

**An Exploration within the Complex Worlds
of Senior and Advanced Nurse
Practitioners Roles:
A Constructivist Grounded Theory Study**

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of the requirements of Edinburgh Napier
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Declaration

I declare that this thesis has been composed by myself. That it has not been accepted in any previous application for a higher degree. That the work of which it is a record has been performed by myself and that all sources of information have been specifically acknowledged.

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Abstract

Over the past 30 years, Senior and Advanced Nurse Practitioners (SNPs/ANPs) have been introduced into the healthcare arena across the world. The international literature reports such roles have created tensions within healthcare systems (Smith 2000; Tye & Ross 2000; Scholes & Vaughan 2002). However, over the past three decades the root causes of such tensions remain still to be addressed. The literature reports the consistent entrenched reluctance to collaboratively engage with SNP/ANP roles (Cummings et al. 2003; Reay et al. 2003; Davies 2006). This led to the aims of my Constructivist Grounded Theory (CGT) study, which were to discover why there continues to be tensions surrounding Senior and Advanced Nurse Practitioner roles in healthcare, in addition to attempting to generate a substantive theory to provide a foundation in which a hypothesis could be tested across a wider arena. Arising from these aims were three research questions which were explored in three phases. The first research question, posed in phase 1, was 'where are tensions created by Senior and Advanced Practitioner roles from a service user and healthcare team perspective?' This led to in-depth interviews taking place with service users (n=12) and members of the healthcare team (n=18). Theoretical sampling consisted of medical staff (n=9), nursing staff (n=7) and Allied Health Professionals (n=2). Data were considered saturated when no new data could be identified and the main categories with focused codes were coherent.

The second research question, posed in phase 2 of my study, was 'where do tensions remain apparent in service and what meanings and actions are attributed to them?' The method of Grounded Theory Ethnography was employed, which gave priority to interactions rather than the setting. This method consisted of a 3 stepped approach, employing participative observation and individual interviews. In total, 13 periods of observation were undertaken, which equated to 64 hours of observation within different sites. The emergent categories from this phase built upon the categories from phase 1.

In phase 3 the research question posed was 'what are the interpretations of Senior and Advanced Nurse Practitioners on interactions with the healthcare team and service users?'

Six focus groups and one paired interview enabled the development of the core category “Status Games”. This subsumed the main categories from each phase and incorporated common themes and patterns across all data. This core category was further verified with five individual interviews and no new properties emerged. This core category reflected the data across all phases effectively. Interpretative theorising incorporated advanced memos across all 3 phases of my study and enabled the development of a substantive theory. Social psychological game theory and underpinning script theory, which is part of the Transactional Analysis Paradigm, provided the theoretical lens to interpret what was grounded in the data. This led to the development of two new concepts, the first was status games which incorporated game analysis and highlighted ulterior transactions which have not been previously reported in the literature. The second was the professional script concept, which it is theorised underpins status games. This is also new and has not been conceptualised in the Transactional Analysis or healthcare literature. This theoretical framework illustrated that status games which fulfil professional script are being played out with awareness. It is proposed that by recognising these concepts, this will reduce tensions with SNP/ANP roles and lead to improved patient-centred care.

As Vandra (2009) reports by recognising the processes and actions of communication it is possible to bring ulterior transactions into full awareness and prevent games, thus problems with communication. This led to the development of the substantive theory in this study which is: *‘The tensions generated by SNP/ANP roles stem from playing status games to fulfil professional script which requires to be recognised and acknowledged by the healthcare team in order to change the status quo and culture’*. Whilst social psychological game and script theories can provide an underpinning understanding of social games and life scripts for individuals, the status game concept which emerged from my study expands our knowledge and provides a unique understanding surrounding the impact of professional script in healthcare organisations. It is hypothesised that this script has led to status games, which is central to the tensions surrounding SNP/ANP roles.

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List of Abbreviations

ACNP – Acute Care Nurse Practitioner

A& E – Accident & Emergency

ANP- Advanced Nurse Practitioner

CGT – Constructivist Grounded Theory

CNC – Clinical Nurse Consultant

CNS – Clinical Nurse Specialist

DOH – Department of Health

ED – Emergency Department

ENP- Emergency Nurse Practitioner

EWTD – European Working Time Directive

GT – Grounded Theory

GP – General Practitioner

HAN – Hospital at Night

HEAT – Health, Improvement, Efficiency, Access Treatment

ISD – Scottish Information Services Division

MMC – Modernising Medical Careers

NHS – National Health Service

NMC – Nursing Midwifery Council

NNP – Neonatal Nurse Practitioner

NP – Nurse Practitioner

NS – Nurse Specialist

PNP – Paediatric Nurse Practitioner

SDM – Shared Decision-Making

SNP- Senior Nurse Practitioner

TA – Transactional Analysis

Glossary¹

Advanced Nurse Practitioner (ANP) - Experienced clinical nurses who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high level clinical decisions and will often have their own caseload (SGHD 2005a).

Biomedical model of communication - A focus on set questions with the prime aim of achieving the diagnosis and treatment of a health problem in a timely manner, thus enabling effective care (Adapted from Memal 2008).

Biopsychological model of communication - A focus on how a service user² is able to function and live in society, identifying individual needs, thus providing effective or quality of care (Adapted from Memal 2008).

Critical research companions - Based on Tichen's (2003 a & b) work, three independent individuals provided high level critical challenge surrounding the research process, assumptions and reflexivity (Figure 3).

EWTD - The European Working Time Directive (EWTD) is a directive from the Council of Europe (93/104/EC) to protect the health and safety of workers in the European Union. It lays down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. The Directive was enacted into UK law as the Working Time Regulations, which took effect from 1st October 1998. The Government negotiated an extension of up to twelve years to prepare for full implementation for doctors in training.

Focused selected literature review - Focusing on a particular area of literature set through inclusion and exclusion criteria.

Grounded Theory Ethnography - A GT study takes a different form than other ethnographic methods as it gives priority to the studied phenomenon or process, rather than a description of settings (Charmaz 2006- Table 10).

Hybrid Role (SNP/ANP) – A mix between a nursing and medical role.

Hybrid Role (In research) – An individual who undertakes research work into practitioners however, who also has professional experience within the phenomena under study.

Informal Interview – In this study, it is an unstructured open-ended interview and notes taken.

Integrated literature review - In this study, this refers to a critical analysis of the literature which was selected in relation to emerging codes.

Life Script - “an unconscious life-plan made in childhood, reinforced by the parents, justified by subsequent events and culminating in a chosen alternative” (Stewart & Joines 1987:330).

¹ Definitions without a reference have been devised by Corcoran 2010

² Service user = patient

Normative rules – “Reflect expectations held by social actors regarding goals and activities for certain individuals or specified social position” (Currie & Sutomlinova 2006:2).

Permuted Index - Enables a focused literature review through showing single-word search terms within the context of similar terms, related terms and used for terms that display in a hierarchical structure based upon controlled vocabulary of the data base (The Knowledge Network 2010)

Professional closure - Is described as professionals adopting to preserve their identity, protect their professional boundaries and maintain the privileges of their social order (Porter 1998).

Professional Script - Defines a profession and also fulfils an individual's life script. It is directly interlinked with life script, which is reinforced through professional socialisation. Each occupational group's professional script is made up of 'Etiquette', 'Technicalities' and 'Character' (page 200).

Senior Nurse Practitioners (SNP) - Nurses who have a higher degree of autonomy and responsibility than 'registered nurse' in a clinical environment or who would be managing one or more service areas in a non-clinical environment (SGHD 2005a).

Shared Decision Making - A process within a person centred consultation that involves both the service user and healthcare professional discussing management options and mutually sharing the decision on treatment and care. (Adapted from Thistlethwaite et al. 2006).

Status Games- Consists of repetitive ulterior transactions which maintains status and fulfils professional script.

Ulterior Transactions – Two messages projected during communication, one is on an overt social level, whilst the other is on a covert psychological level (Stewart & Joines 1987).

Chapter 1

Background – Context to my study

1.0 Introduction

In 2005, the Scottish NHS system was going through radical change. There was a reduction in junior doctors and an increased demand on NHS services, with a requirement to reduce public spending. On a Scottish level, the European Working Time Directive (EWTD) was being implemented, resulting in less junior doctors within acute hospital sites, as they were required to reduce their working hours. This led to the local NHS management considering alternative ways of working, which became known as modernisation of the healthcare workforce (SGHD 2006b). The message from the Scottish Executive Health Department at this time was that the NHS required to consider new ways of working more effectively (SGHD 2006b). This led to the implementation of Senior Nurse Practitioners (SNPs) and Advanced Nurse Practitioners (ANPs) within acute care. The literature acknowledges that the implementation of SNP/ANP roles in acute care had the potential to cause tensions within the healthcare team (Smith & Preston 1996; Bousfield 1997; Read et al. 2001; Banaham & Connelly 2002; Scholes & Vaughan 2002; Jones 2003; Marsden et al. 2003).

This was consistent with the literature surrounding such roles over the past three decades, which has reported on the tensions these roles have created within health services (Little 1978; Fottler 1979; Pleines 1979; Chacko & Wong 1984; Glenn et al. 1987; Hormans 1987; Bowler & Mallik 1998; Wilson 1994; Flanagan 1998; Morton 1999; Gooden & Jackson 2004; Lloyd –Jones 2005). Phillips et al. (2002) points out that such tensions prevent collaborative working across the healthcare team, thus having a negative affect on patient care. It was deemed timely to discover why tensions associated with SNP/ANP roles continued in practice, over a period of 30 years, as at the start of my study there was substantial increase of such roles within acute care due to the modernisation of the NHS.

Several authors reported that the profusion of new nursing roles and titles in the UK had resulted in confusion for patients, Nurse Practitioners (NPs) and other healthcare professionals (Carnwell & Daly 2003; Asbridge 2006; Elsom et al. 2006; Bunnell 2007; Curren 2007). In the UK, rather than being strategic in the approach towards practitioner roles, this nomenclature had been operationalised locally, thus leading to the disparate use of terminology to aid in meeting localised service needs (Willard & Luker 2007). Tye & Ross (2000) report that this lack of consistency is a barrier to the successful implementation of such roles. I questioned whether the confusion surrounding the role and remit of SNPs/ANPs would increase tensions within the healthcare team and also influence the views of service users.

Central to modernisation was placing service users at the heart of the NHS system. This had been reiterated in numerous policies and strategies (DOH 2004a; 2005 a & b; 2006 SEHD 2003; 2006a). However, I found few studies on an international basis which included service users' views or perceptions surrounding SNP and ANP roles. Some authors highlighted the requirement for further research from a service users' perspective (Lawson 2002; Donohue 2003). This raised my curiosity about service users' views of SNP/ANP roles and whether this could be associated with tensions reported in the literature.

The purpose of Chapter 1 is to provide an outline of the historical development and associated tensions of SNP/ANP roles and describes the titles and definitions utilised in my study, incorporating current debate on the regulation of such roles in the United Kingdom (UK).

1.1 The development of SNP/ANP roles

The expansion of Nurse Practitioner (NP) roles has occurred on an international level, due to modernisation in healthcare provision, with the aim of placing the service user at the heart of such change.

However, it has been reported that this in turn has led to the ad-hoc development of NP roles and titles (Anderson 1997; Lørsensen et al. 1998; Atkins & Ersser 2000; Offredy 2000; Woods 2000; Read et al. 2001; Wilson-Barnett 2001; Marsden et al 2003; Bryant-Lukosius 2004; Allen & Fabri 2005; Furlong & Smith 2005; Gardner & Gardner 2005; Asbridge 2006; Elsom et al. 2006; Norris & Melby 2006; Betts 2007; Corazan & Fitzpatrick 2007; Curran 2007; Gardner et al. 2007; Gould & Wasylikiw 2007; Mantzoukas 2007; Aranda & Jones 2008; Callaghan 2008; Partin 2008; Sheer & Wong 2008; Smith 2008; McGrath & Piques 2009; Mullinix & Bucholtz 2009).

The role, title, scope of practice, role autonomy and legislation differs significantly depending on the country and continent in which a NP practices. This has a bearing on the overall analysis and evaluation of the international literature and the comparisons to my study. Howie-Esquivel & Fontaine (2006) make the valid point that due to the limited amount of studies surrounding Acute Care Nurse Practitioners (ACNPs) it is difficult to draw comparisons within and across countries. However, an awareness of how the role is emerging internationally provides the reader with some insight into some of the challenges encountered with such roles, which play a part in the tensions reported in the literature.

1.1.1 Historical development in the United States of America (USA)

Over the last 40 years, there have been considerable changes in health care provision within the USA. Van Offenbeek & Knip (2004) report that these changes were due to an increase in the population and a challenge to provide cost effective health services by the US Government. Nurses who expanded their role were integral to these changes in meeting the service demands both in primary and acute care settings. Dunn (1997) suggests that advanced practice in the American literature describes a number of different roles, dependent on the speciality or work environment in which these practitioners work. The main titles utilised within the USA for nurses expanding their role are “Nurse Practitioners”, (NP’s) “Clinical Nurse Specialists” (CNS), Acute Care Nurse Practitioners (ACNP) and Nurse Anaesthetists (NA) (Sheer & Wong 2008).

Dunn (1997) reported that the concept of CNS was developed to aid in a more cohesive approach to patient care following World War 2, in tandem with changes in health care provision and increased technology. In the 1960's, there was a shortage of medical staff, which led to nurses expanding their skills. By the 1970's, there were master degree programmes for such nurses to prepare them for a variety of settings. At this time, due to local implementation of such roles, a large number of titles were utilised.

In the 1980's, this was addressed through the American Nurses Association, who outlined a clear definition of a CNS (Sparacino 1992). The CNS role was undertaken by nurses within a speciality such as an acute care environment. Each state within the USA has outlined clear requisites and competencies for nurses working with this title (Hittle 2010). Becker et al.'s (2006) exploratory study on the scope of both roles in acute care, highlighted that an ACNP provides an advanced level of direct patient care, whilst a CNS role is more varied, providing research, educational and a nurse manager's role with some areas of direct patient care.

The NP title was first reported by Ford & Sliver in 1967. This was the development of a Paediatric Nurse Practitioner (PNP) to meet service needs in remote areas of Colorado in the mid sixties, within a collaborative organisational model. These roles were quickly adopted across primary care settings with the development of Master's degree programmes, however the organisational models in which the NP practised, varied from state to state. Over the last decade, the NP role has further developed across areas such as ambulatory services, public health departments, and acute hospital settings in high acuity areas (Brown & Grimes 1995; Hravnak 1998; Lorensen et al. 1998; Logan 1999; Atkins & Ersser 2000; Walsh 2001; Bryant-Lukosius et al. 2004; Hoffman et al. 2005; Sheer & Wong 2008).

In the 1990's, due to expansion of hospital speciality services, coupled with a shortage of medical staff, there was an increased need for ACNPs (Geier 2000). The ACNP has since been evolving and the scope of their role has increased (Kleinpell 1997; Haravnak 1998; Geier 1999; Cole & Kleinpell 2006; Rosenthal & Guerrasio 2009).

Each state in North America outlines the standards, scope of practice, describes certification criteria to practice legally, sets reimbursement regulations and determines prescriptive authority for the ACNP role. Each state varies greatly in relation to these elements, in addition to NPs working within differing organisational models (Selph 1998; Sheer & Wong 2008; Phillips 2010).

Organisational models within USA

On review of the literature, three organisational models were described. Firstly the medical practice model, where the ACNP reports to medical staff. The second is where the ACNP works collaboratively with medical staff but are responsible and report to nursing management, referred to as the nursing model. The third model highlighted is the collaborative model where the ACNP and medical staff work as a team and share authority equally for providing care within their respective scope of practice. The reporting infrastructure reflects this as joint reporting to both medical and nursing management. In North America, some but not all states highlight that the ACNP must work with and report to a medical practitioner incorporating a collaborative model of care (Morton 1999; Pearson 2003; Phillips 2009; Mullinix & Bucholtz 2009).

Most states (n=23) require no statutory or regulatory requirement for the ACNP to have physician collaboration, direction or supervision, whilst some states (n=20) highlight physician collaboration is required for the ACNPs scope of practice. In some states (n=3) it is a requirement to have physician supervision incorporated in the ACNPs scope of practice, whilst in other states (n=4) there is a requirement for both senior nurses and physicians to authorise scope of practice (Phillips 2010). However, debate surrounds physician involvement, as it is perceived as an opportunity of continuing traditional medical dominance (Mullinix & Bucholtz 2009), whilst the American Medical Association (AMA 2007) outline that collaboration is important to ensure patient safety.

Yeager et al. (2006) report that due to these variations in collaboration and scope of practice, it makes comparisons difficult and the development of similar roles a challenge. Sheer & Wong (2008) state ACNPs are required to have a minimum of Masters' level of education, regardless of the organisational model employed.

At present, a Doctoral level of education is being developed to meet the needs of the advancing role, with the expectation that in 2015 all ACNPs in North America will require this for entry into practice (Tapper 2008). This is causing widespread debate as physicians argue over the appropriateness of a nurse providing direct clinical care, employing the title of 'doctor' (Tapper 2008; Partin 2009). One could question whether this stance is due to the traditional power associated with the title of 'doctor' or whether this would cause even more confusion for the healthcare team and service users.

1.1.2 Historical development in Canada

The Canadian literature highlights similar titles in relation to nurses in expanding roles, encompassing the titles of CNS and NP roles, however unlike North America, both titles come under the umbrella term 'advanced practice' (Forchuk 2009). Spitzer et al. (1974) outline that the historical development of these roles was supported by the medical profession when there was a shortage of medical staff in the late 1960's. The Canadian Nurses Association (2004) state that due to the lack of continued support by professional bodies, little development occurred until the 1980's. Similar to the UK, the move towards ACNPs emerged during healthcare reforms in the 1990's. Several authors report that there is confusion surrounding the regulation, remit and title of such roles as they differ across the five provinces of Canada, however it is recommended that all ACNPs are educated at Masters' level (Rothwell 2003; Urquhart et al. 2004; Howie-Esquivel & Fontaine 2006; Forchuk 2009; McGrath & Piques 2009; Phillips 2009).

1.1.3 Historical development in Australia and New Zealand

Offredy (2000) states that the role and title of NP in Australia commenced in the 1990's, when a series of national pilot projects were implemented to address setting up an infrastructure for NP's in primary care settings. Each state within Australia has implemented differing approaches to the setting up of this role. In 1986 within acute care settings, the state of New South Wales (NSW) set up a new clinical career structure to enable role development in nursing, due to nursing staff shortages in acute care areas. The aim was to enable nurses to remain in a clinical position with the same salary and status of traditional roles within management and education.

This was done via an award of the title of “Clinical Nurse Consultant” (CNC). As highlighted, the CNC practiced within acute care environments with the role responsible for specialist clinical care areas. The CNC roles are unique to Australia and are considered as working within the remits of advanced practice. However, this role differs to the USA as the majority appointed do not hold a formal qualification. Duffield et al. (1995) state that appointment is based on experience and a post registration specialty certificate is awarded through the local training department of the hospital.

Like Canada and the USA, most nurses who operate with the title of NP work within primary or remote settings, however more recently they have expanded into acute sectors (Government of New South Wales 1998; Allen & Fabri 2005; Smith 2008). Smith (2008) reports with the advent of Australia’s health care modernisation in 2006, more NPs have been implemented into acute care practice to improve care and treatment. However, it is unclear how the CNC role and NP role differ in acute environments. The authorisation of NPs is the responsibility of each state’s nursing board, except the Nurses Board of South Australia, who require NP applicants to undertake an approved Master’s degree (Smith 2008). In 2008, the Council of Australian Governments signed an intergovernmental agreement to implement a single register for health professions across Australia. It is anticipated that in 2010, a formal process of national registration of NPs will be in place (Health Workforce Australia 2008). Gardner et al. (2007) highlight that in New Zealand the NP title is protected by legislation, via the Nursing Council of New Zealand. It requires NPs to undertake master’s level of education, however only fifty NPs are employed across New Zealand (Pirret 2008).

1.1.4 Historical development in Asia

The literature highlights some role developments within Thailand and Hong Kong. The International Council of Nurses (ICN) (2005) report that the Nursing Council of Thailand certified forty nine Advanced Nurse Practitioners (ANPs) between 1998 and 2003. These roles are based within primary care settings. Chang (2002) reports that in Hong Kong there are a number of challenges with clarity, associated with the set up of ANP roles.

In Singapore, there are standards for core skills and competencies for NPs which were developed from the recommendations of the national organisation of nurse practitioner faculties (Sheer & Wong 2008). Yong-Hee et al. (2006) state that there still remains confusion on the scope of practice of ACNPs within Singapore.

1.1.5 Historical development in Europe

There appears to be paucity in the literature surrounding the historical role developments within Europe, outwith the UK. Callaghan (2008) reports in Ireland, like other countries, the development of such roles was in response to meeting changing service needs. The Government of Ireland (1998) set up a commission to report on the evolving roles of nurses. It recommended a clinical career pathway to incorporate the development of CNS and ANP posts. The CNS role, like other countries, was developed in acute areas and was based on service needs. These roles require that the National Council for Professional Development of Nursing and Midwifery along with service providers approve the post on a regional level across the four regions of Ireland (Furlong & Smith 2005). The ANP role was new, with the first post in St James Hospital in 1996. This was in response to the high number of patients attending this hospital's A&E department (Small 1999). In early 2008, the number of acute care ANPs had increased to 100 in Southern Ireland and prior to being set up, they required authorisation from the National Council for the Professional Development of Nursing and Midwifery (NCPDM 2008). The ANP role was set up following a detailed service needs analysis and evidence that a multi-disciplinary organisational supportive infrastructure was in place (NCPDNM 2008).

Buchan & Calman's (2004) survey on skill mix and policy change across Europe identified that Germany, Sweden, Greece and Slovak Republic were in the early planning stages of such role developments. Over the past five years, no further literature outlines any further role developments in these countries. In the Netherlands, ACNPs were developed in 1997 and are viewed as a cost effective solution for an ageing population (Roodbol et al. 2007). Van Offenbeek & Knip (2004) report that the NP's title is used for experienced nurses with a Masters degree in Advanced Nursing Practice.

The NPs' provide a mixture of traditional nursing and medical care, as well as being involved in research, education and consulting roles. In Belgium, ANPs have been in place since 1989 with most working in cancer and transplant areas. These roles were expanded in 2004 due to the shortage of medical staff (Sheer & Wong 2008). Lorensen et al. (1998) suggest that NP roles have not developed in the Nordic countries as there is no shortage of medical workforce. However by 2007, Fagerstrom reported that 19 students graduated in Finland from a Masters' education programme, based on the International Council of Nurse (ICN) definition of NP/ANP. Lorensen et al. (1998) highlight that the main role in Nordic countries is a CNS, developed to aid in increasing quality of care for service users. They suggest that such nurses have been emerging over the last 10-15 years to promote research and scholarship and have been associated with specialist areas of practice.

1.1.6 Historical development in the United Kingdom - UK

Stilwell (1982) reported that one of the first NP roles was piloted in general practice by Barbara Stilwell, who worked within two General Practices in Birmingham in the early 1980's. Based on this work, in the 1990's, expanded nursing roles were implemented across many of the GP practices within the UK. The majority of research over the last decade within the UK regarding NP roles has centred within primary care.

In the 1990's, extended nursing roles within the acute sector began to emerge. These were CNS roles in areas such as outpatient departments, neonatal areas, breast cancer areas, urology, endoscopy, cardiology, dermatology, and pre hospital care in a paramedic role (Coopers & Lybrand 1996; Walsh 2001; Redshaw and Harvey 2002). Like the state of NSW in Australia, they were set up to meet the specific specialist service needs of individual areas of practice. This has led to different roles, responsibilities and levels of autonomy working with the title CNS and appears to have led to confusion surrounding accountability.

Norton and Kamm (2002) provide an example where CNS's in the UK are carrying out procedures which national guidelines state medical staff should undertake due to high risk.

Modernisation and changes in workforce led to an increase in the amount of NPs required within the acute setting, with a more generalist role, rather than specialist role. This has led to the development of NP's in A&E units, primarily minor illness and injury, nurse led clinics, and Hospital at Night (HAN). The Hospital at Night concept aims to redefine how medical cover is provided in hospitals during and out of hour periods. It provides the most efficient method of preserving and enhancing doctors training in reduced hours available (Health Workforce 2008). However, this also appears to have introduced a raft of titles with different roles, responsibilities and levels of autonomy.

There is an ongoing debate and uncertainty surrounding the titles and remits of extended nursing roles within the UK (Cummings et al. 2003; Chang et al. 2006). In 1999, the UKCC attempted to address the problem of different titles and job roles. In relation to the CNS title, they highlighted the differences between a nurse working within a specialist area and a specialist nurse, which focused on higher levels of practice. The Nursing Midwifery Council (NMC 2005) recognised that there remained a difficulty in defining titles and reported on a draft definition and scope of role for advanced practice. In 2006, the NMC sought approval from the Privy Council, to create a further part of the register for the ANP. The white paper "Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century" (DOH 2007) stated that the UK Government asked the Council for Healthcare Regulatory Excellence (CHRE) to work with different health care regulators to support the work on standards for advanced practice. This included developing standards for nurses, AHP's and clinical scientists.

In July 2009, the Council for Healthcare Regulatory Excellence (CHRE) stated that further statutory regulation of advanced practice was not necessary as current mechanisms for regulation were appropriate. Therefore, the sole responsibility for such roles rests with the employer, in this case the NHS organisation. In response to the CHRE report, the NMC (2009) stated that they remained concerned about patient safety due to ambiguity surrounding such roles and recommended statutory regulation for advanced practice. In January 2010, Mr Weir-Hughes the Chief Executive of the NMC outlined that regulating advanced practice was still open for debate (Santry 2010).

In March 2010, the Prime Minister's Commission on the Future of Nursing and Midwifery in England, 'Front-Line to Care' outlined the need for regulation of advanced practice in nursing. In response, the NMC (2010) outlined that they welcomed the Commission's recommendations. However, as these recommendations only cover England, consultation would be required from Scotland, Wales, and North Ireland prior to the NMC regulating advanced practice. During the same week in March 2010, the Scottish Government Health Department issued advanced practice guidance to support local NHS boards with local governance arrangements and regulation of the title of advanced practitioner (SGHD 2010b). However, it stated that this was not mandatory therefore one could argue some NHS boards may utilise this guidance whilst others may not. In July 2010, CHRE reiterated their stance on advanced practice highlighting that responsibility remains with the individual and employer and only in exceptional circumstances should extended practice be recorded by a regulator (CHRE 2010). Therefore at the present date accountability remains with the employer, with a lack of consensus surrounding role definition, scope of practice, and levels of education required within the UK. This has been reported as a barrier to role development fuelling role ambiguity, which may play a role in the tensions associated with SNP/ANP roles (Lloyd-Jones 2005).

1.1.7 Summary – The international development of titles and practitioner roles

It is evident from the literature that the development of such roles on an international level stems from individual countries' various social, political, economic factors and drivers. For example, developments in ACNP roles within the USA have occurred within a different health service and health policy context from other countries (Atkins & Ersser 2000; Sheer & Wong 2008). It is apparent from the literature there is a diversity of titles, with no clear international consensus about how to distinguish ACNP and CNS roles. Some countries such as North America have protected titles, with an outline of what is required from an ACNP, which was introduced over a decade ago. There are two types of practitioner that work within the acute sector, the Clinical Nurse Specialist (CNS) and the Acute Care Nurse Practitioner (ACNP).

Both have been deemed to have separate roles with the CNS enhancing the quality of nursing care, through supporting, coaching, mentoring staff and acting as a change agent. Whilst the ACNP role is to provide direct clinical care, which has been traditionally the role of medics (Morse & Brown 1999; Teicher et al. 2001; Molitor-Kirsch et al. 2005; Yeager et al. 2006). Different organisational models support such roles across different states of Northern America all of which have differing scopes of practice.

Whilst New Zealand, Australia and Canada have protected titles and outlined standards, these roles are different within each of these countries. Ireland have implemented clear definitions and scope of practice for both CNS and ANP working within acute sectors. The literature illustrates that in recent years in the UK, the role of an ACNP has increased with no national guidance on definition regarding the scope of the role, with conflicting views regarding regulation from the CHRE and NMC. It could therefore be argued that there is a need for clearly defined roles and consistency in terms of regulation. Given this lack of clarity, it was important to identify definitions of such roles within my study.

1.2 Titles and definitions of roles within my study

As highlighted, there was no national consensus within the UK regarding such roles on commencement of my study. However a NHS Career framework was implemented within Scotland, led by the Scottish Executive (2005a).

This framework outlined two levels of practitioners: Senior and Advanced Practitioners. In my study, The Senior Nurse Practitioner (SNP) role is defined as:

“Nurses who would have a higher degree of autonomy and responsibility than ‘Registered Nurses’ in a clinical environment or who would be managing one or more service areas in a non-clinical environment” (Adapted from SHED 2005a: 5).

The Advanced Nurse Practitioner (ANP) role is defined as:

“Experienced clinical nurses who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high level clinical decisions and will often have their own caseload” (Adapted SHED 2005a: 5).

For the purpose of my study, these adapted operational definitions were employed for different types of Nurse Practitioners' (NP's) and Clinical Nurse Specialists (CNS's) as this framework had been approved within the study site in Scotland. However, it was noted that whilst nurses may work with these titles, roles and responsibilities could be very different, as many SNPs/ANPs were set up locally due to service modernisation. The following section will provide a history and briefly outline the tensions consistently reported in the literature to illustrate the stimulus for the development of the aims and research questions in my study.

1.3 Historical tensions associated with SNP/ANP roles

As highlighted earlier, tensions associated with SNP/ANP roles have been reported in the literature for the past 35 years. There appears to be a running theme that tensions continue to be associated with such roles. This section provides a brief overview of the literature, illustrating the reported tensions created by SNP/ANP roles over the last three decades.

In the 1970's, tensions were reported with the introduction of Nurse Practitioner roles (Little 1978; Sullivan et al. 1976; Burkett 1978; Alongi et al. 1979; Banahan & Sharpe 1979; Edmunds 1979; Pleines 1979). Tharp et al. (1979) reported that registered nurses were not convinced the role of an NP would be successful in practice. Whilst Alongi et al. (1979) reported that medics in an A&E department were non-acceptant of NPs treating service users. Whilst Fottler (1979) discussion paper reports on a survey undertaken in 1975 which illustrated that medic's had a much more positive attitude towards physician assistants rather than NPs. It was found that physicans were much more willing to employ and delegate tasks to a physician assistant rather than a NP.

In the 1980's, tensions and barriers with the NP role continued to be reported in the discussion literature (Chacko & Wong 1984; Ostwald et al. 1984; Rosenberg 1984; Hayes 1985; Ford 1986; McLain & Ho 1986; Glenn et al. 1987; Ostwald & Abanodi 1987). Hormans (1987) discussion paper suggested that tensions were related to gender issues, as both physicans and NPs remained subject to being forced to play the sex typical role stereotype.

Whilst Campbell & Heider & Pollock (1987) discussed the cultural and social factors which impeded the collegial interaction of physicians and nurses. They hypothesised that tensions with medics would increase with NPs expectations of greater status in the professional hierarchy through increased knowledge and skill. Campbell & Heider & Pollock (1987) argued that NPs models had not taken into account the deeply rooted structures of hierarchy in the healthcare system. They warned that tensions and challenges with NP roles would continue unless NPs developed methods to alter such structural barriers. Nettles-Carlson & McLaughlin (1985) suggested that tensions were created as NPs struggled with their identity within the nursing team as they had to undertake both a NP and a manager's role in practice.

In the 1990's, more NPs were being employed within the acute care settings (Morton 1999). Similar to the 1970's and 1980's, tensions were illustrated in the literature (Wilson 1994; Arslanian-Engoren 1995; Flangan 1998; Glen & Waddington 1998; Waters 1998; Ball 1999). A number of authors reported that medical staff continued to be opposed to SNP/ANP roles, causing tensions and contributing to stress (Glen & Waddington 1998; Ball 1999). Whilst some authors found that registered staff nurses displayed resistance to SNP/ANP roles, which again promoted tension for collaborative working (Flannagan 1998; Glen & Waddington 1998; Ball 1999). Flanagan (1998) reported that resistance which caused tension was more wide-spread among nursing rather than medical staff. Whilst Bousfield (1997) attributed tension between CNSs and their line managers to the fact that the CNSs were more qualified, both in practice and theory than their managers. In some papers it was reported that tensions were apparent even in well established posts (Arslanian-Engoren 1995; Ball 1999). This questioned the rationale for such tensions, as the literature in the 1970's and 1980's suggested it was because such roles were new, whilst in the early 1990's it was hypothesised that tensions arose from implementation, however it was apparent that even 20 years later and in well established posts, tensions remained embedded in practice.

These tensions were reiterated during the period of 2000-2005, on commencement of my study. At the start of this decade, there was a substantial increase in acute care SNPs/ANPs due to modernisation of the NHS. The evaluative literature focused on the benefit of these roles in providing more cost effective care, which was equal to the standards of medics (Chang et al. 1999; Sakr et al. 1999; Horrocks et al. 2002; Kinnerseley et al. 2002; Hoffmann et al. 2005). Equally, the literature illustrated that three decades later tensions still continued with SNP/ANP roles with associated negative attitudes from the healthcare team (Bamford & Gibson 2000; Tye & Ross 2000; Williams & McGee 2001; VanSorean & Micevski 2001; Alan & McDonald 2002; Scholes & Vaughan 2002; Gooden & Jackson 2004; Lindeke et al. 2005). Much of the research at the start of my study highlighted that if such barriers and tensions are not further researched, this would continue to have implications on the successful integration of these roles within a traditional healthcare team and have a negative affect on patient care (Paul 1998; Rashotte 2005; Wilson et al. 2005).

I felt that as such tensions could reduce collaborative working and have a negative impact on patient care in tandem with a substantial increase in such roles, it was timely to discover why tensions continued with such roles in clinical practice. This led to the aims of my study, which were:

- To discover why there continues to be tensions surrounding Senior and Advanced Nurse Practitioner roles in healthcare.
- To attempt to generate a substantive theory to provide a foundation in which a hypothesis could be tested across a wider arena

Arising from these aims were three research questions which were explored in three phases.

Research questions

1. Where are tensions created by Senior and Advanced Nurse Practitioner roles from a service user and healthcare team perspective?

(Phase 1)

2. Where do tensions remain apparent in service and what meanings and actions are attributed to them?

(Phase 2)

3. What are the interpretations of Senior and Advanced Practitioners on interactions with the healthcare team and service users?

(Phase 3)

In this thesis, Chapter 2 provides a literature review, surrounding the challenges, barriers and tensions reported in the international literature at the start of my study in 2005. The literature pertaining to the chosen methodology is presented in Chapter 3. This is followed by the findings from the three phases of my study in Chapter 4. Chapter 4 also presents a number of advanced memos at the end of each phase to illustrate the link between the findings and the theoretical constructs which informed the substantive theory within my study. Chapter 5 highlights the development of a substantive theory with associated implications. Chapter 5 concludes with the limitations and strengths to my study and recommends further research to test the hypothesis generated from the discovery of the substantive theory which emerged from my study.

Chapter 2

The Literature Review

2.0 Introduction

This Chapter presents the literature surrounding challenges, barriers and tensions related to SNP/ANP roles in acute care, reported internationally at the start of my study in 2005. McDonnell et al. (2001) suggest various factors influence the effective practice of SNP/ANP roles in acute settings. Whilst Wilson-Barnett et al. (2000) report that tensions were greater in large acute care hospitals than smaller enterprises such as primary care. This chapter concentrates on the literature in acute care, as this was the focus of my study.

Some quantitative studies which were mostly evaluative in nature have been critiqued to illustrate to the reader the ongoing reported tensions associated with SNP/ANP roles in acute care. Fewer qualitative studies were located in the review, however some were found that described both barriers and challenges as part of their findings and have been included, as these elements can play a part in creating tensions. At the beginning of my study in 2005, I found no qualitative studies which had the main aim of exploring in-depth the reported tensions associated with SNP/ANP roles, which could potentially improve the role.

2.1 Literature Search

The following databases were searched for this literature review: OVID Medline (Index Medicus and the International Nursing Index) 1966-2005, the Cumulative Index of Nursing and Allied Health Literature (CINAHL) 1982-2005, British Nursing Index (BNI) 1994-2005, EMBASE (Excerpta Medica) 1980-2005, AMED (Allied & Complementary Medicine) 1985-2005, Social Work Abstracts 1977-2005, EMERALD data base 1988-2005, PsycINFO 1967-2005, Joanna Briggs systematic reviews 1998-2005, Cochrane library databases 1985-2005. Hand searching, citation searching and footnote chasing (Barrosso et al. 2003) were also undertaken. Searching across international policy documents and unpublished resources was also conducted to inform the literature search of such role developments within a global context. Appendix 1 outlines details of search strategies utilised for this literature review.

2.1.1 Inclusion and exclusion criteria

The search strategy yielded 5,466 citations relating to the main concept of Nurse Practitioners (NPs). A further review highlighted 761 citations in relation to NPs within acute care. Inclusion and exclusion criteria, for the purpose of this literature review were applied (Table 1) as these related to the overall aims and research questions within my study. These criteria led to 20 studies being presented in this chapter. It is worth noting that whilst the aim of some studies did not fit the inclusion criteria, some elements of the findings were related, therefore these have been built into the discussion.

Table 1– Inclusion and exclusion criteria

<p>Inclusion Criteria</p> <ul style="list-style-type: none">▪ Studies/papers highlighting barriers/challenges/tensions surrounding acute care NP/CNS/SNP/ANP roles.▪ Studies/papers relating to acute NP/CNS/SNP/ANP roles and the healthcare team.▪ Collaborative models/collaborative working and acute care NP/CNS/SNP/ANP roles.▪ Studies/papers relating to service users perceptions on acute NP/CNS/SNP/ANP and service users <p>Exclusion Criteria</p> <ul style="list-style-type: none">▪ Studies evaluating the outputs of primary care/acute care practitioner roles/initiative or impact on service.▪ Studies that included outcomes and process measures.▪ Studies evaluating the content of NP/CNS/SNP/ANP programmes (i.e. Masters level programmes).▪ Service users' perceptions of treatment plans by NP/CNS roles.▪ Service user satisfaction surveys with a focus on costs, outputs/management of care and comparison with other healthcare professionals.
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In order to present and critique the literature I have adopted a thematic approach. The themes include role ambiguity and preparation, role conflict within the healthcare team, organisational models and services users. The following sections will present a critical review of each theme within the available literature at the start of my study.

2.2 Challenges and Barriers

A number of challenges and barriers have been reported in the literature in relation to SNP/ANP roles in acute care. A key theme in the literature included role conflict and ambiguity, in addition to preparation (Bousfield 1997; Ligas 1997; Glen & Waddington 1998; Stetler et al. 1998; Bamford & Gibson 2000; Tye & Ross 2000; Van Soren & Micevski 2001; Cummings 2003).

2.2.1 Role Ambiguity and preparation

A number of papers reported that role ambiguity surrounding SNP/ANP roles has played a part in creating tensions (Bousfield 1997; Ligas 1997; Glen & Waddington 1998; Stetler et al. 1998; Bamford & Gibson 2000; Tye & Ross 2000; Van Soren & Micevski 2001; Cummings 2003; Lloyd –Jones 2005). Stetler et al. (1998) found tensions were created through role ambiguity with too much emphasis on technical or medical skills, too few ACNPs to meet service requirements and a lack of preparation for the role. Stetler et al.'s (1998) North American evaluative study found that both service providers and service users accepted the role of the ACNP. The evaluation included the development of a conceptual framework based on local ACNP role descriptors, and key stakeholders input. The evaluation incorporated the views of key multiprofessional providers (n= 106) on the performance and acceptance of thirteen ACNPs. This sample included nurse leaders (n=26) physicians (n=31), nursing staff (n=39) and Allied Health Professionals (AHP) (n=10). A questionnaire was developed and piloted which confirmed face and content validity. Descriptive statistics were utilised and ordinal properties reported as median. It was interesting that physicians' ratings on role performance ($M=4.11$) were much more positive than staff nurses ratings ($M=3.98$). The responses from the open questions were analysed by two independent raters, thus aiding in trustworthiness. The top four barriers to the implementation of this role from service provider's perspective included role ambiguity, too much emphasis on technical or medical skills, too few ACNPs to meet service requirements and lack of preparation for some ACNPs. The facilitating factors identified included demonstration of knowledge and/or competence, physician support and acceptance of the role, nursing staff support and acceptance of the role and willingness of ACNP to collaborate with other staff/disciplines.

The evaluation also took into account the ACNPs' (n=13) perceptions, who participated in a structured interview with an independent researcher. Stetler et al. (1998) highlighted that facilitators to the successful implementation of the role were support from nursing staff, physicians and managers. The ACNPs also identified that role ambiguity was the greatest hindrance in implementing the role. As this was a North American study consideration needs to be given to the cultural and healthcare differences between North America and the United Kingdom. As highlighted in Chapter 1, consideration is also required surrounding the fact that there are differences in titles, roles and education of ACNP roles in North America. However, Cummings et al.'s (2003) Canadian evaluative study highlighted similar results, which reported that a major barrier to implementing such roles was a lack of role definition.

Cummings et al. (2003) undertook an evaluation of the implementation of an ACNP service, utilising an adapted case study method from the perspective of managing organisational change in Canada. A purposeful sample of service providers (n=17) who had been involved in the implementation of the role were interviewed on one occasion. The sample consisted of hospital administrators (n=2) physicians (n=2) CNS (n=1) AHPs (n=3) nurse manager (n=1) clinical supervisors (n=2) and staff nurses (n=6). Thematic analysis was undertaken and highlighted three key themes, 'role definition', 'support of key players' and 'organisational change'.

'Role definition' highlighted that there were differences in perspectives across each profession, in relation to the role of the ACNP. All participating staff nurses' had seen the role as a physician extension and not one that was involved in nursing care. Staff nurses also verified ACNP orders with medical staff, which was linked to a lack of confidence and trust in the ACNP. All participants highlighted that there were unclear boundaries between the role of the ACNP and residents (junior doctors). It is worth noting that whilst this research was undertaken in one hospital, all job descriptions for the ACNPs varied within units, thus this may have influenced the discrepancies in the theme of 'role definition'.

Within the theme 'support from key players' all participants highlighted that medics were threatened by the role of ACNP. However, support for the role had increased over time as more individuals became more familiar with the role and developed a trusting relationship with the ACNP.

In relation to the theme 'organisational change', it was highlighted that no formal strategy or evaluation process had been put in place and this appeared to fuel role ambiguity. Whilst the methodology of this study gave a description of key elements which influence organisational change in relation to ACNP roles, one could challenge the study design. A limitation would be a single post-hoc interview process, which only included those who had been involved in the setting up of the role, as this would question the rigor of the study. In particular it did not include medical residents, who were identified by all participants as being most threatened by the ACNP role. However, Cummings et al. (2003) found that a major barrier to such roles was a lack of role definition. This was similar to Van Soren & Micevski's (2001) findings which concurred that role ambiguity was a factor which created tensions for SNP/ANP roles. Van Soren & Micevski's (2001) findings also highlighted that a lack of preparation and development was also a barrier for such roles. This was similar to other papers surrounding challenges and barriers when implementing SNP/ANP roles (Glen & Waddington 1998; Tye & Ross 2000; McCreaddie 2001).

Van Soeren & Micevski's (2001) Canadian exploratory survey aimed to investigate the perceptions of indicators and barriers to successful role implementation from members of the multiprofessional team (n=69) working with ACNPs. This study was undertaken in the province of Ontario across four sites within two hospitals. It was reported that all ACNPs worked within a collaborative model, however this is questionable as physicians by legislation, determine the level of practice with the ACNP, with no nursing input. Therefore, it appears that the meaning of a collaborative model in Canada maybe different to North America, where both professions provide support. The sample was drawn from the multiprofessional team who worked with an ACNP, this included physicians (n=12) staff nurses (n=34) and administrators (n=8) in addition to ACNPs (n=14). A self administered questionnaire was completed, which consisted of three sections. However, no tests for validity or reliability of this instrument are mentioned in the paper.

Van Soeren & Micevski (2001) report that different groups of professionals within the team had questions modified within each section of the questionnaire to ensure it was appropriate to their role, whilst the themes remained similar. Descriptive statistics were used, calculating means and standard deviations. Content analysis was undertaken on responses to open questions. However, it was noted that comparative statistics were not carried out between the professional groups, due to small sample size and differences in questionnaires. Barriers to implementation of the role according to the ACNP group (n=14) was the level of preparation and support from physicians and nursing leaders. The physicians (n=12) suggested that the lack of knowledge surrounding the role with other team members was a barrier, in addition to a lack of support from nurse leaders. Whilst the staff nurses (n=34) outlined the barrier as a lack of physicians support and the healthcare team's knowledge about such roles. Administrators (n=8) stated that there was a lack of team knowledge surrounding the role and support from nurse leaders.

There were some methodological issues noted in relation to this study. The sample size was small for a survey (Bryman 2004). In addition, it is worth challenging why 'nurse leaders' were not included in the sample as one would assume they were key members of the multiprofessional team and involved in supporting the role. The questionnaire was not validated or indeed tested for any type of reliability, which provides less of an opportunity to make a considered judgement on the results highlighted. Due to the questionnaire being adapted for each professional group, this limits the survey further as the samples were clustered into smaller samples, thus debating the statistical power of the survey (Gomm et al. 2000). External validity needs to be considered given the small sample from one province in Canada, which reduces generalisability. However, given the exploratory nature of the study, it does provide some insight into the perceived barriers to implementing an ACNP role. As this study took place in Canada, similar to Cummings et al. (2003) the cultural and healthcare differences need to be taken into account when comparing findings. However these findings are similar to those reported in a UK study undertaken by Bousfield (1997).

Bousfield (1997) reports that role ambiguity causes stress for SNPs/ANPs and creates tensions when working with different members of the healthcare team. His descriptive phenomenological study explored the personal meaning of the role of the CNS. Purposive sampling was employed taking into account speciality, stage of personal development, responsibilities and clinical directorate of each participant. Semi-structured interviews were undertaken with CNS's (n=7) and Giorgi's (1975) method of analysis was employed, which is consistent with this variant of phenomenology. Participants reported that tensions and conflict were things they all encountered and part of this was due to a lack of role definition and role ambiguity. No methods of verifying the findings were reported in the paper, therefore it was difficult to make a judgement on the trustworthiness and rigor of Bousfield's study. However, the findings once again illustrated that role ambiguity had a part to play in the tensions encountered with the CNS role in acute care. Glen & Waddington (1998) findings again reiterated that role ambiguity and lack of preparation had a part to play in generating tensions associated with such roles.

Glen & Waddington (1998) explored the transition from staff nurse to CNS in the UK, through a case study design with two CNS's. Data were collected via individual supervision sessions, written reflective accounts and semi-structured group interviews. It was difficult to judge the trustworthiness and rigor of this study as the paper did not report on the methods of analysis or validation. Glen & Waddington reported that role ambiguity can occur when an individual does not understand what is expected from the role, or understands but does not know how to meet expectations. It could also occur when an individual's perception on the role is different to others.

An element worthy of consideration is that if team members are not in favour of the role, this may lead to ensuring role ambiguity. It may be that role expectations are clear, however it may be difficult for the SNP/ANP to meet such expectations, if role preparation and development are not provided. This therefore reduces role development and could suggest role conflict in not allowing SNPs/ANPs to meet expectations. As Wilson-Barnett et al. (2001:397) report the "obstruction and obfuscation of roles and responsibilities" from other members of the healthcare team has reduced role advancement with SNP/ANP roles.

2.3 Role conflict with the healthcare team

The qualitative research found in this review describes role conflict as a major barrier to implementation of such roles (Glen & Waddington 1998; Loftus & McDowell 2000; McCreddie 2001). Several authors highlight that there is little research surrounding the integration of such roles within the healthcare team in Europe (Tye & Ross 2000; Smith 2000; Carr et al. 2002). Many authors highlight the requirement for further research to provide an in-depth understanding surrounding tensions and SNP/ANP roles including opposition to such roles from the healthcare team (Smith & Preston 1996; Daly 1997; Cameron & Masterson 2000; Irvine et al. 2000; Read et al. 2001; Van Soeren & Micevski 2001; Cummings et al. 2003; Marsden et al. 2003; Kenny & Duckett 2004; Van Offenbeek & Knip 2004; Wilson et al. 2005). It has been highlighted that the implications of associated tensions causes a lack of collaborative working, which can reduce the quality of care as illustrated by Willard & Luther's (2005) study.

Willard & Luther's (2005) Grounded Theory (GT) study with NP's (n=29) found that the lack of autonomy resulted in less than optimum levels of supportive care for oncology patients, due to the reluctance to change established ways of working within a healthcare system. One limitation to this study was the lack of acknowledgement of the variant of GT employed. In addition, this study utilised a purposive sample, however there is no mention of either theoretical sampling or theoretical saturation, which are key principles within the grounded theory approach (Glaser & Strauss 1967). However, this study does report on the negative implications that role conflict has on the quality of care for service users. Scholes & Vaughan (2002) also report on role conflict stimulated by new nursing roles within the healthcare team.

Scholes & Vaughan's (2002) paper reports on cross boundary working and the impact new roles has on the healthcare team. Their research was part of a bigger study entitled Evaluating New Role in Practice (ENRiP) commissioned by the Department of Health (Read et al. 2001).

The ENRiP study took place over 3 stages with the first stage identifying new roles for both nurses and Professionals Allied to Medicine (PAMs) in a representative 20% sample of NHS acute trusts in England. Stage 1 entailed four processes, incorporating data generated from a range of semi-structured interviews, which in turn led to the development of the sample frame and areas that required further study in stage 2. Scholes & Vaughan's (2002) case studies were carried out in stage 2 and had a focus on organisational barriers and the perceptions of both service providers and service users on new roles. Their article focuses on the impact such roles had on interprofessional and multiprofessional working. Nine case studies (3 in each site) in 3 acute trusts in England were undertaken, employing a case-study methodology.

This took into account various stakeholder perceptions, as well as meeting the overall aims of the ENRiP study. A naturalistic enquiry approach was employed using a combination of interviews, participant observation and reflection. Data were analysed across case studies utilising the constant comparative method as described by Strauss and Corbin (1990). Data were also verified by participants during different points of the study, enhancing the trustworthiness and rigor of this study (Meehan 1999). A number of factors which related to causing tension with both medics and nurses were illustrated. These included tension from medics who felt that such roles were reducing training opportunities for junior medics. However, this was not a view shared by the consultant medics leading the speciality, who outlined such roles reduced fragmentation of the service by having someone who could undertake such tasks rather than having to train different junior medics when they changed over. Tension was also generated with the privileged status gained through being trained by the consultant medic.

In Scholes & Vaughan's (2002) UK study, some tension was also noted with nurses regarding the workload of those with new roles, who were perceived to undertake the less mundane elements of care. This in turn also led to the perceived downgrading of the nurses clinical skills. This relates to Reay et al.'s (2003) study where tensions arose for nurses when they had to give up a particular task to an SNP/ANP.

Scholes & Vaughan (2002) found that medical dominance was illustrated in a covert way, as new roles were tied up in different elements of control. In Scholes and Vaughan's (2002) case studies, credibility was enhanced through the verification of the analysis by participants over different periods of the study. On review of the original study (ENRiP), Scholes & Vaughan's (2002) case study demonstrated auditability, which was confirmed through a clear outline of the processes within the research process (Denzin & Lincoln 2000). Smith's (2000) findings concurred with Scholes & Vaughan, when she found that tensions were created by such roles within medicine and nursing. Smith found that a significant amount of participants highlighted that such roles had led to doctors being deskilled and the loss of the traditional caring role associated with nursing.

Smith's (2000) descriptive study investigated the attitudes and perceptions of medical (n=34) and nursing staff (n=137) to an Emergency Nurse Practitioner (ENP) service in Dublin, Ireland. A questionnaire was developed and piloted with a non-probability sample across two A&E sites in Dublin, which aided the content and face validity of the tool. It consisted of open and closed questions with a total of 38 questions. The four other A&E sites in Dublin took part in the main survey and all were at different stages of developing ENPs. All nurses and doctors were included in the sample (n=171). Clear exclusion and inclusion criteria were given, which included the exclusion of doctors from specialist teams reviewing or referring patients in the A&E department and nurses who were either student nurses or agency nurses. Analysis was undertaken utilising an SPSS package and a chi-squared test used to determine the statistical significant differences between the different professional groups. The level of significance was selected at $< P 0.05$, which is an accepted level in social & educational research (Gomm et al. 2000).

The results showed that 60.9% of nurses (n=83) and 63.8% of doctors (n=21) outlined that ENPs should only treat patients who presented with minor injuries. There was statistical significance in relation to perception of the role of diagnosing and treating patients, with only 4.2% (n=5) of nurses reporting that it was the role of the doctor, whilst 29% of doctors (n=10) were in agreement that it was the sole role of medical staff.

These new roles were viewed with some suspicion by both groups with 24.2% of nurses (n=34) and 25.1% of doctors (n=8) highlighting that it had led to doctors being deskilled and loss of the traditional caring role associated with nursing. Most participants highlighted that ENP's should have at least five years experience in A& E and 96.2% of nurses (n=132) highlighted that they should be educated at post graduate level. However, it was unclear in this particular study what the scope of the role entailed or the level of preparation for these ENP roles. Smith (2000) did however highlight that all four units were at differing stages, which may have implications on generalisability of the results. The overall response rate was good at 70.3% but the statistical power could have been strengthened by carrying out a sample size calculation through power analysis (Munro 2005). Tye & Ross (2000) findings report similar tensions. They found that there was opposition from outside A&E towards the ENP role and they were perceived as a threat to the traditional boundaries of medicine.

Tye & Ross's (2000) paper describes one part of a case study evaluation of the role of the Emergency Nurse Practitioner (ENP) in an Emergency Department (ED) in London. The aim of this part of the study was to explore the perceived benefits and constraints of providing an ENP service from a multidisciplinary perspective within one organisation. The purposeful sample included A & E consultants (n=2) ENPs (n=2) the A & E manager (n=1) a junior sister (n=1) A&E senior house officer (n=1), the director of nursing services (n=1) and the trust's Chief Executive (n=1). All undertook a semi structured interview, with each asked the same open ended questions, 18 months after 2 ENPs had been introduced to the department. Content analysis was undertaken and verified by someone independent to the study. The findings outlined that there was medical opposition from outside A & E towards this role, whilst the SHO highlighted a perceived threat to traditional boundaries of medicine. Similar to the findings of other studies highlighted earlier, the lack of a clear definition of the role was identified as a major problem, whilst the ENPs identified a feeling of isolation from other nursing staff by different role, uniform and shift patterns. The ENPs did not match the patient throughput of the SHOs, as they took longer when consulting patients, therefore influencing the number of patients they seen.

However, this was reflected in high levels of patient satisfaction, and according to the nurse manager, a general reduction in levels of complaints. A number of differences were noted in consultation styles, frequently described as the caring emphasis of the nursing culture and the curing approach of medicine. The study was limited to the perceptions of a small sample within one A & E department, based on their individual perceptions of two ENPs. In addition, no mention is made regarding the scope of practice, preparation or organisational model in which these ENPs worked within, therefore making comparisons difficult. A number of authors described tensions between Registered Nurses (RNs) and SNPs/ANPs (Kleinpell 1997; Reay et al. 2003; Gooden & Jackson 2004). Kleinpell (1997) reported that from an ACNP perspective, they had less partnership working with RNs.

The aim of Kleinpell's (1997) study was to explore the components of the ACNP role. A postal questionnaire was sent to ACNPs (n=125) who had recently applied for certification in the State of Connecticut North America. The questionnaire was adapted from a previously validated tool, and content validity was confirmed by three ACNPs and educators of ACNP programmes. A number of role components were outlined, including satisfaction with current role. The findings highlighted ACNP satisfaction with the degree of collaboration with physicians. However, less satisfaction was stated by ACNP's surrounding partnership working with other healthcare professionals, such as Registered Nurses (RNs). There were a number of limitations noted with the study. The questionnaire was not tested for internal consistency, which would assess the consistency of items within the same instrument (Bryman 2004).

On review of the tool, the element that covered ACNP satisfaction ratings for collaborative working was a 3 point scale and comprised of "very satisfied", "somewhat satisfied" and "somewhat dissatisfied". One would challenge the ambiguity of the wording of this element within the questionnaire. In addition, there was no method to confirm stability using test-retest analysis. Gomm et al. (2000) outline that demonstration of validity requires more than just peer judgements. Therefore, it would have been beneficial to measure construct validity.

A self reported limitation was that the sample frame was only ACNP's seeking certification, rather than the entire population of the state, thus limiting the generalisability of such findings. In some states of North America, it has been highlighted that part of the certification process is to work within a collaborative model which reduces tensions, however this is not mentioned in this paper. One could argue that if this was the case within this study, it could account for high levels of satisfaction with collaborative working with physicians. It does however raise questions around the fact that less satisfaction was reported in connection with working in partnership with other members of the healthcare team, such as RNs.

Reay et al.'s (2003) discussion paper on a qualitative study highlights similar tensions between ACNPs and RNs in the province of Alberta in Canada. Their paper reports on data which emerged from interviewing NPs (n=25) 18 of which were from acute care and their managers (n=7) 4 of whom were based in acute care. Managers outlined that there were difficulties sorting out tensions in relationships between NPs and RN's. Whilst there were positive working relationships between the NP and physicians, this was not the case for NPs and RN's. Similar views were highlighted by the NPs, as they struggled with identifying the nursing tasks they should carry out. Managers reported that they were aware of experienced RNs who were resentful of the newly introduced NPs, however they did not know how best to intervene. They reported that such RNs' felt they had lost the right to perform certain tasks which may have motivational properties for them. Reay et al. (2003) made the valid point that routines and norms of working are well established in most healthcare teams. It is therefore difficult for nurses to change such routines especially if it is perceived as giving up important tasks to others. As this was a discussion paper, it was not possible to comment on the trustworthiness and rigor of the study.

However, the paper did highlight a rationale for tensions between RNs and NP's. Reay et al. (2003) suggest that such tensions may mask system difficulties such as reshaping job design. Considerations need to be taken into account of this Canadian study, due to differences in the culture and healthcare systems.

Such roles differ within each province of Canada, again making comparisons to the UK difficult, however similar to Kleinpell's study, the tensions such roles present to the RN's were highlighted.

Gooden & Jackson (2004) reported that there is little research surrounding the acceptability of such roles from a Registered Nurse (RN) perspective. They undertook a descriptive survey with RNs (n=264) to assess the level of RN acceptance of the NP role. The sample frame of 500 RNs were chosen at random from the 11 southernmost counties within the State of Illinois.

The rationale for the sample was that only 11 registered ACNPs worked within these counties and there was a lack of research at this time on RNs' perceptions and acceptance of such roles. The questionnaire was adapted from a validated tool used to measure school nurses perceptions of their interactions with NPs. The adapted tool reflected RNs, however it did not undergo any further testing to aid in face and content validity or construct validity. Internal consistency was measured using Cronbach's alpha which showed a coefficient of .93, indicating some level of internal consistency, thus aiding in reliability of the instrument. Descriptive statistics were utilised to present the results within the paper.

The findings reported that, despite the small number of ACNPs registered in this state, 78.8% (n=208) of participating RNs had interacted with an ACNP, whilst 86% (n=179) stated that they had a clear understanding of the ACNP role. The study could have been strengthened by undertaking a power analysis to determine the sample rather than the justification of choosing the sample because of a lack of research. Gooden & Jackson (2004) state they did not intend the results of the study to be generalised, therefore results must be noted with caution. They do however recommend further research is undertaken due to lack of knowledge surrounding RNs interaction with ACNPs. It is not clear within the paper what regulations this particular state had in relation to ACNPs, therefore it is difficult to judge if the organisational model may have influenced results. Organisational models have been suggested to play a role in reducing tensions associated with acute care SNP/ANP roles (Geier 1999; 2000).

2.4 Organisational models – Collaborative model

As highlighted in Chapter 1, on an international basis three organisational models are described however these are defined differently. The collaborative model in North America has been associated with facilitating such roles and therefore reducing tensions. Ewens (2003) concur with this view and state that the success of implementation is dependant on the culture of the work organisation and the support provided. Van Offenbeek & Knip (2004) add that such roles will change the work structure of care provided by the healthcare team and is dependent on the changes realised in this structure. Cummings et al. (2003) report that the introduction of ACNPs challenges whole systems of an organisation and questions how such roles will complement other professionals in the healthcare team. Irvine et al's. (2000) discussion paper reports that support from key players is crucial in reducing tensions with the implementation of such roles, therefore the organisational model requires some consideration.

In some states of North America, to gain professional certification it is necessary to work within a collaborative model, which some believe reduces such tensions. Geier (1999; 2000) suggests a collaborative model has altered the power relationship, as the role of the ACNP is holistic patient management which includes both nursing and medical dimensions of practice. She discusses the results of a qualitative study which included ACNPs (n=7) highlighting the perception of their role within such a collaborative model. The socialisation experiences to the role of ACNP were crucial to effectively functioning as part of the team. The support received from the healthcare team and ongoing communication was seen as important by the ACNPs to help them work collaboratively with the team. As this was a discussion paper, there was insufficient information provided to make a judgement on the trustworthiness or rigor of this study.

However, it would appear that working within a collaborative model influences the support for ACNPs and has the potential to reduce tensions associated with such roles. On an international level, North America is the only country to consider the organisational model within which an ACNP works, in relation to gaining employer certification.

This is interesting as one could argue that the organisational model which provides employer certification, in collaboration with medicine and nursing, may influence tensions associated with such roles. Geier (1999; 2000) puts forward a persuasive argument that an organisational model which is collaborative increases communication and therefore reduces tensions. This was also reported by Vazirani et al. (2005) where they report that the ACNP improved collaboration across the healthcare team.

Vazirani et al.'s (2005) paper describes the change in communication and collaboration between physicians and nurses, following the implementation of ACNPs in a medical inpatient unit. One wing of the unit served as the intervention unit, which employed an ACNP as part of the healthcare team. The other wing was the control unit and the healthcare team remained the same in both units. The sample consisted of junior medics (n=264), senior medics (n=325) and RN staff (n=325).

The response rate was good with 58% (264/456) of junior medics, 69% (114/165) of senior medics and 91% (325/358) of nurses. A questionnaire was distributed to both teams at the beginning of the intervention and biannually. Cronbach's alpha confirmed internal consistency of the instrument, therefore enhancing reliability. The analysis was also controlled for repeat responders. The findings illustrated that both physicians and nurses reported higher collaboration with the ACNP than with each other on the intervention unit. However, physicians on the intervention unit reported significantly higher collaboration with nurses than physicians from the control group. The junior medical staff reported higher collaboration than their counterparts, on the control unit. Nurses on the intervention and control unit did not differ significantly in collaboration with physicians. There are several limitations to this study, which include the survey, which was not tested for face or construct validity.

Vazirani et al. (2005) state that they did not define the term 'collaboration', which may challenge the overall internal validity of the findings, as previous research has shown that physicians have a different perception of this term than nurses (Baggs et al. 1988; Neale 1999).

Vaziarani et al. (2005) report that both physicians and nurses highlighted that there was good collaboration with the ACNP. This may have been encouraged through a clear definition and boundaries of the role prior to commencement, which was communicated with the team, in addition to in-service programmes to explain the role as part of the collaborative model. As highlighted earlier, role ambiguity is a barrier therefore it may be that as the role definition was clear, this aided in increasing the collaboration noted in this study. As Knaus et al. (1997) reports, even when a collaborative practice model has been set up, the introduction of ANPs can be disputed by medical staff if role ambiguity exists. Therefore, it would appear that for a collaborative model to be successful, clear role definition and understanding across the team is necessary.

However, an alternative point of view for the findings presented by Vaziarani et al. (2005) is that the ACNPs spend most of their day on the ward, as medics covered other areas, therefore allowing them time to build relationships with the nurses. They also spent considerably more time with physicians through attending the ward rounds and working alongside them, once again promoting an environment for collaboration. One could challenge if this simply enhanced communication, thus affecting the scores of increased collaboration, therefore questioning the validity of the interpretation of increased collaboration due to the intervention of an ACNP. Consideration is required surrounding the fact that there are differences in titles, role and education preparation of ACNPs across the 50 states of North America, and this makes comparisons difficult. Consideration also needs to be given to the cultural and healthcare differences between North America and the UK when attempting to compare findings. However, despite the collaborative model being implemented in certain states of North America, there is a lack of research surrounding collaborative practice (Hallas et al. 2004). In contrast to the above findings Copnell et al.'s (2004) study showed that an acute care Neonatal Nurse Practitioner made little difference to collaboration within the healthcare team.

Copnell et al. (2004) investigated doctors' and nurses' perceptions of interdisciplinary collaboration in two Neonatal intensive care units in Melbourne, Australia. In addition they assessed the impact of a modified Neonatal Nurse Practitioner (NNP) model of practice on nurses' and doctors' perceptions of collaboration. A pre and post intervention design was employed for the study with the intervention being the introduction of the NNP model of practice. Questionnaires were distributed to all staff within the units, however because of changes of employment, it was not possible to ensure the same staff completed both surveys. The questionnaire was based on a previously validated tool, however was significantly adapted and therefore tested for face validity. However, it would have been strengthened if it had been tested for internal consistency and construct validity. The first survey prior to implementation of the NNP model included both nurses (n=47) and physicians (n=15) with an overall response rate of 37.5%. It was repeated eight months later, with nurses (n=59) and physicians (n=16) and an overall response rate of 41%.

Descriptive statistics were generated and the Mann-Whitney *U*-test was used to compare scores for individual items between groups of staff, and between the first and second surveys. The overall findings illustrated that all respondents reported that there was potential for improvement in collaboration between doctors and nurses on both units. Only a small number of nurses (n=9) and a consultant (n=1) thought that collaboration had improved with the NNP model, however this was statistically insignificant. Copnell et al. (2004) outlined that findings suggested that the views of nurses and doctors perceptions on collaboration was significantly different. However, it was noted that no corrective measures to guard against type I error were performed and this may have produced spurious significant results, given the amount of comparisons run on the small sample (Bryman 2004). As such, the comparisons between nurses and doctors should be viewed with caution. There are further questions surrounding the validity and reliability of the findings, the small response rate, coupled with the specialist area in one hospital in a state in Australia, significantly limits the generalisability of the findings. In addition to the fact that the junior medics had rotated over the time frame of the study, nurses were commenting on collaboration with a staff group that had not remained constant, thus challenging the pre and post intervention design.

This would in turn question the internal validity of the findings, in addition to the overall reliability of the study. The findings did indicate that the NNP did not affect overall collaboration.

Hallas et al. (2004) North American study found that collaborative working was a facilitator of such roles, however there were 'red flags' which increased tensions for SNP/ANP roles. Hallas et al. (2004) conducted an exploratory study with Paediatric Nurse Practitioners (PNP) (n=34) and corresponding paediatricians (n=34) nominated by the participating PNP with whom they had worked collaboratively. The aim of the study was to explore the attitudes and beliefs of PNPs and paediatricians concerning collaborative practice relationships. A random sample of PNPs were contacted from the National Association of Paediatric Nurse Practitioners. A questionnaire was developed for this study and piloted for content and face validity. It contained both open and closed questions. Quantitative analysis was undertaken utilising a SPSS package, socio-demographic characteristics were examined by frequency distributions and summary data distributions were compared by chi-square and *t* testing analysis between the PNPs and Paediatricians.

These included age, sex, ethnicity, highest degree held, years of experience and number of years collaborating with a PNP or paediatrician. Participants were asked to rate specific attitudes and beliefs in relation to collaborative practice using a Likert Scale. These data were analysed and compared with chi-squared and *t*-test analysis between the two groups. Answers to open questions were analysed utilised Collazzi's method of analysis. The themes which emerged were identified independently by two researchers and agreement was then made on themes that were common, thus aiding in the reliability of these data. Both the quantitative and qualitative data outlined specific attitudes and beliefs necessary for effective collaborative practice relationships. These included working together in a collegial relationship, similar philosophy and goals for patient care, complementary practice styles, mutual trust and respect as well as open communication.

There were also 'red flags' highlighted, which would reduce the success of a collaborative relationship and cause tensions. These included lack of respect, territorial and controlling behaviours, poor communication skills, dishonesty and competition between the medic and PNP for delivery of patient care. Some elements of the study can be questioned, in particular the sample was drawn from one national organisation (National Association of Paediatric Nurse Practitioners) therefore this could limit the transferability to adult ACNPs. In addition, the response rate from PNPs was only 25 % (n=34) drawn from a random sample of 200, thus questioning the representativeness of the sample. It is worth considering that those who did not respond may not have worked in collaboration with medical staff, even if they were set up within a collaborative model. Results therefore need to be interpreted cautiously.

It would have been beneficial to ascertain if the sample actually worked within a collaborative model, as dictated by state regulation, or if they had different organisational models but worked alongside medical staff. This in turn could have affected the overall findings of Hallas et al.'s (2004) study. However, the paper does give some insight into the attributes and beliefs between PNP's working in acute care with medics, which may increase collaborative working, placing the service user at the heart of the care process.

2.5 Service users

Whilst the NP role has been in place in the UK since the late 1970's and in North America a decade previously, it remains poorly understood or recognised by the public (Catania et al. 2000). The concept of service users being at the centre of healthcare service development and delivery over the past decade has been reiterated in numerous policies and strategies (DOH 1999; 2000; 2001; 2003; 2004a; 2005 a & b). Yet few studies on an international basis have included service users' views on such roles. Most studies which incorporated service users are satisfaction surveys (Hill 1997; Barret al. 2000; McMullan et al. 2001; Clifford 2004; Egan & Dowling 2004; Flynn 2005; Miles et al. 2005). Most of these focus on comparing service users' satisfaction with SNP/ANP care versus medical care.

Two studies were found which reported service user satisfaction on communication with SNP/ANP roles. These were included in this review as Hastings et al. (2003) reports that with the change to an advanced clinical role, the relationship of the NP with the service user is different from the relationship between a nurse and service user. I questioned if this could be associated with tensions reported in the literature.

Some service user satisfaction surveys in primary care have illustrated higher levels of satisfaction with communication received from an NP, compared to a medic (Kinnersley et al. 2000; Allen & Fabri's 2005). In contrast, Lawson (2002) found that NP's use a more controlling communication style than medics, however this was not linked to higher satisfaction scores. Lawson's (2002) descriptive correlation study examined the communication styles of NPs (n=5) and medics (n=4). They questioned whether the style was predominantly informational or controlling and whether this affected patient satisfaction. A convenience sample of service users (n=124) participated in the study, which equated to 12 to 14 service users per NP/medic. The Provider Communication Style Rating Scale (PCRSRS) was developed for this study.

It was utilised in conjunction with audio-taped provider-service user interactions, analysed by trained raters. The tool was verified by experts, therefore enhancing the content validity and piloted to aid in face validity. A minimum of inter-rater reliability of 70% was set for analysis of audio tapes which was maintained above this level during the study. To reduce systematic bias, raters were non-health professionals, blinded to the providers' professions. In addition, tapes were randomly assigned. Patient satisfaction was measured through a previously validated patient Satisfaction Questionnaire (SQ). The alpha coefficient showed satisfactory internal consistency (0.94) for this tool. Service user support for autonomy was considered to represent perceptions of the climate set by the provider. This was measured through a previously validated tool termed the Health Care Climate Questionnaire (HCCQ). Internal consistency for this tool was also deemed satisfactory (0.93). Descriptive statistics were utilised for each scale, which highlighted that patient satisfaction was generally high ($M= 32.5$).

Support for autonomy was also high ($M = 104.15$). When scores from PCRS were converted to mean scores ($M=5.5$) it showed that providers tended to use an informational style. One way analysis of variance showed some significant differences in communication styles, with medics providing a more informational style than NPs.

Due to skewed distribution in PCRS, the Mann-Whitney U test was also employed which verified these differences. NPs became controlling with certain types of service users, Lawson (2002) outlines that these were generally service users who were not following the treatment plan or with certain types of conditions. This links to Clarke's (2001) point of view that nurses can label a service user as 'good' or 'bad' purely on the nature of their illness or compliance. It was interesting in Lawson's (2002) study that the interaction became controlling with the perceived 'bad' service users. Lawson makes the valid point that historically, communication skills have been included in nursing education, however the evaluation of the process and outcomes are limited. Lawson's (2002) North American results were not consistent with other satisfaction surveys, which reported on communication in their findings.

Arthur & Clifford's (2004) satisfaction survey found that rheumatology service users ($n=80$) showed a higher satisfaction rate with provision of information, empathy and attitude towards them from NPs, rather than medical staff. Hills' (1997) satisfaction survey demonstrates higher satisfaction scores with communication from NP's rather than medics. Hill (1997) asserts that this was due to NPs having longer consultation times with each service user. Longer consultation times, which improve communication when more information is given have been associated with greater levels of patient satisfaction (Stewart et al. 1995; Horrocks et al. 2002). Donohue's study suggests that time was an important resource valued by service users. Donohue's (2003) exploratory study with midlife females ($n= 8$) (age range 35-55) aimed to understand the special nature and processes of NP and service users encounters, using a resource exchange perspective. Resource exchange in Donohue's study was defined from the service user's perspective of determining what resources the client expected before the visit.

In addition to determining what resources the service user actually received during the visit and the congruence of what they expected to receive and what they actually received. Resources included time, information, trust, respect, and support. Data were collected via pre-post encounter interviews, audio tapes of entire clinic visits and field notes from researcher's observations during each visit.

Thematic analysis was undertaken, which identified that all expectations were met. Time was an important resource with service users highlighting the importance of having adequate time with the NP to explore individual issues. Donohue reports that whilst the findings are not generalisable, they do start to provide an understanding of service users' perceptions of such roles. This was a North American study therefore cultural aspects and differences in the health care system require to be taken into consideration when attempting to apply findings to a UK context. Given the lack of research surrounding service user's views on SNP/ANP roles, Donohue's (2003) study does provide some insight into what elements are important to service users. Stetler et al. (1998) reports that ACNP roles are accepted by service users.

As highlighted earlier, Stetler et al. (1998) evaluative North American study incorporated service users' (n=58) views on ACNP roles. They were interviewed following discharge and asked about the acceptability of ACNP's as providers of care in an acute setting and to a lesser extent about the visibility of nursing in the ACNP role. Service users reported that ACNP's had a positive effect on the delivery of care and displayed behaviours which incorporated holistic care, which is an integral element to a nurse role. Service users deemed an ACNP an acceptable provider of care with 93% (n=54) reporting that they would like an ACNP to care for them, their families or friends in the future.

As outlined earlier, Read et al.'s (2001) ENRiP study took place over 3 stages. In stage two of this report, Scholes and Vaughan (2001) outlined service users' views on the SNP/ANP role as part of nine case studies (3 in each site) across 3 acute trusts in England, employing a case-study methodology. They found through observation and feedback from post holders that service users realised the benefit of such roles which increased quality of care.

However, Scholes & Vaughan (2001) acknowledged that as this may have been the service users first encounter with healthcare professionals, it could have been difficult for them to compare these roles with the more traditional models of healthcare delivery. Scholes & Vaughan (2001:111) report that further qualitative research is required on service users views, as they state “it is critical to gain insight into the way in which they are viewed by patients”. Several other authors highlight the requirement for further research from a service users’ perspective (Drury et al. 1988; Lawson 2002; Donohue 2003).

As there was a gap in the literature surrounding the acceptance of SNP/ANP roles from a service user point of view, I questioned if this could be linked to the ongoing tensions described in the literature. Given this paucity in the international literature, it was deemed appropriate that the aim of my study would incorporate service users’ interpretation of such roles.

2.6 Summary

Whilst this review focused on acute care SNPs/ANPs, similar tensions and conflict have been reported in other settings (Martin & Hutchinson 1999; Neale 1999; Williams & Sibbald 1999). Within acute care, acceptance by the healthcare team is seen as paramount to the successful implementation of such roles. In particular, support from nurses, medical staff and patients were widely identified as a supportive factor which reduced tensions (Stetler et al. 1998; Geier 1999; Irvine et al. 2000; VanSoeran & Micevski 2001; Katz & McDonald 2002; Cummings et al. 2003). Conversely, non-acceptance was seen as a significant barrier (Appel & Malcolm 1999; Draye & Brown 2000; Irvine et al. 2000; Cummings et al.2003; Ewens 2003). Whilst the organisational models outlined in North America, can vary from State to State, research studies put forward a persuasive argument that indicated that there is a more positive integration of such roles and less tensions noted, when a collaborative organisation model is utilised with SNP/ANP roles within acute care settings (Kleinpell 1997; Stetler et al. 1998; Geier 1999; 2000).

However, when a collaborative model is employed there may not be acceptance from all members of the healthcare team. This was highlighted by the studies undertaken in Canada (Van Soeren & Micevski 2001; Cummings et al. 2003). It was noted that the meaning of a collaborative organisational model was questionable in Canada, as by legislation, physicians determine the level of practice of the ACNP. This may be indicative of the fact that a collaborative model is viewed as physicians outlining the scope of an ACNP role, rather than input from both nursing and medical professionals.

A number of international studies illustrated that multi-factorial tensions exist across both the nursing and medical professions (Kleinpell 1997; Stetler et al. 1998; Scholes & Vaughan 2002; Reay et al. 2003; Gooden & Jackson 2004). These tensions are not new and were first reported over 30 years ago (Little 1978; Fottler 1979; Pleines 1979). This literature review found that the quantitative research provided an indication on where tensions were located with SNP/ANP roles, whilst the qualitative literature described barriers and challenges which play a part in the associated tensions with SNP/ANP roles. However, an exploration of the reported tensions have not been examined in-depth, and this may explain why such tensions have been consistently reported in the literature over three decades. A study which would provide an increased knowledge of the root causes of such tensions could provide an in-depth understanding around the consistent entrenched reluctance to engage collaboratively with SNP/ANP roles (Cummings et al. 2003; Reay et al. 2003; Davies 2006).

This is important as Smith & Preston (1996) highlight communication blockages are due to such tensions and a lack of understanding of each other's role, and this will not only damage professional relationships but also affect patient care, whilst some discussion papers and studies illustrated that such tensions can reduce patient safety and quality of care (Paul 1998; Wilard & Luther 2005; Wilson et al. 2005). Given the implications of such tensions and the paucity in the literature, this led me to developing the aims and research questions for my study.

Chapter Three

Methodology

3.0 Introduction

This chapter presents the research design and methods adopted for my study. It commences with a presentation of the aims and research questions, followed by a brief outline of the philosophical, epistemological and pragmatic considerations which guided the methodological choices. This is followed by a detailed account of the application of Constructivist Grounded Theory (CGT) during the different phases of my study, incorporating the data collection methods. A description of the approach used for data management and analysis is provided. The chapter concludes with a discussion surrounding the rigor and ethics of my study.

3.1 Aims of my study

The overall aims of this study were:

- To discover why there continues to be tensions surrounding Senior and Advanced Nurse Practitioner roles in healthcare
- To attempt to generate a substantive theory to provide a foundation in which a hypothesis could be tested across a wider arena

Arising from these aims were three research questions, which were explored in three phases.

Research questions

1. Where are tensions created by Senior and Advanced Practitioner roles from a service user and healthcare team perspective?

(Phase 1)

2. Where do tensions remain apparent in service and what meanings and actions are attributed to them?

(Phase 2)

3. What are the interpretations of Senior and Advanced Nurse Practitioners on interactions with the healthcare team and service users?

(Phase 3)

3.2 Methodological Considerations

3.2.1 Quantitative and qualitative approaches

In order to answer the research questions generated from the aims of my study, both quantitative and qualitative methodologies were appraised. LoBiondo-Wood & Haber (2010) state that the quantitative approach has its base within the positivist paradigm. It seeks casual explanations, predications and control through deductive reasoning, objectivity and utilises statistical techniques. Pope & Mays (2007) argue that this type of approach limits the depth of information that can be elicited, thus restricting the individual's responses that can be measured. Whilst qualitative research is based within the interpretive paradigm, where we are trying to deepen our understanding of the phenomena rather than focusing on cause and affect. In the process of shaping the aims of my study, an initial broad literature review was undertaken. As illustrated in Chapter 2, there was a lack of understanding of why tensions associated with SNP/ANP roles have been consistently reported over the past three decades. Therefore, I would argue that a deductive approach would have been inappropriate due to lack of in-depth understanding surrounding the continued tensions associated with SNP/ANP roles. I would not have been able to generate a hypothesis from the limited data yielded from employing a quantitative approach.

The interpretivist paradigm involves the researcher studying things in their natural setting, attempting to interpret a phenomena in terms of the meanings people bring to them (Creswell 2007). LoBiondo-Wood & Haber (2010) suggest that within this paradigm, we are trying to deepen our understanding of the phenomena rather than on the cause and affect. Therefore, an interpretive perspective was deemed timely, given the lack of understanding surrounding the reasons for continued tensions reported in the evaluative literature. As Rashotte (2005) reports to examine tensions we need to evoke rich data to increase our understanding of NP roles.

3.2.2 Different qualitative approaches

A number of different qualitative approaches were considered for my study, which included phenomenology, ethnography and grounded theory. To provide context, a brief appraisal is given providing the rationale for the chosen methodology.

Phenomenology is based within the paradigm of philosophy and is employed to obtain the “lived” experience in order to obtain a holistic orientation to the study of individuals (Munhall 1994). Creswell (2007) reports that this methodology places emphasis on the individual’s views and personal experiences, in essence to describe the phenomena under study in the eyes of the participant. I felt that phenomenology would have provided a rich description of tensions. However, I considered that a more detailed analysis to enact social change would deepen the understanding surrounding the tensions associated with the SNP/ANP role, within the context of a modernising NHS.

Ethnography is the direct description of a group, culture or community (Creswell 2007). This approach stresses the importance of studying human behaviour in the context of culture, norms and routines. Whilst this approach has its roots in anthropology, it differs from other approaches due to the emphasis on culture (LoBiondo-Wood & Haber 2010). Creswell (2007) reports that the goal of ethnography is to gain an insider depiction of the studied world. This methodology provides a thick description, which arises from the data collected during analysis. However, as Charmaz (2006) reports ethnographic approaches provide full descriptions of topics within study settings without showing the actions and processes that construct it. Therefore, for the purpose of my study it would not take into account the processes and actions attached to tensions across different contexts, and would therefore not fully answer all of the research questions posed.

Grounded Theory (GT) develops a theory from exploring many individuals’ who share in the same processes, actions or interactions, however unlike ethnography, the study participants are unlikely to be located in the same place or interacting so frequently that they develop shared patterns of behaviour and beliefs (Creswell 2007). Each service area within the study site would have different cultural normative ways of working within the healthcare team. Therefore, the methodology of GT would provide the means of illuminating where tensions arose associated with SNP/ANP roles across different practice areas and hospitals within the study site. As Bevir & Rhodes (2002) report we cannot understand human behaviours unless we grasp the relevant meanings. These can be explored through theorising and this holds the key to unlocking the reasons for behaviours.

I believed it was necessary to explore in-depth the meanings and processes associated with reported tensions to evoke why tensions were continually associated with SNP/ANP roles. GT appeared appropriate as it would allow the interpretation of the processes and actions which framed the tensions reported with SNP/ANP roles. This methodology would therefore provide a means of answering the research questions posed and fulfil the aims of my study.

3.2.3 Grounded Theory (GT)

GT is a general methodology for developing theory that is grounded in data systematically gathered and analysed (Bryman 2008). As Holloway & Wheeler (2002) write, the aim is to generate concepts and eventually theory. One of the main features of this methodology is to recognise that the researcher does not begin with theory. Instead, the researcher identifies constructs from generated data and from these data theory emerges (Streubert & Carpenter 1995).

Strauss & Corbin (1998) highlight GT methods provide a basis upon which social change can be enacted. This approach appeared to be appropriate as there was a lack of understanding surrounding the continuation of tensions associated with SNP/ANP roles over the past two decades. Many researchers highlight that due to the emphasis on discovery and the need to enter the research process with an open mind, this approach is most appropriate for phenomena where a deeper understanding is required (Glaser & Strauss 1967; Chenitz & Swanson 1987; Strauss & Corbin 1998; Holloway & Wheeler 2002; Denscombe 2003). As Rashotte (2005) reports to examine the ongoing tensions with NP roles we need to evoke rich data to increase our understanding.

I felt the methodology of GT would provide a systematic approach that would lead to substantive theory development, which was necessary to discover why tensions with SNP/ANP roles continued to be reported in the international literature. It was deemed that the pragmatic roots of GT would not only develop theory but also aid practitioners within the organisation, with the advent of new frameworks for role development being implemented at the start of my study (NMC 2005; SHED 2006).

3.3 Different approaches in Grounded Theory (GT)

Since the “Discovery of Grounded Theory” by Barney Glaser and Anstem Strauss in 1967, a number of researchers have adapted the GT approach. The four main approaches that were evaluated included Glaser & Strauss (1967), Glaser (1992; 1999; 2004), Strauss & Corbin (1990; 1998) and Charmaz (2006). The hallmark of the GT approach is the emphasis on the discovery of theory, which was necessary to meet the aims of my study. All variants of GT discuss the key principles of ‘symbolic interactionism’, ‘pragmatism’, ‘open mind’ and ‘theoretical sensitivity’.

This approach also incorporates underlying components throughout the research process referred to as ‘theoretical sampling’, ‘constant comparative methods’ and ‘theoretical saturation’. All variants have differing philosophical and epistemological standpoints in relation to some of these key components of GT.

3.3.1 Underpinning principles of GT

In 1967 Glaser & Strauss, the founders of GT, outlined a number of key principles within the grounded theory methodology which included the importance of conducting a detailed literature review following data analysis to aid in theory generation with an “open mind,” whilst at the same time remaining “theoretically sensitive” to the data. “Open mind” refers to entering the research without any fixed ideas, whilst “theoretical sensitivity” centres on allowing the researcher to differentiate between “significant and less important data” (Holloway & Wheeler 2002:156). This is deemed necessary in order to aid in constructing analytic codes from data and not from any preconceived hypotheses. The sampling method employed is referred to as “theoretical sampling” and is utilised to generate and construct theory rather than the aim of population representation. Charmaz (2006) highlights that when utilising “theoretical sampling” the researcher seeks people or events to further illuminate or define emerging theory from categories.

Another principle within GT is the utilisation of a method of analysis entitled the “constant comparative method”. This consists of making comparisons during each stage of data collection and analysis and takes place with a simultaneous involvement in data collection and analysis. This also incorporates the use of “memo-writing” which aids in developing categories and relationships between categories during analysis. Glaser (1992) outlines that during the research process, memos are written to aid in analysing ideas about emerging codes and categories. The following sections outline the underpinning principles of GT and incorporate the rationale for the choice of Constructivist Grounded Theory (CGT). A number of Figures and Tables are included as the creation of visual images is an intrinsic part of CGT (Charmaz 2006).

3.3.2 Symbolic Interactionism

The early works surrounding symbolic interactionism are that of Dewey, Mead and Blumer. Blumer (1969) report three facets to symbolic interactionism. First, human beings react to things in relation to the meaning that they hold for them. Second, one derives meaning from social interaction and thirdly, as the person deals with situations, s(he) modifies the meanings appropriately, thus meaning, according to symbolic interactionists, is created by experience.

According to Charmaz (2006) symbolic interactionists believe that people act and interact on the basis of symbols such as words and body language rather than reacting to objective aspects in the environment, as objects have no inherent meaning. A social situation only has meaning from the manner in which people define and interpret what is happening (Blumer 1969; Reynolds et al. 2003). Charmaz (2006:189) report that symbolic interactionism assumes that people construct selves, society and reality through interaction. Because this perspective focuses on dynamic relationships between meaning and actions, it addresses the active processes through which people create, interact and mediate meanings. Meanings arise out of actions, and in turn influence interactions.

This principle was central to the traditional normative ways of working within the healthcare team as individuals understood the traditional role of a nurse and doctor and this influenced this relationship.

However as the initial literature review highlighted that the role of SNP/ANP was not clear, a question this raised was would the interactions and inherent meanings relate to the continued tensions highlighted in the research? It was therefore deemed important to probe interactions to identify if this portrayed tensions. This is addressed through the research question posed in phase 3 (page 42). I felt this underpinning principle was important to the discovery of the theory surrounding why there were continued tensions associated with SNP/ANP roles.

3.3.3 Pragmatism

The roots of symbolic interactionism are based within pragmatism and this philosophy is clearly outlined in Glaser & Strauss (1967). This related well to my study, as due to the continuing modernisation of the NHS, more SNP/ANP roles were being implemented to aid in service delivery within the acute sector.

However, whilst the evaluative literature was highlighting the tensions associated with SNP/ANP roles there remained little explanation for such tensions. With the construction of a substantive theory, it was my aim to develop a deeper understanding of tensions surrounding such roles and therefore provide knowledge to support such roles within practice. This supported Charmaz's (2006) view that within pragmatism, explanations of events and situations need to be meaningful and relevant to those whose actions and behaviours are involved in the study.

3.3.4 Open Mind

One consideration prior to commencement of my study was the challenge that arises within the different variants of GT of how to maintain an 'open mind' whilst ensuring 'theoretical sensitivity'. As Denscombe (2003) states, the GT approach expects the researcher to start without any fixed ideas about the processes in which it occurs.

One may assume this requires the researcher to enter the research process with no previous knowledge or background to the phenomena. Boychuk & Morgan (2004) however outline that another component within GT is that the researcher must be theoretically sensitive with regards to analysis. As Holloway & Wheeler (2002:156) outline, this refers to the researcher being able to differentiate between "significant and less important data".

Researchers therefore have an insight into their meaning, either from previous experience or through a literature review. Glaser (1992) asserts that experience is beneficial to employing this methodology as it enhances 'theoretical sensitivity'. However, he warns against a focused and extensive literature review, as this may influence data analysis and the ability of the researcher to allow the theory to emerge.

Charmaz (2006) supports this view and states that when utilising this approach, it is necessary to undertake a broad literature review to ensure the need for the research project. However, a detailed literature review should only take place as codes emerge. This was consistent with the approach taken for my study.

A broad literature review was undertaken to develop and rationalise the requirement for my study and ensure that the study was original, thus adding to the body of knowledge around these roles. As categories began to emerge, literature was selected as part of the integrated approach to aid in theoretical sensitivity within the constant comparative analysis method. At the end of the analysis, a focused literature review reported in Chapter 2 took place. Reflexivity was also crucial to maintaining an open mind during my study, as there were times when my unconscious filters required to be challenged, otherwise it may have prevented or forced the construction of data.

3.4 Why constructivist GT

The Glaserian approach, strongly highlights that with an "open mind" coupled with "theoretical sensitivity" the theory is naturally allowed to emerge, rather than forcing meaning onto data. Glaser (2004) strongly highlights that patience is required but with perseverance the theory will emerge. I would argue that one must challenge the cognitive strategies employed in the process of emerging theory, and that the specific mechanisms have not been addressed sufficiently by Glaser (1992; 1999; 2004). One would argue that the context of the discovery of theory is not simply an open-ended psychological process as Glaser (1992; 1999; 2004) implies but a self-conscious and deliberate search for the logic on how one comes to develop theory. Therefore I did not employ this variant of grounded theory to my study as the theory that emerged may be flawed by my own background assumptions.

Strauss & Corbin (1990; 1998:43) have superficially addressed the issue surrounding the validity and reliability of theory development during analysis. They outline certain techniques to aid in maintaining the balance between objectivity and sensitivity including thinking comparatively, member checking and triangulation of data utilising different methods of data collection. However, a concern raised by a number of authors is the rigid procedural techniques utilised in analysis, which could lead to meanings being applied or forced on to the data (Glaser 1992; 2004; Heath & Cowley 2003; Dick 2005). I concurred with these authors and would argue that by applying such rigid techniques, it mirrors a positivist approach rather than enhancing rigor of this approach.

Mills et al. (2006) highlight that the foundations within the Constructivist Grounded Theory (CGT) approach is based on the realities of subjectivism. This relates to Charmaz's (2006) variant of CGT, in adopting a position of mutuality between the researcher and participants in a study. This variant of GT follows the key principles associated with GT, in addition to the researcher reflecting upon underlying assumptions. This variant would therefore heighten my awareness, whilst analysing participant's stories as openly as possible.

This variant took the view that the discovery of theory, based on the construction of meanings is grounded in the participants and researchers experience. Following an evaluation of the differing grounded theory variants, both the founders (Glaser & Strauss 1967), Glaser (1992; 1999; 2004) and Strauss & Corbin (1990; 1998) have paid little attention to the relationships between participants and viewed them as a source of data. Collins (1998) refers to this as a smash and grab philosophy. Glaser (2002; 13) refutes this view in his article surrounding constructivist grounded theory. He refers to these relationships as unnecessary, "if the GT researcher carefully compares much data from many different participants, personal input by a researcher soon drops out as eccentric and the data becomes objectivist not constructivist".

Glaser also refers to reflexivity as a description which is unnecessary within the GT approach. He gives the example of nurses who have worked within the same area for a number of years, he outlines that “they will compare notes of themselves, not impose their experience on the interview or data” (Glaser 2002; 14). This is in contrast to many researchers’ views, who outline that reflexivity is central to qualitative research and is viewed as adding credibility to a study (Dowling 2006; Rolfe 2006; Allen 2004; Hand 2003). Dowling (2006) outlines the strong requirement to move away from keeping a distance from participants, in the belief this will enhance objectivity. She highlights that reflexivity provides a mechanism for the transparency of reality, which in turn addresses both ethical and epistemological concerns within research.

Mills et al. (2006) outlines this key element of constructivist approach, which is to endeavour to commit to a relationship of reciprocity with the participants. In order to move towards an equal position between participants and researcher there is a requirement to assume a reflexive stance throughout this research process. This variant was deemed appropriate, as unlike the other variants, this allowed a partnership with the participants in the research process rather than an objective analyst of subjects’ experiences. In addition to utilising reflexivity to aid in transparency, this enhanced the rigor and trustworthiness of this study.

Analytic directions arise from how researchers interact and interpret their comparisons and emerging analysis, rather than from external perspectives (Charmaz 2006). This was an important component as I worked within the organisation, which was the focus of my study and therefore required to be aware of any underlying assumptions to increase the rigor of this study (Asselin 2003). Reed & Procter (1995:10) illustrate three different levels of researcher activity in relation to qualitative research. The ‘outsider’ is someone who undertakes research with no professional experience, whilst an ‘insider’ is a practitioner undertaking research within their own and colleagues practice. The ‘hybrid’ role is an individual who undertakes research work into practitioners, however also has professional experience within the phenomena under study.

I would be deemed a 'hybrid,' as I worked as the lead for post registration education within the organisation, however was not in a practitioner role. I had some experience of such roles through providing education and training for SNPs/ANPs. I also had an external strategic perspective from leading on a Scottish national project within NHS Education for Scotland. This project produced a succession planning development educational pathway for advanced practice (NES 2007). In addition, I was also a member of a number of different national strategic steering groups within the Scottish Government. This led to the development of a toolkit for advanced practice (SGHD 2009e) Therefore, it was important that systems were put in place to provide a focus for reflexivity and constructive challenge to aid in the rigor of this study. As Dwyer & Buckle (2009:59) state “ *it is not insider or outsider status but an ability to be open, honest, deeply interested in the experience of one’s research participants and committed to accurately and adequately representing their experience*”.

I also recognised that data could not be poured into an unconscious vacuum, as my own experience both historically and culturally had the potential to play a part in the constant comparative process of my study. If these 'taken for granted' assumptions were not probed and acknowledged, it could have led to forcing my meanings on to data (Northway 2000; Hall & Callery 2001; Davies & Dodd 2002; Freshwater 2005; Mills et al. 2006). Figure 1 highlights some of the constructs which raised levels of awareness surrounding my role within the research process.

Figure 1 – Supportive constructs to increase reflexivity & work creatively with the tensions of the hybrid role within my study.



As Figure 1 illustrates, the central construct to reflexivity was my reflective journal which was kept throughout the research journey. This was accompanied by digital recordings of my thoughts and feelings after each data collection event, in addition to memos which helped me to make connections on assumptions (Figure 2). The next construct was my critical research companions who provided a high level of critical challenge throughout the study (Figure 3). The construct of ‘all is data’, refers to my reflection on the influences of my day job which were detailed in my reflexive journal. Reflexivity was also incorporated into both my research and clinical supervision sessions. The last reflexivity construct entitled ‘experts’ refers to the use of different individuals with certain expertise, who discussed emerging categories and provided different points of view.

As the categories emerged, I met with experts in certain fields. Some examples are Pam Smith, who in 1992 published a book surrounding the emotional labour of nursing and Ruth Simpson, who in 2009 published a book entitled “men in caring occupations doing gender differently”. I also spent a number of sessions with Sandra Wilson, who is an expert in organisational Transactional Analysis (TA). These sessions challenged my thinking and raised my awareness on some of my personal assumptions. All the reflexivity constructs worked well together in providing me with tools to analyse and challenge my thought processes.

Figure 2 - Constructs of reflexivity within the research journey

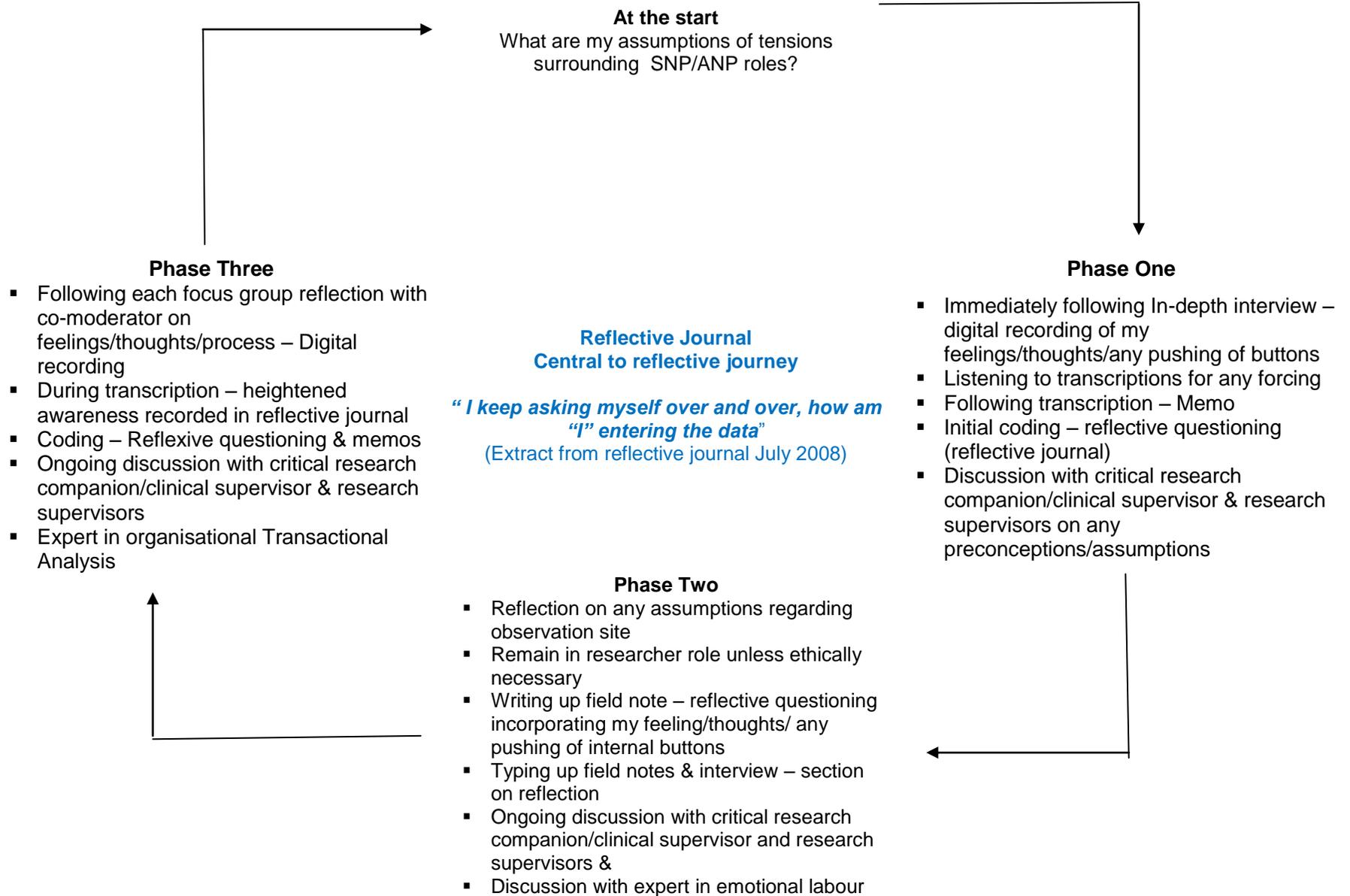
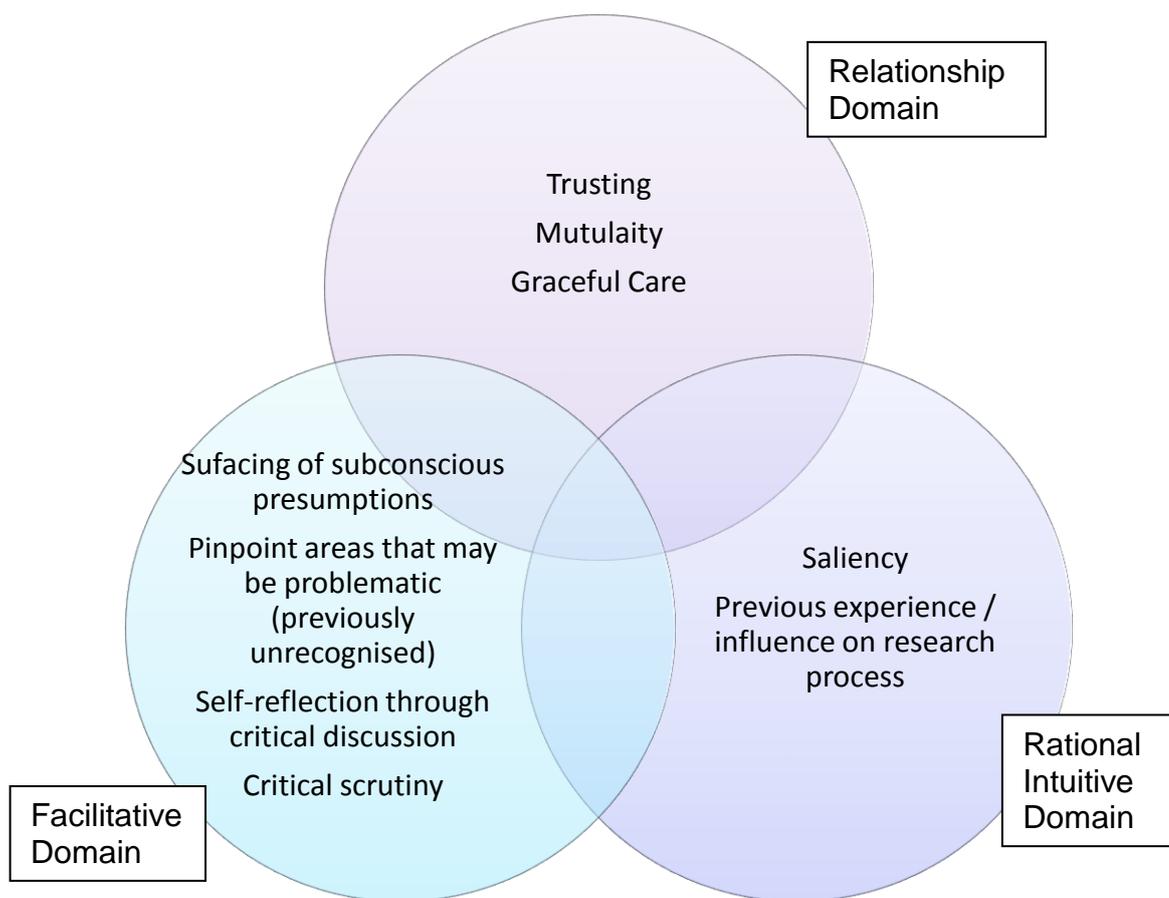


Figure 3: Critical Research Companionship



In this study there were three individuals who provided critical research companionship. Two research supervisors provided the expertise in research/practice, whilst another external individual provided expert advice in Transactional Analysis & clinical practice.
(Adapted from Tichen 2003 & Tichen & McGinley 2003)

Figure 3 highlights three domains to the critical research companionship relationships. The first is the relationship domain which details the importance of mutuality and trust within the relationship, in addition to 'graceful care' which is caring about the individual as a person. The rational intuitive domain was based on the mutual identification and choice on 'helping' strategies, which I likened to the contracting of our expectations on 'helping' methods. These included saliency which was being able to get straight to the heart of the matter, taking into account my previous experience. The facilitative domain was how the helping strategies developed my reflexivity through raising my levels of awareness surrounding my sub conscious assumptions, in addition to providing critical scrutiny.

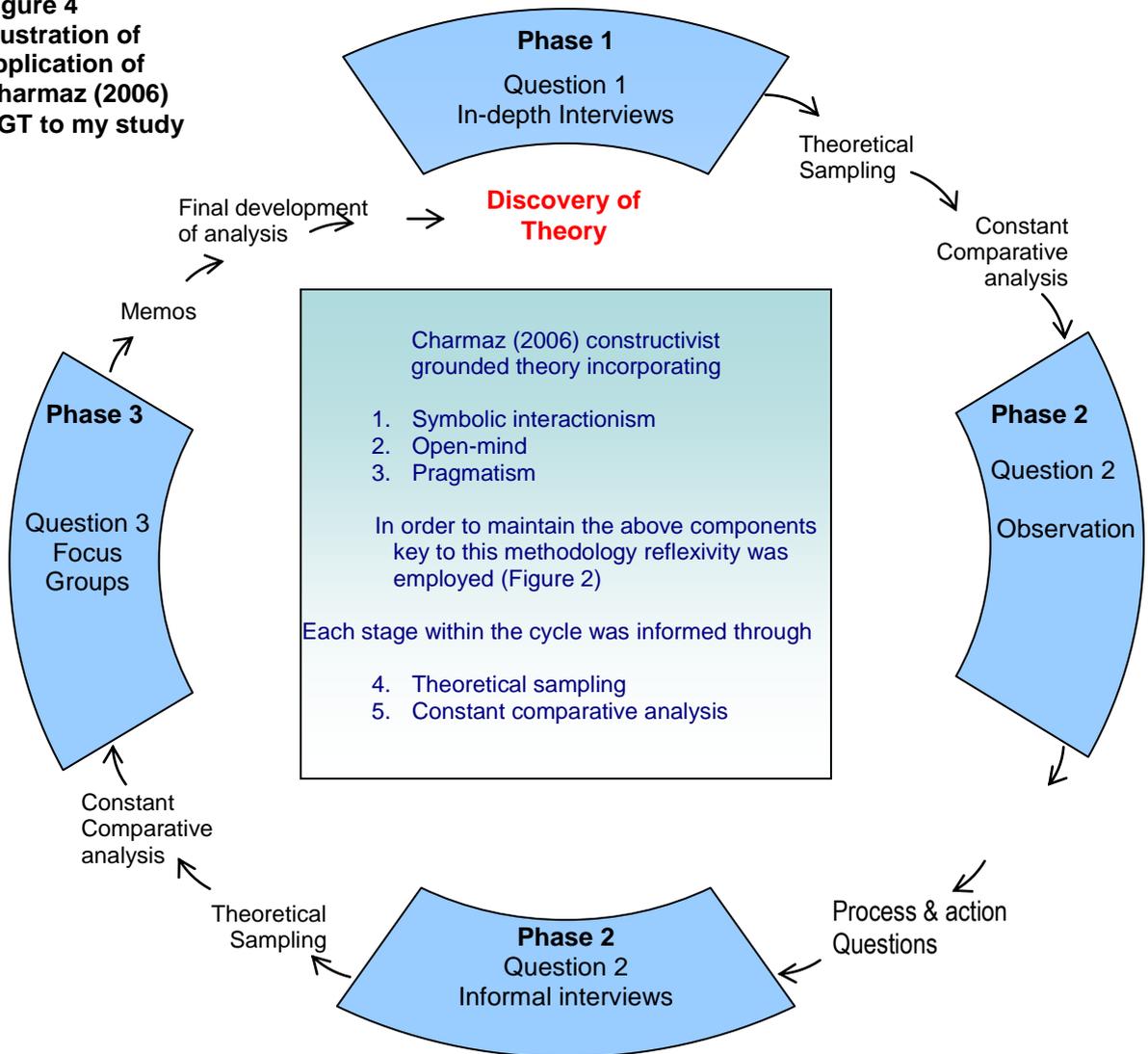
Whilst GT would aid in discovering why tensions continued to be associated with SNP/ANP roles, the constructivist approach would provide the wider facets to be taken into account. Charmaz (2006:130) explains,

“The constructivist approach means learning how, when and to what extent the studied experience is embedded in larger and often, hidden positions, networks, situations and relationships”

There was no consensus within the study site (a large urban Acute NHS Board setting in Scotland) nor across the UK or internationally regarding the titles, roles or responsibilities of SNPs/ANPs, therefore tensions surrounding such roles could be socially constructed differently by service users and service providers. Consequently, to provide a deep understanding it was important that tensions were explored from different contexts and perspectives across the study site. It was acknowledged that whilst not all perceptions surrounding tensions would provide convergence, it was nonetheless important to explore and construct data, thus deepening our understanding. Charmaz (2006: 131) further suggests that constructivists study how and why “participants construct meanings and actions in specific situations”. This variant of GT allowed me to explore how tensions were constructed and why tensions still existed with SNP/ANP roles three decades since they were introduced. Charmaz (2006) argues that through employing a constructivist approach, it can illustrate differences in communication. I deemed this important at the start of my study as differences and communication were reported as barriers to such roles in the literature (Lloyd-Jones 2005).

Due to the dynamics and contexts surrounding tensions with SNP/ANP roles which needed to be taken into account, the methodology of CGT was chosen. Figure 4 (overleaf) illustrates the application of this approach to my study. The cycle and arrows illustrate the ongoing development of the theory through each phase of my study, which was informed through theoretical sampling and constant comparative analysis. In the middle of the cycle is an outline of the underpinning principles applied within this methodology, which have been discussed earlier.

Figure 4
illustration of
application of
Charmaz (2006)
CGT to my study



3.5 Sampling

Theoretical sampling is a distinctive feature of GT which involves two key features, where both the samples and sites are selected by the researcher, as theory is generated to contribute to knowledge, due to their relevance to emerging categories or concepts (Glaser & Strauss 1967; Yun-Hee 2004). Creswell (2007) writes that within this sampling approach, the researcher will not be able to specify exactly what the sample will include. In addition, they cannot state how large or small the sample will be or what sites should be included. This is due to the fact that as theory emerges this will involve the

continued selection of units, until the research arrives at a point of ‘theoretical saturation’.

Theoretical saturation occurs when any new data appears to confirm the analysis rather than anything new, after this point sampling ceases and the sample size is adequate (Glaser 2004). In the initial stages of a GT study, a purposeful sample is necessary to provide the initial data, with theoretical sampling later. Glaser (1978) refers to this as a calculated decision considered in advance of the study, as the researcher approaches the sample groups where the possibility obtaining relevant data is maximised.

3.5.1 Purposeful and Theoretical Sampling in my study

On commencement of the study, a purposeful sample of service users (n=12) were recruited from a NP led unit. This unit was chosen to ensure service users could provide an account of perceptions of NPs, rather than overall perceptions of care from different members of the healthcare team. This enabled me to move forward to stage 2 with theoretical sampling. The theoretical sampling continued throughout my study and enabled further elaboration on focused codes and categories to enhance the discovery of a theory. An outline of the first purposeful and further theoretical sampling within each phase of my study is illustrated in Table 2. This is followed by an illustration of the samples within each phase of my study and a brief description of how the selection of participants was guided through theoretical sampling within each phase of my study.

Table 2 - Outline of theoretical sample

Phase 1	Phase 2	Phase 3
Stage 1 - Service users (n=12) (purposeful)	13 periods of observation followed by individual interviews	6 focus groups (n=27) 1 paired interview (n=2)
Stage 2 - Healthcare professionals (=18)	(n=13) Equated to 64 hours observation	5 individual interviews (n=5)

3.5.2 Phase 1 – Purposeful and theoretical sampling

Stage one (Phase 1)

In total, 12 services users were interviewed in stage one during phase 1. The age range of service user participants was 25-65 years – Table 3.

Table 3 - Profile of service user’s participants in Phase 1 (Stage one)

Male/Female	Age Range	Pseudonym
Female	50-65	Jessica
Male	50-65	Tam
Female	35-50	Jambo
Female	35-50	Susan
Female	35-50	Sarah
Female	35-50	Mille
Female	35-50	Sara
Female	35-50	Annie
Male	25-35	Barry
Female	35-50	Maria
Female	25-35	Nicola
Female	35-50	Monica

This initial purposeful sample enabled a common focus of the experience of being treated by an SNP/ANP. Following the constant comparative analysis over the course of the first six in-depth interviews, the majority of the initial codes were congruent, however there were still differences in relation to the initial code ‘decision-making’. To ensure theoretical saturation, a further six service users were recruited until saturation was reached. The point of saturation was when no new initial or focus codes were generated, but data confirmed focus coding and categories from previous interviews.

Stage Two (Phase 1)

In total, 18 service providers were interviewed in stage two during phase 1 of my study. The sample included medical staff (n=9) nurses (n=7) and AHPs (n=2). The first participant was a medic as service users in stage 1 had indicated differences in communication styles between medics and nurses. The sample included different grades within the professions and this was led through theoretical sampling inherent in the methodology.

The participants were interviewed at differing stages of data collection, rather than in order of profession, as highlighted in Table 4 (below). This order was related to initial coding which emerged from data and supporting literature.

Table 4 - Profile of healthcare team participants – Phase 1 (Stage Two)

Profession	Level	Age Range	Pseudonym
Medic	Consultant	35-50	Rosie
Nurse	Band 6	25-35	Jayne
Nurse	Band 6	35-50	Bernie
Medic	Consultant	35-50	Trish
Medic	SPR	35-50	Mickey
Nurse	Band 7	25-35	Josie
Medic	FY2	25-35	George
Medic	FY2	25-35	Michael
Nurse	Nurse Manager	35-50	Margaret
Medic	SPR	35-50	Russell
AHP	Specialist Physio	35-50	Harry
Nurse	Band 5	25-30	Sam
Medic	Consultant	50-65	Frazer
Medic	Consultant	35-50	Robert
Nurse	F Grade	25-35	Thomas
Nurse	Chief Nurse	35-50	Louise
AHP	Senior Physio	50-65	Mary
Medic	Consultant	35-50	Mark

3.5.3 Phase 2 – Theoretical Sampling

The Scottish Information Services Division (ISD) data sheet highlighted the total population of SNPs/ANPs across the study site in March 2008. The first participant was chosen based on the categories from phase 1, subsequent participants based on the codes emerging from phase 2. For example, participant 1 was chosen because she was part of a multiprofessional approach used to review service users in outpatients. A letter of invitation was sent to selected SNPs/ANPs and all those contacted agreed to participate in my study, as illustrated in Table 5 (overleaf). In this sample, the 3rd observation did generate different data compared to the first two observations in relation to the category of 'shared decision-making' therefore a further 10 observations took place to achieve theoretical saturation. The point of saturation occurred when data collected confirmed focus codes and categories which were generated from previous observations and no further new information were evident during analysis.

Table 5 - Profile of SNPs/ANPs observed – Phase 2

Male/Female	Age Range	Pseudonym	Observation
Female	30-40	Sharon	7.5 hrs
Female	40-50	Harriet	6.5hrs
Female	30-40	Nuala	4.5 hrs
Female	40-50	Jessie	7.0hrs
Female	30-40	Chloe	5.5 hrs
Male	50-60	Michael	4.5 hrs
Female	30-40	Monica	3.5hrs
Female	40-50	Lauren	4.5 hrs
Male	50-60	Michael	3.5hrs
Female	40-50	Morag	5 hrs
Female	20-30	Karen	3.5hrs
Female	50-60	Sophia	5 hrs
Female	50-60	Mary Jane	3.5hrs
Total			64 hours

3.5.4 Phase 3 - Theoretical Sampling

In total, 6 focus groups (n=27) were undertaken, one paired interview (n=2) and five individual interviews (n=5): in total 34 participants were interviewed as part of phase 3 of my study (Table 8). In April 2009, names and contact details for all SNPs/ANPs within the acute division were ascertained from ISD data, as this was the only source of obtaining certain information on SNPs/ANPS who worked across the study site. It detailed gender and title of such roles. A selection of individuals from the ISD data were chosen to participate in my study, and sent a letter of invitation. Earlier data suggested that tensions created by SNP/ANP roles may have been linked to differing titles and gender. I deemed it appropriate that groups were therefore set up through theoretical sampling to aid in comparative analysis. Focus groups were therefore set up in accordance to their title and gender Table 6 (overleaf).

The two main titles were Clinical Nurse Specialists (CNS) and those which contained the word 'practitioner' in their overall title. All focus groups were set at different times and each acute site was utilised to facilitate the groups to maximise participation. Due to the nature of such roles, selected participants had clinical commitments therefore there were a number of 'no shows' on a particular day, which led to a paired interview taking place. In addition, the core category generated from the focus groups and data from all phases of my study were followed up through individual interviews (n=5) for further clarification and consensus, to aid in identification of saturation.

Table 6 - Profile of participants – Phase 3

Pseudonym	Title	Time in post	Gender	Data Collection Method
Skippy	Nurse Practitioner	4 years	Male	Focus 1
D'Griz	Nurse Practitioner	2 years 8 months	Male	Focus 1
Meadhran	Nurse Practitioner	10 months	Male	Focus 1
Charlotte	Broctiectasis CNS	3 years	Female	Focus 2
Elizabeth	Toxicology Specialist Nurse (CNS)	5 years	Female	Focus 2
Emma	Toxicology Specialist Nurse (CNS)	5 years	Female	Focus 2
Linda	Heart failure Nurse (CNS)	4.5 years	Female	Focus 2
Zara	Paediatric Stoma nurse (CNS)	6 years	Female	Focus 2
Jemima	Senior Nurse Practitioner	4 years	Female	Focus 3
Nellie	Senior Nurse Practitioner	4 years	Female	Focus 3
Sarah	Arthroplasty Nurse Practitioner	10 years	Female	Focus 3
Susan Carol	Nurse Practitioner	3 years	Female	Focus 3
Jenny	Trauma Nurse Practitioner	7 years	Female	Focus 3
Florence	Lead Breast CNS	11years	Female	Paired Interview
Katrina	McMillan Project manager (CNS)	2 years	Female	Paired Interview
Anne Smith	CNS liaison psychiatry	6years	Female	Focus 4
Jane Brown	CNS Respiratory	3.5 years	Female	Focus 4
Penny	CNS Palliative Care	4 years	Female	Focus 4
Alison White	CNS Palliative Care	3.5 years	Female	Focus 4
Rosie	Alcohol liaison nurse	17 years	Female	Focus 5
Erin	Clinical Nurse Specialist pain management	6 years	Female	Focus 5
Jill	Paediatric Diabetes nurse specialist	15 years	Female	Focus 5
Kirsten	Clinical Nurse Specialist pain management	4 years	Female	Focus 5
Katie	Nurse Practitioner Cardio-Thoracic unit	2 years	Female	Focus 6
Wanda	Senior Nurse Practitioner	2 years 9 mths	Female	Focus 6
Babs	Nurse Colposcopist	5 years	Female	Focus 6
Sylvia	Ophthalmic Nurse practitioner	6 years	Female	Focus 6
Imelda	Arthoroplasty Nurse Practitioner	4.5 years	Female	Focus 6
Queenie	Senior Nurse Practitioner	4 years	Female	Focus 6
Jake	GI Nurse Practitioner	12 years	Male	Individual Interview 2
Pet	CNS urological cancers	9 years	Female	Individual interview 1
Freya	CNS Lecturer/practitioner	11 years 2 years	Female	Individual Interview 3
Kathleen	NP A & E	8 years	Female	Individual interview 4
Alberto	MS Nurse Specialist	4 years	Male	Individual interview 5

3.6 Data Collection

An important element in employing the CGT approach is the requirement to choose data collection methods that will yield rich data. Charmaz (2006:14) illustrates the relevance of employing a number of different data collection methods to discover theory, when she states:

“Like a camera with many lenses, first you view a broad sweep of the landscape. Subsequently, you change your lens several times to bring scenes closer and closer to you”.

In my study, the in-depth interviews employed in phase 1 provided a general view of where tensions were apparent with the SNP/ANP role. The lens changed to provide a different view in phase 2 through GT ethnography, which observed more closely, describing the associated meaning and actions of where tensions were generated, as described in phase 1. Finally, the focus groups which incorporated stimulus material generated from phase 1 and 2, enabled a rich collection of data and provided the basis to discover a core category at the end of phase 3. The different data collection methods employed within each phase of my study are illustrated in Table 7, which also highlights the timeframes and research questions.

Table 7 – Data collection methods across the 3 phases

Research Question(s)	Timeframes	Data Collection Methods
Where are tensions created by Senior and Advanced Practitioner roles from a service user and healthcare team perspective?	Phase 1 January 2007 - December 2007	In-depth Interviews
Where do tensions remain apparent in service and what meanings and actions are attributed to them?	Phase 2 January 2008 – December 2008	3-step participative observation
What are the interpretations of senior and advanced nurse practitioners on interactions with the healthcare team and service users?	Phase 3 January 2009 – November 2009	Focus Groups Paired Interview Follow up individual Interviews Ya-Ya Boxes

The following sub-sections will provide a brief overview and rationale for the data collection methods within each phase of my study. At the end of each sub-section, a Figure will illustrate the data collections methods, illustrating the connection with the associated research question/s, the sample and underpinning principles applied throughout data collection.

3.6.1 Phase 1- Data collection method employed : In-depth Interviews

Charmaz (2006) outlines that an important element in employing the GT approach is the requirement to choose data collection methods that will yield rich data. During phase 1 of my study, in-depth interviews were employed. This method of data collection were appropriate within this approach (Strauss & Corbin 1998; Glaser 2004; Charmaz 2006; Creswell 2007; Silverman 2010). Goulding (2002) outlines that in relation to GT, semi-structured, open-ended in-depth interviews are favoured as they have the potential to generate rich and detailed accounts of the individual's experience. In-depth interviews were therefore utilised to gain interpretations from a number of different perspectives to add to the richness of understanding surrounding tensions and practitioners' roles. An interview topic guide was developed following the analysis of the first interview, based on initial codes and literature related to these codes. This was part of the constant comparative method.

The guide was employed flexibly during the interviews to allow participants to construct their accounts in their own terms. This was revised and refined throughout the interviewing process, to reflect emerging initial and focus codes from concurrent data analysis. If a code emerged, this was then added to the topic guide and this in turn directed the theoretical sampling process. It was essential to keep the topic guide as broad as possible and also incorporate reflexivity in the rationale for topics within the guide. The transcribed digital-recording of the interviews made it easier to see when the questions didn't work or if there was a danger of forcing of the data. I was reflexive about the nature of the questions and whether they worked for the specific participants and the nascent of CGT.

Figure 5 – Illustration of data collection methods – Phase 1

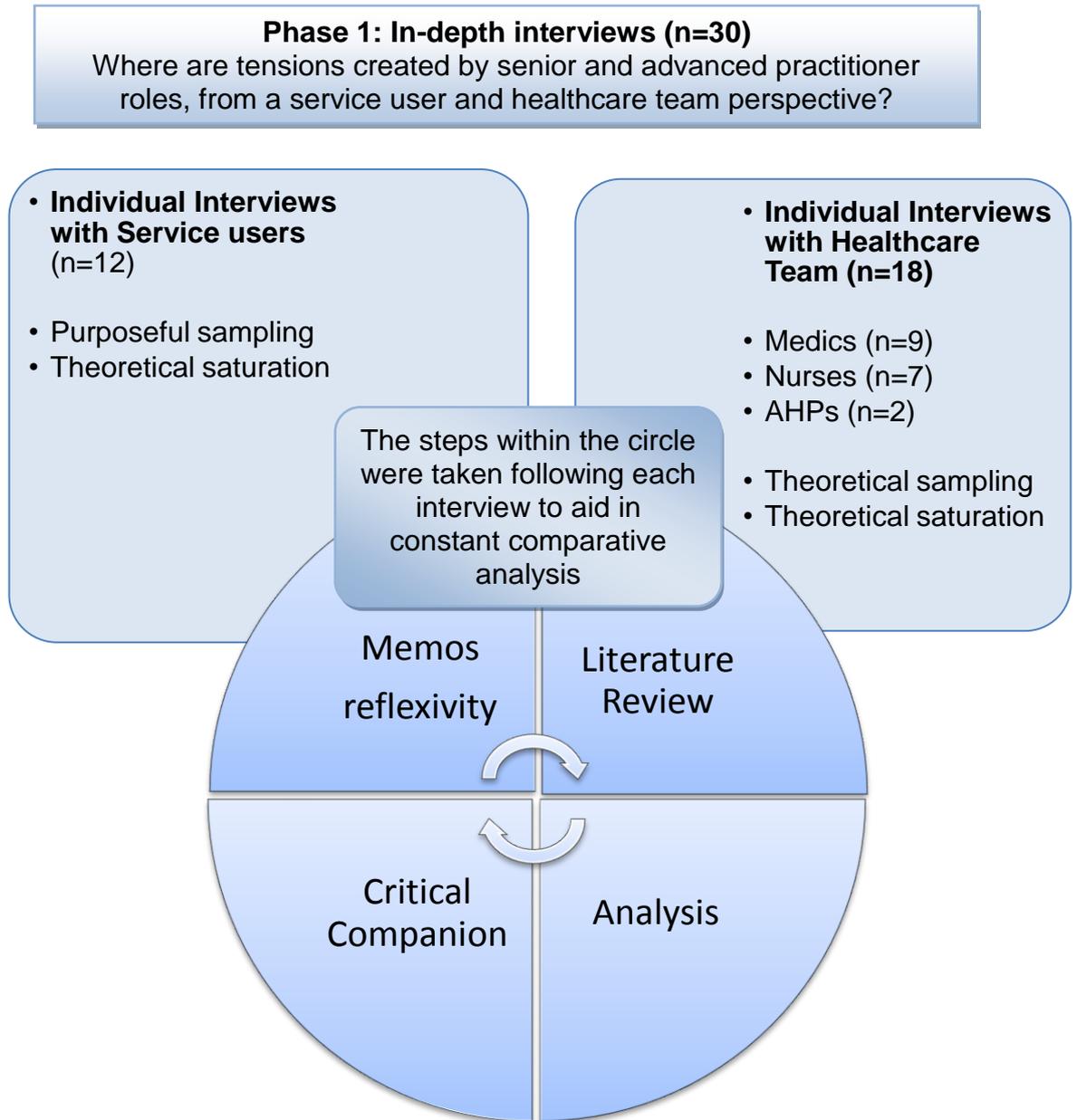


Figure 5 illustrates the methods employed in phase 1 of my study. It starts by illustrating that the first research question was addressed through in-depth interviews with participants (n=30) in phase 1. The next level of this diagram, it highlights on the left, that in stage 1, individual in-depth interviews were undertaken with service users (n=12). Data collection was guided through purposeful sampling and theoretical saturation. The box on the right shows that stage 2 incorporated in-depth interviews with different members of the healthcare team (n=18). It further illustrates that data collection was guided through theoretical sampling and saturation. Following each individual interview, the circle illustrates the constant comparative steps which were undertaken during data collection, these included memos, reflexivity, literature review and sessions with a critical companion.

3.6.2 Phase 2 - Data collection method employed: Participative observation

The method of observation was employed in phase 2 of my study. One form of observation is structured observation, which has an observation schedule. This specifies the categories of behaviours that are to be observed and *Kappa* or correlation statistics can both be utilised in analysis. I would argue that this structured approach would not lend itself well to the research question or the methodology of GT, due to its positivist nature. In contrast, Charmaz (2006:22) outlined a method of observation referred to as “Grounded Theory Ethnography”.

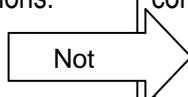
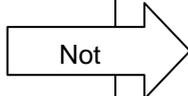
Bryman (2008) added some clarity to this viewpoint by outlining that ethnography is frequently and simultaneously referred to both as a methodology to carry out research and participant observation, which is a research method. Charmaz (2006) states that within an ethnographic study the aim of the method of observation is to obtain a full description of a setting, utilising a structural approach rather than a process approach. Whilst, in “Grounded Theory Ethnography” the method of observation “gives priority to the studied phenomenon or process”, rather than the setting itself (Charmaz 2006:22).

This correlated well to question 2 within my study, as it was the process which incorporated the actions and meanings associated with tensions generated from SNP/ANP roles. The differences between the method of observation being employed within a traditional ethnography study and CGT methodology are further illustrated in Table 8. This also shows the application of this method to my study. This method of observation was structured in a 3 stepped approach which is further discussed in the next section.

Table 8 – Differences in GT Ethnography & Traditional Ethnography

KEY: *GT Ethnography * Traditional Ethnography

GT Ethnography	Traditional Ethnography	Application to this study
*Priority to the processes involved	* A detailed description of the setting	*Required some description of the setting as NP roles differed in scope and socialisation. *Priority of observation was actions and meanings within interactions between NP ³ , SU ⁴ and SP ⁵ rather than just a description of the setting.
*Process Approach At beginning conceptual rendering about actions. Move across settings to construct theory	* Structural Approach A specific focus on one community. Looking for full description of topic studies	* Moved across sites, as important to observe different NPs as they had different levels of scope within their roles. Process Approach
* (A) Allows comparing DATA with DATA from the beginning (B) Compare data with emerging categories (C) Demonstration relations between concepts	* All data collected prior to analysis Rigid and artificial separation of data collection and data analysis	Allowed for initial focus on social interaction based on where tensions were described in phase 1. Also allowed for the theoretical sampling, thus the building of theory through constant comparative method.
*Field Notes Basic social actions & processes that construct the topic	*Field Notes Full description of the topic may document like an object without showing actions & processes that construct it.	* Field Notes Allowed focus on actions and meanings based on initial and focus codes in addition to utilising probing reflective questions to aid in obtaining data.
*Not passive observers Facilitates the selection of the scene through theoretical sampling		*Open ended approach aided in studying how various actions and meaning influenced tensions though systematic checks with data collection & analysis.



³ NP= SNP/ANP- Senior or Advanced Nurse Practitioner

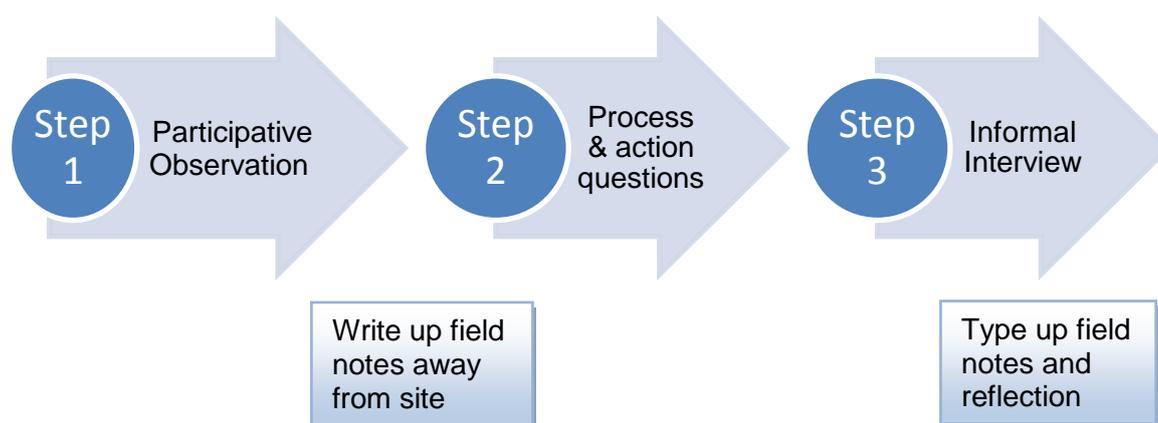
⁴ SU = Service User

⁵ SP= Service Provider

3.6.3 The 3 stepped approach to observation - phase 2

In total, 13 periods of observation (each observation lasting between 3.5hrs and 7.5hrs) were undertaken, which equated to 64 hours of observation within different sites. This observational approach required moving across settings, rather than focusing on one area. This was congruent with both the aims of this study and GT methodology (Bryman 2008). The observation process followed three steps outlined in Figure 6, which is further elaborated upon below.

Figure 6 - Three stepped approach to observation in CGT



Adapted from Charmaz (2006)

Step One

I observed the participant in the setting, taking into account processes, actions and behaviours with the healthcare team and service users. My level of participation during observation was moderate⁶, ranging from dressing/undressing service users to participation in cardiac arrest situations. This enabled me to maintain a more acceptable role and blend in to the study site environment. I believe this brought a sense of normality during the observation. One feature of this data collection method is that the researcher must become involved. Again, this can take on many forms as Charmaz (2006) highlights, the observer needs to share some experiences with participants. Due to the 'hybrid' stance which I had within my study, this particular approach lent itself well to allowing me to obtain data which was rich and relevant within the study sites. However, I was aware this could have led to the paradox of enhancing the Hawthorne affect during observation. This will be further explored in this section.

⁶ Charmaz (2006) advocates engaging in the study environment, with some element of participation.

Step Two

Following the period of observation, I moved out of the setting and wrote up some field notes. I engaged with the reflective process and action questions for my study Table 9 (overleaf). An important component within observation when utilising Charmaz' (2006) methodology is to recognise that reflexivity is crucial and this must also be highlighted within the field notes. By recording the field notes after the observation, this allowed me to incorporate reflexivity utilising the action and process questions to probe the observation.

These questions, as outlined in Table 9 (overleaf) were based on Charmaz & Mitchell's (2001) work and provided some guidance, as it ensured that attention was also given to the basic social processes within the observations. Charmaz & Mitchell (2001) state it is beneficial to study actions and actors within this method. The NP's were the actors and questions were adapted to aid in focusing on actions.

Step Three

On return to the study site, I undertook an informal interview with the participant. This ensured that any meanings given to observations were verified with all participants, in addition to probing the social processes inherent within the observation. I then typed up field notes, incorporating data from the interview and individual analysis within twenty four hours. Savage (2000), states that a researcher undertakes the construction of events during observation. She argues that this construction depends not only on the focus of the observation, but also on the unconscious views of individual researchers. Parahoo (2006) reports different researchers are likely to collect different data while observing the same phenomena. Therefore, it was important that the informal interview took place with the participant following observation, to aid in verifying the construction of meaning within the data from the period of observation.

The table overleaf illustrates the action and process questions that I developed for my study. They were employed to aid in the reflective process when writing up field notes following the period of observation and returning to the site to undertake an informal interview.

Table 9 – Reflective questions employed in phase 2

<ol style="list-style-type: none">1. What is the setting of action? When and how does action take place?2. What is going on between the NP and service user? What is the service user encounter like? Who is in charge? Does direct consultation vary between service users? Are they involved in decision-making? Do they get a choice on care from the NP or Medic?3. What is going on between the NP and others within the healthcare team? What does the NP do in this interaction? What does the service provider do and how do they act?4. How many interactions does the NP participate in over the course of period of observation? Do they welcome these interactions?5. How does the NP organise service users' consultations? What and who causes effect, oversees or promote these consultations? How long do they last. Is it superficial or in-depth?6. What does the NP pay most attention to? What is important or critical and why?7. What do they pointedly ignore that others may pay attention to?8. How do they explain to service users and service providers (not investigator) what they are doing and why they are doing it?9. What goals do they want to achieve? From their perspective, when is an act well or poorly done? How do they judge interactions with service user or service provider and by what standards, developed and applied by whom?10. What rewards do NPs get from their participation in relationships with service users and service providers?11. You're a nurse practitioner in terms of your title, where does the nursing care come through in your role? (Following first interview)

3.6.4 Limitation to the data collection method - phase 2 Hawthorne effect

The Hawthorne effect is a consequence of employing the method of observation (Parahoo 2006). When researchers observe the behaviour and processes of participants, they will alter their behaviour in a positive and temporary way as they know they are being observed. This is known as Hawthorne effect (Leonard & Masatu 2006).

This has been shown in a number of studies internationally (Gimmotty 2002; Das & Hammer 2005; Leonard & Masatu 2006). There are some who dispute the value of discussing the Hawthorne effect in research findings, outlining that it is complex and the effect can be a result of a number of issues (Ampt et al. 2007; Chlesa & Hobbs 2008). I would concur that the Hawthorne effect would appear complex, however would argue the merit in acknowledging this effect on data collection and minimising the effect during the observation.

I acknowledged the potential limitation of the Hawthorne effect from the beginning of my study when employing all methods of data collection. However, in order to answer the research question this method of data collection was deemed the most appropriate. In acknowledging this limitation, it was important that I was a moderate⁷ participant during the observation period in normalising the period of observation. I also wore my nursing uniform to aid in fitting into the environment. As Drury & Scott (2001) assert, it is important to integrate into the setting, to aid in being accepted, therefore reducing the Hawthorne effect.

Most practitioners in my study were very busy and it would have been very difficult for them to alter their behaviour fundamentally from normal. The use of reflexivity was important in the process of observation and I was aware of two occasions where the Hawthorne effect was present. However, whilst the participants may have altered their behaviour slightly, the interaction and behaviours between them and others was difficult to alter. An example of this was in a clinic where they had extended opening times to reduce the waiting lists. The NP was consulting service users in the same way as the doctors' over the same timeframes.

The nursing staff within the clinic made tea and toast for all the doctors, but not the ANP. When probed on this element following the writing up of field notes, the ANP outlined resistance to her role from nursing staff. On another occasion in a different clinic, nursing staff would retrieve notes and x-rays for the doctors but not the SNP. Once again, on discussion in step three of the observation, it was highlighted that the nurses did not covertly agree with a SNP undertaking this role.

⁷ Moderate- Undertaking basic nursing tasks.

Such examples happened in most of the observations, coupled with observation of tone of speech, body language and facial expressions, indicating both the overt and covert interactions with other health team members, which was central to my theory. The main purpose of the observation was to see things from the SNP/ANP point of view and experience the interaction between team members and service users. This would indicate where tensions were apparent with inherent meanings and actions. This was made possible through this method and built upon the main categories from phase 1 of my study.

3.6.5 Data collection - phase 2

The constant comparative method aided in increasing my involvement in the research inquiry as unlike an ethnography study, data were analysed from the beginning, thus comparing data with data and this led to demonstrating relationships between codes during this process. This also allowed me to select scenes to observe and thus aided in reaching theoretical saturation.

This was important as the main aim of the observations was to seek data, describe observed events, in addition to answering fundamental questions about what was happening in relation to meanings and actions and moving towards constructing data to understand it. Munhall (2003) utilises the analogy of a jigsaw, that whilst the data generated from the in-depth interviews in phase 1 made up part of the jigsaw, the method of observation complemented this and enabled a different view which enabled the construction of the overall jigsaw for my study, by identifying inherent actions and meanings associated with observed tensions. An outline of data collection methods in phase 2 is highlighted in Figure 7 (overleaf).

Figure 7 – Illustration of data collection methods – phase 2

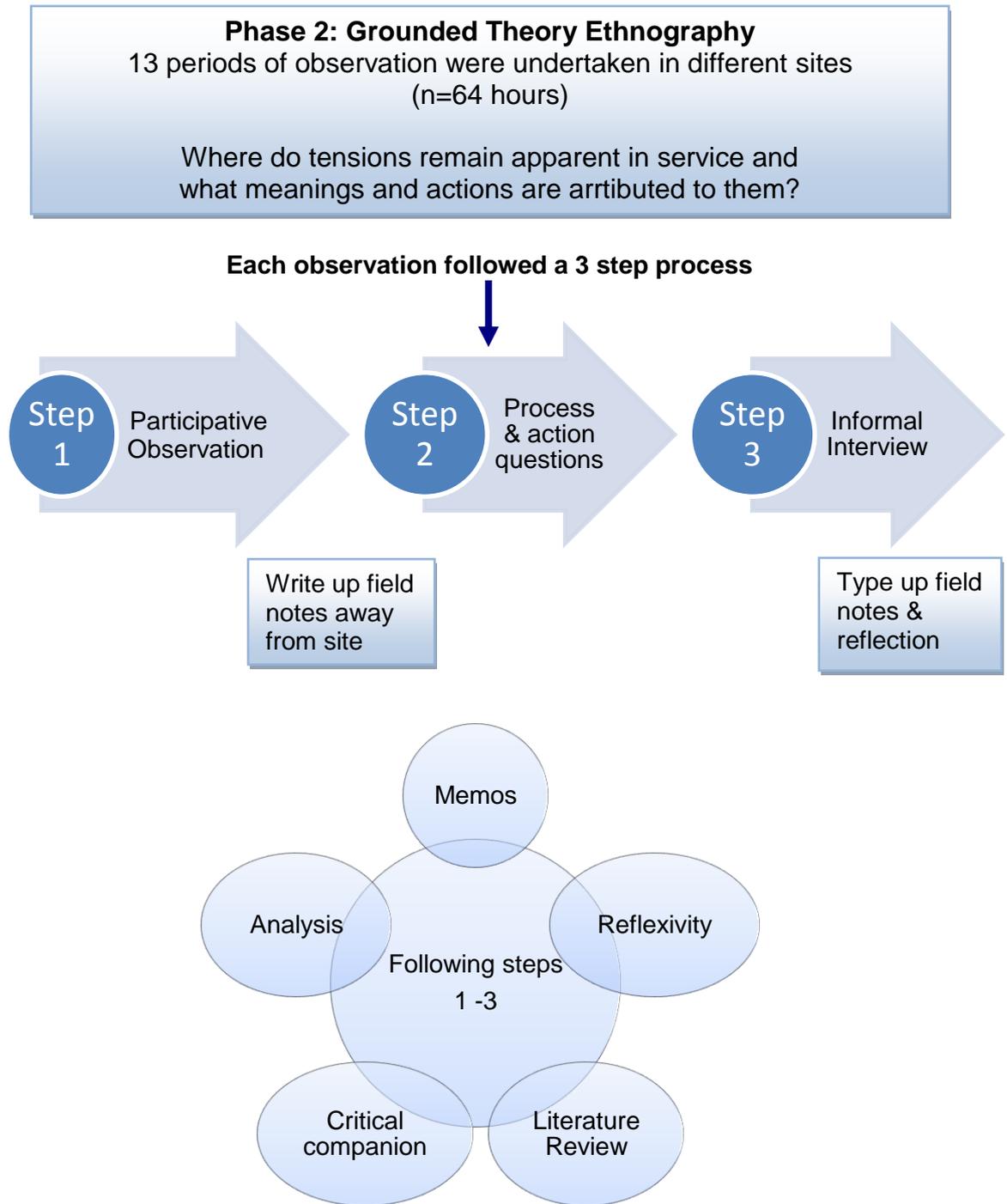


Figure 7 (above) – The top box outlines the research question addressed through the data collection method of GT ethnography, where 13 periods of observation were undertaken which equated to 64 hours across different sites. The arrow guides the reader down to the 3 stage approach to participative observation within this phase (Section 3.6.3). The circle at the end of the figure illustrates the underpinning processes undertaken as part of the constant comparative method after each observation.

3.6.6 Phase 3 – Data Collection methods employed : Focus Groups & Ya Ya Boxes

Focus group interviews were deemed the best method of data collection to answer the research question posed in phase 3. The focus group methodology provides the opportunity to study the ways in which participants collectively make sense of a phenomena (Creswell 2007). This appeared to mirror the theoretical constructs of symbolic interactionism which provides a process of understanding or generating theory surrounding the social phenomena of practitioners' interpretations on interactions with the healthcare team and service users. This would concur with Tranlsen et al. (2004) who highlight that the most salient aspect of focus interviews as opposed to conventional research interview, is that all group members have experienced a particular social situation and this becomes the focus of the interview.

There are a number of advantages of utilising this method in relation to answering the research question posed in phase 3. Kidd & Parshall (2000) illustrate that following a number of studies utilising this method, individuals do not speak or answer questions in the same way as they do during an individual interview. They maintain that more data is generated when this form of data collection is employed. Wilkinson (2004) makes the point that focus group interviews are more naturalistic than other forms of interviews, as it follows an everyday conversation within a group. She further highlights that within the dynamic group interaction, where group members debate and discuss issues, rich data is provided which may not have been gained from other forms of interview. Whilst Agar & McDonald (1995) outline that in contrast to individual interviews, focus group participants relate their experience among peers with whom they share some central frame of reference.

In total, 6 focus groups (n=27) were undertaken, one paired interview (n=2) and five individual interviews (n=5): in total 34 participants were interviewed as part of phase 3. Barbour (2007) suggested that the size of a focus group is dependant on the subject under review and the amount of data required to be analysed. In relation to a minimum number, it was deemed appropriate to have a focus group with 3 to 4 participants (Kitzinger & Barbour 1999; Bloor et al. 2001; Seymour et al.2002; Barbour 2007).

This approach maximised the potential for comparison across different groups and gender, which was indicated as possibly influencing tensions in early data analysis. The data collection method aided in comparing and contrasting, thus gaining a greater understanding of similarities and differences, both within and across similar groups. For example, comparing across the CNS focus groups and NP focus groups as well as between all CNS focus groups and NP groups. Glaser & Strauss (1967) originally returned to the field to test a hypothesis. This method also allowed for the testing and verification of the main categories which emerged from all data at the end of phase 3. This member checking aided in verifying the data and this is further explored in Section 3.9.

Within all the focus groups and the paired interview, I was the interviewer and a colleague (primary school and drama teacher) who was not involved elsewhere in my study, acted as the moderator. Hurd & McIntyre (1996) suggests that an external moderator is helpful, as occasionally the interviewer, may also share some of the 'taken for granted' assumptions. The moderator took notes and also acted as a process observer within the group during the interview. This enabled her to note body language and reactions during the focus groups. This was applied to the transcriptions. It also provided an opportunity for us both to reflect on the process following the focus groups. This was important as Barbour (2007) highlights the importance of the interaction between participants in a focus group and what is happening during a piece of interaction. It also aided me (an experienced facilitator in groups) to work at ensuring all group members participated. For example, if a group member was quiet, the individual was invited to participate by asking their opinion on comments made. Key points were repeated throughout each focus group and interview for validation by the participants. This is a process which has been identified as participant verification (Morgan 1998).

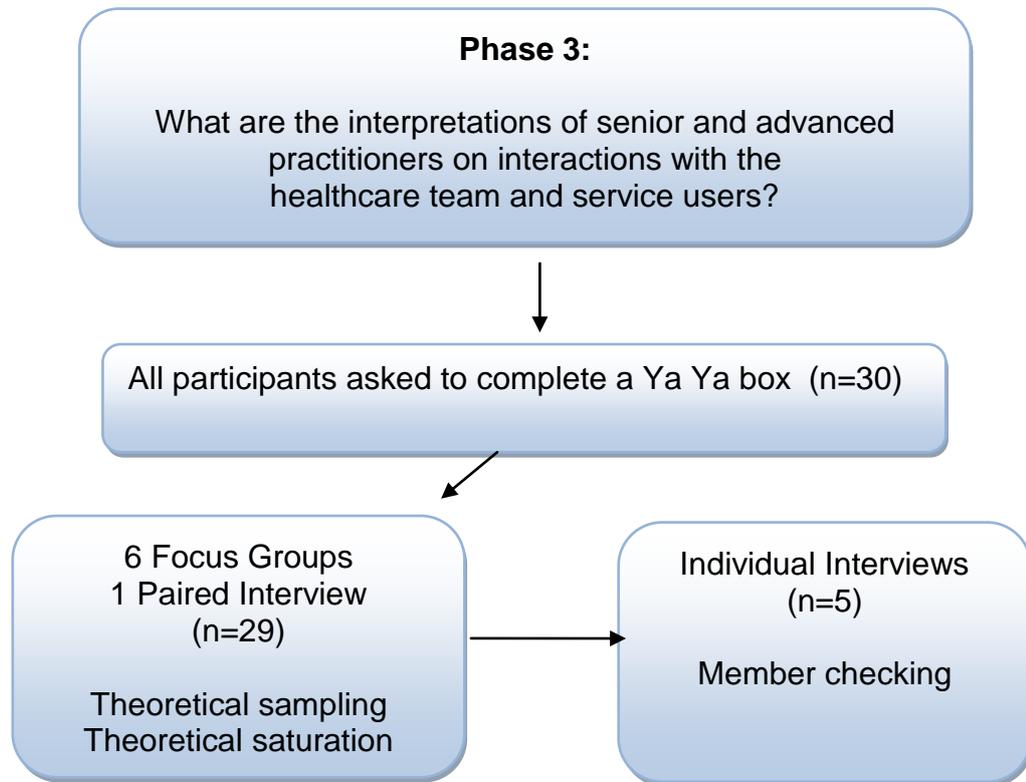
All participants were invited to fill out an individual "Ya Ya" box (Janesick 1998) immediately prior to commencement of the focus groups or interviews, to ascertain if there were differences in their own views of others peoples' perceptions of their role and their individual expectations of the role before their individual views could potentially be contaminated by the group processes.

According to Janesick (1998) the Ya Ya box is adapted from the field of art therapy (Appendix 2). The innermost section of the Ya Ya box represents the person's own perceptions and feelings, whilst the outermost section represents how the individual perceives how others view the same issue – thus gaining the person's innermost thoughts, feelings and perceptions and how they also perceive how others feel / think about the same issue. The use of the Ya Ya box was stimulated from the categories in phase 1 and 2 of my study, which indicated that there may be differences in perceptions and expectations. All participants were also provided with stimulus material in the focus groups, which incorporated quotes from participants in phase 1 and observations from phase 2 of my study. These were related to the emerging main categories from these previous phases. This aided in member checking the construction of data from phase 1 and 2 of my study, which is discussed further in Section 3.9.

Whilst some quotes given to participants were linked to codes and categories consistent throughout my study, some were chosen, as they were not consistent (Appendix 3). This was to aid in the constant comparative analysis and theoretical saturation in seeking disconfirming data. The stimulus material appeared to facilitate participants to explore some complex issues and illuminate underlying less visible tensions within such roles, providing valuable insights into social constructions of such roles. In addition to the stimulus material, all participants were asked at the end if there was anything they would like to add. As highlighted earlier, one planned focus group resulted in a paired interview due to a number of 'no shows'.

To aid in ensuring theoretical saturation and verification of the construction of core category, five further individual interviews took place which confirmed saturation and theoretical themes. Figure 8 outlines the data collection methods employed in phase 3 of my study (overleaf).

Figure 8 – Illustration of data collection methods – Phase 3



The top box in Figure 8 (above) highlights the data collection methods employed to answer the research question in phase 3. The next level shows that Ya Ya boxes were also employed (n=30⁸) to collect data in this phase. The third level of the Figure has two boxes, the one located on the bottom left outlines that theoretical sampling and saturation guided the data collection method of 6 focus groups and 1 paired interview. The box on the bottom right illustrates that verification of the emerging core category was undertaken through individual interviews (n=5). This process confirmed data saturation as no new categories or codes emerged and there was resonance with the core category.

⁸ In total 30 out of 34 Ya Ya boxes handed in at the end of phase 3

3.7 Data Analysis

In relation to data analysis, the coding and categorising continued throughout the research process within this study, in tandem with memoing and an integrated literature review. On commencement of the study, to aid clarity, a comparison was undertaken regarding the differences in key stages of analysis between the variants of GT (Strauss & Corbin (1990; 1998) Glaser (1992; 2004) Charmaz (2006), as illustrated in Table 10.

Table 10 - Variants in GT data analysis

Stages of Analysis Heath & Cowley (2004)	Strauss & Corbin (1990;1998)	Glaser (1992;2004)	Charmaz (2006)
Initial Coding	Open coding Use of analytic technique	Substantive coding Data dependent	Initial coding practices Data dependent with some reflexive techniques
Intermediate Phase	Axial Coding Reduction & clustering of categories (Paradigm model).	Continuous with previous phase Comparison, with focus on data becoming abstract, categories refitted, emerging frameworks	Focused coding Continuous with previous phase. Focus on emerging codes within the data, comparing data with data. Identification of conceptual categories
Final development	Selective coding Detailed development of categories, selection of core, and integration of categories	Theoretical coding Refitting and refinement of categories, integration with emerging core category.	Theoretical coding with Reflexivity Refinement of main categories. Development of core category.

3.7.1 Memos

Central to the analytical process was reflexivity and use of memos. Memo writing is a step that is inherent in CGT, which allows the researcher to analyse their data early in the research process (Charmaz 2006). Memo writing enabled the breaking down of categories and elaborated on focused codes.

Whilst memo writing went on throughout the whole process of analysis, advanced analytical memos are highlighted within the findings of chapter 4 to illustrate the creating and refining of the theoretical links, as this process enabled me to compare categories at an abstract level. As Charmaz (1990;1169) states, memo writing “gives the researcher an analytical handle on the materials and means of struggling with discovering and defining hidden or taken for granted processes and assumptions within the data”. This was an important element in analysing the overt and covert meaning and actions within the data. Memos were a crucial facet in the development of the theory. As Charmaz (2006) outlines there are no set ways in writing memos. I used different types of memos throughout the research process.

As part of the comparative analysis during each phase, I used ‘cluster memos’⁹ to help make connections and comparisons with data and literature, enabling me to analyse data and codes early in the research process (Appendix 4). As I progressed through a phase I used ‘advanced memos’¹⁰ which enabled me to think ‘out of the box’ as well as crystallise questions and identify gaps in the analysis which then guided the constant comparative analysis into the next phase. These memos were central to gaining new insights and ideas. This also guided me to develop the categories within each phase.

At the end of phase 3, during theoretical coding memos played a central role in comparing and making comparisons across all data as well as discovering my ideas about them. This helped identify the core category within my study and rendered all data across all three phases of my study. Whilst searching for the theory all advanced memos helped shape the interpretive theory through the analytical scrutiny and abstract thinking they contained.

⁹ Cluster memos – According to Charmaz (2006) these are spontaneous – they captured my thoughts, comparisons and connections through free writing.

¹⁰ Advanced memos- According to Charmaz (2006) these identify connections across data, in my study this was within each phase and across all phases. They captured my beliefs and assumptions and underpinning theoretical constructs.

3.7.2 Data Management

During the first stages of analysis, I incorporated the data management system of NVivo. However, it became apparent due to personal preferences, this method of data management was not suitable. Therefore, an adapted format of Burnard's (1994) methods of analysis was employed to organise and manage data, which complemented Charmaz's (2006) method of analysis. Burnard (1994) outlines these methods as a means of analysis for qualitative data.

However, I would argue that whilst these methods were useful in organising and managing data, it did not follow the systematic processes incorporated in Charmaz (2006) method of analysis. There were no processes for reflexivity or memos, in addition to the comparison of codes and categories across the different stages of my study. However, in order to manage data, Burnard's (1994) method was very useful. The adapted format, incorporated initial, focus and theoretical coding and is highlighted in Figure 9, (page 83).

3.7.3 Charmaz (2006) method of analysis

Charmaz's (2006) method of analysis was used, which mirrors Glaser & Strauss (1967) original method of analysis. The key difference to Charmaz's approach is the prominence of reflexivity and 'use of self' throughout the constant comparative method. Evidence in this thesis can be seen in advanced memos. Two stages of analysis occurred across each phase of my study. These included initial coding and focus coding, which led to the identification of main categories across all phases of the data. Theoretical coding took place at the end of phase 3, comparing all focus codes and categories using memos to identify the core category.

Stage 1 – First stage - Initial coding

The first stage of analysis within each phase commenced with this stage. This commenced as soon as data was collected. The coding incorporated the coding of each sentence and each incident into as many codes as possible to ensure a thorough examination of the data. This enabled me to remain open to the data and observe nuances within it.

The initial codes were simple and incorporated participants own words or in vivo codes. Charmaz (2006) reports that in vivo codes serve as a symbolic marker of the participant's speech and meaning, serving to crystallise and condense meanings. Meaning units were then applied to the in vivo codes which aided in reduction. These were provisional within each new data set.

Stage 2 – Second stage - Focus Coding

This second stage of analysis which occurred was a continuation of the initial coding in each phase of the study. All meaning units from initial coding were categorised into focused codes to illustrate the condensed themes across the data within each phase. The decision surrounding categories was aided in the questioning of what each focus code might indicate and comparing all initial codes. The main categories within each phase were underpinned by these focused codes and influenced through the use of memos, which enabled abstract thinking. This helped me to decide which category would be appropriate for the grouping of focused codes. The main categories and focused codes from phase 1 were compared with phase 2 and subsequently compared with phase 3 as part of the constant comparative method.

Stage 3 – Final Development

In this final stage, theoretical coding took place where all main categories and underpinning focus codes, from the three phases of my study led to the development of a core category through the constant comparative method. All main categories and codes were compared and memos were sorted to identify how they all related to each other to enable the development of a theory. At the end of phase 3, the possible relationships between the categories were illustrated, these are elaborated upon in chapter 4.

Figure 9 - Adapted method of Data Management (Burnard 1994)

<p>Phase 1 Data Management</p>	<p>Typed up transcripts of digital recordings (n=30) margins inserted to word document to allocate meaning units</p>	<p>Initial Coding</p> <p>Word by word, line by line segment by segment analysis, meaning units attached 'In-vivo codes' via for each transcript. Reflexivity incorporated. Memoing & integrated selected literature review.</p>	<p>Focused Coding & Main Categories</p> <p>In-vivo codes and associated text copied and pasted from each transcript to overall phase 1 analysis document and the same meaning units grouped together within new document. Memoing. Constant reduction of codes to form focus codes. Reflexivity incorporated. Use of memos aided in identification of main categories</p>
<p>Phase 2 Data Management</p>	<p>Typed up field notes and interviews of (n=13) Margins inserted to word document to allocate meaning units. Reflexivity with action & process questions during data collection.</p>	<p>Initial Coding</p> <p>Word by word, segment by segment analysis, meaning units attached via 'In-vivo codes' for each transcript. Memoing & integrated selected literature review. Reflexivity incorporated.</p>	<p>Focus coding & Main Categories</p> <p>In-vivo codes and associated text copied and pasted from each transcript to overall phase 2 analysis document and the same meaning units grouped together within new document. = focus codes Constant reduction of codes. Reflexivity incorporated. Use of memos aided in identification of main categories, comparing focus codes, memos and main categories across phase 1 & 2.</p>
<p>Phase 3 Data Management</p>	<p>Typed up transcripts of digital recordings (n=35) Margins inserted to word document to allocate meaning units</p>	<p>Initial Coding</p> <p>Word by word, segment by segment analysis, meaning units attached via 'In-vivo codes' for each transcript. In-vivo codes also attached to text from different members of the focus group. Reflexivity incorporated. Integrated selected literature review.</p>	<p>Focus & theoretical coding & Core Category</p> <p>In-vivo codes and associated text copied and pasted from each transcript to overall phase 3 analysis document and the same meaning units grouped together with overall code meaning within new document. Reflexivity incorporated with memos =Focused codes Theoretical coding comparing all focus codes, memos and main categories across phase 1, 2 & 3 Lead to Core Category¹¹</p>

3.7.4 Constant Comparative Method

Regardless of which variant of GT is employed, constant comparative methods must be used to establish comparisons. I carried this out throughout my study as highlighted in Figure 10 below.

Figure 10 – Stages of analysis within the data

Phase 1

Initial coding → focused coding → Memos → Main categories

Phase 2

Initial coding → focused coding → Memos → Main categories

Phase 3

Initial coding → focused coding → Memos → Core category

Interpretative Theorising

Core category → Diagrams → Memos → Substantive Theory

Compare

Compare

Compare

Initial coding was carried out in each phase of the study, which entailed line by line analysis then applying meaning units and in-vivo¹² codes to sections of text relevant to each transcript and field note. The codes were further reduced into focus codes which moved across all data within each phase and this condensed data provided a explanation of data. Central to this was asking myself the reflexive questions highlighted by Charmaz (2006). This was to aid in reflexivity and brought to the surface any preconceptions I may have been applying or forcing on to the codes. Cluster and advanced memos were central to the constant comparative method. This was also enhanced through critical companionship, research supervision and self reflection via my reflexivity journal.

¹² Charmaz (2006) highlights that within grounded theory participant's special terms are known as 'In vivo codes'. She states that 'In vivo codes' serve as a symbolic marker of the participant's speech and meaning, serving to crystallise and condense meanings.

After this process, within each transcript and field note, the literature was reviewed in relation to codes which emerged to aid in constructing the categories.

All focused codes were also compared with each other until theoretical saturation was reached with advanced memos aiding in reaching this stage. This led to the development of categories in phase 1. The categories with focus codes and attached meaning were returned to 50% (n=13) of all participants in phase 1 of my study, who concurred with the categories and focused codes. If participants had not concurred with the categories and focused codes, this would have indicated that data was not saturated and further sampling would have been undertaken. At this point, a further integrated selective literature review took place and a draft of initial findings was written.

In phase 2, the same process was undertaken to obtain the initial and focused codes, which informed the categories. Once again, memos were central to this process. Reflexivity was further incorporated within data collection in this phase by employing the process and action questions, as highlighted in Section 3.5.3 (Table 9). The follow up interview aided in participant verification of meaning attached to the data.

Personal reflection was also incorporated into each of the field notes and observation transcripts. This was further challenged through discussion with my critical companion and research supervisors. The categories and focused codes from phase 1 were then compared with the focused codes in phase 2, which developed the main categories at the end of phase 2 with the aid of memos. Once again, the literature was utilised during the formation of the initial and focused codes in phase 2. These data and associated codes were blind checked by research supervisors.

In the last phase, the process for coding was similar to ascertain the initial and focused codes for phase 3. These were then compared with the main categories and focus codes from phase 1 and 2, which also incorporated the sorting of all memos over the course of my study. The focused codes and core category were then verified through 5 in-depth interviews at the end of phase 3.

Participants' verbatim quotes were utilised and this is interwoven within the emerging theory and outlined in the findings chapters, as it was key that this was not rewritten, thus leading to the misrepresentation of the participants words.

3.8 Overview of three phases in my study

3.8.1 Phase 1

Over the course of 2007, two stages were undertaken to answer the research question posed in phase 1. *Where are tensions created by Senior and Advanced Practitioner roles from a service user and healthcare team perspective?*

In stage 1, a purposeful sample of 12 service users undertook individual in-depth interviews and were recruited from a NP led unit. This unit was chosen to ensure service users could provide an account of perceptions of NPs, rather than overall perceptions of care from different members of the healthcare team. In stage two, 18 service providers were interviewed during phase 1 of my study. The sample included medical staff (n=9) nurses (n=7) and AHPs (n=2). The sample included different grades within the professions and this was led through theoretical sampling inherent in the methodology. Constant comparative analysis was undertaken throughout this phase. This led to the development of main categories, further discussed in Chapter 4.

3.8.2 Phase 2

Over the course of 2008, a 3-step participative observation method of data collection was employed to answer the research question posed in phase 2. *Where do tensions remain apparent in service and what meanings and actions are attributed to them?*

The Scottish Information Services Division (ISD) data sheet highlighted the total population of SNPs/ANPs across the study site in March 2008. The sites and sample were guided by the emergent codes within phase 2, in addition to theoretical saturation. This led to 13 periods of observation, which equated to 64 hours across different sites.

Similar to phase 1, constant comparative analysis was undertaken during this phase. This led to the development of the main categories within phase 2, which are further elaborated upon in Chapter 4.

3.8.3 Phase 3

Over the course of 2009, six focus groups (n=27) and one paired interview (n=2) were undertaken to answer the research question posed in phase 3.

What are the interpretations of Senior and Advanced Nurse Practitioners on interactions with the healthcare team and service users?

The core category which emerged at the end of phase 3 were verified through further individual interviews (n=5). Additional data was also collected via Ya Ya boxes (n=30) to verify if there were differences in expectations between SNPs/ANPs and members of the healthcare team. The constant comparative method was also undertaken during phase 3, which led to the development of the core category. These findings are presented in Chapter 4.

3.9 Trustworthiness and rigor of my study

The criteria for exploring rigor must be appropriate to the type of research and methods employed (Davies & Dodd 2002). I recognised that four criteria are usually employed when establishing and assessing the quality of studies, which include credibility, transferability, dependability and confirmability (Denzin & Lincoln 2000). However, in Constructivist GT, rigor encompasses four elements which transfer to the usual criteria. These include credibility, originality, resonance and usefulness (Charmaz 2006). Each criteria is briefly appraised to outline how I ensured that the trustworthiness of my study was maintained.

3.9.1 Credibility

Meehan (1999) states that credibility is judged according to the precision with which data are analysed and the closeness of the final results to both the participants and others' experience of the phenomenon. In order to maintain credibility in CGT, reflexivity is essential (Hall & Callery 2001; Charmaz 2006; McCreddie & Wiggins 2009). As mentioned earlier, I incorporated a number of constructs to aid in reflexivity during my study and an outline of reflexivity can be found in Figure 2 (page 55). In addition an illustration of the critical companionship relationships can be located in Figure 3 (page 56).

This raised my self-awareness and helped with a clear outline of the decisions taken during my study. In addition, to ensure data were credible, member checking also took place within each phase of my study.

In phase 1, the construction of categories and underpinning focus codes was returned to 50% (n=13) of the participants as interim findings, to confirm correct representation. The meaning was confirmed by all participants. In phase 2, all meanings attached to observations were verified with each participant in a follow up interview. The developed categories and focused codes in phase 2 were also checked by independent researchers to aid in trustworthiness. In phase 3, stimulus material was used which incorporated quotes and observations from phase 1 and 2 of my study. Some of which were consistent in coding, however some that were chosen were not consistent. This was to ascertain further member checking and seeking disconfirming data. This again aided in the trustworthiness of the construction of data. In phase 3, verification of the core category were confirmed with in-depth (n=5) follow up interviews. In addition, my supervisors undertook blind coding of some of the transcripts to aid avoidance of forcing or early closing of analysis during each phase of my study. They also blindly verified the construction of the core category. This visibility of decision-making throughout this research process should also aid credibility and enhance trustworthiness and rigor of my study (Koch 1994; Charmaz 2006; Dowling 2006; Koch 2006; Sandelowski 2006; Creswell 2007).

3.9.2 Originality

Charmaz (2006) writes that there are many ways in which a research study can make an original contribution to knowledge. She illuminates this point by highlighting that if a researcher can offer a fresh or deeper understanding of studied phenomena, they can make an original contribution. From the outset of this study in 2005, it was identified that whilst the literature outlined the barriers associated with SNP/ANP roles, the reason for ongoing tensions had not been addressed. Lloyd-Jones' (2005) systematic review and meta-analysis of qualitative research studies reporting on effective working in specialist and advanced nursing roles in acute hospital settings, highlighted the need for further qualitative research, to provide a deeper understanding of why tensions or challenges remained with SNP/ANP roles.

Therefore, it was deemed timely to ascertain why tensions were continuing three decades after SNP/ANP roles had been introduced in to the healthcare systems.

My study provides fresh insight into where the tensions surrounding the SNP/ANP role are most apparent and encompasses the ulterior transactions associated with such tensions. This is further elaborated upon in Chapter 5. It also provides a new theory with underpinning theoretical understanding on why tensions continue with SNP/ANP roles. This has not been reported in any of the international literature.

3.9.3 Resonance

Charmaz (2006: 182) asked the question, 'how well will the findings resonate for participants'? Member checking throughout each phase of my study confirmed the findings resonated with participants.

3.9.4 Usefulness

Collaboration is perceived to be a conscious learned behaviour that increases, as individuals learn to value and respect one another's practice (Moeller et al. 2007). However, whilst the characteristics of collaboration have been long recognised in the literature, health professionals have resisted adopting the philosophy, commitment and behaviours necessary to develop collaborative practice with SNP/ANP roles (Kleinpell 1997; Stetler et al. 1998; Smith 2000; Scholes and Vaughan 2002; Reay et al. 2003). I hypothesise this is due to the underpinning theoretical concept of status games and the underpinning professional script which emerged from the findings of my study. These are discussed in-depth in Chapter 5. This is outwith awareness and has not been conceptualised in the literature. I would argue that by raising the awareness of status games and facilitating open dialogue, it would aid in changing the status quo and decrease the tensions which have emerged with the implementation of SNP/ANP roles. As both Berne (1968) and Vandra (2009) report by recognising the processes and actions within communication, it is possible to bring ulterior transactions into full awareness and prevent games. These new concepts could be applied across different organisations and aid at improving collaboration thus illustrating the usefulness of my study.

3.10 Ethical consideration

Ethical considerations will be presented under two ethical dimensions as described by Gullemin & Gillam (2004). The first is procedural ethics, which highlight ethical procedures applied over the course of my study. The second dimension is ethics in practice, which address the specific ethical issues which arose during my study, whilst undertaking data collection and analysis. This discussion incorporates the four basic principles of ethics (Beauchamp & Childress 2009)

3.10.1 Procedural Ethics

Ethical approval was sought and granted from the Local Research Ethics Committee (LREC) for my study. Permission was given by the local Research and Development (R&D) department and the principles of research governance were observed (SEHD 2006c; RCN 2009d).

The principle of beneficence, is defined as a group of norms providing benefits and balancing benefits against risks and costs (Beauchamp & Childress 2009). In order to adhere to this principle approval and access was sought and granted from the Director of Nursing and Chief Operating Officer to ensure access to both service users and members of the health care team within the acute division. As managers within the healthcare setting are responsible for confidentiality of patient information, discussion surrounding my study also took place with local clinical managers. However, Kvale (2006) makes the valid point that institutional consent may imply a subtle pressure on employees to participate.

Ethically, under the principle of respect for autonomy it was important that no individuals felt obliged or coercion to participate in my study. This was assured through requesting volunteers through the distribution of information sheets, which also stated that participation was voluntary and an independent contact was also provided, should individuals like to discuss my study further, prior to making a decision. Information sheets and consent sheets were sent to all participants in my study. If they agreed to participate, they returned a signed copy of the consent highlighting a date, time and venue suitable for them.

I counter signed each consent form with participants prior to data collection and provided reassurance that they did not have to answer any questions or be observed if they did not feel comfortable. Munhall & Boyd (1993) named this type of consent as process consent. All data were stored securely in accordance with the provisions of Data Protection Act (1998). In addition, all data were stripped of any identifying material and pseudonyms chosen by each participant were applied.

3.10.2 Ethics in Practice

I encountered a number of ethical issues throughout my study, some examples are provided for illustration within this section. In phase 1, the method of data collection was in-depth interviews with service users who had experience with an SNP/ANP. During one of the face to face interviews, a service user identified an upsetting incident that had occurred whilst they were an in-patient receiving treatment in the hospital. Due to the professional ethics which guide me as a nurse, I had an obligation to care (NMC 2008), which equated to ensuring the service user did not suffer unnecessary anxiety. I asked if the participant would like to stop the interview and stopped the digital recording as requested as they were upset, which allowed time and space for the individual to talk through their experience. As a researcher, I also had an ethical obligation to adhere to the principle of non-maleficence, where the benefits of my study should be seen to outweigh risks for the individual. As Polit and Beck (2008) explain, in qualitative studies the psychological consequences may be subtle and therefore require closer attention and sensitivity. So whilst the service user had been advised of potential risks of involvement and given time to reflect and consult an independent individual before committing themselves in any way, this issue surfaced for this individual during interview.

COREC (2006) highlight the disclosure of sensitive material can happen at any time during the research process and it is good practice to consider the likely results of any possible actions that may be taken. Through reflexivity on possible affects this has been considered, therefore the service user was given the Patient Liaison Officer's name and contact details, who was willing to address any such issues that may have arisen for service users.

They were also willing to see individuals following the interview if required, which was taken up by the aforementioned individual. In addition, I ensured that the individual was aware of the complaints procedure within the acute division.

In phase 2 of the study, the ethical dilemma I faced was how to maintain the stance of a researcher whilst also remaining within the nursing ethical imperatives of care. This particular role challenge is well recognised within the literature (ICN 2006). An example of this dichotomy arose within the first observation where the SNP was undertaking a consultation. The service user directed a question towards me, as the SNP had outlined she did not know the answer. At this time, I felt it was important to provide an answer to the particular question, as I had the knowledge and if left unanswered, it was deemed this would have caused anxiety for the service user following the SNP consultation. On reflection, both myself and my critical companion challenged the appropriateness of this element within a research setting.

On reflection, one could argue that I did not implement role distancing (Dickson-Swiff et al. 2006). Role distancing inhibits researchers from bringing other roles into the research setting. These views are highly debatable, because as a nurse I had an obligation to care (NMC 2008), which equated to ensuring the service user did not suffer unnecessary anxiety. Eide & Kahn (2008) make the valid point that if a nurse researcher has the expertise or knows of resources of other experts who could help, this information should be given and they argue that this cannot be ethically avoided through distancing. Several authors highlight similar cases where conflict arises between nursing and research roles and outline the nursing imperatives take precedence (Allan & Cloyes 2005; Haigh et al. 2005; Eide & Kahn 2008). Eide & Kahn (2008) are of the opinion that it is necessary to have self awareness of such role conflict, and incorporate methods to enable a balance to be maintained. This was incorporated into my study, through reflexivity, support from both the supervision team and critical research companion who met regularly and provided opportunities for critical challenge to aid my self awareness.

3.10.3 Research relationships – Ethical considerations

Another ethical element which I found challenging was working within the organisation whilst undertaking research. It was important that measures were put into place prior to my study, to avoid conflict within the research relationships. I have an educational role within the organisation, and worked in different roles prior to my study therefore I was aware that this may affect the researcher-SNP/ANP participative relationships. From an ethical perspective however, I did not have any managerial responsibility for any of the participants.

I had explored that some participants may have the perspective that I would be evaluating or critiquing their practice, due to my education role. During the period prior to data collection, I reiterated the aims of the research and obtained process consent. Confidentiality was also reiterated, highlighting that all data collected would be stored safely until the study was completed and it would then be destroyed. It was also emphasised that nowhere in any reports or publications resulting from this research would the participants or the organisation be named. However, on occasion, participants asked questions or for advice in relation to training and education.

At the beginning of each observation or interview to aid in normality, it was made clear to all participants that my role was one of a researcher. Asselin (2003) reports this is known as reaffirmation of roles in this type of insider research situation. I outlined that I would come back to the training or educational questions at the end of the observation period. This appeared to be acceptable to participants, however I did feel initially uncomfortable with this explanation. I had also explored the possibility of my ethical stance if a participant's practice was unsafe, however this did not surface during my study.

There is a historical power relationship between nurses and doctors. I therefore had to consider this element when interviewing a wide range of medics in phase 1, in addition to observing their interactions in phase 2. Snelgrove and Hughes (2000) make the valid point that a researcher's role could be subtly influenced by the power relationship between medicine and nursing. Through the process of reflexivity, I had a raised self awareness of the potential for this influence during data collection and this did not occur with any level of medic during phase 1.

In phase 2 however, during one observation period, I found a medic rude and this 'pressed an internal button'¹³. I had to reflect in action on processes and continued to accept the behaviour in my researcher's role. The behaviour was questioned in the follow up interview with the SNP and it was ascertained that these very overt power differences were working norms of that particular observation site. I required to reflect on my actions and why it had upset me, to ensure this did not distort these data. Following reflexivity, my action of not challenging this behaviour was deemed correct as otherwise I would have disrupted the normal routine power enactments within the observation site.

As a nurse I was aware prior to undertaking interviews with service users that this may influence the relationship. As Wilde (1992) reports it is difficult to separate one's occupational interaction from a research interview, which she highlights may lead to premature summarising. As this was within my awareness during the interview, I ensured this did not occur. I also paid attention to this detail when listening to the digital recordings of each interview. Kvale (2006) outlines in an interview there is an asymmetry of power. I was again aware of this possibility therefore explained the value and importance of individual service users perceptions. I also did not wear a uniform and carried out the interview in the venue of their choice. I was encouraged by the frankness of service users in portraying their views and felt the participants were comfortable in revealing their views.

3.11 Summary of Methodology

The underpinning principles of GT connected well to the aims within my study. Whilst the constructivist variant of GT allowed me to answer the research questions which arose from the aims of my study, it also enabled an exploration of how and where tensions were constructed and why tensions still existed three decades following the introduction of SNP/ANP roles.

The findings were constructed through multiple coding, encapsulated in a clear audit trail. Whilst the sample may appear large for this type of study, this was necessary due to the complexity of such roles and to ensure theoretical saturation. This, it is argued, adds to the credibility of the findings.

¹³ 'Pressing internal button' – In this thesis this has the meaning of something triggering an internal emotional response, for example this could be feeling upset, anxious or anger.

The data collection methods were invaluable in providing different views of complex interpretations, thus enabling the discovery of the overall picture. The reflexive epistemological stance of constructivist GT lent itself well to my study. This enabled the juggling of my 'hybrid' part-time researcher stance with building in steps such as member checking to enhance credibility. The memos were central to enabling the development of the theory through discovering and defining hidden processes, which were at the core of tensions created by SNP/ANP roles.

Chapter 4

The Findings

4.0 Introduction

This chapter will discuss the findings from each phase of my study. Each section presents the different phases and an advanced memo to illustrate the theoretical constructs which informed the overall substantive theory.

4.1 Introduction Findings Stage one – Phase 1

On commencement of my study, I felt it was important to identify service users' views on SNP/ANP roles. At this time there was little research which provided an in-depth understanding surrounding service user's interpretations or acceptance of receiving treatment from an SNP/ANP rather than a medic. Due to this lack of research I questioned whether this could have an affect on the reported tensions surrounding SNPs/ANPs in the international literature. Therefore the incorporation of service users in phase 1 was deemed timely.

4.1.1 Population and sample – Stage one – Phase 1

The first stage of phase 1 was undertaken within a minor injuries unit led by SNPs in an acute division of a large urban acute NHS Board in Scotland. Data collection took place in 2007. The exclusion criterion for service users in this phase of my study was participants who did not have any experience with a Senior or Advanced Nurse Practitioner (SNP/ANP). The sampling strategy was consistent within the initial stages of the CGT method. In total, 12 services users were interviewed with each interview lasting between 38 to 64 minutes. The age range of service user participants was 25-65 years (Table 3 – page 60). An interview topic guide was developed following the analysis of the first interview, based on initial codes and literature related to these codes. The guide was employed flexibly during the interviews to allow participants to construct their accounts in their own terms. This was revised and refined throughout the interviewing process to reflect emerging initial and focused codes from concurrent data analysis.

4.1.2 Overview of the category and underpinning focus codes

A large number of initial codes were generated during phase 1 of my study. These were reduced during constant comparative analysis, with memos helping to guide the analytical process. The main category of 'traditional belief systems' emerged in this stage of phase 1 and is presented in the following section. This incorporates a discussion of the focused codes, which underpin this category, these include, 'traditional roles' and 'passive roles'. An advanced memo has been included at the end of this section to illustrate my analytical thinking at the end of stage 1.

4.2 Category – 'Traditional Belief Systems'

Stage one – phase 1

The data generated within the category, 'Traditional belief system' illustrated that all service users had traditional views surrounding professional roles and playing a passive role during interactions with SNPs/ANPs. All service users in phase 1 of my study illustrated that they held traditional beliefs in relation to a medic's role and a nurse's role, within the healthcare system. The main difference highlighted by service users was in relation to the communication style employed by each profession. They also appeared to hold the traditional view of medics' role, which was to 'cure' and a nurses role was to 'care'. In relation to service users role in healthcare interactions, they outlined the traditional belief of being expected to be passive. The two focused codes which underpinned this category were 'traditional roles' and 'passive roles'.

4.2.1 Traditional roles

Berry (2006) reported that there was a lack of research surrounding Nurse Practitioner (NP)-patient communication and outlined that the literature surrounded mostly physician-patient or nurse-patient communication. Berry (2009) suggests that with the change to nurse practitioner roles, the relationship of the NP with the patient is different to that of a nurse and patient. Berry (2006) argues that the NP role is a grey area between a nurse and a medic therefore the communication relationship is different. This corresponds to Young (2005) who suggested that the doctor's role has been predominately related with 'cure', whilst a nurse's role is related to 'care'.

Seale et al. (2006) suggests that this implied that nurses have better communication skills, as they are caring. This linked to all of the service users interpretations of the differences between an SNP/ANP and medics communication styles. Susan and Sara illustrate this point:

“Some doctors do not have good people skills, most nurse practitioners have been trained to have relatively good people skills, though there are the exceptions. You know, but that’s the really important thing”

(Susan-Service User-phase 1)

“I think with doctors...its different...I find they don’t tell me enough information and if they do I have to question it as I don’t understand...with nurses it’s more simple language.”

(Sara – service user- Phase 1)

Tam highlighted that the SNP gave very clear explanations when both carrying out the assessment and giving treatment.

“He went to great lengths to explain step by step as he examined me”

(Tam-Service User-phase 1)

When probed on whether, during this consultation, he was asked if he had any questions, he elaborated:

“No, but it was the NP’s nature..., as he explained he stopped and looked at me.... Making sure as he was working.... How’s that?”

(Tam-Service User-phase 1)

This “nature” was important to Tam, which illustrated the significance of quality of care for patients (Kendall 2001). He was given lots of information regarding aftercare and written information on his treatment. Sarah outlined that the SNP was good at communicating with her and gave her time to ask any questions.

“She asked, do you mind if we do this. What do you think? She even explained why she was putting the white cloth there so we could see it better”

(Sarah-Service User-phase 1)

This is in contrast to the view taken by Berry (2006). He suggested that as the NP's role was evolving, one could therefore assume that some will take the stance of 'cure' or using a biomedical model of communication, which is receiving information, focusing on the outcome of treatment rather than 'caring' which he equates to a biopsychological model of communication providing information, thus increasing quality of care. A question this raised for me, was whether traditional views of the differences between a medic and nurse affected the service users perceptions of receiving treatment or 'cure' from a nurse, such as SNP/ANP.

Redsell et al. (2007) suggested that little research has focused on whether patients' were given a choice on whether a medic or Nurse Practitioner (NP) would provide their treatment. Some service users in my study highlighted that the most important thing to them on presentation to hospital was timely, effective service and appeared to have given very little thought to which professional treated them. They were happy for any professional to treat them as long as their care was appropriate and that the professional ensured they were reviewed in a timely manner.

As Jambo stated:

"It doesn't matter if you're seeing Dr Smith or Nurse Jones, do you know ...as long as you've been seen to"

(Jambo-Service User-phase 1)

Whilst Tam outlined:

"As long as they are competent in what they are doing, I don't mind if they are a doctor, nurse or physio"

(Tam-Service User-phase 1)

Sarah suggested that she was happy with a minor illness being treated within a SNP led unit, as long as she was aware a medic was "nearby" in case of any problems. This was echoed by Susan:

"I would like to know that there was always someone [a doctor] on call in the building nearby. I don't know if there always is, so that if they [NP] felt that they were out of their depth, that they weren't sure. You know, and that's where I would want to make sure there was someone else there as well"

(Susan-Service User-phase 1)

Anne and Barry stated they would have presented at a different site, despite longer waiting times, if it was something more “*serious*”. They pointed out they would have liked to be seen by a doctor in this situation, whilst Jambo also implied that if she perceived that she had a serious problem, she would have preferred to see a doctor and would have presented to a different site.

“But if it was something like, ... major... I would want a doctor. In a ... in a position like that, yeah it depends how bad I was”

(Jambo-Service User- phase 1)

Whilst two of the participants were unaware they were treated by an SNP and assumed they were treated by a medic. As June outlined:

“ I didn’t know there were no doctors. I didn’t realise I was treated by a Nurse Practitioner... I didn’t think of it at the time...” (Referral via ambulance)

(June-Service User-phase 1)

Whilst Tam stated:

“When I got your letter I had to think, ... was I seen by a nurse practitioner, I thought he was a doctor, but was happy with it all...” (Referral via NHS)

(Tam-Service User-phase 1)

All service users’ within my study, presented to a Minor Injury Unit led by SNP’s within an acute hospital in Scotland. They were all treated and either referred or discharged by an SNP. Therefore, one could argue that most of the service users’ in my study made an informed choice on the health professional that would treat them.

These service users’ actively chose to be treated at the site, this was related to their perceptions of shorter waiting times in this unit. They all said that they would return to this unit for further treatment as Millie stated:

“I mean I don’t have a problem with Nurse Practitioners, I think they’re trained ... they’ve got their extra training to do what they’re meant to be doing”

(Millie-Service User-phase 1)

This latter verbatim quote illustrated a point that was consistent across all interviews as it reflected the participants' assumptions that anyone they were treated by, within a hospital setting, had gained the correct level of training and competencies. This was consistent with Calman's (2006) study, which found that patients trust that nurses have the correct level of technical competency. However, it was worth noting that most service users identified that they would have presented to a larger traditional A & E Department if they felt their problem was more serious and would have expected to have been treated by a doctor. As Michael illustrated:

"I had background knowledge on waiting times and what was dealt with at that department ... I know that the likelihood of being seen quicker was here. If it was something I didn't think was minor. I'd be more likely to go to [another hospital] because there would be doctors who could treat me."

(Michael-Service User-phase 1)

4.2.2 Cluster Memo

Whilst the NP role has been in place in the UK since the late 1970's and in North America a decade previously, it remains poorly understood or recognised by the public (Catania et al. 2000; Armer 2007; Redsell et al. 2007; Hart & Mirabella 2009). As little research is available in relation to service users interpretations of SNP/ANP roles, it was apparent in my study that 'minor' illness were viewed acceptable to be treated by such roles. However, a 'major' illness would be viewed as a medics role. This highlighted that there was a traditional belief system on what nurses and medics roles were within the healthcare team.

4.2.3 Passive roles

Some service users' highlighted that they were happy to play a passive role in the decision-making processes and were within different age ranges and demographics (Table 3- page 60). As illustrated by verbatim quotes from service-user participants.

"No real decisions to be made...if you know what I mean". When probed on this he highlighted that "I just wanted the pain to be dealt with"

(Tam-Service User-phase 1)

“But I think ultimately, I would rather someone said “Right this is what I think, this is the best thing for you” and I would go with their decision. Nine times out of ten I would. Because I trust them”

(Millie-Service User-phase 1)

“I think 9 times out of 10 I expect them to make the final choice, on the assumption that their actual knowledge is better. But as I say, if my choice is to have my leg cut off now or later I expect someone else to make the decision as to which is better”

(Susan-Service User-phase 1)

“I mean I think they are the experts in that field and have the answers to that and I think we have to listen to them”

(Sara-service user-phase 1)

Interestingly, several studies report differences in levels of decision-making in relation to age, as younger patients preferred a more active role than older patients (Florin et al. 2006; Spies et al. 2006; Deber et al.2007; Elkin et al. 2007). This was consistent with the data that emerged from this phase of my study, where participants in the younger and middle age group (25-35; 35-50) outlined that they liked to play an active role in the decision-making process. In the words of Annie:

“... It is my right and I am entitled to make decisions, but for me ... I need the information and knowledge of the practitioner, so it's much more about, in some ways maybe sharing the decision making process that we've both been a participant in it. And neither one, nor the other being very passive”

(Annie-Service User-phase 1)

Nicola added further illustration,

“I think it's important that patients get information about what assessment practitioners are making and what the diagnosis is, and if there are treatment choices, what those are, and enough information to make an informed decision”

(Nicola-Service User-phase 1)

Dealey (2005) offered an explanation when she suggested that older patients may not have many expectations of being included in decision-making, as they have had the least choice in the past.

When Tam (age 64) the eldest participant within my study was probed on expectations, he outlined:

“I just wanted a little angel to make me better. Didn’t have none really...to get rid of my pain and discomfort. I didn’t know how they would do this,.. But it’s what I wanted”

(Tam-Service User-phase 1)

Tam highlighted that from his experience he wouldn’t change anything, he outlined that he was *“100% comfortable going back”*. This may have indicated that he was happy with his level of participation in the decision-making process. Alternatively, Sarah reflected and felt that she was given choice and asked for her opinion. She highlighted strongly throughout her interview that this was important to her, as she has to live with these decisions. She outlined:

“She explained everything and asked “what do you think”... all the way through”

(Sarah-Service User-Phase 1)

This may have indicated that the SNP sensed Sarah’s preference for involvement. When probed on this, Sarah gave a number of examples in other hospital situations where she had driven the facilitation of her involvement in the decision-making process in relation to her care. She stated that she had a previous unpleasant experience in hospital which had made her realise the importance of her involvement in any decision-making process. This is consistent with Thompson’s (2007) findings, which illustrated that involvement or participation in decision-making is complex and a number of factors play a role in the level of participation a patient may actually want.

This included previous “bad” experiences, similar to Sarah’s experience. One could therefore argue, that decision-making is complex and does not relate to age alone, but is one of a number of factors, such as previous experience playing a part in patients’ preferences (Lam et al. 2003; Florin et al. 2008; Stewart et al. 2010). Thompson (2007; 1306) produced taxonomy to aid in identifying a service user’s preference to be involved in the decision-making process. The taxonomy had five discreet levels of “patient-desired involvement” in consultations, which ranged from 0 =non-involved to 4 = autonomous decision-making.

Within these different levels, it was acknowledged that patients may fluctuate or may not wish to be involved due to vulnerability, traditional views on being a service user, lack of interest or out of an act of detachment. Thompson (2007) concluded that whilst patients support involvement, they would like professionals to recognise that this needs to be optional and varies according to the context and previous experience of patients. Much of the literature suggests that service users do want information, however choose to play a passive role (Davidson et al. 1995; Bilodeau & Degner 1996; Butow et al. 1997; Gandegnoli & Ward 1998; Florin et al. 2008; Wenzel & Shaha 2008; Stewart et al. 2010). This was consistent within the data, where some service users highlighted that they did want further information, as Barry stated:

“It would have been helpful to have maybe more of a commentary as to what they’re doing, with a bit of in-depth analysis behind it. You know ‘This is what I’m doing, this is why and then however I’ve not found anything there so I’ll try this, and then I’ll try that’ But it was just kind of, ‘I’m going to do this now, I’m going to do this now, now I’m just gonna feel here, any pain?’ And there was no real explanation as to the reasoning behind it”

(Barry-Service User-phase 1)

However, due to the traditional belief of being a passive recipient of care, participants within my study did not feel they could challenge or question for further information during the interaction. Cahill (1998) suggests that a successful relationship is the vehicle for the exchange of information and the power transfer to patient and clinician and visa versa until a decision is reached. When probed on this aspect, Barry outlined that he did not feel comfortable questioning or asking for further information, he stated:

“...Because it’s someone’s professional opinion you don’t want, you know a They’re in the position of power, you don’t want to ... you don’t want to question them, kind of thing,”

(Barry-Service User-phase 1)

This confirmed Godfrey’s (2004) view that if real involvement in decision-making is to happen between the health professional and service user, there requires a shift in the traditional balance of power. One could question if this occurred as Barry still perceived the SNP to be *“in the position of power”*.

This was reiterated by Millie who outlined:

“I don’t expect to be explained to, so maybe...I don’t actually, I don’t think much was explained to me. We’re taught to do that from an early age...I think. You don’t .you know these people are Gods you don’t question them... you don’t .. You know... you just don’t”

(Millie-Service User-phase 1)

One could therefore argue the importance of SNPs/ANPs in assessing the level of decision-making a service user may want, is an important aspect of these roles.

As Annie illustrated:

“...If the nurse practitioner, is not holding that awareness that they need to put a bit more effort, they need to work slightly harder at engaging a way that encourages the person to hold onto their decision making capacity and not, in their vulnerability, want to hand it all over, ...equally its not about “well it’s your decision” and it can leave you maybe in a place “oh my God I’ve got to make this decision. How am I going to make it?” It’s about practitioners having that awareness and having communication skills in working with people...”

(Anne-Service User-phase 1)

This point is verified by Ford et al.’s (2006) mixed method study which outlined that some doctors are significantly better than others at meeting individual service users’ preferences in identifying the preferred level of involvement in decision-making. This is also consistent with Millard et al.’s (2006) ethnographic study that found the extent in which nurses involved service users in making decisions varied considerably. Several studies suggest healthcare professionals often do not have a level of awareness of the degree of participation an individual may prefer in the decision-making process (Florin et al. 2006; Pulbrick et al. 2006; Kremer et al. 2007; Florin et al. 2008; Morton 2010). A number of studies have found that central to service users experiences of participation in decision-making is based on the healthcare professionals communication skills (Keating et al. 2002; Efaimsson et al. 2004; Millard et al. 2006; Almborg et al. 2009). This appeared to be linked to the communication skills or language described in my study and the level of awareness SNPs/ANPs held on service users’ preferences within the consultation process.

“...They just almost ignore you and no one really think’s that maybe you’re stressed or worried, you know, I just think it’s time, there’s no time anymore for them to talk...”

(Mille-Service User–Phase 1)

“She made me feel, right get her in, get her seen to, and get her out the door”

(Jessica – Service user – phase 1)

Interestingly, from the twelve service-user participants in this study, all but one felt they were included in the decision-making process. During constant comparative data analysis however, it was found that some participants on describing the interaction, were not included in this process.

Despite this, all remained positive about the level of involvement in decision-making when treated by an SNP. A number of authors reiterate the importance of communication during the consultation process and underline that information giving is crucial if the patient is to be involved in the decision-making process (Campion 2002; Ford et al. 2006; Koutsopouious et al. 2010). This was a view shared by all of the service users in my study. Sara illustrated the differences in communication styles, between a doctor and an SNP when she highlighted that:

“I think with doctors... its different...I find “they don’t tell me enough information and if they do I have to question it as don’t understand...with nurse practitioners it’s more simple language.”

(Sara-Service User-phase 1)

Coulter & Jenkinson (2005) reported that communication styles and language employed can influence the service user’s ability to become informed and play an active role in the decision-making process. Following the interviews with service users, a number of factors appeared to influence the complexity of service user involvement in decision-making. However all service users played a passive role as this was the interpretation of their expected role. At this stage, the question this raised for me was whether SNPs/ANPs had a level of awareness to facilitate inviting service users to shift from this passive role. The next section highlights an advanced memo at this stage of my study.

4.2.4 Advanced Memo – Stage one - phase 1

There were 'traditional beliefs' surrounding the role of a medic and nurse from a service users point of view. The accepted form of communication from a medic was "complicated jargon" and required to treat more "serious problems". Whilst "with nurses its more non-jargon filled language" and they were viewed to be trained to now undertake "minor illnesses". If it was "something major", service users would like to be reviewed by a medic.

On describing the processes and actions of the interactions with SNPs, service users described playing a passive role. Some wanted to play this passive role, however others wanted to be involved. Despite this they continued to play a passive role throughout, as in the words of many service users, they were "taught this at an early age". This could be linked to 'script theory' (Steiner 1990). Stewart & Joines (1987:330) define life script as "an unconscious life plan made in childhood; reinforced by parents, justified by subsequent events and culminating in a chosen alternative". Similarly, one could argue that social script is learned from childhood on what to expect in certain social situations and how to behave in a particular culture. In society, people learn what is expected from a doctor (to cure) and what the role of the nurse entails (to care). They learn this from experience, parents and media. As highlighted by the Centre of Research, "curing may be a doctors job but caring is singularly an ambit of nurses. Nursing finds synonym with caring. Kindness and goodness are integrated into this profession" (CORC 2010).

In social environments, people learn how to present themselves in certain roles and social behaviour is scripted, this is known as social script (Wagner & Clair 2002). Service users presented themselves as passive recipients of treatment, which raised the question whether SNPs/ANPs reinforced this passive stance by not encouraging active involvement in decisions. It appeared that 'social script' may be a concept which underpinned the main category of 'Traditional social beliefs'. One could question if this 'social script' caused tensions, as it was not expected that SNPs/ANPs would be treating 'serious illnesses'. As service users have learned through 'social script' to play a passive role, one could question if they would overtly highlight their discomfort at receiving treatment for "something major" from an SNP/ANP rather than a medic.

4.3 Introduction – Findings - Stage two – Phase 1

In Chapter 2, it was reported on the requirement for further research surrounding SNP/ANP roles, as tensions were consistently reported within the healthcare team (Smith & Preston 1996; Bousfield 1998; Read et al. 2001; Banaham & Connelly 2002; Scholes & Vaughan 2002; Jones 2003; Marsden 2003; Willard & Luker 2007). Whilst the literature reported on such tensions over three decades ago, it was deemed important to ascertain the interpretation of the healthcare team on where tensions were created by SNP/ANP roles. As by identifying where tensions were apparent could provide a deeper understanding of why tensions have continued over the past thirty years.

Banham & Connelly (2002) highlighted the need for team working, to aid in person focused care within the NHS. This was prominent in a number of policies to transform the health service within Scotland at the time of my study (Delivering for Health SEHD 2005a; Delivering Care Enabling Health SEHD 2006a; Better Care, Better Health, SGHD 2007a). Whilst there was a growing body of evidence supporting the role of the SNP/ANP, little was known about how such tensions created by SNP/ANP roles influenced communication and the dynamics of the healthcare team. Due to the gap in the literature, part of the research question in phase 1 was to explore where the tensions were created by Senior and Advanced practitioner roles. This was stage two of phase 1, which is presented in the following section.

4.3.1 Population and sample

The second stage of phase 1 was undertaken in a large urban acute NHS Board in Scotland. Data collection took place over 2007. In total, 18 members of different healthcare teams were interviewed during phase 1 of my study, with each interview lasting between 43-70 minutes. The sample included medical staff (n=9) nurses (n=7) and AHPs (n=2). The sampling strategy was consistent within the methodology, data were analysed and a number of initial and focused codes emerged that informed the subsequent sampling of participants. The sample included different grades within the professions and this was led through initial and focused codes inherent with the constant comparative analysis method.

4.4 Overview of the category

A large number of initial codes emerged from the healthcare team interviews. These were further reduced during the constant comparative analysis, and focused codes were identified which underpinned a category. The overarching category for stage 2 was 'professional tensions' which was underpinned by the focused codes, 'professional cultures', 'Doctor-SNP/ANP tensions' and 'Nurse-SNP/ANP tensions'. The following sections will illustrate the focus codes which constructed the category of 'professional tensions'.

4.4.1 Professional cultures

A lack of team work and tensions can be traced back to the evolution of the healthcare professionals and limits true healthcare team working (Firth-Cozens 1998; Finch 2000; Zwarensten & Reeves 2000; Kavanagh & Cowan 2004). The NHS can be deeply hierarchical, with big differences in status between team members. This relates to the history of both professional cultures. Firth - Cozens (1998) stated these differences can reduce communication and encourage resentment. This was reinforced by all service providers during phase 1 of my study. Thomas (Nurse) illuminated one of the issues in relation to communication and professional cultures when he stated:

"I mean it's all very hierarchical, and I think we ...are very aware of that because we are lower down in the hierarchy than them and that naturally breeds a resentment, you know, 'Oh why should I clean up after them, they earn more than me!'"

(Thomas-Charge Nurse-phase 1)

All service providers outlined that a barrier to SNP/ANP roles was differences in professional cultures. In the words of George (Medic):

"We are from different professional cultures maybe that's why it doesn't work".

(George-Consultant Medic-phase 1)

Whilst Mickey (Medic) and Rosie (Medic) further elaborated:

"I think for the junior doctors that's much more difficult, there is still kind of 'I'm a doctor you're a nurse, you're below me'"

(Mickey-Senior Registrar-phase 1)

"You still get doctors without a shadow of a doubt, who still think that they're better than the nurse practitioner you know, remember I'm the doctor and you're the nurse"

(Rosie-Consultant Medic-phase 1)

This indicated that some medical staff still held the traditional view of a nurse being subordinate and did not understand the true role of a SNP/ANP.

An example of this was given by Mark (Medic):

“ The arrogance of a lot of the junior doctors, there were two of them sitting this far apart and a phone ringing beside the junior doctor and eventually the junior doctor just pushed it towards the nurse practitioner, and said ‘answering the phone is your job, if it is something for me let me know’. That worries me as ultimately it’s the patients who suffer...”

(Mark-Consultant Medic – phase 1)

Davies (2000) suggests nurses continue to work around doctors rather than as part of a healthcare team. One could view the SNP/ANP as a hybrid role due to the evolving nature of their work, as they did not carry out the traditional work of a nurse and appeared to be infringing on traditional medical work activities. Difficulties in team working could be expected due to the underlying philosophical base in each profession, prior to implementation of such roles. Throughout the constant comparative analysis in phase 1, it appeared that where tensions were created, was linked to role boundaries across nursing and medicine. Russell (Medic) further highlighted this interpretation and suggested that in his view SNPs/ANPs wanted to be doctors.

“Do you know, if I’d had have had a decent education I could have been a doctor. I could have been earning twice as much ...”

(Russell-Senior Registrar--phase 1)

I found it interesting that the medical viewpoint was not centred on a nurse who wanted to extend their clinical capability to improve service user care through a SNP/ANP role, but the assumption that she/he wanted to be a doctor.

Fitzimmons & White (1997) proposed these professional differences exist due to separate training and underlying philosophical approaches which underpin different professions. This was highlighted by Rosie (Medic) who claimed that medics do the” thinking” and nurses are “the doers.”

“But it’s interesting, which bits can the nurse practitioner pick up of the doing or the thinking?”

(Rosie–Consultant Medic- phase 1)

Traditionally, nurses have been viewed as holistic care givers or ‘caring’, whilst medical staff are seen to focus on the treatment of illness to achieve health or ‘cure’ within a healthcare team (Baumann et al. 1998). This was the view of all service providers in phase 1. As Trisha (medic) highlights:

...” They [NPs] do actually have different skills sets and while they can do some of the same jobs, they do actually bring quite different things to the party”

(Trisha-Consultant Medic –phase 1)

As Trisha suggests both roles bring “different things to the party” illustrating the co-created nature of identity for medics and nurses in the team. However, Leung et al. (2003) proposed that team role dynamics is a complex psychological issue as each role will hold underlying values and beliefs. Health professionals in my study held a view of SNPs/ANPs in relation to the different underlying philosophy of their profession. This was dependent also on whether a SNP/ANP was based within a ward area (specialist/senior practitioner reporting into nursing profession) or within a medical health care team (senior/advanced practitioner reporting into medical profession). Scholes et al. (1999) outlined similar types of role, which were complementary or substitution roles.

In phase 1, it appeared that complementary roles had the title of Clinical Nurse Specialist (CNS), whilst substitution roles had Nurse Practitioner (NP). Josie (Charge Nurse) inferred perceived differences between both types of role when she stated:

“Clinical nurse specialists are more autonomous, more nurses, whereas nurse practitioners are task orientated. How much of that is actually what I know as nursing is debatable, because nursing is about, is about caring”

(Josie –Charge Nurse-phase 1)

Fraser (Medic) outlined perceptions of a SNP/ANP undertaking the traditional work of a medic:

“The doctor’s handmaiden aspect that some of the nurses felt, I think there’s still some of that about. I’ve heard [name] and others still have the view that the model that we have here is, you know, just, you know along the lines of just holding the hands of the junior doctors”

(Fraser-Consultant Medic-phase 1)

Whilst Margaret (Nurse Manager) outlined:

“... They [medics] tend to use the nurse practitioners, if they can get away with it, they see it as their little ... sort of handmaiden I suppose, however that very quickly gets stamped out”

(Margaret-Nurse Manager-phase 1)

It was interesting that both a nurse and medic from different sites used the word “handmaiden”, as this work and inherent meaning illustrated the perceptions of all service providers within phase 1 of my study. This originated over thirty years ago in the Briggs (1972) report, which claimed a “handmaiden” image of the relationship between doctors and nurses. Zwarensten & Reeves (2000) twenty years later compared this relationship to a “bad marriage”. Turner (1987) highlights this cultural perception can be linked back to the historical processes of the professions. Nursing as a profession has had a challenge with its subordination to the medical professional, suggesting that nurses in theory merely execute decisions arrived at by doctors. Turner (1987) discussion paper debated whether this historical culture has changed and is therefore having a negative affect on healthcare team working. Rosie (Medic) reiterated the medical viewpoint in phase 1.

“The traditional role of the doctor was that they were better than a nurse, you know where traditionally the doctors interpretation of things was ...you know there was this big divide and, you know, the relationship was terrible between doctors and nurse”

(Rosie-Consultant Medic-phase 1)

This concurred with Tracey (2006) who undertook a study utilising a GT methodology, which highlighted the tensions between nursing and medicine is still present within the healthcare system.

Tosh (2007) outlined the level of resistance or challenges faced by nurses extending or expanding their roles, rests within the remit of whether it is seen as a substitution role, traditionally the role of trainee medics or a complementary role, traditionally within nursing. This reiterated the view that nurses are 'caring' providing quality care and doctors are seen as 'curing', ensuring efficient treatment. Therefore, depending on the role of an SNP/ANP and the professional infrastructure in which a SNP/ANP reported this had an effect on the healthcare teams' interpretation of an SNP/ANP. As Louise (Nurse) outlined:

"What are they [NPs] doing that's proper nursing? ... They're doing tasks, assessing and treating."

(Louise-Chief Nurse-phase 1)

4.4.2 Medic-SNP/ANP tensions

All medics (n=9) in phase 1 highlighted that there was a lot of tensions working with SNPs/ANPs as they were undertaking roles that they would never have been "allowed" to do previously. As illustrated by Michael, a junior surgeon:

"There comes a point where, sort of, a boundary may well have to be drawn where if somebody would say you know essentially this is the kind of thing that medical school might prepare you for, and not nursing school"

(Michael-Foundation Year 2 Medic-phase1)

Both Michael and George, who were junior medical staff, stated significant tensions existed with such roles. Both suggested that the SNP/ANP role was reducing training opportunities for junior medical staff. As medics had undertaken five years training they required practice which was reduced as the SNP/ANP were providing this treatment. Whilst the consultant medics outlined tensions were reducing in relation to SNPs/ANPs, all nurse and Allied Health Professional's (AHPs) appeared to have a different view. As Thomas (Nurse) illustrated:

"I mean there's huge amount of resistance here, from the consultants; to them it's almost that, they're medics and therefore want another medic to do their work for them, because they don't quite trust them, [NPs] I don't know"

(Thomas-Charge Nurse – Phase 1)

In the words of Jayne (Nurse):

“Some of the medical staff focus on the negative component. Whether that be that they’re threatened because of their roles changing or a general blurring of roles in departments”

(Jayne –Junior Charge Nurse –phase 1)

Tosh (2007) proposed that nurses had successfully managed to enhance the role of the SNP/ANP when there had been discussion with all members of the healthcare team and agreement on the scope of the post. Posts formed by doctors alone appeared to be more limited in scope, as they preferred a medical model therefore a focus on efficient treatment (Tosh 2007). This reiterated medic’s viewpoint in my study as Fraser (Medic) illustrated:

“I think the places that you end up with the most resistance are the big teaching hospitals where you have loads and loads of doctors and the consultants feel much more comfortable with a medical model where their work and their patients are being seen by doctors”

(Fraser – Consultant Medic – phase 1)

However, he highlighted that with the implementation of Modernising Medical Careers (MMC) in the next couple of years there would be a shortage of medical staff. In the words of Fraser:

‘Oh yes, I think maybe we can look at the role of other professions to help us here’. So I think they’re forced into it and I don’t think there’s many who are enlightened enough to see the benefits until it’s really forced on them”

(Fraser – Consultant Medic – phase 1)

The junior and middle grade medics all highlighted that such roles were put in place by management, however they did not believe they were the best option. Such tensions were illuminated by Michael (Medic):

“Are they thinking about the patients, that’s the question? Who is best to do the job, some one up there in their wisdom decided on these roles? Doctors view themselves as an entity from within. So when we think about our training, sort of someone doing our job there’s always going to be an element of being protective of our job, our work area and our boundaries”

(Michael – Foundation Year 2 Medic –phase 1)

Whilst Josie (Nurse) outlined:

“They [medics] say this will be a disaster, management don’t know what they are doing, just putting them in, because there is no way that the nurse practitioners will be able to deal with emergencies”

(Josie – Charge Nurse- phase 1)

Most of the participants illustrated that SNP/ANP roles were implemented by management and not discussed with the healthcare team. This “forcing” of the role appeared to feed the tensions between medics and SNPs/ANPs. Many authors report that by enforcing such changes without involvement or ownership of those involved can cause resistance to change (Nadier 1993; Beer & Nohria 2000; Burke 2002; Carnell 2007). It also appeared that as some medics were reluctant mentors, this had implications for enabling the SNPs/ANPs to meet role expectations. This also caused some tensions, as highlighted by Mickey (Medic):

“Our SPRs wrote to the Postgraduate Dean and said they didn’t want to supervise the Senior Nurse Practitioners anymore because they felt it was inappropriate”

(Mickey –Senior Registrar-Phase 1)

The SNP/ANP role appeared to cause tensions for the middle grade (Senior Registrar SPR) and junior medics (FY1-FY2/SHO) as they were taking on activities previously associated with medicine. This was perceived as reducing the training opportunities available for medics. In a memo, at this stage of my study, I questioned if this could be associated with professional closure theory (Porter 1998). Professional closure is described as professionals adapting to preserve their identity, protect their professional boundaries and maintain the privileges of their social order (Porter 1998). This would relate to medics questioning whether they should supervise SNPs/ANPs. They were controlling the division of labour by denying access to specialist knowledge and preventing or restricting clinical practice by non-members (SNPs/ANPs). This reflected Barton’s (2000) ethnographic study which found that NPs presented a threat to medical mentors, linked to the disruption of the normative boundaries between nursing and medicine. Barton reports that the concept of a nurse taking on an explicit autonomous role remained controversial and difficult for medical mentors.

Bernie (Nurse) reiterated this point:

“There’s a downside to having to rely on medics to mentor when they did not want the roles in the first place, it was put upon them. They may not understand or want to understand fully the scope of the nurse practitioner and sometimes that can be quite limiting for the nurse practitioner”

(Bernie—Junior Charge Nurse – phase 1)

Forsyth (1990;495) outlines a role to be a “behavioural characteristic of a person in a context, the part played by a member of a group”. The DOH (2000) promoted the overlap of roles to aid in service users being treated quickly rather than waiting to see a particular professional. Banham & Connelly (2002) proposed that as doctors and nurses roles overlap, rather than an appreciation of each others role on what it contributes to the service user, it results in conflict and tension between the professions. Whilst Patterson & McMurray (2003) report a barrier to nurse/medical collaborative practice is a lack of understanding concerning each other roles and responsibilities.

As Robert (Medic) suggested:

“It’s like the Fire Fighters from France¹⁴. You’ve got a pile of people who are all doing important things and making decisions that are gonna influence what everybody else is doing. So everybody’s got to know what everybody else is doing, but don’t...”

(Robert-Consultant Medic-phase 1)

This related to Griffin and Melby’s (2006) survey on the attitudes of nursing and medical staff on the development of the new role of NP within an emergency department of a health board in the Republic of Ireland. The major finding from Griffin & Melby’s (2006) study illustrated that the blurring of boundaries and roles of the NP within the team promoted tensions. Only a total of 11% (n=24) of the total population in Griffin & Melby’s survey had a clear understanding of the NP role. Griffin & Melby (2006) highlight the best way forward is through defined roles within the healthcare team and argue that if a team are unsure of each others roles, this has implications for patient care. Bleakley (2006) gives the stark example that in the UK 850,000 medical errors occur on an annual basis which results in 40,000 deaths, most of which are related to tensions in communication within a team.

¹⁴ In 2003 major forest fires broke out across France. The fire-fighters did not have a co-ordinated approach which was associated with the further spread of the fires.

Therefore, if professionals are not clear on what their role involves and are not working effectively within a team, this can have adverse affects on service users' care.

As Harry (AHP) highlighted:

“You know, you do get people coming in like you get speciality consultants, you get your practitioners and now I suppose you could include myself in that, and we're all trying to do the best we can for our patients but it's the joining up of, yeah it's a role blurring this can be as bad as no one knows what's happening with the patient”

(Harry– Allied Health Professional –phase 1)

Gould & Wasylikiw's (2007) exploratory study on NP's (n=7) experiences one year post implementation of the role, highlighted that role blurring was a common problem which can lead to further tensions within a healthcare team. Their study does highlight that the effective integration of NP's is less than clear cut and the requirement for a transparent outline of the role of the SNP/ANP is required if these roles are to be successful in clinical practice. This is also highlighted by Irvine et al. (2000) who reported that unclear role expectations can have a negative influence on the implementation of NP roles.

All medics highlighted that there was a lack of clarity for both junior medical staff and SNP's/ANP's on their role within the team. Faux (2007) states a neglected area in the literature, is the affect of Modernising of Medical Careers (MMC) has had on the healthcare team. Modernising Medical Career's (MMC) came into operation in August 2005. This appeared to affect the clarity of junior medics' role within the healthcare team. As Michael (Medic) illustrated:

“I think it does confuse the junior doctors, they haven't got to grips with their role yet, so they won't have a clue what a nurse practitioner is and anyway they are different in each area which makes it more confusing”

(Michael-Foundation Year 2 Medic-phase 1)

Another element that was considered in phase 1 was that the SNPs/ANPs may therefore have been unclear of their role, as a number service providers (n=10) commented that some appeared to utilise their skills, whereas others did not. Mickey (Medic) illustrated this point:

“I think that there’s probably what, I’d estimate 10% of the people that started it are using their competencies now”

(Mickey- Specialist Registrar SPR Medic –phase 1)

I questioned if SNPs/ANPs were not clear on their role identity within the traditional team. This may be a reason why they were not utilising their skills. Bernie (Nurse) reiterated this viewpoint:

“Well, we’ll train them up because there might not be a doctor here at night time, if you like, but they’re not going to be actually doing much more than what they’re doing at the moment.’ As far as I can see with some of them”

(Bernie-Charge Nurse-phase 1)

As highlighted by all medical participants within my study, it was clear that medics were not aware of what the role of the SNP/ANP was. This reflects the findings from McDonough et al.’s (2004) evaluative survey on the new role of an emergency department mental health and triage and consultancy service. Whilst McDonough et al.’s evaluation outlined the benefit such a service had for service users, an area of improvement was outlined as providing educational sessions for medical staff to explain the role and how they could access the service. The problems with role blurring was identified by all service providers in phase 1, as Robert (Medic) pointed out:

“It comes back to this collective decision ... decision making, sort of responsibility type thing. So it’s a bit like, trying to conduct an orchestra that is full of soloists. ... is the effect of affect on how you ... how you work and how you work in the team”

(Robert-Consultant Medic-phase 1)

All medics identified role blurring as playing a role in creating tensions, and maintained that in order to provide the vision of “seamless” delivery of care within the changing healthcare context, team working was crucial. The consensus from medics was that it would have reduced tensions if the role was discussed prior to implementation with a clear outline of role and responsibilities and how such a role would integrate with other members of the healthcare team. I found during constant comparative analysis that there was literature highlighting the tensions between medics and SNP/ANP roles, however less was available surrounding nurses interpretations of such roles.

4.4.3 Nurse-SNP/ANP Tensions

All nursing and medical participants (n=16) outlined that SNPs/ANPs were treated with hostility from other nurses. As highlighted in Chapter 2, there is less research surrounding the relationships between nurses and SNPs/ANPs (Kleinpell et al. 1997; Reay et al. 2003; Gooden & Jackson 2004; Shebesa et al. 2006). The conflict between nurses and SNPs/ANPs was reiterated on a number of occasions from all participants within this stage of my study. This led to nurses at all levels being interviewed to aid in theoretical sampling inherent within the methodology of CGT. Mark (Medic) illustrated the medical participants' views:

“The bigger issue that there is nurses not accepting them ... and I’ve had this where ... nurses have phoned up and said ‘I need to speak to the doctor and refused to speak to the nurse practitioners. ... But those are the people who make some nurse practitioners lives miserable ‘you think you’re something special now!’

(Mark-Consultant Medic-phase 1)

This tensions appeared to be linked to a change in the social structure within the nursing team. Turners' (1987) seminal work provided a useful analogy to aid in this understanding as traditionally nurses are seen as compliant with medical decision-making. He made the point that medics, particularly older and at consultant level, tended to come from higher socio-economic groups and their authority was rarely challenged by nurses. However, as the SNPs /ANPs originated from the same profession as nurses, it appeared that tensions were generated from such practitioners making a decision rather than a medic. In the words of George (Medic):

“The nurses say, who’s this jumped up so and so coming and telling me how to do my job”

(George- Foundation year 2 – Medic – phase 1)

And Fraser (Medic) further elaborated:

“And I think nurses...are threatened by somebody new coming in and... who might potentially try and tell them what to do”.

(Fraser- Consultant Medic-phase 1)

The findings highlighted there were tensions when nurses perceived that their autonomy was being compromised by a SNP/ANP taking on specific decision-making responsibilities.

As Louise (Nurse) illustrated:

“Nurses are hard on nurses...Other staff will do things for a doctor but won't help if it's a nurse practitioner...something in the hierarchy of nursing”

(Louise-Chief Nurse-phase 1)

Turner (1987) suggested that nurses are resistant to traditional ways of working, bureaucratic regulation and having to be compliant with medical instructions. He argued that this dissatisfaction is located in “vocabularies of complaint” which characterises nursing. All occupations have an informal culture in relation to attitude and practice including conventional topics of complaint. He suggested that during a nurses training they are introduced to occupational ideology or vocabulary of complaint. Nurses voice their dissatisfaction on their lack of autonomy in relation to patient treatment and other aspects of healthcare delivery. These complaints typically devalue the medics' role with the service user and de-legitimise the system of authority between the professions. It also produces a sense of solidarity and social identity within the nursing workforce against the dominance of bureaucracy of the medical profession. This enhances the unity and coherence of nurses as a social group against the authority of the medical hierarchy. Complaining acts as a release of frustration and if done in a collective way, the solidarity of the group is reasserted but this complaining does not lead to change. As the nurse is in a subordinate position, this is generally ineffectual in challenging the structure of the healthcare team.

I questioned if SNPs/ANPs taking on roles, which was the original domain of medics, had shaken the “vocabulary of complaint” and thus the social identity within the profession of nursing. Murray (1998) suggests roles become personal for individuals and these personal expectations shape or define the role of a nurse. As Rosie (Medic) illustrated it was like the SNPs/ANPs had “*deserted their kind*” and went off to the “*dark side*”.

“It was really interesting to hear them say they don't feel they're accepted by nurses, you know the nurses in the ward don't seem to accept them, it's like they're deserting their kind, you know and going off to the dark side as such... it seems to be the nurses that are actually having the issue accepting what this role is...”

(Rosie- Consultant Medic –phase 1)

Margaret (Nurse Manager) illustrated the threat for nurses:

“There is a lack of clarity of the nurse practitioner’s role, as nurses don’t understand that they are trained to undertake much of what medics used to do. There’s the jealousy factor, there was the Charge Nurse who doesn’t like this nurse practitioner coming in and giving direction about patient care because, she did not understand what is the nurse practitioner’s role”

(Margaret- Nurse Manger– phase 1)

Paladichuk (1998) highlighted this point in a discussion paper with a NP, and outlined in clinical practice the relationships between a NP and nurse are blocked via egos, power struggles and territorial issues. One could debate if the tensions described were moving into an era of social identity struggles.

As Louise (Nurse) outlined:

“They’re keen to impress and they’re the Senior Nurse and I’m speaking to the wee E grade staff nurse forgetting the E grade staff nurse has worked in [speciality based area] for seven years. And I’m going in and trying to canulate up here, and she’s telling me no. Difference is the junior doctor would listen to staff within specialist areas where as the nurse practitioner’s do not”

(Louise – Chief Nurse- phase 1)

This focused code indicated that where ‘nurse-SNP/ANP tensions’ were created was linked to SNPs/ANPs raising identity issues for nurses as nursing participants highlighted that they were confused and unhappy about the identity of such roles and how it affected their own role as a registered nurse.

As Thomas (Nurse) outlined:

“From a charge nurse point of view, you might feel threatened because they may know more than you. The reason I was talking about definition of the roles is their [NPs] roles overlap with mine, who does what?”

(Thomas –Charge Nurse-phase 1).

4.4.4 Emerging Category 'professional tensions' – Stage 2- phase 1

The literature highlighted the long standing tensions between medics and nurses. (Arford 2005; Sirota 2007; Taylor 2009; Tjia et al. 2009; Yeh et al. 2010). Participants described the traditional professional cultures within a healthcare team context contributed to where tensions with the SNP/ANP roles were created within practice. This led to the view that the SNP/ANP was a hybrid role, with an unclear identity within a deeply rooted traditional belief and values systems between the nursing and medical professions. Therefore, I questioned if this could be where the crux of such tensions were held in relation to service providers interpretations of such roles in phase 1 of my study.

Tensions between medics and SNPs/ANPs were heavily described in the data, a number of examples were illustrated by participants. This corresponded with the international literature, which highlighted a main barrier to the implementation of SNP/ANP roles, was the tensions generated from medical staff (Smith 2000; Scholes & Vaughan 2002; Griffin & Melby 2006; Norris & Melby 2006; Willard & Luker 2007). Where tensions arose for junior medical staff appeared to stem from a professional belief system, encompassing the perceived reduction in training opportunities due to the implementation of such roles. Whilst where tensions were illustrated by senior medical staff appeared to be linked to the struggle such roles created due to an internal belief system attached to nursing. Tensions between registered nurses and SNPs/ANPs were described in the data. It appeared that SNP/ANP roles raised identity issues for most nurses, with the undercurrent tension that such individuals within these roles were deserting their profession and siding with medicine.

4.4.5 Advanced Memo 2 –Stage two – Phase 1

'Professional tensions' were grounded in the data and this reinforced previous literature surrounding the traditional conflict between nurses and medics (Stein 1990). Walby & Greenwell (1994:2) suggest that "professionalisation" plays an important role within the healthcare team. Traditionally, medics have had sole responsibility for treating and diagnosing service users with a higher occupational status than nurses within a healthcare team. To undertake this task, they are referred to as the "thinkers" in the data of my study, as highlighted by Rosie (Consultant medic –page 110). In the past 20 years, nurses have moved to increased professionalisation through higher levels of university education (Halford & Leonard 2006). The interpersonal aspects of nursing are termed holistic and patient centred, which presents a parallel process to medicine thus providing a valuable independent contribution to the care of service users (Halford & Leonard 2006). To undertake this independent element, they are referred to as 'the doers' in data (stage two phase 1). Therefore, it appears that both professions have co-created roles and social identities which forms the normative way of working between medics and nurses in the healthcare team.

The 'tensions' described by medics and nurses stemmed from the SNP/ANP breaking this normative way of working and disrupting the co-created roles and social identities of both nurses and medics. As illustrated by Rosie (Consultant medic), "they both bring different things to the party". This linked to 'Social Identity Theory', where people classify themselves and others into various social categories (Ashforth & Mael 2004). Individuals identify with a set of group values and practices in their in-group (such as nursing or medicine) which become more salient and perceived as unique and distinctive. Social identity affects group formation, collaboration and cooperation with different groups. The group identification is associated with loyalty and pride in group activities. Ashforth & Mael (2004:141) ascertain that "during competition, group lines are drawn more sharply and the differences are accentuated". This appeared to have happened when SNPs/ANPs threatened medic's social identity by undertaking medical activities. SNPs/ANPs also posed a threat to senior nurses' social identity when undertaking higher status technical tasks, which were previously in the senior nurses' domain. I would suggest this is where tensions were created by SNP/ANP roles in my study. The co-created roles of medicine and nursing with associated professional cultures, were shaken by SNP/ANP roles.

4.5 Introduction – Findings from Phase 2

As illustrated in chapter 2 some qualitative studies have described barriers and challenges in their findings surrounding SNP/ANP roles (Bousfield 1997; Glen & Waddington 1998; Willard & Luthers 2005). It was ascertained that in order to identify why tensions have continued to be reported with SNP/ANP roles it was necessary to evoke rich data which explored meanings and processes attached to such tensions which has not been reported within the international literature. As Bevir & Rhodes (2005) report we cannot understand human behaviour unless we grasp the relevance of meanings, as this holds the key to unlocking reasons for behaviours. As elaborated upon in Chapter 3, a CGT ethnography method was employed to answer the research question posed in phase 2, 'To discover where tensions remain apparent in service and what meanings and actions are attributed to them?' I integrated the categories from phase 1 into data collection, as outlined in Chapter 3, to focus my lens and build a richer picture surrounding the overall aims of my study.

4.5.1 Population and Sampling

In total, I undertook 13 periods of observation, with follow up interviews, equating to 64 hours across a large urban acute NHS Board in Scotland. Data collection took place over 2008. A 3 stage approach was employed, as previously discussed in Chapter 3 (See Figure 6). The sample included SNPs/ANPs (n=13) across a wide range of practice areas within different hospital sites (Table 5). The sampling strategy was consistent within the CGT method and data were analysed and as a number of initial and focused codes emerged, this informed the subsequent sampling of participants. The sample included SNPs/ANPs with different titles across an acute division.

4.6 Overview of Categories

As highlighted earlier in the chapter, a number of categories were generated during the two stages of phase 1 of my study. Initial and focused coding took place in phase 2, these were compared with categories from phase 1 and led to the development of two categories in phase 2. The two categories were 'Shared Decision-Making (SDM)' and 'Turf Wars'. The latter was underpinned by two focused codes 'unclear expectations' and 'know your place'. The following sections will discuss the categories and associated focused codes which emerged in phase 2 of my study.

4.6.1 Shared-Decision Making (SDM)

This was a category which emerged from phase two. There is a paucity of research surrounding SNPs/ANPs style of communication and the implications for service users (Lawson 2002; Berry 2006; Charlton et al. 2008). In phase 1, playing a 'passive role' in decision-making was identified as a focused code. As part of the constant comparative analysis and memoing in phase two, a focused selected literature review was undertaken surrounding decision-making. It was found that a key component of decision-making was the ability of a healthcare professional to engage a service user in decision-making, thus sharing the control of the decision-making processes with the service user. This is known as Shared Decision-Making (SDM). The international requirement for active participation has been advocated over the last 30 years (WHO 1978; ICN 2003). Whilst there has been growing evidence in relation to service user participation in decision-making, the main focus has been within medicine. There is a paucity of research surrounding inviting participation in nursing (Florin et al. 2006; Gravel et al. 2006; Florin et al. 2008; Clark et al. 2009). No studies were identified in relation to practitioner's roles and service user participation in decision-making (Wenzel & Shaha 2008).

The constant comparative method and memoing in phase 2 guided me to further clarify the steps in SDM. The body of literature surrounding decision-making focuses on three levels of participation; the passive role; a collaborative role; or an active role in the decision-making process (Florin et al. 2008). The passive role, sometimes referred to as paternalistic decision-making includes leaving the decision to the health care professional after they have considered the service users' opinion on information given. The collaborative role sometimes referred to as interpretative decision-making is where the health care professional shares responsibility for decision-making with the service user. The active role or shared decision-making is when the service user makes the final decision after considering all the opinions (Charles et al. 1997; Coulter & Ellins 2006; Florin et al. 2008).

Shared decision-making is a complex process, involving a number of steps which are outlined in Table 11.

Table 11 - Steps in Shared Decision-Making (SDM) process

- Listen to service users and respect their views;
- Recognise and clarify the problem;
- Identify potential solutions;
- Check decision making role preference;
- Maximise service users opportunities and their ability to make decisions for themselves;
- Discuss opinions and uncertainties;
- Provide individualised tailor made information;
- Check understanding and reactions;
- Check service users' views and respect their decisions;
- Implement a chosen course of action;
- Arrange a follow up;
- Evaluate the outcome.

(Adapted from Charles 1999; Elwyn et al. 1999; Siminoff & Step 2005; Coulter & Ellins 2006; GMC 2008)

Whilst undertaking an advanced memo at the end of phase 1, I questioned if SNPs/ANPs invited service users to participate in decision-making or if they reinforced the 'passive role' as described by service users participants in phase 1 of my study. This led to a detailed retrospective analysis of the steps inherent with SDM, across data in phase 2 (Table 11 above). This analysis is detailed in Figure 11 (overleaf).

Figure 11 - Retrospective analysis of the steps inherent with SDM

Key:

✓ = Observed

X = Not observed

NP Name	Listen to service users and respect their views	Recognise and clarify the problem	Identify potential solutions	Check decision making role preference	Maximise service users opportunities and their ability to make decisions for themselves	Discuss opinions and uncertainties	Provide individualised tailor made information	Check understanding and reactions	Check service users' views and respect their decisions.	Implement a chosen course of action	Arrange a follow up	Evaluate the outcome	Mentor observed in practice	Similar consultation Style as mentor
Sharon	✓	X	X	X	X	X	X	XX	X	X	✓	X	✓	✓
Harriet	✓	✓	✓	X	X	✓	✓	✓	X	✓	X	✓	✓	NA
Nuala	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Jessie	✓	✓	X	X	X			X	X			X	X	NA
Chloe	✓	✓	✓	X	X	X	X	X	X	X	X	X	X	NA
Michael	✓	✓	✓	X	X	X	X	X	X	X	X	X	X	NA
Monica	✓	✓	✓	X	X	✓	✓	✓	X	✓	✓	X		X
Lauren	✓	✓	✓	X	X	✓	✓	✓	X	✓	✓	X	X	NA
Michael 2 nd observation	✓	✓	✓	X	X	✓	✓	✓	X	✓	✓	X	X	Differs due to medic & environment
Karen	X	X	✓	X	X	X	X	X	X	X	X	X	X	NA
Morag	X	X	✓	X	X	X	X	X	X	X	X	X		✓
Sophia	✓	✓	✓	X	X	X	X	X	X	X	✓	x		✓
Mary ¹⁵ Jane	✓	✓	✓	X	X	✓	✓	✓	X	X	✓	X	X	NA

¹⁵ Mary Jane = As some of service users detained under Mental Health Capacity Act this would have affected shared DM processes.

Ford et al. (2006) suggest that for a service user to be part of the shared decision-making process, good communication is vital and the healthcare professional should provide the information required, helping inform the decision taken.

As Figure 11 (previous page) illustrated, only one ANP (Nuala), from phase 2 implemented all of the steps inherent with SDM. She checked what role preference a service user would like in the decision-making process. Prior to each consultation, Nuala acknowledged the level of anxiety coming to the clinic must bring to a service user. She highlighted what her role was and what would be expected from the consultation. She also spent time ascertaining the level of anxiety each service user had and encouraged them to ask any questions or queries they may have had. Additionally, she provided information that would help them ask such questions. This was consistent throughout all her interactions, Nuala quickly appeared to pick up the level of involvement that service users wanted in the sharing of decisions. Most service users became involved in the decision-making process, with the exception of one gentleman. She ascertained that he did not want a shared level involvement in the decision making process, as highlighted below.

The second patient was a 66 year old male, who presented to the breast clinic. He was encouraged to ask questions, however did not appear to want to engage with decision making and replied with short answers such as “yes” or “no”. He quickly changed the subject to the weather and other chit chat, reflecting a feeling of anxiety. Following the consultation he was given a number of different treatment options he remained silent, when asked if he had any questions, he replied “ I want you to tell me what to do”. Nuala responded with “What I normally would recommend is XXX, what do you think”. His response was “yeah, that will do, this is a story for the pub”. He then went for a scan.

When the gentleman went for the scan, Nuala recognised that it was difficult for an older Scottish gentleman to come into the breast clinic full of woman and he must be anxious however was not verbalising this maybe due to the expectations surrounding the culture of Scottish older males (Be strong). On his return, she provided clear explanations, again offering an opening for any questions and provided a lot of reassurance.

(Extract from Field notes -Nuala – Observation 2- phase 2 – page 3)

Nuala highlighted in her follow up interview that she had undertaken an oncology communication skills training course. The majority of international literature surrounding SDM, is associated with the area of oncology, the area in which Nuala worked as an ANP. Therefore, this may explain her heightened awareness surrounding the process involved at ensuring service users are invited to participate in the sharing of decisions.

The communication style and steps associated with SDM varied across all other practitioners in phase 2. All other SNPs/ANPs (n=11) in phase 2 did not check what role preference a service user would like in decision-making or maximise the service users' opportunities to make decisions for themselves. Eight practitioners (Mary-Jayne, Michael, Jayne, Monica, Jessie, Harriet, Lauren, Sophia) did apply some steps inherent with SDM. They listened, recognised and clarified the problem, in addition to providing opportunities to discuss options of the problem, however it was interesting that they only gave a choice of one course of action. Due to my background in nursing and education, I recognised occasions when a service user could have been given different options. This was probed in the follow up interviews and all SNPs/ANPs felt that they had chosen the best course of action. I questioned whether the treatment option would have been the service users' choice if all relevant information was provided. I also noted the lack of awareness illustrated by the SNPs/ANPs on the implications of not providing all information. Lee et al.'s (2010) cross-sectional study found that women's (n= 1893) treatment decisions are shaped by information provided by their consultant. Whilst Sepucha & Mulley (2009) suggest that service users treatment decisions can be based on knowledge gaps of the healthcare professional and a lack of awareness surrounding service users preferences for involvement.

The observations indicated a lack of understanding and awareness surrounding SDM, as the service user should be sharing if desired, the decision on all choices available. Wirtz et al. (2006) report that for service users to be part of the decision-making process regardless of their preferred role, they require information and explanation in order to make a choice. This did not happen during the interactions with the above mentioned SNPs/ANPs.

I would challenge whether the eight SNPs/ANPs enabled the service user to make an informed choice as they had not provided all of the information, for example other options available. Clarke (2001) outlines that individualised therapeutic communication is an integral element of the philosophy of nursing. However, Hastings et al. (2003) questions if nurses who move into this role have received adequate preparation to enable them to ascertain service users choice in partaking in decision-making. I questioned if this reinforced the social script of service users playing a passive role in decision-making. Rosenzueig et al. (2008) asserts that competence in SDM skills is not necessarily intuitive just because individuals have previous experience in nursing. As McCaffery et al. (2010) point out healthcare workers require awareness, skills and competencies in the different stages of decision-making. Frank (2009) argues to ensure SDM health professionals must be able to demonstrate that they are prepared to share all knowledge with the service user. This was not the case in the majority of interactions observed with behaviours and actions indicating that service users were expected to play a passive role as they were not invited into sharing the decisions. Some SNPs/ANPs did however check the understanding of the course of action. Whilst they all implemented a course of action, they did not check the service user's views on the decision that had been made. Instead, they asked if they had any questions, service users passively accepted the course of action the SNPs/ANPs recommended. This raised my curiosity surrounding SNPs/ANPs' level of awareness surrounding the importance of encouraging and inviting participation in decision-making. A lack of awareness was also apparent in the other three observations. Three SNPs (Karen, Morag & Monica) did not follow any steps inherent with SDM. They told the service user what was going to happen and did not allow time for them to ask questions.

Coulter & Ellins (2006) highlight that this is the traditional model of decision-making, assuming that the health professional and service user have the same goals. The health professional ensures the service user is informed and involvement would consist of them providing consent. This is a very paternalistic approach, which is outdated given the movement towards a person-centred NHS service (DOH 1998; 1999; 2005 a & b; 2006a; 2008; 2009a; 2010; SEHD 2003; 2006a; SGHD 2007; 2008 2009b; 2010a & c; SGSR 2008).

Legare et al. (2008) report that SDM is a relatively new concept to be adopted in clinical practice, despite being advocated over thirty years ago. It appeared that a lack of awareness had a part to play in SNPs/ANPs not following the steps inherent with SDM. Chloe was a SNP working in the Hospital at Night (HAN) service and throughout the course of the observation did not undertake any of the steps related to SDM, when interacting with service users. However, when one service user asked “what other options are there?” she proceeded to go through some of the steps related to SDM. The service user had asked the question which appeared to raise awareness for Chloe of the requirement to involve the individual in some of the decision-making processes.

I questioned if SNPs/ANPs were aware that service users would not feel comfortable challenging the decision, as they had learned through social script the expectation of playing a passive role in decision-making. This seemed to explain why no service user (70 interactions) questioned, or challenged a single course of action which eight of the practitioners (Mary-Jayne, Michael, Jayne, Monica, Jessie, Harriet, Lauren, Sophia) recommended. Wilson (2009) concluded that if service users feel they can ask questions their perception of control is increased. Therefore, I questioned if by raising awareness surrounding the effects of social script and shared decision-making, this may increase a sense of control for service users.

Similar to the findings in phase 1, the literature surrounding decision-making highlights that some service users' do want the information however choose to play a passive role in the decision-making process (Davison et al. 1995; Bilodeau & Degner 1996; Butow et al. 1997; Gaudognoli & Ward 1998; Schnieder 1998; Florin et al. 2008; Wenzel & Shaha 2008). There are a variety of reasons for adopting a passive role, however one consideration that has not been reported in the literature is the deep rooted social script that a service user will play a passive role in decision-making. In phase 2, the observations illuminated that SNPs/ANPs behaviours reinforced the covert meaning that service users were expected to play a passive role in decision-making.

4.6.2 Turf wars

Turf wars was a main category in phase 2. It was underpinned by two focused codes 'unclear expectations' and 'know your place'. These are further explored in the next two sections.

4.6.3 Unclear expectations

During the observations in phase 2, I noted that overall there were unclear expectations of those within SNP/ANP roles. Each SNP/ANP who participated in my study had a different role and inherent responsibilities, dependant on the area in which they worked. This reiterated the health care professionals' viewpoint in phase 1, as Michael highlighted:

"...What is a nurse practitioner ...they are different in each area which makes it more confusing"

(Michael-Foundation Year 2 Medic-phase 1)

Cummings et al. (2003) outlined similar problems with role definition. They found that all participants in their study were unclear on the boundaries between the role of the ANP and junior medical staff. This emphasised the lack of identity for SNPs/ANPs within my study. In service areas data illustrated this point as there was a lack of consensus surrounding the expectations of SNP/ANP roles. An example was Sharon (SNP) who identified her main role as collecting research data for the consultant medic. I noted during her interactions that her focus was ensuring each service user filled out specific questionnaires for the research, in addition to collecting bloods for the consultant's study. During this period of observation, an opportunity arose for me to speak briefly with the consultant medic, who set up this role. He explained that the main focus of the SNP role was health promotion to help service users change their lifestyle habits that may have contributed to their respiratory disease.

This was in contrast to Sharon's (SNP) expectation of her role and at no point, throughout the 14 interactions with service users observed, did she fulfil a health promotion role. This illustrated the stark difference in expectations of Sharon's (SNP) role with that of the respiratory consultant.

I noted further examples of the mismatch of expectations of such roles. These were illuminated well in the Hospital at Night (HAN) service. HAN was set up four years prior to data collection carried out in phase 2. The main aim of the service was to deliver quality care overnight, through a collaborative multi-professional team approach. Both SNP's (Chloe & Sophia) worked in the HAN service, each were based in different acute hospitals and despite dissimilar sites, evidence of unclear expectations and tensions were illustrated across the healthcare team. Chloe (SNP) was responsible for a number of ward areas overnight. The following extract from field notes highlighted that nurses may not have been aware of what her role entailed, thus questioning her social identity in the multiprofessional team.

In total, Chloe visited 10 ward areas, all of which had 3 bases and a registered nurse in charge of each base. Chloe introduced the observer to a registered nurse and explained that I was shadowing her to see what SNPs/ANPs done in practice.

The registered nurse commented "Wouldn't we all like to know what they do".

(Extract of field notes -Chloe- Observation 5- phase 2- page 5)

This indicated that the nurse was not aware of Chloe's role. This was probed in Chloe's follow up interview, where she explained that the role was not the one she had "*signed up to*". She highlighted that she spent most of her time cannulating and taking bloods which she termed as "*menial tasks*". This was similar to Sophia who worked on a different hospital site, highlighted in field notes.

When Sophia (SNP) was asked to insert a venflon on a busy medical ward where only two nurses were on duty and they were "rushed off their feet", she made a face. To which the staff nurse quickly replied "*only joking*". Therefore, Sophia did not insert the venflon, she then highlighted that HAN were very busy, which as I was observing knew was not the case. She proceeded to return to the HAN office for a coffee.

Follow up Interview

During interview this was discussed, she outlined that the post was not what she expected, as she liked seeing unwell patients and dealing with them. She outlined that she spent half her night putting in venflons which "*really is the nurses' job*". When probed on whether she would consider going around the wards to support or facilitate education, she highlighted that the nurses would not thank her for that "*there is a reason they do night shift*"

(Extract of field notes -Sophia – SNP- Observation 12 –phase 2- page 3)

Both SNP's in HAN outlined their expectations were that they would be reviewing and 'treating' more critically unwell service users. However, on speaking with some of the medical staff on the HAN team in both sites, they perceived putting in venflons and taking bloods as an SNP role, and explained that this was a role of junior medics during the day.

The medics explained that as they had a stronger knowledge base, it was their role to review the "*sick patients*" overnight. These data illustrated the marked differences in expectations, stimulating tensions across both the HAN team and wider healthcare team. The HAN medics felt taking blood and venflons were part of the SNP role and the medics' role was to review the "*sick patients*". In stark contrast, the SNP's expectations were that they should be reviewing the "*sick patients*" and the task of taking bloods and insertion of venflons deemed as a "menial task" was part of the registered nurses role, whilst the registered nurses did not appear to know what the SNP role involved. Such unclear expectations were reiterated by Monica's (SNP) observation who worked in a surgical area, she stated that:

"The older nurses think I am there to give them a hand, but that is not my role, I review the medical elements of the patients, to support the medical staff, not the nursing side"

(Monica- SNP-Phase 2)

The SNP/ANP role had "nurse" in the title, however during observation many were taking on the role previously associated with junior medics. These types of NP roles appeared to cause tensions for some of the healthcare team. The data suggested that this was due to a mismatch in expectations on how such roles would interact with established role identities. This was a threat to the co-created professional roles and social identities of both nursing and medicine. In phase 2, I also observed that on a number of occasions, when an SNP/ANP reviewed a service user they would not carry out nursing care as they perceived that this was not within their role. As illustrated in the following extract of field notes (overleaf).

Mary-Jayne (SNP) was asked to review a service user as a venflon was not working therefore she had not received Inter-Venous (IV) fluids for over an hour. Mary-Jayne undertook the task of inserting the venflon. She did not flush the venflon or reattach the IV fluids. She then spent time looking for the staff nurse, asking her to flush the venflon and reattach the fluids. The staff nurse appeared to be busy with another service user, however Mary-Jayne suggested that it was important she flushed the venflon so it did not “block off”.

(Extract field notes- Mary-Jayne 12-phase 2- page 4)

In the follow up interview, I probed this interaction, as it would have taken Mary-Jayne (SNP) less time to flush the venflon and reconnect the IV fluids, than searching for the staff nurse. This would also have been more beneficial for the service user, who had not received IV fluid at this point for 1.5 hours. Mary-Jayne (SNP) explained that this was a ‘menial task’ and part of the nurses’ job and not her role. However, it was noted that when a junior medic inserted a venflon, they flushed the venflon and reconnected fluids. Therefore, it was not clear why this particular element of the task was not perceived by Mary-Jayne as part of her role.

This indicated how different the expectations of SNP/ANP roles appeared to be in practice, in addition to the marked differences in expectations between SNP/ANP roles, as Mary-Jayne (SNP) viewed the insertion of a venflon was within her role, however in contrast Chloe and Sophia (SNP HAN) did not and viewed this as a staff nurse role. Actions and behaviours observed suggested such differences in expectations were linked to identity issues as the traditional role of a nurse was complementary to a medic. The SNPs/ANPs interactions illustrated that they crossed these co-created boundaries, leading to a blurring of expectations. This built upon findings in phase 1, where tensions were associated with ‘professional cultures’ and provided a deeper understanding in where tensions arose, illustrated through behaviours and actions observed.

4.6.4 Know your place

The focused code 'know your place' was illustrated by overt behaviours and covert meanings in phase 2 of my study. There was a paucity of research surrounding the tensions SNP/ANP roles created from a registered nurse perspective (Cummings et al. 2003; Gooden & Jackson 2004; Chang & Tsay's 2006). Data from phase 1 illuminated that tensions arose from the social identity of nurses being threatened by SNP/ANP roles. The findings in phase 2 of my study further illustrated the actions and meanings associated with such tensions. It was illustrated that if a registered nurse did not agree with the role and remit of an SNP/ANP, this led to increased tensions, as alluded to in the following field note extract.

Following assessment and clinical examination, the ANP outlined to a medic that the lady required pain relief. She took the drug Kardex to a medic to write up some morphine. She then walked over to a staff nurse, gave her the drug Kardex and asked if she could give the lady some pain relief and to set up a bag of fluid.

The *look* the nurse gave her was one of "why don't you do it yourself". However she did not say anything, and proceeded to carry out the instructions.

(Extract of field notes -Jessie-ANP-observation 4 – phase 2 - pg 3)

I probed this interaction in the follow up interview. Jessie (ANP) explained that as she was required to review other service users, she could not undertake nursing tasks. She stated that she was aware of the "look" the staff nurse gave her and suggested that some nurses felt uncomfortable taking instructions from an ANP rather than a medic. Whilst the nurse overtly undertook the task, the 'look' indicated an covert tension with Jessie asking the nurse to undertake the task. This strained communication was reiterated in Chloe's (SNP) observation when a staff nurse remarked, "*they think they are above us*". This was highlighted in the extract from the following field notes (overleaf).

Whilst undertaking the observation with an SNP (Chloe) on nights, a staff nurse on one of the wards asked if she could speak to me in private after she was informed about the study. She outlined that when she phoned up asking for advice, the SNP asked things like “*patients observations*”.

She felt they should “*come*” and not question. She outlined she did not like being questioned by another nurse and that she was a senior nurse too. She used the term they “*think they are above us*”. She outlined it was ok for a medic to ask these questions as they were doctors. (It was actually observed that doctors asked this when giving advice).

In the follow up interview Chloe (SNP) was asked if there were any challenges with other nurses, she stated, “*They would always prefer a medic*”.

(Extract from Field notes-Chloe- observation 4-phase 2- page 5)

I found it interesting that the staff nurse wanted to speak to me alone, thus not overtly questioning Chloe on her role. It appeared that she did not mind a medic asking questions but this created tension when an SNP asked for information surrounding a service user. This reiterated the normative ways of working and co-created role identities of nurses and medics, as it was a medics “place” to question but not an SNP. The covert meaning appeared to be that the SNP role threatened the co-created roles of nursing and medicine and as a ‘nurse’ SNPs/ANPs should not question another ‘senior nurse’. These data reflect the findings of Chang & Tsay’s (2006) exploratory study, which reported that difficulties arose when nurses felt ANPs were exceeding their authority, by taking on medics’ duties. An alternative point of view is that identity is built from surrounding social structures, in this case the traditional working of the healthcare team. Status in both nursing and medicine emerges from local knowledge and expertise, I would argue a senior nurse would bring local knowledge to her ward area and this contributes to her status and role in the healthcare team. Bowler & Mallik (1998) suggest that senior nurses adopt an elitist position not wanting to share their knowledge, thus protecting their status in the healthcare team. As SNPs/ANPs work across a number of wards or areas, the nurses may feel threatened that their knowledge and expertise is challenged, thus nurses status, identity and role in the team is being eroded by practitioner roles. This may explain some of the behaviours and actions I observed during phase 2.

Another observation of an SNP/ANP in an outpatient's clinic provided an illustration of such overt behaviours and covert meanings attached to interactions between an ANP and nurses.

The interactions with nurses in the clinic appeared strained. It was observed that they let the medics know when results or x-rays had returned, so patients could be seen. However, Nuala spent time searching for the results and x-rays of patients she had reviewed. The nurses seemed attentive to the medical staff, however smiled at Nuala.

It was a busy clinic, Nuala and the medical staff did not take a tea break that morning. The clinic nurses made tea and toast for all the medical staff, including themselves, however did not do this for Nuala.

(Extract from field notes-Nuala –Observation 2 –phase 2-page 5)

I noted the overt behaviour of smiling and being polite to Nuala in addition to the covert meaning of making tea and toast for everyone but Nuala in this busy outpatients clinic. I probed these observations in the follow up interview, where Nuala outlined:

“I am afraid I do have some problems with the nurses in outpatients”

(Nuala-ANP-phase 2)

She explained, she had discussed these tensions with the nursing sister in the outpatients department, explaining that she was spending considerable time locating notes and X-rays, when she could be reviewing service users. She was met with *“That is not our job. We see to the doctors not the nurses”*. Nuala highlighted the nursing sister had commented that she was getting *“all high and mighty”* thinking other nurses would run around after her.

This indicated a covert tension surrounding the SNP/ANP role, and confirmed that some nurses were not happy helping an SNP/ANP, but happy to play the co-created traditional role of working with the medics. This built upon data in phase 1, on where tensions were created and also illustrated the overt and covert behaviours and meanings associated with tensions generated by the SNP/ANP role. It appeared that the nurses in outpatients were covertly making the point that Nuala was a ‘nurse’ she should ‘know her place’ and identity in the co-created professional hierarchy of the healthcare team.

Therefore, she should look for her own results and x-rays and because she was “*all high and mighty*” she would not partake in the co-created social interaction over tea and toast with the medics and nurses. Whilst the overt behaviours observed illustrated acceptance of SNP/ANP roles the covert meanings appeared to be registered nurses putting SNPs/ANPs in their traditional place within the co-created professional hierarchy in the healthcare team.

In contrast, in a number of other observations the behaviours and actions suggested good relationships with nursing staff on the ward areas (Michael, Mary-Jane, Lauren). When I probed this in the follow up interviews, it was ascertained that all of these SNPs/ANPs had worked as a senior nurse in the area, prior to taking up the practitioner post. Therefore had built up “*credibility*” as well as having established collegial relationships. It was interesting all of these posts were substitution roles rather than complementary roles. However, it appeared that as they had built up established relationships with the registered nurses on the ward areas, this enabled the SNPs/ANPs to include them in identifying how they would integrate into the nursing team, thus not threatening nurses’ social identity. In relation to medics, I noted in all but two of the observations there was evidence of behaviours that indicated tensions between them and SNPs/ANPs. During an observation with Michael (ANP) it was evident that there were poor relationships with both junior and middle grade medics. As illustrated from the field note extract in phase 2.

Poor relationships with both junior and middle grade medical staff were observed. They ignored Michael as he tried to update them prior to the consultants ward round (playing a game on computer in doctors’ room). When he asked if they could undertake some investigation there were audible “sighs” and answered with “whatever”.

In the follow up interview, Michael outlined that this resentment from junior and middle grade medical staff was due to the good relationship between himself and consultant, he felt the junior doctors were “*not in favour of this status as he was a nurse*”. He found it “*embarrassing*” during the observation, due to the junior medic’s behaviours.

(Extract from field notes-Michael-observation 6-phase 2-page 2)

Michael maintained that these medics had on more than one occasion outlined to him he was *“the nurse not a medic”*. There were obvious communication difficulties with these medics and Michael (ANP) which appeared to centre on the status of being a nurse, therefore this should not include a favourable relationship with the consultant. This indicated covertly that he should ‘know his place’, as a nurse in the co-created professional hierarchy. This was transparent during most of the observations, junior and middle grade medics felt that SNPs/ANPs should *“know their place”* as a nurse. As Chloe (SNP) outlined in her follow up interview:

“They talk to the doctor rather than the team, it’s like we should know our place as nurses.”

(Chloe-SNP-phase 2)

Chloe (SNP) worked in a multi-professional team, known as the Hospital at Night (HAN) which comprised of medics and Senior Nurse Practitioners (SNP). As a team, they were responsible for medical care overnight. This HAN service had been running for four years and *“knowing your place”* was evident during the handover process, as illustrated from the field note extract.

The HAN team was made up of four foundation year 2 medics, one middle grade medic (SPR) and four SNPs. The observation started with the HAN handover. A number of medics covering different areas of the hospital during the day presented to hand over patients to the HAN team.

During handover, it was noted the HAN medics sat in a circle with a spare chair for the day time medics to sit on when handing over, the SNPs’ randomly sat outside this circle. As an observer I had no knowledge of traditions therefore sat in the spare seat in the circle prior to handover and was told this was for medical staff.

Nine daytime medics came in turn to hand over the patients to the HAN team. When the handover was taking place, the medic’s maintained eye contact and spoke directly to the other medics. It was as if the SNPs were not in the room.

(Extract from field notes-Chloe- observation 4-phase 2-page 3)

I noted that the behaviours of medics on an overt level was polite and they made small talk with SNPs prior to handover. However, I questioned the covert meaning attached to SNPs not being allowed to sit within the inner circle of medics during handover and also how the direct communication surrounding service users with other medics indicated that the SNPs/ANPs should ‘know their place’ as nurses.

These observed behaviours and actions placed a new dimension to the tensions described in phase 1 of my study. As overt and covert behaviours and meanings were present in most of the observations, this had not been reported in the international literature.

A further example involved an SNP working in a large teaching hospital's A & E department. Jessie (ANP) reviewed critically unwell service users and undertook differential diagnosis. However, I observed that some junior and middle grade medics in other areas of the hospital refused to take a referral from Jessie. She stated this was a frequent occurrence and at the time of observation she required to get a medic in A & E to confirm the referral to another middle grade medic on the ward area. Jessie stated in her follow up interview, this was because of the word "nurse" in her title. At the time of observation, she reported that the medics in A & E felt it would be better if the word "nurse" was removed so that medics elsewhere would accept ANP referrals. She stated:

"I think they trust a medic as they still have the traditional view of a nurse, which is they don't know enough"

(Jessie-ANP-Phase 2)

The covert meaning appeared to be that Jessie should 'know her place' as a nurse, therefore should not be referring service users to a medic. I found it interesting that another medic felt that by taking the word 'nurse' out of the title this may reduce tensions. I questioned if by taking the word 'nurse' from the title would strip the SNP/ANP of the social and role identity associated with nursing. The medic may have realised that this would reduce tensions between medics and individuals in SNP/ANP roles.

The ANP service in A & E had been running for two years and Jessie outlined initially there was resistance from consultant medics within the department. This had decreased as it was recognised that the ANPs were "*filling the gap*" due to reduced medical staff within the department. This reduction in tensions could also be linked to the consultant medics' status at the top of the co-created professional hierarchy in the healthcare team. Therefore their individual social identity and status would not be threatened by an SNP/ANP in the same way as junior or middle grade medics.

It could also be attributed, as suggested by Jessie (ANP), to the consultant shaping her role to complement his own role within the department, thus ensuring a parallel process of co-creating roles within the department.

Monica, an SNP working in vascular surgery, described similar experiences. She explained that it had taken 2 years to build up a trusting relationship with consultants in vascular surgery. She stated in her follow up interview that for a period of 18 months, any service user she had reviewed in the outpatients setting was double checked by the consultant medic. I questioned if this was a way of covertly ensuring Monica understood her social status in the healthcare team and reinforced the fact that the consultant was at the top of this hierarchy and her role was to complement his role in outpatients. At the time of observation, she explained that the new Government targets on waiting times appeared to accelerate the acceptance of her role by the consultant medics. I questioned if this may have provided recognition on a management level of the consultants achievement of effectively reducing waiting times in outpatients. This linked to Herzberg's et al. (2008) work, which found that intrinsic factors such as job recognition and achievement provided motivation to work. It could be that as the consultants were gaining recognition of reducing waiting times from a management level, this increased their motivation to accept the work of an SNP/ANP. This created an identity for the SNP/ANP that complemented consultants in reducing waiting times in outpatients.

In phase 2, there were two observations where I noted no tensions between the medics and SNPs/ANPs. Harriet (SNP) was responsible for medical cover for surgical areas, within a community hospital during the day. During the period of observation, she had eighteen interactions with different levels of medical staff. She appeared to have good relationships with all grades of medics, including General Practitioners (GPs) who referred surgical emergencies to her for admission. She highlighted that the post had been in place for 18 months prior to her commencing and that all members of the healthcare team and GPs had been involved in the setting up of the surgical service and thus agreed the role of the SNP. It was worth noting that her role did not overlap with other medics therefore it could be said that this role did not threaten the role identity associated with medicine.

This was reiterated by Nuala (SNP) who worked in oncology, who was observed whilst undertaking a clinic. During the course of the observation, she interacted with four consultant medics and all displayed overt behaviours with no covert meanings noted. In her follow up interview, I probed her on the relationships she had with junior and middle grade medics. She explained that there was no tensions with other medics, as her role had been set up to complement the consultants role in clinics and did not overlap with junior or middle grade medics work on the ward areas. Therefore, by not threatening medics' social and role identity, this led to less tensions for Nuala with her medical colleagues. However, I questioned if this had escalated the tensions noted with clinic nurses. As highlighted earlier, the interactions observed between Nuala and the clinic nurses were filled with covert meanings and tensions. A possibility was the co-created complementary role which Nuala had with the consultants had a large part to play in the covert meanings and tensions noted with clinic nurses. It reiterated that the clinic nurses' social identity and status in traditional team working had been shaken and threatened by Nuala's new status of complementing consultant medics.

I noted throughout the observations that overt behaviours with attached covert meanings emerged, which provided a new dimension in understanding the tensions described in phase 1 of my study. It appeared that both nurses and medics behaviours and actions were aimed to ensure that SNPs/ANPs should 'Know their Place' as a nurse. My observations indicated that the traditional co-created occupational structures between medicine and nursing were shaken by the SNP/ANP role and tensions were projected on a covert level.

4.6.5 Advanced memo- Phase 2

In phase 1, I hypothesised that the concept of social script appeared to influence service users' perceptions of playing a passive role in consultations. In phase 2, data reinforced this hypothesis as in over 70 interactions the processes and actions observed showed the service users playing a passive role. However, the data also revealed that only one SNP invited service users to partake in the decision-making process surrounding their care and treatment. This extended the concept of social script to SNP/ANP roles. Could it be that this was the social script learned in professionalisation?

Advanced memo- Phase 2 (continued)

The nursing curriculum focuses on communication skills and holistic care, however good communication skills do not necessarily provide skills in enabling decision-making (Rosenzweig et al. 2008). As care is a central concept to nursing, it may be perceived as uncaring to burden the service user with decision-making when they are unwell (Kennedy 2003). This was an area that required further exploration in the next phase. Did SNPs/ANPs have an awareness of Shared Decision-Making?

'Turf wars' were grounded in the data in phase 2, with SNPs/ANPs wanting to carry out the more "technical activities" whilst leaving the "mundane tasks" to other nurses, as the medics perceived the "technical activities" as their role and the "mundane tasks" as the role of the SNP/ANP. This builds on the social identity theory suggested in phase 1. The actions and behaviours observed in phase 2 highlighted that, as both medics and nurses had co-created professional roles and social identities, this formed the normative ways of working in a healthcare team. The behaviours suggest these co-created roles and identities were threatened and tensions escalated in a covert way.

The behaviours and actions observed in phase 2 verified that individuals in such roles were covertly treated with hostility and this promoted tensions within the healthcare team. The behaviours and actions were covert, such as nurses 'giving dirty looks' to the SNP indicating "why don't you do it yourself" and nurses' making tea and toast for everyone, except the SNP. On an overt level, nurses and medics appeared to accept SNP/ANP roles, however on a covert level they appeared to be threatened by these roles. Both nurses and medics behaviours suggested that individuals in such roles should 'know their place'. This led to me questioning 'what is their place'?

Given that the actions and behaviours observed in this phase illustrated that there were 'unclear expectations' between members of the healthcare team and those within SNP/ANP roles, how could such roles identify their professional social identity within the healthcare team?

This appeared to link to role theory, which is a complex mix of both psychological and sociological constructs and premise (Brookes et al. 2007). Central to the concept of role theory is the description of the behaviour, characteristics and norms and values of a position (George 1993). The two main theories in relation to role theory are social structuralism and symbolic interactionism (Murray 1998). As symbolic interactionism was central to my study, this theoretical perspective in role theory was deemed most appropriate to explore 'turf wars' in phase 2.

Advanced memo- Phase 2 (continued)

Symbolic interactionism was developed in the 1930's by theorists such as Mead, which emerged from the interest in relationships between mind, self and understanding human nature in relation to groups and society (Mead 1934). The individual plays a key role in this theory and is influenced by not only what is expected from the role, as in the structuralism approach, but also influenced by others behaviours and expectations. This led to the question if expectations are different, how could SNP/ANP roles successfully integrate into a role within the normative ways of working in the healthcare team? In addition, what affect were the negative covert behaviours having on SNP/ANP roles? The process of preparation for a professional role can be labelled professional socialisation (Ajjawi & Higgs 2008). Professions are occupational groups with specific responsibilities (Cant & Higgs 1999). However, what were the specific responsibilities of SNP/ANP roles? If there were different expectations how could they undertake preparation for this role? Stern (2006) suggested that key to professional socialisation is setting clear expectations. Do the professions of medicine and nursing have different expectations than the SNPs/ANPs?

I believed that further exploration of this element needed to be carried out in the next phase, to ascertain if SNPs/ANPs could identify if there were differences in their own and others expectations of the role. If there were differences in expectations, did this play a role in the covert behaviours/meanings observed in phase 2, as such roles disrupted the normative ways of working in the healthcare team

4.7 - Introduction – Findings – Phase 3

It was acknowledged that in order to complete the aims of my study, it was necessary to ascertain SNPs/ANPs interpretations on their interactions with the healthcare team and service users. I believed this would provide a deeper understanding surrounding the tensions created by SNP/ANP roles. This section presents the findings from phase 3 of my study. The categories from both previous phases were integrated into data collection as reported in Chapter 3, to re-focus my lens and continue to build a deeper picture surrounding the overall aims of my study.

4. 7.1 Population and Sampling

Names and contact details for all SNPs/ANPs within a large urban acute NHS Board were ascertained from the Directorate of Nursing in April 2009, via the Scottish Information Services Division (ISD) data. The sample was drawn from SNPs/ANPs within these roles across four acute hospital sites in 2009. As outlined earlier the chapter, it appeared that there were two types of SNP/ANP roles within my study. One was deemed “complementary” (Clinical Nurse Specialist - CNS) and the other ‘substitution’ (Nurse Practitioner - NP in title). The sampling strategy, as discussed in Chapter 3, was consistent with the CGT method and data collection took into account the two types of role, in addition to gender. As data were analysed and codes emerged, this informed the subsequent sampling of participants.

Due to the complexity of setting up focus groups with different titles across a wide geographical area based on coding, this process took three months. All focus groups were set at different times and each acute site was utilised to facilitate the groups to maximise participation. Due to the nature of such roles, they all had clinical commitments and on one particular day there were a number of “no shows” and this led to a paired interview being carried out. The focused codes and categories which emerged at the end of phase 3 generated from the focus groups and paired interview, led to an emerging core category. This was followed up through individual participant verification interviews for further clarification and consensus to aid in identification of saturation and development of the core category.

In total, 6 focus groups (n=27) were undertaken, a paired interview (n=2) and five individual interviews (n=5). In total 34 participants were interviewed as part of phase 3 of my study (Table 6). The focus groups, paired interview and individual interviews lasted on average 1 hour 20 minutes.

4.8 Overview of Core Category

The core category of 'status games' emerged at the end of phase 3 within my study. The focused codes and main categories from previous phases, also informed this core category. The focused codes which emerged at the end of phase 3 included 'The game plan', 'Nurse-SNP/ANP game', 'Doctor-SNP/ANP game', 'Service user-SNP/ANP game'. The following section's will provide a discussion on the focus codes which underpin the core category of 'status games'. These are presented and supplemented with group extracts from focus groups, in addition to individual's quotes within different focus groups. Data from both paired and individual interviews are also incorporated. Data from "Ya -Ya boxes" are illustrated which further illuminate the interpretations of SNPs/ANPs.

4.8.1 The game plan

All the Ya Ya boxes illustrated the stark difference between others expectations and individual SNP/ANP expectations of their role (Appendix 5). The main differences illustrated were that others expectations centred on meeting targets and medical management. In contrast, individual SNP/ANP expectations focused on professional development as a key part of their role. Professional development was not seen as an expectation of the healthcare team. I questioned if this was a 'game plan' which was out of the healthcare teams awareness, as a means of protecting the social and role identity of each profession, thus maintaining established ways of working for both nursing and medicine. This game plan would ensure such roles would not receive professional development and successfully socialise into the new role. It would be impossible for SNPs/ANPs to fulfil the expectations of their role without the associated preparation and development. This subconscious game plan linked to the tensions that unclear expectations created for individuals within such roles as illustrated by an extract from focus group 2.

Linda *"I think there's still no understanding of our roles, despite the fact that we've got a lead nurse from the senior management"*.

Zara *"I think the isolation bit, very much when I started six years ago, because I was managed by someone who wasn't even a nurse... they didn't know or even care what I did"*.

Charlotte *"I'd like to have a definite plan, a plan of where I was going and where the service was going, what they expected of me because I am just going along blind with no support or development it's scary"*

Focus group 2– page 2 (phase 3)

I questioned that if by not having a 'definite plan' for such roles, this protected the co-created established ways of working between medics and nursing in the healthcare team. There was also a lack of professional socialisation into these roles, and little supportive infrastructure, which linked to a game plan in protecting co-created social identities and established ways of working of both occupations. The impact and prevalence of professional socialisation in nursing has been reported on widely (Wilson & Sartup 1991; Du Toit 1995; Murray 1998; Gray & Smith 1999; Gerrish 2000; Fagerberg 2004; Mackinstosh 2006; Mooney 2007; Brookes et al. 2007; Furaker 2008). However, I found that there was a paucity of literature regarding role transition and professional socialisation in NP roles, with authors recommending further research (Brown & Olshansky 1997; Glen & Waddington 1998; Hayes 1998; Wade 1999; Griffen 2004; Steiner et al. 2008).

Much of the literature surrounding role socialisation and transition into such SNP/ANP roles has been undertaken in North America. In North America, the majority of states have a professional register for NP roles, in addition to a core curriculum undertaken over a 2 year period, inclusive of clinical placements (Woods 1997; Smithson 1999; Towers 2005). In some states, they also incorporate a collaborative model, which ensures that the NP role is complementary to other health care professionals' roles, whilst maintaining a nursing identity. The North American role socialisation and transition literature surrounds initial socialisation into such roles commencing with the student NP role in university and practice placements and moves onto describing professional socialisation on graduating (Brown & Olshansky 1997; Towers 2005).

This is in contrast to the UK, where there is not a single definition for an SNP/ANP and no professional regulation, thus a lack of consistency surrounding expectations of an individual undertaking this role (Woods 1997). There is also a lack of consistency in levels regarding SNP/ANP education and it is recognised that some SNP/ANP roles may undertake training whilst in the workplace and therefore do not have the status of being a student during the transition from registered nurse to an SNP/ANP.

I found this was similar to individuals within my study. All SNPs/ANPs did not have a set time for formal training or education within a university setting, incorporating clinical placements. They were successful in application for the post and then described identifying their initial learning needs with their nursing manager. This was consistent in phase 3, across all SNP/ANP roles. The SNPs/ANPs were allocated to work alongside a medical mentor for a period of time and learned through experiential learning. All appeared to be given different amounts of time to undertake the required training. Some undertook a module or training day/s to enable them to undertake the role. This method of transition and socialisation was described by all SNPs/ANPs as difficult, with a number of personal and professional tensions and challenges. As illustrated by Meadhran in focus group 1:

“At first when you had all this knowledge pouring in. I wasn’t really exposed to anyone I could ask about it, there was no other nursing staff I could ask about it, and when you’re in with the consultants, you know that in the outpatient clinics they only have five minutes per patient, they just go ‘bm, bm, bm, bm, bm’ And it’s very difficult to get answers to your questions, I must have thousands of things rattling about in there ...”

(Meadhran- focus group 1- phase 3)

All SNPs/ANPs outlined that there was no time given for socialisation into such roles, they had to “*get on with the job*”. I would argue that this may have been a way of ensuring such roles did not succeed and was part of a subconscious ‘game plan’, by nurses and medics to protect the normative way of working. It was difficult for SNPs/ANPs to get on with the job due to different expectations which continued to evolve and whilst they may have established a role within two years, this changed due to service needs.

Brennan & McSherry (2007) assert that professional socialisation occurs over an unspecified timeframe. During this timeframe behaviour changes, in relation to ability, identity, role and relationships and the concept of transition is a successful change. One could challenge if such transition and socialisation was successful with SNPs/ANPs within my study, as it appeared that the “hybrid role” did not have social or role identity due to the differences in expectations described by participants.

SNPs/ANPs in phase 3, outlined that within their ‘hybrid role’, they were lonely and many of them worked in isolation. However, all the SNPs/ANPs received some support from medical mentors within clinical practice. However, tensions and conflict were present due to differences in medical and nursing training and a lack of understanding of what was required from the mentorship role. This was illustrated by focus group 1:

Meadhran *“Especially when you’re working with the consultants or registrars, as house officers or SHOs come onto wards, they can just go off, be shown how to do this and there’s a do one, see one, teach one medical model thing. And I think very much that my line manager’s [nurse] into everything being competency based, and you’ve got to have it ... supervise your practice, all signed off, all the i’s dotted, t’s crossed. Whereas something like the registrars, they just do it. They are teaching me and don’t understand why I need to do this.”*

D’ griz *“There is a difference between accountability as an individual nurse practitioner verses the medic on the part of your employers. There’s always going to be a conflict”.*

Focus group 1- page 5 (phase 3)

A number of studies exploring professional socialisation of nurses highlight that a role model can influence beliefs surrounding the role and thus shape behaviours (Wilson & Startup 1991; Du Toit 1995; Gray 1997; Brennan & McSherry 2007; Mooney 2007). I found little research or papers reporting the impact of having a role model or mentor from a different profession for example between nurses and medics. Whilst a lot of research surrounds mentorship across nursing, little guidance is available for mentorship across professions (NES 2009).

As Gray & Smith (1999) outline professional socialisation happens through interaction with individuals within clinical practice and that the role of a mentor is crucial within this process. Quinn (2000) reiterates this view and asserts that mentor supervision promotes the development of professional attitudes, which affects the skilled interaction with service users' and members of the healthcare team. In my study, as highlighted in phase 1, middle grade medics did not want to mentor SNPs/ANPs, however ended up taking on this role. This could again be linked to a subconscious 'game plan'. In addition, interactions in phase 2, suggested that such medics believed that SNPs/ANPs should undertake 'menial tasks', which raised a question surrounding the effectiveness of such a mentorship process with unclear expectations between SNPs/ANPs and medics. Hunter & Walsh (1999) debates the appropriateness of having a medic as a mentor and calls for further research on mentorship across professions. Davies & Lynch's (2007) discussion paper indicates the importance of ongoing collaborative supervision from both nurses and medics as part of the socialisation process.

All SNPs/ANPs in phase 3, highlighted the challenges in obtaining support when in such posts, thus questioning if the socialisation process was being subconsciously sabotaged to fulfil 'the game plan'. The lack of support by their direct line nursing manager was highlighted in all focus groups, as illustrated by the SNPs/ANPs in focus group 4.

Alison "We don't have anybody that we report to, as it were. You're expected to just ... deal with it"

Jane "Manage your own caseload, and be autonomous and ... I'm line managed by someone in *** [name of city] who's miles away ... But if we had a problem, there's nobody that we can speak to, but generally speaking there's no one ... from a nursing ... from a person point of view we don't, immediately .. but with patients I'll go back to discuss with the consultant on call "

Alison "Me too"

Focus group 4 – page 19 (phase 3)

It appeared the differences in expectations between medical staff within clinical practice and nursing managers inhibited the socialisation process and played a role in the lack of development opportunities as outlined by focus group 3, thus ensuring such roles did not threaten the normative ways of working between medicine and nursing.

Sarah *"We have a bit of a dichotomy in that, because the [nursing] management side's very reticent to let us go, but the medical side are insistent that we take on the new responsibilities what to you do, management won't let you do training"*

Susan-Carol *"The medics now want us to go further and progress, however we have resistance from senior management and senior nursing within the area because we're establishing a job which we've now fully established". "The medics are extending our role but we have no funding to get the training for this and it's sad that I have to say it's nursing that's holding us back"*

Focus group 3- page 33 (phase 3)

Whilst SNPs/ANPs identified their learning needs initially when new in post with their manager, they described a dichotomy, as all individuals highlighted that the current nursing management structure did not know what was appropriate for their ongoing development. This was compounded by budget constraints, as their medical consultant would see the benefit of ongoing development to meet the extra responsibilities being taken on due to organisational pressures, whilst their nurse managers would not. This appeared to cause tensions as medics would have liked SNPs/ANPs to develop the service, however without the necessary training and nursing management backing, they were at times unable to engage in service developments. As focus group 2 illustrated:

Charlotte *"I know the consultant I work with has got big ideas in how he wants to progress and can be quite unrealistic with what he's expecting of me. Do you just want to go and do nurse-led clinics?" He says, because our clinic's getting so busy now, patients are waiting months and months for appointments. So that's his plan but then I've got a whole training to do for that, I can't just go and do the nurse-led clinics, I have to go through training so It's a bit daunting."*

Linda *"I think one of the problems is these jobs were all ... people were all put in place, there's no clear plan as to how the service would develop..."*

Elizabeth *"It's very much self driven. We're a bit like you in that the consultant would like this post to go further but it's almost that there's nothing in place to take it further. I think there needs to be a senior nurse somewhere in the management who looks after us."*

Focus group 2-page 22 (phase 3)

This was again reiterated by Erin in focus group 5:

“Ours is the same, it just evolved. I think it causes frustration to the medical staff, if they want to see our role develop and take on new tasks, I think it causes frustration that they then have to go to the nurse manager. And the nurse manager doesn’t understand what we do, whereas the medics do. And that’s caused a lot of frustration at the moment.”

(Erin-focus group 5-phase 3)

Again this was consistent within the follow up interviews.

*“Yeah, I think our consultant, ***, [name] he’s always been very supportive but he can’t really say that I can have time off, it’s more the nurse manager”*

(Freda-individual interview-phase 3)

It appeared that the socialisation of SNPs/ANPs into the healthcare team was complex with a number of elements playing a role. There was no specified transition period for such SNPs/ANPs to enable a successful socialisation into the role. Challenges were evident in regard to the mentorship and role modelling, seen as key for successful socialisation into such roles. The collaborative support of both medics and nurse managers was not apparent as both had different expectations of the role. It was also demonstrated in most of SNPs/ANPs’ Ya-Ya boxes that training and development within their current role was their expectation, however this was not what others expected for individuals within these roles. Others expectations centred on meeting targets and undertaking medical elements of care. Therefore, the socialisation process necessary for the development of role and social identity was not in place I questioned if this could be part of a game plan?

These roles had a background in nursing and were undertaking medical activities and this had led to their professional social identity consisting of an amalgam of identities with participants’ describing themselves as in a “hybrid role”. As described by Kathleen:

“You’re almost a mid between a nursing structure and a medical structure. You’re midway between. There’s almost a feeling because your role is no longer in the traditional nursing role, you’ve stepped away from that. It’s almost like you’re neither. It’s a hybrid role”

(Kathleen-individual interview – phase 3)

This imposed inconsistent demands on SNPs/ANPs and threatened the co-created professional social identity of medicine and nursing. Therefore, this escalated tensions and conflict with the values, beliefs, norms and behaviours inherent with both professions. It became clear during phase 3, that there were issues with the reporting infrastructure as the nurse manager did not always know what SNPs/ANPs actual responsibilities were as the role had evolved to meet the organisational pressures. As illustrated by Katie in focus group 6:

“...they’re soon going to employ the fourth nurse practitioner, but to employ them they don’t have the job description sorted out so they asked us to update and she [NM] looked at it and said, ‘You don’t do all of those do you?’ (Laughter). Three months ... exactly it’s been three months in her office and she can’t get her head round it, how the job has evolved”

(Katie-focus group 6 – phase 3)

As also illustrated by Jake:

“...The last time I went to ask for something they [nursing manager] didn’t know they were my manager. So I had to prove that they were my manager and then try and prove the worth of what I was doing”

(Jake – Individual interview – phase 3)

As nurse managers were unaware of the role of the SNP/ANP this translated to most not receiving an annual appraisal to aid in personal development. As illustrated from an extract in focus group 6.

Wanda *“Our boss has said she can’t give us an appraisal...on our clinical bit.”*

Queenie *“She said she can’t give us an appraisal.”*

Katie *“It’s interesting though, who would do it? A medic should do an appraisal or the nursing ... should do. It’s somewhere in the middle isn’t it?”*

Focus group 6 – page 35 (phase 3)

It appeared that the unclear expectations, lack of professional socialisation into the new role and support was part of a subconscious game plan of ensuring such roles did not threaten the established rules of working between medicine and nursing.

4.8.2 Nurse and SNP/ANP Game

Tensions with nurses were identified in phase 1 of my study. Where these tensions were most apparent was the threat such roles created to the social and role identity of registered nurses. In phase 2, the overt behaviours and covert meanings that emerged reiterated that SNP/ANP roles threatened the nurse's identity, which was co-created with medicine to build the normative ways of working in the healthcare team. All SNPs/ANPs confirmed these findings in phase 3 of my study. Many examples were given of ongoing covert tensions towards such roles from registered nurses. As highlighted by SNPs/ANPs in focus group 3.

Sarah *"...you're not visible to everybody and there has been comment made before that, 'Are you elitist?' I suppose in some ways it is professional jealousy because you're doing something that's an extended role, or is it people saying you're going beyond where you should because you're stretching the boundaries of the team".*

Susan-Carol *"Our medics want us to go into HDU, ITU and because that is seen as the elitist... the medics want us there, but the nurses don't."*

Focus group 3 – page14 (phase 3)

As part of the focused code in phase 2, 'knowing your place' I observed that within an outpatients department the nurses made a cup of tea and toast for the medics, but not for the ANP, despite running the same clinics. I questioned the covert meaning attached to this behaviour as it appeared that clinic nurses were highlighting that the SNP/ANP should know their place as a nurse. As I only observed this once and to aid in trustworthiness of data collection, focus groups were asked to comment upon this. I found it surprising that most SNPs/ANPs experienced the same behaviours, with covert meanings particularly in outpatients across different hospitals, some examples were:

"Yeah I run a nurse-led clinic and they don't make me tea, but they do for the doctors. So, yeah. And they're very ... I think in the ward situation, especially when I was new to the post, it was very much, 'Who does she think she is?' They did not actually say that, its just...they'd smile and give you that look..."

(Anne –Focus group 4 - phase 3)

Thus indicating on a social overt level they smiled, however on a covert level the 'look' they gave Anne projected "*Who does she think she is?*"

Whilst Jake outlined:

"Some older nurses have felt I'm getting above myself so they don't think it's appropriate that I should be acting like a doctor, sometimes. There's still a hangover, the way I get treated, we all see patients in clinics, the doctors get the bloods put in the bags and taken away for them, and I have to do my own bloods. Just little things like that, but 'He's just a nurse"

(Jake-Individual interview-phase 3)

This verified the covert meanings and crux of the tensions such roles created with registered nurses. As Jake stated, he was just a nurse, therefore should know his place and not expect the same level of help as a medic would receive as this was an established way of working. Florence (ANP) and Katrina's (SNP) extracts below from the paired interview illustrated the same behaviours, with attached covert meanings.

Florence *"Like clinic nurses, because ... you do get some nurses that have been in clinic since the day they qualified and have never ... and they do have a very different relationship with the consultants and doctors that they work with."*

Katrina *"I would agree and I would say that I've seen that happen. I would say that it still happens."*

Florence *"They probably were old school and they'd grown up in ... where it was ... doctors and nurses (Gestures with hands showing doctors higher than nurses). And you didn't ... and a nurse entering into that world didn't ... and it still happened in some respects, nurses fudging the boundaries."*

Katrina *"I've seen it in a busy surgical outpatient clinic. And if the nurse hadn't been organised, if she had her own patients and hadn't organised the x-rays or the notes, there's no way somebody would go and find them for her, despite her having 10 patients to see outside, she would have to make ... go in between her patients and go and get those notes. And it would just be per chance if she got a cup of tea when everybody else got a cup of tea."*

Paired interview – page 8 (phase 3)

This overtly showed the established hierarchy in the healthcare teams, particularly in an outpatient setting. Nurses did not perceive SNPs/ANPs to be of equal standing of a medic in the healthcare team.

Therefore SNPs/ANPs did not receive the same support from nurses as a medic, and through such behaviours illustrated the covert meaning of knowing their place in the healthcare teams' way of working. This co-created order of hierarchy was described in ward situations in all focus groups. As illustrated by Linda and Erin :

"I do think the bit that nurses are hard on nurses is probably quite true. And I think it does go back to the hierarchy of nursing. I would never ask some other nurse to look for case notes that I can look for, but sometimes they don't even lift their head off the desk, whereas if you were a medic I think it would be different. But I still think that sometimes they're maybe not ... willing to help"

(Linda-ANP-focus group 2- phase 3)

"...We kind of get the cold shoulder and, 'Who do you think you are?' I think they think you're trying to be one up on them and you're better than them, but you're not,"

(Erin-SNP-focus group 5- phase 3)

The above verbatim illustrates behaviours of ignoring or giving the "Cold Shoulder" to SNPs/ANPs illustrating the covert meaning of knowing their place as a nurse. As SNPs/ANPs highlighted, nurses would not treat medics like that as this was part of the accepted established ways of working. In phase 3, it was illustrated that unlike other phases the SNPs/ANPs may take the view that they are above nurses in the social hierarchy of the healthcare team. This was illustrated in the words used to describe nurses in outpatients by some SNPs/ANPs, as Pet's individual interview demonstrated:

"Well in my experience it's mainly nurses who work in outpatient clinics. Sorry, I'm trying to be diplomatic, because it's ... For the most part they're skivvying after doctors, with no extra training so making them tea and toast, yeah fine no problem"

(Pet- SNP-individual interview-phase 3)

This brought to mind a picture of clinic nurses lacking experience, as they had been working there since they qualified with little further development, whilst running after medics. This was an interesting analogy as subconsciously the game playing is continuing, with SNPs/ANPs perceived as higher up or better than the clinic nurses, in part playing the traditional role of a medic.

This appeared to be linked to SNPs/ANPs having a higher status due to their extra education and more autonomous role, which was not running about after medics. As Freya illustrated her fellow SNP carried out this game playing within the ward areas.

“I’ve been there when one of my colleagues has gone up to the ward and she’s quite ... she’s a bit like, ‘I’m like a doctor and you’re only a nurse.’ It’s that sort of attitude that I think she’s got.”

(Freya- Individual interview – phase 3)

Whilst Alison went on to describe the importance of having a higher status than the staff nurses within the ward areas.

“Because when you go to the wards and you assess the patients and then you go and speak to the people who are looking after the patient, it’s easier if you’re slightly higher, because they seem to give you that respect. It’s just about people feeling you are a certain grade because you’ve earned it because of your knowledge and skills”

(Alison- focus group 4- phase 3)

In phase 3, the nurse-SNP/ANP game emerged and confirmed where the tensions existed as described in phase 1 and verified that the game consisted of both overt and covert levels of game playing between registered nurses and SNPs/ANPS.

4.8.3 Doctor-SNP/ANP game

The traditional role of the nurse was perceived as subordinate to that of a medic (Tabak & Koprak 2007). This was alluded to in phase 2, within the focus code of ‘know your place’, where it was found that both junior and middle grade medics’ behaviours with SNPs/ANPs highlighted that they should know their place and status as a nurse. This inferred that the SNPs/ANPs should know they were below medics in the status order within the healthcare team. As with previous data, Katie in focus group 6 and Susan-Carol in focus group 3 highlighted that after the initial transition period, consultants finally accepted the role, and preferred to liaise with the SNP/ANP rather than a junior medic.

“We’ve been there longer and the doctors come and go, they’re kind of a mobile population crowd, and we’ve been there, we know the system, how it works, so they rely a lot on what we have to say”

(Katie- Focus group 6-phase 3)

“When the consultants appear in the ward, it’s a nurse practitioner they go to and ask to review the patients, and they ignore the doctors”

(Susan –Carol-focus group 3 – phase 3)

A view I considered was if the consultant who has the most authority, thus status in the hierarchy of the healthcare team was asking an SNP/ANP to review the service users and ‘ignoring’ the medics this could have challenged their identity and status. This may have led to behaviours and overt meanings from medics asserting their social standing and status within the team by asking SNPs/ANPs to undertake menial tasks. I found it interesting that some SNPs/ANPs accepted the subordinate role on a covert level, however if this was acknowledged overtly this would increase tensions between medics and SNPs/ANPs. As Meadhran and D’griz in focus group 1 illustrated:

Meadhran *“ I still see very much, it’s the doctor, then the nurse an it’s the unsaid rule. I don’t have an issue with that. If someone said, ‘You’re a nurse, and I’m a doctor, and you’re below me,’ I would have an issue with that. So that’s the difference. We don’t outwardly say it.”*

D-Griz *“We have to be realistic. They’ve got a medical training that we don’t have, so they are higher up and that’s life”*

Focus group 1- page 3 (phase 3)

This was further verified by Alberto (SNP) in a follow up interview when he stated:

“It’s a hierarchy and it’s historically a hierarchy. The nurse-doctor relationship, it’s very much been that they [medics] would expect the nurses do it and nurses that have been nurses for many years are trained to just do it, kind of thing. And I suppose maybe that’s the way the nurse practitioner gets what they want as well, by getting an easy life from the consultants. So I just go along with it. You’ve got to accept that...I’m still subservient to the consultant because she’s in charge of the patient, kind of thing”

(Alberto - Individual interview – phase 3)

Some SNPs/ANPs agreed with Meadhran in focus group 1 that this was the “*unsaid rule*” and was the reality of practice, as nurses were below the medics in hierarchy. This linked to McCoppin & Gardner’s (1994) sociological view of the Nurse-Doctor game. They argued that the historical differences between nurses and medics based on class, gender and social standing were accepted by both parties. A number of authors suggest that submissiveness associated with nursing was central to the routine enactment of the higher status of medicine (Stein 1967; Stein et al. 1990; Warelow 1996; Porter 1999; Jansky 2004; Tabak & Koprak 2007). Medicine was perceived as the highest status in the hierarchy of the healthcare team, with the associated knowledge base to make decisions, whilst nurses carried out instructions. This led to the seminal work of Leonard Stein, termed the doctor-nurse game (Stein 1967). He illustrated that such differentials between the two professions led to indirect communication and game playing. Whilst Stein recognised that there was indirect communication this was not analysed in his work. Whilst in my study, I found that there was indirect communication, this was linked to the covert meanings attached to behaviours displayed by medics, which appeared to be associated with status.

Both types (substitute and complementary) of SNP/ANP role reported tensions working with both junior and middle grade medics, as outlined by Sarah in focus group 3.

“I’ve been in my job for ten years and I think a lot of these new roles depend on where it came from. If it’s enforced by management you get a huge amount of resistance from the medical staff because it’s imposed on them. But it’s getting your foot in the door, the acceptance of such roles with different levels of medics including GPs takes years. But I think it’s also driven by the consultant’s need for you”

(Sarah -NP – Focus group 3- phase 3)

The initial transition period was difficult for SNP/ANP roles that were perceived to be forced upon medics. Despite these roles being set up due to a shortage of medics, such as HAN, both junior and middle grade medics were described as displaying behaviours with overt meanings.

As elaborated on by Jemima an SNP in HAN in focus group 3, when she stated:

“I sometimes find that young women find us quite ... I don't know if it's intimidating but we're good at what we do, we know our job very well and sometimes we can work with a wee bit of resistance”. Because some of the juniors will say, ‘Do my bloods, do this, do that.’ And often we just say, ‘Get it yourself. We're doing it together, but were not handmaidens”

(Jemima – focus group 3- phase 3)

Kathleen expressed the same views, regarding medics expecting SNPs/ANPs to undertake menial tasks:

“Oh there's a nurse practitioner there.’ They [medics] still expect the nurse practitioner to do the running, to do the menial tasks for them, instead of them just doing their own bloods and ECGs, they'll go and seek out a nurse practitioner who's consulting, and say, ‘Would you do X, Y and Z’. In actual fact, we're an independent care provider and should be doing our own consulting, our own workload, managing our workload, and the doctor should be managing his”

(Kathleen- Individual interview – phase 3)

The behaviours of requesting SNPs/ANPs to undertake ‘menial tasks’ appeared to contain the covert meaning of putting the SNPs/ANPs in their place as a nurse's and one of sub-ordinate to the medics. This element of being a subordinate to a medic by undertaking menial tasks was also identified as “others expectations” within the Ya-Ya boxes. As with phase 2, it was also illustrated in phase 3 that whilst the SNPs/ANPs had been accepted by senior medical staff following a transition period, which could take up to 2 years, junior doctors who rotated, created tensions when working with such roles. SNPs/ANPs highlighted that this was due to an overall blurring of the occupational hierarchy, which threatened the status in medicine as illustrated by Wanda.

“I think the whole medical profession itself has undergone so much change in the last six ... there's bound to be threat and worry, or concern about where are they going to fit in this expansion”

(Wanda- focus group 6- phase 3)

The interpretations from SNPs/ANPs elaborated upon data generated in phase 1 and 2 of my study. The participants suggested that junior and middle grade medics was where most tensions to such roles existed. Wanda, like many in phase 3 made the point that there had been so much change in the NHS which may have contributed to medics feeling threatened. This appeared to escalate the tensions due to SNPs/ANPs taking on more activities associated with medicine. The junior and middle grade medics' status was threatened due to the blurring of where SNP/ANP roles integrated with a medics identity. As outlined in the extract below,

Rosie *"I've quite a lot of dealings with junior doctors and I have had, when I'm maybe advising about a script or something, I've had a slight sort of resentment or that they know better. But they've only done that once. I think it might be a lack of understanding of what my role actually is, in some respects, so I will give them that."*

Jill *"And is it kind of the new doctor thing, insecure and threatened by us, so I'll be ... difficult."*

Erin *"Yeah, we get them less and less but we do get junior doctors and some of them, I think, like to think they're better, or higher than you are, but they'll only do it once".*

Focus group 5 – page 7 (phase 3)

The data in phase 3 not only further illuminated the overt and covert interactions from medics, it also outlined the responses from SNPs/ANPs. As Erin (extract above) states *"...but they'll only do that once"*. SNPs/ANPs who had been in post for a number of years would challenge any behaviour perceived as medics putting them lower down in the social standing within the healthcare team. This was emphasised in the following extract from SNPs/ANPs in focus group 6:

Sylvia *"I eventually said to him, 'What did your last slave die of? I'm here to do a job not run your errands.' And he was quite taken a back. And I said, 'No, nurses aren't handmaidens. I know that's what you want but you're not getting it"*

Wanda *"Yeah, I don't hear clicking fingers actually, just keep going until somebody goes, 'Nurse' and then I ..."*

Sylvia *"Yeah I would just ... if somebody expects me to go get something I'll tell them where to find it, and carry on ..."*

Babs *"We've got a consultant who's probably quite near to retirement and he will occasionally click his fingers or his head will come out the door and you'll get, 'Nursey!' But it's almost tongue in cheek, because you know ... you just do the same back so it's almost become a kind of game in some ways."*

Focus group 6- page 15 (Phase 3)

Stein et al.'s (1990) follow up work regarding the doctor-nurse game found that nurses were playing a more assertive role with medics, due to increased education and the feminist movement. Stein et al. also reported that whilst nurses were no longer playing the traditional 'game', a number of medics were still trying to engage in this dysfunctional activity. This appeared to be the case within my study and SNPs/ANPs were being assertive and playing the role of ignoring or challenging overt behaviours with underpinning covert meanings. I questioned if this linked to the role of SNP/ANP, as most outlined they were no longer a 'mere nurse', therefore would not play the subservient role for medics. This indicated a shift in the established ways of working, whilst SNPs/ANPs covertly acknowledged they were lower down the status hierarchy they would not overtly play this role. This data indicated that there was the breaking of traditional ways of working, whilst the SNP/ANP was perceived covertly to be below the medic in social ranking of the hierarchy, they were covertly above the "wee nurse". As suggested by Anne in focus group 4:

"Yeah, the hierarchical thing ...introducing me to a new team, he always used to say, 'And this is Dr. so and so.' Like that was the compliment! By thinking that calling you doctor is a ... because there's also the implication that .. You couldn't actually rise to that level, but you're so much better than just a wee nurse"

(Anne - Focus group 4-phase 3)

This indicated that the medics may have covertly interpreted the SNP/ANP role as above a staff nurse in the healthcare team hierarchy, as they had further education. Therefore, as SNPs/ANPs had more knowledge than the 'wee nurse' this increased their social standing and status within the healthcare team. Charlotte in focus group 2 appeared to share such interpretations, when she stated:

"... A third year medical student shadowed us and the number of reports that I get back saying, 'I didn't know nurses did this, this and this. I thought the doctors made all the decisions and the nurses carried them out.'.... We are different to ward nurses we make the decisions"

(Charlotte -Focus group 2 –phase 3)

She considered those within SNP/ANP roles were not merely carrying out medics instructions, but making decisions, thus having a higher social status within the healthcare team. This focused code built on the categories 'professional tensions' (phase 1) and 'turf wars' (phase 2) SNPs/ANPs elaborated upon the tensions with medics. They illustrated that they would challenge medical instructions, unlike their previous role as a nurse where they would comply with such requests. On a covert level Jemma highlights "*they learn pretty quick; they need to make friends with us*". Similar to Phase 2, there appeared to be overt and covert messages within the transactions between medics and SNPs/ANPs. As Jill outlines,

" ... it's kind of the new doctor thing, insecure and threatened by us, so I'll be difficult".

In other words, on an overt level she may be pleasant however on a covert level she has decided she is going to be difficult. The result in this game playing, appeared to be that the SNPs/ANPs would become assertive, as outlined in the paired interview.

Florence *"Some of the surgeons aren't happy with me because I won't bow to them and I won't be their little handmaiden. That's not our role and so they see what I'm doing with the CNS role and its not as they envisaged. Because for years they've been there, they've snapped their fingers and somebody's gone running. And that's not happening anymore so. And it is almost like a power thing"*.

Katrina *"I think it depends what the nurse specialist goes in and dictates on what it is she will do, what her role is, what the surgeons would expect from a nurse specialist and I don't think that is what a nurse specialist's role is. It's almost re-educating them. There is no structure or accepted set role of what a nurse specialist should do, so it depends on whoever's in that role and how they develop that service and how they work in a multi-disciplinary team as well."*

Paired Interview – Page10 (phase 3)

I noted however the covert SNP/ANP responses appeared at times hostile. As Jill in focus group 5 illustrated:

“We certainly within our team don’t have that, because they learn pretty quick they need to make friends with us. They learn pretty quickly, that if they try and do that ... they’ll hang themselves.”

(General agreement and nodding – “They need to make friends with us”)

(Jill- focus group 5- phase 3)

This was consistent across phase 3. If junior or middle grade medics did not accept the increased social status of an SNP/ANP “*they’ll hang themselves*”. The doctor-SNP/ANP game builds upon where tensions were described in phase 1. Participants verified that medics were threatened by the increased social standing and status of the SNP/ANP role. The overt and covert transactions illustrated in phase 2 were elaborated upon with SNPs/ANPs reporting that medics would request them to undertake ‘menial tasks’ to ensure individuals within these roles understood their place and status in the hierarchy of the healthcare team. In phase 3, SNPs/ANPs illustrated that they too responded in this game on a overt and covert level, trying to assert their new status in these extended roles.

4.8.4 Service User- SNP/ANP game

This focused code built upon the category ‘Traditional belief systems’ in phase 1 where it was described that service users played a passive role in decision-making. It also illuminated the category of ‘Shared Decision-Making’ in phase 2 where it was found that SNPs/ANPs did not invite service users to participate in decision-making. In phase 3 it was identified that SNPs/ANPs overt behaviours may have underlying covert meanings that would reinforce service users to play a passive role in decision-making. Coulter & Ellins (2006) highlighted that the traditional model of decision-making assumes that the health professional and service user have the same goals. In this model the health professional would ensure the service user was informed and involvement would consist of them providing consent. This is a very paternalistic approach which is outdated given the movement towards a person-centred NHS service (DOH 1999; 2000; 2004 a & b; SEHD 2006a; SGHD 2007).

This approach was outlined by Alberto in phase 3:

“...I think, sometimes, all health professionals think, ‘Ok somebody’s vulnerable here, let’s fix them, let’s give them something”

(Alberto- Individual interview –phase 3).

Coulter & Ellins (2006) make the valid point that whilst service users’ want information, it does not necessarily mean that they want to participate in decision-making processes. As discussed in earlier sections the body of literature surrounding decision-making focuses on three levels of participation: the passive role; a collaborative role; or an active role in the decision-making process (Florin et al. 2008). Several authors acknowledge the paucity of research surrounding NPs style of communication and thus the implications on service user outcomes such as participation in decision-making.

They acknowledge the requirement for further research (Lawson 2002; Berry 2006; Charlton et al. 2008). The data in phase 2, outlined the steps in SDM and a retrospective analysis inherent with the constant comparative method, highlighted that only one ANP undertook steps in SDM (Figure 10 page xxxx). I questioned if this was related to the status of SNPs/ANPs, as they had the specialist knowledge, which at times was not shared with the service user to enable an informed decision on treatment.

The three approaches to decision-making, paternalistic, collaborative and shared were evident across the focus groups and interviews in phase 3 of my study. Similar to phase 2, a small number of participants (n=4) in phase 3 discussed the SDM process. In focus group 1, the male SNPs/ANPs illustrated a paternalistic method of consultation, highlighting consent as the main component of SDM.

Meadhran *“... And I suppose it is meant to be an agreed decision.”*

D’griz *“You’re not going up to patients saying, ‘You’re going to have this done to you, you’re going to have that’ ... You’re saying, ‘This is what I think’s going wrong, and I’m going to do this, and I’m going to do that.’ You’re always looking for feedback when you’re saying things like that to a patient, you know.”*

Meadhran *“99.9% of interactions are shared, just not overtly. You say ‘I don’t know if you want to pop up there on that bed and just lie down and I’ll do this thing to you. If there’s no ‘Why’ or ‘No’, they get up, so that’s a decision, you’re not forcing them on to it. But we do that all the time.”*

Focus group 1 – page23 (Phase 3)

I questioned whether participants in focus group 1 had an awareness of SDM processes. Some of the literature suggests differences in gender can play a role in control (Ely & Padavic 2007). As these SNPs/ANPs were male, I debated whether this affected their ability to share control of the decision with the service user. However as Simpson (2009) points out this viewpoint is highly speculative as there is little empirical research to justify the differences in gender and application of sharing control. A female ANP also shared this paternalistic view of SDM.

“But it’s ... patients understanding, ultimately, the benefits perhaps of what you’re suggesting. ‘This is how this ought to be treated,’ or ‘This is what perhaps you should consider.’ And very often patients say, ‘Thanks I was thinking that myself.’ But you’ve got to be very careful that you’re not there just saying you will do this!! (bangs on the table), ‘This is what you will do! .They don’t want to make the decision. They want somebody to care for them, or somebody to just take it out of their hands”

(Kathleen –individual interview- phase 3)

Kathleen described what course of action she would suggest to the service user. She maintained that service users’ do not want to make decisions as they want someone to care for them. I questioned how Kathleen knew that service users did not want to make a decision. On an overt level Kathleen described being a ‘caring’ nurse, however I would argue that the covert meaning attached to this is discounting the service user’s ability to make a decision. This does not empower the service user to become involved. I found this was a traditional view held by some SNPs/ANPs in my study. As Kennedy (2003) asserts it is perceived as uncaring to burden the service user with decision-making when they are unwell. Thus through this traditional viewpoint, SNPs/ANPs on a covert level are not providing the opportunity for the service users to decide if they want to be part of the decision-making process.

The SNPs/ANPs in focus group 3 appeared to have some awareness into the importance of involvement and outlined some of the stages required for a SDM, which appeared to be the collaborative approach to decision-making. The following extract from the focus group outlined the complexity of elements that could have an impact on SDM processes.

Jemima. *“I always try and involve the patient, I give them a bit of choice”*

Susan-Carol *“They think that you’ll deal with it all for them. And I suppose it is a level of skill in identifying that, what level do they want”.*

Nellie *“If the patient is really breathless, they want you to make them less breathless, they don’t care how you get there, at that point”.*

Jemima *“If a patient’s acutely unwell, a patient isn’t involved in the decision at all... But if your patient’s well, I always try to involve them, I always ask them what they want. I always try to give them a choice. So shared decision-making for me is involving the patient and other members of the team”.*

Sarah *“I have had some really difficult consultations because the patient has decided they want surgery, and you know it’s not the right thing for them. And obviously you’re not going to give them the surgery, but it’s trying to get them round to the thinking like this”.*

Focus group 3 – page 27 (phase 3)

In the above extract, Nellie pointed out that if a service user was acutely unwell, they would prefer you to address the situation. This would be expected, as the role of any healthcare professional is to protect the wellbeing of the service user in an emergency situation. Jemima reiterated this point and suggested that where service users are not acutely unwell, she would involve them in the decision-making process. However, I would debate what she perceived as ‘involvement’.

Whilst Susan-Carol stated the important element was identifying what level of participation a service user would like in the decision-making process, she identified that many did not want to be involved and it is important to ascertain an individual’s preference for involvement. As found in phase 2, the importance of ascertaining the level of participation a service user would like is paramount in SDM. This was reiterated by Alberto in an individual interview, which indicated his awareness surrounding empowering service users, so that they can become involved in the SDM process.

“So some patients love that they’ve got this choice, when other patients turn round and say, ‘Well you tell me what to do.’ But people are feeling vulnerable, you’ve got to try and empower them, so that the nurse practitioners see that patient as an individual. It is difficult when the patients are vulnerable and you’ve got to support them as best you can”

(Alberto- individual interview –phase 3)

In contrast, Jake suggested that some service users wanted him to tell them what to do. He did not highlight an awareness of trying to empower individuals to become involved in decision-making. As Castledine (2009) reported if a health professional does not have the awareness of the importance of empowering individuals to become involved this can reduce the participation in decision-making. Therefore on an overt level he describes that he is happy to tell them what to do as this is what they want. However on a covert level he is not inviting them into the process and is reinforcing the traditional passive role in decision-making.

“But every patient’s different as well, and some people just want you to tell them what to do, and they do like to be dictated to. I’d maybe try to discourage that, but I’d be happy to do it, if that’s how they want the relationship to be”

(Jake- individual interview – phase 3)

Hubbard et al. (2008) suggested that the association of factors such as age, gender, level of education, marital status, socio-economic status and health status with preferences in decision-making were inconclusive. This was discussed by SNPs/ANPs in focus group 4.

Jane *“I try to constantly reinforce it by saying it ... choice. I give the patients options, and informed options and ... across the board as far as possible just say, like patients who want to stay home, not going into a hospice, and things like this, it’s about choice... if you allow them to feel as though they’ve got some sense of control, when they have none because of their disease.”*

Alison *“And taking time. It’s the time, that’s the big thing”.*

Anne *“And having that more collaborative relationship that’s central to nursing, rather than doctors who do struggle with involvement, they say, fix it.”*

Alison *“Especially the older generation would be, they think, ‘Oh the doctor thinks this ... so that’s what I need to do.’ So whereas somebody thirty, forty years younger they would say that...”*

Jane *“They’d challenge”.*

Alison *‘Well thanks for your advice, and I’ll think about it.’*

Jane *“It is changing isn’t it.”*

Focus group 4 – page 22 (Phase 3)

Focus group 4 suggested that the older generation maybe would not challenge the medics due to the status associated with the authoritative figure of a medic. As Wanda highlighted in focus group 6:

“I think with some patients there’s sort of the consultant’s still ‘The man’ the person who is god...”

(Wanda –focus group 6-phase 3)

However in phase 1, service users highlighted that they would not question any health care professionals’ not just medics, highlighting the historical learned passive behaviours linked with social script. Overall, there was a lack of awareness from SNPs/ANPs on the interpretation of SDM processes with many discounting the ability of service users to make decisions. Finlay (2006) reiterates this point, that with this learned historical practice, the service users, would come into hospital environments with a guided ‘script’ on how they were to behave, which would include not to ask questions. As hypothesised in phase 1, this appeared to link to social script. In phase 2, over 70 interactions confirmed that service users played the passive role. However, SNPs/ANPs appeared to be unaware and in some instances reinforced this passive role.

It appeared that unless probed to ask questions by a skilled practitioner, the service users’ may not engage in the decision-making process, thus reducing the likelihood of sharing a decision about their care. This was reiterated by Davis et al. (2008) who found that service users were unwilling to ask questions unless directed by the health care professional, illustrated by Charlotte and Linda in focus group 2,

Charlotte *“I think the older generation are still wanting the doctor to make the decision, but things are changing and I’m dealing with a lot more younger patients.”*

Linda *“It probably isn’t changing as much as it should. I think it’s very much still, if you come in as a patient, you are dictated to ... unless you challenge it, which I think a lot of people are now. But not everybody’s able to do that, or feels able. If you’re feeling vulnerable you’re not able to do that”.*

Focus group 2 – page 17 (phase 3)

Linda outlined that *“if you come in as a patient, you are dictated to...”* highlighting that service users are not provided with the opportunity to share decisions surrounding treatment. This was similar to phase 2 where most service users were only given one course of action. Sepucha (2004) reported the extent to which treatment choices are consistent with service users’ values have been frequently studied, and they argue that this should be the primary outcome of decision-making process. However, a focus group outlined that it was medics who made the decisions in most cases, not the service user. They indicated that due to their interpersonal skills, learned in their previous role as a nurse, they had the skills to inform the service users on the implications of decisions. As illustrated in the extract from the focus group 2.

Charlotte *“The consultant makes the decisions, so then I have to go and speak to the patient about it. And if they’ve got any concerns, then I’ll go straight back to him. whereas maybe they wouldn’t have voiced those concerns to him, but they would to me.”*

Emma *“It goes back the old problem isn’t it, always through nursing it’s communication.”*

Zara. *“Because I find patients come away, they haven’t a clue. A decision has been made, you say, ‘What’s going to happen?’ They can’t tell you what surgery the child’s having, for example. But I think if a nurse is there then you ... as you say, you’re the advocate”.*

Emma *“I must admit on a ward round if it does happen and you can see the patient ... and I will always go back afterwards and say, ‘Did you understand what the doctor told you?’ And sometimes they’ll say, ‘Yes.’ And one probing question will come back with, ‘No you didn’t.’ And then I’ll sit down and talk them through it again.”*

Focus group 2 – page 12 (phase 3)

Whilst the SNPs/ANPs were going back to explain the decision, it does highlight that the service users were not part of the process. Whilst they can provide information regarding the decision to the service user, I questioned why the SNPs/ANPs did not intervene at the time the decision was being made, to include the service user. For example, why did Emma go back after the ward round, instead of intervening during the ward round? It appeared that medics ‘told’ the service users about treatment, whilst the SNP/ANP went back to ‘explain’ the decision. The service user did not have involvement in the decisions. These overt behaviours illustrated that both the medics and SNPs/ANPs were not inviting the service user to be part of the decision-making process.

On a covert level this was reinforcing that service users were expected to play a passive role which I would argue is associated with the status of being a healthcare professional. A particular focus group moved on to discuss how the service users who “*challenge*” or even question a decision are labelled. The SNPs/ANPs appeared to be uncomfortable with service users who questioned via email, or attended and appeared to be informed prior to consultation, which would enable them to make a decision. This could be that they were not playing the traditional passive role thus threatening the status of the SNP/ANP, as illustrated from an extract from focus group 2.

Charlotte *“And they’re often put down as difficult patients, but we’ve got a few and he’s constantly ... emails me, constantly asking about his medication all the time. It does take up a lot of your time, he isn’t the only patient and he is branded a difficult patient.”*

Zara *“The ones that come in with printed things off the internet and this is what my child has got. And they’ve diagnosed before they even see the doctor.”*

Emma *“But we don’t just go steaming in there and say, ‘This is what’s happening.’”*

Elizabeth *“But every patient’s different some question it, some don’t, some just sit there and say, ‘Right if that’s what’s to happen for the next six hours then that’s fine.’”*

Emma *“And you can’t even say in our case it’s an age thing, because you can get really stroppy teenagers and you can get really stroppy fifty year olds. And other teenagers have had such a fright when they see us, that they just say, ‘Yeah get on with it, just do it.’ So it really is a case by case scenario.”*

Linda *“I think it sometimes depends on the patient’s past experiences as well.”*

Elizabeth *“You can see that with patients, some patients are just going to totally accept what you say has to happen. And others just won’t and they take up your time”.*

Focus group 2 page18 (phase 3)

Emma highlights these service users as “*stroppy teenagers and you can get really stroppy fifty year olds*” illustrating that it is not just related to age. SNPs/ANPs did not like it when service users were informed through other methods. This also could be linked to status, which results from individuals’ authority and resources to ‘help’ service users (Proctor 2002).

Whilst Elizabeth outlined *“patients are just going to have to totally accept what you say has to happen”*. I would argue that on a covert level this indicated that some SNPs/ANPS liked the control in decision-making as this reinforced their status of being the healthcare professional. As Broom (2005) reported healthcare workers disempowered service users by limiting their involvement in information exchange and ability to make choices, based on information they attained prior to the consultation. This was further verified by Edwards & Edwards’ (2009) Meta study which illustrated that health care professionals need to be more receptive to informed service users, to build a mutual relationship enabling shared decision-making.

Only four participants in phase 3 highlighted an awareness surrounding the steps and processes inherent with SDM. Three of these practitioners worked within oncology services, similar to the ANP observed in phase 2, who implemented the steps of SDM. All of these practitioners had undergone extra training, which indicated the potential benefits of raising awareness surrounding SDM in a SNP/ANP curriculum. McQueen (2000) reports that most believe that nurses will be gifted with good interpersonal skills, which may not be the case. According to Cronenwett et al. 2009 a host of literature suggests that as SDM is a relatively new concept, consideration should be given to incorporating this into the SNP/ANP curriculum to build an awareness of the learned behaviour with covert meanings which has long been established in the healthcare system.

4.9 Development of Core category – Status games

The core category of status games was constructed from all data and memos within my study. I would use the analogy of peeling an onion, each phase within the study was like a layer which was peeled away to discover the core category. In phase 1, the category of ‘traditional social beliefs’ illustrated that service users had a traditional view of medics and nurses roles, in addition to learning that their role was to be passive in decision-making processes. This was linked to social script theory where service users had learned these ‘traditional belief systems’ from the wider society. Another category which emerged in phase 1 was ‘professional tensions’. It was identified that where tensions were created by SNP/ANP roles was threatening the social identity of both registered nurses and medics.

Memoing, at this stage revealed the link to social identity theory, where it was found that when a group's social identity is threatened group lines are drawn more sharply and differences are accentuated to protect the group's identity. This led to increased tensions for SNP/ANP roles with both nurses and medics.

In phase 2, the category of 'Shared Decision-Making' provided a deeper understanding surrounding 'Traditional belief systems' (phase 1) as in over 70 interactions service users had with SNPs/ANPs, they played a passive role in decision-making. It was noted that only one ANP actively invited the service user to play a role in the sharing of decisions. This was linked to social script theory and raised the question of whether SNPs/ANPs had an awareness of the processes associated with shared decision-making. In phase 2, the category of 'Turf wars' provided a new dimension for understanding the 'professional tensions' described in phase 1. In phase 2, I suggested that both medicine and nursing had co-created professional roles and social identities which formed the normative ways of working. The behaviours observed suggested that these co-created social identities were threatened and tensions were projected on a covert level. Role theory was used to explore the data and this raised the question on what was the SNPs/ANPs identity in this co-created way of team working?

In phase 3, the final layer discovered 'status games' which incorporated a game plan and different games which were associated with tensions played out across all data. These games emerged at the end of phase 3, where it was found that whilst these incorporated registered nurses, medics, service users and SNPs/ANPs all had overt and covert levels associated with status. Status is a "complex concept, encompassing one's position and degree of authority within a social order" (Whitehead 2007: 1012). I proposed that this was attached to both medics and nurses professional roles and social identities within the occupational order of the healthcare team.

4.10 Advanced Memo 4 – Phase 3

At the end of phase 3 it was discovered that all data linked to game theory. A number of different theories are employed in game theory in relation to communication. Mathematical game theory classifies human behaviour in terms of cooperation and competition (McCabe et al. 1996; Sonnerberg 2005; Kruger & DiDonato 2010). In cooperation, players' work together to reach a common goal, whilst in competition they fight each other to reach their own goal. Whilst the data does link to mathematical game theory, due to the overt and covert messages grounded in the data, social psychological game theory was the most appropriate theoretical lens as it provided a unique understanding surrounding the processes and actions grounded in the data. Social psychological game theory involves an ulterior transaction where two messages are conveyed at the same time. One is on an overt (social) level and the other is on a covert (psychological) level. This is carried without the individuals' awareness (Berne 1968). On revisiting all data and employing this lens, it led to a number of games being identified across all data. This built up a picture of the social psychological games termed 'status games' with ulterior transactions. Vandra (2009) highlights that by recognising ulterior transactions, and bringing these into awareness, can prevent games and the associated problems with communication.

The next chapter will explore the ulterior transactions associated with status games, which is new to the international literature. It will also discuss a new concept of professional script which it is hypothesised underpins the processes and actions inherent within the status games, which were grounded in the data.

Chapter 5

Emerging Theory, Discussion & Conclusion

5.0 Introduction

This chapter provides a discussion on how the theory was constructed within the interpretive paradigm tradition of CGT. The connection between all data is provided in order to clarify the process underpinning the findings and underpinning theories. As advocated by Charmaz (2006; 146) I continued to “delve into implicit meanings and processes” in the data. The use of cluster and advanced memos, diagrams, tables and reflective journal enabled me to move forward with the theoretical analysis. As part of the interpretative stage, a large amount of new literature was also reviewed to provide a deeper understanding of the processes grounded in the data (Charmaz 2006). Social psychological game theory and underpinning script theory literature, which is part of the Transactional Analysis (TA) paradigm, provided the theoretical lens to interpret what was grounded in the data. The key literature from TA has been included in this chapter to provide the reader with an illustration of how the theory evolved during the interpretative stage.

5.1 Core Category

The goal of grounded theory is the generation of a theory which emerges around a core category (Glaser & Strauss 1967; Glaser 1978; Corbin 1986; Struass 1987; Struass & Corbin 1990; Glaser 1992; Eaves 2001). Several authors report that neglecting to ascertain a core category in GT can lead to fragmented codes rather than an overarching integrated concept (Eaves 2001; Seale 2004; Atkinson & Delamont 2005; Dey 2007; Elliot & Jordon 2010). Whilst Charmaz (2006) does not make this explicit in her book, she highlights that her version is a contemporary revision of Glaser & Strauss (1967). She does describe her analysis through the terminology of the founders of Grounded Theory (Charmaz 2008). Therefore, an important step in this methodology was that a core category was discovered within my study. As Glaser (1978; 1992) outlines, if a core category is not established this can lead to a theory which is lacking relevancy and workability. Once I had created the categories within each phase, these were compared and contrasted and links were made to pull the theory together around the core category.

As illustrated in the previous chapter this was the case in my study. As reported, the establishment of the core category was not a passive process. I incorporated memos to aid in abstract analytical thinking and the constant comparative method incorporating new literature enabled me to actively engage with the emerging data. I also incorporated reflexivity throughout the research process as this provided me with a wider lens to take in an abstract view leading to the discovery of the core category.

5.2 The substantive emerging theory

Charmaz (2008) outlines that a theory is a set of relationships that provides an understanding of the phenomenon under study. Glaser & Strauss (1967) illustrate the different levels of theory building. A formal theory provides explanations across a range of situations, over a long period of time involving multiple researchers across different organisations (Goulding 2002). In contrast, a substantive theory is developed within a specific area or organisation and does not attempt to generalise. It aims to provide a foundation in which a hypothesis can be tested across a wider arena, thus leading to a formal theory (Glaser & Strauss 1967). In my study, one of the aims was to attempt to develop a substantive level of theory as the study was carried out in one specific organisation with underpinning cultural aspects.

The data suggested that status games are being played out of awareness¹⁶. It is suggested that by bringing these status games to a level of awareness, this would reduce tensions with SNP/ANP roles. I propose that this new theory, which is grounded in the findings, could be tested across organisations to aid in further developing a formal theory. The substantive emerging theory grounded in the data is that:

“The tensions generated by SNP/ANP roles stem from playing status games to fulfil professional script which requires to be recognised and acknowledged by the healthcare team in order to change the status quo and culture”.

¹⁶ In TA lanuage out of awareness means that individuals are not aware.

The following sections will explore the development of this theory, inclusive of the literature which provided the theoretical lens to interpret what was grounded in the data.

5.2.1 Advanced Memo

I found that it became apparent through the process of understanding social psychological game theory that this was one of many theories associated with Transactional Analysis (TA) theory. In order to develop a new deeper understanding from the processes within the data, it was necessary to understand different elements of TA. Berne (1963) reports that social psychological game theory incorporates both transactions and ego states. Ego states have two models which include a structural and functional model. The structural model is the internal psychic process (Berne 1963).

This model is used in individual psychotherapy, whilst the functional model illustrates how we use these ego states and is used to illustrate the transactions which underpin 'status games'. There are a number of different transactions in TA, social psychological game theory revolves around social (overt) and psychological (covert) transactions occurring at the same time, these are known as ulterior transactions. Berne (1963) states the reason people play games is to fulfil their individual life script. I propose the reason health professionals play 'status games' is to fulfil 'professional script'. All of these underpinning concepts and theories are presented in the next sections of this chapter to illustrate how this lens enabled the construction of my theory.

5.3 Final stage of Constant Comparative method – Interpretive theorising

Charmaz (2006) outlines the importance of re-entering analysis following the construction of core category. She suggests that this is an important element of CGT as it allows the researcher to work on the integration of all codes and categories, comparing them at an abstract level. This is part of the interpretive tradition associated with CGT. As Charmaz (2006:126) writes, "Interpretive theory calls for the imaginative understanding of the studied phenomenon. This type of theory assumes emergent, multiple realities, indeterminacy, facts and values as linked; truth as provisional and social life as processual". Thus within an interpretive view, theories are rhetorical¹⁷.

¹⁷ Theories are rhetorical – meaning theories are discovered

A constructivist approach acknowledges that the resulting theory is an interpretation (Bevir 2000; Bryant 2002; Charmaz 2000; 2002; 2006). As part of this interpretative approach, a number of theories were reviewed and some key theories from a Transactional Analysis (TA) Paradigm were employed. These provided the theoretical lens to develop the substantive theory from the data grounded in my study.

TA is a theory of personality which provides an illustration of how people are structured psychologically. It is also used as a method of analysis in communication, culture and organisational development (Balling 2005; Chevalier 2005; Kreyenberg 2005; Schmid & Messmer 2005; Vandra 2009). I would agree with Kreyenberg (2005) when she suggests that in TA, thinking is constructivist with a clear focus on interdependencies among self, society, culture, families, groups and organisations.

“TA contains many systemic constructivist assumptions that it could be called a systemic constructivist approach” (Kreyenberg 2005: 301). As highlighted in Chapter 3, this perspective also underpins the research methodology of this study. Therefore by employing this theoretical perspective, it complemented the research methodology in understanding the processes and actions associated with the tensions from SNP/ANP roles grounded in the data. Over the past decade, organisational TA has emerged which maintains a constructivist approach. Balling (2005) highlights that organisational TA has its roots in the original concepts and models in TA, whilst Kreyenberg (2005) illustrates that TA theories are interlocking as script theory includes games, game theory includes transactions and transactions include ego states models. The following sections will explore these interlinking theories and models as this informed the discovery of the substantive theory in my study.

5.4 Formation of theory – Ego States and transactions

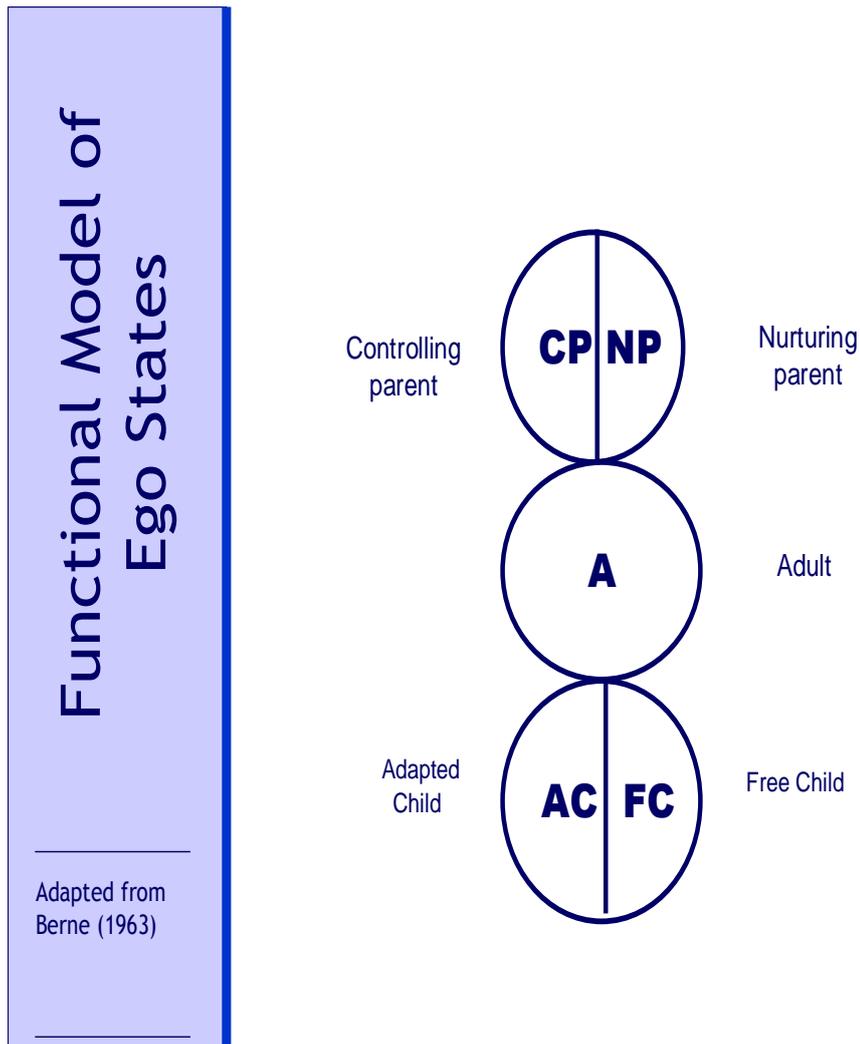
Social psychological game theory incorporates both transactions and ego states (Berne 1963). In TA, a persons' behaviour is best understood if examined in terms of ego states, whilst two or more individuals' behaviour is best understood in terms of transactions (Steiner 1990).

The ego-state model which has three parts provides an illustration of how people are structured psychologically, as well as detailing how people express their personality in terms of behaviour (Stewart & Joines 1987). Ego models are examined using two separate models, structural and functional (Kececi & Tasocak 2009).

Berne (1963) theorises that each person has three ego states, which include 'Parent', 'Adult', and 'Child'. He maintains that the underpinning principles of the structural model is that everyone carries their 'Parents' inside them, everyone has an 'Adult' and a 'Child' inside them.

This is the internal psychic process (Berne 1963). The functional model shows us how we use these ego states. As Stewart & Joines (1987) report the functional model is concerned with behaviours, thus underpinning processes of communication. In the functional model, the 'Parent' ego state is separated into the 'Controlling Parent' and 'Nurturing Parent'. The 'Child' ego state is separated into the 'Free Child' and the 'Adapted Child' and the 'Adult' in the functional model is not subdivided (Figure 12).

Figure 12 – Functional Model of ego states



The 'Controlling Parent' and 'Nurturing Parent' are the thoughts, feelings and beliefs that are learned from parents or parental figures (Berne 1963). In adulthood, the 'Controlling Parent' is when our behaviours entail a put down (discount) of the other person, - this is beyond our awareness (Stewart & Joines 1987). In adulthood the 'Nurturing Parent' appears when help is given that discounts the other person, for example when making decisions for a service user.

Whilst the 'Adult' in the functional model is not subdivided, the behaviour in this ego state is a response to the here and now situation, using all the individual's grown-up resources (Stewart & Joines 1987). The 'Adapted Child' is the part of the personality that develops from parental messages that were learned as we were growing up (Stewart & Joines 1987). In adulthood, in this ego state we behave to comply or adapt to fit in with parental or others expectations.

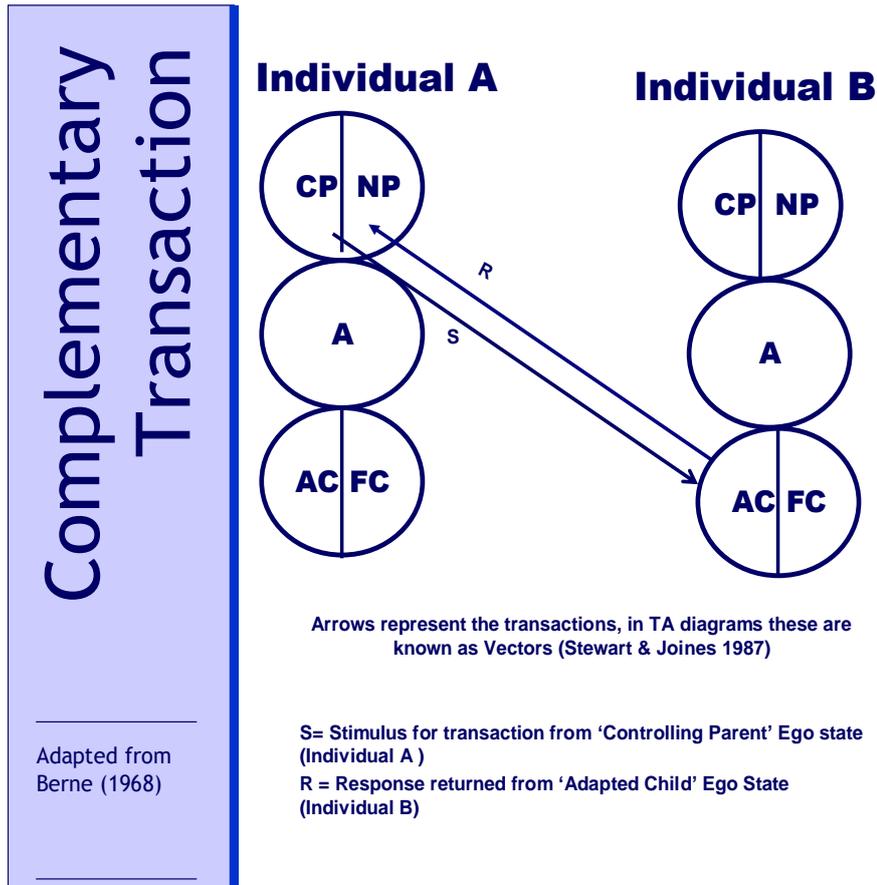
We may also rebel against others expectations however in TA this is also an 'Adapted Child' response (Stewart & Joines 1987). An 'Adapted Child' response is when we replay childhood patterns that are not appropriate to our current situation. An example would be adapting to the "unsaid rule" of nurses adapting to fulfil medics' orders. A 'Free Child' is spontaneous, does whatever they feel like doing and is active and creative (Berne 1963). However in 'Free Child' our behaviour can satisfy childlike 'Child' urges for example acting stubborn and deciding not to do something which is inappropriate in that given situation (Stewart & Joines 1987).

In TA, the communication process is comprised of transactions that contain a stimulus and a response between individual ego states (Berne 1988).

TA is concerned with diagnosing which ego state implemented or simulated the transaction and which ego state responded. There are three types of transactions 'complementary', 'crossed' and 'ulterior' (Berne 1968).

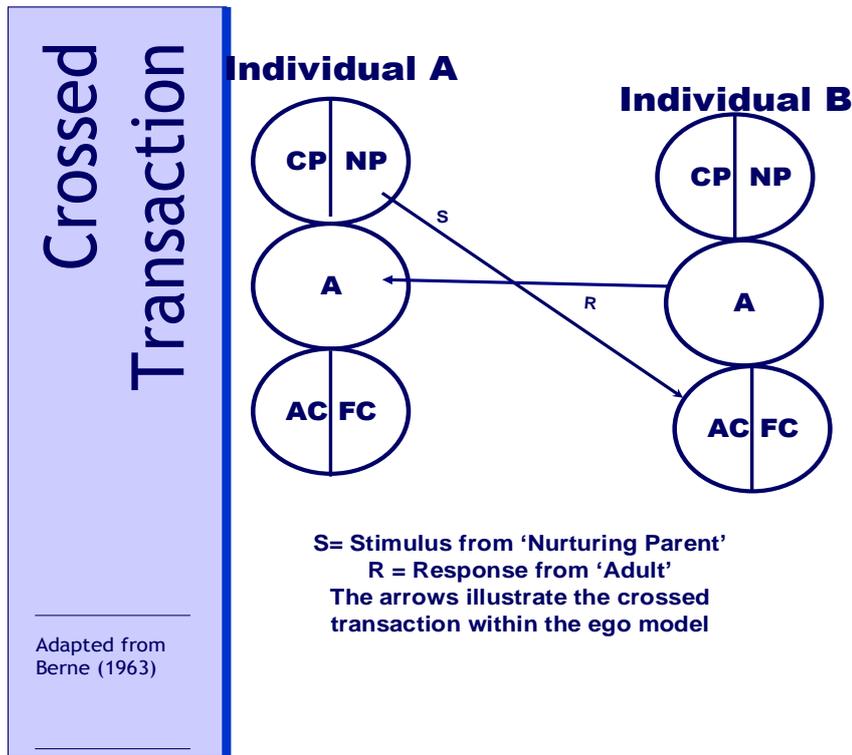
A complementary transaction is when an individual sends a message or stimulus from any ego state to another person and the other person responds from the targeted ego state (Berne 1968). Figure 13 (overleaf) highlights a complementary transaction. The message or stimulus came from the 'Controlling Parent' (Individual A) and the response was from 'Adapted Child' (Individual B).

Figure 13– Complementary Transaction



A crossed transaction occurs when a person sends a message or stimulus from any ego state to another person. The other person responds from a different ego state than the one being targeted (Berne 1968). Figure 14 (overleaf) highlights individual A stimulating a message from 'Nurturing Parent' looking for a response from 'Adapted Child'. However, the response from individual B is from 'Adult'. This is known as a crossed transaction (Berne 1968).

Figure 14 – Crossed Transaction



As indicated earlier, the last type of transaction is known as 'ulterior' and these are associated with social psychological game theory. Games entail an exchange of ulterior transactions between individuals. In games something different is happening on a covert psychological level than what appears to be happening on an overt social level. It is on the psychological level where "secret messages" are being sent, which is the true intention of the transaction (Stewart & Joines 1987:234).

5.5 Social psychology game theory

A number of typical features have been identified with games (Stewart & Joines (1987:233). These include the fact that "games are repetitive", which means that the context and circumstances of the game may change however the pattern of the game remains the same. Numerous examples of similar patterns were grounded in my data, whilst the context and circumstances were different across all three phases of my study. It is proposed that these patterns in behaviour suggest status games are repeated over and over within the organisation, ignited by SNP/ANP roles.

Solomon (2003) highlights that games are played out of our 'Adult'¹⁸ awareness and entails an exchange of ulterior transactions, as described earlier. This causes tensions for individuals, with a feeling of it has happened again. It is proposed that the traditional doctor-nurse relationship is based on ulterior transactions, thus is a game. The doctor-nurse game has been documented in the literature (Stein 1967; 1990 Reeves et al. 2009; Simpson 2009; Taylor 2009; Tjia et al.2009; Le Blanc et al. 2010). However, this literature does not employ the lens of game theory within the TA paradigm and thus my work provides a new and original perspective, not previously reported in the international literature as highlighted in Figure 15.

Figure 15 – Traditional doctor-nurse game

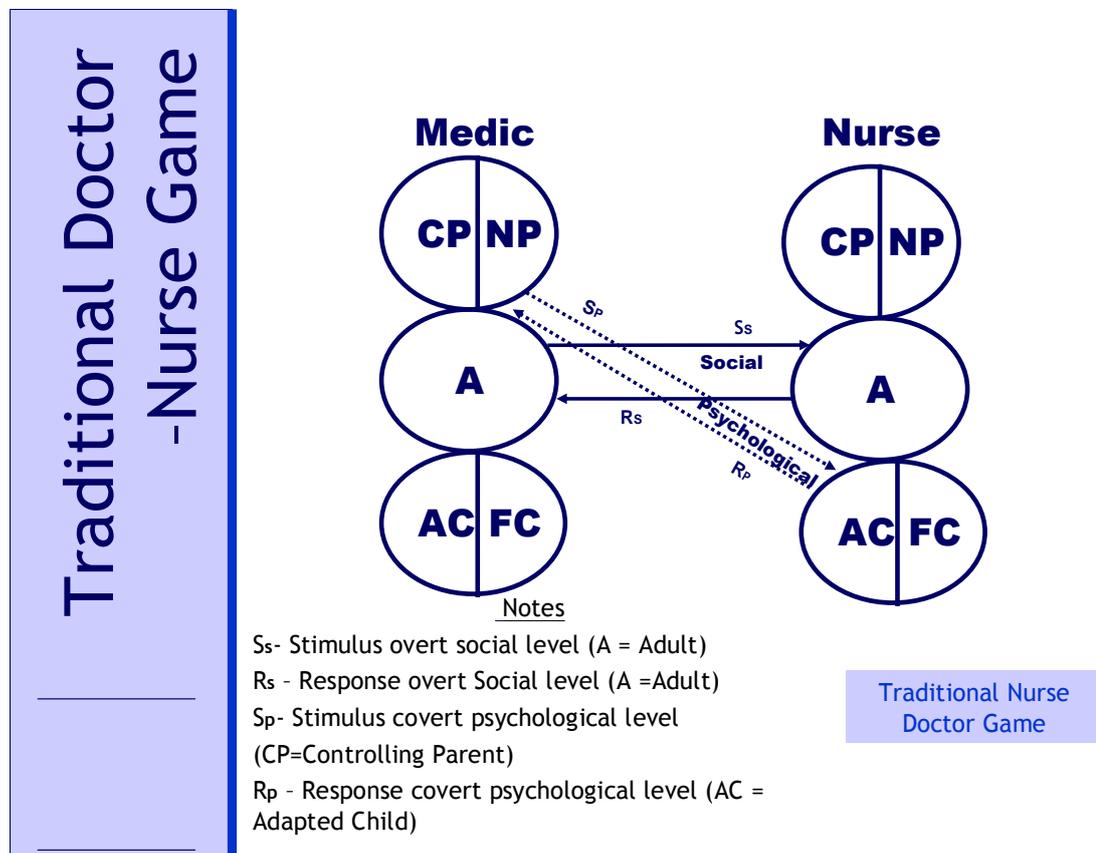


Figure 15 – using the concepts of ego states and ulterior transactions, the diagram illustrates my data showing the overt and covert transactions in the traditional doctor-nurse game.

¹⁸ In TA when something is out of 'Adult' awareness, it is termed to be unconscious

5.6 Foundation to status games – The “unsaid rule”

Employing game theory in the TA paradigm provides some understanding of the tensions with SNP/ANP roles, as it is proposed this traditional game is the foundation of status games. This links to the sociological healthcare literature where traditionally medics have had the sole responsibility for treating and diagnosing service users, with a higher controlling occupational status than nurses within the healthcare team. Nurses were perceived as lower down in the occupational structure, therefore playing a subservient role to medics (Currie & Suchomlinova 2004; Halford & Leonard 2006).

By using the TA ego state model and game analysis in Figure 14 (previous page) we can see that on a social or overt level, both the medics and nurses transactions are from the ‘Adult’ ego state. However, on a psychological or covert level, the medic stimulates the transaction from ‘Controlling Parent’ and the nurse responds from ‘Adapted Child’.

I propose that this relationship is based on the historical roots and co-created roles and social identities of the hierarchies within the two professions. As Berne (1968) suggests that the general advantage of a game is to maintain the homeostatic functions. This status game ensures that both medics and nurses maintain their status in the healthcare team. This also ensures that both medics and nurses know their place within the team. This is consistent with the literature surrounding conflict resolution between medics and nurses. It has been found that medics adopt authoritarian attitudes (in TA, Controlling Parent ego state) and nurses try and resolve this conflict through avoidance and adapting (in TA, Adapted Child ego state) to these attitudes (Barton 1991; Jones 1992; Skjorshammer 2003; Tabak & Koprak 2007; Miller et al. 2008; Mills & Hallinan 2009).

These games cause tensions between the two professions, as highlighted in the literature (Reeves et al. 2009; Simpson 2009; Taylor 2009; Tjia et al. 2009; Le Blanc et al. 2010). However, Tellis-Nayak & Tellis-Nayak (1984) found that whilst there is covert asymmetry between the professions of medicine and nursing, both elaborate social rituals that facilitate effective communication between them, without diluting the differences in status and authority.

In TA, rituals are a series of transactions programmed by external social forces (Berne 1968: 34). I suggest that the role of the medic and nurse are learned in professional socialisation, which maintains the status and social identity of each profession. I propose that with the historical background of both professionals, this has enabled these games to become ingrained in everyday relationships between medicine and nursing. In tandem, the social rituals between medics and nurses enable them to co-create professional roles and social identities. As illustrated by Meadran in my study (phase 3) this is the “unsaid rule”. It is proposed that the SNP/ANP role disrupted this covert or “unsaid rule” of the game and provided the foundation for status games, which was the core category within my study.

5.7 Status Games

The games identified within the core category of ‘status games’ in my study were nurse/S(A)NP game, doctor/S(A)NP game and service user/S(A)NP game. I have used an organisational TA perspective where theoretical game analysis has been employed to provide abstract and generalised characteristics of each of these games. This was to facilitate recognition independently of the verbal content or context. This was consistent with the CGT approach as theorising is not limited to individual actors or micro situations (Charmaz 2006).

Berne (1968) states that in game analysis the end product is the chief concern and what actually happens is always the outcome of the covert psychological level transaction. I propose that to enable a deeper understanding of behaviour and the underpinning processes of communication which creates tensions with SNP/ANP roles, we must, as Berne (1968) suggests, pay attention to the covert or psychological level of transactions. The following section illustrates the covert psychological level of transactions. Examples are provided from each phase of my study to demonstrate the patterns of behaviour within each game.

5.7.1 Nurse-SNP/ANP Game

In the nurse-SNP/ANP game, the nurses are civil to the SNPs/ANPs, however as illustrated in phase 1, there appeared to be ‘professional tensions’.

Through observation in phase 2, it was found that whilst they were civil, their behaviours illustrated covert messages indicating transactions that SNPs/ANPs should ‘know their place’. Both the overt and covert transactions were confirmed by SNPs/ANPs in phase 3. The ego state model illustrates both the overt or social-level transactions and the covert or psychological-level transactions (Figure 16).

Figure 16 – Nurse-SNP/ANP game

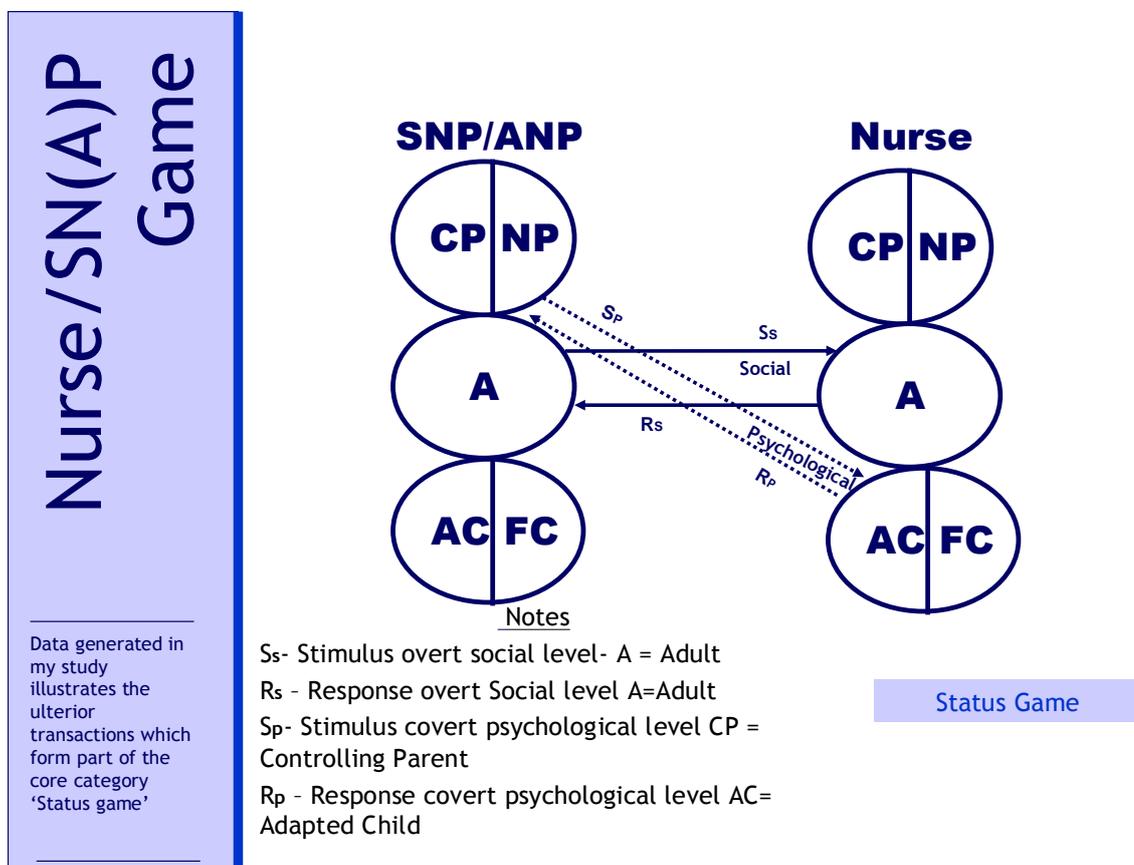


Figure 16 – using the concepts of ego states and ulterior transactions, the diagram illustrates the data from my study highlighting the overt and covert transactions in the newly recognised status game between nurses and SNPs/ANPs.

On a social level, the SNPs/ANPs were asking nurses to undertake treatment plans or for help in clinics/wards. The response was to carry out treatments or provide limited help in the clinics/wards. On a social level, it appeared that this was taking place in 'Adult'. However, on a covert level as the SNP/ANP was asking the nurse to undertake so called 'menial tasks', they were perceived as mimicking the medics. Therefore, on a psychological level, the covert stimulus of the transaction was from 'Controlling Parent'. Whilst this was traditionally a covert transaction between medics and nurses, this caused an escalation of tensions, leading to the nurses responding from a rebellious 'Adapted child'.

This was evident in behaviours such as making tea and toast for everyone except the SNP/ANP, thus rebelling against the practitioner role. This was reiterated in phase 3, by most participants as nurses would comply or help a medic but not the SNPs/ANPs. These patterns with underpinning communication processes were grounded in the data across all 3 phases of my study. Some examples from each phase from my study are illustrated below. In phase 1, medics illustrated the stimulus from a covert psychological-level identifying a key word of "telling" which provided the perception that the SNP/ANP were stimulating the transaction from 'Controlling Parent'. As both Fraser and George highlight,

*"The nurses say, who's this jumped up so and so coming and **telling** me how to do my job"*

(George- Foundation year 2 – Medic – phase 1)

And Fraser (Medic) further elaborated:

*"And I think nurses...are threatened by somebody new coming in and... who might **potentially try and tell them what to do**".*

(Fraser- Consultant Medic-phase 1)

Whilst the response on a covert psychological level was from 'Adapted Child' with "just shut up and give me the doctor" (overleaf) illustrating that whilst it was in most cases accepted that a medic's transactions were stimulated from 'Controlling Parent' it caused increased tension when this came from a SNP/ANP as they stemmed from the nursing profession and should "know their place". They were disrupting the "unsaid rules" of the game.

As Thomas illustrates:

“When they answer the phone, you’re just like ‘Just shut up and give me the doctor because that’s what I’m asking and I’ve made that decision because I’m the nurse here looking after that patient now”

(Thomas - Nurse-phase 1).

In phase 2, a number of interactions were observed which illuminated the ulterior transactions. The following extract from field notes illustrates the same pattern of the SNP asking a registered nurse to give pain relief. This was perceived as telling the nurse what to do, thus stimulating the covert transaction from ‘Controlling Parent’.

The nurse on an overt or social-level took the kardex indicating she would do this, however at the same time responded on a psychological level from ‘Adapted Child’. This was manifested through the look described below and this caused tension between the nurse and SNP/ANP.

Following assessment and clinical examination of the patient, the ANP outlined to a medic that the lady required pain relief. She took the drug Kardex to a medic to write up some morphine. She then walked over to a staff nurse, gave her the drug Kardex and asked if she could give the lady some pain relief and to set up a bag of fluid.

The *look* the nurse gave her was one of “why don’t you do it yourself”. However she did not say anything, and proceeded to carry out the instructions.

(Extract of field notes -Jessie-ANP-observation 4 – phase 2 - pg 3)

The next extract from field notes highlighted that the nurse smiled at Nuala, therefore was pleasant on an overt social level. On a covert psychological level however the nurses did not help Nuala during the clinic. This again highlighted the covert psychological level message of the ‘know your place’ transaction.

The interactions with nurses in the clinic appeared strained. It was observed that they let the medics know when results or x-rays had returned, so patients could be seen. However, Nuala spent time searching for the results and x-rays of patients she had reviewed. The nurses seemed attentive to the medical staff, however smiled at Nuala.

It was a busy clinic, Nuala and the medical staff did not take a tea break that morning. The clinic nurses made tea and toast for all the medical staff, including themselves, however did not do this for Nuala.

(Extract from field notes-Nuala –Observation 2 –phase 2-page 5)

This status game was confirmed by most SNPs/ANPs in phase 3. Examples are provided below which illustrate similar patterns of the covert transactions with SNPs/ANPs stimulus from 'Controlling Parent' ego state and nurses responding from the ego state of 'Adapted Child'.

"Some older nurses have felt that I'm getting above myself so they don't think it's appropriate that I should be acting like a doctor sometimes. There's still a hangover, the way I get treated, we all see patients in clinics, the doctors get the bloods put in the bags and taken away for them and I have to do my own. Just little things not outwardly said but it's like he's just a nurse".

(Jake- individual interview- page 5 – phase 3)

"They [clinic nurses] are old school and they've grown up in...where it is doctors and nurses (gestures with hands showing doctors higher than nurses). And what you get with nurses like us entering into that world is a lack of respect because we are fudging the boundaries".

(Florence –paired interview– phase 3)

Jill and Sarah provide examples illustrating that SNPs/ANPs were disrupting the "unsaid rules" of the traditional game. This appeared to threaten nurses' status in the co-created professional roles and social identities between medics and nurses.

"We kind of get the cold shoulder and 'who do you think you are?' You think you're special, you think you're better than anyone else. I think there is quite a bit of a niggle about the title 'specialist' because of the status".

(Jill SNP- focus group 3-phase 3)

"...there has been comment made before 'Are you elitist'? I suppose in some ways it is professional jealousy because you're something that's an extended role or is it people think we're going beyond where we should because we're stretching the boundaries..."

(Sarah SNP –focus group 3- phase 3)

5.7.2 Medic-SNP/ANP Game

In the Medic-SNP/ANP game medics described tensions with SNPs/ANPs in phase 1. In phase 2, it was found that medics acknowledged the SNP/ANP however their behaviours illustrated that SNPs/ANPs should "know their place". The overt and covert transactions which were observed in phase 2 were confirmed and further elaborated upon by SNPs/ANPs in phase 3.

The ego state model below highlights the overt social level messages and the covert psychological level messages within the doctor-SNP/ANP game (Figure 17).

Figure 17 – Medic-SNP/ANP game

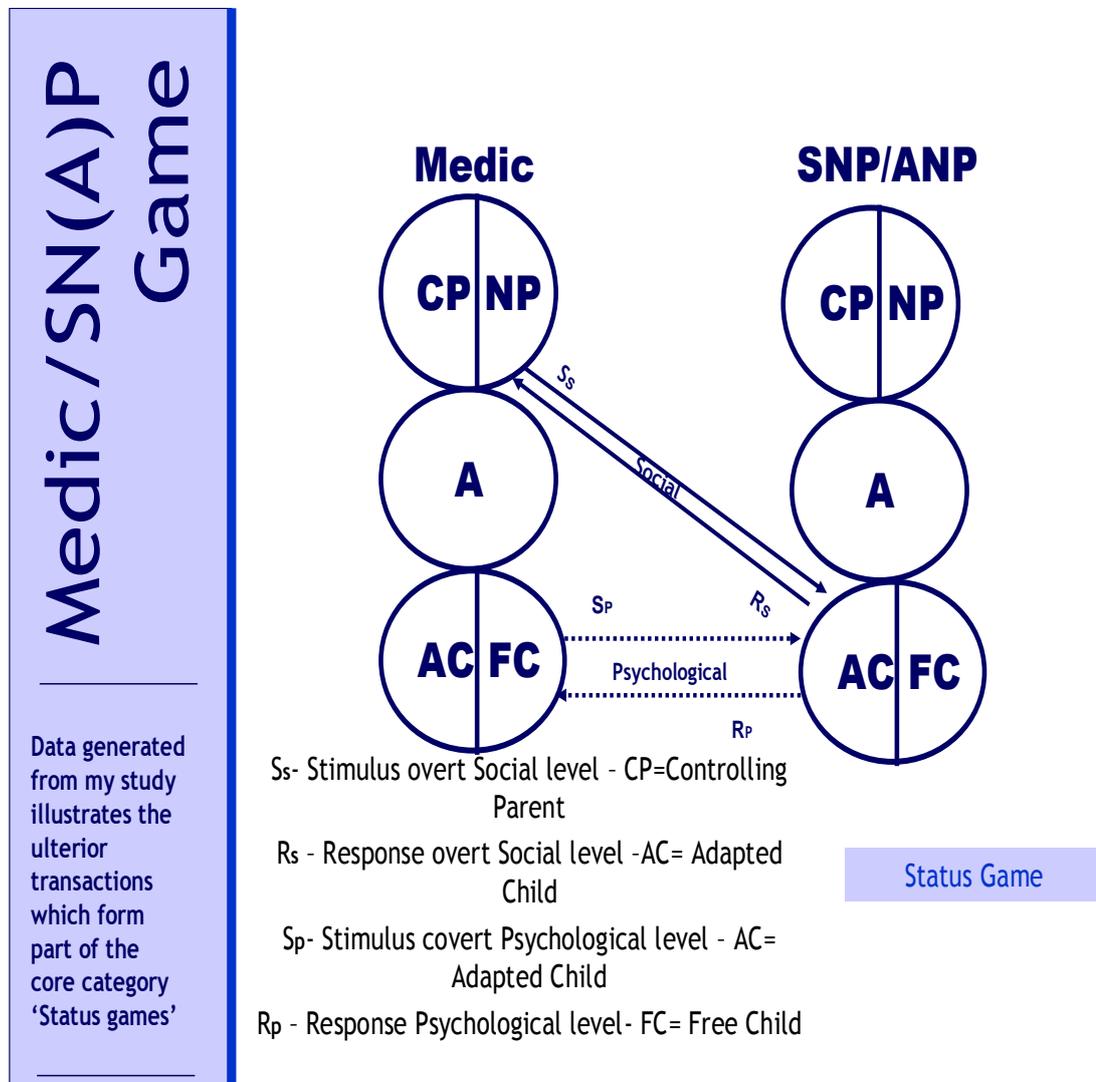


Figure 17 – using the concepts of ego states and ulterior transactions, the diagram illustrates data from my study showing the overt and covert transactions in the newly recognised medic –SNP/ANP status game.

Within the medical–SNP/ANP game on an overt social level, the medical staff are asking SNPs/ANPs to carry out tasks from 'Controlling Parent'. The SNP/ANP responds overtly from 'Adapted Child'. However, I found over the different phases of my study it became apparent that medics were stimulating the messages on an covert psychological level from 'Adapted Child' to ensure their traditional (status) place in the occupational hierarchy was maintained.

As illustrated in the memo from phase 2 (page 123), SNPs/ANPs threatened the medics' social identity by undertaking what had been traditionally medical tasks. The SNP/ANP role threatened their status, therefore promoting a level of anxiety and stimulating the game from 'Adapted Child'. Whitehead (2007) reports that the total amount of status always remains fixed, therefore for a group with lower status to move up, a higher status group such as medics must necessarily lose status. It is therefore not possible for medics to maintain their high status when at the same time the numbers of SNPs/ANPs are increasing. SNPs/ANPs were responding from 'Free Child'. They were not adapting and co-operating with medics' orders, they were rebelling in trying to break the "unsaid rule" in competition for status.

Some examples from the three phases of my study are provided as an illustration. In phase 1, it was evident that there were tensions with medics and SNP/ANP roles. As Rosie highlighted it appeared that tensions arose from the medics status within the occupational hierarchy being threatened, thus by asking the SNP/ANP to undertake the 'menial task' they were asserting their status.

"You still get doctors without a shadow of a doubt, who still think that they're better than the nurse practitioner you know, remember I'm the doctor and you're the nurse"

(Rosie-Consultant Medic-phase 1)

This was reiterated by Mickey (medic):

"I think for the junior doctors that's much more difficult there is still kind of 'I'm the doctor you're a nurse you're below me'".

(Mickey-Consultant Medic – phase 1)

In phase 2, many of the observations highlighted tensions which were particularly noted between junior/middle grade medics and SNPs/ANPs, as Michael highlighted, they were "not in favour of his status" as he was a nurse. These covert psychological level messages were to ensure SNPs/ANPs knew their place. They were breaking the "unsaid rule" which appeared to cause a significant amount of tension. In phase 3, these patterns of behaviour and processes of communication were confirmed by most SNPs/ANPs. A number of examples were provided, which confirmed the ulterior transactions.

As Jemima illustrated below:

“Because some of the junior doctors will say ‘Do my bloods, do this, do that’. And often we just say ‘get it yourself, we’re doing this together’ but we are not handmaidens”.

(Jemima – focus group 3 -phase 3)

Whilst Kathleen reaffirms this viewpoint and indicates that as an SNP/ANP they would be carrying out their own ‘consulting’, thus implying greater status than a nurse therefore not undertaking the ‘menial tasks’ for junior medics, in trying to maintain their status.

“ Oh there’s a nurse practitioner there. They [medics] still expect the nurse practitioner to do the running, to do the menial tasks for them, instead of them just doing their own bloods and ECGs, they’ll go and seek out the nurse practitioner who’s consulting and say, ‘Would you do X, Y, and Z.’ In actual fact we’re an independent care provider and should be doing our own consulting, our own workload, managing our workload and the doctor should be managing his”.

(Kathleen-individual interview- phase 3)

Whilst Erin outlines,

“We do get junior doctors and some of them, I think, like to think they’re better or higher than you are but they’ll only do that once”.

(Erin –focus group 5 –phase 3)

5.7.3 Service user- SNP/ANP game

I propose that the service user –SNP/ANP behaviours were based on social script, which was highlighted in the advanced memo phase 1 (page 107).

I hypothesised that service users had learnt the ulterior transactions or how to behave with healthcare professionals on a sociocultural level. This lead to overt transactions from ‘Adult’ ego states, however on a covert psychological level the stimulus appeared to come from ‘Parent’ (Figure 18 - overleaf).

Figure 18 – Service user-Senior/Advanced Nurse Practitioner game

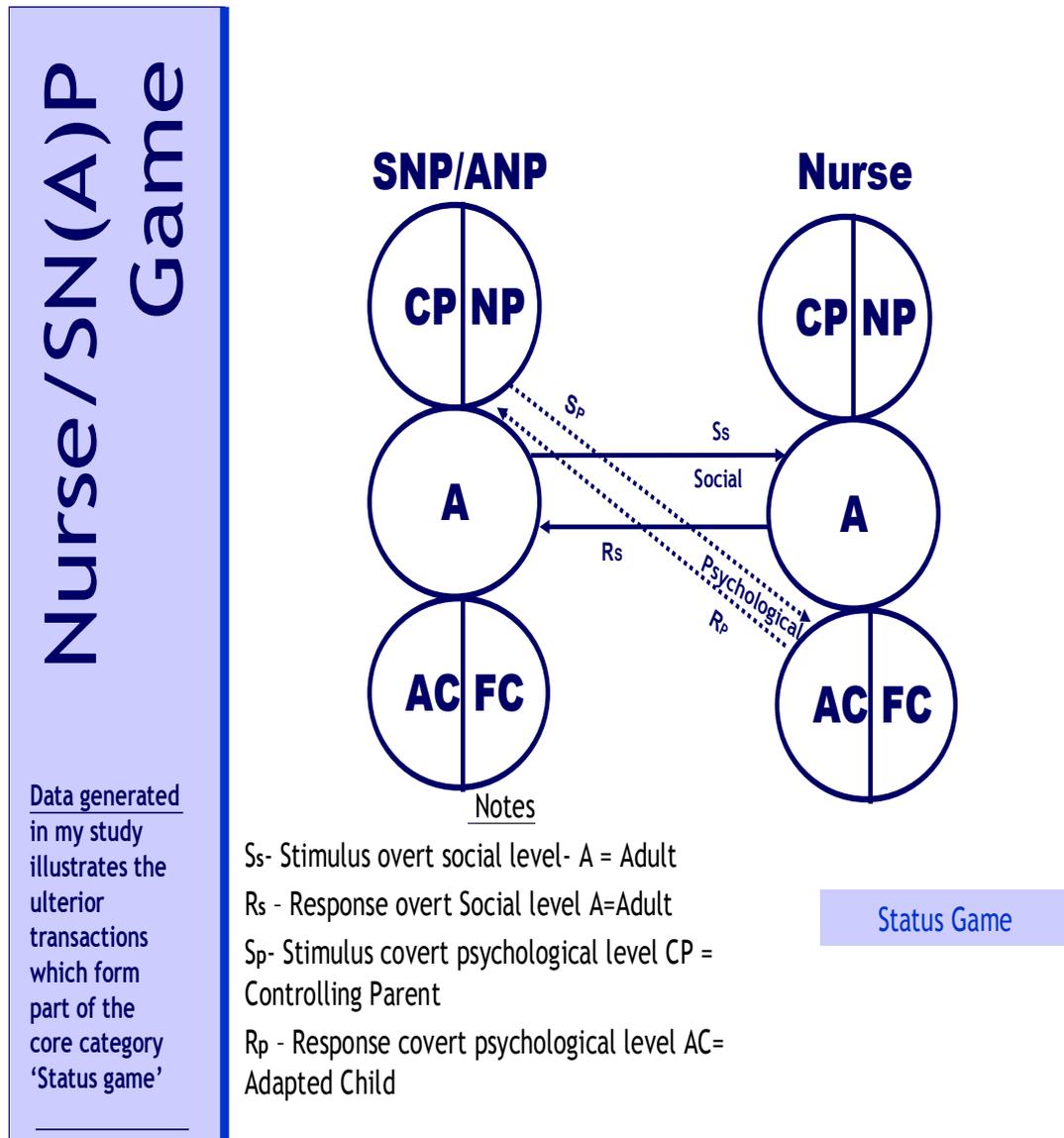


Figure 18 – Employing the concepts of ego states and ulterior transactions the diagram illustrates data within my study showing the overt and covert transactions in the newly recognised service user – SNP/ANP status game.

An interesting observation I made was that because of the 'hybrid' role the SNP/ANP occupied, the stimulus appeared at times to come from 'Nurturing Parent' or as Stewart & Joines (1987) state 'smoother-mother'. They were 'caring' for service users therefore perceived their role as making the decisions for service users or felt it was best that not all the information was provided to the vulnerable service user. The service user adapted to this from 'Adapted Child' even if they did want to participate, as illustrated in phase 1.

“Because its’ someone’s professional opinion you don’t want to...you know...they’re in the position of power you don’t want to question them”.

(Barry – Service User – Phase 1)

Whilst other service users described the interactions as if the SNP/ANP were stimulating the transaction from ‘Controlling Parent’. As Millie illustrated:

“... You know these people are Gods, you don’t question them...you don’t ... you don’t ...you know... you don’t.”

(Millie – service user- phase 1)

This ‘Adapted Child’ response appeared to be linked to social script. It could be proposed that this social script was part of professionalisation with medics’ stimulus messages stemming from ‘Controlling Parent’ and nurses’ stimulus messages occurring from ‘Nurturing Parent’ thus enabling co-created professional roles and social identity of both medics and nurses when interacting with service users. As Susan explains,

“Some doctors do not have good people skills they just tell you! Most nurses have been trained to have relatively good people skills, they care, though there are exceptions”.

(Susan – service user- phase 1)

It would appear that due to the ‘hybrid’ nature of the SNP/ANP they undertook different stances of both stimulating the transactions from ‘Nurturing Parent’ and ‘Controlling Parent’, thus questioning their role in the professional status games. However, what was clear throughout was that there were ulterior transactions with SNPs/ANPs stimulating a response from ‘Adapted Child’. This provided status for the SNP/ANP stemming from their knowledge as a health professional. In phase 2, this ‘status game’ was reiterated in over 70 interactions with service users as they were not invited to share in the decision-making. They remained passive throughout this process indicating ‘Adapted Child’. In phase 3 this was again illustrated, as the large majority of SNPs/ANPs did not have self awareness around inviting service users to share in the decision-making process, indicating a stimulus from the ‘Parent’ ego state.

5.8 Summary of Status Games

The core category of status games was discovered at the end of phase 3, which found that there were both overt and covert messages in transactions with SNPs/ANPs. Social psychological game theory provided the theoretical lens to analyse the processes associated with these covert and overt messages, illustrating the ulterior transactions. The consequence of these games is the ongoing tensions with SNP/ANP roles. Therefore, it was deemed important to question why status games were associated with SNP/ANP roles.

Charmaz (2006) reports that literature is a source of data and to aid in further analysis, the TA literature provided the lens to hypothesise why status games were associated with SNP/ANP roles. In TA, it is proposed that individuals play games to fulfil 'life script' (Steiner 1990). I identified that an understanding of the type of script which was linked to status games could provide a deeper understanding of why such games were associated with SNP/ANP roles. It is proposed this understanding could reduce tensions associated with SNP/ANP roles. The next sections provide a brief overview of the literature surrounding life script in TA. This is followed by the proposed script that underpins status games.

5.9 Status Games and links with Script theory

In TA, games are not fun and are segments of a larger more complex set of transactions called scripts (Steiner 1990). In TA, it is thought that the reason individuals play games is to fulfil their 'Life Script' (Steiner 1990). The data generated in my study clearly identified games, incorporating ulterior transactions. In the interpretative stages of theorising, I therefore identified that an understanding of the type of script which was linked to these games could provide a deeper understanding of why health professionals play status games. The understanding of status games and analysis of the TA literature led to the development of the new concept of 'professional script'. It is hypothesised that 'professional script' underpins status games. One of the main contributions of understanding 'professional script' is to provide a frame of reference for understanding why tensions with SNP/ANP roles are the outcome of unconscious group processes in status games.

Whilst professional script has not been found in any of the TA or healthcare literature, I propose that the discovery of this script underpins the status games grounded in the data of my study. I hypothesise that in understanding 'professional script' we can disrupt the implications of this script on generating tensions for SNP/ANP roles or indeed any new roles that stem from outwith these two occupational groups. I combined the original life script theory within the TA paradigm and the findings of my study to illustrate 'professional script'. The following sections will firstly provide a brief outline of the traditional life script theory, followed by a discussion surrounding the development of professional script.

5.9.1 Life Script

Both Steiner (1990) and Berne (1968) maintain that people play games to fulfil their life script, which is a blueprint for their life course. Life script is "an unconscious life-plan made in childhood, reinforced by the parents, justified by subsequent events and culminating in a chosen alternative" (Stewart & Joines 1987:330). In other words, we all have decided on what our path in life will be as a child, with a beginning, middle and end. As we move through adulthood, we seek out games to provide us with the script payoff¹⁹ we need to fulfil our life plan (Steiner 1990). In TA theory, the end scene of the life script is the pay off. This is outwith our awareness and both parents and parental role models will have influenced this decision. Stewart & Joines (1987:100) provide the example of a mother telling two brothers that "You'll finish up in an asylum". One of the brothers became an in-patient and another became a psychiatrist. This illustrates that life script is not just determined by the parents or environment but more importantly by the decisions the child makes (Steiner 1990).

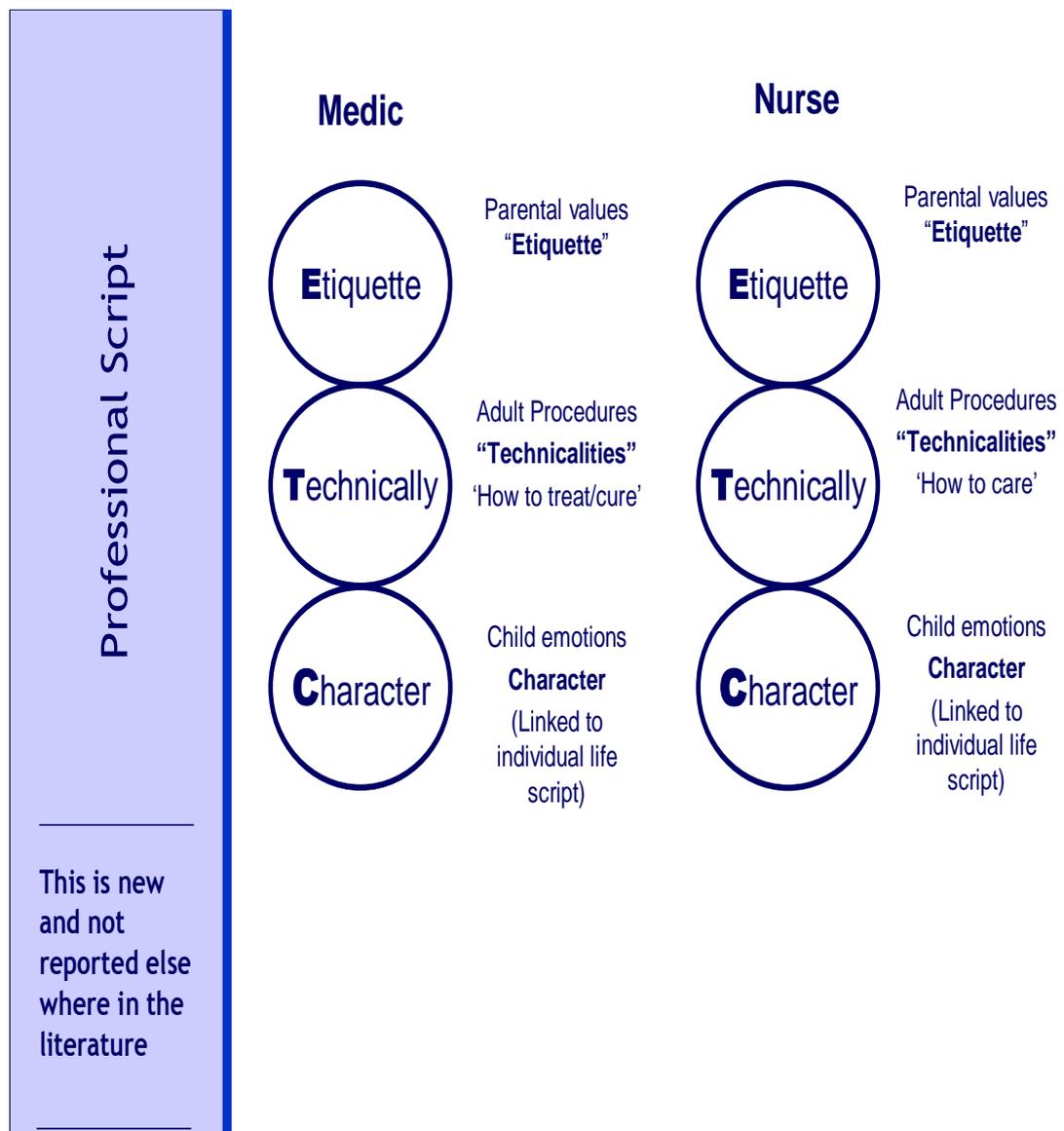
5.10 Professional Script

Professional script is new and original and builds on life script and extends Berne's (1963) original ideas about the nature of groups. It shares the same theoretical perspective of life script, which outlines that an individual's life script defines their identity (Tosi 2010). Similarly, I argue that the term professional script defines the identity of an occupational group. Krausz (1993) suggested that similar to individuals, cultures, subcultures and groups within organisations create script.

script payoff -

However, the particular type of script an organisation or profession can create has not been reported upon or analysed within the literature, therefore professional script provides a unique understanding surrounding game analysis. Berne (1963) developed concepts surrounding groups, which was based on the ego state model of individual personality, as discussed earlier in this chapter. Berne proposed that when a group of individuals are from a social network they share three components: the first is 'Parental' values, termed 'Etiquette'; the second is 'Adult' procedures termed 'Technicalities'; and lastly 'Child' emotions known as 'Character'. In professional script, it is proposed that these three components make up professionalisation within nursing and medicine. This generates the professional roles and social identities within nursing and medicine, as illustrated in Figure 19.

Figure 19 - Professional Script



5.10.1 Components of professional script

I hypothesise that ‘Etiquette’ is the code of behaviour within a profession, whilst ‘Technicality’ is the different knowledge, vocabulary, jargon, practices and skills learned and linked to ‘Etiquette’ of a profession. ‘Character’ of a profession is formed through the learning of ‘Etiquette’ (how to behave) and ‘Technicality’ – (How to do) and is intrinsically linked to an individual’s own life script. These components will now be discussed in more detail.

5.10.2 Etiquette

The background of both medicine and nursing is steeped in historical culture. It is proposed that script messages of each profession are translated during professionalisation via training and education; practice placements and interaction with others and parental figures such as Charge Nurses, mentors and other role models. Van Mook et al. (2009) report that medics learn how to behave as part of the ‘hidden curriculum’ within medicine, whilst Melia (1984) and Gray and Smith (2000) suggest that nurses learn from ‘fitting in’ to the ward traditions. In my study, Wanda explains,

“You learn what to do on the floor from people, but it’s different with medicine and nursing”

(Wanda NP– focus group 6 – Phase 3).

As Berne (1963) explains, etiquette is the learning of how to behave within certain traditions. He further emphasises that this includes ascertaining what the acceptable ‘games’ are in a particular system. I propose that in learning the etiquette of a profession, we learn the traditional doctor-nurse game or “unsaid rule” previously discussed (page 184). As Alberto illustrates,

“...The nurse-doctor relationship, it’s very much that they [medics] would expect the nurses to do it and nurses that have been nurses for years are trained to just do it...”

(Alberto- Individual interview-phase 3)

Napper (2010) suggests that ulterior messages, necessary to play games, are covertly embedded in transactions rather than being encompassed in an overt informal introduction into a role. I suggest that to learn the etiquette of a role, professionals covertly learn the ulterior transactions of the traditional doctor-nurse game.

This leads to learning what the acceptable games are between medics and nurses. Thus, both professions learn the “unsaid rule” of the medic stimulating transactions from ‘Controlling Parent’ and nurses responding from ‘Adapted Child’. It is proposed that the SNP/ANP role has disturbed the “unsaid rule” and this has led to a number of complex ulterior transactions with nurses and medics, as discussed in the previous section.

5.10.3 Technicality

Technicality is the different knowledge, vocabulary, jargon, practices and skills that are learned within an associated role (how to do things). The professions of medicine and nursing both have a process of registration which provides status and privilege over particular practices. Much of the sociological theories on ‘professionalisation’ suggest for an occupational group to become a profession it depends on traits highlighted in technicality (Turner 1995; Earl & Letherby 2008). In order to learn technicality, it is proposed that professionals learn the underpinning professional stance of their occupation. In life script, how to do things is learned from parental figures (Erskine 2010). I propose that in professional script, how to do things are learned from mentors, role models and experienced professionals within the associated role.

In medicine, how to do things are illustrated through the sociological literature, which predominately suggest that the role of a doctor is to ‘cure’ using a biomedical model (Jaye et al. 2006; Groopman 2007; Earle & Letherby 2008; Kiltzman 2008). Whilst in nursing, the focus suggested is how to ‘care’ for service users (Ray & Reed 1994; Turner 1997; Clarke 2001; Earle & Letherby 2008; NMC 2008). As Walby & Greenwell’s (1994) study found, many nurses perceive themselves as responsible for providing care as distinct from treatment or cure, which is seen as the medics’ role. As discussed in the findings chapter this was reinforced by data within my study. As illustrated by Fraser:

“I suppose the medical model tends to cure people, or can often look very specifically at somebody’s physical symptoms, they’re numbers, what they’re looking at, what drugs they’re on. And in many specialities based on purely the physical problems, doesn’t tend to look at the patient very holistically.... And I suppose the nursing model was the empathic, holistic, supportive, caring model”.

(Fraser – Consultant Medic – Phase 1)

It is proposed that these underlying core beliefs are learned by both medics and nurses through their professional education. This in turn enables both professions to develop different technicalities or knowledge, vocabulary, practices and skills within their associated role. This also allows both professions to co-create professional roles and reinforces their social identity within the healthcare team. This appeared to be a source of tension associated with the SNP/ANP role, as the findings illustrated in the previous chapter. As they did not carry out the traditional 'caring' work of a nurse and appeared to be infringing on the traditional 'curing' work of a medic. As Louise & Josie outlined:

"What are they doing that's proper nursing? That I see, here in ... they're doing tasks, assessing and treating..."

(Louise – Chief Nurse – Phase 1)

"...Nurse practitioners are task orientated. How much of that is actually what I know as nursing is debatable, because nursing is about caring".

(Josie-Charge Nurse-Phase 1)

As illustrated in Chapter 4 this was the view of many of the nursing participants in my study, as many did not view SNPs/ANPs undertaking "proper nursing", whilst medics felt uncomfortable with sharing their technicalities with SNPs/ANPs. In Michael's words:

"Doctors view themselves as an entity from within. So when we think about our training, sort of somebody else doing our job. And there's always going to be an element of being protective of you're ... of your work area and your boundaries, so to speak"

(Michael – medic- phase 1)

As previously discussed in Chapter 4 it was evident that many of the medics were reluctant mentors, as they would be sharing their professional technicalities. As illustrated by Mickey:

"And to the extent that our SPRs wrote to the Postgraduate Dean and said they didn't want to supervise the decision making nurses anymore because they felt it wasn't appropriate".

(Mickey-SPR medic-phase1)

It appeared that the SNP/ANP, undertaking both a caring and curing role, threatened the technicalities of both nursing and medicine, fuelling games to maintain the status associated with the unique technicalities of each occupation.

5.10.4 Character

I hypothesise that the character of professional script is the underlying informal culture of each profession. As Fitzimmons & White (1997) propose, differences in cultures exist due to separate training and underpinning philosophical approaches which underpin different professions. The etiquette and technicality form the culture of a profession. It is also proposed that individual life script guides people in choosing careers with corresponding character, thus fulfilling their life script. As Berne (1963) proposed, organisations can provide contexts for individual scripts.

This is reiterated in the contemporary organisational TA literature, which outlines that individuals choose a profession or occupation to help fulfil their life script (Clarkson 1992; Krausz 1993; Balling 2005; Napper 2010). Krausz (1993) suggests those individuals' life script messages shapes the professional role they choose to undertake and particular tasks associated with that role. Krausz (1993) further proposes that this is outwith the individual's awareness. Therefore, it could be hypothesised that individuals are drawn into the professions of medicine and nursing, due to the different character or informal culture associated with the occupation. This does question the hybrid role of the SNP/ANP and poses the question of how character affects their role. As George states:

"We are from different professional cultures maybe that's why it doesn't work".

(George- Consultant Medic-phase1)

When analysing the etiquette, technicality and character within professional script, it appears that medicine and nursing are significantly complementary as well as competitive. I propose that these two occupations have co-created the structures in the professional script model, thus providing effective care and treatment for service users within a healthcare environment. This allows both medicine and nursing to reap the rewards of status and professional privilege associated with each complementary occupation. This script is the basis of status games, and the rules of the game are in place to fulfil this script. However, it appears that the SNP/ANP "hybrid role" has disrupted both medics and nurses fulfilling the different elements of professional script, thus fuelling the 'status games' discussed in the previous section.

In social psychology game theory, if an individual cannot fulfil their script, the games escalate (Stewart & Joines 1987). As discussed previously, it is proposed that both medics and nurses fulfil their co-created professional script from the traditional nurse-medic game or “unsaid rule”. As SNPs/ANPs have been introduced they have not been able to fulfil their co-created script, therefore this has led to the escalation of the newly reported ‘status games’ discussed in the previous section. The postulated professional script theory provides a frame of reference to illustrate why status games cause the documented role tensions associated with SNP/ANP hybrid roles. It is also proposed that the co-created professional script has led to SNPs/ANPs losing their professional nursing and social identity in the co-created professional script. As highlighted by Kathleen:

“You’re almost a mid between a nursing structure and a medical structure. You’re midway between. There’s almost a feeling because your role is no longer in the traditional nursing role, you’ve stepped away from that. It’s almost like you’re neither. It’s a hybrid role”.

(Kathleen NP – individual interview – phase 3)

In the words of Frazer (Medic):

“There’s the two nurse practitioners always sit somewhere outside, it’s almost you get to the level and there’s always this kind of, them [SNP/ANP] not knowing where they fit. There’s not a...there doesn’t ever seem to an ‘at peace’ with their role.”

(Frazer Consultant-Medic-phase1)

In addition, as discussed in the previous chapter, all the Ya-Ya boxes in phase 3 illustrated that there were stark differences between others’ expectations and individual SNP/ANP expectations of their role. This led me asking the question ‘what is the professional script for an SNP/ANP?’ Allen and Pilnick (2007: 685) report that membership within a health group becomes a point of reference, through which individuals make meaning of their work and manage their identities. However, given the hybrid nature of the SNP/ANP within professional script, one has to question what is their place within the healthcare team. The findings illustrated that this was also a source of tensions for individuals within SNP/ANP roles. As illustrated by Babs:

“I work in complete isolation and it is a problem. I’ve been made to feel uncomfortable in my role...”

(Babs –SNP-focus group 6-phase 3)

A further example was illustrated by Sylvia when she stated:

“And I think people working in isolation, it is very difficult if you feel isolated and then you get this sort of behaviour going on. Who do you turn to? There is nobody there for that.”

(Sylvia-NP-Focus group 6-phase 3)

5.11 Consequences of Professional script payoff

As discussed in section 5.9.1, individuals play games to fulfil their script payoff associated with their individual life plan. Similarly, I propose that medics and nurses play games to fulfil professional script with the payoff of status and professional privilege. One could question the consequences of script payoff in relation to status and professional privilege. Summerton (1993) provides some insight when he suggests that the rationale for analysing games in an organisation is to facilitate leaders to deal with Poindexter syndrome.

Poindexter syndrome is one “in which unconscious dishonesties among its members result in the ulterior moves that unknowingly oppose the intended goals and purposes of the organization” (Summerton 1993:95). One could argue that a goal for the NHS was to modernise its services with the introduction of SNP/ANP roles. It was promoting the overlap of roles to aid in service users being treated quickly rather than waiting to see a particular professional. This was to ensure service users were at the heart of the NHS (DOH 2004a; 2005 a & b; 2006; SEHD 2003; 2006a). However, one could argue that through professionals playing games to fulfil script pay off of status and professional privilege, they are preventing the organisation from reaching its goal in allowing the service user to be at the heart of the NHS, thus promoting Poindexter syndrome. This links to Turner’s (1995) viewpoint that professionalisation provides a basis for occupational control. I would argue that professional script has provided a social system, which in turn provides each professional with status and social dependence between each occupational group and service users. It is hypothesised that if individual staff members reduced the intensity of the games they played whilst in practice or if they became game free, then the healthcare organisation would benefit because more energy would be available for achieving the goal of modernisation, truly placing the service user at the heart of the NHS.

I also hypothesise that as both nurses and medics play the traditional nurse-medic status game to fulfil their professional script, the introduction of SNP/ANP roles threatens the fulfilment of this script. The SNP/ANP taking on the hybrid role has resulted in new complex 'status games' to enable both medics and nurses to continue to fulfil their co-created professional script. Whilst such roles were introduced into the healthcare system, to enable an organisation to meet their goal of modernisation, the data illuminates that such roles threatened both occupations payoff from professional script, thus enabling Poindexter syndrome to come to the fore.

5.12 Summary of Substantive theory

"Constructivists study how and sometimes why participants construct meanings and actions in specific situations" (Charmaz 2006; 130). The findings illustrated how tensions were constructed through games. These were complex transactions with both covert and overt meanings and actions. Social psychological game theory enabled the identification of the processes through ulterior transactions associated with status games. The TA literature was utilised as a source of data and incorporating script theory enabled the development of the concept of professional script, which provides a new and unique understanding of why status games are associated with SNP/ANP roles. This led to the substantive theory:

'The tensions generated by SNP/ANP roles stem from playing status games to fulfil professional script which requires to be recognised and acknowledged by the healthcare team in order to change the status quo and culture'.

As the theory outlines, the consequences of not taking into account status games and underpinning professional script, will be the continuation of tensions associated with SNP/ANP roles as reported in the international literature over the last two decades. The implications of the identification of this new and unique theory are discussed in the following section.

.5.13 Implications

The substantive theory, which emerged from the findings of my study, has illustrated the new concepts of status games and professional script. This has not been reported in the literature or previous research therefore it is proposed that these discoveries will reduce tensions and enhance collaborative working in the healthcare system.

Hanson et al. (2009) report that efforts to modernise the healthcare system to improve care, safety, quality, efficiency and cost effectiveness will fail if clinicians and teams do not work in collaboration. Collaboration is perceived to be a conscious learned behaviour that increases as individuals learn to value and respect one another's practice (Moeller et al. 2007).

However, whilst the characteristics of collaboration have long been recognised in the literature, many health professionals have resisted adopting the philosophy, commitment and behaviours necessary to develop collaborative practice (Lingard et al. 2004; Tabak & Koprak 2007; Miller et al. 2008; Hanson & Sposs 2009).

I hypothesise that this is due to status games and the underpinning professional script which is outwith awareness and has not been conceptualised in the literature. I would argue that by raising the awareness of status games and professional script through open dialogue, it would aid in changing the status quo and breaking current professional script therefore decreasing the tensions which have emerged with the implementation of SNP/ANP roles. As both Berne (1968) and Vandra (2009) report that by recognising the processes and actions within communication, it is possible to bring ulterior transactions into full awareness and prevent games. I would argue that this would require a two pronged approach, firstly to cover both professional script and status games in both the nursing and medical curriculum by starting the awareness at an undergraduate level. Secondly, to ensure a change on an organisational level, raise awareness and promote curiosity through multiprofessional leadership programmes. In addition to equipping these senior medical and nursing managers with skills to support challenging the associated behaviours of status games through coaching and supervision.

5.14 Limitations of my study

Several limitations were reflected upon within this study. The first was my 'hybrid role' from working on a regional and local level, in addition to the fact that I was a nurse, therefore, I would argue that I had a 'professional script'. This had a potential to bias the accuracy of the findings, as I held views which were out of awareness. As previously discussed in Chapter 3, my role did influence the choice of methodology for this study.

In an attempt to ameliorate these limitations, using Constructivist GT methodology and acknowledging that I was part of this research and not separate to it, this enabled a number of steps to be put into place to ensure the trustworthiness and rigor of this study. These are highlighted in Chapter 3. An outline of my reflexive journey can be found in Figure 2 (page 55).

Through the reflexive epistemological stance of Constructivist GT, this potential limitation transformed to become one of the strengths of this study. My hybrid role raised awareness of the ulterior transactions, which emerged during data collection and aided in the construction of status game theory and professional script theory. It also enabled a balance of my hybrid role with steps such as member checking to enhance credibility.

The second limitation was the potential affect of my role as an education lead within the study site. This may have encouraged socially desirable responses from participants, learned through social script, which could have clouded the accuracy of responses. Steps were built into the research process to reduce this potential limitation. These are discussed in-depth in Chapter 3.

This study took place in one specific NHS organisation with its own cultural aspects, therefore the results of this study are not necessarily transferable and this may be perceived as a limitation. However, one of the aims of this study was to attempt to develop a substantive theory, which would act as a platform enabling further testing across different health organisations building a formal theory. It is recognised that further research into this area in other international healthcare institutions is necessary. The results from my study could be viewed as an important contribution, to enable a comparison of findings with other countries, to build a formal theory.

Another potential limitation was the sample of service users in phase 1 of my study. The purposeful sample was drawn from one specific, albeit large, unit which was run by SNPs. It was however acknowledged that if this sample had been drawn from across the wider organisation, it would have been difficult to ascertain service users' perceptions on SNP/ANP roles separate from other healthcare providers. However it must be acknowledged that through choosing this one unit, there may be a micro-climate that would be different to other units/ward areas in the study site. Furthermore it was noted by the service users that the perception of how serious their condition was influenced whether they attended a minor injuries unit or an A& E department. In the latter area, they would be seen by a medic rather than an SNP/ANP. Therefore, I would recommend further research, incorporating service users across different sites to test the hypothesis which has been generated from the substantive theory in my study.

As outlined in Chapter 1, the title and definitions for this study centred on two levels of practitioners, adapted²⁰ from the NHS Career Framework (SEHD 2005a). This incorporated a number of titles and it could be argued that this could be perceived as a limitation to this study, as the focus could have been on roles with specific titles such as CNS or NP, with the aim of providing some consistency. As illustrated by the findings however, no two roles were the same, even if they shared the same title, as they had been developed to fulfil different gaps in service. Therefore the 'titles' were not indicative of a specific role and would therefore fail to provide consistency. It is therefore suggested that by employing the two levels of practitioners as an operational definition, this enabled rich data to emerge from differing roles and prevented the distraction of focusing on titles. This in turn was a strength of my study as the focus was not on titles but on 'tensions' which had been reported with all types of new roles. Therefore, the substantive theory generated is applicable to all types of roles regardless of the actual title.

²⁰ Adapted word "practitioner" to "nurse" from original definition in the NHS Career Framework

5.14.1 Strengths of my study

The chosen methodology discussed in-depth in Chapter 3 was a strength to this study. Due to the complexity surrounding tensions associated with such roles, the flexibility inherent with Constructivist GT allowed an in-depth exploration of the process and actions of communication, which was at the root of reported tensions. For example, each research question informed the design of the study. The flexibility of this approach allowed the addition of theories, literature and methods to extend understanding. The approach allowed an in-depth understanding surrounding the ongoing tensions surrounding SNP/ANP roles, which has not been reported in the literature.

5.15 Conclusion and further research

In phase 1 of my study, I explored where tensions were created by Senior and Advanced practitioner roles, from both a service user and healthcare team perspective. It was found that where tensions were apparent for service users, was associated with the traditional beliefs surrounding the role of a medic and nurse in a healthcare team. In addition to service users interpretation of the need to play a passive role in decision-making when consulting with an SNP/ANP. Whilst the healthcare team participants in phase 1 illustrated that where tensions were evident was in the teams relationships, this was underpinned by the professional cultures of both nursing and medical occupations.

In phase 2, a deeper understanding started to emerge, with the research question of discovering where tensions remained apparent in service and what meanings and actions were attributed to them. It was found that where tensions were apparent, there were overt actions with associated covert meanings attached to them. In phase 3, the interpretations of Senior and Advanced Nurse Practitioners on interactions with the healthcare team and service users confirmed the findings, which emerged from the research questions posed in phase 1 and 2.

The research question in phase 3 provided further depth to the understanding surrounding tensions created by SNPs/ANPs. It was found that different types of games, linked to status were being played out of awareness, which were the 'Service user-SNP/ANP' game, the 'medic-SNP/ANP game' and finally the 'nurse-SNP/ANP game'.

A number of theories were reviewed, linked to game theory. The Transactional Analysis paradigm was employed to illuminate the social physiological games described in the findings. I suggested that the reason medical and nursing professionals played these games was to fulfil 'professional script'.

This led to the substantive theory which was:

'The tensions generated by SNP/ANP roles stem from playing status games to fulfil professional script which requires to be recognised and acknowledged by the healthcare team in order to change the status quo and culture'.

I would therefore propose that following the discovery of this substantive theory further research is undertaken. I would suggest research to test the hypothesis that "status game theory which fulfils professional script for medics and nurses is evident in healthcare across both acute and primary care sectors". I would recommend this research be employed across different health boards in the United Kingdom to test this hypothesis.

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Appendix 1 – Search Strategies for Literature Reviews

Data bases

1 – Data based employed for main concept of - Nurse Practitioners (NPs)/Clinical Nurse Specialists (CNS)/Acute Care Nurse Practitioners (ACNP)

- 1.1 CINAHL search strategy
- 1.2 British Nursing Index search strategy
- 1.3 Embase search strategy
- 1.4 Medline search strategy
- 1.5 AMED (allied & complementary medicine)
- 1.6 Social Work Abstracts 1977-2005
- 1.7 Emerald search strategy
- 1.8 PsycINFO search strategy
- 1.9 Joanna Briggs search strategy
- 1.10 Cochrane library search strategy

Permuted Index & search terms employed for each data base for focused literature review

1.1 – CINAHL search strategy <1966 to Dec Week 4 2005>

1. exp *Nurse Practitioners/ or exp *Clinical Nurse Specialists/ or exp *Advanced Nursing Practice/
2. exp*Nurse Practitioners/or exp* Emergency Nurse Practitioners/or exp* Gerontologic Nurse Practitioners/ or exp * Neonatal Nurse Practitioners/ or exp *OB-GYN Nurse Practitioners/or exp* Pediatric Nurse Practitioners/ or exp* Acute Care Nurse Practitioners/ or exp * Adult Nurse Practitioners/ or exp* American College of Nurse Practitioners
3. 1 and 2
4. exp *MULTIDISCIPLINARY CARE TEAM/
5. 3 and 4
6. exp *NURSE-PHYSICIAN RELATIONS/
7. 3 and 6
8. Multidisciplinary care team + Advanced nursing practice
9. Education, Interdisciplinary
10. communication barriers and nurse practitioners

1. 2 British nursing index <1985 – Dec 2005>

- 1.exp NURSE PRACTITIONER/
- 2.exp nurse patient relations/ or exp NURSE PRACTITIONER/
- 3.exp nurse practitioner/ and exp MULTIDISCIPLINARY TEAMS/
- 4.1 and 2
- 5.2 and 3
- 6.skill mix/ and interprofessional relations/ and practice nursing/
- 7.exp nursing role/ and exp communication/ and exp multidisciplinary teams/
- 8.exp INTERPROFESSIONAL RELATIONS/
- 9.1 and 8
- 10.8 and 9

Appendix 1–Permuted Index & search terms employed for each data base for focused literature review

1..3 – EMBASE <1980 to 2005>

- 1.exp NURSE PRACTITIONER/
- 2.exp *Nurse Practitioners/ or exp *Clinical Nurse Specialists/ or exp *Advanced Nursing Practice/
- 3.exp interprofessional education/ or interprofessional relations/
- 4.2 & 3
- 5.exp *PEDIATRIC NURSE PRACTITIONER/ or exp *CLINICAL NURSE SPECIALIST/ or exp *NURSE PATIENT RELATIONSHIP/ or exp *ADVANCED PRACTICE NURSE/ or exp *DOCTOR NURSE RELATION/ or exp *ACUTE CARE NURSE PRACTITIONER/ or exp *NURSE PRACTITIONER/ or exp *GERONTOLOGIC NURSE PRACTITIONER/ or exp *EMERGENCY NURSE PRACTITIONER/
- 6.exp INTERPROFESSIONAL RELATIONS/
- 7.5 and 6
- 8.exp *Medical Profession/ and exp *Health Care Personnel/
- 9.5 and 8
- 10.exp *Teamwork/
- 11.5 and 10

1.4 – Medline

Ovid MEDLINE(R) <1950 to Dec week 4 2005>

- 1.exp *Nurse Practitioners/ or exp *Clinical Nurse Specialists/ or exp *Advanced Nursing Practice/
- 2.exp nurse practitioner/ and exp MULTIDISCIPLINARY TEAMS/
- 3.1and 2
- 4.exp interprofessional education/ or interprofessional relations/
- 5.exp *PEDIATRIC NURSE PRACTITIONER/ or exp *CLINICAL NURSE SPECIALIST/ or exp *NURSE PATIENT RELATIONSHIP/ or exp *ADVANCED PRACTICE NURSE/ or exp *DOCTOR NURSE RELATION/ or exp *ACUTE CARE NURSE PRACTITIONER/ or exp *NURSE PRACTITIONER/ or exp *GERONTOLOGIC NURSE PRACTITIONER/ or exp *EMERGENCY NURSE PRACTITIONER/
- 6.4 and 5
- 7.exp *NURSE-PHYSICIAN RELATIONS/
- 8.5 and 7
- 9.exp INTERPROFESSIONAL RELATIONS/
- 10.5 and 9
- 11.exp interprofessional education/ or interprofessional relations/
- 12.exp nursing role/ and exp communication/ and exp multidisciplinary teams/
- 13.11and 12
- 14.(conflict and team).mp.
- 15.5 & 14
- 16.exp *Role Perception/ or acute care nurse practitioner.mp.
- 17.(\$communication and nurse practitioners).
- 18.collaborative models.mp.

1a5 AMED – <1985 to Dec 2005>

- 1.nurse practitioners.mp
- 2.Clinical nurse Specialist.mp.
- 3.team working.mp.
- 4.1 & 3
- 5.2 & 3
- 6.multidisciplinary team
- 7.\$communication.mp
- 8.collaborative models.mp
- 9.1 & 8
- 10.(\$communication and nurses).
- 11.(\$communication and nurse practitioners).
- 12.(conflict and team).mp.
- 13.exp Interprofessional relations/
- 14.1 & 12
- 15.2 & 12

Appendix 1–Permuted Index & search terms employed for each data base literature review

1.6 Social work abstracts – <1968 to December 2009>

- 1.nurse practitioners.mp.
- 2.acute care nurse practitioners.mp
- 3.advanced nurse practitioners
- 4.clinical nurse Specialist.mp.
- 5.doctor-nurse realtions.mp.
- 6.doctor-nurse game.mp.
- 7.team working.mp.
- 9.multidisciplinary team.mp.
- 10.\$communication.mp.
- 11.(\$communication and team).mp
- 12.collaborative models.mp.
- 13.(\$communication and nurses).
- 14.(\$communication and nurse practitioners).

1.7 Emerald <1967 to Dec 2005>

- 1.Nurse practitioners
- 2.Acute care nurse practitioners
- 3.Clinical nurse specialists
- 4.doctor-nurse game
- 5.multidisciplinary team
6. multidisciplinary teaching
- 7.doctor-nurse practitioner communication
- 8.Collaborative models
9. Collaborative models and nurse practitioners

1.8 PsycINFO <1967 to Dec 2005>

- 1.nurse practitioners.mp
- 2.acute care nurse practitioner.mp.
- 3.Clinical nurse Specialist.mp
- 4.team working.mp.
- 5.multidisciplinary team.mp.
- 6.(\$communication and team).mp.
- 7.collaborative models.mp.
- 8.(\$communication and nurses).mp.
- 9.(\$communication and nurse practitioners).mp.
- 10.(conflict and team).mp
- 11.1 and 10
- 12.exp *Professional Identity/ or exp *Professionalism/
- 13.1 and 12
- 14.exp *Role Perception/ or acute care nurse practitioner.mp.

1.9 Joanna Briggs Systematic Reviews – <1998-2005>

1. Advanced Practice
2. Nurse Practitioners
3. Clinical Nurse Specialists
4. Nurse AND roles
5. Nurses AND Nurse Practitioners
6. Team working
7. Mulidisciplinary teams
8. Teams AND Teamwork
9. Teams AND group dynamics

1.10 Chochrane Library Databases <1985-2010>

1. Nurse practitioners
2. Specialist nurse/clinical nurse specialist nurses
3. Advanced nurse practitioners
4. Multidisciplinary teams
5. Team working
6. Communication in Teams
7. Communication barriers
8. Mulitprofessional educatio

Appendix 2 - Example of Ya Ya box – Phase 3

How do other people perceive you within your role?

What are your expectations?

Appendix 3 - Stimulus Material employed in phase 3

*"Both professions don't want to be out of control , I mean it's really sociological....there is probably hierarchical stuff, there's probably gender stuff".
(Martin Nurse)*

"I think for the junior doctors that's much more difficult, there is still this kind of 'I'm a doctor, you're a nurse, you're below me' (Russell Medic)

During observation it was noted that a consultant "clicked his fingers" at the NP when wanting something done.

I think there's a problem with the management structure in that it does not allow, it's not allowing them to educationally develop and professionally develop in the way that they should and I think there's a degree of short-sightedness." (Robert – Medic)

Nurses' are hard on nurses...Other staff will do things for a doctor but won't help if it's a nurse practitioner...something in the hierarchy of nursing."(Louise – senior nurse)

During observation nurses made tea & toast for medics not NP despite running same clinics, they also got x-rays and notes for medics and not NP

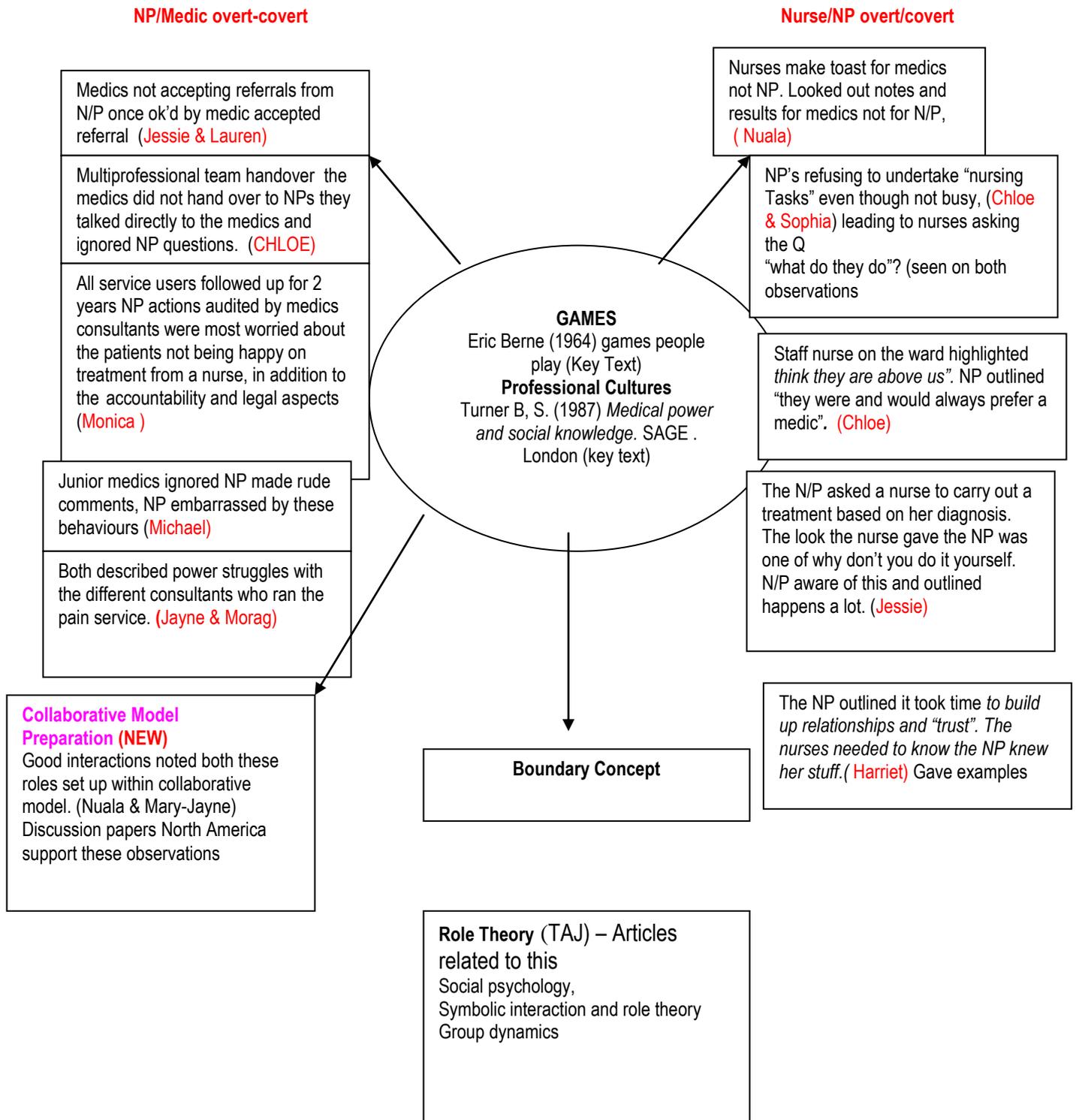
Clinical nurse specialists are more autonomous, more nurses, whereas nurse practitioners are task orientated. How much of that is actually what I know as nursing is debatable, because nursing is about, is about caring (Margaret – Nurse Manager)

"I mean I think they are the experts in that field and have the answers to that and I think we have to listen to them". (Sara – Service User)

"I don't think practitioners have the level of skill... well not all practitioners have the level of skill to be able to support people when they're feeling vulnerable. They (NPs) still feel they've got the influence but they're at the centre of the decision making process and that they, (service users') ultimately, they will agree the decisions being taken".(Anne Service user)

Appendix 4 – Example of Cluster Memo from Phase 2

MEMO – Observation with links to literature reviewed



Appendix 5 – Analysis of Ya Ya boxes

Personal Expectations Versus Others Expectations (Phase 3)

Name	How do other people perceive you within your role?	What are your expectations of the role?	Differences in expectations
Skippy 1²¹	Act as a bridging gap for contact – continuity of care Act on a senior Level. To know what to do next i.e. crisis management To meet the cardiac targets	Acceptability Respect & recognition To be able to move forward within a speciality Need feedback in role & development	Yes
D'Griz 1	To contribute to the medical care of patients in hospital overnight, due to reduction in doctors Resolve site issues Needlework	Improve nursing understanding of goals of medical care out of hours Improve communication generally Educate staff (both nursing & medical) as to appropriate interventions Out of Hours	Yes
Meadhran 1	Help meet RTT targets Provide effective/safe service Provide consistent service/care	Work toward becoming experienced/"expert" practitioner Provide worthwhile & appreciated service Increase knowledge and skill base (both professional & personal satisfaction)	Yes
Charlotte 2	Patients expectations are high Regular phone calls expecting prompt treatment Medical staff expect a lot and at times not supportive	To provide a good service for patients but not to feel unsafe and under pressure Also to develop the role and my own personal development	Yes
Elizabeth 2	Senior Nurse in the unit Respond to any situation in the clinical area even on own office day Publish papers as the office team	Improve knowledge in the area Deliver presentations over Scotland Develop local protocols & policies Develop e-learning resources	Yes
Emma 2	Supporting staff – (nursing) – Complete knowledge of subject Liaising between clinicians, senior nurses and expanding role Developing protocols – research, audit, publishing papers	Improvement of the service Broadening my knowledge/skills Outreach – locally/ nationally	Yes
Zara 2	HUGE – Everything vaguely related to bowel and bladder conditions acute & community	Stoma nurse/bowel management Teaching Advisor/facilitator Writing guidelines/protocols etc	Yes
Anne 4	Provide miraculous results with people who are clearly unnameable to any interventions. Often people who have been seen by other mental health practitioners repeatedly in the past. Doctors seem to feel they should "prescribe" my time. Provide a service to cover for doctor's holidays. Contain difficult patients by seeing them even if the only outcome is to stop them attending GP	Provide psychotherapeutic interventions to people with treatable psychological problems Personal development Provide group interventions Provide training to other health care professionals Provide support & education to patients and carers.	Yes

²¹ For audit purposes the figures denote which number focus group each participant was within

Appendix 5

Personal Expectations Versus Others Expectations (Phase 3)

Name	How do other people perceive you within your role?	What are your expectations of the role?	Difference
Jemima 3	Often others expect us to take responsibility or everything they like to pass the buck. Also they expect you to have the answers to everything	I would like my role to develop more in a clinical aspect also to expand the educational aspect of my role	Yes
Nellie 3	Cannulation and phlebotomy nurse Clinical guidance and sometimes very little support from ward staff who disappear as soon as we appear Site management resource	Competent clinical decision making, including CXR interpretation, Blood chemistry gases and safe practice. Being capable of dealing with sick patients to an acceptable and agreeable level.	Yes
Sarah 3	To have expert knowledge about joint replacements To be as knowledgeable as medical staff in defined area (joint replacements) To bring nursing skills to long term follow up To be the patients advocate Expert resource for staff in primary and secondary care and truly share care for patients	To provide expert care for patients to optimise their rehabilitation To work autonomously to the benefit of patients To further develop the role to keep up to date and improve the service for patients To work as an integral part of the team	Yes
Susan Carol 3	Support & encouragement Information Teaching resource The presence gives confidence	To be able to make a difference for all nursing, medical and patients To know the limitations and rise above the frustrations caused by lack of communication Personal development	Yes
Jenny 3	Reduction in numbers of patients required to be seen in clinics by medical staff Reducing waiting times for clinical appointments & reducing actual wait in clinic Reduce pts coming into clinic from outlining areas i.e. GORU	Career Development & Job satisfaction Ongoing development in terms of knowledge base, clinical skills, critical thinking skills & decision making Ongoing development of role improvement in patient journey in holistic care	Yes
Jane 4	Vary from simplistic to complex – different expectations from different medics and nurses. Develop service Good level of expertise, good teaching/lecturing presentation skills To meet targets Pot of information all things to all people	Constantly changing improving level of expertise/knowledge Develop service Liaise profile/awareness of respiratory care Work towards master's level but not enough time	Yes
Rosie 5	To be available 24hrs/day – 7 days a week Expand my service Quick response Excellent knowledge	Professional Leadership Responsible Organised Communicator Listener.	Yes

Appendix 5

Personal Expectations Versus Others Expectations (Phase 3)

Name	How do other people perceive you within your role?	What are your expectations of the role?	Difference
Erin 5	To sort out every-ones pain and take it away completely Nurses expect us to over rule medical staff decisions about patients pain management To be here 24/7	To be able to assist teams in management of pain by education, protocols & guidelines To review analgesia regimes ensuring patient safety To introduce new equipment related to analgesic	Yes
Jill 5	To lead the team to be able to do everything, to be constantly available to everyone! To challenge boundaries and take things forward	To support children/families with diabetes. To support team members. To take the service forward in an appropriately structured way. To Listen to me!!	Yes
Wanda 6	Sometimes to do what they don't have time or staff to do for example meal breaks assist with injections on ward Be used as a scapegoat for example asking to make a decision & then believing my answer absolving them of all responsibility Do menial tasks – for example venflons, venopuncture for some of my medical colleagues	Be able for more fully review patients who become unwell. Use my knowledge and experience to educate junior staff in recognition of a patient's obs/demeanour and be able to interpret change signs.	Yes
Babs 6	Perfection!! 24/7 working Meeting targets i.e. waiting times, 62 day cancer reporting	High Standard, smooth patient journey Job satisfaction, good working relationship with the multi-disciplinary team Sense of humour Time keeping paperwork turn around on time	Yes
Sylvia 6	Too high at times Some are confused to what levels of patients can be seen Some see us as junior medical staff i.e. we should be able to deal with anything – our remit is tighter than they realise	To improve an speed up patient care Increased job satisfaction To encourage younger staff to expand their roles Better patient satisfaction	Yes
Imelda 6	We're cheaper than medical staff to employ to follow up hip/knee replacement patients. Opinions respected by medical staff – mostly working autonomously	Optimise outcome for patients following hip & knee replacement, give appropriate advice, interpret x-rays, clinical examination. In the future would like to start database to enable more formal outcome reassessment	Yes
Katie 6	I am expected to know all the answers to every medical, nursing, Bed management even domestic information	Personal development Some time to learn	Yes
Queenie 6	To grow arms & legs fast and use without appropriate training & support	To develop as plan at beginning and expand my knowledge and skills To work as part of a growing team	Yes

Appendix 5

Personal Expectations Versus Others Expectations (Phase 3)

Name	How do other people perceive you within your role?	What are your expectations of the role?	Differences in expectations
Jake NP single 1	Meet Targets Holiday cover	Provide help, support, care, information and easy access to healthcare for GI patients.	Yes
Pet single 2	Anything & everything to ensure a smooth pathway for patients with urological cancers.	To work as an equal member of urological cancer MDT. To feel I make a valued contribution to the patient experience To feel supported by my team.	Yes
Florence Paired	Problem solving “can fix everything” Pick up the pieces emotionally with patients Jack of all trades Clinical expertise/knowledge Clinical expertise – need to know what I’m talking about Develop services – take things forward	Improve quality of patient care Consistency for patients Encouraging others learning and enthusiasm	Yes
Katrina Paired	Work autonomously create a sense of co-ordination Expert in speciality Take the service forward for medics!	Develop both professionally and personally Time to develop & put skills into practice Take ideas forward	Yes
Freya Single 3	An expert where I work Treatment and support	Personal development	Yes
Alberto single 5	Education for Nurses Organisation of caseload, management of medication Up to date information on treatments and trials. Signpost of services	Support information and advice for people affected by MS Education Audit Research	Yes

There were some Ya Ya boxes that were not handed in at the end of the session, the individuals wanted extra time to fill these in, however did not return them to the researcher

