distinguished the nature of POONSS' work from their own, or that of other senior staff. In the main, 'specialist' knowledge was construed around the backgrounds of both the POONSSs they worked with and, for some, POONSSs at other regional centres (through the professional bodies the Paediatric Oncology Nurses Forum of the RCN and the United Kingdom Children's Cancer Study Group, several senior staff at regional centres possessed global insight into POONSS' backgrounds); it was reflected in post-basic qualifications and 'specialist' work experience (Figure 1). One sister indicated this by saying:

The people I've worked with are people who've had a community background and paediatric training plus oncology... to me it appears to work well so therefore I feel that is what they need

(Sister 4, Southern Regional Hospital)

In this 'peer-driven agenda' there was an axiom amongst sisters and consultants that all senior nursing staff had attained previous work experience and formal training in paediatrics and oncology. The formal

training and work experience which distinguished POONSs' 'specialist' knowledge from that of their nursing peers, as suggested above, concerned community nursing work:

I think there is a dimension to care in the community, which we who work in hospital don't understand.

(Consultant 5, Northern City Hospital)

Not only was great emphasis placed upon formal training and 'specialist' work experience in community nursing, but this type of agenda uniquely recognized the importance of POONSs' in-depth, 'specialist', 'medical' knowledge. It is this in-depth 'medical' knowledge which distinguished the 'specialist' knowledge of POONSs from that of consultants. Here, consultants and sisters alike, overtly recognized that POONSs' 'specialist', 'medical' knowledge lay in symptom management during terminal care, which exceeded the knowledge of consultants. One commented:

Nearly always they (POONSs) know more about pain control than the doctors do, they have a much better feel for it...beyond sort of straightforward anti-emetics, you know, they're usually very good on second and third line anti-emetics.

(Consultant 7, Southern Regional Hospital)

A second feature of this 'peer-driven agenda' which separated POONSs from other 'specialists', distinguished between POONSs and community children's nurses. This arose when health care professionals across community and acute hospital sectors had experience working with both groups of outreach nurses. (Although Whiting (2000) noted that community children's services have developed substantially during 100 years of community children's nursing, nationally there had been a dearth of community children's nursing services (Whiting 1995). The Southern Regional Hospital however, was located in a region that had been particularly well served by community children's nursing teams for a number of years). Whilst it is formal training and experience in community nursing which stood

POONSs apart from hospital-based health care professionals at regional centres, it was community nursing which linked POONSs with community children's nurses. However, there are components of conferred 'specialist' knowledge which distinguished POONSs from community children's nurses. The different experiences of primary health care professionals and acute hospital staff meant that professionals across the two health care sectors drew on different components of conferred 'specialist' knowledge to determine the specialist nature of POONSs.

Primary health care professionals predominantly distinguished the 'specialist' nature of POONSs' work from community children's nurses through hands-on technical skills. Whilst they acknowledged that both possessed 'specialist' technical skills relative to their own fields, the skills of POONSs were perceived to be more 'specialist' than those of community children's nurses. Hospital-based health care professionals on the other hand, distinguished POONSs from community children's nurses because of their formal qualifications, previous 'specialist' work experience and in-depth 'medical' knowledge. One hospital doctor said: '(POONSs) are likely to have had to have done more, longer, specialist training (than community children's nurses)' (SHO 3, Southern Regional Hospital), whilst a consultant commented: 'I don't know how they (community children's nurses) get trained but I assume as part of their training they wouldn't have a lot of emphasis put on how you manage a child dying of cancer at home' (Consultant 6, Southern Regional Hospital). The differences in formal training, specialist work experience and hands-on tasks were confirmed by a community children's nurse interviewed during the course of the this study who said:

Nurses in that speciality usually have gone through courses for blood-letting and, you know, the practical things.

(CCN2, Southern Regional area)

The professional status of POONSs

A second 'peer-driven agenda' concerns the professional status of POONSs. This feature of conferred 'specialist' knowledge was predominantly associated with senior hospital doctors who assumed a level of responsibility for the professional welfare of POONSs. The reasons why these perceived responsibilities arose are unclear. However, they were particularly developed in consultants who had procured charitable funds to establish POONS services (Hunt 1998a). In this instance, consultants appeared to maintain a vested interest in the well-being of POONSs to ensure the success of the service. The concerns for the professional status of POONSs, which steer this 'peer-driven agenda', arose firstly from perceived 'specialist' knowledge required to establish successful relationships with local communities. Secondly, they existed for district-based consultants concerned that POONSs maintain professional credibility through sustaining 'specialist' knowledge.

Regional consultants, concerned for the professional status of POONSs, were troubled by relationships between POONSs and local communities. In this scenario, professional status was assumed by consultants to be gained through credibility with community nurses. This was achieved through POONSs accomplishing community nursing qualifications. Here, it was anticipated that POONSs required a community nursing qualification to make them: 'more acceptable to the local people' (Consultant 6, Southern Regional Hospital) and 'to the local paediatric teams' (Consultant 7, Southern Regional Hospital). Credibility as a 'specialist' was then established when, it was perceived, the post-basic qualifications of POONSs both matched and exceeded those of community nurses. In this agenda great value was placed on post-basic formal qualifications (Figure 1).

Concerns for the professional status of a district hospital-based POONS, by consultants, took a different form. Here, sustaining and up-dating knowledge was required in order to establish credibility amongst hospital-based health care professionals, thereby maintaining a 'specialist' status. In the main,

this concerned keeping up-to-date with hands-on technical skills. When it was perceived that hands-on skills were kept up-to-date, professional credibility, 'specialist' and consequently professional status was maintained. As one consultant commented: 'she's very good at going off and going into all the sessions and forth' (Consultant 2, Westlands District Hospital).

CONCLUSION

Reflecting on the continuing confusion surrounding 'specialist' nurses, advanced practitioners and nurse consultants, this chapter has argued that health care professionals' perceptions of 'specialists' were subjective, being grounded in their personal experiences of, in this instance, childhood malignancy. They were also embedded in the hospital locations and individual backgrounds of the POONSSs they work with. Disregarding nursing's professional agenda in which 'specialist' nurses are expected to attain a high degree of post-basic education, health care professionals generally conferred specialist status on anyone they perceived as more experienced or 'specialized' than themselves. These perceptions and experiences gave rise to two personal agendas which have been termed 'needs-driven agendas' and 'peer-driven agendas'. 'Needs-driven agendas' comprised: POONSSs' abilities to fill a knowledge gap, resolving anxieties, pursuing 'specialist' nursing careers and knowing families. 'Peer-driven agendas' were drawn from the distinctions regional senior hospital staff made between POONSSs and other oncology 'specialists' and differentiations between POONSSs and community children's nurses. Secondly, they were derived from senior hospital doctors' concerns about the professional status of POONSSs.

Both 'needs-driven' and 'peer-driven' agendas drew upon formal qualifications, hands-on technical skills, 'specialist' work experience, in-depth medical knowledge and/or insight into families' dynamics (Figure 1). The relative contribution which each of these 'knowledge' components made to conferring specialist status on POONSSs was primarily dependent upon the regional or district work location of

POONSs. In the main these concern distinctions between 'specialist' paediatric experience and education, and 'specialist' paediatric oncology and community nursing experience and education. These factors contribute to the adoption and adaptation of George Orwell's (1945 p.114) slogan that: 'All nurse specialists are specialists, some nurse specialists are more specialist than others'.

Current policies present dichotomies for those working within the health care sector generally and in specialties such as paediatric oncology in particular. On the one hand, there is a national drive towards reducing the 'post code' lottery (DH 2000) and providing 'specialist' cancer services at designated 'specialist' centres (DH 2001). On the other hand, current health policy ensures that patients have access to health services within their local communities (DH 2000). In keeping with this dichotomy, this research has suggested that 'specialist' POONS status may be gained within both local 'general' and regional 'specialist' settings. Nurses seeking specialist status within paediatric oncology should be mindful of this and the ways in which other health care professionals confer 'specialist' status to nurses. Those wishing to acquire 'specialist' status without undergoing more 'specialist' training beyond first level registration, may chose to work within a district general hospital trust. In contrast those aspiring to have 'specialist' status conferred to them within a specialist centre, would be advised to gain both extensive experience and post basic 'specialist' education in their selected 'specialist' field.

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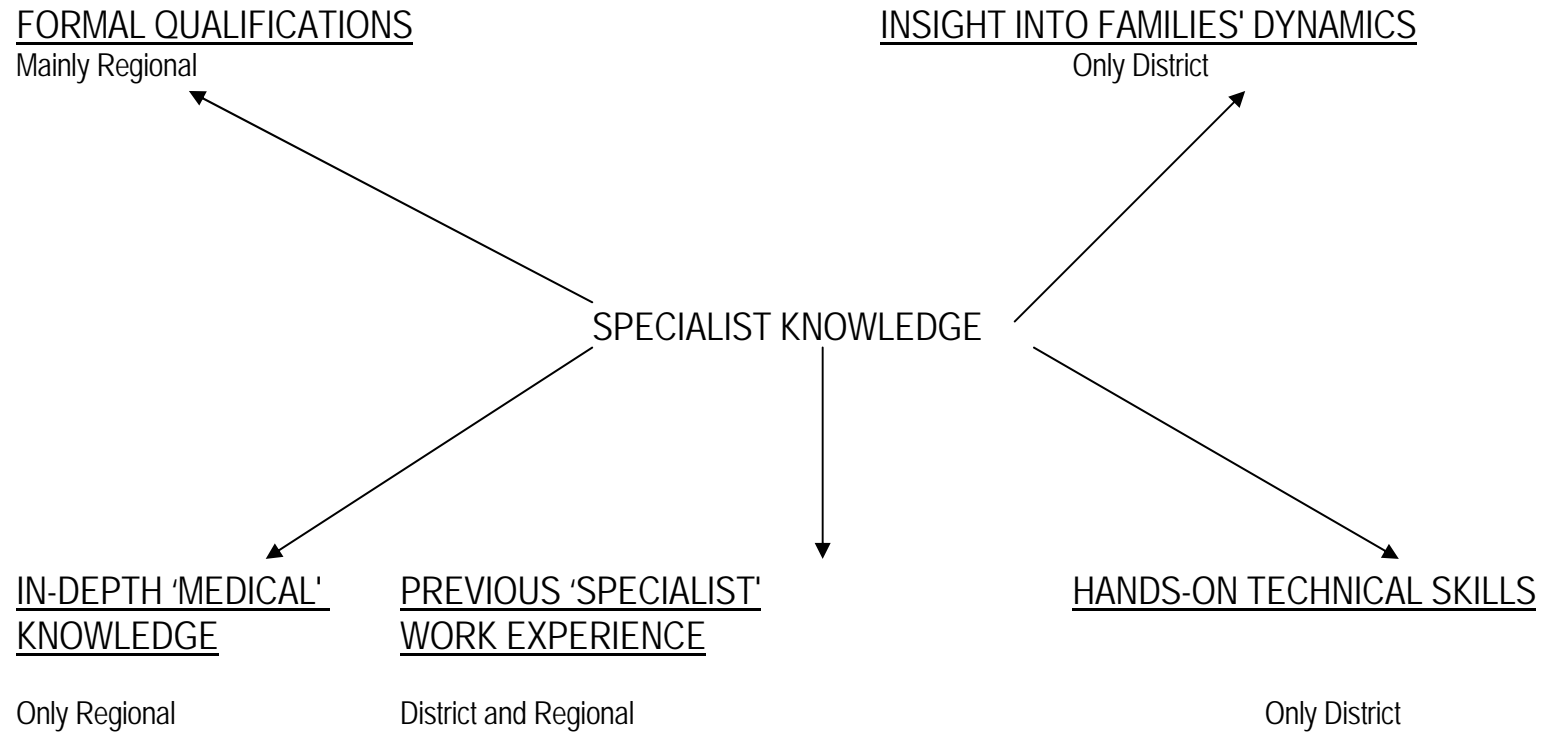
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Figure 1 Components of 'specialist' knowledge conferred on POONSs by other health care professionals



Fell
ows
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_ * 1 GP included twice since interviewed both in connection with a newly diagnosed child and a terminally ill child
I - Individual Interviews, G - Group Interviews (2-4 interviewees)