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**A nurse practitioner's tale:
an autoethnographic interpretive study of
the values of nurse practitioners, general
practitioners and district nurses.**

Alison Crumbie

Submitted to the University of Wales in fulfilment of the
requirements for the Degree of Doctorate of Nursing Science

Swansea University

2005

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Summary

Nurse practitioners began practising in the UK in the 1980s. Since then the numbers have grown and a body of research has developed relating to the role. The criticism of nurse practitioners has been that they work as “mini doctors” and that they no longer belong to the family of nursing. If nurse practitioners have more in common with medicine than they do with nursing one might expect to find that nurse practitioners have moved away from the values of nursing and have instead moved toward the values of medicine. To date we know relatively little about the role of the nurse practitioner.

The aim of this study was to determine to what extent nurse practitioners share the values of nursing or medicine. In recognition of the author’s own role as a nurse practitioner an autoethnographic approach was used. Unstructured interviews were carried out with general practitioners (GPs), nurse practitioners and district nurses and their values were revealed through descriptions of meaningful practice.

Significant and important differences were found between the three groups of practitioners both in the form and the content of the narratives. The form of the narratives revealed the cultural connection of the nurse practitioners to nursing. The content of the narratives revealed the pioneering nature of the role and the nurse practitioners’ concern with acceptance, recognition and respect. When analysed from a MacIntyrean perspective, the nurse practitioners lacked the purpose and goals that were evident in the descriptions of meaningful practice from the GPs and district nurses. Such a finding seems to be congruent with an emerging practice and challenges the nurse practitioner community to determine for itself the nature of its contribution to patient care.

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Abbreviations

AACN	American Association of Colleges of Nursing
BIDS	International Bibliography of the Social Sciences
BMA	British Medical Association
BNI	British Nursing Index
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CSA	Cambridge Scientific Abstracts
DN	District Nurse
ENP	Emergency Nurse Practitioner
GMS	General Medical Services
GP	General Practitioner
JSTOR	Journal Storage
NHS	National Health Service
NP	Nurse Practitioner
NWI	Nursing Work Index
PCT	Primary Care Trust
RCN	Royal College of Nursing
SHO	Senior House Officer

Dedication

This work is dedicated to six significant people in my life: my Mum and Dad Margaret and Jim Crumbie for their unending encouragement and love throughout my life; my sister Gill Denvers for her continual friendship; my mother-in-law and father-in-law Dr Margaret Batten and Dr Hugh Batten who embraced me in their arms twenty two years ago and never let go; and to my husband Chris Batten who makes life exciting and challenging and without whose support, encouragement, patience, and love this thesis would never have been possible.

CHAPTER ONE

INTRODUCTION: CONTEXTUAL OVERVIEW

Introduction

At the conclusion of a fifteen minute consultation the following exchange took place:

Patient	“Thank you doctor. You are a doctor aren’t you?”
AC	“No I’m a nurse.”
Patient	“Oh are you going to become a doctor? You’re just like one.”
AC	“No I will always be a nurse.”

This is representative of a not uncommon exchange that takes place in my every day practice. People pass three signs on their journey through the health centre to my room indicating “Alison Crumbie, Nurse Practitioner” and I frequently introduce myself to new patients with a hand shake saying “Hello I’m Alison, a nurse practitioner” and still, on occasion, patients confuse the role of the nurse practitioner with that of the general practitioner (GP). This confusion is illustrative of the changing nature of nursing roles in the United Kingdom (UK) in recent years and it is not limited to the role of the nurse practitioner. Over the past two decades we have seen the emergence of a variety of nursing roles that have challenged the boundaries between nursing and medicine. Nurses are now using endoscopes to work with people who have bowel problems, they are carrying out minor surgical techniques and prescribing medications; these are all examples of activities that were formerly only in the domain of medical practice. The growth of the nurse practitioner movement has perhaps challenged the profession more than most nursing roles. Nurses are now working in roles in both primary and secondary care that would have previously been identified with the role of a doctor. They consult with patients in general practice, emergency departments, walk-in centres and medical assessment units and, when appropriate, they are able to assess, diagnose and treat without referral to a doctor.

In April 2000 the British Medical Journal and the Nursing Times ran simultaneous feature issues of their journals which were focused on the changing roles of nurses and doctors and particularly on the evaluation of nurse practitioner practice. These two influential journals thus marked a significant moment for health care delivery in the UK. Nurse practitioners have gradually become established in general practice over the last two decades and the two journals provide evidence of

this development. Nurses have moved into the nurse practitioner role to meet the needs of underserved populations (Smith, 1992), to enhance the capacity of general practice in areas of poor GP recruitment (Kenny, 1997) and to deliver innovative health care services to populations with specific needs (Walsh and Howkins, 2002). Examples now exist of nurse practitioners taking on triage roles (Reveley, 1999), running minor illness clinics (Marsh and Dawes, 1995), accepting same day clinic appointments (Kinnersley et al., 2000; Venning et al., 2000) and operating open access clinics (Stilwell et al., 1987; Salisbury and Tattersell, 1988).

The Cumberlege report on community nursing can be seen to have provided the groundwork for such developments by stating that “the principle should be adopted of introducing the nurse practitioner into primary health care” (Department of Health, 1986 p.32). In 1991 the National Health Service Executive Management published “Junior doctors: the new deal” which paved the way for the reduction in junior doctors’ hours (National Health Service Executive, 1991). With junior doctors being less available and fewer recruits entering general practice a need was developing for nurses to advance their roles and to take on some of the work that had previously been the domain of doctors. This has been recognised more recently in a government document “Making a difference: strengthening the nursing, midwifery and health visiting contribution to health and health care” (Department of Health, 1999). In addition to the supportive policy emanating from the government, the British Medical Association has also recognised the contribution of nurses by stating that a nurse practitioner could be the first point of contact for most patients in primary care (2002). In the light of such support, nurse practitioners have been gradually expanding their roles and have been moving into areas of practice that would have previously been seen as the domain of medicine.

The delivery of health services in the new millennium is characterised by a mix of medically prepared and nursing prepared health care professionals, who in many cases, are providing the same or similar services to patients. The health care community therefore has a responsibility to explore these changes and to examine what meaning this might have for patients and health care professionals alike. This thesis will aim to examine the increasing complexity in clinical roles with a particular focus on the role of the nurse practitioner. Specifically, the aim will be to

explore whether nurse practitioners, in taking on many of the skills that were previously associated with the role of the doctor, have moved away from the practice of nursing and closer to the practice of medicine.

The practices of nursing and medicine

Medicine and nursing represent two different practices; doctors undertake the practice of medicine and nurses undertake the practice of nursing. The work of Alasdair MacIntyre provides a useful theoretical underpinning to understanding the different practices of nursing and medicine. MacIntyre describes a practice as:

... any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence which are appropriate to and partially definitive of that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved are systematically extended (MacIntyre, 1984 p.187).

He goes on to describe goods external to the practice as those objects which form the basis of much competition such as a salary or a title. Goods internal to a practice can only be identified and recognised by the experience of participating in the particular practice. Goods internal, like goods external can be the product of competition to excel however their achievement tends to be for the good of the whole community who participate in the practice. Medicine and nursing are both socially established forms of cooperative human activity. Wilson-Barnett (1988) points out that members of the general public tend to have an image of the nurse. Indeed the quotation from the patient at the introduction to this thesis suggests that there is a broad public understanding that the form of nursing differs from the form of medicine. One might expect to find that both the goods internal and external to each practice and the standards of excellence could provide some clarity on either side of the boundary between the two groups.

One method of attempting to understand the goods internal and external to the practices of medicine and nursing might be an exploration of the values and beliefs of each of the groups. In “The dawn of value theory” Lepley states that:

The first and cardinal principle is, however stated, that values are verified goods. Goods may be recognised as being, or having expression in 'any interest in any object' or 'any object of any interest' that is in the responses of sentient creatures toward and away from things and conditions, external and internal (Lepley, 1937 p.363).

Lepley's quote would suggest that expressions of values could provide some indication of the internal and external goods in a particular practice. If the nurse practitioner role has created some genuine confusion relating to the roles of medicine and nursing, it could be suggested that nurse practitioners have moved closer to the values of medicine and away from the values of nursing.

Definitions of nursing and medicine

If the goods internal and external to nursing and medicine could be identified, it might be possible to determine clear definitions of the practices of the two professions. However, widely accepted definitions of medicine and nursing remain elusive. Many nurse theorists have attempted to define nursing (Peplau, 1952; Rogers, 1970; King, 1981; Orem, 1985) however, none of these definitions on their own seem to have satisfied the nursing community. The recent Royal College of Nursing (RCN) definition of nursing (2003) acknowledges that any definition of nursing needs to be dynamic and constantly evolving like nursing itself. A definition that is fixed in written language is therefore unlikely to adequately capture the complexity of nursing practice. There are similar difficulties with the definition of medicine. Greaves (2004) suggests that the task of defining medicine is unending because the boundaries of healthcare and medicine are derived from the constantly changing values and goals concerning our lives. In the absence of agreed definitions of medicine and nursing, a clear delineation between the two practices becomes problematic.

The lack of clarity in defining the practices of medicine and nursing is evident in the ongoing debate relating to the role of the nurse practitioner. Articles entitled "Are nurse practitioners merely substitute doctors?" (Professional Nurse, 1996), "When nurses take on doctors' roles are they just gap-filling?" (Fullbrook, 2004b) and "Nurse practitioner or physician's assistant?" (Sharkey, 1996) demonstrate the breadth of concern relating to the professional boundaries of nursing. Fullbrook (2004a) refers, in a deprecating manner, to the new "nurdoc" role

and Cahill (1996) suggests that the nurse practitioner movement is merely producing second class doctors rather than first class nurses. Barton et al. (1998) refute Cahill's position by arguing that she defines the nurse practitioner by the medical procedures that have been taken on by this group of nurses. They state that the nurse practitioner is not simply defined by tasks and that Cahill's suggestion, that the unique characteristics of nursing may be threatened by nurses taking on increasing amounts of medical work, is based on a historically dated view of health care practice.

In 1996 the Royal College of Nursing agreed a definition for those nurses who could be identified as nurse practitioners and this was detailed in a leaflet that was produced in 1997. A nurse practitioner was defined as:

... a nurse who has undertaken a specific course of study to at least first degree and: makes professionally autonomous decisions for which they [nurse practitioners] have sole responsibility, receives patients with undifferentiated and undiagnosed problems, screens patients for disease risk factors and early signs of illness, develops with the patient a nursing care plan, provides counselling and health education and has the authority to admit or discharge patients from his/her caseload and refer to other health care providers as appropriate (1997 p.2).

This definition describes nurse practitioner practice as embracing the diagnosis and clinical decision-making that hitherto was considered to be within the sphere of medicine. The definition is broad enough to encompass a wide range of activity resulting in some authors suggesting that the title of nurse practitioner "means different things in different settings" (Spilsbury and Meyer, 2001 p.8). The practice of nurse practitioners is clearly challenging the boundaries between medicine and nursing with consequent blurring and confusion for those who seek to clearly define and control healthcare practice. This situation is characteristic of the tensions that exist in the postmodern world where no tradition or theory has a universal claim to represent truth. Instead postmodernism is characterised by pluralism, heterogeneity and a multiplicity of meanings and perspectives. The nurse practitioner movement is just one example of the increasing professional ambiguity that is associated with the complexity of a postmodern world.

The postmodern crisis

It is clear from the quote at the start of this thesis that I am a nurse practitioner. I work in general practice alongside another nurse practitioner and our two GP colleagues. It is also clear from the quote at the start of this thesis that I have some clear views relating to my membership of the world of nursing rather than the world of medicine. What might seem like a compliment from a patient “Oh, are you going to become a doctor? You’re just like one” is in fact not received as a compliment. The patient is praising me so highly that I could almost be a doctor! With such strong views and such clear group membership, one might suggest that my exploration into the values of nurse practitioners and doctors is bound to be biased by my perspective. The tenets of positivism would suggest that every attempt should be made to eliminate the effect of the researcher (Hammersley and Atkinson, 1995) and therefore if I am going to explore the worlds of nursing and medicine I should make every effort to remain objective, detached and removed from the groups I wish to study. In positivism there is a presumption that there is a real world “out there” that can be captured by the researcher (Denzin, 1997) and a further presumption that all social phenomena exist independently of the researcher (Hammersley and Atkinson, 1995). All political and practical commitments of the researcher are therefore considered to be extraneous to the research process and are a potential source of distortion. Denzin (1997) points out that critical poststructuralism challenges these assumptions.

Poststructuralism is a term that is closely linked with postmodernism. Both terms have been described as representing a period of time following on from modernism (Harvey, 1989; Fox, 1993). Indeed it has been suggested that the passage from modernism to postmodernism occurred at 3.32pm on July 15th 1972 when the Pruitt-Igoe housing development in St Louis was demolished as it was an uninhabitable environment for the low-income people that it housed (Harvey, 1989). Fox (1993) also states that the modern era refers to a historical period that is suggested to have commenced in the West with the Age of Enlightenment at the end of the eighteenth century (Fox, 1993). This age was characterised by the rise of scientific and philosophical rationalism and a commitment to discovering the truth. The foundation of truth was considered to be the human subject and this marked a change from earlier periods when all truth was founded on religion. Descartes’

“cogito, ergo sum” which translates into “I am thinking, therefore I exist” (Urmson and Ree, 1989) is an example of a rational strategy for realising the aims of the Enlightenment as there was a presumption that there existed a single correct mode of representation of the world. Hume is considered to be a pivotal figure in the Enlightenment project as he set out to establish the foundations of an empirical science of human nature and he believed that the only important field of demonstrative reasoning was mathematics (Urmson and Ree, 1989; Blackburn, 1994).

In spite of these accounts, it is perhaps unhelpful to think of postmodernism as a period of time. Instead it is preferable to conceptualise postmodernism as a perspective that adopts a critical position in relation to modernism. Lyotard (1979) suggests that “modern” relates to any science that legitimates itself with reference to a metadiscourse whereas postmodernism takes a critical position in relation to metanarratives. Postmodernism, according to Lyotard, has altered the rules of the game for science, literature and the arts. Thus he describes the postmodern society as falling less within the province of structuralism or systems theory and more within the heterogeneity of language particles. Scientific knowledge, states Lyotard, does not represent the totality of knowledge, it has always existed in competition with a different kind of knowledge that he refers to as “narrative”. In postmodernism reality is replaced with simulation, rationality by multivocality and monolithic organisation by fragmentation (Fox, 1993). Hierarchy is replaced by anarchy, transcendence with immanence and distance with participation (Harvey, 1989). In postmodernism there is a realisation that there is no one great reality or truth to be discovered, there is no one big picture to be constructed. Instead there is a multiplicity of perspectives; there are multiple truths and multiple realities. The postmodern researcher is not above and detached from the research subjects, instead the researcher and the participants of a project become entwined. The researcher’s role is to represent the plurality of perspectives of the participants, to recognise his or her own influence on the work and to acknowledge the interactive nature of the written form as readers of the completed work bring their own values and beliefs to bear on their reading and understanding of the presented text. An example of the plurality of the postmodern perspective is Rorty (1980) who states that there is no one “essence”; instead, our description of ourselves is just one view that is on a par with various alternative

descriptions. He suggests that “discovering the facts” is simply one project of edification among a variety of others. Denzin (1997) suggests that the postmodern text is based on a parallax of discourses in which there is no stability and from which no firm or certain conclusions can be drawn.

It could be suggested that the anti-realism, multiplicity and heterogeneity associated with poststructuralism and postmodernism has resulted in fragmentation. If there is no one truth out there waiting to be discovered but instead there are a series of perspectives that could change with each passing moment, the quest for truth and knowledge could indeed be regarded as a futile and hopeless process. Ellis and Bochner (1996) suggest that the question “how is it true?” has been replaced with the question “how is it useful?” The retort to this suggestion might be, “we can only determine if something is useful if we know it’s true”. Indeed Brewer refers to extreme postmodern ethnographers as descending into a state of “utter relativism, the epitome of the postmodern dissolution into nothingness” (Brewer, 2000 p.47) and Dingwall et al. refer to the methodological anarchy of postmodernism and state that “it’s fantasy that all standards are arbitrary, that all versions of the world are equal and that whatever we choose to declare to be true, is true” (Dingwall et al., 1998 p.169). The challenge for research conducted in a postmodern context is to determine the way in which such work can contribute to human understanding and meaning.

Denzin refers to the legitimation crisis in research in the poststructuralist world. He states that triangulation, trustworthiness, credibility, fit, coherence, comprehensiveness and a host of other terms associated with the validity of research are “attempts to reauthorize a text’s authority in the postpositivist moment” (Denzin, 1997 p.6). In an effort to save ethnography from the postmodern morass Hammersley (1998) points out that we can never be absolutely certain about the validity of any knowledge claim although we can make reasonable judgements about the likely validity of these claims. True knowledge corresponds in relevant respects, to the phenomena that we seek to represent and we make our judgement based on the plausibility and credibility of the text. Hammersley refers to this as “subtle realism”. Hammersley’s (1998) subtle realism and Brewer’s (1994) post postmodern critique of ethnography will be explored further in the methodology section of this thesis.

Autoethnography

The postmodern perspective paves the way for the development of research strategies into alternative and innovative forms. The researcher's personal perspective and individual interpretation of research materials provides a legitimate contribution to the development of understanding amidst a variety of other perspectives and interpretations. Autoethnography is a particular form of ethnography that acknowledges the researcher's subjective contribution to the research process. In autoethnography the credibility and plausibility of the text will depend in part upon the researcher's willingness to share his or her values and beliefs with the reader. Brewer (2000) suggests that even natural science produces socially situated knowledge and the reader of the work would benefit from understanding the perspective of the researcher. He goes on to point out that the procedural rules associated with any particular methodology involve researchers in adopting particular ontological and epistemological assumptions whether they are aware of it or not. All research then, can be considered to be autoresearch (Ellis and Boucher, 2000). In qualitative research in particular, the inseparability of the researcher and the research makes any effort to control the effect of the researcher on the research futile (Sandalowski and Barroso, 2002). The personal involvement of the researcher and likely subjectivism are not considered by Hayano (1979) as methodological problems, instead they are seen as assets to deepen understanding.

Autoethnography is a methodological perspective that has, more than most other methodologies, recognised and even celebrated the influence of the researcher on the research. Reed-Danahay (1997) explains that autoethnography is a useful term as it calls into question the binary conventions of self and society and of subjectivism and objectivism. Autoethnography also highlights the multiplicity of identities and cultural displacement that are present in the postmodern world. It is a term that has a double meaning referring either to autobiographical writing with ethnographic interest or to the ethnography of one's own group (Reed-Danahay, 1997). A number of autobiographical autoethnographies have explored a wide range of human experiences including: Ellis (1998) who explores speech impediment; Kolker (1996) who writes about her experience with breast cancer and the battles she had with insurance companies to cover her treatment; Sparkes (2003) who writes about his back surgery and subsequent disability; and Richardson (2001) who writes about her

road traffic accident and the effect it had on her mental abilities. These writers present themselves as the researcher and the subject of research. It takes courage to write these stories because they expose the deeply personal experiences of the writers to the analytical gaze of their readers. The stories are often evocative and moving and the reader is drawn into an interaction with the text. In some cases the writer is obviously trying to make a political point (Kolker, 1996), in others they are offering their own interpretation and analysis (Ellis, 1998) and in others they are allowing the readers to make their own interpretation of the multiple perspectives offered by the writer (Sparkes, 2003). These are essentially personal stories that have been presented as narratives using a range of literary and textual forms to communicate with the readers of the work.

The study of one's own group is also referred to as autoethnography (Reed-Danahay, 1997). The exploration of a group of which the researcher can claim membership can have advantages because the researcher will already share an understanding of the group's language and norms. Indeed Van Maanen (1988) states that writing an ethnography requires, at minimum, some understanding of the language, concepts, categories, practices, rules, beliefs and so forth, used by members of the written-about group. Membership of the group is one way of gaining such understanding. An example of this approach is the work of Fox (1996) who wrote about child sexual abuse. She presented the text in three columns on the page representing the voices of the abuser, the abused and the researcher. Through the voice of the researcher Fox shares her own experiences of sexual abuse. Fox presented her work in this way to provide equal emphasis on the three voices thereby avoiding the inequality of privileging one particular perspective. As she presents the work Fox shares her personal reactions to the voice of the abuser and the voice of the abused so the reader is made aware of Fox's personal views and the impact her past experiences have on the data she is presenting. This is an example of the researcher aiming to give equal status to the voices of the researcher and participants of the study. It also recognises the impact of the researcher's previous experiences on her own interpretation and understanding of the responses of the participants. Autoethnography can enhance equality between the participants of a study and proffers respect for research participants.

The interactive reader

The examples of autoethnographic research listed above are illustrative of an approach to research that recognises the researcher's influence on the work. It is important to also recognise the influence of the reader and to acknowledge the interactive nature of the written form, as readers of the completed work bring their own values and beliefs to bear on their reading and understanding of the presented text. This issue has relevance for research conducted in the positivist tradition, although it has greater significance for research that relies on interpretation, meaning and the development of understanding. Each reader will have a set of values, beliefs, perspectives, experiences and membership of various cultural groups and these will all influence the way in which the work is subsequently interpreted. As Atkinson (1990) points out, the meaning of a sentence to a reader may not be coterminous with the writer's intentions. A reader interpreting Fox's work on child sexual abuse, for example, will react in a variety of ways if he or she has had personal or professional experience of sexual abuse, and in a different, perhaps more detached, way if she or he has had no experience of abuse. Ellis and Bochner (1996) describe their reluctance to provide an introduction to their edited collection of autoethnographic writing as they explain they do not want to influence the reader's interaction with the individual texts. Instead they present a conversation between themselves that reveals some of their own values and beliefs interspersed with personal experiences, desires and sadness and this provides the reader with an understanding of how the editors of the volume brought the various texts together. It also emphasises the role that the reader plays in interpreting autoethnographic writing. When the reader is provided with information about the researcher, they are equipped to interpret the presented text or data and are therefore able to make their own inferences based on that knowledge. It is therefore important for researchers to consider the reader (the receiver of the information presented on the page) as an interactive component of the research process.

Personal narrative

In presenting my work on the values of nurse practitioners and how they compare to the practices of medicine and nursing I am choosing to adopt an autoethnographic approach. I intend to share with the reader some of my own beliefs about my role so that the remainder of the study can be interpreted with full knowledge of my

perspective and how that particular view might have had an impact upon the research design, the data collection and the subsequent interpretation. The following section is a short narrative relating to my role as a nurse practitioner. A fuller discussion of the methodology underpinning this work will follow in later chapters.

Right hand turn, left hand turn

Right hand turn, left hand turn, right hand turn, there. I arrive in the car park and avoiding the three spaces reserved for the health centre doctors, I come to a halt. There are no other cars at the health centre at this time in the morning and no-one in the building. There is an air of calm in the early morning that allows me to prepare, get organised and feel a sense of control. Step through the door, turn left, switch off the security alarm. Back down the corridor to write on the white board that lists who is in the building in case of fire - "Wednesday" "Alison" - soon to be followed by the rest of the health centre staff.

Turn right, turn left, into my room. A locum GP was in my room the previous day. The roll of paper on the examination couch is crumpled and torn from the last patient to lie on it, toys from the toy box are scattered across the floor, a dirty cup sits on the desk. I push the start button on the computer and set about tidying the room. New paper on the couch, put the toys away, tidy the desk and remove the cup.

*Now the computer is ready for my password, *****, a place Chris and I went on holiday last year, it always makes me smile. A little jingle plays, the computer is ready for work. I check the e-mails, blood results and practice notes, responding to requests and making decisions about treatments. I write notes to myself, making a list of patients who need to be phoned, those I need to discuss with the GPs or those who need a prescription. Having cleared the e-mails, blood results and practice notes, I turn to the list of people who are booked in to see me for the day. The first group are likely to be people with chronic conditions such as hypertension, heart disease, stroke, heart failure, diabetes or those who are at risk of these conditions. I take a closer look at the first few patients, reviewing their results and rehearsing what we might need to focus on. Later patients could be anybody with an acute or chronic illness or anyone who just needs to see a health care practitioner for any reason. I enjoy the variety and the uncertainty of not knowing what the patient's problem or concern is going to be.*

The health centre is starting to come to life, people walk down the corridor to make tea, and shout "hello" as they pass my door. The GP has arrived and made me a coffee, we've discussed the weather at the weekend and the progress we're making with running and cycling. I have such great respect for my GP colleagues and regularly turn to them to discuss patients or to ask for their advice. They never seem to tire of offering support and helping me to develop my understanding of medicine.

A few moments to spare before the patients start to arrive. I check the audits on the computer to see how we are progressing with reaching our clinical targets. 98% of the people with hypertension have had their blood pressure checked in the last year (who are the 2% who have not?). 88% of the people with diabetes have had

their eyes checked this year (who are the 12% who have not?). I am excited to see the blood sugar results for people with diabetes slowly but surely improving.

The first person arrives early. I press the buzzer, eager to get started and not to fall behind. I do not like to keep people waiting. I angle the computer screen so that it can be easily viewed by both myself and the patient. The patient walks from the waiting room, right hand turn, left hand turn and left again, "Hello Mr S, I don't think we have met before. I am Alison a nurse practitioner, how are you today?"

Concluding comments

The preceding narrative provides me with what Richards (2003) refers to as a "reflexive platform" from which to interpret the voices of the participants in this project. Like Porter (1995) I hope that by sharing some of who I am with the reader I have made it possible for a more discerning evaluation of the work. The reader can then decide whether my specific view has led to distortions in the analysis of the data. I have purposefully referred to the story about my arrival at work as a "narrative". Narratives are relational (Sparkes, 2002) and for the listener the telling of the story allows for interpretation from their own perspective (Rapport, 2004) so that the work can be "contextualised in the narrative of each reader" (Richards, 2003 p.55). Taylor (1991) refers to the fundamentally dialogical nature of human life and suggests that we define ourselves in dialogue with others. This thesis shares with the reader my own narrative from clinical practice and the narratives of the healthcare professionals who participated in this study and thereby offers an opportunity for dialogue between the reader and the text.

Primary care in the UK is now characterised by a blurring of boundaries between the roles of a variety of health care professionals. The nurse practitioner represents a challenge to traditional boundaries more than most other roles and this has implications for both the patients and the health care professionals involved. It could be suggested that nurse practitioners, having taken on some of the work of medicine, now share a set of values that more traditionally were associated with doctors than with nurses. The aim of this work, therefore, is to adopt an autoethnographic interpretive approach to examine whether nurse practitioners share the values of nursing or medicine.

CHAPTER TWO VALUES: DEFINITION AND THEORETICAL PERSPECTIVES

Introduction

In an editorial for the British Medical Journal, Smith (2000) states that doctors and nurses are divided by gender, background, philosophy, training, regulation, money, status and power. If the two professional groups are separated by so much it could be suggested that doctors and nurses are operating from fundamentally different value systems and this in turn might have an impact upon the way in which services are delivered to patients. This is a particularly interesting and important issue when the two groups are reported to be offering similar services to patients (Horrocks et al., 2002). Smith's statement leads one to believe that there is a division between the two groups. Such divisiveness and difference (if indeed it exists to the extent that Smith is suggesting) has important implications for patients and healthcare practice. An exploration of the cultural diversity between medicine and nursing may help to expose these differences and divisions. Fekete suggests that we can only understand the history of cultures if we also understand the history of value orientations, value ideals, goods values, value responses and value judgements:

Not to put too fine a point on it, we live breathe, and excrete values. No aspect of human life is unrelated to values, valuations and validations. Value orientations and value relations saturate our experiences and life practices from the smallest established microstructures of feeling, thought and behaviour to the largest established macrostructures of organisations and institutions... Yet it is no exaggeration to say that the oceans and continents of value, though much travelled, remain almost entirely uncharted in any way suitable to the navigational contingencies of postmodern itineraries (1988 p.i).

Fekete's view would suggest that an exploration of values could prove to be a rich and fruitful exercise in aiming to enhance and deepen our understanding of particular cultures. Even though values are much written about and are much discussed, according to Fekete, there is a paucity of literature pertaining to the issue of value in the postmodern era.

In order to explore this area further, a literature review was carried out to identify work that had been conducted on values. When presenting a thesis such as

this, there is an expectation that a mechanistic search of the literature will take place. Such an approach would tend to suggest that once the search is completed, the researcher would know all that has been previously written about a particular subject area. A concept such as “value” can be interpreted in multiple ways and is used widely in many different contexts; therefore large numbers of the articles revealed in a literature search may be irrelevant. The researcher has to discriminate between articles and sources of information, selecting those pieces that might contribute to the developing thesis and those that might not. In addition, the researcher will have access to their own knowledge that has built up over a number of years of study into a particular subject. The literature review therefore goes beyond the expected mechanics of exploring the search engines and incorporates the researcher’s previous knowledge of a variety of sources of literature that have relevance to the current study. Hence, the literature review included: a web based search; use of search engines; and a review of my personal collection of literature that I had gathered over a numbers of years whilst exploring and engaging with the literature related to values and nurse practitioners.

The web-based search revealed 91 million hits for “values”, 11 million hits for “professional values”, 17 million hits for “personal values” and 171 thousand hits for “comparing the values of nurse practitioners and doctors/physicians/medicine”. When the search was refined to: “words in the title must include: comparing nurse practitioners’ and doctors’ professional values” there were no hits and similarly when the search was broadened to “comparing nurses’ and doctors’ professional values” there were no hits. The search was broadened further to: “words in the title must include: nurses’ professional values” which resulted in two hits and “words in the title must include: doctors’ professional values” which also resulted in two hits. To continue the search the terms: “values”, “personal values”, “social values”, “values clarification”, “attitude”, “nursing” and “medicine” were entered into the search engines, JSTOR, CSA, BIDS, CINAHL, BNI, PUBMED, the Cochrane Library, the National Research Register and the Department of Health Research Findings Register (see page 8 for an explanation of the abbreviations). The literature review revealed no articles comparing the value systems of nurse practitioners with those of GPs or physicians. Hence the search was broadened to include comparisons between nurses and doctors in areas such as communication styles, ethical decision-making

and emotional socialisation. There seemed to be a division between those articles that contributed to the literature on value in general and those that provided examples of empirical research. Therefore the literature review will be divided into two sections. The first section is an exploration of value theory and the definition of value and constitutes the remainder of this chapter. The second section will consist of a critical review of the research conducted in this area to date and will form chapter three.

The definability of value

The terms “value”, “values” and “value systems” are used widely and in a variety of contexts by organisations, governments, politicians and individuals. Values are considered to be a positive attribute of an individual’s character or an organisation’s culture whereas assumptions, judgements, thoughts, beliefs and interests are less positive. A value-driven organisation is thought of in a positive light in comparison to one that is guided by its interests and an individual with a strong value system is commended above one who holds assumptions or judgements. Value is an apparently simple term described by Pattison (1998) as a portmanteau concept which chases after meaning. “The notion of value and values can happily slip, chameleon-like, between users and utterances, delighting all and offending none because most people do not take the trouble to think about what it actually means in their own lives or those of others” (1998 p.353). Other authors have described “value” and “values” as a “suspect term [that] has to be put through the mangle to be legitimated” (Baker, 1991 p.17) and as “peculiar” by Saarmann et al. (1992 p.28). A universally agreed definition of value is elusive and yet debate about the meaning of value is evident in the work of the early philosophers and continues throughout the ages to the present day.

My aim here is to explore some of the difficulties with the terms “value”, “values” and “value systems” in order to gain some clarity for the present study. One of the difficulties with the clarity of value as a concept is the fact that “value” can be used as a noun, a verb or an adjective. The desk in my study has monetary value as a piece of furniture (the noun), I value its presence as it provides a convenient and comfortable place for me to work (the verb), and the desk has value beyond the economic context because many hours have been spent sitting in front of it writing thereby adding to its significance and meaning in my life (the adjective). The 2002

Oxford English Dictionary definition of value is “the regard that something is held to deserve; importance or worth, material or monetary worth” (the noun), “to estimate the value of” or “to consider to be important or beneficial” (the verb), and it is also possible to consider something as “valueless” (the adjective) (Pearsall, 2002). The dictionary definition also includes values as “principles or standards of behaviour”.

Barton Perry (1914) suggests that value is adjectival rather than substantive, (we describe valuable things as having value) so it would be feasible to describe value as having value. He suggests that it is impossible to describe a predicate in terms of that which is predicated, otherwise the subject and the predicate would be indistinguishable. If an object’s value is a function of the interest taken in it, it would be impossible for anything to possess intrinsic value. The problem lies in the nature of value as a relational predicate making it possible for the subject of the judgement to stand in the relation or to contain the relation (Barton Perry, 1914). An example of a relational predicate is harmony which may be the predicate of one musical note in the sense of it being in harmony with another, or of both notes in the sense of them possessing harmony. Hence value may be possessed internally by the relationship or externally by the object of the relationship. If we take this view, both the object and the relationship of the person to that object become significant.

Fallding (1965) points out that in view of the centrality of the concept of value, our inability to clearly answer the question “What is a value and how is it to be recognised?” is alarming. In the field of ethics there is a similar difficulty with the concept of “good”. Moore suggests that how “good” is to be defined is “the most fundamental question in all ethics” (1959 p.5). Baldwin (2003) in presenting Moore’s thesis determines that there may be no analysis of the concept “good”, there cannot be a definition of the property of being good, although there can be a definition of things that are good. Moore states that “good” is indefinable nevertheless it is possible to define “that which is good” (1959 p.9). If we equate this argument to the definition of value we might be able to determine lists of things that are identified as being of value, even though the property “value” eludes definition.

Marx (1976) describes the elementary definition of value in terms of quantity of human labour-power that has been expended in the production of a commodity.

He refers to exchange-values which are merely different quantities of various commodities that can be exchanged, for example a length of linen for a quantity of gold, and use-values where the property of a commodity is independent of the amount of labour required to produce its useful properties. Clearly exchange-values relate to the quantitative value of a commodity. Use-values touch on that element of value which is qualitative in nature and less easily defined. A commodity such as a wheelbarrow might be valuable to me because it helps me to move manure around my garden; it would be less valuable to my friend who lives in a flat in the city centre. A wheelbarrow clearly has an exchange-value as it can be purchased for a particular price, its use-value however, would vary according to the needs of the person who is considering making the purchase. It would appear that identification of things that have value relies on individual judgement which is based on the complexity of that individual's needs, desires, beliefs and interests.

An exploration of those things that are identified as having value can assist in illustrating some of the difficulties with the definition of value. Herrick's exploration of the question "Is truth a value?" highlights some interesting points. He refers to values conceived in terms of "the satisfaction of interest, need, appetite, desire, or aspiration" (1936 p.169) hence we might value equality because it satisfies our aspiration toward human justice or, it could be suggested, that we might value an apple because it satisfies our need to be satiated. It is clear from these examples that the object of the interest, need, appetite, desire or aspiration is not necessarily a value because the value lies in the relationship and not in the object per se. From a Marxian perspective an apple *could* be an example of an exchange-value (my one apple is worth ten damsons). Herrick would suggest that the apple is not a value; however, it is possible to value an apple if one is hungry or if one is attempting to make an apple pie. Turning to the example of truth as a value, if we follow the logic of this argument, truth cannot be a value because the truth is independent of a person's interest in it. Herrick ultimately rejects this position by stating that science knows no absolute truth and therefore truth cannot be independent of our interest in it. In accordance with this argument Oliver (1998) states that there are no objective values, there is only the world of natural properties and our reactions to it. He claims that we project our reactions back onto the world and speak of it as if it contained such properties. According to Herrick (1936) then, values lie in relationships and

according to Oliver (1998) truth, equality and human justice could not be identified as values because there are no objective values.

Evidently, it is important to distinguish why there is a difference between an apple and human justice. Fallding (1965) points out that it is possible to define value as “things valued” but this is so broad that it becomes meaningless. It is better, he suggests, not to refer to specific ends (such as apples) but instead to refer to certain classes of objects that have more autonomous “worthwhile-ness” and consequently give rise to principles that guide our behaviour. A value according to Fallding is “a generalised end that guides behaviour toward uniformity in a variety of situations, with the object of repeating a particular self-sufficient satisfaction” (1965 p.224). In Fallding’s view a value is an end state (for example human justice) and its purpose is to guide behaviour in order to achieve an autonomous satisfying state (for example having achieved justice). Thus, he describes values as “organising ends” because many other actions are subordinate to them (1965 p.225). This definition helps us to distinguish between those things that are simply objects of desire and those that represent values.

Rokeach refers to values not only as generalised end states but also as instrumental modes of conduct. He states that value is:

... an enduring belief that a specific mode of conduct or end state of existence is personally or socially preferable to an opposite or converse mode of conduct or end state of existence. A value system is an enduring organisation of beliefs concerning preferable modes of conduct or end states of existence along a continuum of relative importance (1973 p.3).

It is interesting to note that Rokeach describes both value and value systems as “enduring”. He suggests that through experience and maturation, absolute values that we have been taught become ordered in priority. This would suggest that values are relatively stable and resistant to the effects of particular contexts. Indeed his approach to collecting information about individual human values is context-free as he has developed the Rokeach Value Survey which is administered to participants requiring them to prioritise sets of values. His work is based on a number of assumptions including: the total number of human values is relatively small; all

people possess the same values but to different degrees; and these values are organised into systems. The Rokeach Value Survey was developed in a positivist paradigm exploring the nature of values by asking participants to rank eighteen instrumental and eighteen terminal values in a value system hierarchy. There are a number of examples of the use of this approach in the nursing literature (Furnham, 1988; Prothero et al., 2000).

Rokeach states that his aim was to develop a value-free approach to the examination of human values. Interestingly, it could be suggested that the use of quantitative methods to examine values provides evidence of a value system in operation, therefore this method cannot be described as value-free. The Rokeach Value Survey is however, unashamedly context-free. If, as Oliver (1998) suggests, values are relational, the context makes an essential contribution to the understanding of human values. Indeed Barton Perry commences his work on the definition of value with the comment, “when one examines values one not only finds them in the context of subjectivity and judgement but is from the first puzzled to know how much of that context belongs to their structure” (1914 p.141). It is difficult to think of values without placing them in some sort of context or setting. The majority of the time I might value communicating in-depth with a patient, attempting to give them the time and space to express their worries and concerns; however, in the middle of an extremely busy surgery, having had a number of extra patients squeezed in to the clinic, I might be forced to value an in-depth conversation less and instead value efficiency and speed. This might be because I value and respect the patients who need to see a nurse practitioner and I want to give each one of them an opportunity to get the help they need. An alternative explanation might be that I need to satiate my hunger and get to lunch as quickly as possible.

Other authors have also suggested that an individual’s values are not stable and therefore the value system is not enduring. Rezsosazy (2001) suggests that a set of values is a living system which is complex and subject to seesaw motion and variation. Lepley states that values do not “lie around like polished pearls waiting to be picked up” (1937 p.366) instead, values are best verified in the light of human history. If value can be found in both the relationship with an object and the object itself, that relationship might be so dynamic that we might value an object or an idea

more or less according to the circumstances in which we find ourselves. Fekete (1988) describes value systems as a “force field” resulting from a network of evaluations and the circulatory process of a collective system of value relations and practices. He describes the subject and object terms as being “deconstructed and drawn into the circulating medium of value” (1988 p.66). In Fekete’s conception, value is not a static reducible entity, instead he describes the relations of value as being “constructed, deconstructed and disseminated” in a circular rather than linear scale. The methodological narrowing of the positivist-modernist tradition resulted in a reductive model of the concept of value. Fekete’s perspective opens up new possibilities for the study of value where the focus shifts from the exploration of specific values to the examination of value orientation (the relationships between the individual and the value) contextualised in the dynamism of human experience. In this sense value is a thoroughly postmodern concept.

Even if a value system is considered to be a dynamic, changing, circulatory process, it could still be possible to recognise within that system things that are valued and an individual’s relationship with the thing that is valued. According to Pattison (1998) values can be confused with preferences, choices, interests, beliefs, attitudes, standards and principles. If values are to be identified as those things that we value, how then are we to distinguish between valuing something and having a preference for it, an interest in it or having a belief about it? Pattison (1998) states that preferences, choices and desires are expressions about the things that people value, and that if we value something we also desire it, prefer it above other options and will make a choice about it. In addition to the problem with preferences, choices, interests, beliefs, attitudes, standards and principles, Pattison (1998) points to the world of manufacturing and management as providing words such as “standards”, “visions” and “goals” as synonyms for value and the world of ethics as providing the words, “morals”, “principles” and “commitments”. Judgements, prejudices and assumptions can also be associated with values; these tend to be thought of as unthinking or uncritical whereas values are not (Pattison, 1998). If we value something, we are also likely to have an interest in it, as described above by Herrick (1936). It is possible to have a number of interests and people who have many interests tend to be admired (Fallding, 1965). However, having more than one value at any one time can result in a certain amount of tension and can even result in

irresolvable conflict. Fallding (1965) states that this highlights the essential and subtle difference between a value and an interest. Many of the words listed above provide important pointers to an individual's values but they also highlight the difficulties in reducing value to a clear and concise definition.

Value pluralism and value monism

As the term "value" can be employed in such a variety of ways, clarification of the focus of a study into values and value systems is essential. When we are exploring the values or value systems of others we need to consider whether we are aiming to explore the lists of objects or ideas that are regarded as valuable to that individual or the nature of value itself. If we explore lists of objects or ideas that are regarded as valuable we could be exploring lists of "values" or a number of items that can be described as "valuable". Value pluralism is a metaphysical thesis that holds that there are many values that cannot be reduced to a single super-value. Conversely, value monism is a thesis that there is ultimately one value into which all other values can be subsumed. The pivotal issue to be examined here is how values are properly individuated (Chang, 2001). Chang (2001) suggests that if a value is "merely instrumental to" another value, or "merely part of" a second value, or "merely symbolic of", "wholly constituted by" or "merely contributory to" a further value, then the first value becomes reducible to the second. So if love is merely instrumental to pleasure, what it is to feel love is fully explained by the pleasure it brings. There has been no agreement on which value might be the super-value but there is an attractive simplicity to this perspective. If value monism holds, there should be no conflict because all choices between values can be tidily arranged according to the quantity of the super-value that each value bears. Thus there would be no moral dilemmas and no difficult choices. Moral dilemmas seem to be all around us in most walks of life and are particularly evident in the health care arena. Lindseth et al. (1994), for example, explored ethically difficult care episodes and the reflections of physicians and nurses upon those episodes; Kelly (1991) found numerous examples of value conflict in her study of the values of nursing undergraduates; and Varcoe et al. (2004) found tensions and conflicts in values in their study of ethical practice in nursing. Value monism appears to be problematic because there are so many examples of value conflict, moral dilemmas and difficult choices.

A number of authors have identified lists of values and have used these lists to compare groups of health care professionals. Clearly these authors are working from a value pluralism perspective. Altun (2002) states that the prevailing values in nursing today are: aesthetics, altruism, equality, freedom, human dignity, justice and truth. In comparing doctors' and nurses' expressed values Grundstein-Amado (1992) looked at: the basic values of survival, dignity, respect, knowledge, quality of life and comfort; the moral values of carefulness, responsibility, truthfulness, honesty, courage and avoiding harm; and the social values of informing, co-operating and equality. The naïve observer could be led to believe that such lists would suggest that it might be possible to clearly identify particular values and to compare professional groups by measuring numbers of values aspired to. Indeed Sivberg and Petersson (1997) and Prothero et al. (2000) provide examples of studies that have taken this approach. An interesting point to note is the wide diversity of the values identified by these authors. How the authors of such studies arrive at these lists is not always clear and will be examined at greater length in the subsequent review of research into value. The lists of values used by these authors demonstrate their allegiance to value pluralism; these are also examples of positivist-modernist epistemology in action using predetermined definitions of values resulting in a narrow view of the concept of value.

Typology of values

In addition to the variety of values that can be identified, values can also be classified into different typologies. Consideration of the different typologies can help to uncover the multidimensionality of value. Rezsóhazy (2001) outlines a number of different classifications of values. There are core values which are held by the whole population and specific values that are held by smaller groups, for example health care workers or particular religious groups. There are structuring values defined as those in the centre of a value system or peripheral values which are those that are more open to external influences. There are final and instrumental values, with final values being at the top of the hierarchy and instrumental values being those values that are needed to achieve the final values. There are global values such as justice that transcend different spheres of social life and sectorial values that are confined to a special sphere of society. There are communities that tend to have unanimity in

their value systems and others that tend to have pluralistic values.

Fallding (1965) felt that a typology of values was important to pave the way for the empirical study of values. Thomas (1998) offers a typology for values, in suggesting that the theory of value can be split into subjectivists, objectivists and neo Kantian-rationalists. The subjectivists claim that the only value is in the subjective states of sentient organisms whilst the objectivists claim that there is some degree of independence between the value and human interest. These two approaches rest on the arguments made above, namely: if as Oliver (1998) suggests there are no objective values then values based on the subjective states of human beings would be reasonable. However, if, as Barton Perry (1914) suggests, there can be value in both the object and the relationship with that object then some degree of independence between the value and human interest is reasonable. The neo Kantian-rationalists offer a third approach according to Thomas (1998). This group argues that subjective interests result in reasons which are tested by the individual to see if they are sufficient to achieve the desired ends. If the reason passes the test the end becomes valuable and worthy of choice. Something may be valuable for the contribution it makes to achieving a further state. Hence going to work may be tedious at times but it results in earning a wage and therefore going to work becomes valuable. This is an example of the distinction between instrumental and final values as described by Rezsosazy (2001) and by Rokeach's (1973) instrumental and terminal values. Thomas (1998) states that this distinction between the instrumentally and finally valuable is located within the theory of practical reasoning.

If we adopt as our perspective Fekete's view of value as a force-field that is being constructed and deconstructed in a circular rather than a linear fashion, a typology that portrays a static representation of values will not adequately illustrate the complexity of human values. Instead a typology that recognises the importance of the interaction of the person with the value object, for example the perspective of the neo Kantian-rationalists, may potentially provide a greater depth of understanding. Therefore, when exploring the nature of values, it is important to consider not only the object or idea that is valued, but also the context in which it is valued.

Value and meaning

Pattison (1998) describes values as “relative and transitory” and he states that the tangible external reality of value is “illusory”. Values according to Pattison are non-realist, postmodern and closely related to meanings. Frankl’s (1959) work “Man’s search for meaning” is based on his experiences in the concentration camps of World War II. He developed a form of psychotherapy called “logotherapy”. Logotherapy is based on the premise that striving to find meaning in one’s life is the primary motivational force in human beings. Frankl states that there is no general answer to the meaning of life because the meaning of life differs for all people from day to day, hour to hour. What matters then is not a person’s general meaning in life but the specific meaning at a given moment. This position is congruent with Pattison’s (1998) suggestion that values are relative, transitory and illusory and Fekete’s (1988) suggestion that the relations of value are “constructed, deconstructed and disseminated” in a circular rather than linear scale. Frankl suggests that meaning is discovered in three ways, “by creating work or doing a deed; experiencing something or encountering someone; and by the attitude we take to unavoidable suffering” (1959 p.133). If we can discover our values hidden in the complexity of the meaning in our lives, they are clearly context-bound, relational and relative. This is a level of complexity that is denied by the hierarchical lists of value statements described by the authors referred to earlier in this thesis (Rokeach, 1973; Grundstein-Amado, 1992; Sivberg and Petersson, 1997; Prothero et al., 2000; Altun, 2002).

If, as Pattison suggests, values are closely related to meaning, it could be suggested that values and value systems could be explored by asking people what is meaningful to them in their lives. Fagermoen (1997) took this approach and explored the values embedded in meaningful nursing practice. She suggests that values are articulated as meanings both experientially and existentially. She states that meaningful nursing practice can be realised through interactions with patients, work performance, collaboration with other professionals and in personal outcomes. She also suggests that “professional identity is defined as the values and beliefs held by the nurse that guide thinking, actions and interactions with the patient” (1997 p.435). If professional identity is defined by values and beliefs, it would follow that the study of values is paramount to understanding the characteristics of nursing and medicine. It would also follow that different professional groups could potentially display

differences in the meaning of (and therefore the values relating to) their practice.

Values and professional socialisation

It might be reasonable to expect that two groups of practitioners who have been educated separately, and have been exposed to different professional socialisation processes, could indeed describe differences in the meaning of their respective practices and value systems. Even prior to their entry into professional education, a number of factors in life will have contributed to the individual making a choice to commit to a career in nursing or a career in medicine. As new members of professional groups are socialised into the profession, they are initiated into a deliberately selected and adopted value system. As Tompkins (1992) suggests, professional standards of behaviour are established that reflect an underlying value system. Indeed Kuczynski's definition of values is: "Values are patterns of regulation accepted as desirable by persons in a given culture or family environment and serve as guiding principles in their lives" (2001 p.16148). Saarmann et al. (1992) point to the internalisation of values and traditions of a profession as a fundamental, primarily subconscious, process through which new members of the profession must pass. Rezsóhazy (2001) states that values are structured primordially by the process of socialisation and the agents involved in this process are the family, the school, the media and peer groups. These models of professional socialisation suggest that the new recruit to the profession is a partially created painting to which the current members of the profession can add the colours of their multi-layered value system. A contrary perspective is the predispositional model which suggests that people with specific personalities, values, beliefs and needs are likely to be attracted towards certain occupations (Furnham, 1988). Furnham (1988) suggests that from a researcher's perspective, a person's value system must represent their past socialisation. Fekete (1988) has a different view. He highlights the debate over whether values are derived from empirical existence or whether they are constructed by universal reason in line with the practical reasoning of the neo Kantian-rationalists. Values are therefore either simply derived from an accumulation of experiences or result from the unique interaction of each individual with life's past, present and future. Once again Fekete uncovers the complexity and dynamism of values and value systems which has clear methodological implications for the study of value.

Empirical considerations in the study of values

Why are values important and what is the worth of studying them? Values are said to have an impact on actions (Altun, 2002) and serve as guiding principles (Kuczynski, 2001). Values are described by Oyserman (2001 p.16150) as “internal compasses or springboards for action”. Anderson (1996) points out that the core issue in the theory of value is the nature and structure of reasons for action. Oyserman states that “the most profound influence of values may be through the ways that they influence rules, norms and procedures within a society and in this way structure the everyday life choices for individuals within a society” (2001 p.16152). Fekete states that value is “a medium of orientation, a primary, underivable, and universal category of social praxis” (1988 p.67). It seems that values have an impact on, indeed could be suggested to be the main drivers for, the action and behaviour of each human being.

Given the preceding discussion it would seem that the study of values is paradigm-sensitive. If one agrees that value can be defined and studied in isolation from contextual influences then lists of values can be used to study the hierarchy of an individual’s value system. If one were to study value as a postmodern concept, a hierarchical list of values would have no place and instead the study would focus on the relationships between the individual and the object of value and/or the value itself. Peacock (2001) states that the researcher can explore values from an objectivist or an engagement perspective. The analyst who takes an objectivist stance should control and suppress the expression of values, whereas one who adopts engagement should express the values of one’s informants, one’s own and others’.

Pattison (1998) states that values are very difficult for us to study because it is so challenging to stand outside our own values and to survey them objectively. This is compounded still further when they concern the fundamental way in which we operate in the world, for example values operating in our field of work or an area of interest about which we feel passionately. It is extremely difficult to divorce our own values from such a study. If we choose to take the objectivist approach in a modernist paradigm using a predetermined list of values to be ranked by our respondents in a hierarchy, that in itself is an expression of our own values as it demonstrates that we value the objectivity of the positivist perspective. However, if we adopt the approach of engagement and choose to include not only the values of

our respondents but also our own values, then clearly our values have influenced the study and we have to be candid about that fact, recognising that the usual tenets of validity, reliability, replicability and generalisability need to be addressed and that the rigour of the study has to be defended in alternative ways.

Another challenge to the study of values includes our ability to conceal our thoughts, desires and perceptions (Piper, 1996). Values have tended to be associated with favourable attitudes (Piper, 1996), however, one might value power over others, or inequality or personal enrichment at the expense of others. Asking people directly about what they value is unlikely to elicit a meaningful list of values whereas watching their behaviour is unlikely to tell us much about their internal values because behaviour is contaminated by other antecedents of action. Rezsosazy (2001) suggests that free non-directive interviews or autobiographies allow respondents to choose their own words and to produce rich material in relation to their values, the only difficulty being that the material is a challenge to analyse and generalisability is problematical. Pattison (1998) states that people suffer much emotional pain when values and fundamental meanings are threatened and therefore one way of discovering what their values are is *via negativa* (asking them what distresses them or ask them what makes them unhappy in their life and work).

Conclusions

The preceding exploration of value theory has highlighted the multiple, diverse and sometimes incongruent perspectives of the concept of value. Nevertheless, it is possible to extract from these works a broad understanding of the issues that are related to values and value systems. This will provide a platform from which to develop a subsequent methodology and will also provide a structure within which to critically analyse the existing work on this subject. It has been argued that there are no objective values (Oliver, 1998) and that value is located in relationships (Barton Perry, 1914; Herrick, 1936). Value has been presented as a living system (Rezsosazy, 2001) that is dynamic and changing (Fekete, 1988; Pattison, 1998). Values have been shown to be related to human history (Lepley, 1937) and professional socialisation (Tompkins, 1992; Kuczynski, 2001). Value has been linked to the meaning of life (Frankl, 1959; Fagermoen, 1997; Pattison, 1998) and according to Frankl, the meaning of life differs for all people from day to day, hour

to hour. The modernist-positivist paradigm explores value as decontextualised hierarchical lists and thereby does not acknowledge the complexity of value systems. A postmodern perspective on the concept of value recognises the importance of context in the expression of a value and also recognises the dynamic nature of value systems. The modernist-positivist perspective would provide an inadequate paradigm from which to explore the complexity of value. A study of value and value systems that adopts a postmodern perspective is able to explore the dynamism, complexity, pluralism and individual nature of human values.

Various approaches have been used in the study of values in medicine and nursing. The following chapter provides a critical analysis of the research that has been conducted to date. The authors of these works not only use different methodological perspectives and methods, they also utilise different working definitions of value, if indeed they define it at all. The literature review will focus on the implications of these epistemological and ontological perspectives on the findings of the work and will aim to identify important concerns for the present study.

CHAPTER THREE

LITERATURE REVIEW: NURSE PRACTITIONERS AND VALUES IN NURSING AND MEDICINE

Introduction

The preceding chapter demonstrated that researchers have a number of choices when they are delving into the world of value, values and value systems. The choices they make in the approach to their study reveal something about the values of the researchers concerned. Several of the studies identified in the literature search were firmly in the positivist paradigm, using quantitative approaches with surveys and statistical analysis while others had varying degrees of qualitative methodology. The aim of this thesis is to examine the values of nurse practitioners and how they compare to the values of nursing and medicine. The literature review will therefore commence with a brief overview of the studies that relate to the development of the nurse practitioner role in the UK in an effort to set the scene for this study. This will be followed by a critical analysis of the major studies on values, with an emphasis on the research conducted around the values of nurse practitioners, nurses, doctors and other professionals.

Nurse practitioners

Hooker and Mayo (2002) carried out an overview of doctoral dissertations on nurse practitioners in the United States. They found one study which was conducted in 1964, a second conducted in 1970, and a further 132 from the mid 1970s onwards. Feldman et al. (1987) also conducted a review of studies into nurse practitioner effectiveness in the United States and found 56 articles from the mid 1970s onwards. In the UK, research into the role of the nurse practitioner commenced with Barbara Stilwell in the early 1980s. Stilwell provides a description of the pilot project in which she was involved (Stilwell, 1981) and, later on, an analysis of her role (Stilwell, 1985; Stilwell et al., 1987). The analysis included a description of the types of conditions she dealt with, how many required referral for further investigation, and a patient questionnaire. The patients gave reasons for consulting with the nurse practitioner including: "I thought I could talk better to her", "to save the doctor's time" and "she's got more time for you". The conclusions from this study were: the nurse practitioner could deal with one-third of all consultations without referral to a doctor; additional problems were raised in 46% of consultations which mostly

involved health education; and most patients made an appropriate choice to consult with the nurse. Stilwell acknowledged that she had twenty minute appointment times and that this was considerably longer than the GP.

Due to the small number of qualified nurse practitioners in the UK during the 1980s and early 1990s, evaluation of the role was focused on single practitioners (Salisbury and Tattersell, 1988; Reveley, 1999) or on newly qualified practitioners (South Thames Regional Health Authority, 1994; National Health Service Executive, 1996; Reveley, 1999). In a similar approach to that of Stilwell, Salisbury and Tattersell's (1988) work provided a description of a single nurse practitioner and they found that the nurse practitioner could deal with 78% of her consultations without referral to a doctor and that 97% of patients when asked stated they would consult with the nurse practitioner again. Salisbury and Tattersell, like Stilwell, report that the nurse practitioner had lengthy consultation times of 20-30 minutes. Salisbury and Tattersell also noted that the nurse practitioner role that they were studying had evolved quite differently to a similar post in another practice and they concluded that this emphasised the need for flexibility in defining the role. In the 1990s, nurse practitioner research in the UK moved on to larger projects involving multiple sites with rigorous evaluation.

The South Thames Regional Health Authority study (1994) commissioned Touche Ross to undertake a two year evaluation of twenty nurse practitioner projects in primary care. All the nurses either held the Royal College of Nursing nurse practitioner diploma or were currently studying for it. This was a descriptive study using site visits, interviews, retrospective analysis of consultations, and a survey of patients. The study concluded that: there was a diversity of roles across the sites, patients liked the role and commented on the relaxed, approachable style of the nurse practitioners, consultation times were lengthy and cost effectiveness was difficult to assess. Fawcett Henesy reports that there was "overwhelmingly positive evidence from this study" suggesting that "nurse practitioners offer something quite different from conventional medical or nursing services" (1995 p.35). It is interesting to note that the researchers point out that the two nurse practitioners who were working in general practice tended to work more like GPs than other nurse practitioners with less emphasis on preventive health and yet without reducing patient satisfaction.

In 1996 the National Health Service Executive commissioned ten different nurse practitioner projects that were subsequently evaluated by Coopers and Lybrand (National Health Service Executive, 1996). Four of the projects were based in secondary care, demonstrating the way in which the nurse practitioner role gradually diversified during the 1990s. The study was based on a survey of health professionals and patients, and examined access to services, cost of services, impact on waiting times and benefits to other services. The report emphasised that cost effectiveness is difficult to prove because nurse practitioner services are different from conventional services; but on the whole the report is very positive and supportive of the role of the nurse practitioner.

Towards the end of the 1990s, nurse practitioner research began to compare the work of the nurses with that of the GP. Concerns were raised that nurses may be acting as cheap alternatives to the GP and therefore could be providing a lesser service to patients and at worst could even be unsafe (Dickson et al., 1996; Crawford, 1997). Reveley (1999) carried out an evaluation of the triage role of a single nurse practitioner working in general practice with seven GPs. The study was conducted using a patient satisfaction questionnaire, follow up interviews with 30 patients and an analysis of the nurse practitioner's work. In Reveley's study, the nurse practitioner had fifteen minute appointments whilst the GPs had seven and a half minutes. The nurse practitioner tended to see patients who were younger than those who saw the doctor and also tended to deal with more patients who had infections and/or respiratory conditions. The nurse practitioner was more likely to carry out a physical examination during the consultation. Most respondents felt their problem had been dealt with well, regardless of whom they saw. The patients were satisfied with the role and commented that it would take pressure off the doctors, and reduce waiting times.

Reveley's study was, once again, focused on a single nurse practitioner. It is appropriate to study a single person in the early stages of enquiry into a particular area of practice. The problem with single person studies is that the uniqueness of the particular situation can lead to concerns over generalisation to the wider population of nurse practitioners across the country. Venning et al. (2000) and Kinnersley et al.

(2000) have now both reported on randomised controlled trials involving nurse practitioners in general practice.

Venning et al. (2000) analysed data from 1292 consultations in twenty different general practice settings across England and Wales. The patients were randomised to see a GP or a nurse practitioner and their health status was assessed using the Short Form 36 (SF36) questionnaire before the consultation and two weeks after the consultation. Patient satisfaction was measured using the medical interview satisfaction scale (MISS) and the researchers also carried out a cost analysis. The results of the study show once again that nurse practitioner consultations are longer than those of GPs, and also that patients were more satisfied with nurse practitioners than they were with GPs. The patients in this study were more likely to return to the practice within a two week period if they had seen a nurse practitioner and there were no differences in health status between the two groups at the end of the two weeks. The authors concluded that there were no significant differences in health service costs between the two groups.

Kinnersley et al. (2000) also carried out a randomised controlled trial involving ten sites across Wales and England with 1368 patients. The outcome measures in the study included: patient satisfaction immediately after the consultation, and resolution of symptoms and concerns at two weeks. Other outcome measures included: care in the consultation (length of consultation and information provided), use of resources, follow-up consultations, and patients' intentions for dealing with future similar situations. The patients completed a questionnaire on their level of discomfort before the consultation and the consultation satisfaction questionnaire (CSQ) immediately after the consultation. The results of the study show that the nurses' consultations were longer than the GPs' and patients were significantly more informed about their illness by the nurse practitioners than they were by GPs. There was no difference in any of the measured health outcomes. It is interesting to note that in three of the ten practices, patients were significantly more satisfied with the nurse practitioner than they were with the GP, while in the remaining seven practices there was no difference in level of satisfaction. This highlights a methodological difficulty with studies using randomised controlled trials where the independent variable is a person. A randomised controlled trial uses an

experimental design to determine whether factor x leads to factor y. Such a design aims to control all extraneous variables including the independent variable which should remain exactly the same for each instance of its use. Both Salisbury and Tattersell (1988) and the South Thames Regional Health Authority (1994) referred to the diversity in nurse practitioner roles pointing to the potential variability in the nurse practitioners. It would be difficult to argue that all nurse practitioners in both the Venning and Kinnersley studies were identical in their practice. It therefore seems inappropriate to use a randomised controlled trial to examine the work of nurse practitioners because the independent variable is a person.

Examples of other studies that used randomised controlled trials to compare the work of the nurse practitioner with doctors in the same setting are Sharples et al. (2002) who examined care in a bronchiectasis clinic, Cooper et al. (2002) who focused on emergency nurse practitioner services and Mundinger et al. (2000) who compared nurse practitioners and physicians in primary care in the United States. Sharples et al. (2002) used a randomised crossover trial. A randomised crossover trial is an approach that is used in pharmaceutical research whereby a drug is administered for a certain period of time and then the patient crosses over to the placebo arm of the trial (or vice versa). In the Sharples et al. study the “drug” was a single nurse practitioner who was also a student in training and the placebo was the doctor (or vice versa). The conclusion was that the nurse practitioner was as safe and effective as a doctor but tended to use more resources. The Cooper et al. (2002) study compared emergency nurse practitioners (ENPs) with senior house officers (SHOs) in an Accident and Emergency department. The ENPs were found to be: easier to talk to, they gave more information to patients on accident and illness prevention and overall the patients were more satisfied with care from ENPs when compared to SHOs. There were no differences in recovery times, unplanned follow-ups, time off work or missed injuries between the two groups. Mundinger et al. (2000) found that the diastolic blood pressure value was statistically significantly lower for patients who saw a nurse practitioner when compared to those seen by a physician. In this study there was no overall difference in patient satisfaction between the two groups. These three studies provide examples of the use of randomised controlled trials in the study of nurse practitioner practice, the methodological problems of which were discussed earlier. Nonetheless, they do highlight some interesting findings: that nurse

practitioners appear to be safe (even when in training) (Sharples et al., 2002), have similar outcomes to doctors (Mundinger et al., 2000; Cooper et al., 2002; Sharples et al., 2002) and have an impact on patient satisfaction (Cooper et al., 2002).

In 2002 Horrocks et al. reported on a systematic review of the literature relating to whether nurse practitioners working in primary care can provide equivalent care to doctors. They state that it is important to consider whether nurse practitioners can substitute for doctors by providing safe, effective and economical management of patients. The results of their review demonstrate that patients are more satisfied with care by a nurse practitioner and that the quality of care offered by a nurse practitioner when compared to a GP is “in some ways better” (2002 p.821). Nurse practitioners tend to have longer consultations and make more investigations, however, there is no difference in prescriptions, return consultations, referrals or in patient health status between the two groups. The authors conclude by stating that future research should address factors that lead to patients’ increased satisfaction with nurse practitioners.

The preceding discussion demonstrates that the UK literature has developed from descriptive studies of single practitioners, through larger evaluative studies to large randomised controlled trials. These later studies have tended to use doctors as the established gold standard. The research has suggested that nurse practitioners operate safely and that they achieve the same health outcomes as the doctors. The one factor that is consistently raised as being significantly different between nurse practitioners and doctors is patient satisfaction. Patient satisfaction is a multidimensional construct and components of satisfaction change over time (Fitzpatrick, 1993). Baker (1993) points out that in the case of patient satisfaction it is not entirely clear what is being measured and yet many patient satisfaction surveys report that 90% of patients say they are satisfied with health care services. Patient expectations have been found to effect subsequent patient satisfaction (Merkouris et al., 1999). There is a possibility that when a patient consults with a nurse practitioner, they have lower expectations than if they consult with a doctor and hence they are more likely to be satisfied.

Whatever the reason might be for increased satisfaction, the results of the patient satisfaction data in the studies reviewed above would suggest that there is some kind of qualitative difference between nurse practitioners and GPs. There is no information relating to the nature of this difference and this therefore provides an interesting area for further study. I suggested earlier that if a difference exists between nurse practitioners and doctors, this could possibly be found in an exploration of their values. As the discussion of MacIntyre's (1984) view of practices showed, values are integral to practices. Understanding the nature of values can help to understand the nature of different practices. The literature review will now turn to a critical examination of the research relating to the values of nurses, doctors and other professions.

Value research

The following literature review relating to values research has been loosely divided in to sections guided by the broad theoretical design of the research. Studies that have explored the values of nurses in quantitative, qualitative or mixed approaches are reviewed followed by studies that have examined the values of medicine, comparisons of medicine and nursing and finally social workers and teachers.

Quantitative approaches

A number of studies have used quantitative approaches in the form of attitudinal surveys and ranked lists to explore the values of nurses and doctors with comparisons between groups. The Maslach Burnout Inventory was used in two studies (Altun, 2002; Flynn and Aiken, 2002), the Nursing Work Index was used by Flynn and Aiken (2002), the Rokeach Value Survey was used by Furnham (1988) and Prothero (2000), the Minnesota Satisfaction Questionnaire was used by Mitchell (1994) to explore links between job satisfaction and work role values, the Gordon's Personal and Interpersonal Values Scales were used by Saarmann et al. (1992) and Sivberg and Petersson (1997), the Nursing Professional Values scale was used and developed by Weis and Schank (1997; 2000) and Nolan et al. (2004) used a 39-item specially designed questionnaire. These studies were all aiming to discover statistically significant similarities or differences between various groups of nurses, nurses and doctors and other health care professionals, and their results are as varied as the tools they used.

Burnout and its relation to values

Altun (2002) explored professional values in nursing and related this to the occurrence of burnout. The authors devised a questionnaire which asked nurses to prioritise seven values. The values included aesthetics, truth, freedom, justice, human dignity, equality and altruism. Altun states that altruism refers to personal qualities such as commitment, compassion and generosity and the value of aesthetics refers to personal qualities such as imagination, appreciation and sensitivity. Interestingly, these are the same seven values that have been used by Tompkins (1992) and originated from the seven values deemed as necessary for the professional nurse by the American Association of Colleges of Nursing (AACN) (1986). The AACN identified the seven values that were deemed to be essential for the professional nurse by receiving written and verbal feedback from 1500 members of the nursing profession on a working document that aimed to identify the essentials of college and university education for nurses (1986). The Maslach Burnout Inventory was also delivered to the nurses. There were 160 participants in the study and the results demonstrated a statistically significant relationship between the nurses' priority values and their level of exhaustion ($p = 0.000$). This study suggests that there could be a link between an individual's values and their level of well-being. It is difficult to ascertain from the data provided whether nurses who are burnt-out are unable to prioritise particular values simply because they are emotionally exhausted or whether it is because holding particular values in some way protects them from burnout. The study is based on an assumption that the respondents could meaningfully rank the seven values identified from the literature. It might be reasonable to suggest that ranking these values when they are decontextualised could be very challenging.

Flynn and Aiken also used the Maslach Burnout Inventory to determine if nurses value the professional practice environment, which was defined as an environment where "nurses have autonomy consistent with their responsibilities, control over the patient care and work environment, and collaborative relationships with physicians" (2002 p.68). They were particularly interested to compare the views of nurses from differing cultural backgrounds surmising that nursing is a culture with its own set of values, beliefs and practices shared by nurses globally and therefore differences in an individual nurses' cultural values should be insufficient to produce

differences in professional practice values. A twenty-one page survey was delivered to eight hundred and twenty nurses, all of whom were working in the United States at the time of the study. The survey included the Nursing Work Index (NWI) which was designed to measure: job satisfaction, values related to job satisfaction, perception of an environment conducive to quality nursing care, and professional practice values. Kramer and Hafner (1989) designed the NWI to be an all inclusive list of factors affecting professional practice and job satisfaction. The tool consists of a sixty-five item Likert scale which was developed from instruments found in the literature over two decades and characteristics listed in the Magnet Hospital studies. No statistically significant differences were found between nurses from collectivist or individualistic cultural backgrounds in their importance scores on the NWI. The authors state that this demonstrates that there are no differences in values between international and US born nurses relating to the importance of a professional nursing practice environment. An alternative perspective on this finding might be that nurses who work in the United States adapt to take on the values of their host country. Flynn and Aitken do not explore the length of time each participant had been practising in the United States. This therefore leaves open to question the nature of human values and whether values are stable from childhood or can be influenced by subsequent experiences and life changes.

Comparing groups

The work carried out by Altun (2002) and Flynn and Aitken (2002) are examples of studies that are based on the premise that an individual's values can be measured using scales of predetermined values. Furnham (1988) and Prothero et al. (2000) worked under the same assumption by employing the Rokeach Value Survey (Rokeach, 1973). The Rokeach Value Survey is a two-part questionnaire that requires participants to rank order two sets of eighteen values. The first set is classed as terminal values such as freedom, family security, a comfortable life and equality, while the second set is instrumental values such as courageous, ambitious, loving and independent. The first set is concerned with end states of existence and the second set with modes of conduct. The values are listed alphabetically and the respondents are requested to arrange the values in order of importance as guiding principles in their lives. The assumption is that all people share the same values but the relative ordering of the values differs between individuals. Rokeach arrived at the eighteen

terminal and instrumental values by carrying out a review of the literature, interviewing thirty graduate students and one hundred adults and he included his own values. He arrived at several hundred values and gradually reduced this number to eighteen by removing and eliminating values that seemed to be more or less synonymous with one another. He states that this process was largely intuitive. He then put the tool through a number of tests to determine its reliability.

Rokeach (1973) reports that median test-retest reliabilities of terminal values were found to be 0.62 for seventh graders and 0.8 for college students and for instrumental values 0.53 for seventh graders and 0.72 for college students. Rankin and Grube (1980) report test-retest reliabilities of 0.62 for the terminal values and 0.60 for the instrumental values. On closer examination Rokeach found that individual test-retest reliabilities ranged from 0.3 to 0.9 for the terminal values and 0.1 to 0.9 for the instrumental values. Test-retest reliabilities below 0.7 are unacceptably low (Polit and Hungler, 1995) and challenges one of Rokeach's major assumptions that values are enduring. He found that women tend to have more stable terminal and instrumental value systems than men and that younger college students, those with favourable attitudes towards civil rights and those who preferred intellectual activities, as opposed to social activities, tended to have more stable value systems. Rokeach also examined the reliability of individual values. He found that those values that were ranked by an individual as highest or lowest in their value system were more reliable than the values that were ranked in the middle. It appears that a significant finding when asking an individual to rank a number of values is not only the order in which they place those values but also how those values change over a period of time. It is also interesting to note that Rokeach found very little correlation between terminal and instrumental values, for example the correlation between the instrumental value "forgiving" and the terminal value "salvation" was found to be 0.28 and the correlation between "mature love" and "loving" was 0.31. He points out that the semantic meaning of a value might not be identical to two individuals, for example how do we interpret the results of two Christian ministers who ranked "salvation" as number one in each of their value systems but one of the ministers ranked "forgiving" second whilst the second minister ranked "forgiving" last in his value system? Rokeach suggests that the psychological significance of a particular value can only be inferred by looking at the way each of the values in an

individual's value system relates to the other values. It is also possible to suggest that interpretation of such data is problematic without understanding the meaning of each of the values to each individual.

When Rokeach was developing the values survey tool he had two versions: one which asked the respondents to rank the values using numbers to signify the rank from one to eighteen (Form E) and a second version (Form D) which provided the respondents with gummed labels allowing them to move the values around and then finally stick them all in the rank order of their choosing. Interestingly he found that the use of Form D resulted in a higher test-retest reliability. Is it possible that our value systems are so changeable that the type of form used to examine them has a bearing on the way in which we portray them? Both Forms D and E are now widely used to examine value systems and a number of studies have been conducted in the health care setting using the Rokeach Value Survey, two of which are reported below.

The Rokeach value survey was used by Furnham to compare the value systems of groups of nursing, medical and psychology students (Furnham, 1988). The survey was administered to one hundred and ninety-three students: seventy-four were medical students, sixty-seven were nursing students and fifty-two were psychology students. A one-way analysis of variance was computed across each value for the three groups and the Mann-Whitney U-test was carried out between each pair of groups. Furnham found that there were significant differences between the groups in seven of the eighteen terminal values and nine of the eighteen instrumental values. Nursing students rated family security, happiness, a sense of accomplishment, cheerfulness, obedience and cleanliness more highly than the medical students. The medical students ranked an exciting life, being capable and being logical more highly than the nursing students. The author points out that gender differences relate to values and whilst gender differences in this sample did not reach significance he feels that some of the differences between the groups could be explained by gender given that the nursing group was predominantly female. Indeed it is highly likely that gender could have an influence on such a study given the statistically significant differences found in the test-retest reliability of value systems in the original work carried out by Rokeach (1973).

Work satisfaction and values

The Rokeach Value Survey was also used by Prothero et al. (2000) to explore the personal values and work satisfaction of registered nurses working in hospitals. The Index of Work Satisfaction was used to assess six aspects of work satisfaction and these were then correlated with the results of the Rokeach Value Survey. The authors found that there was a statistically significant link between a number of the values and the aspects of work satisfaction. For example satisfaction with autonomy at work was linked to the following values: sense of accomplishment, equality, being imaginative, helpful, broad-minded and loving. The study was conducted with a convenience sample of forty-nine nurses and the return rate is not reported. The authors make recommendations based on their findings such as administrators should support an environment that: fosters a sense of accomplishment, promotes fairness, allows activities of fairness and promotes creativity. It is difficult to understand how such a claim can be made when there has been no attempt to explore in any depth whether the personal values identified in the survey are causally related to job satisfaction and whether the sample size and response rate demonstrate a sufficiently rigorous approach to the study.

A further example of the use of a quantitative approach to measure values is Mitchell's study which examined the relationship between work role, work role values and job satisfaction (Mitchell, 1994). She used a three-part survey that consisted of a list of seven work roles and participants were asked to rank these roles first, in order of most valued role and then, second, the amount of actual time they spent in that role. The seven work roles mirrored the domains of practice as identified by Benner (1984), namely: helping, teaching, diagnostic and patient monitoring, effectively managing rapidly changing situations, administering and monitoring therapeutic interventions, ensuring the quality of health care practice and organisational and work role competencies. The third part of the survey consisted of the Minnesota Satisfaction Questionnaire. Mitchell had a response rate of 33% and found no association between a nurse's job satisfaction and the correlation between work role values and actual role values. Mitchell points out that the domains used to examine work role values had not been tested for reliability and validity and suggests that an interview technique may add strength to the study design.

It could be suggested that the weakness in the Mitchell study lies in an oversimplification of the use of values. Values have been suggested to follow a hierarchical structure (Rokeach, 1973) and therefore Mitchell's approach to ranking values is congruent with the approach of other researchers. However, can the domains of practice be described as values? Benner's domains of practice do not represent discrete activities allowing a participant to rank one of the domains above another. Rokeach (1973) suggests that there are terminal and instrumental values, and yet Benner's domains of practice are neither modes of action nor end states of existence. Benner herself describes a number of the domains as "functions" and "roles" (Benner, 1984). The expert nurse is able to demonstrate competency in a wide range of the domains which illustrates the way in which the domains unite together as a whole. For example, if a participant indicated that they valued rapidly changing situations, they might also value the administering and monitoring interventions that are so often a part of rapidly changing situations. Organisational and work role competency appears to be a broad domain that could encompass many of the other competencies. A participant might value organisational and work role competencies because they help in the execution of the teacher and helper role. This study demonstrates how an unclear definition of values leads to much confusion in the literature.

Codes of ethics related to values

Schank and Weis have produced a number of articles exploring professional values in nursing (Schank et al., 1996; Weis and Schank, 1997; Schank and Weis, 2000; Weis and Schank, 2000). These authors found that professional values are not consistently operationalised in nursing. They examined the nursing philosophy statements of ten institutions and interviewed the directors of nursing in each hospital. Schank et al. used the American Nurses Association Code of Ethics (1985) as a reflection of the profession's values. They found there was considerable variation amongst the hospitals, ranging from one institution where only one of the code statements was reflected in the nursing philosophy and, in contrast, others that reflected seven of the eleven statements. These authors used the same approach when comparing nursing students and nurse educators from England and the United States (Weis and Schank, 1997; Schank and Weis, 2000). The Code of Ethics was used to

develop a professional values scale instrument and congruence of professional values was identified in both the student nurses groups and the nurse educators groups.

Schank et al's (1996) use of the professional code to reflect values in nursing is an interesting approach to this field of study. Wilmot (1995) suggests that identification of professional values involves exploring different manifestations of values in four ways. These include exploring values that are embodied in: the formal codes of practice, the knowledge base of the profession, the professional literature and those that are reflected by practitioners in their accounts of their actions. Wilmot's account then adopts this approach to explore the comparative values of social workers and nurses. He uses a review of relevant literature to develop his own impressions and concludes that value differences between social workers and nurses are real and consistent. Nursing values seem to be more individualistic and social workers are more concerned with collective, structural and political issues. He suggests that in a plural society, diversity of values may be an asset for clients as different professional groups may represent the client in different ways. Wilmot also suggests that the content of professional tasks may propel practitioners towards certain values, which is a particularly interesting comment in view of the nurse practitioner role. If nurse practitioners are carrying out tasks that were hitherto in the domain of medicine, might that in fact alter their value systems? If Wilmot's suggestion has some merit, the work by Flynn and Aiken (2002) described above could provide an example of value system assimilation when nurses move from one international setting to another.

Professional socialisation

Lurie (1981) explored the professional socialisation of the adult health nurse practitioners who were graduating from a training programme in California. Five cohorts of graduates were studied longitudinally using self-reported data, semi-structured interviews and observations. The self-reported data involved attitude items grouped into twelve scales. The observations were guided by an activity check-list and the purpose of the interviews was to explore: the nature of activities undertaken by the nurse practitioners, procedural details, working arrangements with physicians and presence of support or conflict. The nurse practitioner graduates were compared with non-practitioner nurses in an ambulatory setting. The results of this study show

significant shifts in both attitudes and activities from entry onto the nurse practitioner programme through to graduation and one year post graduation. Lurie comments that the effects increase in magnitude after the training period is over and the graduates are established in their work situation. In some work settings, this was not evident in all activities and attitudes and Lurie concludes that educational socialisation can be counteracted by the structure of the work situation. Lurie's work reveals the competing influences on professional socialisation and this has significance for the present study. If nurse practitioners are socialised through a programme of education and if their socialisation is subsequently consolidated according to the structures within which they work, it could be suggested that their value systems are also formed and consolidated over time and that they might differ significantly from the values they espoused prior to the move into the nurse practitioner role.

Saarmann et al. (1992) also aimed to explore socialisation into professional nursing by examining the relationship of education to critical thinking ability and values. The authors defined values as beliefs and preferences held by an individual. They used the Gordon's Personal and Interpersonal Values Scales to measure the nurses' values and beliefs. The Gordon's Personal and Interpersonal Values Scales are made up of thirty sets of three items. For each set of items the individual has to choose the value that is most important to them and that which is least important. For example, personal values include practical-mindedness, achievement, variety, decisiveness, orderliness and goal orientation. After discussion the authors decided that the values of recognition, decisiveness, independence, leadership, achievement, and benevolence were the most important for nurses and these were subsequently identified as "superior values". The authors found that there were striking similarities between faculty, associate degree and baccalaureate degree nurses. This finding was not congruent with their hypothesis as they had suggested that: "exposure to faculty is a major influence on critical thinking ability and professional values, faculty must be assumed to be superior in these characteristics; therefore, students exposed to faculty in longer curricula can be expected to achieve higher levels of critical thinking ability and values than those completing shorter programs" (Saarmann et al., 1992 p.26). They provide two possible explanations for their findings. One is that individuals who choose nursing as a career have values that are acquired in youth and are therefore self-selected from childhood. The second is that the values the

group decided to study are those that are deemed to be important by society and are not necessarily unique to nursing. They conclude their work by stating that qualitative research would be useful to examine nursing; this approach, they suggest, would allow the data to define the entity rather than testing a preconceived definition of value.

Sivberg and Petersson (1997) used the Gordon's Personality Inventory in a longitudinal study to examine changes in values during the course of a programme of study for nurses. Interestingly there were no significant changes in the students' self-values and interpersonal-values over time, when the authors' hypothesis had been that a new academic course of study would have the power to change the students' self-image and professional values. They conclude by stating that the training programme has not succeeded in developing the basic skills that are important for nursing care and communication. Alternatively, it could also be suggested that they have found that values tend to be fairly stable over time, which would be in contrast to the suggestion of Wilmot (1995) as described above and contrasts directly with work carried out by Deutscher and Montague (1956).

Deutscher and Montague (1956) set out to illustrate that a system of formal professional education can be used to indoctrinate people with one set of values at the expense of others. This is an older piece of work; nevertheless, it does highlight the lack of clarity that exists in relation to the nature of values. The authors carried out interviews with nursing students and used content analysis to explore their hypothesis that "religious schools of nursing tend to reinforce the traditional Christian-humanitarian values... while non-sectarian schools... tend to produce students who are more oriented toward professional values and goals" (1956 p.127). They suggest that as professional values move upward in an occupation, humanitarian values must be reduced. Clearly this is an example of authors working on the assumption that values are hierarchical in nature and are not stable over time. They use as a surrogate marker for the acceptance of professional goals, the 181 participants' value statements about post-graduate education. These value statements were extracted from the interviews, and non-sectarian students were compared with religious schools. The authors found that there was no significant difference between the first year students in each of the schools but there was a difference between first

year students and graduating students in both the non-sectarian schools and the religious schools. What is particularly interesting here are not the findings of the study but the assumption made by the authors that positive or negative comments about post-graduate education in some way indicate the value systems of the nurses in relation to the acceptance of professional values and goals and a shift away from humanitarian values. It is not clear how they justify such an assumption.

Nurse/client value congruence

A further example of the use of rank orders of values to explore values in nursing is Tompkins' (1992) study into nurse/client value congruence. Tompkins studied the values of nurses and clients by administering a three-part questionnaire aimed to clarify the two groups' value systems. The first part of the questionnaire involved ranking the seven values deemed as necessary for the professional nurse by the AACN (1986). As described earlier, the seven values include: altruism, equality, aesthetics, freedom, human dignity, justice and truth. Interestingly the author does not report on the findings of part one of the study because test-retest reliability was carried out and found to be unsatisfactory. The lack of test-retest reliability in this study raises concerns for the Altun (2002) study reported earlier. The current study had a greater number of participants (257) than the Altun study (160) and the Altun study does not report on test-retest reliability. It could be suggested that the method of data collection is flawed in that it is difficult for people to rank values with any degree of congruency with their actual beliefs. Alternatively it could be suggested that values do change over time and a multitude of events could influence the responses of the participants, demonstrating the fluidity of individual value systems. Tompkins suggests that part one of the study demonstrates the difficulty of working with a limited number of values. She suggests alternative approaches such as using a greater number of options might be useful.

The remainder of the Tompkins (1992) study involved a number of statements about professional nursing behaviour and the respondents were asked to score them as "very unimportant" to "very important" on a Likert scale. The respondents were also asked to indicate how much each of the seven values meant to them personally by using a ten point scale. Interestingly the authors found a significant difference between nurses and clients on every value except for altruism

and human dignity. Tompkins concludes by stating that the variation in value meanings held by the respondents suggests an important area for qualitative study.

Qualitative studies

A number of the studies described above conclude that the exploration of value and value systems is a rich area for qualitative study (Saarmann et al., 1992; Tompkins, 1992; Mitchell, 1994). A postmodern perspective would conceive of value as a dynamic, context dependent concept that should most properly be explored using approaches to research that are capable of representing the complexity and interactive nature of value systems. The quantitative studies listed above raised some interesting issues worthy of further exploration; however, their findings tend to lack the depth that is required to gain a full understanding of value and value systems. The approach taken in these studies, and the findings that they present in their conclusions, represent an association with a naïve reality and a belief that values can be labelled, boxed, ranked and ordered to represent the values of nurses in a context-free milieu devoid of the complexities and confounding variables of everyday life. It is therefore surprising to find that there are so few studies that have adopted a purely qualitative approach in studying the values of nurses.

One study that provides an example of the use of a qualitative approach to explore the norms and values of nurses is Peterson's (1988) work that examined the setting within which the occupation of nursing was performed. Peterson examined the norms and values of three groups of nurses concerning psychosocial care. She suggested that groups of diverse nurses must develop norms and values to allow them to function as a group. She spent 120 hours on each of three units that externally were very similar; however, on closer examination there were some important differences between the three. The first unit had a reputation for high and exacting standards and had a low turnover of staff. The second unit was also considered to have high standards and had a reputation as being friendly and casual. The third unit had an average standard of nursing care and had a high turnover of staff. Peterson used a grounded theory approach to the research allowing her to work within a matrix comparing each piece of datum with other pieces of data to discover core variables and to develop an explanatory statement as the research progressed. She found that each group of nurses was influenced by the norms and values of the

group. In two of the units the group leader had a major influence on the norms and values of their respective groups and, according to Peterson, the third unit did not develop any work-oriented norms and values. It is not clear how Peterson defined values for this study. She describes unit one's norms and values as:

... characterised by efficiency, neatness and politeness. These nurses' typical approach to patients was cool, polite and neutral. Patients were given physical care which ranged from adequate to excellent. The unit one protocols resulted in nurses being rushed and spending only one to two hours in the patients' rooms each morning. Unit one nurses focused on task oriented rather than person oriented nursing. Nurses were expected to be calm and polite to patients at all times (1988 p.97).

The term "value" seems to be used rather loosely in this work, indeed Rokeach (1973) suggests that the observation of an individual's behaviour is very difficult to interpret and quantify and is open to the bias of the observer's own values (an issue that Peterson does not acknowledge). This study raises an important point relating to the potential influence of colleagues on the behaviours and attitudes of staff.

Peterson's work was explicitly designed to observe the actions of nurses in clinical practice. She felt that a study that simply relied on what nurses say about their practice is unlikely to produce reliable data. She suggests that nurses are likely to try to persuade a researcher that their actions conform to the expectations of the nursing profession and the employing institution. Pattison and Malby made the same suggestion in justifying the approach taken in their work that examined values in the National Health Service (NHS) (Malby and Pattison, 1999; Pattison et al., 1999). Pattison et al. (1999) held seven one-day workshops where they invited participants to write down a story about their experiences in the NHS. The participants included: chief executives, nurses, doctors, ward clerks, patients, health care assistants and health authority managers. The story was supposed to be one that had particular significance for the participant, for example an event that had given them particular pain or pleasure. Pattison et al. (1998) state that there were many potential benefits of such a study. They suggest that narratives help to reveal the values of the individual and the values of the organisation. Tension occurs where official and unofficial values are discordant. Revealing or exposing the gaps between personal values and those of the NHS could help to illuminate the nature of the unofficial aspects of the

organisation and thereby assist in evaluating the NHS and contributing to its future. The study was reported to find that the NHS subscribes to the values of “equality of access, putting patient needs first, being caring, and valuing individuals and their differences” (Malby and Pattison, 1999 p.2). The study also found that people’s lived experience of the NHS is “desperately mixed” and they conclude that they revealed a hugely contrasting and complex picture of the NHS.

Studies adopting both qualitative and quantitative approaches

An example of a study that uses both qualitative and quantitative approaches to explore values in nursing practice is Fagermoen (1997). Fagermoen looked at professional identity by exploring values embedded in meaningful nursing practice in Norway. She states that the internalisation of values is fundamental to the socialisation process into the norms and ethical standards of a professional culture. She defines professional identity as the values and beliefs held by the nurse that guide actions, thinking and interactions with patients, thus highlighting the action-oriented nature of values. The study was conducted by analysing the responses of 731 nurses to the open-ended question “What is most meaningful in your work as a nurse?” This question formed part of a questionnaire in a comprehensive study of Norwegian nurses. Having analysed the responses to the question relating to meaning in nursing practice, Fagermoen developed a number of value categories for thematic content analysis. A total of eighteen codes were identified and used to analyse interviews that formed the second part of the study. In-depth interviews with six female nurses were then conducted. Prior to the interview the participants were asked to provide a written description of a patient care situation that was an exemplar of what was meaningful to them in nursing. The exemplar was not analysed but was used to guide the interview.

Results from the survey data demonstrated overall agreement on four specific values. Fagermoen categorises these values as: “other-oriented”, which includes upholding humanness and attending to needs for help, and “self-oriented values”, which include intellectual stimulation and personal stimulation. The results of the survey, she suggests, support the proposition that values are expressed through what is perceived as meaningful in nursing practice. The data were exposed to several different levels of hermeneutic analyses and, interestingly, she found that there were

many more values identified during the interviews than there were through the questionnaires. Fagermoen's work is illustrative of the depth and complexity that can be discovered when examining an individual's values and value systems. She states that with each step of the analysis she revealed more and more differentiated and distinct values. After analysis of the interview data, Fagermoen found a number of interrelated values which included an overriding value of altruism with interrelated values of: trust, fellow human, personhood, integrity, humanity, privacy and autonomy, and these were all focused around a core value of human dignity. The author states that the results of this study depict nursing as "a human and moral practice concerned with providing personalised care to patients" (1997 p.439). Fagermoen does not suggest that this description is owned by nursing alone, indeed it is possible to suggest that this statement might also refer to medicine.

Interestingly, Fagermoen's work commences by stating that:

A core characteristic of nursing as a practice discipline is that its practitioners work in close and continuous relationships with patients who are both vulnerable and partially or totally dependent on the nurse for the maintenance of their basic needs in coping with health deficiencies (1997 p.434).

It is interesting to note that the work of nurse practitioners in general practice results in short-term contacts with many patients as evidenced in the research reported earlier (Stilwell et al., 1987; Salisbury and Tattersell, 1988; Kinnersley et al., 2000; Venning et al., 2000). It could be suggested that the nurse practitioner has moved away from the traditional model of nursing and this shift might also involve a period of socialisation into a different group and therefore the internalisation of a different set of values. This suggestion would be congruent with the theoretical perspectives outlined by Kuczynski (2001) and Rezsóhazy (2001) and the research conducted by Lurie (1981). The findings of Saarmann et al. (1992) and Sivberg and Petersson (1997) (that values do not appear to change over time) are not congruent with those of Lurie (who found that there were significant shifts in both attitudes and activities over time) resulting in some lack of clarity regarding professional socialisation and the acquisition of value systems. Furnham (1988) suggests that a person's value system must represent their past socialisation. If there is legitimacy in this claim one might expect to see different value systems in different professional groups.

Research and values in medicine

The homogeneity of the results in the Fagermoen study is interesting and contrasts significantly with the heterogeneity of the results in a study by Cooke and Hutchinson (2001) who examined doctors' professional values. This study was based on a postal survey of 545 doctors who had graduated from medical school in 1995. The response rate to the questionnaire was an impressive 95%. A stratified random sample was used to gain a representative sample in terms of gender, ethnicity and location of medical school. The postal survey consisted of a number of statements relating to professional regulation, teamwork and skill mix, priority setting in the NHS, clinical autonomy and private practice. The aim was to examine the doctors' core values and each respondent had to answer using a Likert scale to agree or disagree with statements relating to each of the areas. The values identified in the survey were based on a British Medical Association (BMA) conference and a report on the conference that was subsequently circulated for consultation (British Medical Association, 1995). A more detailed analysis of the BMA study appears below. It is interesting to note that Cooke and Hutchinson's study revealed significant differences between male and female doctors. For example female GPs and female hospital doctors were most likely to agree with a primary commitment to work in the NHS whilst male doctors did not. There was also a statistically significant difference between female hospital doctors who believed that the opinions of all members of the multidisciplinary team were of equal value and should be given equal weight and male hospital doctors who did not agree with this statement.

The 1994 BMA conference aimed to explore the core values of the medical profession for the twenty-first century. The conference was organised because it was perceived that changes in society were challenging doctors' traditional roles and core values. The executive summary is based on the main themes emerging from the workshops and lists a number of core values in medicine. The report states that "The professions' ancient virtues distilled over time remain doctors' greatest asset and will be relevant to the practice of the 21st century" (British Medical Association, 1995 p.7). The basic and ancient virtues are identified as commitment, caring, compassion, integrity, competence, spirit of enquiry, confidentiality, responsibility and advocacy. These contrast markedly with the seven values (altruism, equality, aesthetics,

freedom, human dignity, justice and truth) that are deemed as necessary for the professional nurse (American Association of Colleges of Nursing, 1986). It might be possible to suggest that there are no values that are shared between medicine and nursing. An alternative explanation might be that this diversity is due to the use of different terminology and/or different interpretations of the meaning of values (for example is “truth” the same as “integrity”).

Reissman et al. wrote that: “it is to the distinct credit of medical educators and medical schools that they graduate so many well-trained relatively uniform professionals despite the variety and dissimilarity in motivations and attitudes that characterised those same individuals as prospective students” (1960 p.174). Reissman et al. marvelled at the homogeneity of the graduating students and suggested that students are indoctrinated with a set of attitudes which are deemed to be necessary for doctors to perform their professional role. These authors group the students into scientists, humanitarians or professionals, stating that individuals have distinct motivations for entering into the medical profession. They then argue that during the course of their medical education the students become increasingly cynical and anxious and there is a subsequent decrease in humanitarianism and idealism.

Reissman et al’s research was based on grouping students into one of the categories of scientists, humanitarians or professionals by asking them a single question “Why did you choose a medical career?” The authors themselves point out the impossibility of probing such complex psychological motives with a single question and they also question the sincerity of the responses from students. Even with these concerns they did go on to use this approach to question two sets of randomly selected students, one group of juniors and one group of seniors. The respondents completed questionnaires which included a series of questions relating to attitudes such as “In the event of an emergency with a patient would you handle it yourself or call or send for a resident?” The three groups were then examined for significant differences and similarities. The authors also compared the groups of senior and junior students. The results showed a high correlation between the reasons given for entering medicine and the respondent’s attitudes towards the profession. The scientists, for example, stated that their greatest discovery had been that there are

gaps in the knowledge of the medical profession, while the humanitarians' greatest discovery was that people are more difficult to help than they had expected. There were fewer humanitarians in the senior group with an increase in both scientists and professionals. There is no statement about statistical significance and the authors state that their work should provide a basis for more rigorous study. What is interesting about this paper is the suggestion that there is a process of socialisation into the profession whereby doctors adopt a series of values that are shared with the rest of the medical community, a perspective shared by Wilmot (1995) and Deutscher and Montague (1956) and the homogeneity of the nurses' values in the Flynn and Aiken (2002) study point to the same conclusion.

Hafferty (1988) examined the use of cadaver stories in the emotional socialisation of medical students. Cadaver stories are jokes that are played by medical students on unsuspecting and emotionally vulnerable victims. Cadavers or cadaver parts are used by medical students to shock and derive humour from the victim's distress and Hafferty (1988) refers to this as part of the oral culture of medicine. The author used participant observation over a period of fourteen years to collect information about cadaver stories. Students would share cadaver stories with him and more than one hundred students were questioned formally about their stories. Hafferty (1988) concludes that the act of telling cadaver stories is linked to the anxious anticipation of anatomy lab and those periods in the lab when the cadaver is most likely to appear as a human referent. He suggests that cadaver stories are linked to the transition between lay and medical cultures and that they depict an environment which is "hostile, combative, and emotionally dangerous" (1988 p.349). The author has, in a very vivid way, highlighted an aspect of medical education that provides an insight into the particular culture of the medical profession. It is interesting to consider then, whether the indoctrination referred to by Reissman et al. (1960) and the unique experiences in dissection lab referred to by Hafferty (1988) set medical professionals apart from other health care professionals. A number of studies have compared the differences in ethics (Lindseth et al., 1994), decision-making (Grundstein-Amado, 1992) and approaches to patient care (Robertson, 1996) between doctors and nurses.

Comparison of values in nursing and medicine

Lindseth et al. (1994) explored nurses' and physicians' reflections on their narratives of ethically difficult care episodes by carrying out a series of interviews at the University Hospital of Tromsø in Norway. A previous study had recorded interviews with thirteen registered nurses and eight physicians exploring ethically difficult care episodes (Uden et al., 1992) and found that the two groups emphasised different points in their stories. The physicians appeared to focus on the ethics of justice and the nurses on the ethics of care. Physicians were often cited by nurses as a source of ethical conflict whereas the physicians thought that the nurses were too eager to give up on patients due to their lack of medical knowledge. It is interesting to reflect back at this point on the values identified by the BMA (commitment, caring, compassion, integrity, competence, spirit of enquiry, confidentiality, responsibility and advocacy) (British Medical Association, 1995) and those identified as nursing values by the AACN (altruism, equality, aesthetics, freedom, human dignity, justice and truth) (American Association of Colleges of Nursing, 1986) and to note that, contrary to the findings of Lindseth et al. (1994), the BMA link caring to the values of medicine and the AACN link justice to the values of nursing.

Lindseth et al. (1994) wanted to explore the stories further. They state that their work is based on the assumption that utterances of life are spontaneous and work best when we don't have to think about them. They also suggest that we give meaning to lived experience by narrating it in speech. The narratives from the first round of interviews were summarised and fed back to the respondents in the second round of interviews. In the second interviews respondents were encouraged to explore issues raised in the first interviews further. The authors found that there was much more common ground between the two groups in the second round of interviews with both physicians and nurses describing meeting death, finding a proper balance between being open to the situation and one's own and other people's experiences, handling advanced medical technology and striving to grasp care as a whole. They found one physician who focused on care to the same extent as the nurses; however, other physicians indicated that the patient's experience was irrelevant to their understanding of the important thing, the disease. The authors state that the physicians and nurses demonstrated different cognitive styles and different types of rationality. They suggest that nurses tend to have a praxis perspective and

the physicians a poiesis perspective. Nurses tended to refer to their personal experience of giving care and the physicians referred to science and proven experience. By asking the participants to relay stories of ethically difficult care situations, the first round of interviews focused on the professional aspects of care. Lindseth et al. (1994) state that they feel the second round of interviews allowed the participants to go to greater personal depth with the interviewers and therefore revealed a more complex picture than had previously been the case.

A further example of comparisons between nurses and doctors is a study performed by Grundstein-Amado (1992) that aimed to explore the differences in ethical decision-making processes among nurses and doctors. She reported that moral reasoning is hierarchical, beginning with a particular value judgement which is based on the individual's value system and these values are justified in ethical principles. Eighteen semi-structured interviews were conducted with nine female nurses and nine male doctors in Canada. The nurses were based in secondary care and the doctors were from both primary and secondary care. The interviews involved a series of open-ended questions followed by a more structured exploration of a hypothetical situation. The participants' references to ethical principles, their patterns of decision-making and their value systems were analysed. Grundstein-Amado concludes that nurses and doctors act out of different values, motivations and expectations and view the patient's best interests from two different perspectives. Nurses are motivated by a value of caring whilst, in contrast, the doctors value the patient's rights and the scientific approach, the latter of which implies a major concern with disease and its cure. It is important to note that the groups, apart from being nurses and doctors, were also female and male (respectively) and therefore some of the findings may be related to gender differences rather than diversity among professional groups. Of equal importance is the fact that the two groups came from a variety of settings and their responses could be a product of the place in which they work.

An example of a study that highlights the significance of the place of work to the development of values is the work of Thomas-Lawson (2002) who explored the communication styles of nurse practitioners and physicians. The study was based on a small convenience sample of five nurse practitioners, who were women, and four physicians, three of whom were men, using audiotapes of 124 interactions and

patient satisfaction questionnaires. The nine participants had all worked together collaboratively for at least two years. The pattern of differences between nurse practitioners and physicians cut across the two professional groups. Overall the health care professionals were informational in their communication style; however, this tended to vary according to the type of patient they were talking to rather than between the two groups. This homogeneity of communication styles might be related to the fact that the nine participants had worked together for some time and had influenced each other. An alternative explanation might be that nurse practitioners and physicians operate in similar ways.

Robertson (1996) studied a team of doctors and nurses who worked together in a gerontological psychiatric setting. His aim was to study whether ethical theory usefully describes the approaches taken in everyday health care settings. He employed an ethnographic approach using participant observation to record four hundred events in the clinical setting. Robertson used an ethical framework to analyse the data from his fieldwork and he found that the doctors and nurses had many shared approaches to patient care but there were also some important differences. Both groups tended to be committed to beneficence and to patient rights and autonomy. However, when tensions arose between doctors and nurses, the nurses tended to be committed to autonomy and the doctors to beneficence, a scenario observed by Robertson on eight out of nine occasions. Conflicts were typically between rights-based autonomy and utility-based beneficence. Robertson observed that the nurses tended to have closer relationships with patients whilst the doctors appeared to be more concerned with problem-solving and improving organic function. Robertson's work did not aim to discover the breadth of ethical values held by either nurses or doctors but primarily set out to determine whether ethical theory can usefully illuminate the moral considerations present in the everyday provision of health care. It is interesting to note that he discovered differences in the priorities of doctors and nurses in the ward settings that he observed, which contrasts with the homogeneity of communication styles described by Thomas-Lawson (2002) in the study described above.

Comparison of the values in social work and teaching

A comparison of the different value orientations of two groups of professionals is based on the assumption that the membership of the profession is the important distinction between the groups. Meyer et al. (1968) point out that a Marxian perspective would focus on the importance of “class” as the crucial source of differentiation, whereas Weberians would argue that the probability of achieving life chances based on position in the market place would be the central issue. In contrast Durkheim would suggest that it is the occupations themselves rather than the social class that is significant.

Meyer et al. (1968) use the Durkheimian sociological tradition to explore the differences between social workers and teachers. They suggest that social work as a profession has emerged historically to stress different values to those of teaching. The authors selected five work values that had been found to be associated with social work and administered a questionnaire to 721 public school teachers who worked in a number of settings in a large city. They demonstrated a clear difference between the value dimensions of social workers and teachers with a larger proportion of social workers adhering to the five values than the teachers. This they suggest provides evidence that within a given class, occupational groups can display distinctive value positions. When they analysed their data further they also found that teachers with more experience were less likely to share social work values than were those with less experience. They also found that the location of work had an impact on the expressed values of the respondents to their questionnaire. Elementary school teachers were more likely than secondary school teachers to have high scores on the value dimensions and teachers working in middle class schools were more likely to express social work values than those who were working in non-project working class schools (project schools were those schools where a special project was in progress the aim of which was to re-orient the school toward the educational problems of deprived areas). This, they suggest, points to the possibility that the values of the various areas are different and that the teachers reflect those differences either by drifting towards the type of school that fits their values or by assimilating those values. The authors conclude by stating that their work suggests that both selection and socialisation are at work to produce the variation within and between occupations in the same social class. They suggest that research into the values of

occupational groupings should consider both selection and socialisation effects as well as the social milieu within which the occupation is performed.

Comparison of the values in social work and nursing

Itzhaky et al. (2003) set out to explore the values, skills and empowerment of nurses and social workers with a view to enhancing each profession's understanding of the other and thereby improving collaborative relationships. The sample consisted of 213 social workers and 152 nurses, all of whom were women and were working in Israel. A value scale of fifty-seven items was used and participants were asked to rate each item on a nine point Likert scale. The value scale was developed by Schwartz (1994) and consists of thirty terminal values and twenty-seven instrumental values.

Schwartz's value scale is based on very similar assumptions to the Rokeach Value Survey (Rokeach, 1973) and items are ranked according to their level of importance as "a guiding principle in my life" (Schwartz, 1994 p.26). Other items in the study were: empowerment, which was measured using an empowerment scale, and skills, which were measured using a skills scale. The authors found that there were significant differences between social workers and nurses in their skills and empowerment and that nurses place greater importance on spiritual and material values than social workers do.

Conclusions

The preceding literature review has demonstrated that research into the values of different professional groups is based on varied epistemological and ontological assumptions. The majority of the work adopted a positivist approach utilising lists of values to explore the value orientations of different groups. The Rokeach Value Survey has been tested to determine its level of validity and reliability (Rokeach, 1973; Rankin and Grube, 1980); test-retest reliability is variable however and appears to be gender sensitive. Altun (2002) and Tompkins (1992) used a list of values that had been identified by the AACN (1986) as being important for the developing nurse. There is no evidence that such a list of values can be meaningfully ranked. Mitchell's (1994) work using Benner's domains of expert practice demonstrates the difficulties in making such an assumption and Tompkins' (1992) work reveals problems with test-retest reliability.

If value systems are dynamic, changeable and related to meaning, quantitative approaches to the study of values can only provide a narrow glimpse of the depth and complexity one might expect to encounter in such work. Malby and Pattison (1999) used stories to discover the values that reside in the organisation of the health service and they concluded that their work revealed the vast complexity that exists within the NHS. Fagermoen (1997) used a mixed approach of surveys and interviews and found that the interviews enriched her understanding of the values of the participants as she found many more values in the interviews than in the questionnaires. Peterson (1988) used an observational study to identify values in the workplace but there was no regard for the influence of the researcher's values on the interpretation of her observations.

Whilst the majority of studies described in this literature review have provided only disconnected insights into the complexity that is associated with values and value systems, a number of them have highlighted interesting and valuable points. Lurie (1981) and Reissman et al. (1960) refer to the changes in values over time with Reissman referring to the "indoctrination" of doctors and Lurie to the change in attitudes and activities of nurse practitioners. Hafferty (1988) also refers to the socialisation of doctors and highlights the use of cadaver stories in the emotional socialisation of medical students. Conversely, Saarmann (1992) and Sivberg and Petersson (1997) indicate that values do not change over time suggesting instead that values are developed early in life and remain stable, an argument that is congruent with Furnham (1988). Lindseth (1994) and Grundstein-Amado (1992) suggest that doctors and nurses have different values. Thomas-Lawson's (2002) study presents a different picture by describing a homogeneity in value systems that develops when doctors and nurses have been working together over a period of time. Robertson (1996) states that there are conflicts between nurses and doctors in ethical decision-making, and differences have been found between social workers and nurses (Wilmot, 1995) and social workers and teachers (Meyer et al., 1968).

Value has been presented as complex, relational, dynamic and associated with meanings. It is therefore surprising to find that there is a paucity of qualitative research exploring the values of nurses and doctors. Values are said to guide behaviour and have an impact on actions, they structure everyday life choices and

have a profound influence on each human being. Values are integral to practice and can help us to understand the nature of practice. It is therefore even more surprising to find that there are no examples of studies that have compared the values of nurse practitioners with GPs. When two different professional groups are offering the same or similar services to patients, it is important to explore the qualitative differences between the groups so that we can then begin to understand the nature of the two practices. Equally, when a new role is developing in nursing that appears to have moved into a different realm of clinical practice, it is important to consider what impact that might have had on the nature of practice being carried out by the practitioners who are operating in that new role. Given the fundamental nature of value in guiding behaviour and accounting for actions, it is important that the values of nurse practitioners are compared to those of the practice of nursing and the practice of medicine. This study aims to explore this issue. The methods adopted to carry out this work will be presented in the following two chapters.

CHAPTER FOUR METHODOLOGY AND STUDY DESIGN

Introduction

The preceding overview of value theory and value research highlighted the complexity of the nature of value and the challenges that are presented in the study of value. The complex and dynamic nature of value systems, together with my own involvement with the study group, resulted in the selection of an autoethnographic approach for this work. An introduction to the rationale for this choice was presented in chapter one. This chapter will expand on the arguments of chapter one and will go on to explore the issues that are raised when an autoethnographical approach is employed in the exploration of values. Interview techniques, sample selection and ethical issues will be considered alongside the use of reflexivity. The discussion will commence with an overview of ethnography and autoethnography followed by a consideration of the issue of validity in a postmodern context.

Ethnography

Ethnography is a term used to describe both a method of data collection and a theoretical and philosophical framework or methodology (Brewer, 1994). It is a method of study that aims to capture social meanings and ordinary occurrences by studying people in naturally occurring settings (Brewer, 2000). Usually the researcher is involved directly in the setting and data is collected in a systematic manner, thus it is described by Van Maanen as “highly particular and hauntingly personal, yet it serves as the basis for grand comparison and understanding within and across a society” (1988 p.ix). In this particular study the setting could be viewed as the world of general practice, the worlds of nursing or medicine and the world of the nurse practitioner. I am also a person who has a certain perspective on values; I have my personal value system and I hold certain beliefs about my role as a nurse practitioner. I certainly, therefore, have direct involvement with the setting that is the focus of this study, making the exploration of values in this context a personal and particular perspective.

Baszanger and Dodier (1997) characterise ethnographic research by outlining three simultaneous requirements. They suggest that in ethnography there is a need for

empirical research, a need to remain open to elements that cannot be codified at the time of the study and a concern for grounding the observed phenomena in the field. The first requirement relates to the fact that the phenomena under study cannot be deduced through introspection and philosophical inquiry. Instead there is a need to study the phenomena in the field, gaining data through empirical observation. The need to remain open refers to the researcher approaching the study without predefined rules and fixed ideas. Baszanger and Dodier (1997) refer to “a priori codified studies” as having strict schedules and the phenomena under study having to fit into these predefined frameworks and guidelines. In contrast “in situ” studies are predicated on flexibility, allowing subjects to behave in ways that are not influenced by the study arrangements. The uncertainty in research design associated with in situ studies results in tensions as the researcher needs to maintain at least some loose structure in the method of the study whilst simultaneously working with a reasonable level of flexibility. The third requirement, according to Baszanger and Dodier, is that the researcher connects the observed facts with the specific backdrop against which these facts occur. Ethnographic studies, then, consider the context in which the phenomena are occurring and take this context into account when interpreting and analysing the data.

Baszanger and Dodier’s characterisation of ethnographic studies is helpful in exploring the fit of the current focus of study to an ethnographic approach. Philosophical inquiry would not allow me to learn about the perspectives of others and their views on values. A philosophical approach is more suited to introspection and therefore would limit the exploration of the views of others. The nature of value, as described in the literature review, is open to interpretation and is likely to reveal as many perspectives as there are participants in the study. I felt it was important to remain flexible and open to the responses of the participants, allowing them to respond freely and openly and to share with me whatever they thought was relevant. It was also important for me to consider the context within which the data collection was taking place. One aspect of the context within which the phenomena are occurring is recognition of the influence of the researcher. I decided to take the recognition of this influence one step further by including my own narrative in the study. This enables the reader to make his or her own interpretation of the findings, having had the opportunity to learn about the author of the study and to be more

aware of my particular perspective and focus.

The ethnographic tale

The particular perspective of the author also has an impact on the presentation of the findings in ethnographic studies. The resultant writing is often referred to as the “ethnography”. Van Maanen (1988) outlines the different approaches that can be taken when presenting the narrative referred to by him as the ethnographic “tale”. He suggests that ethnographies can broadly be organised into three categories which he refers to as “realist tales”, “confessional tales” and “impressionist tales”. These three categories reflect the way different ethnographies are written. They are useful in directing thought relating to the underlying epistemological and ontological assumptions of the ethnographer. Realist tales are those that are associated with naïve realism. A single author tends to take a dispassionate third person approach to the narrative and the interpretive omnipotence of the author is rarely made evident. The world represented by the author of realist tales tends to be presented as the real world dictated by the single interpretation of the lone anonymous ethnographer.

Confessional tales represent an attempt to demystify fieldwork by showing examples of events that actually happened in the field. Episodes of uncertainty, dramas, hardships and blunders are shared with readers with the result that the human qualities of the author become apparent. This results in a blurred account that combines a partial description of the culture under study alongside a partial description of the fieldworker’s experiences. Confessional tales are often incorporated into realist tales as a means of defending the fieldwork as scientifically valid, thus appealing to the canons of positivism. Impressionist tales differ from realist and confessional tales as they are figurative and represent a highly personalised view of the world. The readers of such work can evaluate the tale by assessing its plausibility and believability. Accuracy or representativeness are less important in impressionist tales.

Autoethnography is an example of an impressionist tale described by Van Maanen as “a continuous and deepening interpretive process” (1988 p.118). The authors of impressionist tales provide accounts of a deeply uncertain world; there is a silent disavowal of grand theorising and a focus on the particular, the unusual, the contextual and the eventful. Van Maanen suggests that cultures cannot be known

once and for all; they tend to be illusive, appear in many apparitions and look different from different angles. He states that we can never be free of doubt and ambiguity. Knowing a culture, even one with which we are intimately engaged, is a never-ending story. Writing up fieldwork in any of the three forms of tales described by Van Maanen brings the discomfiture of the uncertain world to the surface. This is perhaps shared more openly by the authors of impressionist tales.

Van Maanen's work is helpful in illuminating the choices made by authors based on particular epistemological and ontological perspectives when presenting ethnographic texts. The postmodern perspective of ethnography recognises that the researcher forms part of the context within which the data are collected and the resultant narrative is therefore an impressionist tale. Postmodernism is in stark contrast to the perspective of naïve realism where the researcher is attempting to understand a world "out there" that exists independently of the researcher. In Van Maanen's view, such authors are likely to produce a realist or confessional tale. In realist or confessional tales the truth is there to be discovered; if all the pieces of the jigsaw can be assembled, the big picture will eventually reveal itself and can be presented in its entirety to the readers of the research. The postmodernist perspective recognises plurality and multiplicity in representations of the "truth" but, according to Dingwall et al. (1998), this perspective results in problems with differentiation between social scientific study on the one hand and journalism or propaganda on the other. Committed postmodernists risk falling into an ultimately pessimistic, unproductive and completely inward-looking perspective (Davies, 1999) referred to by Silverman as "navel-gazing" (1997 p.240).

Methodological rigour

It is important for the present study to avoid the criticisms of journalism and navel-gazing that can be associated with the authors of impressionist tales and autoethnography. An autoethnographic approach has been selected in order to provide the reader with a dimension beyond the reported findings of the study. A personal narrative and personal reflections have been interwoven with the findings of the study in order to provide the reader with information about the author. Armed with this information, the reader can then engage with the findings by developing a personal interpretation. The illumination of the author in this study contributes to the

rigour of the approach. The reader is made aware that while the findings are a product of the responses of participants to an interview focused on the participants' values, they are also coloured by the researcher. Indeed the perspective of the researcher has had an impact on the study design, the nature of the interviews and the interpretation of the participants' responses. An autoethnographic approach simply brings the author to the fore, rather than hiding behind an anonymous façade, that creates the illusion that the researcher has had no influence on the research process.

Ropers-Huilman (1999) suggests that we have an obligation to talk of the way in which our own personal tales affect the stories we tell about those we have witnessed. She goes on to say, "When we map certain practices and discourses through our witnessed accounts, we have an obligation to note our own locations in that mapping" (1999 p.29). Atkinson (1990) suggests that the autobiographical account serves to strengthen the researcher's claims for authenticity. Hammerlsey and Atkinson (1995) state that by systematically exploiting our personal participation in the study, we can produce accounts of the social world and justify them without relying on futile appeals to positivist or naturalist empiricisms. This, they suggest, can be achieved through the use of reflexivity. It is important for a researcher, who is intimately familiar with a particular group, to be alert to the hazards of taken-for-granted assumptions about social behaviour and the possibility of being blind to common everyday activities (Hayano, 1979). McEvoy (2001) states that the emic perspective of the insider can be viewed with suspicion as it is potentially limited and parochial. Adopting a reflexive approach to the research process helps to guard against such problems and this will contribute to the validity of the current study.

Validity

Some authors have suggested that autoethnographic texts and impressionist tales could be labelled as meaningless, introspective studies that have no place in contributing to the development of human knowledge and understanding (Silverman, 1997; Dingwall et al., 1998; Davies, 1999). Altheide and Johnson point out that a growing number of critics refer to ethnographic accounts as "partisan, partial, incomplete and inextricably bound to the contexts and rationales of the researcher" (1998 p.288). In the context of such criticism of autoethnographic work it becomes necessary to address the issue of validity, albeit within a qualitative framework. An

article in the British Medical Journal entitled “Assessing quality in qualitative research” (Mays and Pope, 2000) was followed by a series of letters to the editor which criticised and ridiculed the authors (Isbister, 2000; Poses and Levitt, 2000). Isbister referred to the many strangely unscientific terms in the article such as “reflexivity” and “inductive inquiries” and he concluded that quality in qualitative research remained a mystery to him. Poses and Levitt focus on the anti-realist slant taken by Mays and Pope and they argue that this is merely an excuse for sloppy work. It is exactly this type of argument that highlights the need to ensure that the rigour of qualitative research is enhanced and that the approaches taken to ensure rigour are clearly explained to the reader. This is, of course, no different to quantitative research. Nonetheless, the continued criticisms of qualitative research by those who take a sceptical view of it, as evidenced by the letters outlined above, requires qualitative researchers to be particularly vigilant about the rigour of their work especially whenever and wherever they communicate their findings to an audience. Indeed Barbour states that “in medical research the question is no longer whether qualitative methods are valuable but how rigour can be ensured or enhanced” (2001 p.1115).

Qualitative researchers have, on occasion, argued that the standards associated with quantitative research, such as external validity and generalisability, have no place in the assessment of rigour for qualitative research (Morse, 1999). The application of positivist measures of validity and reliability, such as statistical probability, to determine the generalisability of the findings of a study cause a tension and difficulty with fit when applied to ethnographic studies, particularly those taking autoethnographic approaches. Strauss and Corbin (1999) suggest that the usual canons of science have value but require redefinition to fit the realities of qualitative research. Cutliffe and McKenna (1999) suggest that the criteria used to critique quantitative studies are not necessarily appropriate for qualitative studies as the two are operating in completely different paradigms. Instead they suggest that qualitative studies can be assessed using criteria that are specific for the qualitative paradigm, such as: the use of an expert colleague to verify the data, the use of an audit trail or triangulation of methods of data collection. Even these criteria create difficulty for the researcher who adopts a postmodern perspective because they are all aiming to determine whether the study is representing the “truth” when the

postmodernist perspective would suggest that there are multiple truths. In addition, the use of “expert” colleagues to verify the findings is absurd when the researcher is producing an autoethnography and/or an impressionist tale where the text is dependent upon a unique creative process between the author and the data from the field. The creative process in autoethnographic studies also makes the notion of reliability a nonsense, as the unique combination of participants in the study can never be replicated and therefore a different author will never be able to produce exactly the same findings described by Sandalowski and Barroso as the “sum of an irreplicable sociocultural performance involving researcher and subject” (2002 p.215). “Life moves on, stories change with that movement, and experience changes” (Frank, 1995 p.22) and therefore the notion of reliability does not fit with autoethnographic work.

Subtle realism

Qualitative researchers could be left wondering how their studies can claim any form of legitimacy given the postmodern critique. Hammersley has outlined new criteria for the validation of ethnography which he calls “subtle realism” (1998 p.78) and Brewer developed a different perspective on the issue of validity in ethnographic studies which he entitled the “ethnographic imagination” (1994 p.236). Brewer refers to these two approaches as “post postmodern ethnography” (2000 p.48). Hammersley (1998) believes that it is possible to retain the concept of truth. He suggests that no knowledge is certain but knowledge claims can be assessed in terms of their likely truth and, therefore, phenomena do exist that are independent of us as researchers or readers, about which we can have this type of knowledge. Based on this point of view he then suggests that the validity of ethnographic claims can be assessed by judging the plausibility and credibility of the work. He suggests that knowledge claims should be assessed for plausibility, the ethnographer’s judgement should be assessed for credibility and if neither claim is sufficiently plausible or credible the evidence used to support the claims should be assessed for plausibility and credibility. Hammersley acknowledges that plausibility and credibility are a relatively weak basis for judging scientific claims. If Brewer’s post postmodern ethnography is linked with Hammersley’s assessment of plausibility and credibility a reasonably robust framework for the assessment of rigour in ethnographic studies can be constructed.

Brewer (1994) states that evaluations of the ethnographer’s integrity and good practice can contribute to the confidence with which others can assess the work. He states that the injunctions for good practice are clear and these are outlined in Table One.

Table One:
Injunctions for Good Practice in Ethnography (Brewer, 1994 p.235-236)

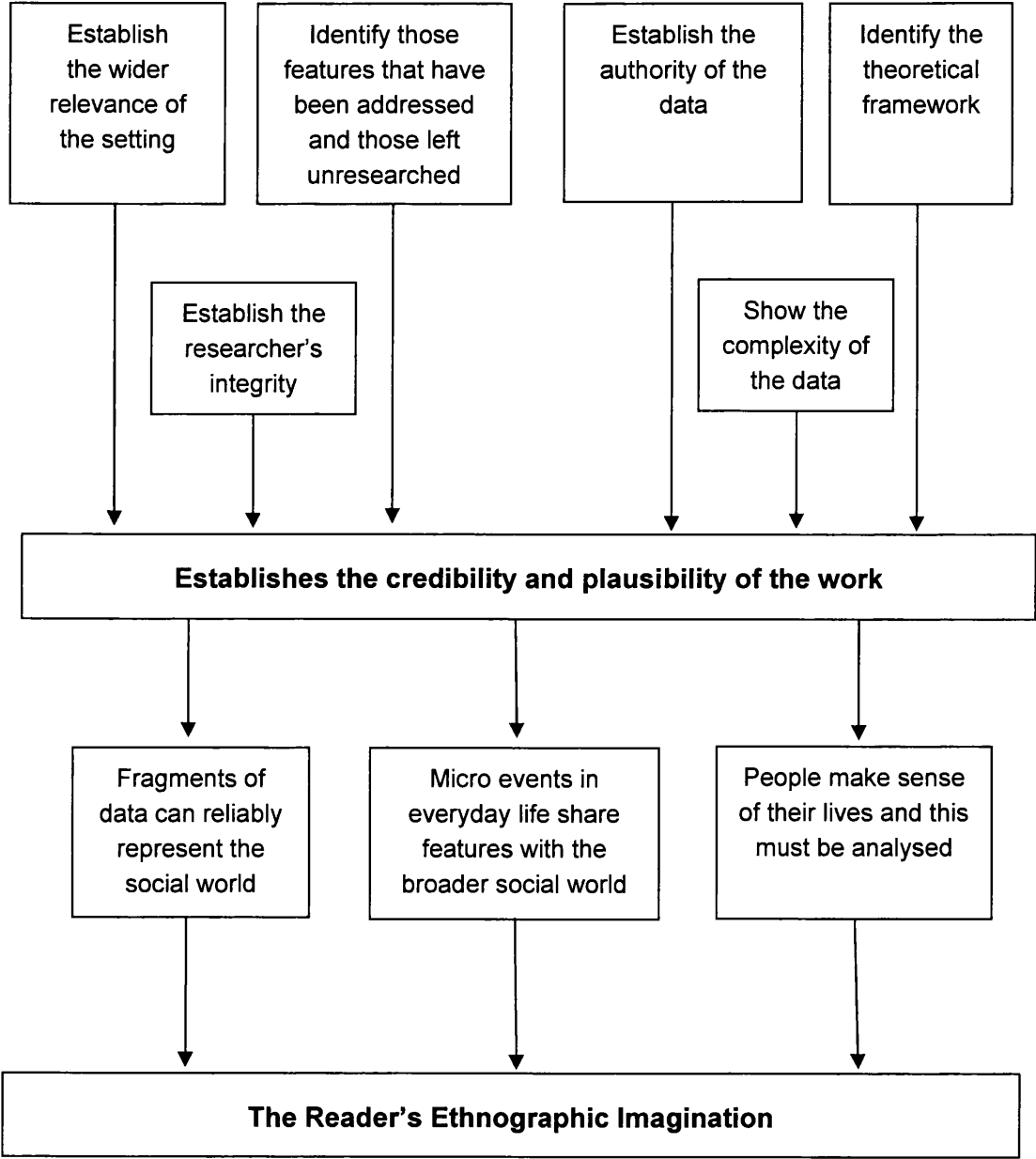
Injunctions for Good Practice in Ethnography
Establish the wider relevance of the setting and the topic, and clearly identify the grounds on which empirical generalisations are made, such as by establishing the representativeness of the setting, its general features, or its function as a special case study with a broader bearing.
Identify the features of the topic that they are addressing in the study and those left unresearched, and discuss why these choices have been made and what implications follow from these decisions for the research findings.
Identify the theoretical framework they are operating within, and the broader values and commitments (political, religious, theoretical and so on) they bring to their work.
Establish their integrity as a researcher and author, by outlining: The grounds on which knowledge claims are being justified. Their background and experience in the setting and topic. Their experiences during all stages of the research. The strengths and weaknesses of the design strategy.
Establish the authority of the data by: Discussing the problems that arose during all stages of the research. Outlining the grounds on which they developed the categorisation system. Discussing rival explanations. Providing sufficient data extracts in the text to allow readers to evaluate inferences made from them. Discussing power relations within the research.
Show the complexity of the data avoiding the suggestion that there is a simple fit between the social world under scrutiny and the ethnographic representation of it by: Discussing negative cases. Showing multiple and often contradictory descriptions proffered by respondents themselves. Stressing the contextual nature of the respondents’ accounts.

Brewer states that there is one further requirement to enable ethnographic data to have authority and that is that the reader should adopt a particular perspective to the ethnography that he calls the “ethnographic imagination” (1994 p.236). The ethnographic imagination is based on the belief that: first, extracts from the data can reliably represent the social world; second, small scale micro-events in everyday life share features with the broader social world; and third, through complex reasoning

processes people make sense of their everyday lives and their accounts and descriptions must be analysed if the social world is to be understood. The perspectives of Hammersley (1998) and Brewer (1994) have been combined in Diagram One.

Diagram One:

Subtle realism and ethnographic imagination in postmodern ethnography



Verisimilitude

Subtle realism and the ethnographic imagination are based on establishing credibility and plausibility. These terms are closely linked with truth, indeed the 2002 Oxford English Dictionary refers to the “credibility gap” as an apparent difference between what is said and what happens or is true (Pearsall, 2002). Hence what is credible is also real and true. Some authors have rejected validity completely and instead appeal to the concept of verisimilitude. Atkinson states that verisimilitude is the “extent to which the ethnography appears to be truthful” (1990 p.47). Schwandt lists three ways that verisimilitude can be used:

- Verisimilitude as a criterion such as plausibility, internal coherence and correspondence to the reader’s own experience.
- Verisimilitude as a criterion for judging the evocative power or sense of authenticity of a textual portrayal.
- Verisimilitude as the relationship of a text to agreed standards of a particular interpretive community (1997 p.170-171).

Sparkes (2002) suggests that verisimilitude allows us to respect the value of personal, literary and poetic forms of knowledge. The restriction of truth to those forms of knowledge that are literally true discounts forms of knowledge that can be judged to be metaphorically true. Altheide and Johnson suggest that the social world is an “interpreted world and not a literal world” (1998 p.284) and therefore interpretations of the world in the form of narratives, literature, poetry, drama and art all have value in contributing to our understanding of the human condition. Sparkes (2002) puts forward a number of criteria lists that have been developed to assess the quality of narrative study. Examples of these lists are:

- Width: comprehensiveness of evidence.
- Coherence: the way different parts of the interpretation create a complete and meaningful picture.
- Insightfulness: the sense of innovation or originality in the presentation of the study and its analysis.

- Parsimony: the ability to provide an analysis based on a small number of concepts, and elegance or aesthetic appeal (Lieblich et al., 1998 p.173).
- Substantive contribution: does this contribute to our understanding of social life?
- Aesthetic merit: does this text invite interpretive response?
- Reflexivity: is the author cognisant of the epistemology of postmodernism?
- Impact: does this affect me? Does this generate new questions?
- Expression of a reality: does this text embody a fleshed out embodied sense of lived experience? (Richardson, 2000 p.937).

Lists such as these provide some guidance for researchers who are working with autoethnographic techniques. The concept of verisimilitude has congruence with the postmodern perspective where multiple voices, pluralism and multiple truths are embraced. The reflexive nature of the text is an important component of verisimilitude and it is to this issue that I will now turn.

Reflexivity

“Good ethnographies” write Altheide and Johnson “show the hand of the ethnographer” (1998 p.301). One method of showing the hand of the ethnographer is the use of reflexive practice. Reflexivity refers “to the ways in which the products of research are affected by the personnel and process of doing research” (Davies, 1999 p.4). Altheide and Johnson state that the meaning of reflexivity is that “the scientific observer is part and parcel of the setting, context and culture he or she is trying to understand and represent” (1998 p.285). Koch and Harrington (1998) state that researchers should incorporate a reflexive account into their writing because this will help the readers of their work understand what is going on in the research process. Reflexivity, they suggest, helps the reader to decide what is plausible. According to Brewer (2000) reflexivity affects both the status of the data (legitimation) and the writing up (representation). A reflexive ethnographer needs to consider the location of the setting, the sensitivity of the topic, power relations and all other potential social processes and phenomena that might influence the data. Brewer goes on to say that reflexivity is a fundamental part of postmodern ethnography. He is therefore

implying that it is futile to attempt to eliminate the effects of the researcher; instead we should set about trying to understand them.

An autoethnographic approach provides the reader with rich data relating to the researcher of the study. Not only can the reader make judgements about the plausibility of the author's reflexive comments but they can also make a judgement about those statements based on their interpretation of the author's perspective presented in the autoethnographic account. Reflexivity can be incorporated into a study through the use of a reflective diary and sharing excerpts from the diary in the presentation of the findings. The reflexive process starts at the inception of the study and captures the evolving understanding of the researcher as the study progresses. Excerpts from my reflective diary will be presented in the remaining chapters of this thesis in an attempt to share with the reader the ways in which my reflections, my thoughts and my emotions shaped the development of the study.

Methods: issues in an autoethnographic study

Sample selection

Patton (1990) states that nothing captures the difference between qualitative and quantitative research better than the different logic employed to select the sample. When research is conducted with a distinct group of subjects of which there are very few in the total population, the researcher may elect to employ a purposive sampling technique. Purposive sampling involves the conscious selection of certain subjects and efforts may even be made to select "typical cases" (Burns and Grove, 1993). In essence the researcher in a qualitative study may make a judgement relating to the type of subjects they wish to include in their study. This enables the researcher to explore issues in depth with the subjects. A random sample may completely miss the subjects who have most to say about the particular focus of the study. Morse (1999) suggests that it is the selection of the sample that ensures that the research findings are complete as each participant has been specifically selected for their potential contribution toward the emerging theory.

Williams (1998) suggests that it is important to remember that the purpose of qualitative research is to explore phenomena and to subsequently be able to comment on meaning and contribute to understanding the theoretical basis of those

phenomena. Thus, she suggests, it is important to ask; who are the people who will be most able to assist in exploring the area that forms the focus of the study. The aim of this study was to examine the values of nurse practitioners and to consider to what extent this particular group of nurse practitioners share the values of medicine or nursing. I therefore needed to select a group of nurses who could represent the values of nursing and a group of doctors who would represent the values of medicine. The one major group of doctors working in primary care in the UK are the GPs and as the study was located in the primary care setting it seemed appropriate to approach this group to represent the values of medicine. District nurses were selected to represent the values of nursing. There would have been some sense in interviewing practice nurses as they are also employees in general practice and it would have made the organisation of the study less complicated; however, it is important to consider how far this group would represent “nursing” values. Practice nurses are closely linked to nurse practitioners in general practice (Smithson, 1999) and therefore there could be some blurring of roles. If, as Thomas-Lawson (2002) has suggested, people who work together influence each others’ values, the practice nurses would not provide an adequate example of nursing values for comparison with the nurse practitioners. District nurses work in a team of nurses who are employed separately to the rest of the team in general practice and are therefore less likely to have assimilated the values of the general practice-based team who work more closely together. Blackie states that community nursing specialists in the home (district nurses):

... provide nursing care directly to individuals and groups through direct access... they care mainly for people who are ill or who are recovering from illness and require physical, practical nursing care as well as psychological support ... The district nurse has responsibility to the person receiving treatment as the primary client and also to any carers as secondary clients of the service (1998 p.97).

This definition highlights the link to practical care associated with district nursing. District nurses have different skills to those of the nurse practitioner; they are engaged in a different type of nursing care and have evolved from a different historical background and tradition. Many qualified district nurses are now team leaders and in addition to their work with clients, they manage personnel in their teams. They are also responsible for the assessment of patients and delegate various activities and tasks to other members of the community health nursing team. Hence,

their roles are not purely based in the practicalities of nursing. The work of the district nurse is sufficiently different to that of the nurse practitioner and sufficiently located in the traditions of nursing practice to provide a valuable contrasting group for this study.

The above arguments led to the selection of GPs, nurse practitioners and district nurses as the sample population for this study. The GPs and district nurses both form clearly defined groups who can be identified by their recordable qualifications with their regulatory bodies. Nurse practitioners are not so easily identified. There are a diversity of nurse practitioner roles in the UK and some nurses are using the title “nurse practitioner” with no formal training or qualification for the role (Smithson, 1999). I decided that nurse practitioners would be eligible to enter the study if they held a recognised nurse practitioner qualification which is either the Royal College of Nursing (RCN) qualification or one that meets the same standards as the RCN course. The definition of the nurse practitioner according to the RCN was outlined on page 15. In addition to the qualification, I decided that the nurse practitioner should be working in a practice that recognises them as a nurse practitioner (i.e. their name and the title “nurse practitioner” appears in practice literature or on a practice notice board). This decision was made because not all nurses who are qualified as nurse practitioners operate in the role as it is recognised by the nurse practitioner competency framework (Royal College of Nursing, 2002). It was important to select nurses with the appropriate experience and I was therefore looking for evidence at the practice of the nurse practitioner operating in an advanced nursing role, such as managing nurse-led chronic disease management clinics or open access clinics.

In addition to clear identification of the three groups of practitioners, I decided that it would also be important for all of the participants to have at least one year’s experience in their role. This decision was based on MacIntyre’s (1984) proposition that goods internal to a practice can only be achieved by engaging in that practice. It would follow that a practitioner who had little experience of the practice would be less likely to have achieved or even be aware of the goods internal to that practice. Lurie (1981) points out that no definitive data exist on the time that is required for a nurse practitioner to become institutionalised into the role. In the

absence of any guidance Lurie decided that after twelve months of practice in the nurse practitioner role, the nurse would have been accepted by other health care professionals and would be fully functioning in that role. The results of her work would suggest that twelve months was long enough to uncover differences in the socialisation of nurse practitioners when compared to nurses in ambulatory care settings. Brown and Olshansky's (1997) work agrees with Lurie's suggestion that twelve months is a reasonable time in which to consolidate the role. They carried out a study that examined the transition of nurse practitioners during their first year of practice and they concluded that the nurses had a clear sense of themselves as nurse practitioners by the end of the first year. Returning to William's (1998) suggestion that the selection of the participants of the study should take into consideration who will be most able to assist in exploring the area that forms the focus of the study, it was important to consider what length of time the study participants should have been in practice to enable them to talk about the values associated with their particular role.

Interview techniques

The views and opinions of nurse practitioners, GPs and district nurses can be explored using a variety of approaches. The literature review revealed the range of quantitative and qualitative approaches that had been used by other researchers. I rejected working within a quantitative paradigm due to the recognition that values are complex, dynamic and sensitive to context and that quantitative approaches cannot adequately detect nor explore such complexity. I was aiming to develop my understanding of the nature of values for nurse practitioners, GPs and district nurses. Exploratory work such as this is most appropriately conducted within a qualitative paradigm and therefore the options of fieldwork, focus groups and interviewing were considered. Ethnography is often associated with fieldwork and the collection of notes based on participant observation. Brewer (2000) however, states that ethnography does not represent one particular method of data collection, instead it is a style of research that is distinguished by its objective to understand social meanings and activities. Indeed Ellis and Bochner (1996) suggest that laying down rigid rules relating to the methods will reduce the flexibility that is necessary for adopting different discursive strategies, depending upon the circumstances of the research project.

As I work closely with district nurses, nurse practitioners and GPs I expected that the availability of their time would be a significant concern in deciding which method to use in this study. Observing people in practice could have been considered but this would have given very limited information relating only to patient-health care professional interactions with possibly a few incidental professional-professional interactions along the way. The nature of practice in primary health care results in health care professionals working predominantly on their own. I felt that observing them in these settings would be valuable but would provide incomplete data that could be difficult to interpret. My aim was to understand what each individual found meaningful in their practice and how this related to their lives outside work, their career choices and their broad views on life. Focus groups could have resulted in people agreeing with each other and wanting to share the most socially desirable values with the group. Again this would have been valuable from a group perspective but would not have provided the rich personalised data that I was hoping to gain from each individual practitioner. Warren (2002) suggests that researchers often choose qualitative interviews when their focus is not on particular settings but their concern is with establishing common patterns and themes between different types of respondents. Johnson goes on to say:

... if one is interested in questions of greater depth, where the knowledge sought is often taken for granted and not readily articulated by most members, where the research question involves highly conflicted emotions, where different individuals or groups involved in the same line of activity have complicated, multiple perspectives on some phenomena, then in-depth interviewing is likely the best approach (2002 p.105).

I therefore decided to use unstructured interviews as this seemed to offer the most likely possibility to achieve a rich and in-depth understanding about the values of district nurses, GPs and nurse practitioners. Indeed the work by Fagermoen (1997) provided a precedent for such an approach. Fagermoen states quite specifically in her research that she discovered greater complexity, relating to the integration of values in nursing, when she moved from the questionnaire phase of the study to the interview phase.

Ellis and Berger state that the interviewing process should not be regarded as the passage of information from the respondent to the interviewer, instead the interview is a “sea swell of meaning making” where researchers connect their own experience to those of the research participant (2003 p.471). Ropers-Huilman describes participating in discourse as a process of “dynamic meaning-making” (1999 p.32). Collins (1998) states that in an unstructured interview, it is more useful to talk of data generation rather than data collection. Brewer (2000) describes people as having the capacity to interpret and construct their world; people are discursive and linguistically formulate their ideas, and thus he refers to people as “meaning-endowing” (2000 p.34). The role played by the interviewer contributes to data creation and therefore data are context-bound to the interviewer (Brewer, 2000). Brewer states that social researchers need to:

- Ask people for their views, meanings and constructions.
- Ask people in such a way that they can tell them in their own words.
- Ask them in depth because these meanings are often complex, taken for granted and problematic.
- Address the social context which gives meaning and substance to their views and constructions (2000 p.35).

One method of achieving the aims for social researchers outlined by Brewer above is through the use of unstructured or non-standardised interviews. The unstructured interview is used to avoid structure to enable the exploration of participants’ meanings without them being trammelled by formality (Brewer, 2000). Denzin (1970) suggests that this tool is best suited to exploratory studies.

The question

Collins (1998) suggests that one criticism of the interview is that respondents are likely to provide the interviewer with the “official account”. It is therefore absolutely vital that the researcher selects the right question or questions to get the interview started. Denzin (1970) states that the question must fit the experiences of those being interviewed, therefore it does not need to be static. He suggests that the question does need to be fixed in its meaning but not in its wording. The researcher can therefore

rephrase the question for individual participants depending upon their personal interpretation of the message buried in the question. The development of the question for the present study aimed to enable the participants to use their own words to talk freely about their values and what they valued in their work as a nurse, nurse practitioner or doctor. The opening question was therefore essential and was gradually developed through a review of the literature and subsequently through the use of a pilot study. The development of the question is outlined in detail in the following chapter.

Ethical issues

Davies (1999) suggests that increasing reflexivity in social research leads to a greater awareness of ethical questions. An annotation from my reflective diary after one of the interviews emphasises the concern felt for participants of the study when a researcher is engaging in reflective practice: *“My main concern is that I might have unsettled her in some way”*. This was a comment on an interview that had been particularly challenging when the participant had difficulty in sharing anything that was positive in her practice. It became clear at the end of the interview that the participant had received the information about the study and the consent form but none of the information had been read before the interview. This event highlights one of the difficulties with informed consent. After engaging in the interviewing process a participant might discover, that the research is focused on a subject that they would really rather not discuss. Consent is an evolving process and the researcher should check, both before and after (and sometimes during) the data collection process, that the participant is willing to remain engaged with the research. Davies (1999) suggests that there is the technical question of how to present the research in a manner that is meaningful to participants whilst simultaneously avoiding any contamination of the research process as a result of the disclosures on the consent form. I had to consider this issue when developing my consent form and information about the study, and this will be discussed further in the following chapter.

McEvoy (2001) highlights a further potential ethical dilemma that is relevant to the conduct of the present study. He states that interviewing colleagues with whom one has a close relationship can interfere with the participant’s ability to give freely informed consent. My experience parallels that of McEvoy in that I found that my

colleagues very readily agreed to give up their time to be interviewed. I remained aware of the possibility that they felt obliged to agree to participate because they did not want to appear discourteous. Their continued consent to engage with the study was checked on a number of occasions. The process for this will be explained further when I outline the method used in this study.

Concluding comments

This chapter has explored the methodological concerns associated with autoethnographic research. The aim of the current study is to explore the values of nurse practitioners, GPs and district nurses. I am a member of the groups that I have set out to study in that: I am a woman, a nurse, a health care worker, a health care worker in primary care and, most specifically, I am a nurse practitioner.

Autoethnography can be defined as the study of one's own group and can also be defined as the study of one's personal biography. Therefore the autoethnographic approach is relevant and appropriate for this work. This chapter has outlined the ways in which methodological rigour can be upheld: by using the tenets of Brewer's (2000) post postmodern ethnography, and by appealing to the concept of verisimilitude. The implications of using this methodological approach, and the ways in which the rigour of the work can be defended when applied to the study of GPs, nurse practitioners and district nurses, will be the focus of the following chapter.

CHAPTER FIVE METHOD

Introduction

The aim of this study was to explore the values of district nurses, GPs and nurse practitioners with a view to examining the similarities and differences between the three groups and thereby understanding whether nurse practitioners share the values of nursing or medicine. Having considered the complex nature of value from a postmodern perspective and explored the dynamism and contextual characteristics of value systems, I decided that qualitative interviewing would be the most appropriate approach to develop an in-depth understanding of this subject area. It was clear that I could not be separated from the research design, the data collection or the analysis due to my group membership. Reflexivity would form an essential component of the work. I therefore decided that an autoethnographic approach would enable me to reveal my own perspective and to ultimately interweave this perspective with that of the participants of the study. Having explored Van Maanen's (1988) work I decided that the product of my work would be an impressionist tale. I would be appealing to the rigorous practice associated with post postmodern ethnography and I would be aiming to achieve verisimilitude. I therefore decided that this work would be called:

"A nurse practitioner's tale: an autoethnographic, interpretive study of the values of nurse practitioners, GPs and district nurses".

This chapter outlines the way in which this study was carried out.

Ethical approval

Ethical approval was sought and gained from the Primary Care Trust (PCT) Local Research and Ethics Committee in the geographical location within which the study was to take place (see appendix one). A second application to a neighbouring PCT Local Research and Ethics Committee was made in order to carry out the pilot study. The neighbouring PCT also agreed to the study (see appendix two).

Consent form

The participant consent form and the sheet outlining information about the study can be found in appendices three and four respectively. When creating these forms it was

important to be clear about the intentions of the study without influencing the participants in any way. I therefore introduced the idea of values as follows:

The aim of this work is to explore the values of nurse practitioners, district nurses and general practitioners. Values can be difficult to describe, they are linked to ideals, beliefs and meanings and tend to influence our choices, behaviours and actions. These issues will be explored with you in an interview.

The intention of this statement was to keep the description as broad and all-inclusive as possible.

Both the consent form and the information sheet introduced the participants to the idea that they would be asked for their feedback on the transcript and on a subsequent analysis of the transcript. The participants' ongoing participation in the process of feedback gave them further opportunity to withdraw their consent if they felt the need to do so.

Sample selection and gaining access

The study employed a purposive sampling method in order to carefully select those participants who would have something to say about the values associated with the roles of nurse practitioners, district nurses and GPs. I therefore determined selection criteria that included: the participant must be qualified as a GP, nurse practitioner or district nurse and must have had at least one year's experience in their role. The length of time in the role was based on Lurie's (1981) study as described earlier. The GPs and district nurses have nationally recognised recordable qualifications with their respective registering bodies. This is not the case for the nurse practitioners. For the nurse practitioners the appropriate qualification was deemed to be a specialised qualification as a nurse practitioner, either from a recognised Royal College of Nursing (RCN) course, or one that met the RCN competency framework (2002) for the education of nurse practitioners. In addition, due to the diversity and confusion that exists around the nurse practitioner role, I looked for evidence that the nurse practitioners were working in a recognised nurse practitioner role in their place of work. I also looked for evidence in the practice literature, on practice notice boards or the self reports of the nurses to determine if each potential participant was

working in a role that would be recognised as a nurse practitioner by the RCN competency framework.

In the PCT where the study was to be carried out, there were nine qualified nurse practitioners who were working in practices that referred to them in the practice literature as “nurse practitioners”. Two of the nine were in my own practice (myself included). There were a further three nurse practitioners who had been qualified for more than a year but their role in their practices was not clear. The practice literature or practice notice boards referred to these three nurses as “practice nurses”. I excluded these three nurses from the sample and also excluded my work colleague. I felt that the three nurses were not fully working in the role of nurse practitioner as it appeared that there was some confusion in their practice relating to their role. I also felt that I was unable to carry out an interview with my work colleague as we work very closely together and I did not want her to feel obliged to participate or to have any difficulty in sharing her personal thoughts with me in an interview. The sample was therefore selected by approaching the seven practices that employed the nurse practitioners who met the sample selection criteria. A minimum of four practices was set for the study. If fewer than four practices agreed to engage with the research the geographical boundaries were to be broadened to include other PCTs.

Having been involved with nurse practitioners for nearly a decade I knew all of the local nurse practitioners and I also knew many of their GP mentors, which made access to the potential participants easier. However, I did remain aware of McEvoy’s (2001) caution that colleagues and acquaintances might agree to be involved in a study just to be courteous and feel less able to decline an invitation. I addressed this potential difficulty by approaching the participants through their practice manager. I felt this would enable them to decline the invitation to participate in the study (if they so chose) by working through a third party.

All seven practices were approached. Initially I wrote to the practice managers outlining my research proposal and what it would mean for their practice if they chose to get involved. Following this, I was put in contact with the relevant nurse practitioner, a GP participant and a member of the district nursing team. Six of

the seven practices consented to become involved in the study which resulted in a sample population of six GPs, six nurse practitioners and six district nurses. In addition I approached a practice outside of the PCT area to act as a pilot site; they agreed and I interviewed a district nurse, GP and nurse practitioner at that site.

The demographics of the respondents are outlined in Tables Two and Three:

Table Two:
Demographics of GPs and Nurse Practitioners

	Roles	Gender	Age Range	Practice Size	Number of Partners	Years Qualified
Pilot	GP	Male	51-60	8,500	5	20
Pilot	NP	Female	31-40			3
Main study	GPs	5 Males 1 Female	31-50	1,500 - 13,500	1-10	3-18
Main study	NPs	6 Females	31-60			2-7

Table Three:
Demographics of District Nurses

	Roles	Gender	Age Range	Case Load	GP Surgeries Covered	Years Qualified
Pilot	DN	Female	41-50	130	3	8
Main study	DNs	6 Females	41-60	80-210	1-5	8-20

The demographic information shows that the pilot site was reasonably representative of an average practice for this study. Further information regarding the pilot study will appear later in this chapter and the relevance of the demographics will be discussed in later chapters.

Interview strategy

The aim of the interview was to provide the participants with the opportunity to share with me whatever they felt was of value to them in their role. Fagermoen's (1997) work had involved asking respondents to a questionnaire "What is most meaningful in your work as a nurse?" She found that the responses to this question provided her with a number of value categories that she subsequently used in the thematic content analysis of her interviews. Having explored Frankl's (1959) work I felt that values could potentially be found in the complexity of meaning in people's lives and I therefore decided to ask people:

“Can you tell me what you find most meaningful in your role as a GP/nurse practitioner/district nurse?”

I felt that this was a sufficiently open question which was not too dissimilar to the example provided by Moyle (2002) who used the example of the open question *“Tell me about your childbirth”*. This, she says, can have no set answer and thus it allows the respondent to explain their reply in their own words. Such open-ended questions help to ensure that the reply is from the perspective of the participant and is not shaped by the interviewer. Interestingly, I had to defend the use of a single question interview when I attended the ethics committee. The committee described my interview schedule as “under-developed” until I explained the purpose of the approach and the flexibility it would afford in allowing each participant to respond in their own unique way.

All interviews commenced with the question as outlined above. It transpired that not all participants were able to make sense of what “meaningful” meant. If a participant was finding it difficult to understand what the focus of the study was because of the use of the word “meaningful” I adjusted the question and used words such as “What do you find most satisfying in your work?” “What do you enjoy in your work?” or simply “What makes you tick?” This was following Denzin’s (1970) advice that questions should be fixed in meaning but not in words. Having explored the literature on the theory of value it was clear that there could be a number of substitutes for the words that people might associate with their values.

A total of eighteen interviews were conducted over a period of seven months. The interviews ranged in time from twenty minutes to fifty minutes. Three interviews were conducted in one day for the pilot study. I had to travel some distance to get to the pilot site and the practice manager felt that it would be best for me to see all three practitioners on the same day. It transpired that conducting three in-depth qualitative interviews in one day was quite an onerous task and I found myself having to concentrate extremely hard with the third participant as my energy had steadily decreased during the first two interviews. In the main study almost all of the interviews were conducted on separate days.

Denzin (1970) suggests that it is important to consider the choice and style of dress when carrying out interviews. He states that the style of dress is a prerequisite for establishing meaning and purpose in the interview. I therefore had to consider how I might present myself in each interview. Johnson (2002) argues that non-comparable interviews in studies that use in-depth interviewing pose no problem to the validity of the research. The purpose of such interviews is not to “count” or to “statistically analyse” the findings, instead, the aim is to explore and understand the participant’s point of view. With such a diverse group of practitioners the setting of each interview was bound to be different for each individual. In spite of the recognition that these would be non-comparable interviews, I decided to wear the same clothes for each encounter to enable me to portray the same message to all participants. I subsequently found that it helped me to get into the role of the interviewer as the study progressed.

The consent form instructed the participants to determine a time and place that would be convenient for them. I asked the respondents to find a room that would allow us to hold an interview with minimal interruption and to identify a time that was most suitable for them. The locations in which the interviews took place varied between the groups and the significance of this will be discussed in the subsequent chapters of this thesis.

In addition to his comments on style and dress Denzin also refers to “body-equipment” (1970 pp.140-141). Body-equipment according to Denzin are items such as cigarettes and cups of tea that the researcher might have to handle during the process of the interview. Denzin describes how he started smoking in an interview and then became acutely aware that he had insulted his interviewee; he goes on to describe how he then knocked over his coffee in an attempt to put out the cigarette! Items of body-equipment can assist in the process of communicating with the participants or they can create barriers. In almost all the interviews, I was offered a cup of tea or coffee. Very early on in the research process I decided that I would accept a drink whether I wanted it or not as I felt this helped to contribute to the informality of the setting. I felt that this would help to break down barriers and contribute to the impression of a conversational style rather than the formal structured interview that some of the participants might have been expecting.

Respondent validation

In addition to the impression of informality, I wanted to make the study as participatory as possible. At the same time I appreciated the demands on time for most health care professionals in primary care. I also felt it was important to recognise that some participants might not necessarily communicate all they wanted to during the course of the interview and so I endeavoured to give them the opportunity to share their values with me in written form, if that suited their style. I sent all individualised transcriptions of interviews to the participants and I asked them to comment on the content of their interview and whether they felt they had any further comments or anything they would like to change. The transcript check form can be found in appendix five. After receiving the transcript check form back from the participants, I then summarised the transcript into a short coherent summary of what I thought they had shared with me regarding their values. This was sent to the participants for their further comment and they were asked to complete a transcript summary check form, an example of which can be found in appendix six.

The participants' comments on the transcripts contributed to the subsequent analysis of the interviews. In a few cases participants felt that what they had said did not really represent what they meant to say, and in another case a participant felt she had not said all she wanted to and sent a further three pages of notes to complement her original transcript. In most cases the participants stated they had nothing more to add and did not want to change anything in the transcript. The response to the request for transcript checks varied between the participants and provides useful information in the interpretation of the findings.

The process of checking the transcript summaries with the participants was a method of respondent validation. I wanted to check with each participant that I had understood what they had said and that I had adequately captured what they wanted to present as their values. Hammersley (1992) states that the responses of participants are useful sources of data; although, at times, feedback from participants can be highly problematic (Hammersley and Atkinson, 1995). Respondents can decide that it might be in their interests to deny something they said in an interview or they might feel the need to tone down particular views or responses. Hammerlsey (1992)

suggests that respondents do not necessarily have privileged access to the truth and they cannot necessarily validate or falsify data. What is interesting, according to Hammersley and Atkinson (1995), is the enthusiasm, indifference or hostility with which participants engage with respondent validation. This process of so-called validation should be seen as yet another valuable and interesting addition to the original transcripts. In this study the responses certainly contributed to the depth and complexity of the subsequent analysis.

It was a condition of the PCT's Local Research and Ethics Committee's approval for the study that I should only publish the amended transcripts. All transcripts and transcript summaries appear in the appendices of this thesis and these are the amended versions after receiving feedback from the participants. The few participants who did want to make changes commented that they felt embarrassed by their poor grammar. Others felt that what appeared on paper did not adequately reflect what they had meant to say. The Ethics Committee wanted me to respect the possible concerns of the participants and thereby only share with others the amended versions of the transcripts. The extent to which participants of the study engaged in the process of transcript checking did provide a useful contribution to the subsequent analysis of the narratives.

I have chosen to include all the amended transcripts and transcript summaries in the appendices of this thesis. The rationale for sharing with the readers such a great deal of data is to recognise the interpretive nature of this work. In the discussion of findings I will invariably select sections of text to illustrate points or to develop ideas. If a reader is puzzled by a quotation or feels there is an alternative interpretation, they will have the opportunity to turn to the original transcript and to review the context of that quotation. Sandalowski and Barroso's (2002) "Finding the findings in qualitative research" highlights the difficulties associated with the presentation of "findings" or "results". In an attempt to avoid long sections of description based on lengthy quotations from the transcripts, the readers of this work will be directed to the transcripts for further detail if they wish to gain more information about a particular participant or a particular section of transcript. What will be reported in the findings section of this work will be my interpretations based on my own perspective and my understanding of the relevant theoretical

perspectives. As the full transcripts have been made available, the reader has the opportunity to explore alternative interpretations of the data.

Excerpts from the transcripts that appear in the remainder of this thesis will have repeated words removed. In addition “ums”, “ers” and other utterances such as these will be removed from the excerpts. The repeated words and other utterances will only be included where they are of some significance to the evolving narrative. Where they do not contribute to the interpretation of the transcripts the repeated words and the “ums” and “ers” will be removed. The reason for taking this action is two-fold. The first is to ease the process of reading the work for the readers as repeated words can disrupt the flow of the sentence and thereby detract from its message, as Lieblich et al. state, “a full and redundant text is hard to read” (1998 p.30). The second reason is out of respect for the participants of the study, several of whom commented that they felt acutely embarrassed at their language when they saw it in writing as an extract from my reflective diary demonstrates:

NP1 returned her transcript check form obviously feeling quite uncomfortable about how she sounds on paper. The transcript check states “I felt a bit stupid and saying so many ‘ers’ etc”.

And a further example is from the transcript check of GP2 who stated:

I was not happy for my incoherent inarticulate responses to your questions to be left unedited. So I have amended the transcript so that it now makes sense.

This GP then went on to make 142 grammatical corrections to the transcript.

Where more than repeated words or “ums” and “ers” have been removed from a passage, an ellipsis (...) has been used to demonstrate that a section of the transcript has been omitted. This is merely to avoid unnecessarily lengthy segments of transcript appearing in the text and disrupting the flow of the narrative.

Practice interview

Prior to embarking on the pilot study I decided to practise the interview technique with a district nursing colleague who works locally. This was someone that I knew

reasonably well although we did not have a close working relationship like the one I have with my nurse practitioner colleague. I therefore felt that it would be appropriate to practise my interviewing skills with her. I do have some past experience of carrying out interviews for the purposes of qualitative research. My prior work had involved the use of semi-structured interview schedules, gathering the views of the users of various health care services (Crumbie, 1997; Crumbie and Barnes, 2003; Barnes et al., 2004) but this was significantly different to the type of interviewing required for this study. The interview for this research was not structured and was based on one opening question, as discussed earlier. In this first interview with the district nurse, I found that the lack of structure was difficult to cope with. I started the interview with:

AC: ...can you just tell me whatever you want to tell me about your role as a district nurse?

I found that after forty minutes of interview we were still engaged in describing her role and what she does and who she is responsible for and how she organises care. At approximately forty minutes I asked:

AC: ...it's a really broad, wide ranging role that you've talked about. What in all of that would make you really tick, what is it that you really love about the role?

The remaining six minutes of the interview were much more informative in relation to what was meaningful to this particular nurse. An excerpt from my reflective diary after the interview states:

It's clear from some of the questions that I am leading her and helping her through. I am putting ideas in her head and sometimes directing her to say things she may not have otherwise said. The best example of the less directive but probing questioning is between paragraphs 51-66 and it is clear from this passage that some very valuable and useful points can be gained from this approach. I added in the questions about what made her tick and what made her angry to test out how this might draw out values.

This experience helped me to address the fear that I had regarding the use of unstructured interviews. I shared this with my supervisor and I realised that I was asking multiple questions to help *me* feel safer but this was not allowing the

participant to respond in her own words. I therefore resolved to stick to the interview plan, ask the one opening question, and then use minimal prompts from there on to help the participants to continue to talk. This technique was then formally tested in the pilot study.

Pilot study

A pilot site was selected from a neighbouring PCT. The practice was right on the border of the PCT which formed the location for the study. As can be seen from the demographics outlined on page 93, this particular practice was reasonably representative of an average practice for this study. The nurse practitioner's qualifications and experience met the inclusion criteria for the study, as did the GP's and the district nurse's. The transcripts from the pilot study can be found in appendix seven.

Having had the experience of the practice interview, I was concerned that I needed to be less directive and to try to limit my question to: "Can you tell me what you find most meaningful in your role as a GP/nurse practitioner/district nurse?" I remained concerned that participants might dry up and have nothing to say so I went into the interviews with three other questions written down that I thought I would be able to substitute if necessary. The back up questions were: "Tell me what being a GP/nurse practitioner/ district nurse means to you", "Tell me how you see nursing/medicine" and "What does it mean to be a nurse/doctor?"

Lessons learnt from the pilot interviews

The pilot interviews revealed the strength of unstructured interviewing techniques as the participants talked at length about what was meaningful to them in their practice. A subsequent analysis of the transcripts revealed that the participants talked about a wide range of values, some of which were shared between all three participants (such as the need to be valued) and some of which were particular to an individual participant (such as variety). I therefore felt that the interview question was going to help the participants to provide a narrative that would be revealing and meaningful. I did try some of the back up questions but I felt that they just resulted in the participants going over old ground and did not significantly contribute to the interviews.

In addition to the responses to the interview question there were other lessons to be learnt from the experience of the pilot study. Prior to the interviews taking place I was sitting in the coffee room and had a chat to a number of staff who came and went. Eventually the pilot study GP came in to the room and we had a coffee together. During this time we were talking about my work and about the aims of the study. I found myself wishing I had turned the tape recorder on as he started to talk about his values and his value system. In the main study I decided to refer to this previous chat in the interviews with comments like:

AC: When we were making the tea you said that you felt passionately about the leadership thing. Do you want to explain a bit about that?

The same issue arose when, after the second pilot interview the participant suddenly mentioned three other issues that she wished she had talked about before the tape was switched off. I asked her if she could remember these things and then write them on the transcript check when I sent it through to her. Only seven days elapsed between the interview and her receipt of the transcript but unfortunately she did not remember to write anything on the transcript check. In the main study interviews, therefore, I asked the participants' permission to add to the interview transcript any comments that were made after the tape was turned off. This allowed me to capture some of their thoughts and ideas that otherwise would have been lost.

The pilot interviews also made me aware of the tension that can be caused by conducting interviews. There can be a general anxiety around being taped and I found that different participants responded in quite varied ways. The pilot study GP talked freely about what was meaningful to him in his work as a GP; however the district nurse and nurse practitioner were more anxious. An excerpt from my reflective diary refers to the difficulty some respondents encountered with unstructured interviewing:

The interviewee seemed anxious and just seemed to run out of things to say. Approaching the question from different angles resulted in the same response time and again. Maybe it's more difficult for some people to respond to this approach.



It could also be possible that some respondents really do have difficulty articulating what is meaningful to them in their work. This problem recurred in the main study interviews where, for a few of the participants, I had to use a variety of words to explain the word “meaningful”. Even after having used alternative words to explain the question two of the participants had difficulty in describing anything that was meaningful to them in their practice. This proved to contribute to my understanding of the participants’ varied value systems. With the lessons learnt from the pilot study, the main study was set to begin.

Analytic process

The data from the interviews were analysed using Gubrium and Holstein’s (1998) combined with Lieblich et al’s (1998) analytic procedure and practice as a guide. Gubrium and Holstein suggest that:

... an interactionally and institutionally sensitive vocabulary is necessary if we are to expand the purview of narrative analysis into the various sites where stories are told in contemporary life. Such a vocabulary can help us capture the complex dynamics of narrative practice, providing detailed portrayals of story-in-use within diverse contexts of narrativity (1998 p.181).

They suggest that the analytic process should begin by examining the “whats” of a narrative. The “whats” of a narrative relate to the specific themes that can be identified in the transcripts and how these themes are located within the context of the story. The themes can be examined for their foregrounding in the context of professional roles, personal lives and institutional settings. Therefore individual themes may be located within multiple layers of meaning. Lieblich et al. (1998) refer to the “whats” of a narrative as the “categorical content” and the “holistic content”. Categorical content can relate to predefined theory-based categories (a priori codified studies) or empirical categories that are suggested by the text (in situ studies). These categories can then be subjected to quantitative analysis or can be used to describe the content universe using an impressionistic-interpretive approach. Holistic content takes into account the entire story and forms a general impression of that story. It might be possible, for example, to identify an overarching theme for each story and then to analyse the narrative from that particular perspective.

In an impressionist tale there is a great deal more to be discovered in a text than simply the categorical content of the story. Gubrium and Holstein suggest that *how* the story takes shape is as important as *what* is told. They suggest that *what* has been said should be temporarily bracketed in order to focus on *how* the account was developed. Lieblich et al. (1998) suggest that a narrative can be analysed for its “holistic form” and “categorical form” in order to explore the way in which the story takes shape. Holistic form relates to the progression of the plot of the narrative. For example, a story might take a generally downward trajectory as the participant describes a difficult struggle with depressive illness. Conversely a story might take an upward trajectory as a participant describes the achievement of a number of goals in life. Lieblich et al. (1998) suggest that stories such as these can be plotted on a graph to visually depict the progression of the narrative. Categorical form examines formal aspects of the narrative such as style of speech and methods of communication.

In addition to Lieblich et al.’s (1998) analytic approaches to examining the way in which stories are constructed, Gubrium and Holstein (1998) suggest that in exploring the *how* of a narrative it is important to take into account examples of narrative editing where the storyteller shapes the story by telling the listener what should be heard. The storyteller is constantly monitoring, modifying and revising the story, demonstrating the reflexive nature of narration. Terms such as “now don’t get me wrong” or “you will understand what I mean” are examples of the storyteller trying to manage the message being conveyed to the listener. In exploring *how* the account is developed it is also important to consider narrative control. Gubrium and Holstein suggest that people do not own stories as much as occasions do. They refer to the “*metaediting*” (1998 p.174) that takes place when participants address what they think is expected of them; this is influenced by the formal relations between the parties in the interview. In a research project, for example, it could be suggested that formal control of the narrative lies within the project, as the interview is designed to access a particular sort of story. The research interview also involves a listener who might actively participate in the production of the story, as narrative production is necessarily collaborative, and therefore the interviewer’s influence beyond passive co-operation should be considered when analysing the narratives. Stories are creative pieces, and in examining the *how* of the narratives it is possible to explore the

coherence of the story line, its method of composition and controlling factors in its production. An exploration of the *how* of the story can reveal complexities in the narrative that will contribute to a deeper understanding of the personal perspectives of individual participants.

Having considered the focus of the analysis I decided to break the process down into a series of deconstructing and reconstructing steps. The following is an overview of the stages of the analysis.

- As suggested by Bryman and Burgess (1994) I acknowledge that the analytic process starts with the research design and continues throughout the study. Analysis is therefore also evident during the interviewing stage. The interviewing process can be described as the active production of meaning (Silverman, 1997) and therefore the analytic process commences while the interview is still taking place (Rubin and Rubin, 1995).
- Immediately after each interview I transcribed the tapes and notes were made in my reflective diary. The transcripts were then sent to the participants with a transcript check form (appendix five).
- The transcript check forms were returned and any comments from the participants were noted. When requested to do so, I amended the original transcript and sent an amended version to the participant for their information.
- I then produced a summary of each transcript. This was achieved by working through the transcript looking for any examples of things that were valued by the participants. In order to do this I used an eclectic definition that emanated from the earlier exploration of value theory. This can be summarised as:

A value can be identified in expressions of an ideal, judgements, guiding principles, enduring beliefs, thoughts, desires, reactions or reasons for action. A value might be identified as a specific instrumental mode of conduct or a terminal end state of existence, a core or specific value, a structuring or peripheral value or a global or sectorial value. There may be multiple values and the value may be possessed internally to an object or externally by the object.

The things that were identified as being of value to the participants were then synthesised into a short summarised version of the interview. The transcript summaries were then sent to the participants along with a transcript summary check form (appendix six).

- The transcript summary check forms were returned by the participants. I returned to the transcripts and repeated the exercise of identifying examples of things that were valued. These were listed and were contextualised by writing a short description of what each theme was referring to. For example one nurse practitioner referred to: *“being valued”* and the context was: *“feels feedback is important”*; a different nurse practitioner referred to: *“being valued”* and the context was: *“has worked hard to ensure that her medical colleagues support her role, GPs miss her when she’s not there and she likes that.”* The value categories were cross-checked with the transcript summaries and if additional things that were valued emerged from the summaries I returned to the transcript for further analysis.
- I then had a list of things that were valued for each participant that included a brief description linking the value category to the context in the narrative. I then linked the categories across the groups by grouping them into units of meaning. Hence all participants who commented on the value of teams were grouped together and the relevant sections of transcript that related to the issue of teams were copied into a document entitled “teams”. Within the category “teams” I was then able to group together participants who had different interpretations of the meaning of teams and teamwork. This allowed me to identify the **categorical content** of each narrative.
- The list of categories for each participant commenced with the thing that was valued most by that particular participant. This was identified by noting which category was talked about more often than other categories and by gaining a general impression of the narrative. This allowed me to identify the **holistic content** of each narrative.

- The preceding steps provided the *what* of the transcripts; I was able to identify a series of themes and group them together into meaningful categories. This whole process allowed me to become familiar with the transcripts. I was gradually building up an impression of the *how* of the narratives and noted a number of striking differences between individuals and between groups in my reflective diary. I then returned back to the full transcripts and reviewed each one for the *how* of the tale.
- I returned to the transcripts and plotted a simple narrative trajectory for each one. I was able to identify if the narratives were generally positive or generally negative in their story line. This allowed me to identify the **holistic form** of each narrative.
- Finally I reviewed the transcripts for the detail of the communication pattern used by the participants. I examined the narratives for the form of argumentation used, the narrative style and their coherence. This allowed me to examine the **categorical form** of the narratives.

Concluding comments

This chapter has outlined the evolution of the present study from its inception to the completion of data collection. The interview was shaped by my experiences in both the practice interview and the pilot study. The data were collected both during the interviews and in written form after the interviews had taken place, allowing the participants to communicate in a variety of forms. The analytic process commenced before the first interview took place and continued on throughout the data collecting process until all of the transcripts and transcript checks had been subjected to the series of analytic steps outlined above. The narratives were therefore deconstructed and reconstructed as they were analysed using the variety of perspectives described by Gubrium and Holstein (1998) and Lieblich et al. (1998). The following two chapters will present the findings of this study, chapter six will focus on the content of the findings and chapter seven will focus on the form.

CHAPTER SIX

A TALE OF SHARED VALUES? THE CONTENT OF THE NARRATIVES

Introduction

The general feature of human life that I want to evoke is its fundamentally dialogical character... We define [our identity] in dialogue with, sometimes in struggle against, the identities our significant others want to recognise in us. And even when we outgrow some of the latter – our parents, for instance – and they disappear from our lives, the conversation with them continues within us as long as we live (Taylor, 1991 p.33).

The internal, ongoing, complex and evolving discourse of human beings is fundamental to our understanding of who we are. Like Taylor's suggestion that human beings are dialogical, MacIntyre (1984) suggests that we understand our lives in terms of narratives. Therefore the form of narrative is appropriate for understanding the actions of others. The basis of the present thesis is that the internal dialogue of human beings can be examined, in part, through the lens of the intensive interview. The interview is focused on what people say and mean and yet the temporal range extends into the biographical, the past and the future (Warren, 2002). By asking the participants of this study what they found meaningful in their practice, I was asking them to offer a narrative of themselves. Narrative ontology is concerned with the "storied nature of human existence" (Schwandt, 1997 p.99) and focuses on complex interactions between consciousness and the world. I have suggested that values are hidden in the complexity of meaning in our lives and that differences in meaning could reveal differences in values between the participants in the study. The intensive interview provided the participants with the opportunity to describe what was meaningful to them in their practice and the subsequent narrative provided the basis for an analysis of the contrasting values and value systems within the group.

At the outset of this thesis, human values were identified as dynamic, complex and pluralistic. They were also identified as being individual and embedded in the meaning of life for each human being. Values are therefore inextricably linked to the self. Exploring human values could reveal glimpses of the selves of the participants in the study as these selves are both shaped by the values and are simultaneously the origin of the values. Mead (1934) suggests that the self develops in an individual as a result of relations to other individuals. He also suggests that the

self develops through the process of social experience and activity. According to Goffman (1959), the self is formed in the variety of situations that occur in everyday life. The postmodern perspective has resulted, according to Holstein and Gubrium (2000), in a crisis of confidence in the continued existence of the self. The sceptical or radical postmodernists doubt the existence of reality altogether and this includes the existence of the self. Such a position puts an end to the narrative of the self and catapults us into, what Holstein and Gubrium refer to as, an altogether different universe where the self is an image amongst others for conveying identity and is therefore a “mere shadow” of its former self (2000 p.57). The affirmative postmodernists hold a different view. For the affirmatives, the self in a postmodern world is polysemic, refracted, diverse and complex but not displaced. Lincoln and Denzin (2000) and Gergen (1991) are examples of postmodern affirmative theorists who consider the world to be exploding with a kaleidoscope of images and representations of who we are, resulting in the deconstruction of the “authentic self” (Lincoln and Denzin, 2000 p.1060). Holstein and Gubrium (2000) suggest that this viewpoint could be considered to be “late modern” rather than “postmodern” as the authors who align themselves with affirmative postmodernism do not doubt the fundamental reality of the self. Nevertheless Holstein and Gubrium draw on Lyotard to conclude that:

The self then, is a particular set of sited language games whose rules discursively construct the semblance of a more or less unified subjectivity centred in experience...The ‘fabric of relations’ and institutional ‘nodal points’ in a postmodern world are so complex and mobile as to keep self construction a constant undertaking (Holstein and Gubrium, 2000 pp.70-71).

Hence they suggest that the self is subjective, constantly evolving and revealed in discourse. The self is embedded in relations with the self and others and is also linked to institutional life. They go on to suggest that discourse is a constructive history of the present and that discursive practice is “the means through which the self is constructed” (2000 p.89). The self of contemporary life can be found in the interplay of discursive practice and discourses-in-practice as exemplified by the ongoing self construction referred to earlier by Taylor (1991) and communication through the use of language games referred to by Lyotard in “The postmodern condition” (1979).

Earlier in this thesis I referred to Fekete (1988) who suggests that we can only understand the history of cultures if we also understand the history of value orientations, value ideals, goods values, value responses and value judgements. Geertz (1973) uses a semiotic description of culture as he turns to an analogy (which originated with Weber) that humans are suspended in webs of significance that are spun by themselves. Geertz believes those webs to represent culture and states that the analysis of it is “an interpretive one in search of meaning” (1973 p.5). Holstein and Gubrium (2000) state that the phenomenon of interest in the story of the self is not the cloth or the fabric, rather, it is the process of the self being spun that should be the focus of the analysis. In relation to the present study then, the interest will lie in the *way* the participants told their stories in addition to identifying the values they talked about (the *what*). The interest lies in the *how* as well as the *what* to provide a narrative of the self and of the construction of the culture within which the self is suspended. The remainder of this chapter will present the findings of this study commencing with first impressions to help set the scene for the remainder of the analysis which will focus on categorical content, holistic content, holistic form and categorical form.

First impressions

Before attending to the particulars of the transcripts I would like to share some of my broad general impressions from the experience of interviewing GPs, nurse practitioners and district nurses. As I have already mentioned, I knew all of the nurse practitioners who participated in this study and most (although not all) of the GPs and district nurses. The first GP I interviewed in the main study appeared to be irritated by the whole process of being interviewed, as an excerpt from my reflective diary demonstrates:

She almost didn't sign the consent form stating that this was all too soul searching and that she felt uncomfortable about the whole process. I reassured her that if she did not want to consent I would destroy the tape – she signed and I told her she could still withdraw her consent when she views the transcript. The interview was extremely hard going and I wonder if part of it was that she had very little enthusiasm for her work and very little that was positive to say about being a GP. It felt disastrous and I wasn't sure whether I should stop the interview mid flow or continue on, hoping it might improve.

I had been warned before the interview that this particular GP had been concerned that there was no financial reimbursement to compensate for the time that would be spent in the interview with me. Eventually this GP did consent to the interview and subsequently responded to the transcript check and transcript summary check with numerous comments and alterations. This experience resulted in me feeling anxious when I interviewed other GPs though it was never repeated and the remainder of the GPs were welcoming and willing to participate, as the following excerpt from my diary shows:

It took a while to find a time when this GP and I could meet but when I got there he was on time and extremely accommodating.

This excerpt more accurately reflects my experience with the remaining GPs in the group who were willing to meet with me even though there would often be difficulties in finding a mutually agreeable time for the interview. In most practices the GP was the last person in the trio to be interviewed. There was a subtle message in this for me as the GPs seemed to have greater demands on their time resulting in me being even more respectful of their time during the interviews. The following extract from my diary demonstrates the impact that awareness of time pressures can have on an interview although, in this situation, the difficulties were related to family problems rather than the pressures of work:

The only problem with this interview is that I felt the need to cut it short. I asked GP6 at the outset if he had a surgery that morning and he said he had the day from hell ahead of him. His son had broken his arm and his daughter had broken her thumb and he had to get one to fracture clinic and one to A&E that morning! The interview lasted about 20-25 minutes and I felt there was more we could have delved into – he was not rushing me but I did not want to impose when his children needed help.

On the whole my experiences with the nurse practitioners and district nurses were different:

DN 13 was very easy to interview – I knew she would be the moment I met her. She was very chatty and could have talked for as long again I'm sure!

The nurse practitioners seem most relaxed and able to talk ... One of the district nurses was clearly very nervous and anxious, the other was quite relaxed and confident.

It is important to note the subtle differences in relationships between myself and the participants according to their group because this could potentially have had an impact upon the participants' willingness to share their thoughts, beliefs and feelings with me in the interviews. This is an issue that I will remain aware of throughout the analytic process. At this point, it is perhaps sufficient to say that after preliminary anxieties, nervousness and difficulties with arranging appointments, almost all of the participants settled into a relaxed style and talked at length about what was meaningful to them in their work. I have highlighted here the difference in the relationship between myself and the GPs and the two groups of nurses. Another issue that cannot be found in the words of the transcripts, but nevertheless should be noted, is the setting of the interviews as this also varied between the groups.

Scenic identity

Holstein and Gubrium refer to the importance of "scenic presence" in shaping the way that identity is conveyed (2000 p.190). The setting in which the interviews took place mediated the selves of the participants, both myself and the person I was interviewing. In all of the meetings with the GPs and some of the meetings with the nurse practitioners, the interview took place in their consulting room with me sitting in the patients' chair and the GP or nurse practitioner sitting in the chair in which they normally carry out consultations. With the district nurses and three of the nurse practitioners the interviews were carried out in a mixture of shared offices, spare rooms and, in one case, a coffee room. The setting seemed to have an impact upon the communication in the interview as the following excerpt from my reflective diary suggests:

DN 5 was less relaxed. The setting was not ideal as we were in the tea room but that's all we had available and so we were interrupted twice with people making tea. She continued to talk throughout; she talked at speed and continued to talk about what she and the service does rather than about her feelings, ideals and beliefs about what she does, even though I approached the question several times and from different directions.

It is possible that a coffee room is an unlikely place for someone to share their deepest feelings in an interview. The descriptive nature of this particular transcript perhaps demonstrates the level of depth that was appropriate for the setting of the coffee room and I should not have expected to delve into any greater depth with this participant. This was different for participants who were interviewed in their own offices as the following excerpt from my diary illustrates:

I just sat there whilst he talked continuously for half an hour. His rate of speech was double anyone else's I've interviewed so far – the numbers of pages in the transcript go way beyond the others! He was on time and ushered me into his room, we had tea to start with and a good starting point were his photos of Kathmandu on the wall. He seemed completely unimpeded in sharing his views with me many of which were controversial but it didn't seem to stop him at all!

Other participants had photographs of family and travel locations on their walls (most notably the GPs) adding to the impression of the multiple narratives that exist in individuals' lives. The participants who sat in their own offices and surrounded themselves with pictures of their choosing were demonstrating their ability to stamp their identity on the room, whereas those without offices were less able to display their identity in their physical surroundings. It is common practice for district nurses to share office space with their community nursing colleagues; in addition all of the district nurses were wearing uniform unlike the nurse practitioners who were wearing their own clothes. The district nurses were therefore less likely to be able to portray their scenic identity in the interviews when compared with the nurse practitioners, some of whom had their own office space, and the GPs all of whom had their own space and most of whom had decorated that space.

My first impressions of the interviews highlight the subtle differences in settings. This already points to a number of differences between the three groups of participants. The reader is reminded at this point that this is the interpretation of a nurse practitioner whose particular and personal perspective has been revealed in the preceding chapters of this thesis. The presentation of the findings will now turn to the four analytical perspectives outlined by Lieblich et al. (1998) namely: categorical content, holistic content, holistic form and categorical form.

CATEGORICAL CONTENT

The starting point for this analysis was the identification of things that were valued by the participants as represented in each of the narratives. This is the *what* of the story. The transcripts revealed a complex picture of meaningful practice. There were few individual areas that all the participants mentioned or agreed upon and even when the same issue was highlighted, different participants seemed to be talking about the issue in different ways. There will be numerous examples of the same issue being valued by different participants in different ways as the presentation of the findings progresses demonstrating the postmodern nature of value. There was however, one common area of interest that emerged from the narratives: namely a focus on relationships. Examples of these statements are:

GP 2 80

I enjoy having a relationship with my patients

GP 6 7

I get a lot of pleasure out of the interaction with patients

NP 7 106

Contact with people full stop really for me

DN 8 254

I mean we're privileged we get so close to people

GP 12 5-6

Seeing patients I suppose (AC right) and that's why I think most doctors go into medicine in the first place because they like people

DN 13 32-34

I just think the interaction with the patient and their family is the thing that I enjoy the most really

NP 16 91-92

Just being in contact with people seeing them it's nice that in general practice I think that you see patients or clients over years don't you?

The participants expressed many of the things that were meaningful to them in their practice in terms of relationships. I took the idea of relationships as a lead from the responses of the participants and I then used this as a perspective from which to view the diverse collection of things that were valued. It gradually emerged that these could be broadly categorised into: relationships with the self; relationships with others; and relationships with society. Relationships with the self are examples of

those themes that contribute to a sense of self; for example, how you want to develop personally and professionally. Relationships with others relate to relationships with patients, other health care professionals and family. These themes are revealed in comments relating to interactions with patients, teamwork and the value of family life. Relationships with society are focused on the participant's sense of place within their own professions and their sense of their own profession's place within society. The three categories are interconnected and have an impact upon each other, creating an image of an evolving sense of self which is shaped by, and continues to shape, the individual's values and value systems. I have referred to these three categories as "discourses" to represent the discursive nature of the narratives. Each category has a number of sub-categories. The categories and sub-categories evolved from the data and the method of labelling and identifying each category was outlined in the previous chapter in the overview of the analytic process (see page 105). The categories have been summarised in Table Four:

Table Four: Categorical Content

MAJOR CATEGORY	SUB-CATEGORIES	
Discourse with the self	Personal and professional development	
	Doing a good job	
	Clinical competency	
	Challenge, change and variety	
Discourse with others	Relationships with colleagues	Autonomy
		Teamwork
		Being accepted, respect and recognition
		Operating at a strategic level
	Relationships with patients	Patient partnership
		Disease and illness
		Working with the whole family
		Holistic care
		Palliative care
		Relationships with colleagues and patients
Discourse with society	Family life	
	Contributing to the development of the profession	
	Financial reward	

Discourse with the self

Cassell (2004) suggests that “self” represents aspects of personhood that may only be known to oneself, may only be known to others or may be known by both oneself and others. He states that there is no self without others as it is in relationships with others that the full range of human emotionality finds expression. Self-esteem, self-approval and disappointment are all examples of the ways in which people can have relationships with themselves. A person who was not successful in their examinations at school might feel the disappointment of that failure for the rest of their life. Conversely that same person may also carry a personal sense of achievement related to the commitment they showed to their dying neighbour in the final few days of their life. Such events add to the multiple selves and variety of personal narratives that are available to each person. There were a number of themes that related to a discourse with the self. These were recognised by identifying those themes that did not involve relationships with others or society and seemed to be associated with the participant’s view of themselves either in the present, historically or their aspirations for the future.

It appeared that some of the participants were restructuring their value systems during the interview. These were examples of discourse with the self occurring at the time of the interview. It also demonstrates the developing nature of value systems and the role of the interview as a potential catalyst for this.

DN 3 264-265

Having gone back on what I said earlier I probably couldn't do eight visits a day I mean I couldn't.

GP 9 61-62

I suppose I've completely undermined just what I said because I quite like seeing lots of different people.

Personal and professional development

I identified personal and professional development as a sub-category that was representative of ongoing personal dialogue. Awareness of the need to develop personally and professionally demonstrates a certain amount of personal reflection and willingness to identify gaps in knowledge and skills. There were a number of

examples of nurse practitioners and district nurses who talked about the value of personal and professional development and fewer examples from the doctors. The nurses appreciated having the time and opportunity to reflect on their practice and to learn:

DN 3 520-5227

It's probably quite nice that the jobs are developing rapidly (AC uhum) because it does mean that you do have to learn more skills (AC uhum) to cope with the job so that's probably actually we might not like all of it but it's probably quite a good thing (AC mm in that it) from a challenging point of view and it does keep you you can't stagnate I mean I know nurses shouldn't anyway and we don't (AC mm) but it keeps stretching you there's yet more different aspects (AC mm) that will need that need sort of learning about (AC mm) and dealing with.

NP 14 49-51

Then of course there's the bad consultations that you have that you acknowledge are bad consultations but then when you actually start to reflect on them they give you so much opportunity to develop yourself that that's almost as rich again.

DN 18 103-112

I think that it is good for the team in that it does make you think about what you're doing all the time. It's so easy with any job isn't it to sort of get into to a rut and say this is what we do and this is how we do it whereas it's also very important that we do have research based practice and we're actually up to date with changing ideas in nursing and medicine and it does keep you on the ball having students.

NP 16 202-206

It's nice to go off and do things like study days (AC mm) and meet other health professionals I enjoy that it's nice to be able to chat now to the GPs on a more equal basis (AC mm) that's quite nice I don't feel inferior anymore and sometimes they actually ask me for advice (both laugh) or ask me to teach them how to do something (AC right) that's quite nice (laughs) (AC right) for my ego anyways.

This final excerpt from the transcript of NP 16 may provide an explanation as to why the nurses are more focused on personal and professional development than their GP colleagues. NP 16 states that she does not feel inferior anymore and therefore her personal development has contributed positively to her sense of self.

Two GPs referred to personal development and reflection on their practice:

GP 6 218-226

I have to make a special effort to try and keep up to date with that but I do sort of try and watch for my own personal development plan areas where I feel I'm a bit weak and not spending so much time. I don't see so much gynae for example ... but I think that's a question of self awareness and having a think about your personal development plan.

GP 17 250-257 (in reference to referrals to consultants)

It also would be nice to get feedback on like referrals if we do a referral and they feel that this was an inappropriate referral most of them will just go in do what's what and send them back they won't actually give you some feedback like saying okay we should have seen this patient six months ago.

These are the only two examples of GPs addressing their potential learning needs. It is interesting that the nurses (particularly the nurse practitioners) repeatedly stated that they valued reflection, learning and personal development whilst the GPs hardly mentioned it at all. The nurse practitioners were relatively new to their roles, (the maximum length of time since qualification was seven years) whereas the GPs and district nurses were eighteen and twenty years respectively. Reflection and development could be features of new roles and the uncertainty associated with being in a new role. The nurses may be searching to clarify for themselves not only who they are but also (particularly in the case of the nurse practitioners) where their role fits within the primary health care team. It is interesting to reflect upon the words of GP 9:

GP 9 598-599

I'm competent in my own abilities and confident in my self belief.

This GP appears to have a well developed sense of self which is possibly related to the centuries old, socially recognised role of the doctor.

Doing a good job

Doing a good job or working to the best of one's ability was a feature of the district nurse transcripts. Almost all the district nurses referred to this theme with statements such as the following:

DN 3 261-264

At the end of the day I think you come out and think well actually yeah I think I've done quite a reasonable job.

DN 10 144-147

I'm working doing my best because of my own personal code of practice conduct or whatever contract and then of course I'm contracted by the NHS to do it so I'll do it to the best of my ability.

DN 18 8-9

You sort of come out and think yes I did that to the best of my ability and I've achieved something there and they're satisfied with that.

It is interesting to note the less assertive language used by these district nurses as they aim to work “to the best of my ability” or aim to do a “reasonable job”. This is shared with NP 1 who uses the word “hopefully”:

NP 1 37-38

I'm happier in here (AC right) in this room seeing people one to one and hopefully having done my best for them.

GP 6 also commented that he values doing a good job but the language he uses in relation to this is different:

GP 6 6-9

I enjoy the intellectual challenge particularly of the diabetes (AC mm) work that I do I enjoy keeping up to date I suppose as with everybody I like the feeling of doing a good job.

GP 6 192-194

I suppose there's one time when I feel good and one time when I feel bad about things. If I feel we're offering a good service here at X then I feel really sort of you know proud (AC mm) to be part of it.

This GP refers to doing a good job at both an individual and organisational level. There is a greater sense of certainty in this language; if this GP feels the practice is offering a good service then this is as good a service as can be offered. This sense of certainty contrasts markedly with the language of the nurses. This difference in language is reflected throughout the transcripts and will be explored further when the analysis turns to the categorical form of the transcripts.

Clinical competency

Almost all of the participants referred to clinical competency as a meaningful aspect of their work. This was either in relation to the value of clinical skills, the sense of

satisfaction related to using the breadth of skills they had acquired or the value of evidence-based practice. Several of the nurses referred to the sense of satisfaction they felt when they were able to use their clinical skills to the full:

DN 3 210-213 (reference to palliative care)

I think you'd probably find ... all of our skills are being used (AC right) and I think whilst we all have to use communication we all have to use you know our sort of listening skills our organisational skills but I think it all comes I think it all comes together every visit maybe.

NP 1 23-29

I think I like the fact that I see the patients from the minute they come in with their problem and nobody else has sent them to me (AC uhum) and I have to diagnose (AC uhum) using all the skills we were given in college (AC uhum) and I really enjoy that I really enjoy thinking I've done an examination to the best of my ability (AC mm) and them saying they haven't been examined like that before or something like that so that you know that you've done it to the best of your ability.

The excerpt from NP1 suggests that she has a sense of satisfaction from not only using her skills to the full, but also from being given feedback from patients that she has been more thorough than any other health care professional the patient might have seen. It is probably reasonable to suggest that the nurse is comparing herself with her doctor colleagues and therefore her implication is that she's not only doing it to the best of her ability but she's also performing her clinical examinations more thoroughly than the doctors. NP 1 does not openly say this and, like NP 4 in the next excerpt, there is an underlying sense of self-deprecation in the tone of her language.

NP 4 162-165

I had a health care worker who's training up coming sitting in one of my surgeries (AC right) and she was quite amazed at what I knew (AC mm) and she said "god you know so much" and you know I said you know it's just years of experience.

NP 4 suggests that it is *just* years of experience implying that the health care worker could perhaps do the same if she had the same number of years of experience. In addition to the satisfaction the nurses gained from using their clinical skills, a number of the nurse practitioners referred to the pleasure they felt when they made an accurate diagnosis:

NP 4 209-211

So when I came out of there I felt really quite pleased with myself (AC mm) because I thought you know I managed to deal with all those issues (AC mm) and it was totally on my skills (AC right) that I was able to do that.

NP 1 31-33

If I find out something and then it's right and I've actually questioned somebody else and it is right it gives me lots of satisfaction.

The GPs also referred to clinical competency and the effective use of consultation and history-taking skills.

GP 2 38-41

... in order to achieve that objective you have to be able to consult effectively (AC uhum) the consultation skills and communication skills that you use to arrive at that objective (AC aha) are obviously important (AC yes right right) so when that goes well that's helpful.

GP 2 is referring to the satisfaction she feels when a consultation goes well.

Interestingly GP 15 expressed his frustration that his income is not related to the skill with which he carries out a consultation.

GP 15 128-138

They can only give us money on something they can measure so everything's based on measurements (AC yeah) and they think that that equates to quality but it's purely quantitative. It's there's no way I can measure a good consultation with an upset person a patient a parent (AC no) a child don't get any points for it I can't get any money for it therefore (AC mm) I can't show I'm good at it. (AC mm) All I can show is I can measure a blood pressure and the cholesterol the blood count and peak flow and thyroid function every so often and whatever (AC yeah) and if I don't do that I get penalised.

Indeed Cooper and Stoflet (2004) would agree with the position of GP 15 as they state that when health outcomes include satisfaction, comfort, patient empowerment or reassurance, conventional measures of cost-benefit analysis are elusive and standard measures of effective health care are absent. There were other more specific areas of clinical practice that were identified by the GPs as enjoyable and satisfying to them in their work. For example, GP 6 referred to his extra training in musculoskeletal medicine:

GP 6 66-69

The other sort of clinical aspects that I'm particularly keen on is joint injections and musculoskeletal medicine (AC mm) side of things which is an area that I've done quite a bit of training and reading about over the last year or two.

Several of the district nurses referred to wound management as a source of enjoyment in their work.

DN 5 9-12

I think I get a lot of reward from my patients because I'm very keen on wound care and to see a wound healing and leg ulcers healing I think is very rewarding from our point of view.

The majority of the participants stated that they found their clinical work meaningful in some way and that they valued doing their clinical work well. Exceptions to this were DN 10 who did not mention clinical competency at all and GP 12 who also did not refer to clinical competency. DN 10 was significantly different to the remainder of the participants and this will be revealed repeatedly throughout the analysis. GP12 was the only participant to highlight his Christianity as meaningful in his work as the following excerpt demonstrates:

GP 12 34-38

I suppose I ought to say one very big thing for me is as a Christian I feel that this is what I should be doing (AC uhum) and it's a very important part of who I am and I feel quite certain that this is where God wants me to be doing what God wants me to do (AC mm) which obviously adds a very major element of certainty to it as well.

GP 12 differed from the rest of the GP group in other categories such as disease and illness as a feature of the patient relationship as we will see later in the categorical content analysis. The certainty and harmony associated with the Christian beliefs of GP 12 could play an important role in shaping his perspective on his relationships with patients and on his clinical competency. Equally this departure from the rest of the GP group in a few categories could be a feature of the unique perspectives of all the participants, most of whom were not wholly congruent with any one particular group in all aspects.

As well as finding wound management to be a source of enjoyment in their work, the district nurses were also interested in the ways in which evidenced-based practice had helped them in wound care:

DN 8 182-184

Leg ulcers that didn't used to heal you're using research and you're getting the leg ulcer healed.

Several of the GPs also referred to evidence-based practice:

GP 6 25-30

I mean I feel also that I try and practise very much evidence-based medicine you know ... if I'm able to apply evidence-based medicine and practise evidence-based medicine during a surgery then I feel that I have been doing my job properly (AC mm) and I get some satisfaction out of that.

NP 16 talked about the need to keep up to date but she was the only nurse practitioner to do so:

NP 16 67-70

I suppose I've got more knowledge about different conditions now (AC uhum) I'm very very aware that I need to keep up-to-date all the time (AC mm) especially for sort of legal reasons and also for the best care for your clients that are coming in as well.

It is interesting to note that NP 16 linked the need to keep up-to-date with an awareness of legalities. This hints at the nurse practitioners' sense of working in new ways and which inevitably involves a degree of risk:

NP 11 44-48

Depends how far you want to take how you develop because some people probably wouldn't push the boundaries as far as I do sometimes (AC mm) and yet I maybe don't push them as far as other people (AC right) so I'm a bit of a risk taker sometimes (AC uhum) which is scary (AC mm) but then we're all here taking risks aren't we?

The nurse practitioners were the only group to talk about the boundaries of their roles:

NP 4 150-154

But when you do present yes I'm limited by this they can then you can then say "look I think you need to see the doctor about that". I don't see that as negative either I think they actually think okay she knows where to draw the line (AC mm) and she'll tell me when I'm right to go to the doctor.

NP 14 130-137

I mean I did think about doing home visits and things like that but the more I actually think about it you are out there on your own it is very difficult to actually get somebody admitted even from the surgery when you ring in and you know you want them in it takes a lot and without formal tools of assessment to just rest purely on clinical skills I think it would take a lot to get an admission so I think you'd be practising unless the current climate changes a lot I think you'd be practising on the line and find it quite stressful (AC mm) so I don't tend to do visits.

NP 11 41-43

You don't have to refer to another person always you can deal with the situation and you know when your boundary's there that you don't deal with it you pass it on.

It is interesting to note that when the nurse practitioners talked about clinical competency they also talked about being aware of the limits of their abilities. This is in contrast with the GPs and district nurses none of whom mentioned the boundaries of their clinical skills. It is also interesting to compare the different nurse practitioner's reactions to being aware of their boundaries. NP 11 describes herself as being a "risk taker" and NP 11 identifies her limits "you'd be practising on the line" and refuses to cross that line. Either way, awareness of the limits of one's clinical competency appears to be a feature of the nurse practitioner role which perhaps is not surprising given its embryonic nature.

Challenge, change and variety

Several of the participants referred to themes that seemed to relate to intellectual challenge in their roles. There was a spread across all of the groups relating to challenge, change and variety in their roles. It is interesting to note that the participants, whilst valuing challenge and variety in their roles, identified different aspects of their practice as sources of that variety. For example some of the nurses referred to the variety of people, their different responses to illness and their different experiences with those people as sources of variety and challenge:

DN 13 434-437

I enjoy the challenge (AC right) that the job presents and I enjoy the variety (AC uhum) within the job as well (AC mm) and that can be the variety of things that we do (AC mm) it's the variety of the people (AC mm) that we come across (AC mm) and deal with the variety of experiences that that they've had and that you find out about.

NP 7 106-108

Contact with people full stop really for me (AC right aha) and just the complete diversity of how people view what goes on I enjoy their humour and you know the way they look at things so differently.

The following three GPs identified variety in patients who were presenting with illness and disease as sources of interest and challenge:

GP 15 19-21

I also quite like being the first port of call because that's what makes the job interesting the fact that any single day any patient can come with any problem so it is actually still quite challenging.

GP 15 87-100

I do get bored very easily I have to move on. (AC right) I'm the sort of person that easily gets bored and one that worried me about coming into general practice I came into it because I wanted to be a family doctor and I wanted to have a better work-life balance than I did as an A&E specialist but what did worry me was that I would actually become bored. I thought perhaps most GP problems would be very minor and routine and although there is a high number of patients with that there is also certainly within a week every single week I see some very serious illnesses or I help diagnose or spot something that's critical or crucial and that is what makes the job interesting.

GP 2 86-88

I suppose the variety of presentations in general practice must be the beauty of it really. (AC mm) I mean I think it would be very tedious sitting in a cardiology clinic seeing angina patients day in day out.

GP 9 61-68

I quite like seeing lots of different people (AC right) and it suits me because as I say I like medicine and when I say medicine I mean you know archetypal heart disease not medicine from the global spectrum and that's what I deal with ... our populations are old with multiple medical problems (AC uhum right) that you've got to get to grips with.

NP 14 describes the value she places on the variety in her work and this seems to be a blend of enjoying the variety of medical presentations and the variety of people:

NP 14 30-36

I just love the wealth of you know types of people that you see the interactions that you have the fact that it's not the same thing the fact that it stimulates your brain all the time (AC mm) that it's you can jump from a mental health problem to you know asthma (AC mm) and that there's so much complexity around it and it stimulates my brain in trying to understand things unpick things put the pieces together (AC mm) and that whole picture (AC mm) is just so rich.

The following two district nurses refer to the professional development associated with working in a challenging and varied environment:

DN 7 39-42

The fact that you're always learning (AC right) that's a challenge and I think the day that you feel that you've learnt everything that you know everything that's the day that you should stop.

DN 3 542-555

I think we're probably quite privileged in community and that's probably you know GPs general practice whatever (AC uhum) in we are presented with such a wide variety of different things (AC yes) requiring different skills. If you're working on a surgical ward you become perhaps very limited I mean from a sort of professional skills level.

It is interesting to note that thematic content analysis might have identified the themes “challenge”, “change” or “variety” as aspects of meaningful practice for a spread of nurse practitioners, district nurses and GPs. When the themes are contextualised it becomes apparent that the participants are referring to subtly different aspects of challenge, change and variety. The GPs seem to value the variety of presenting disease. GP 2 states that: “it would be very tedious sitting in a cardiology clinic seeing angina patients day in day out” and does not acknowledge the variety of *people* who present with angina as being interesting whereas NP 7 states that she enjoys: “the complete diversity of how people view what goes on I enjoy their humour and you know the way they look at things so differently”. The district nurses refer to the global variety in their jobs and point to the variety of tasks and the variety of people they deal with as being sources of meaning in their work. Once the theme of “variety” is contextualised and embedded in the meaning of the participants’ narratives it is possible to reveal significant and important differences in perspective between the responses. The participants’ values are revealed in the meaning associated with the categories rather than the categories themselves. We are therefore reminded of the statement by Pattison (1998) that values are non-realist,

postmodern and closely related to meanings.

Summary: discourse with the self

The findings thus far have focused on the themes that seem to reveal something about an internal discourse with the self. Reflection is an example of an internal discourse as the person is self-critical or self-approving and it seemed that the nurse practitioners and district nurses engaged in this self analytic behaviour. The GPs appeared to be less involved in active reflective practice or personal and professional development as they tended to display greater certainty in their roles relating to who they are and what they do.

Doing a good job was a feature of the district nurses' transcripts and clinical competency was a feature of almost all of the participants. These categories were related to a sense of satisfaction in being able to use one's skills fully and being able to operate to the best of one's ability. Challenge, change and variety were identified as themes associated with self-awareness. Many of the participants in this study enjoyed the breadth of experience associated with work in the community or general practice; defined by the GPs as the variety of disease and illness and by some of the nurses as the variety of people and their reactions to disease and illness. Interestingly NP 14 (see page 125) provided a response that fell somewhere between the responses of the GPs and the responses of other nurses and this is a phenomena that we will see repeated as the analysis proceeds.

Discourse with others

In the "Essentials of College and University Education for Professional Nurses" the American Association of Colleges of Nursing (1986) states that professional values guide professional behaviour with clients, colleagues and others. During the interviews, and through the subsequent transcript checking process, the participants in this study provided examples of ways in which they value having relationships with clients and colleagues and the ways in which the relationships with clients and colleagues have an impact upon the self.

Relationships with colleagues

Autonomy

An interesting theme that emerged from the findings of this study was the extent to which participants valued the level of autonomy they had in their roles. One nurse practitioner referred to autonomy in relation to making a clinical decision for a patient:

NP 1 147-152

I think it's just the fact that we've become more autonomous and somebody's not telling me what to do (AC mm) I didn't realise how much I was told what to do (AC mm) because you don't think you are being but it's never your ultimate decision whereas it is more now (AC uhum) not all the time but most of the time you've decided that the patient has got a chest infection that needs this, this and this (AC mm) you've decided.

Others referred to it in the same way:

NP 4 6-7

Probably the autonomy of managing patients (AC right) looking after patient care from the beginning to the end.

NP 16 26-43

It's not just a one-off consultation anymore I can see them lots (AC mm) and lots of times and get involved and pick up and get to know them better (AC mm) which I found when I was I hadn't done the nurse practitioner I was just seeing them as the practice nurse odd times and I would think "how's Mrs so and so doing?" (AC mm) And unless you looked in the notes you'd not find out but now I know how she's doing and other problems will crop up in the meantime and (AC right) I can deal with those and get on and do it ... don't think I could go back now to being a practice nurse I think I would feel that there was something missing. (AC right) So if I had to cut myself off and say oh well that's only my task off you go (AC mm) you go back to see X I mean I do still refer patients back to X especially things like men with sexual problems because I think it's best that X actually examines them (AC mm) because with just being a single-handed GP (AC mm) and just me here but you know a lot of things I totally solve myself really (AC mm) and help patients.

DN 18 209-215

I do enjoy the autonomy as well of district nursing. I think it's rather nice that the experience that I have particularly in areas such as wound care and palliative care that I can go in and make decisions about (AC mm) how I'm going to deal with these wounds that I can go and do that

rather than I know in hospitals they are very much limited to their prescribing. Whereas of course with nurse prescribing it's really rather nice (AC mm) I'm not limited by what the pharmacy are going to provide I can look at a wound assess what it needs and take it from there (AC mm) that's rather nice.

These four excerpts highlight the satisfaction that the nurses feel when they are able to complete episodes of care for patients where previously they had not been able to do that without referral to a GP. NP 1 discusses how her autonomy has increased since she no longer has anyone telling her what to do and NP 16 discusses the increased confidence and increased knowledge that have helped her to work more autonomously.

Wade (1999) refers to professional autonomy as being divided into structural and attitudinal autonomy. Structural autonomy is the worker's freedom to make decisions whilst attitudinal autonomy is the belief that one is free to exercise judgment. The examples above demonstrate the nurses' belief that they have freedom to exercise their own judgement and the description of their practice suggests that they have the freedom to make those judgements which would suggest that they have both structural and attitudinal autonomy. There is a subtle difference in the portrayal of autonomy from the following two nurses:

DN 13 25-30

I think probably with the training that I've done and the knowledge that I've accumulated over the years somebody with a health problem be it that they've got a wound or they're looking after a relative who needs caring for I can go in and assess the situation sit down and talk to them and try and I suppose get hopefully get down to their level but that they see me as someone they can access for information about how to deal with the situation that they're actually in.

NP 11 41-48

You don't have to refer to another person always you can deal with the situation and you know when your boundary's there that you don't deal with it you pass it on (AC mm) so it broadens how you talk to the patient your communication skills your collaboration with the other team members.

The first participant refers to “sitting down” with the patient and “talking” to them and the second refers to how autonomy broadens the way she talks to patients and

collaborates with other team members. Wade (1999) points out that the traditional view of autonomy is based on a male model of separation and control and she suggests that this devalues relationships with clients. She describes nurse autonomy as involving affiliative relationships with clients and collegial relationships with others. The above sections of narrative from DN 13 and NP 11 are more closely aligned to nurse autonomy as described by Wade than the sections from the previous four nurses.

Two of the GP participants referred to autonomy at an organisational level. They both described how much they valued having freedom from external controls over their daily working lives:

GP 9 595-599

I like it because it gives me more independence than hospital medicine. (AC okay) I'm a very independent person (AC yes) I like trotting around on my own (AC yes) doing all sorts of things (AC yes) and I'm competent in my own abilities and confident in my self belief if it doesn't work I move on.

GP 15 100-111

I like being my own boss as a GP. In the end I can within reason within the partnership work the shifts days hours mornings lates whatever. I can swap around to sort my personal life out you know which I just couldn't do in a hospital (AC mm) where the patterns are set

Working in general practice has provided these GPs with a sense of control over their working lives and they describe this as being a meaningful aspect of their work. Interestingly, when control over an aspect of their clinical work appears to be exercised by an outside agency, such as the Department of Health, they find this frustrating and demoralising:

GP 12 85-90

Constantly changing demands in terms of fill this form in, achieve that target, do the other. (AC mm) Now we've changed our minds we'll do something else. (AC mm) A sense of I suppose a loss of control isn't it? We think we know what's best for our patients and don't take kindly to somebody outside telling us what's best for our patient so that tends to frustrate and demoralise.

GP 15 202-266

So much emphasis being put on those targets (AC mm) and yet it's the only way we are going to be measured in the future is the targets. (AC mm) So you know I accept that they're there now you know and I don't have much choice ... it's forcing us into consulting in a different way (AC mm) it's actually altering the relationship we have with people... and the group of people who negotiate that contract have completely altered the way we work (AC mm) we're no longer working as individual doctors.

The frustration that these GPs describe in relation to losing control is illustrative of their values via negativa. They appear to value autonomy in their working lives and when this autonomy is taken away they become distressed and frustrated. Cash (2001) refers to “autonomy” as residing in the contractual space in which the individual practitioner practices. According to these GPs that contractual space has been narrowed with the introduction of targets and this has had an impact on their autonomy. According to Greaves (2004) general practice has been the main locus of healing within orthodox medicine. He refers to the GP as the “archetypal healer” as the reductionism associated with Cartesian dualism, most often linked with hospital medicine, has been resisted by the doctors who work in general practice (2004 p.9). According to Greaves, this position has been gradually eroded in the UK over recent years as the fragmentation of the GP’s role and quantitatively derived guidelines and standards have been imposed. The sections of transcript presented above reveal tensions associated with this change and provide some insight into the value placed on the doctor’s supremacy (GP 12 “we know what’s best for our patients”) and on the autonomy associated with the role when consulting with patients (GP 15 “it’s forcing us into consulting in a different way”).

It was interesting to note that the GPs did not talk about their autonomy in clinical decision-making with patients, except to air their frustrations when that autonomy appeared to be curtailed by outside influences. In contrast, the nurses talked repeatedly about how meaningful autonomous practice was to them in their work. Wade (1999) refers to “aggregate professional autonomy” as being the socially and legally granted freedom from external forces. GPs have greater aggregate professional autonomy than nurses do and it is perhaps the normality of autonomy that makes it less noteworthy to them and they therefore did not feel the need to mention autonomous practice in their narratives except in instances where

that autonomy was threatened.

Teamwork

Many of the participants in this study stated that they valued the team with whom they worked. Once again there are subtle differences between the view of the team as seen by the nurses and the view of the team as described by the GPs. The nurses tended to refer to the diversity of roles in their teams and the value of the variety of team members. The following examples illustrate this point:

DN 3 347-351

Well obviously you've got different skills within the team (AC uhum) you've got different sort of characters within the team (AC right) and people it's very good in that people handle the same situation differently (AC uhum) and it's quite good from a sort of support thing really.

NP 4 25-31

I look at things probably more objectively than I did before (AC right) about how to do skill mix. Probably look more macro than I did. I used to just look at things micro at the particular patient rather than the whole issue (AC mm) of how we can manage health care (AC uhum) and accept other people's roles and the roles that they may offer in health care and how they may offer different dynamics to the health care (AC mm) and respect where your limitations are and where someone else has probably got better expertise (AC mm) than you.

DN 8 32-33

I enjoy palliative care terminal care I enjoy being part of the team.

DN 13 82-89

Around team working with the other team members as well (AC right) not just in our own little team but in the wider sort of primary health care team the trust that we have in our little team that we're in. I suppose that comes from working together knowing each other's strengths. I suppose sharing again sharing the same values looking at the you know we're all working towards the same ends really and the same goals we all want to maintain the same standards and improve.

DN 18 65-69

Teamwork is the other thing I would certainly look at. I work with a very big team here and I think it's really quite important that we work together and that's not just the district nursing team but the multidisciplinary team (AC uhum) because that's the only way you can achieve all the things you want to achieve by working alongside other people.

The GPs referred to their appreciation of teams in a different way. When they referred to how much they valued their team it seemed that they were referring to the team of doctors in their practice rather than the whole practice staff:

GP 15 407-410

I enjoy working in a small team (AC uhum) I didn't mention that I'm lucky that I get on well we get on well as a little group of doctors these particular doctors it's the doctors ... if you didn't get on with your partners it would be a problem.

GP 17 270-272

I think so part of what's missing in a single-handed practice is working with colleagues. (AC mm) That's something which would have been nice to have done more of. That's single-handed life.

It is interesting that a “colleague” in GP 17’s view is another partner or another doctor. He does not appear to consider the rest of the practice team (nurse practitioner, reception staff, practice manager, district nurses and health visitors) as being colleagues. This perhaps has implications for the type of relationship he has with the rest of the practice staff. GP 6 also referred to teamwork as being meaningful to him in his practice:

GP 6 230-239

I think I feel very privileged to work as part of a good team really. (AC mm) You know I think if I wasn't confident with the team I was working with that would be difficult. I do feel that we work as a team I mean as with any team we have minor disagreements from time to time (AC uhum) but they are only minor and we all tend to push in the same direction (AC right) and I feel that you know everyone works really hard so you don't feel that you know you're carrying anybody you feel everyone's (AC mm) working hard and got their head down and I enjoy that sort of aspect of being part of a part of a group. I'd find it very difficult working on my own I don't think I'd like that at all (AC mm) although you know obviously six other people.

I have included the rather lengthy excerpt from the transcript of GP 6 above to share with the reader a sense of the perspective of the GPs in relation to teams. When GP 6 made this remark I was assuming that he was talking about the practice team including the nurses and reception staff. As the narrative progressed, it became apparent that he was, in fact, referring only to the six GPs in the practice. This seemed to be a feature of the GP narratives and clearly my reaction to it reveals my

own position on the issue of teams in primary care. The other perspective that the GPs had on teamwork was how valuable it was to be able to delegate to others in the team.

GP 2 153-158

AC So working in the team were you saying that's something you do enjoy?

GP 2 I do I think that's an essential part of it isn't it? It would be very difficult to perform the whole range of activities in general practice without having secretarial support (AC erm) without having administrative support without having nursing support.

GP 9 155-158

I delegate an awful lot of my stuff I get the district nurses and Macmillan nurses to go in and do ... I've got it quite taped really the staff know my angle on things (AC right) and where I'm coming from and what I'm going to do and what I'm not going to do.

GP 12 151-156

Well designate and delegate as much of it as possible to our very good ancillary staff or our nurse practitioner (AC right) or our practice nurse so a lot of the clinical governance stuff chronic disease management targets and things I don't have to do very much to (AC mm) or very much for thankfully.

This idea of delegation and designation contributes to a view of the team that is led by the GPs with the remainder of the team endeavouring to support the work of the doctors. It is interesting to note GP 9's comment that the "staff know my angle on things" and that they "know what I'm going to do and what I'm not going to do". There appears to be little acknowledgement that other members of the team might have a different view on what to do. This further illustrates the dominant position of the GP within the team. When the GPs did refer to the wider primary health care team, most of their focus was on the role of the practice manager:

GP 6 170-173

We have a fantastic practice manager (AC mm) who will you know take things and run with them and you know only bothers us if there's something that we actually need to make a decision on.

GP 9 480-482

We've a fantastic practice manager ... god knows what you do without one in this day and age.

GP 12 60-67

As a partnership we get on very well we have our ups and downs have our niggles (AC uhum) but the five of us are professionally close although not personally that close we socialise a bit but not a huge amount (AC mm) I get on very well with the other full time male partner which is very nice the youngest partner so he's very much complemented the practice team (AC mm) but we're very different people but we get on very well. So just the whole teamwork thing really is good. The ancillary staff are for the most part of very high standard practice manager's fantastic so I consider myself very fortunate to work where I do really.

It is interesting to note the contrasting focus on the partners of the practice by the GPs and the focus on the multidisciplinary team by the nurses. When the nurses were referring to the multidisciplinary team, none of them specifically mentioned GPs as being part of that team. Instead the emphasis appeared to be on the nurses with different skills within the team. The excerpt from the transcript of GP 9 below perhaps provides some explanation for this apparent divide:

GP 9 235-238

The trouble is with staff, and I don't mean it now because we've got a great bunch (AC aha) touch wood they're really good, but you are at the whim of people's idiosyncrasies their emotions whatever aren't they that will not necessarily conform with you.

This excerpt is a reminder that the GPs tend to be the employers in general practice and the rest of the staff are therefore seen as providing a service to the partners of the practice. Almost all of the GPs and nurses mentioned teams as being a meaningful aspect of their practice. Two of the nurses (DN 10 and NP 14) did not mention teams at all. Interestingly DN 10 had more "I" statements in her transcript than any other participant and she even acknowledged that her transcript was mostly focused on herself:

DN10 398-399

I think it's focussing on myself and I don't know whether it's what you want.

I will return to this issue during the analysis of holistic content. NP 14 had been qualified as a nurse practitioner for seven years but had only been in her current practice for three months when the interview took place. This might have had an impact on her sense of belonging within the wider health care team.

Once again, it would be possible to conclude that the majority of the participants valued teams and teamwork. On closer inspection, the data would suggest that the GPs have a different view of teamwork to the one that is shared by the majority of the nurses. GPs and nurses seem to exclude each other from their respective views of teams. The GPs seem to have a doctor-centric view of the team. In contrast, the nurses seem to acknowledge the wider multidisciplinary team and they also seem to value skill mix and acknowledge the expertise of other members of the team. The participants of this study value teams but they have contrasting views of the meaning of teams.

Being accepted, respect and recognition

Being part of a team also involves being accepted as a member of that team. Two of the nurse practitioners described how meaningful it was to them when they felt that they were finally accepted by the wider primary health care team:

NP 1 199-204

It's meaningful I suppose that I feel I've crossed a few bridges and ended up okay (AC right)(pause) and some people who I knew felt like that are actually coming to ask my advice now (AC mm) so that's nice. (AC uhum) So all these things I think are meaningful because it means you've (pause) you've been accepted (AC mm) in the role that you're doing now (AC uhum) I think they accept me as me.

NP 4 308-311

I think it's improved it's been a hard slog (AC yeah) (both laugh) but I think from having fifty per cent of them not sure of me or should I say even against me I know I've got all of them now they totally support the role (AC mm) and if I was to leave I'm sure they would want another nurse practitioner.

NP 4 15-16

I've been a bit more accepted by the medics for my skills as a nurse practitioner.

It is interesting to note that I responded to NP 4 when she stated: "it's been a hard slog" I responded with: "yeah" and we both laughed. It was difficult for me to control this spontaneous expression of empathy with the participant because, having had the experience of having to change jobs to find a practice that would accept the nurse practitioner role, I had my own understanding of what she meant by "hard

slog”. These concerns match the problems encountered by nurses introducing the nurse practitioner role into the hospital setting. Reveley and Haigh (2001) refer to the scepticism of nursing colleagues and the wariness of medical colleagues when introducing the role. Hupcey (1993) states that one of the main barriers to nurse practitioner development is the attitude of professional colleagues and particularly other nurses. Such resistance from colleagues is likely to contribute to a feeling of uncertainty for the nurse practitioners and therefore they value acceptance of their role when they feel their colleagues are supporting them. This issue was mentioned by nurse practitioners alone.

Themes that are linked to acceptance are recognition and respect. One nurse practitioner referred to her frustration when others did not refer to her as a nurse practitioner:

NP 16 269-276

*And another thing that I've just thought of (both laugh) what really bugs me is when people still insist on calling me a practice nurse (AC right) (laughs) it's really petty but I think I've done all these years of studying please give me my correct title (AC yes) isn't that stupid?
AC Is this patients or other health care professionals?
NP 16 It's other health care professionals.*

NP 16 refers to this frustration as “petty” and “stupid” and yet it clearly is important to her. On a similar theme NP 1 refers to the lack of respect from others who feel they are able to walk into her room when she is consulting:

NP 1 137-140

One little thing that frustrates me is that I don't like it when people just walk in the room (AC mm) 'cause I wouldn't do it to other people who are consulting (AC mm) but people do it to me.

The implication here is that there are a set of rules that apply to GPs when they are consulting relating to respect for the practitioner and respect for the patient. However, the same rules appear not to apply when the patient is consulting with a nurse practitioner. The nurse practitioner's frustration here is an indication of how she values recognition of her role from other staff members and how she values the respect that she feels should be associated with her position. It is possible that the nurse practitioner's concern here is for the privacy and confidentiality of the patient;

however, her comment that “people do it to me” indicates that some element of her frustration is linked to a concern for personal respect and recognition.

Operating at a strategic level

Several of the participants talked about operating at a strategic level in their organisations. This was associated with being involved with the management of health care within the organisation and being able to influence the work of others. The nurse practitioners in particular valued being able to have an influence on the work of the practice:

NP 4 250-254

Some of the changes that have gone on have been because of myself (AC uhum) which is quite nice because when you look back and you think well that wouldn't have happened if I'd not challenged things or said "why don't we try someone doing this?"

NP 11 21-25

To be involved in development of the nursing team to be considered as an adviser to management issues with other staff including reception and dispensary staff (AC right) so it's not just you being a nurse managing patients' chronic disease or abdo pain or it's the whole global situation (AC mm) of running a general practice I think.

NP 14 110-114

Here I've picked up management in that I have complete responsibility for the quality and outcomes framework and do an awful lot of the practice management nurse management even receptionist training and more and more getting involved in business things.

These three excerpts from the nurse practitioner transcripts reveal the way the nurses have moved into operating at a more strategic level in their practices. This is noteworthy and meaningful to them because general practice has been traditionally run and managed by the GPs. The nurse practitioners seem to value being able to operate at this level because it allows them to have an impact on the practice and to effect change (NP 4), to be involved in development and to help manage the practice (NP 11) and to have greater responsibility and breadth of involvement in the practice beyond patient care (NP 14). A few of the district nurses also commented that they found operating at a strategic level a meaningful aspect of their practice:

DN 3 10-11

I'm obviously sort of a team leader so I obviously sort of enjoy sort of the organisational skills (AC aha) and management skills to a degree.

DN 18 149-153

It's really important for me to look at clinical supervision and be involved in the day to day management and ensure that everybody's quite happy with the job they're doing and training the new staff as well.

For these district nurses, team leadership and operating strategically within that team, would be part of their job description and it is therefore perhaps less worthy of note as something that is meaningful to them in their practice. DN 3, for example, mentioned working as a team leader but her description of enjoying that aspect of her role is not convincing "I ... sort of enjoy ... the organisational skills ... to a degree". Only two GPs referred to operating at a strategic level and this was in relation to managing the business of general practice:

GP 9 23-26

I've got quite a business head on me I think (AC right) probably more than the other partners ... I quite like the concept of running our own businesses (AC aha) driving the finances making it work quite like that. I dislike intensely staffing issues but don't we all?

GP 9 205-214

I don't know I suppose I've always been quite fiscally minded ... I think it's a barometer of the success of what you're doing as well. (AC mm) You know if you can see that you're hitting your targets for immunisation, which equates to money inevitably, so the two are directly linked. I'm not saying we're just doing it for the targets we're not just doing it for the targets we're doing it for the money but the two are part and parcel then clearly we're going well (AC mm) you know you're meeting your targets you're getting your payments so by definition things are going well.

GP 12 160-161

Then the other area of responsibility I have is the dispensary (AC mm) and looking at the running of that which is important financially.

The comments made by GP 9, relating to his dislike of dealing with staff, matches with his earlier comments regarding the idiosyncrasies of other people (on page 134) and his preference for clear cut archetypal medicine (on page 124). It's also interesting to note GP 9's definition of success: "you're getting your payments so by definition things are going well". The nurse participants in this study appeared to

consider that things were going well when they got feedback from patients and colleagues and when they felt they were doing a good job. The GPs' comments relating to the management of the business and success being defined by income do serve as a reminder of the GPs' overall responsibility for the practice. This responsibility perhaps has an impact on their view of the team. It perhaps also has an impact on their view of operating at a strategic level within the practice in that it is such a normal part of their practice it is hardly worth mentioning.

Relationships with patients

At the start of the presentation of the findings for this study I referred to how all the participants focused on relationships with patients. As can be seen from the excerpts on page 113, having a relationship with patients was one of the most meaningful aspects of the role for many of the district nurses, GPs and nurse practitioners. The participants went on to discuss a variety of themes that related to having relationships with patients including: patient partnership, disease and illness relating to patients, working with the whole family, holistic care and palliative care.

Patient partnership

There were a large number of references to working in partnership with patients or viewing a problem from the patient's perspective. This was particularly noticeable in the district nurse interviews and less so in the nurse practitioner and GP interviews, although examples of participants valuing working in partnership with patients could be found across all three groups. The following excerpts are representative of these types of comments:

NP 7 12-22

I'd feel you start by ensuring that they understand what the problem is and then getting their perception of it... (pause) I suppose you see I see myself as a facilitator to them and that's what I find rewarding.

NP 11 167-170

I suppose empowerment is the word isn't it really? (AC mm) That they feel they own part of what's gone on (AC mm) and that it isn't just me sitting here saying this is what we'll do this is what's happened to you you know it's got to be an explained situation it's got to be an agreed outcome.

DN 13 42-48

I think it's a journey of learning together because I may not have all the knowledge that I actually need to deal with in that situation and so it's a matter of sometimes the patient educating me in some way maybe around the difficulties that they're actually having and not so much about the disease processes ... a lot of it really is that it's not so much the element of the disease processes as the encumbrances that that gives them and the difficulties in maintaining their day to day life.

DN 18 24-34

Healing it would be satisfying but I think as a district nurse we're looking you've got to have a degree of flexibility you've got to be aware of all the factors that go towards healing. And the fact I have a number of people that still want to be out on the farm working (AC mm) and I know that if I said to them "you've got to stay at home you've got to rest your leg" we would probably heal that but that would be no quality of life for them. (AC mm) So I have to be quite flexible there and look at what their lifestyle is (AC mm) so their lifestyle and their quality of life means that yes we go and dress the leg so many times a week but once we've gone they go out and work on the farm (AC mm) so we know that is contrary to good healing so there's a bit of a balance between what's good for the patient and what is right to heal an ulcer.

GP 15 75-80

I do know that patients do like to come back to a doctor that they find they think is sympathetic but also not just a good listener but actually does you know what they want or if it's appropriate (AC mm) they feel they can come and ask me to refer them. I would never I don't think I would ever block somebody asking for a second opinion (AC mm) whereas I know other doctors do that.

The excerpt from GP 15 contrasts subtly with the excerpt below from GP 2

GP 2 113-116

Yes and being able to cover, in consulting jargon, their agenda (AC uhum) and matching it with your agenda (AC uhum) of what you feel ought to be achieved in the consultation in terms of health promotion data collection which of course we have to do.

GP 2 refers to matching the patient's agenda with the GP's agenda whereas GP 15 refers to attempting to do "what they want". This contrasts again with GP 9 who used the example of headaches to explain the mismatch between his agenda and the agenda of the patient.

GP 9 97-104

... and you look at them and it's not just headaches it's illness behaviour it's depression it's everything else and you try and get a route into these

people and say look we should stop worrying about your headaches we should start talking about maybe your depression or maybe what else is bothering you and inevitably they end up back on headaches and I'm pretty quick to draw stumps on that one (AC right) which probably makes enemies to be quite honest but I'm pretty quick to say look you know we've done your headaches I've tried really hard for a year and got nowhere (AC mm) I'm not going to pursue these anymore.

Whilst there were examples in all three groups of working in partnership with patients, there was more of an emphasis on this in the district nurses' transcripts with fewer examples in the nurse practitioner transcripts and fewer still in the GPs' transcripts. For example in comparison to the excerpt from GP 9 above, DN 18 describes the mismatch of patient expectations with the nurses' expectations and how she would address the issue "gently":

DN 18 338-345

One of my nurses this morning was met by "I'm for a late call this afternoon" as the lady got in the car and drove away to the hairdressers (AC mm) and that's an abuse of the system (AC mm) but it's very difficult here because they're of an age group that they expect that the nurse will call (AC right) and again that is something that we're working on it's something that we need to sort out (AC mm) it's doing it gently isn't it?

Some individual nurses emphasised patient partnership as a major feature of meaningful practice for them. The excerpts of the transcripts above provide examples of the nurses' desire to work *with* the patient, to work towards mutual understanding and to empower the patient to make choices. Whilst there are a few examples of this approach from the GPs, this was not a feature of their transcripts. Instead the GPs focused consistently on the patient's disease and illness.

Disease and illness as a feature of patient relationships

This sub-category is notable for the fact that five of the six GPs mentioned it and none of the nurses did. GPs reported disease and illness as meaningful aspects of their practice and they shaped the relationship with their patients around that disease or illness. GP 12 did not mention disease and illness as being meaningful to him and his departure from the rest of the group was mentioned earlier (see page 121). It seemed that GP 12's Christian beliefs had an impact on his view of the patient marking him out as being slightly different to the rest of the GP group in this regard.

The following excerpts from the transcripts are examples of the remainder of the GPs' comments:

GP 2 26-28

Well it's the problem solving aspect of it isn't it? (AC aha) And if I'm really honest I find the clinical aspects of that more satisfying than putting it within psychological and sociological contexts.

GP 9 8-11

I'm very sort of pragmatic young male GP so I deal with a lot of elderly people with heart failure, ischaemic heart disease, prostate disease, chronic lung disease. (AC right) I don't get a lot of soft psychology (AC mm) a lot of probably young people with depression, anxiety. I think they tend to go to my partners.

GP 15 94-100

Every single week I see some very serious illnesses or I help diagnose or spot something that's critical or crucial and that is what makes the job interesting (AC mm) and that is absolutely no doubt that it's better than I thought it would be I didn't expect perhaps so many people to turn up with so many interesting or unusual or serious illnesses (AC mm) at the GP surgery but they do you know with lumps bumps pains whatever so you got to be completely on your toes and I actually quite like that it's actually quite stimulating challenging and I'm not bored by it which I thought I might be.

GP 17 79-84

In many ways I'd love to be in a practice where a lot of the more day to day chronic disease management was done by practice nurses nurse practitioners and I was dealing with the more complex (AC mm) clinical situations you know perhaps with half an hour per appointment or something (AC mm) to really work the patient instead of a quick ten minutes and get them out the door. (AC mm) That's something that would be nice but it's not achievable in this practice as it stands.

It seems that the more complex and serious the disease the more exciting and interesting it is for these GPs and therefore the more meaningful it is to them in their practice. Cassell (2004) refers to the historical development of medicine and the promise of scientific discovery. To know the disease was to know its cure and hence to know the treatment of the ill person. Cassell suggests that the patient might have been a help or a hindrance in gaining access to the disease but the focus remained firmly on the disease and not the patient. It is really interesting to note GP 17's comment that if he had more time he would like "to really work the patient". This contrasts with the view of the nurses who like to get to know the patient and to

understand the social, emotional and spiritual aspects of the patient's life. Porter (1995) refers to Trotsky's dictum that throughout history the mind limps after reality. Hence he suggests that the imprint of earlier social formations continue to haunt the present. There are numerous examples of the GPs in this study group referring to the value of working with patients and enjoying having relationships with patients, nevertheless, it is interesting to note that disease and illness is a particular interest to them and features only occasionally in the transcripts of the nurses.

Working with the whole family

A number of the participants stated that they valued working with families, explaining that their work in the community, or in primary care, supported a view of the family as the focus of their care. This was a particular feature of the narratives of the district nurses and the GPs, with an occasional reference to the family from the nurse practitioners:

DN 5 162-164

If the families know that someone is going in to make their loved one comfortable (AC mm) it's all that they need sometimes (AC mm) we're not just there to support the dying person we're there to support the whole family it's a holistic thing really.

DN 8 18-22

Well particularly in the community as opposed to the hospital it's being involved with the whole family (AC right) social nexus of the family the total care including the family friends and neighbours it's not just caring for the patient (AC uhum) I find that quite satisfying.

GP 12 21-30

It's nice to build up a relationship with people and that's the big strength obviously of family medicine, the ongoing familiarity with patients and again that's a nice thing about this particular practice it's a particularly stable practice in terms of a patient base so people tend to come to the area and stay or don't go away in the first place so (AC mm) ... so I've been here fifteen years now and have had fifteen years of a relationship with some patients (AC mm) so you can see the Mums I can look back and think about ones who I was doing antenatal care for and now they've got adolescent children and so it goes on (AC mm) so that's very rewarding (AC mm) and good old fashioned family medicine really.

DN 13 32-34

I just think the interaction with the patient and their family is the thing

that I enjoy the most really and where I think I can make a difference to them.

NP 14 172-177

And I think it is the continuity of care that when I first started as a nurse practitioner I worked in a practice where I had been a practice nurse for eight, nine years and very much took for granted a lot of information that I knew (AC mm) and I also worked with GPs who would say "oh by the way Mrs so and so do you remember Mrs so and so she's got the daughter with the" you know (AC mm) and they knew very much the infrastructure of that family.

GP 15 10-14

One big aspect is the actual family medicine being involved with the whole generations of grandparents parents and grandchildren children knowing the dynamics of the family and therefore knowing how illness fits into that which I don't think anyone else within the medical field knows what's going on really in a family.

GP 15 406-407

I enjoy being a family doctor for the whole family.

Whilst all of the participants listed above referred to the value of the family in their work, there is a subtle difference between the participants' perspectives. GP 15 refers to understanding the illness within the context of the family. Hence the value of the family is in helping the GP to understand the illness of a particular patient. For the district nurses the family is the focus of their care; the person with the illness is simply one component of a more complex picture. GP 12 finds meaning in building up relationships with patients and families over time and this departure from the perspective held by GP 15 is congruent with GP 12 being the only GP not to describe meaning in disease and illness. NP 14 was the only nurse practitioner to mention the family; her view of the family was similar to that of the GPs' in that understanding the infrastructure of the family helped to enrich her understanding of the patient.

Holistic care

A category that is related to the participants' view of the patient embedded in the context of the family is holistic care. I would like to refer back to an excerpt from the transcript of GP 2 that I discussed earlier in relation to disease and illness as a feature of relationships with patients:

GP 2 26-28

And if I'm really honest I find the clinical aspects of that more satisfying than putting it within psychological and sociological contexts.

This view of the patient contrasts markedly with the view of many of the nurses.

Holistic care was a particular feature of the transcripts of the district nurses.

DN 5 201-204

We're looking at the patient from a whole aspect not just physically we look at them psychologically emotionally spiritually.

DN 8 243-250

Because you see a patient not in isolation and that is more holistic care isn't it? (AC mm) If you look at a patient psychologically, physically, emotionally, spiritually, that must involve the family, (AC mm) well in most cases we're all part of a family, so I think in hospital and I think that's the biggest thing the students mention when they come in to the community the first thing they say is "oh it's so different walking into someone's home". (AC mm) It's that being taken into someone's personal space that's of value (AC yes) and being trusted and I know in the community I find that very special privilege.

DN 13 50-53

So it's not just about going in and doing a wound dressing which you know might be where our expert knowledge lies but it's also anticipating and finding out how that actually affects the rest of their life (AC right) and trying to help them deal with those difficulties.

NP 7 referred to the holistic view of the patient in a similar way to the district nurses:

NP 7 57-65

So I suppose meeting people's what I perceive to be their needs (AC right) and trying to be sure that you've perceived their needs correctly that's the crux of it. (AC mm) Try not to have preconceived ideas as to what they do need (AC uhum) and be sensitive to what each because everybody needs dealing with differently don't they? (AC mm) And every diabetic has different needs (AC uhum) psychological needs I mean. So I suppose to try and put it in a nut shell, it's to meet that individual's holistic care needs but with a big emphasis on psychological (AC right) and how they cope with what's going on for them.

As the analysis of the content of the narratives progresses we will discover the ways in which NP 7 differs from the rest of the nurse practitioner group. Shotter and Gergen (1989) state that persons are ascribed identities that are embedded within their own discourse and the discourse of others. It is interesting to note that the GP

who worked with this nurse practitioner made the following statement:

GP 9 426

... we've got one we don't use as a nurse practitioner unfortunately.

NP 7 was working in such a way as to qualify for entry into this study in that I saw publicity material in the practice for the services of the nurse practitioner, she did not wear a uniform and she was appropriately qualified but it would seem that the comments of GP 9 indicate that she was having difficulty fully implementing the role in practice. It is possible that NP 7 may not be fully engaged with the nurse practitioner role and may therefore demonstrate beliefs, thoughts and ideas that are not necessarily associated with being a nurse practitioner. Other nurse practitioners referred to holistic care of the patient in relation to the variety of illnesses or disease a particular patient might have which contrasts to the psychological, emotional and sociological contexts referred to by the district nurses:

NP 4 104-116

The other thing that I'm trying to do from that is often patients will have more than one chronic disease management and rather than pull them in for one set thing try and pull them in to cover both areas (AC yeah) which is what I'm already trying to do now is to see people who have ischaemic heart disease who have a respiratory problem come to see me ... and they're only coming once (AC mm) rather than coming back for these repeat annual reviews to different places with people's different views you've (AC mm) just got one person (AC mm) saying this is holistically how we should manage all your chronic disease management.

NP 14 88-98

Only the other day somebody came through and essentially it looked as if she was coming about her chest the whole of the first ten minutes was about her chest and then we got onto, so what impact is it having on your life, and actually the reason she had come was the stress incontinence and probably wouldn't have mentioned it until you know or maybe would never have mentioned it but because we asked a question about you know impact on her life out comes well actually that was the impact and that's what made her come. (AC mm) So she really wasn't bothered about her chest did she need antibiotics was it bacterial viral all that went out the window despite having gone through it (AC right) it was really what we going to do about the stress incontinence because since I've been coughing more frequently...

NP 16 19-25

I used to feel very not annoyed but that there was something missing I didn't with the patients I didn't get the patient contact either because I'd

just see them once and off they'd go and I wouldn't find, it's more rewarding for me now because I find out how they've got on and with the treatment and I bring them back and review them and you know if they've got any problems I can start putting things in like social services and also the home care you know you can look you can look at the problems that they have the sort of more holistically really.

The excerpt from NP 16 is another example of a nurse practitioner combining elements of the responses from the doctors with elements of the responses of the district nurses as she talked about both the illness and the patient's social circumstances. There was little mention of holistic care from the GPs although GP 17 did refer to the minutiae of the patient's social life as being important:

GP 17 123-126

It's probably more of a mental thing than anything else it's tying in all the minutiae of patient care social life clinical results of investigations etcetera putting it all together maybe going for a diagnosis that hasn't been made (AC uhum) maybe polypharmacy comes into it.

This GP is describing a view of the patient that goes beyond the narrow focus of the patient and the disease process but the purpose for being interested in the minutiae of the patient's life is to go "for a diagnosis that hasn't been made". Hence, the value of the holistic perspective of the patient for this GP is to avoid missing a diagnosis whereas for the nurse it is to provide holistic care.

Palliative care

Palliative care has been identified as a significant category because it was mentioned repeatedly by the district nurses, less so by the GPs and not at all by the nurse practitioners. GP 9 was the only GP to refer to palliative care:

GP 9 180-186

It is quite satisfying medically to look after someone who you diagnose their disease you see them through the surgery the trauma of it they become terminal especially if they're in their eighties (AC mm) they're usually quite easy to look after they're accepting they're you know ready to die (AC mm) and they die peacefully at home (AC mm) so yes I don't say that I enjoy that it's the wrong expression (AC yes) to use but it is satisfying.

For this GP the meaning associated with caring for a person with terminal illness is

related to being involved with the progression of the whole disease process from diagnosis to death. Palliative care was a feature of the district nurses' role that was identified as being meaningful to them on numerous occasions. When asked to explain this a bit further they referred to the complexity of the care associated with the terminal stages of illness, the holistic nature of the care and the feedback they received when they had been involved in assisting a patient at the end of their life.

DN 3 242-244

I think probably with palliative care you've got family members you've got all sorts it's quite sort of complex.

DN 5 165-167

It is lovely to know that you've made someone comfortable so as that they can die (AC mm) in the place where they've chosen to which is at home (AC yes) most of the time.

DN 8 22-23

I enjoy palliative care and terminal care the feedback that you get.

DN 8 64-67

I think it's seeing families and patients experiencing what we could call or hopefully what we could call a good death if that is possible (AC mm) or as good as we can make it (AC mm) to try and make sure that they have support and to build up that relationship prior to the death.

DN 13 135-156

I suppose one of the big areas that we do quite a lot of terminal care (AC mm) and I really enjoy that sort of work which sounds strange and a lot of people sort of "how can you enjoy doing that?" But in that environment you're in a position to really make a big difference.

The nurse practitioners did not mention palliative care at all which perhaps reflects one of the boundaries of their role. A feature of the district nurses' comments on palliative care was the feedback that they get from patients and families and the way in which they themselves feel valued because of that feedback:

DN 13 145-152

I think it's a privilege (AC mm) to be able to support somebody in the very emotional stage and to be not even to be thanked afterwards but you can just tell how appreciative families are (AC mm) of the support that you've given them and that to me is one of the most they don't have to say it they don't have to give a card (AC mm) or whatever you can just you can tell that you just being there has made a big difference to them (AC mm) and that is a very meaningful part (AC mm) of my job really.

Being valued and being of value were categories that featured on numerous occasions throughout the transcripts and I have therefore identified this as a major subcategory of relationships with colleagues and patients.

Relationships with colleagues and patients

Being valued, being of value and making a difference

Again there was a striking difference between the GPs (only one of whom talked about being valued, being of value or making a difference) and the nurses all of whom talked about these issues. Being valued relates to a person's sense of purpose in life and being of value and making a difference to patients can also contribute to an individual's sense of self-worth. Interestingly within the category of "being valued" some of the nurses were concerned about being valued by patients and others were also concerned about being valued by colleagues, particularly the doctors. Two of the district nurses who described the satisfaction they gain from being valued by patients felt that the need to be needed was characteristic of nursing roles:

DN 3 61-64

I think probably ninety nine per cent of patients appreciate the visit (AC uhum) the care that they're getting and it's a sort of two way process really.

DN 8 256-262

It is a two way thing (AC uhum) I think in nursing it's the need to be needed as well isn't it? (AC uhum) I think sometimes so although patients feel that they get something out (AC mm) of the service I think the nurses get something back (AC mm) and that making a difference and being needed perhaps is part of us as nurses (AC mm) perhaps that's an inherent part of a nurse I don't know.

Other comments relating to the need to be valued by patients were:

DN 5 13-15

I do enjoy my work obviously patients value what we do they listen to us.

NP 7 110-116

I think it makes quite a difference to feel valued in the job that you do by the patients and you get a lot of feedback in that way... I think in this kind of role you do get a lot of appreciation and that helps you feel as though you're doing a good job.

NP 16 103-107

So it's nice as well when people come back and say and thank you (AC mm) that they've actually you've got somewhere with them with the treatments and things (AC mm) you've improved their quality of life I think that's nice (AC mm) you know and they'll actually thank you or even thank you just for listening to them and (AC mm) it's you know that's a nice part of it.

The one GP who stated that being valued by patients was important to her was the only female in the GP group. She referred to the satisfaction she gains from patients who make return visits to see her as this demonstrated that these patients respect her judgement.

GP 2 80-86

I enjoy having a relationship with my patients (AC aha) and fortunately if the relationship's good they carry on coming to see you and if the relationship isn't good they tend to go somewhere else (AC right) and see somebody else. (AC self selecting) That's quite satisfying as you are aware that patients have respect for you and put value on your judgment and your opinions and the fact that you have a relationship such that you can share treatment and management options treatment options with them.

Another GP expressed completely the opposite view when he stated that he does not need to be valued at all:

GP 9 572-580

I've been here long enough to define who I am and what I am from the patient's respect which makes my life so much easier. (AC right) You know I hear people hear them muttering in the corridors he's a git (AC laughs) but that's fine you know because maybe I am a git but then that's fine because I'm probably not going to address what they want me to address ... but certainly I've got well beyond the stage of getting vaguely concerned if someone doesn't like me or doesn't want to come and see me that's absolutely fine.

It is interesting that all the nurses and the female GP commented on how meaningful it is to be valued by patients. I suggested earlier that differences in values could fall either side of a gender divide. This is the only example of such a division in the findings of this study and it would not be appropriate therefore to make any far reaching conclusions about it except to say that this is an interesting point that would be worthy of further exploration. Other authors have also pointed to differences in values and the stability of value systems between genders (Rokeach, 1973; Furnham,

1988; Grundstein-Amado, 1992). It would be possible to utilise feminist theory to conduct an analysis of this whole study as one view might be that the gender divide could be identified between the nursing groups and the medical group. I have already referred to the doctors' view of the team as being doctor-centric and dominated by medicine and the nurses' view of the team as being multidisciplinary and collegial. This could be explored from a feminist perspective. I have decided not to take this approach here as I believe the feminist perspective is worthy of detailed exploration that would go beyond the bounds of the present study. The central focus of this study is the variation in values between the participants and the position of the nurse practitioner group in relation to the values of nursing and medicine. The need to be accepted, recognised and respected is one of the points of departure for the nurse practitioner group. In addition to being valued by patients, several of the nurse practitioners were also concerned about being valued by their colleagues:

NP 4 278-285

Yeah I think since the nurse practitioner and the extended prescribing because you're much more closely involved I felt doing that because you're discussing clinical aspects at a greater level that I think I've gained their respect more because they don't know what they perceived or what they perceived my knowledge base was but because you're being more open and discussing things probably at a deeper level than I was as a practice nurse (AC uhum) I think that's led them to acknowledge where you are (AC mm) and where your level is and probably have a better comprehension about who you are and what you are.

This nurse practitioner referred to the frustration she felt when the appreciation or respect from colleagues was not evident:

NP 4 368-384

I've got a couple of GPs who still under estimate you or take over (AC mm) for instance if I'm setting up a process for respiratory like for instance we had a meeting not long ago about how we are going to meet the GMS contract and I did loads of (as much as I didn't like it) background work on how we should do it how we should improve the templates maybe where we're missing out like people. Doctors not completing templates and trying to get them to get on board they have to do that whether they like it or not. (AC mm) And I came up with a list of ideas after the practice manager said we were going to have an away day. (AC uhum) And then doing it and then finding that the GP was responsible for that area just took over got his own paperwork didn't want to look at my issues (AC mm) and then came back and sort of said

well the respiratory nurse in the area does this and the respiratory nurse in the area does the other and you're going "yes that's exactly what we do" but he's not listened to you he's just gone off (AC mm) and not listened to you but I think he's guilty of that at some times but that really annoys me I find it demotivating and really frustrating (AC mm) because he doesn't he probably wouldn't do it to another colleague but he is doing it to me because I'm a nurse.

The end of the section of narrative from NP 4 demonstrates the strength of feeling she has in relation to her position as a nurse compared to her GP colleagues. It also illustrates the strength of emotion felt by this nurse practitioner when her views were not listened to and the way in which this devalued her potential contribution to the meeting. Acceptance, recognition and respect seemed to be important to the nurse practitioners and these issues were not a concern for the GPs and district nurses.

A theme that is related to being valued by patients is being of value to them and making a difference. This was mentioned repeatedly by the nurses and contrasts markedly with the GPs who did not mention it at all.

DN 3 160-162

I think again it's because it's very obvious that you are going in and making a difference.

DN 5 140-144

I think that knowing that you've gone into a patient's home especially if they physically restricted housebound and they're lonely sometimes if you've just made their day sometimes you're the only face they see.

NP 7 4-8

AC Can you tell me what you find most meaningful in your work?

NP 7 Making a difference I think (AC aha) to how people feel about their disease or problem (AC right) making them feel better about it or more able to cope with it.

DN 8 25-29

I enjoy being able to make a difference.

NP 11 32-37

What I get out of it I think are those personal development things that I feel involved that I'm valued that you make a difference to every single patient you see even if it's just they leave with a smile.

DN 13 17-21

Well there's a great variety of things but I think probably the overriding

thing is my ability to make a difference to somebody who has some sort of problem or difficulty.

NP 14 217-222

I think it is it's the patient feedback it's the you know like I say living for the one or two cases that you think yeah I've really made a difference today.

A number of the nurses in the sections of narrative above refer to the satisfaction gained from “making someone smile” or “making them feel better” and referring to the belief that making a difference is psychological and not just physical. Earlier, in some of the comments relating to clinical competency, the participants identified physical aspects of care, such as healing a wound, as a meaningful aspect of their practice. This is perhaps an example of a hierarchy of values in existence. The nurses gain satisfaction from making a difference to patients on both physical and psychological levels but simply making someone smile or making them feel better is enough without necessarily healing their wound or curing their illness.

Family Life

Family life featured briefly in some of the narratives. When it was mentioned it was usually in relation to there being too few hours in the day to meet all the demands on one's life.

GP 12 140-145

I will tend to stay late and make sure that the referral letters are done and pathology results are (AC mm) seen because I get stressed if that's all sitting there looking at me (AC mm) but then the family life suffers of course because you don't get home and don't see the kids for their tea (AC sure) you know (AC mm) but (AC it's that balance) yeah I think I strike it most of the time.

DN 13 415-420

... and then you start getting your home life sort of impinging I suppose you know (AC mm) well you're stopping on to do this but then you've got to get home to sort the kids out then you're doing the shopping and who's making the tea (AC right) (DN 13 laughs) you know so yeah I don't know whether that's a frustration or a bit of an anxiety I'm not sure (both laugh) (AC right) but it all makes for an interesting life I suppose.

Only NP 1 mentioned her husband as a support at home:

And another really nice thing is and I feel very very privileged is that I can discuss my day briefly at home (AC mm) with somebody who understands.

No other nurse practitioner mentioned family life whereas three of the GPs mentioned the tensions of balancing work life and home life and just one of the district nurses.

Summary: discourse with others

The sub-categories identified within the major category of discourse with others provide examples of the diversity of values between the groups of practitioners. In many instances an issue would be described as meaningful to a participant but once that issue was contextualised it became clear that one participant's view of the issue would differ from another participant's perspective. What follows is a summary of the ways in which a number of the significant categories revealed these differences. The participants valued autonomy; the nurses valued autonomy in decision-making with patients and the GPs valued autonomy in their working lives, free from the constraints of outside forces. The nurses repeatedly talked about how meaningful autonomy was to them, the GPs only mentioned it when their autonomy was threatened. The participants valued teamwork; the nurses valued the multidisciplinary team and appreciated the breadth of skills in the team and the GPs valued the team of GP partners and viewed the remainder of the team as supporting the role of the doctor. The participants valued partnerships with patients; the GPs valued the variety of disease and illness in general practice and the nurses (particularly the district nurses) valued understanding the patient's perspective and described "being on a journey" with the patient. The GPs and district nurses identified working with the whole family as an important feature of their work; the GPs felt that understanding the family could help in understanding the patient's illness and the district nurses identified the family as the focus of their care. Holistic care was valued by the district nurses who acknowledged the effects illness could have on the rest of the patient's life and by the nurse practitioners who focused on viewing the patient holistically in terms of multiple illnesses and disease. Palliative care was described as meaningful by most of the district nurses. The nurse practitioners valued being accepted and gaining respect and recognition from their

colleagues. All of the nurses said that they found being of value and making a difference meaningful in their work; this was only mentioned by the one female GP. Nurse practitioners enjoyed operating at a strategic level in the practice whilst the GPs referred to running a business and the district nurses referred to their leadership role within the district nursing team. Three of the GPs and one of the district nurses mentioned family life as being of value to them.

The above summary of the categories covered in discourse with others provides a broad generalisation of the diversity of responses that resulted from the participants being asked about what was meaningful to them in their work. There were some interesting individual responses from the nurse practitioners that combined the responses of the other two groups and there were other unique responses that could be seen as sufficiently different from the rest of the respondents that they could be identified as outliers. The significance of the outliers will become more apparent in the analysis of the form of the transcripts, and subsequently, in the analysis of practices from a MacIntyrean perspective in chapter eight.

Discourse with society

Some of the participants referred to the wider population beyond having relationships with patients or colleagues. For example GP 6 responded to my opening question with: “I feel that I’m doing a worthwhile job” which seems to suggest that he felt he was contributing to society in a meaningful way. DN 10 altered her transcript summary so that it ultimately read “She ... chose to do nursing because she wanted to do something useful”. More specifically the participants referred to the ways in which they valued contributing to the development of their professions.

Contributing to the development of the profession

Participants referred to their contribution to professional development, particularly in relation to teaching students. NP 14 described as a “debt” that she owed to others who had helped her along the way:

NP 14 194-198

I have come through an awful lot of experience and that maybe other

people could benefit from that (AC mm) you know and therefore it's a bit like if somebody hadn't believed in me in the first place to allow me to develop into what I am and given me a leg up on the way then maybe I wouldn't be here now (AC mm) I know I wouldn't be here now and therefore there's a certain debt isn't there?

Other participants referred to the satisfaction they gained from working with students:

GP 12 49-52

Education clearly is an important part (AC uhum) for us having been involved in various different aspects of education for different parts of the primary health care team.

DN 5 265-270

I feel it is a two way thing with students (AC mm) not just you know I'm teaching them that or I'll show them that (AC mm) I really I do enjoy the students (AC mm) and I enjoy knowing that you've helped to sort of develop their knowledge as well (AC mm) and allowed them to become competent in the areas they want to become competent in (AC uhum) because at the end of the day they're going to be trained registered general nurses with a diploma or a degree (AC uhum) so you feel you've contributed to that (AC mm) it's quite rewarding.

At the start of this excerpt from DN 5 it is clear that teaching is not just about contributing to society and to the development of the profession but it also has an impact on personal development. Other participants made similar comments:

DN 8 42-44

It's quite good fun having students (AC mm) that's a two way process we learn from each other. It's interesting to see how their training is obviously different to my training.

GP 12 56-59

Education's important and challenging and refreshing and stimulating (AC mm) and so medical students ask "why? what are you doing that for?" which is always a useful question to make you think "well why am I?" (AC yes indeed) and keep you up to date.

The interactive nature of relationships with society, others and the self is particularly apparent in the participants' comments on teaching and links to the ways in which they value having a contribution to their profession, working with individual students and working on their own personal and professional development.

Financial reward

In response to my opening question (What do you find meaningful in your work as a doctor?) GP 9 stated the following:

GP 9 4

What's everybody else said? Money money (!)

And again later in the interview he reinforced his earlier quip:

GP 9 571

I'm here primarily to earn money.

Financial reward can be seen as an external good which can be gained as a result of participating in a practice. It is therefore worthwhile noting that two of the GPs mentioned their financial reward even though this is a subject that people do not always readily discuss:

GP 12 13-16

I mean you keep reading these things about how awful it is in general practice and no-one wants to be a GP anymore I can understand that but this is a really nice practice and a really nice area it pays reasonably well I don't have to work my socks off (AC mm) it's a very pleasant place to be.

NP 11 was the only nurse practitioner to refer to salary and this was to emphasise that financial reward was not important to her:

NP 11 145-154

No I don't think about the salary to be quite honest (AC mm) I just think about the work (AC right) the money's good (laughs) at the end of the month but it doesn't ever enter my head about should I have had a pay rise this year.

It seems that money is not the sole motivator for NP 11 and that might be because "the money's good". If the money was less good it might become more of an issue. DN 10 also referred to being paid for her work:

DN 10 149-153

They'll say to me "oh Sister X you're so kind" now I know I'm not kind (AC mm) I'm not a kind person or "you are very sweet" I know I'm not

sweet I know my personality (AC right) does not come over as sweet and I say to them but I'm paid to do this.

The section of transcript from DN 10 presents a picture of someone whose primary motivator is her salary. Indeed, the opening sentence of the transcript summary is:

DN 10 Transcript summary

This transcript suggests that DN 10 carries out the role of district nursing sister because first and foremost it is a job.

As mentioned previously, DN 10's view of her role in district nursing was sufficiently different to the other district nurses for her to be considered an outlier. This will be examined further in subsequent chapters.

Financial reward is a significant, although little mentioned, category. The level of remuneration received by the various groups is an indicator of that particular professional group's relationship with society. Financial reward can also contribute to the person's sense of self and be a signifier of personal and professional achievement.

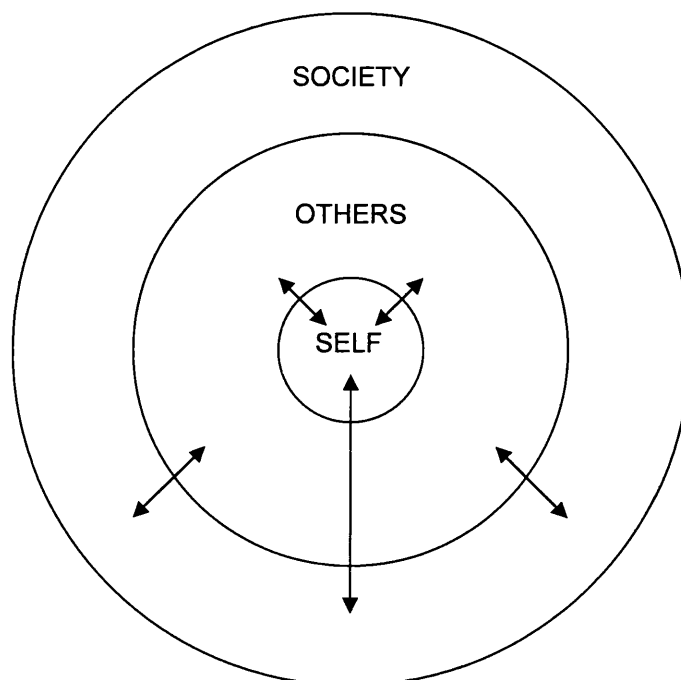
Summary: discourse with society

The participants of this study said that they found meaning in teaching others. The value of their efforts in this regard are related to their sense of satisfaction in helping others and the sense of personal and professional development. Similarly financial reward can be seen as an indicator of the profession's relationship with society. Simultaneously, financial reward has an impact on the person's sense of self and contributes to what they know about themselves with regards to their relationship with society.

Summary: categorical content

The analysis of categorical content has revealed the breadth of issues raised by the participants of this study when they were asked to talk about what was meaningful to them in their practice. Those issues were broadly grouped into three major categories labelled as: discourse with the self, discourse with others and discourse with society. It was clear from the narratives that the three levels of discourse were interdependent and this is summarised in diagram two:

Diagram Two: Interdependency of Self, Others and Society



It was possible to identify particular categories that predominantly fell within the narratives of one group more than it did with the other groups, or to identify categories that were shared between two or all of the groups. All three groups of participants highlighted teamwork, autonomy, clinical competency, challenge, change and variety and development of the profession as being meaningful to them in their work. The GPs had a particular focus on disease and illness and mentioned their personal family life more frequently than the other groups. The district nurses had a particular focus on palliative care, holistic care, wound care, working in partnership with patients and doing a good job. The nurse practitioners highlighted acceptance, recognition and respect and operating at a strategic level. In addition the nurse practitioners referred to the boundaries of their practice and being aware of the limits of their skills, something the other two groups did not mention at all. A number of categories were shared between groups, for example: the district nurses and GPs valued working with the family; the nurse practitioners did not mention this

spiritual and physical care of the patient; this contrasted with the GPs and nurse practitioners who tended to focus on the holistic nature of patient care to help them manage the patient's disease and illness effectively. The significance of the categories as representations of the varied value systems of the groups will be discussed further in chapter eight. At this point it is simply important to note that differences between the three groups were revealed in the categorical content analysis and this will contribute to our understanding of the three groups as different practices when they are viewed from a MacIntyrean perspective. The same can be said of the holistic content analysis to which we will now turn.

HOLISTIC CONTENT

The purpose of holistic content analysis is to determine the broad foci of an entire story. Lieblich et al. (1998) suggest that the holistic content can often be identified by the space devoted to the theme in the text, the detail with which the participant describes it and the repetitive nature of the theme. They suggest that there are no clear directions for proceeding with the analysis of holistic content, it simply relies on reading the material several times until a pattern emerges. It is likely that I will have formed a global impression of each narrative during and immediately after the interviews took place as the following excerpt from my reflective diary demonstrates:

As she was talking I was thinking that the same themes keep coming up – holistic care, completing episodes of care, palliative care (particularly the DNs) and wound care (again particularly the DNs).

In some cases I was building an impression before the interview took place:

I had to wait to interview X because he was in the middle of a teaching surgery. I saw him come into the waiting room and put his arm around an elderly gentleman who quite obviously had dementia and guided him into his surgery to have a discussion with his wife.

After transcribing the interviews and receiving feedback from the participants I was able to embark on the formal analysis of categorical content. As I worked through each transcript I identified the theme or themes that seemed to form the focus of the interview. I identified these themes by searching for issues that were raised

repeatedly or were associated with a level of emotion that revealed an issue as being important for a particular participant. In the majority of cases it was clear that there was one overarching theme and often it was the theme that the participant started with as the following two excerpts demonstrate:

GP 12 3-5

AC What is it that you find most meaningful in your work as a GP?

GP 12 (laughs) Wow. Seeing patients I suppose.

DN 8 18-22

What I find meaningful in my work (AC yes) well, particularly in the community as opposed to the hospital, it's being involved with the whole family (AC right) social nexus of the family the total care including the family friends and neighbours it's not just caring for the patient (AC uhum) I find that quite satisfying.

As I worked through the categorical content analysis I developed a list of things valued by each participant and at the top of the list I placed in bold the thing most valued by each participant. After working through the detail of all the categories identified by each participant I then left the transcripts for a while and returned to them later to carry out a further reading. On this occasion I read each transcript and wrote down what I thought the broad general foci of the transcript was. I then cross-checked this with the category identified in bold during the earlier stages of analysis. In the majority of cases the two impressions were consistent. In two cases I had been undecided during the first stage of the process and had identified more than one category in bold for these participants. For example DN 8 had “working with the whole family” and “learning and personal development” as two important categories and competing foci for her narrative. The subsequent reading of the transcript identified “working with the whole family” as the focus of the narrative and I therefore identified this as the holistic content. Table Five summarises the findings of the holistic content analysis.

Table Five: Holistic Content

PRACTICE	GPs	NURSE PRACTITIONERS	DISTRICT NURSES
1	Diagnosis	Challenge	Patient care
2	Providing a good service	Autonomy	Patient relationships
3	Clearly defined problems	Patient perspective	Working with the whole family
4	Contact with patients	Personal development	Control
5	Disease and illness	Personal achievement	Making a difference to patients
6	Diagnostic process with patients	Personal development	Patient satisfaction

An interesting feature here is the focus on personal achievement and development by the nurse practitioners, a focus on problem-solving and diagnosis by the GPs and a focus on patients with the district nurses. Another interesting feature is that there is an example of one participant in each of the groups who seems to differ from the rest of the participants in their group. I mentioned earlier that DN 10 seemed to be different in many ways from all of the other participants. Her transcript included some of the following excerpts:

DN 10 33-35

I do not like work I do not like work but I have never yet found a way that I could avoid working (AC right) in order to live.

DN 10 116-117

There is nothing that is very wonderful in that I get great satisfaction from this work because as I said earlier (AC mm) I do not like work.

DN 10 128-131

I do not see myself as the answer as a Florence Nightingale I do not because I don't like this image of nurses as angels (AC mm) because come five o'clock I'm not interested anymore (AC mm) I don't care anymore (AC mm) I'm paid to care.

DN 10 135-137

If I'm paid to do a job I will do it (AC mm) till five o'clock or whatever (AC mm) and then it's home time.

DN 10 346-351

One particular family I've been advised never ever to go in to by a

solicitor because whatever I do I put my work my career whatever you perceive it to be in jeopardy could do (AC mm) it perhaps would never be right. So management knew about it and it was arranged if I had to go in another nurse from another area would have to go in and I would have to go to her or his area (AC right) which I would quite willingly do (AC right mm) I can cope I can rise above things.

Interestingly when I interviewed the nurse practitioner who works with this particular district nurse she made the following completely unprompted statement:

NP 11 71-74

It was about one of the patients who has got metastatic disease not wanting one of the district nurses to go because he doesn't get on with them and it was how we were going to approach the district nurse team without offending them because it was the case holder that they didn't want in the house.

It would seem that DN 10 is not happy in her work and it would also appear that she has some significant problems in working with her client group in the community. None of the other participants described a view of their work or of their interactions with patients that would be congruent with this nurse who states that she does not care beyond five o'clock and has been advised by a solicitor not to go into a particular patient's house.

GP 12 appears to differ from the rest of the GP group in his focus on patient relationships. He mentioned patients repeatedly throughout his narrative and when he focused on other issues such as access in general practice, he did so in order to emphasise the inconvenience for patients. I referred to GP 12's Christianity on page 121 and identified this as a unique feature of his transcript. This may, in part, explain the difference in the holistic content of his narrative. Alternatively, it could be suggested that such a difference simply demonstrates a certain level of heterogeneity within the GP group.

GP 6 also appears to differ from the remainder of the GP group. His holistic content focused on providing a good service and doing a good job. He mentioned these issues on a number of occasions and it therefore seemed appropriate to use this label for the holistic content of his narrative. The following, rather lengthy, excerpt from his transcript perhaps demonstrates that providing a good service does not

depart significantly from the remainder of the GPs' perspectives:

GP 6 15-30

Doing a good job when I feel that on a more difficult case I've come up with a diagnosis when I feel that I've helped my patients through a difficult time. I mean I think doing a good job is a very sort of nebulous thing that you can only really get from gut feelings (AC mm) I mean we all go through surgeries when we get to the end of the surgery and we think oh my god that was a nightmare god knows what was going on in you know three quarters of those cases (AC mm). Other times you go through surgeries where you know you feel you interact well with the patients you feel that you are being useful to the vast majority of them (AC uhum) and it's overall very satisfying and you haven't had too much time pressure and stress (AC mm) and feel you've not kept people waiting and all the rest of it (AC mm) these things are very nebulous how else doing a good job? I mean I feel also that I try and practice very much evidence-based medicine ... (AC mm) if I'm able to apply evidence-based medicine and practice evidence-based medicine during a surgery then I feel that I have been doing my job properly (AC mm) and I get some satisfaction out of that.

GP 6 feels that he is offering a good service when he can use evidence-based medicine, when he can come up with a diagnosis and he refers to nightmare surgeries full of nebulous cases. He also feels he has offered a good service when he has helped someone through a difficult time in their lives, when he has not kept people waiting and when he has been useful to his patients. It is the focus on doing his job properly and being useful to people that led to the label of "offering a good service" rather than "diagnostic process" but it could be argued that this is quite congruent with the remainder of the GP group.

The nurse practitioners mostly focused on personal development and achievement with the exception of NP 7 whose whole transcript focuses on the patient perspective almost to the exclusion of anything else. I have mentioned earlier that NP 7 differed in some ways to the rest of the nurse practitioner group and that she may not be fully engaged in the nurse practitioner role in her current place of practice (see page 145).

GP 6, NP 7, GP 12 and DN 10 provide examples of departures from what otherwise seems to be three homogeneous groups of practitioners who have focused on broadly similar issues in their narratives. It is interesting to note not only the

homogeneity within the groups but also the diversity between the groups when holistic content is examined. The significance of these findings will be addressed in a discussion of the findings in chapter eight.

Summary: a tale of shared values? The content

This chapter has utilised a wide range of excerpts from the transcripts and transcript summaries of the participants of this study to demonstrate the diversity of issues that were covered in the interviews. By contextualising each category it is apparent that the issues raised mean different things to different individuals. In the categorical content analysis it was the examination of the participants' meanings that revealed the differences between the groups and in some situations the similarities between the groups. In the holistic content analysis an overview of the broad focus of each narrative revealed a general consensus within the groups and significant differences between the three groups.

In many ways the findings of the categorical content analysis are congruent with the holistic content analysis. In the holistic content analysis: the nurse practitioners seemed to focus on personal achievement and personal development; the district nurses seemed to focus on patient care and patient relationships; and the GPs seemed to focus on the diagnostic process and disease and illness. In both of the analytic steps presented in this chapter a number of departures from the general consensus have been identified and some possible explanations have been put forward in each of these cases. As the analysis progresses, it will be revealed that a small number of narratives are significantly different from the remainder of the group. These narratives will be identified as being "outliers" and their difference will inform the subsequent analysis. The way in which the participants told their stories adds an important dimension to the analysis of the narratives. The analysis of form is the focus of the following chapter.

CHAPTER SEVEN

A TALE OF SHARED VALUES? THE FORM OF THE NARRATIVES

Introduction

Lieblich et al. (1998) suggest that the formal structure of a narrative can reveal a participant's personal construction of his or her life experience and therefore can reveal their values, perceptions and identity. Shotter and Gergen (1989) state that identities are created both textually and linguistically. They go on to say that "persons are largely ascribed identities according to the manner of their embedding within a discourse – in their own or in the discourses of others" (1989 p.ix). The analysis of the form of the narrative focuses on both the structure of the text and the language used. The purpose of this step in the research is to reveal meaning in the narratives that goes beyond the content and what was said. Lieblich et al. (1998) suggest two approaches to the analysis of form: holistic form and categorical form.

HOLISTIC FORM

The goal of analysis of holistic form is to examine the structure of the narratives. In the present study I felt that holistic analysis of form would contribute to an understanding of whether or not the participants valued their roles. Hence, this stage of the analysis is not exploring the particular issues raised by the participants or searching for particular themes, rather, the aim is to gain a general perspective on whether the participants were generally positive, negative or neither positive or negative about their work. An example of this approach to the analysis of narrative is Frank (1995) in his work with illness stories. He proposed three types of illness narratives: the restitution narrative, the quest narrative, and the chaos narrative. Each of these narratives has a particular type of plot. In presenting these three types of plot Frank points out that he does not wish to suggest that a particular narrative is wholly one type or another. He warns that such an approach could result in yet "another 'general unifying view' that subsumes the particularity of the individual experience" (1995 p.76). Nonetheless, the advantage of viewing the transcripts with general types in mind encourages the reader to pay closer attention to the narratives. Frank suggests that this aids listening to (in his work) the stories of the ill. A further example of this approach is Sparkes' (2004) analysis of the Lance Armstrong story. Sparkes points out that in any illness narrative, all three types of plot can be present

with one particular type being dominant before fading away as another type moves to the fore. As holistic form analysis can add to the complexity of the findings in narrative studies, I decided to engage with this approach using the methods described by Lieblich et al. (1998).

The method

The first stage of this process was to read each transcript in detail identifying the structure of the plot. The content of the narrative was only important insofar as it provided the raw material for the structure. Lieblich et al. (1998) state that the progression of the narrative can be identified in three basic formats. The three formats relate to the development of the plot over time. In the “progressive” narrative the story advances steadily, in the “regressive” narrative there is a decline or deterioration in the narrative and in the “stable” narrative the plot is steady and does not change over time (Lieblich et al., 1998 p.89). The three formats can be combined to reflect the complexity of a story over time. The detailed reading of the transcripts allowed me to identify what Lieblich et al. refer to as the “axis” of each stage of the narrative. If the structure was generally positive, developmental or progressive, the narrative could be identified as moving in an upward or positive direction. If the structure around the themes was generally negative, destructive or regressive then the narrative could be identified as moving in a downward or negative direction. An example of a positive section of narrative would be the following:

NP 1 341-353

So I'm very fortunate I've done lots and lots of different things and hopefully I'll be able to retire although they might not let me retire might they not? (both laugh) Hopefully I'll be retiring in four years after this and if it carries on like this until the end I'll feel really fortunate (AC mm) that I'll be ending what has been a great career to me (AC mm) love doing this work only doing this sort of thing because it's new (AC mm) and modern (AC mm) and challenging and you know it's at the front isn't it at the cutting edge of nursing ... yes I just feel really privileged.

This excerpt from the transcript of NP 1 is clearly positive, words such as “fortunate”, “great career” and “really privileged” provide clues to the progressive and positive nature of this section of transcript. Examples of negative sections of narrative are the following from GP 2:

GP 2 146

I keep thinking about all the things I don't enjoy.

GP 2 164-166

Well I particularly don't enjoy all the computer work checking of blood results (AC yes) checking that people have reached targets etcetera (AC mm) I'm not interested in that at all I'm afraid (AC mm so all the data) all the data.

GP 2 186-188

I've already said that we don't have enough time (AC mm) to do things properly. (pause) I don't like all the paperwork we have to do (AC mm) I don't like writing reports and filling in forms (AC right) I'm not very interested in that.

Clearly when GP 2 states that she keeps thinking about all the things she does not enjoy, this provides some evidence of the overall negative nature of this narrative. At the outset of the narrative, GP 2 had difficulty answering the question “What do you find meaningful in your work as a GP?” She stated that she did not like the word “meaningful” and struggled to find anything positive to say in response. She went on later in the narrative to outline the number of things that she did not enjoy and these sections of narrative were identified as negative, regressive and moving in a downward direction.

Lieblich et al. (1998) suggest that holistic analysis can be enhanced by the sensitivity of the researcher to the degree of emotion expressed in an interview. I therefore referred back to my reflective diary and made a note of events such as NP 1 becoming tearful at one stage during the interview and these were tears of joy and love. Conversely, GP 2 almost refused to sign the consent form and then, as mentioned earlier (in chapter five), made 142 alterations to the transcript and three alterations to the transcript summary. In her transcript summary check GP 2 stated:

I was not happy for my incoherent inarticulate responses to your questions to be left unedited. So I have amended the transcript so that it now makes sense.

The majority of the alterations amounted to the deletion of repeated words and utterances such as “ums” and “ers” and the deletion of words that were tentative such

as changing “I think I find....” to “ I find....”. This general disapproval of what had been written seemed to fit with the generally negative nature of this GP’s narrative. Taking into account the overall structure of the narratives alongside recollections from my diary, I was able to form a general holistic impression of each narrative and subsequently identified NP 1 as being on a generally positive trajectory and GP 2 on a generally negative trajectory.

There were some sections of narrative that combined both progressive and regressive plots in very rapid succession. Overall such a sequence would level out as being neither positive nor negative as the following example from GP 9 shows:

GP 9 537-548

... does that sound really depressing? (AC laughs no it doesn't) I don't think it should be because it's not it's not it's pragmatic isn't it? You just can't do everything anymore (AC sure) and now that we've got our touch wood we've got a very good practice manager we've got really nice staff we're quite stable from that point of view (AC mm) we have a dispensary the staff are great and they run a really nice show (AC mm) we're lucky same bunch as you've got we've basically got nice patients easy to deal with very appreciative a cross word is unusual and usually provokes a letter from one of us saying don't be cross again you know we're not wallowing in deprivation and (AC no) and drugs and alcohol (AC mm) we're not we're really not you know so yeah we're very fortunate (AC mm) our life is easy but from another point of view it is difficult.

This section of narrative is preceded by GP 9 describing himself as being short-fused and hassled which could be considered to be somewhat depressing (as he identifies himself at the start of this section of narrative). He then moves on to describe himself as “pragmatic” then “lucky”, then “fortunate”, and then “difficult”. Previously this same GP had described being at the “whim of people’s idiosyncrasies” and went on to say that “I dislike intensely staffing issues”. There are a whole host of messages in this narrative and it is my impression that it could be described as being in some ways negative, in some ways positive, but overall neither predominantly positive nor negative.

What I was searching for was the predominating type at a particular moment in each narrative. Even though the graph of the narrative progresses up and down

according to the focus at any one particular time, it also has an overall trajectory that is either up (positive), down (negative) or neutral (evidence of being both positive and negative) over the course of the transcript. I decided to use the word “neutral” rather than “steady” as those narratives that were both positive and negative were often oscillating quite dramatically in places and “steady” does not provide an adequate description for this rapid change of direction. It is important to emphasise here that the angle of the graphs, the height of the lines and the shape of the movements in one direction or another are in no way quantifiable. The graphs are schematic and illustrative and their purpose is to provide a visual image of each narrative representing the general progression of the plot in either a progressive, regressive or neutral trajectory. This will enable comparisons between structural graphs to provide a different perspective on the narratives in this study. Lieblich et al. (1998) suggest that this also allows the researcher to search for the common denominators between those graphs that have similar structures.

Examples of graphs that were produced in this first stage of the analysis for the three narratives mentioned above are presented below:

Figure One: NP 1 Positive

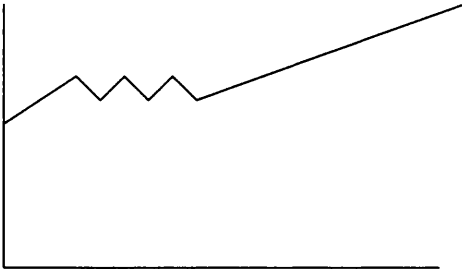


Figure Two: GP 2 Negative

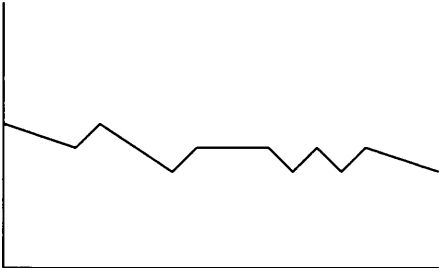
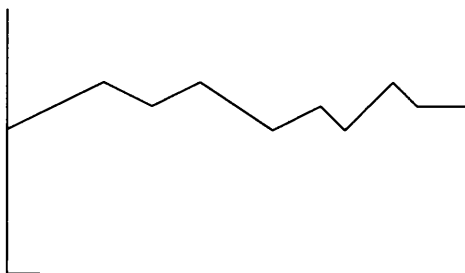


Figure Three: GP 9 Neutral



Holistic form according to group

Having developed a chart for each narrative I was then able to group the narratives together and to develop a prototypical graph for each of the three groups. I did this by examining all of the charts for each group and deciding whether they were generally positive, negative or neutral. Clearly each narrative was unique and followed a complex pattern of positive and negative forms, however it was possible to gain a general impression and to decide upon the overall trajectory for each narrative. The holistic form of each narrative is summarised in Table Six:

Table Six: Holistic Form

PRACTICE	GPs		NURSE PRACTITIONERS		DISTRICT NURSES	
1	Negative	GP 2	Positive	NP 1	Neutral	DN 3
2	Positive	GP 6	Positive	NP 4	Positive	DN 5
3	Neutral	GP 9	Positive	NP 7	Positive	DN 8
4	Positive	GP 12	Positive	NP 11	Negative	DN 10
5	Positive	GP 15	Positive	NP 14	Positive	DN 13
6	Neutral	GP 17	Positive	NP 16	Positive	DN 18

Having identified the overall holistic form for each narrative it was then possible to develop a prototypical graph for each of the three groups of participants. The GP narratives consisted of: one that was negative, two that were neutral and three that were generally positive. The nurse practitioners were all generally positive and the district nurses' narratives consisted of: one negative, one neutral and four generally positive. The difference between the three groups represented in the form of prototypical graphs can be seen below:

Figure Four: Prototypical Graph GPs

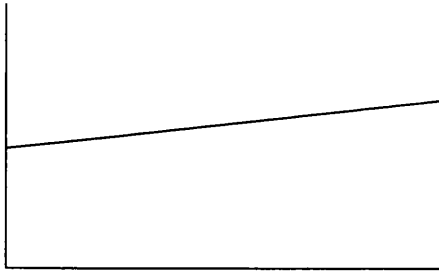


Figure Five: Prototypical Graph Nurse Practitioners

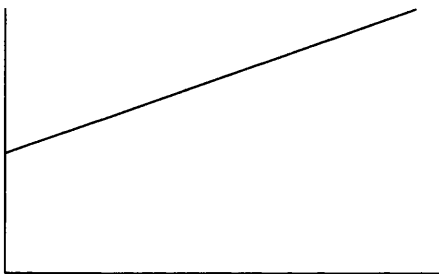
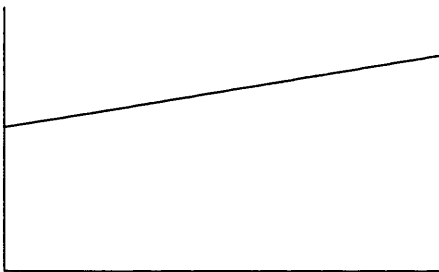


Figure Six: Prototypical Graph District Nurses



Given the opening question of the interview “What do you find meaningful in your work?” one might have expected that the interviews would be generally positive and this is reflected in the generally positive trajectories of all of the three groups. This question invited people to describe what they enjoy and what makes them feel satisfied about their work. It is therefore perhaps surprising to find that there were two generally negative transcripts, one GP and one district nurse. The significance of these two transcripts as being deviant from the rest of the group will be addressed in some detail in chapter eight.

Commonalities in shared trajectories

Lieblich et al. (1998) suggest that it is possible to identify commonalities in the narratives that share similar trajectories. Thirteen of the eighteen narratives were generally positive and a common feature was the value placed on working in the community or in primary care as opposed to working within the constraints of the hospital setting. The participants of this study seemed to suggest that they would be unable to work autonomously or be able to take a holistic view of the patient if they were working within the organisational structure associated with secondary care. Indeed, they suggested that primary care allows people to work autonomously and to take a holistic view of the patient. Work in the community was described by one district nurse as a “ward without walls” which perhaps sums up literally and metaphorically the view of primary care held by the participants of this study.

It is interesting to note that all of the nurse practitioners’ narratives were positive. In chapter six I suggested that the narratives would reveal something of the selves of the participants. The analysis of holistic content indicated that the nurse practitioners were focused on their personal achievement, their autonomy and personal development. It is perhaps not surprising, then, to find that the participants who described personal fulfilment in their roles were generally satisfied, positive and progressive.

Three of the narratives were neither wholly positive nor wholly negative. DN 3 described some overall dissatisfaction with her role. She repeatedly stated that she would have preferred to remain intimately involved with patient care and her current team leader role prevented her from being with patients for the majority of the time:

DN 3 18-28

There’s obviously much more management (AC right) for team leaders a larger proportion of my day is spent actually in the office (AC right) which is not is probably not really what I most enjoy (AC mm) (both laugh) (AC right) ... probably the percentage of management to actual going out doing patient visits (AC uhum) and actual sort of on the ground hands on sort of work has changed quite dramatically (AC right) and I preferred the emphasis being maybe fifty fifty or something but now it’s almost it can be ninety per cent office and ten per cent patient contact but that’s the way nursing’s gone.

Having discussed how much she enjoys working with patients she went on to contradict herself later and said:

DN 3 264-267

I probably having gone back on what I said earlier I probably couldn't do eight visits a day I mean I couldn't (AC right) perhaps be a Macmillan nurse maybe at the end of the week that could be a bit (AC mm) exhausting (laughs).

The following excerpt demonstrates how she oscillated between the two perspectives in quite quick succession:

DN 3 373-392

I would think being a sort of staff grade nurse from a pure day to day (AC uhum) probably is much more satisfying because you're going out you're just doing your job and you're not involved with all the admin. (AC right) Having said that you do sort of evolve don't you and probably I would feel very frustrated (laughs) (AC If you were in that role) yeah I probably would. It's nice to sort of think wouldn't it be nice to go out do as you're told go off finish at the end of the day (AC uhum) don't have all this extra admin to do just do your you know the admin concerned with your actual daily visits all your daily work (AC mm) and then not have all this extra sort of management type stuff that would be quite nice but on the other hand maybe maybe that's too easy.

GP 17 also revealed a certain ambivalence about his role:

GP 17 5-11

The actual patient care is probably the most important bit. I would enjoy the actual management of the practice if that was my job that bit 'cause there's so little time to do it all being squeezed in than the sort of sitting back organising a practice population like diabetes going through it all sorting that out which I would find very satisfactory it's just an add on lump that doesn't get done (AC mm) and it's that erodes the job satisfaction but basically the bottom line is patient care (AC mm) I do enjoy it when I have to do it.

There are mixed messages in this excerpt: "I would find very satisfactory" (if I had time to do it) and "I do enjoy it" (when I have to do it). Again there appears to be a general level of dissatisfaction with the practicality of his role which does not appear to meet with his expectations. The mixed messages associated with the transcript of GP 9 were highlighted earlier (see page 170). For each of the three participants who have neutral narratives there seemed to be a mismatch between their personal values and the way in which they could enact those values in their current roles. In the cases of GP 17 and DN 3 it seemed that there was a lack of clarity on their part regarding

their personal values. GP 9 seemed very clear in expressing his values but there was a tension associated with what he valued and how he was able to enact those values within the organisation within which he worked. Altun (2002) suggested that a mismatch between personal values and work place values could cause burnout in nurses. Whilst there is no suggestion that the participants who have either negative or neutral narratives are burnt out, it would appear that there could be a link between regressive, destructive or negative narratives and a tension between personal and role related values in the workplace.

A further interesting observation is that none of the narratives that were identified as being neutral mentioned contribution to the development of their profession as being meaningful to them. The same can be said of GP 2, one of the negative narratives. The second negative narrative is DN 10 and she did mention the satisfaction she gains from acting as a mentor to students but she added this when she amended the transcript summary and there was also one fleeting reference to education in her transcript:

DN 10 26-27

I see myself as an educator not just for student nurses and specialist practitioners but to educate the carers and the public.

All of the remaining participants referred to the development of their profession as being meaningful to them in some way. There appears to be a link here between the trajectory of the narrative and the participants' view of their contribution to their profession. Participants with a positive trajectory seem to value their roles and the way in which they can contribute to their profession and those with a negative or neutral trajectory do not seem to find meaning in contributing to the wider professional community. I will return to this finding when the nature of practices is examined further in chapter eight.

Summary: holistic form

The analysis of holistic form has demonstrated that the generalised trajectories of the transcripts revealed differences between the individual narratives of the participants. It was also possible to identify commonalities in the narratives of those transcripts that had similar trajectories. The positive trajectory of the nurse practitioner

narratives could be associated with the focus on personal development discovered in the holistic content analysis. The negative and neutral narratives were associated with those participants who seemed to describe tensions between their personal values and the values associated with their work role. In addition, those participants who had generally negative or neutral narratives did not appear to find meaning in contributing to the development of their profession. Lieblich et al. (1998) suggest that the analysis of holistic form is a key to understanding the personality of the narrator of a story. They state that this provides a deeper level of understanding than that which can be gleaned from the contents of the transcript because the form of a narrative is less likely to be affected by intentional falsification. The analysis of holistic form has enriched my understanding of the narratives and is congruent with the messages from the categorical content and holistic content analysis conducted thus far. Each analytic approach has revealed a different perspective from which to view the narratives. None of the approaches alone is as productive as the combination of the methods of analysis for developing a rich understanding of the transcripts (Lieblich et al., 1998). I will now turn to the fourth and final approach, the analysis of categorical form.

CATEGORICAL FORM

Sparkes (2004) suggests that each individual has a number of narrative resources available to them in a given cultural setting. Each person has a narrative repertoire that is based on developmental opportunities and personal history. Shotter (1989) suggests that we are socially disciplined to give accounts of ourselves in certain ways and that only particular ways of talking are deemed to be legitimate. Such socially established forms of communication not only constrain our language but they also restrict our understanding of ourselves and of the world around us. The structure of language forms the basis of categorical form analysis. Lieblich et al. (1998) suggest that analysis of categorical form might reveal something about the participants that had not otherwise been apparent. They state that this analytic approach is based on the assumption that the manner in which narratives are told in some ways reflect the participants' thought processes. These thought processes can be revealed by searching for examples of categorical form such as generalisations, use of concrete or abstract concepts or use of criticisms and evaluative statements.

I returned to the transcripts once again and read through each one with a focus on searching for examples of categorical form. At this stage I was using the approach, advocated by Holstein and Gubrium (2000), of bracketing the *what* of the stories to focus on the *how*. I had to remain aware of the difficulty, highlighted by Shotter (1989), that my own history and developmental opportunities would be shaping my view of the narratives and I also had to remain sensitive to the way in which my presence in the interviews could have shaped the data (Hammersley and Atkinson, 1995). The examination of categorical form in this study revealed striking and important differences between the groups in the use of storytelling. Other differences were found in the use of the first person versus second person narrative and in the use of pioneering language.

Storytelling

Up to this point I have been using the term “narrative” to describe the general discourse that took place between the participants and the interviewer. This is an example of the use of the term “narrative” in its broadest sense. In contrast “storytelling” is an example of narrative grounded in concrete situations (Frid et al., 2000) which tends to be a description of a specific situation (McCance et al., 2001) involving events, characters and settings (Toolan, 2001) that are placed within a plot that has a beginning, a middle, and an end (Kerby, 1991). Frid et al. (2000) point out that the etymology of the terms “narrative” and “story” differ as narrative comes from the Latin “gnarus” and story stems from history in French, Latin and Greek. A person’s narration creates narrative and from narrative a plot may be constructed (Frid et al., 2000). The plot constructed from a narrative is different to the examples of stories that can be found within the narration. In this study a particular feature of the narratives was the division between the doctors and the nurses in examples of the use of concrete symbols in the form of storytelling as opposed to the use of abstract concepts in the form of general examples and ideas. Examples of these stories are listed in the excerpts from the transcripts below:

DN 8 23-25

... for instance yesterday a lady who has just come on our books who's she's palliative really she said "I just want to thank you (AC mm) because you really make a difference".

NP 16 55-58

I've got gentleman who lives out in the wilds and he's had a cerebrovascular accident bless him and he can't get in he's got no family (AC mm) and I go and visit him look after him so he's not missed really (AC right) and he gets the same care as everybody else.

NP 14 88-91

Only the other day somebody came through and essentially it looked as if she was coming about her chest the whole of the first ten minutes was about her chest and then we got onto "so what impact is it having on your life?" And actually the reason she had come was the stress incontinence.

This contrasted with the GPs who used examples of situations in their narratives but these examples were presented in more abstract forms:

GP 12 98-103

The ones who want to come about their chronic disease processes or their long term mental health things it becomes increasingly difficult for them to plan any sort of follow up. (AC mm) So there's then the half past eight in the morning telephone lottery (AC mm) can you ring up and get your appointment made for that day or the next day is it a day when doctor X's on duty taking the telephone calls because I want to see him.

GP 9 555-561

You ask them to see someone with a cut head they're coming down could you see it for me. You are invariably asked to see it (AC right) you know because they are not confident or they don't want to take on that responsibility. (AC yes) It's a cut head it's not rocket science this you know most mums will deal with a cut head but it's a mind set (AC yes) you know I don't have to take responsibility for this so why should I? (AC mm) I look at it and straight away say that's fine strip it put a bandage on it whatever.

Table Seven summarises this finding:

Table Seven: Comparison of the Use of Storytelling in the Narratives

PRACTICE	GPs	NURSE PRACTITIONERS	DISTRICT NURSES
1			Evidence of stories
2		Evidence of stories	
3		Evidence of stories	Evidence of stories
4		Evidence of stories	Evidence of stories
5		Evidence of stories	Evidence of stories
6		Evidence of stories	Evidence of stories

Rosenwald states that “when people tell stories they do so in accordance with models of intelligibility specific to the culture” (1992 p.265). Langellier and Peterson examined the use of storytelling in families and in a similar vein to Rosenwald they stated that:

... family storytelling describes a multileveled strategic process constrained by social and historical conditions, oriented by a variety of narrative means and structures, framed by the interactional dynamics of telling and audiencing, and punctuated by particular choices and actions (1993 p.73).

Langellier and Peterson describe both the way in which the stories that are told are framed in the context of history and culture and the way in which storytelling can be used for a purpose. They point out that a story needs an audience and that it is shaped by the choices of the teller of the tale. In the present study the participants were the storytellers and at the time of the interviews I was their audience. I am also a nurse practitioner and therefore the participants would have framed their stories according to the telling of the tale to someone who understood the language of health care. An example from the transcript of DN 3 illustrates this point:

DN 3 74-78

... but I think those of us that have been around for a few years (both laugh) actually we went in to sort of bath people and make them more comfortable (AC mm) and you know just sort of basic care.

DN 3’s intonation when she referred to “those of us who have been around for a few years” included me as a nurse who had been in nursing for some time which is why we both laughed. In addition to the immediate impact of myself being present in the interview room with the participants, the more subtle influences of culture and history were evident in the narratives.

Lieblich et al. (1998) would suggest that the use of storytelling is an example of the use of concrete forms of communication as opposed to abstract forms. They suggest that the abstract form of communication is an example of “advanced” thinking as opposed to concrete forms that are less advanced (1998 p.145). They also suggest that the ability to move freely between abstract and concrete forms of communication is an example of a high level of cognitive development.

The suggestion of Liebllich et al. (1998) could lead one to suppose that the use of concrete language on the part of the nurses demonstrates that their thinking is less developed than that of the GPs. There are, however, examples of the nurses moving freely from abstract communication to concrete communication when they have used a story to illustrate a point:

NP 7 12-22

I suppose I'd feel you start by ensuring that they understand what the problem is (AC aha) and then getting their perception of it. So for instance diabetes (AC yes) I had a guy this morning and just told him he is diabetic after doing a glucose tolerance test (AC right) so what do you already know, establishing what they already know and believe (AC uhum) and his first thing is "I'm not going to be on insulin am I?" (AC mm) Which is so you're the getting to know what their beliefs are and then helping them to adjust in some ways giving bad news but in other ways in giving good news you know it's very not mild diabetes but early (AC mm) we caught it early so the chances are much better and trying to get them to take ownership of it. (AC right) (pause) I suppose you see I see myself as a facilitator to them (AC uhum) and that's what I find rewarding.

DN 18 334-345

I think the other area of frustration while I'm thinking about it is the abuse of the system again it's not that can be I've found it mainly in this area more than in cities where I've worked. This is an area where a hairdresser in the clinic it would be fine (both laugh) you see what I mean? (AC yes) Because they're more than happy to go to the hairdresser but they can't come to us (AC right) we have to go to them or when we say can we come on Thursday "Oh I'm going to the hairdresser that day you'll have to come later." (AC right) One of my nurses this morning was met by "I'm for a late call this afternoon" as the lady got in the car and drove away to the hairdressers (AC mm) and that's an abuse of the system (AC mm) but it's very difficult here because they're they do sort of they're of an age group that they expect that the nurse will call (AC right) and again that is something that we're working on it's something that we need to sort out (AC mm) it's doing it gently isn't it?

The two excerpts above demonstrate the ways in which the nurses used stories to illustrate abstract ideas and thoughts. They would move freely from one form of narrative to another. If Liebllich et al. (1998) suggest that transitioning from concrete to abstract ideas provides evidence of the participants' ability to work at higher cognitive levels, it is perhaps too simplistic to suggest that the only explanation for the difference in the use of the storytelling between nurses and doctors is that the

doctors are able to work at higher levels of thinking than the nurses.

Rosenwald suggests that any event in a life can be better understood if we “recognise earlier moments surviving and resonating within it” (1992 p.272). A different explanation for the use of storytelling therefore might be that this method of communication is a product of nursing and medical history embedded in the culture of the two professions. Langellier and Peterson (1993) describe storytelling as discursive practice that produces familial culture. The same could be suggested of nursing culture or medical culture. The nursing handover is a ritual that has been present in nursing for decades with formal evaluative research on the subject being present in the nursing literature for the last twenty years (Richard, 1988; Sexton et al., 2004). In contrast, doctors tend to be socialised into a method of communication which is either in the written form, as they write up the patient’s case notes, or in the verbal form as they present the case history to their colleagues. There is a recognised format for presenting case histories amongst doctors (Finsterer, 2002) which tends to be focused on the disease or illness rather than on the patient themselves. The examples of storytelling in the current study are possibly reflections of the socialisation process in nursing and medicine where the two groups have learnt to speak in particular ways, nurses telling stories about patients and doctors talking in more abstract ways to convey their message. There is a long history of such discursive practice in the two professions and it is therefore perhaps not surprising to find such a striking difference in the categorical content of the two groups.

In addition to the historical and cultural influences upon the modes of communication of doctors and nurses, telling stories may have other advantages for the nurses who choose to use this approach. Witten (1993) suggests that a well constructed narrative tends to emotionally involve both the storyteller and the listener, it tends to provoke attention and engagement in the story. Thus narrative discourse tends to be strongly persuasive and the assertions made are often masked from examination and challenge. This contrasts with case histories that tend to be free of emotional language. Witten (1993) states that stories are often more persuasive than statistics in generating belief in the listener. Indeed Lillian Wald, who is credited with the foundation of school nursing in the United States in the early 1900s, was reported to have said that when she was approaching various dignitaries

for funding she would always use a story from her work in the settlements because she realised that these stories were far more effective than any amount of statistics and figures (Wald, 1915; Wald, 1934). The nature of narrative discourse is that it is based on emotionally compelling language that tends to prevent any critical response from the listener with the result that truth claims that are implicit in the story often go unchallenged. Hence there is value in using the genre of storytelling in communicating messages to others. Stories are interesting, compelling and emotionally engaging and they tend to be persuasive and go unchallenged. On the other hand, the case study eliminates emotion and it tends to be presented as a scientific evidence based report.

It is interesting to reflect back on the findings of Uden et al. (1992) who explored ethically difficult care episodes in nursing and medicine. The authors found that the physicians appeared to focus on the ethics of justice and the nurses on the ethics of care. Lindseth et al. (1994) developed this work further and they found the physicians and nurses demonstrated different cognitive styles and different types of rationality. They suggested that nurses tend to have a praxis perspective and the physicians a poiesis perspective. Nurses tended to refer to their personal experience of giving care and the physicians referred to science and proven experience. The categorical content of the narratives presented in this study support the view of a praxis perspective in nursing as the nurses provided stories of patients to illustrate their ideas and a poiesis perspective in medicine as the doctors illustrated their narratives with abstract examples and ideas and never used direct stories to convey their message.

First person versus second person narrative

Like the issue of storytelling, the use of first person or second person narrative was a categorical form that seemed to differ between the groups of participants. This idea gradually emerged as I worked through the reading and rereading of the transcripts. I then decided to read each transcript and to write down my general impression as to whether the narrative was mostly in the first person or second person. This was based on a broad general impression and an awareness of the frequency with which the participants used the words “I”, “you” or “we” during the interviews. Table Eight summarises these findings:

Table Eight: Comparison of the Use of First Person or Second Person Narrative

PRACTICE	GP		NURSE PRACTITIONER		DISTRICT NURSE	
1	1 st / 2 nd	GP2	1 st	NP 1	1 st	DN 3
2	1 st	GP6	1 st	NP 4	2 nd	DN 5
3	1 st	GP9	1 st / 2 nd	NP 7	1 st / 2 nd	DN 8
4	1 st / 2 nd	GP12	1 st / 2 nd	NP 11	1 st	DN 10
5	1 st	GP15	1 st	NP 14	1 st / 2 nd	DN 13
6	1 st / 2 nd	GP17	1 st	NP 16	1 st / 2 nd	DN 18

There seemed to be a greater emphasis on first person narrative in the transcripts of the nurse practitioners and GPs and more of an emphasis on second person narratives in the transcripts of the district nurses. The use of first or second person could be to do with the personal attributes of the speaker, an individual style of speech or it could be related to the topic of discussion in a particular interview, nevertheless it is interesting to note that the narrative style of the participants is in a number of ways congruent with findings elsewhere in this study. The nurse practitioner from the third practice (NP 7) seemed to use the second person narrative form as frequently as the first person form. This is perhaps congruent with the description of her role on page 145 where it seemed that she was not fully engaged with the nurse practitioner role and seemed to be closely associated with the district nurses in many of her responses in the interview. The district nurse from the second practice (DN 5) used the second person narrative throughout most of her interview. The reader is reminded that DN 5 was the nurse whose interview was conducted in the coffee room. It is possible that the lack of privacy in the surroundings of the interview with DN 5 resulted in her using less personal language than she might have otherwise done in other surroundings. Indeed Shotter states:

... if our ways of talking are constrained in any way – if, for instance, only certain ways of talking are considered legitimate and not others – then our understanding, and apparently our experience of ourselves, will be constrained also (1989 p.141).

Shotter suggests that the majority of everyday communication is constrained by the social order; our language gives outer expression to our inner thoughts and other persons interpret the language used as an indicator of future actions. Earnest (1992) suggests the same stating that social forces impose certain contents upon individuals

and therefore they shape and constrain reflective dialogue. Hence language is not merely an expression of that which is prior in the person. Shotter (1989) suggests that our talk is the product of a certain dominant social ordering and he refers to Wittgenstein who emphasised the function of language being to create and sustain social orders.

The significance of the use of the word “I” (and hence first person narrative) is that it is associated with clear statements about oneself:

NP 11 57-58

... and if I'm not clear about that then I'll go and discuss it with one of the GPs.

GP 6 101-103

Yeah like in my morning surgery I'll put four spaces in (AC right) I'll see the same number of people (AC I see) but I'll start earlier and I'll finish later (AC right) just that I feel more comfortable doing that.

Such statements contrast with the second person narratives of the district nurses:

DN 18 5-8

I suppose patient satisfaction really achieving and that covers a variety of things whether it's satisfaction in as much as you've healed a wound or whether it's purely making them comfortable if you're dealing with palliative care you know a whole range of things.

Harré suggests that “I” is a word that has a role in conversation that is not referential, it has a form of life that is “not a kind of hidden cognitive engine” (1989 p.26).

Shotter (1989) suggests that exchanges between “I” and “you” tend to be to do with who has responsibility for what activity. “I” is the active agent, “I” tends to take responsibility. “You” is associated with a person other than oneself and is a way of deflecting responsibility. Use of the word “you” means that the speaker does not have to own the statement made whereas a statement that includes the word “I” is a declaration of that person’s position on a matter and the statement becomes owned by that person. It is therefore interesting to note the frequency with which the nurse practitioners used the word “I”. This is perhaps not a surprising finding given that the findings of the categorical content analysis revealed a focus on personal achievement, personal development and autonomy in the transcripts of the nurse practitioners. Perhaps the more surprising finding is that one of the groups of

participants seemed to use the second person narrative form more predominantly than the other groups. Given that the question was: “What do you find most meaningful in your work as a district nurse?” one might have expected to find many more “I” statements in their responses in comparison to “you” or “we”. The use of “I” statements represents people who are prepared to make clear statements about who they are and what they feel and are prepared to take responsibility for those statements. This group of people could be described as the dominant group. The use of “you” statements tend to be associated with people who prefer to defer responsibility and do not want to take ownership of their statements. This group of people could be described as the less dominant group. The findings that were presented earlier in relation to the views of the participants on teams suggest that a hierarchy does exist in the primary health care team where the GP is dominant, and the district nurse and nurse practitioner are less dominant. This may go some way to explaining the variation in the use of “I”, “you” and “we” between these groups of practitioners with the nurse practitioners’ use of “I” being explained by their holistic content and the focus on self.

Linguistic researchers would examine the transcripts of the narratives of this study in intricate detail taking into account the length of pauses, the intonations of speech and so on. All I would like to claim here is that there seems to be a difference in the use of the first person and second person between the three groups of participants and that this could be indicative of social constraints, historical context, cultural referents and some of the emotional and psychological components of the participants’ stories. I have also identified other broad examples of differences in categorical form including storytelling, as discussed earlier, and pioneering language to which I will now turn.

Pioneering language

A feature of the nurse practitioner transcripts that did not appear to be evident in the transcripts of the other participants was the use of what I have termed, “pioneering language”. By pioneering language I mean the use of references to being at the “forefront of nursing”, “paving the way for others”, “shaping the future” and “new ways of working”. The following excerpts are examples of the nurse practitioners’ use of pioneering language:

NP 1 344-350

I'll be ending what has been a great career to me (AC mm) lovely love doing this work only doing this sort of thing because it's new (AC mm) and modern (AC mm) and challenging and you know it's at the front isn't it at the cutting edge of nursing (AC yes aha) and with change everybody changing NHS changing and the way we working and everything it's a new role to deal with (AC uhum) new policies and new ways.

NP 11 137-140

I like the fact that I think we're leading the way forward for nurses and I feel it's like I said to you before I wish I was ten years younger because I just think we're on the brink (AC mm) of something better (AC mm) and if I worked until I was seventy I would never be out of work (AC mm) and it's exciting for me.

NP 14 203-206

We've done well for ourselves now but if we are going to shape the future then we really need to give people a leg up to get to where we are so that they can build further (AC mm) and the nurse practitioners in ten years time will be doing so much more than we do.

Brown and Draye (2003) explored the experiences of pioneer nurse practitioners in establishing advanced practice roles. They approached nurse practitioners in the United States who had pioneered the role in the 1960s and 1970s. The nurse practitioners in the present study could also be seen as pioneers in their field. They are six of only fourteen fully qualified nurse practitioners in a PCT that serves 300,000 patients and they are carrying out a role that is still reasonably new in the UK as evidenced by the current consultation on the use of the title "Nurse Practitioner" by the Nursing and Midwifery Council (Nursing and Midwifery Council, 2004). It is therefore perhaps not surprising to find examples of pioneering language in the narratives of the nurse practitioners in this study. There are a number of similarities between the nurse practitioners in the Brown and Draye study and the nurse practitioners in the present study. Brown and Draye found that the nurse practitioners had a commitment to advancing autonomy in order to make a difference to the quality of patient care and they explored this further through six themes: breaking free, moulding the clay, encountering obstacles, surviving the proving ground, staying committed and building eldership. The pioneer nurse practitioners "repeatedly emphasised that their ability to make a difference arose from the autonomy to create a practice style consistent with their values" (Brown

and Draye, 2003 p.395). Autonomy was an important issue for the nurse practitioners in the present study. I have referred to the ways in which the nurse practitioners raised the issues of encountering obstacles, surviving the proving ground and staying committed in the categorical content analysis with issues such as: recognition, acceptance and contribution to the development of the profession. In addition NP 1 and NP 16 both talked about not being able to go back to their previous roles (breaking free), NP 1, NP 4, NP 11, NP 14 and NP 16 all talked about shaping their roles and the work of the practice (moulding the clay) and NP 11 talked about helping other nurse practitioners to grow and develop (building eldership). There are numerous excerpts from the transcripts of the nurse practitioners in this study that are congruent with the findings of Brown and Draye. This type of language was not evident in the language of the district nurses or GPs who in contrast made statements such as:

DN 3 27-28

... that's the way nursing's gone.

GP 15 151-154

... and the paperwork is well every doctor I think complains about it but it really is incredible (AC mm) the number of directives and things that change and yet actually very few of them have any real clinical meaning or change much anything that we do day to day.

DN 5 12-13

We do obviously keep updated we work we do lots of courses at X to do this (AC mm) and to see a wound heal I think is very is a great bonus for us.

GP 12 27-30

I can look back and think about ones who I was doing antenatal care for and now they've got adolescent children and so it goes on (AC mm) so that's very rewarding (AC mm) and good old fashioned family medicine really.

DN 3's comment "that's the way nursing's gone" conjures up an image of the practice of nursing changing around her without any contribution from herself. There is a sense of victimisation about this perspective which is similar to the excerpt from GP 15 who claims that all GPs would make the same complaint as he does. DN 5 talks about keeping "updated" which suggests catching up with the leaders and therefore this contrasts with the excerpt from NP 11 who suggested she was "leading

the way”. GP 12 refers to “good old fashioned family medicine” which seems to be steeped with tradition and stability. The nurse practitioners’ use of pioneering language contrasted markedly with the lack of pioneering language in the transcripts of the district nurses and GPs and this revealed a qualitative difference between the groups in this study.

Summary: categorical form

The analysis of categorical form has demonstrated that there are striking differences between the nurses and GPs (in the use of storytelling), the nurse practitioners and the district nurses and GPs (in pioneering language) and between all three groups in the use of first person and second person narratives. I have suggested that the use of storytelling is related to the historical and cultural context of nursing. This compares to the more abstract and less emotive language used by the doctors which seems to be related to socialisation into a profession that communicates through the presentation of case histories and case notes. I have also suggested that the use of first person and second person narrative is related to social dominance and, in the case of the nurse practitioners, is related to the holistic content of the narratives with a focus on personal development and achievement. Finally, the presence of pioneering language in the narratives of the nurse practitioners and its absence in the narratives of the district nurses and GPs, points to a group of practitioners who are working at the edges of their profession, pushing at the boundaries and developing new ways of working. This thesis set out to examine whether nurse practitioners shared the values of nursing or medicine. The pioneering language that became evident in the categorical form analysis of the nurse practitioner transcripts seems to suggest that this group of practitioners are indeed on the boundaries of nursing and therefore an examination of their values is both significant and important.

Summary: a tale of shared values? The form

The analysis of the form of the narratives has provided a further perspective on the findings of this study and has enriched the view of the values of GPs, nurse practitioners and district nurses that was created during the analysis of the content. The form of the narratives has been shown to vary between the groups. The trajectory of the narrative was shown to be generally positive for all of the nurse practitioners, less positive for the district nurses (one of whom was negative and one

was neutral) and even less positive for the GPs (one of whom was negative and two neutral). Only one of the participants who had a negative or neutral narrative trajectory mentioned contribution to the development of the profession as being meaningful to them in their transcripts and even then the mention was fleeting and added as an afterthought. The narratives also varied between groups in terms of the presence of storytelling, the use of first person and second person narrative and the presence of pioneering language. I have suggested that this might be related to historical and cultural contexts and that these issues are significant and important in understanding the development of the group of individuals called nurse practitioners in this study.

The analysis of form has enriched the ethnographic tale relating to the values of GPs, nurse practitioners and district nurses. Lieblich et al. (1998) suggest that the synthesis between form analysis and content analysis can be very fruitful. The four analytic approaches have viewed the findings through different lenses, in some cases shining new light on an issue that was already evident and in other cases shining a light on an issue that hitherto had not been revealed. Hence issues have emerged from the findings that have been reinforced through different analytic approaches and other issues have emerged as a result of one of the analytic approaches alone. The following chapter will aim to synthesise the findings of this study in a discussion using MacIntyre's (1984) view of practices to understand the nature of practice and the values that underpin the roles of nurse practitioners, district nurses and GPs.

CHAPTER EIGHT THE NARRATIVE OF PRACTICES

Introduction

The postmodern condition is replete with transitory images, diverse and variegated patterns of social life, protean characterisations of who and what we are. The self is all over the place, yet it's not randomly placed across this landscape. Its construction involves a multitude of institutions, unfolding in a thousand social spaces (Holstein and Gubrium, 2000 p.95).

Earlier in this thesis I presented value as a postmodern concept. I referred to Fekete's conception of value as a "force field" that resulted from a network of evaluations and the circulatory process of a collective system of value relations and practices (1988 p.66). The postmodern view of value provided the foundation for my examination of the values of GPs, nurse practitioners and district nurses. The subsequent study was based on the premise that I could learn something about the values of the GPs, nurse practitioners and district nurses by exploring what was meaningful to them in their practice. The findings of the study revealed the varied perspectives of the participants and demonstrated how problematic this would be for those who choose to study value in a positivist paradigm. The findings of this study were congruent with the quotation from Holstein and Gubrium above in that the issues that were identified as valuable to the participants were infused with multiple meanings. Participants were found to describe meaningful practice that was at one moment congruent with their particular group and at the next moment in some way divergent from the group. What follows is my personal interpretation of the findings of this study and I present this to the reader with the following cautions. First, Rosenwald (1992) points out that we cannot assume that narrators represent their lives accurately. He suggests that it is enough to note that they *believe* they are representing themselves accurately and therefore he warns against conflating the teller and the tale. It is important to be aware that I am presenting what Foucault (1977 p.31) refers to as a "history of the present"; it is a history based on emerging language games, emerging social practices and on subjectivity (Holstein and Gubrium, 2000). Qualitative methodologies tackle questions that explore human experience rather than observed fact (Rapport et al., 2004) and therefore there is no claim that this work represents a universal truth, instead I claim that its authenticity

can only be evaluated with reference to Brewer's (1994) injunctions for good practice in ethnography presented on page 78 of this thesis and by aiming to achieve verisimilitude. Second, I have suggested that I have been intimately involved with this research. My perspective is particular and personal (Van Maanen, 1988) and I have conducted the investigation from a position of active involvement rather than contemplative withdrawal from it (Shotter, 1989). Maggs-Rapport (2001) points out that an ethnography may be a construct of the researcher's own making, but nonetheless it remains a valuable representation of social phenomenon. Shotter (1989) suggests that a central feature of such work is the ethical logistics to do with who has responsibility for what in the social construction of meanings. It is for this reason I have presented this work as an autoethnographic tale and it is to the interpretation of this tale that I will now turn.

The nature of practice

I argued earlier that medicine and nursing represent two different practices and I referred to MacIntyre's (1984) definition of a practice to provide a theoretical basis for such a claim. I then suggested that nurse practitioners, in taking on some of the work of doctors, could have moved away from the values of nursing and closer to the values of medicine and indeed they have been accused of so doing (Cahill, 1996; Fullbrook, 2004b; Fullbrook, 2004a). Such a shift, I suggested, could be revealed in what the participants of the study found meaningful in their work as representations of what they valued. Lepley described values as "verified goods" (1937 p.363) and therefore we can expect to see examples of the goods internal and external to practices in the narratives of the participants in this study. It is perhaps reasonable here to refer back to MacIntyre's definition of a practice and to consider in what ways the participants of this study demonstrate their membership of a practice. MacIntyre begins his definition of a practice with: "any coherent and complex form of socially established cooperative human activity ..." (1984 p.187). The roles of nurses and doctors working in the community are socially established forms of cooperative human activity as both MacIntyre (1984) and Miller (1994) refer to medicine as a practice and Sellman (2000) and Wainwright (2000) have made the same claims for nursing. MacIntyre goes on to say:

... through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence which are appropriate to and partially definitive of that form of activity with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved are systematically extended (1984 p.187).

Hence members of a practice deliberately and systematically work towards the purposes and goals of the practice and in striving for excellence the goods internal to the practice are achieved. MacIntyre makes the distinction between the goods internal and goods external to practices and at times this has caused some confusion in the literature. Miller (1994), Sellman (2000) and Wainwright's (2000) critiques of MacIntyre's conception of practices are helpful in clarifying this issue.

MacIntyre provides examples of those activities he suggests are practices and those activities that are not. Bricklaying, planting turnips and tic-tac-toe are not practices but architecture, farming, football and chess are. For Miller (1994) it is important to draw a distinction here between those practices whose *raison d'être* consists entirely in the achievement of internal goods (referred to by Miller as "self contained") and those who exist to serve social ends beyond themselves (referred to by Miller as "purposive"). Hence, the practice of health care has an external purpose which gives the practice its point and more particularly the practices of nursing and medicine develop standards of excellence in response to the wider needs of the community. To use Miller's example, if the medical community attached special weight to the performance of spectacular operations whose long-term efficacy was doubtful, the practice would have fallen victim to, what he calls, professional deformation. A good practice, for Miller, is one whose standards of excellence are related directly to its wider purpose and therefore it must be understood by "reference to the needs and purposes that predominate in a particular society" (Miller, 1994 p.252). According to Miller, purposive practices have socially constructed ends and he suggests that the goods internal to those practices are observable and measurable by those who are external to the practice itself. Sellman (2000) points out that the claim that internal goods can be judged in accordance with the ends of a practice fails to recognise the distinction between the ends of production on the one hand and the means of production on the other. He goes on to say that the ends are only part of what defines a particular practice and instead of

making a distinction between those practices with and without a purpose, he distinguishes between types of practice by describing a particular type of practice called “professional practice”.

According to Sellman (2000) nursing is a “professional practice”. He uses this term to encompass: commitment to the rules and traditions of nursing; commitment to the best interests of any given individual in receipt of care; and a commitment to the development of the practice of nursing:

... commitments that call attention to the virtues required to sustain those commitments and that have the potential to influence the narrative unity of the life of a given individual if for no other reason than the investment of time given to the practice (2000 p.30).

As the student nurse moves from the performance of tasks and becomes immersed into the wider role of nursing, the goods internal to nursing become available. Sellman goes on to suggest that the good internal to nursing is the satisfaction to be obtained from helping others. Wainwright (2000) suggests that there are two difficulties with Sellman’s distinction between types of practice. First, satisfaction, pursued for its own sake, is an external good, rather than an internal good, as this feeling can be gained in other ways and not just by engaging in the practice of nursing. Satisfaction, as an end, is like money, privilege and status and these are external goods that can be achieved through a variety of activities. Indeed, like satisfaction, MacIntyre (1984) refers to pleasure as an external good that can be sought as an external reward. In contrast internal goods are “ends worth pursuing for their own sake” (MacIntyre, 1999 p.66) and therefore they are valued for their intrinsic value rather than for any instrumental value. The satisfaction gained by a nurse when helping others seems to have more to do with personal achievement and fulfilment on behalf of the nurse rather than being an intrinsic value in itself. Wainwright’s second objection to Sellman is the difficulty with the commitment to rules. This, he suggests, undermines the importance of the virtues as they cannot be reduced to mere rule following. If the core moral virtues of courage, justice and honesty are important we would expect to see them in the lives of any person at any time and not just when that person is engaging in the practice of chess, architecture or nursing. He concludes by suggesting that a typology of practices is unnecessary,

instead distinctions between practices can be made with respect to their content, goals, purposes and their traditions and this remains in accordance with the MacIntyrean perspective.

The preceding discussion provides clarity in relation to the focus of this study. The aim was to explore to what extent nurse practitioners shared the values of nursing or medicine. If the findings of this study are to be understood in terms of practices one might expect to see: examples of divergent content, traditions, purposes and goals because the participants are engaged with different particular practices; examples of shared purpose between all of the participants because they are all engaged in health care; and shared features such as external goods and the pursuit of excellence because all of the participants are engaged in practices.

Content and traditions

Whilst the most significant difference between practices is present in a comparison of the internal goods, practices can also be contrasted in terms of sets of technical skills that form the content of their work and also the set of traditions that emanate from the history of the practice. The content of practices is changeable and evolving, this is particularly evident in health care as podiatrists start to take on surgical procedures of the foot, nurses carry out endoscopies, health care assistants perform phlebotomy and radiologists assess patients in accident and emergency departments. The participants of the current study discussed the ways in which the content of their roles was changing. Some were relinquishing particular aspects of their work with regret:

DN 3 23-28

... the percentage of management to actual going out doing patient visits (AC uhum) and actual sort of on the ground hands on sort of work has changed quite dramatically (AC right) and I preferred the emphasis being maybe fifty fifty or something but now it's almost it can be ninety per cent office and ten per cent patient contact but that's the way nursing's gone

In contrast, others enjoyed the development of the content of their roles and embraced the challenge, change and variety associated with taking on new areas. The nurse practitioners, in particular, seemed to comment on challenge and change

as being meaningful to them but this was less evident in the narratives of the district nurses and even less so in the narratives of the GPs.

The content of a practice is not definitive of that practice because, as we have seen, content is changeable over time. Broadly, the participants of this study suggested through their narratives that: district nurses care for patients and families in the community with a special emphasis on wound management and care of patients who are terminally ill; GPs consult with patients with a view to diagnosis of illness and disease; and the practice of nurse practitioners is characterised by consulting with patients, carrying out diagnosis and operating at a strategic level within their organisations. Where practices engage with similar tasks and skills it is in the purposes and goals with which those tasks are executed that reveals the contrast between them. All of the participants in this study consult with patients and yet their narratives revealed the ways in which the contrasting view of the patient relationship might shape the way they implemented their practice. The content of their practice has little to contribute to our understanding of their roles. What is of greater concern to the present thesis is the evidence of the traditions of the practices in the narratives of the participants of this study.

MacIntyre suggests that the act of entering into a practice is to “enter into a relationship not only with its contemporary practitioners, but also with those who have preceded us in the practice” (1984 p.194). The traditions of practices represent a relationship with the past for each practitioner. This was revealed in a number of ways in this study. The varying perspectives on the team, autonomy, the evidence of dominance in medicine, the use of storytelling and the use of first person or second person narratives are all linked to the traditions in medicine and nursing that continue to have an impact upon working practices today. The following description of an event that occurred in practice is particularly illustrative of the hierarchy that continues to exist in nursing and medicine:

NP 14 312-327

The other day I was asked to do an ECG which I really didn't bother about you know I was actually in the middle of a consultation when the phone rang and I was asked to do an ECG so I was very polite and said yes I'll just finish my consultation I'll come down and I'll sort it out,

what's the patient's name and I'll collected him and everything and it turned out that the house officer was actually supervised by one of the doctors and he hadn't realised that I was a different kind of nurse (AC mm) and just thought "I'll get the nurse to do that" but when the doctor had come through and said "well why aren't you doing the ECG yourself?" "Oh I've asked the nurse to do it" so she came flying through apologised to me profusely (AC right) and said "I think he should be in here get him in here" (laughs) (AC right) and so it was quite nice because it was a bit like you know in the past that would have just happened all the time (AC mm) you know the nurse's role isn't as important you just get on with it and it was actually quite nice that she actually thought to say "no he should be doing this you know he's new in and he needs to realise that you do these tests yourself" (both laugh) (AC yes) so it was quite nice I thought yes attitudes are changing

What is particularly interesting here is not necessarily the GP's reaction toward the younger doctor but the nurse practitioner's willingness to break off from her own surgery to carry out an ECG for the house officer. An experienced and highly qualified nurse who works autonomously and strategically and thinks of herself as a "different kind of nurse" is forced by the traditions of her own particular practice to bow to the wishes of a young house officer. The same sentiment is revealed in the words of this nurse practitioner:

NP 11 100-107

The downside is the just I think the naivety of often (pause) the multidisciplinary side of it not being aware of the role of the nurse practitioner ... and we have to influence it in a subservient manner sometimes (AC mm) just really to get round to what we want (AC mm) which doesn't bother me because I'm just here to do my work like anybody else.

It is interesting to note that NP 11 uses the word "subservient" to describe how she gets what she wants. These findings are congruent with those of Porter (1995) who found numerous examples of the use of subservient language by nurses in his participant observational study of nurses and doctors in intensive care units.

If the subservience of nursing was revealed in the nurse practitioners' descriptions of their practice, the dominance of medicine was revealed in the GPs' descriptions of teams. The GPs considered the team to be the group of GP partners and referred to other people who worked with them as the people to whom one could delegate. The remainder of the team existed to support the role of the GP and, whilst

the practice manager was seen to be an essential member of the team, the role existed to allow the GPs to carry out their role “If you don’t have a good practice manager who’s got a good handle on all this legislation and where we’re going you might as well pack up and go home” (GP 9 494-496). The traditions of medicine were also revealed in the way that the GPs only referred to autonomy when their ability to make their own decisions and choices on behalf of their patients was constrained by external forces. Autonomy is so embedded in the culture of medicine that it only becomes significant when it is under threat.

In addition to the issues revealed in the content of the narratives in this study, other examples of medical dominance were evident in scenic presence (the doctors’ and some of the nurse practitioners’ control over their environment) and in the pressures on time (the greater difficulty in making appointments with the GPs because of the pressure on their time). In my personal narrative at the start of this thesis I referred to the doctors’ parking places in the car park and the way the locum GP left debris from the previous surgery scattered around my consulting room. These issues could be seen to indicate the continued existence of a hierarchy between medicine and nursing. The nurse practitioners’ and district nurses’ use of storytelling and the district nurses’ predominant use of the second person in their narratives all demonstrate the way in which the influence of practice traditions on today’s practitioners are both powerful and enduring. This point is particularly significant and important if the practices do not share the same purposes and goals, the issue to which I shall now turn.

Purposes and goals

MacIntyre (1984) states that:

What is distinctive in a practice is in part the way in which conceptions of the relevant goods and ends which the technical skills serve ... are transformed and enriched by these extensions of human powers and by that regard for its own internal goods which are partially definitive of each particular practice or type of practice (1984 p.193).

Thus the ends, purposes, or goals of a practice are intricately linked with the goods internal to the practice. MacIntyre suggests that the goals are not fixed for all time,

they tend to evolve somewhat like the evolution of the technical skills. It is the internal good that transforms and enriches the ends of the practice. MacIntyre (1984) suggests that goods internal to practices can only be recognised and identified by participating in the practice in question. He uses the example of chess to state that “we can only specify (*the goods internal*) in terms of chess or some other game of that specific kind” (p.188). He goes on to say that those who lack the relevant experience of a particular practice are incompetent judges of the internal goods. Others may judge a practice on its purposes and goals and the practices’ ability to contribute to the common good in society but they are unable to judge what it means to be a good nurse practitioner, a good GP, or a good district nurse.

Wainwright suggests that an internal good of nursing might be “flourishing”. People who are nursed are assisted in their flourishing, and he claims that:

In pursuing this end by means of engaging in the practice of nursing the nurse will develop and sustain the qualities (or excellences) in him or her self that are necessary for the practice and that contribute to his or her own flourishing as a human being (2000 p.35).

He goes on to say that nurses contribute to the greater good of society as flourishing is a good to the patient and to the people who are close to the patient. MacIntyre (1999) describes “flourishing” as being central to the development of independent rational thinking. As we acquire the necessary virtues, skills and self-knowledge to become independent rational thinkers we can be said to be flourishing as a human being. In order to understand this concept more fully we need to also understand the more fundamental concept of “good”. “Good” can be used to describe what might be good for a human being (for example, five portions of fruit and vegetables a day) or what a good human being might be (one who benefits her or himself and others).

Good is what benefits human beings as such and to what benefits human beings in particular roles within particular contexts of practice ... To be good in a role is to judge that agent good insofar as there are goods internal to that activity that are genuine goods, goods that are to be valued as ends worth pursuing for their own sake ... And for every society there is the question of whether it is good for that society that the goods of this or that practice should have this or that place in its common life (MacIntyre, 1999 p.65-66).

MacIntyre goes on to state that as we learn to be independent practical reasoners, we gradually acquire a grasp of what human flourishing is, and we do this by learning to distinguish between those kinds of relationship that structure a flourishing individual and communal life and those that inhibit or frustrate individuals and communities from flourishing. An individual learns through experience about the places of both independence and dependence on others at different stages in a flourishing life. Ultimately, finding one's place within a network of givers and receivers allows for the achievement of individual good which is deemed by MacIntyre to be inseparable from the common good.

According to MacIntyre (1999) for a human to flourish it is his or her life as a whole that must flourish. He goes on to say that we need to identify the characteristics that an individual or a community need in order to flourish in a particular environment. The importance of the concept of flourishing is two-fold. First, it could be suggested that human flourishing is a purpose, goal or an end with intrinsic value for all practices (including town planning, plumbing, medicine, farming and even chess), not just for the practice of nursing. If we accept this suggestion then the practices explored in this study would share the same overarching and unifying goal and one might expect to see evidence of this in the narratives. The individual practices of nursing and medicine, or of general practice, district nursing and nurse practitioner, would then be defined by different, more specific purposes, goals, content and traditions. Second, if an individual is frustrated and inhibited from flourishing, one would expect to find they are not achieving the internal goods of their particular practice.

If the overriding purpose of the collection of practices whose concern is healthcare is to assist individuals to flourish, support will be required on multiple levels for each individual in relation to the unique context within which they find themselves in need. Flourishing may be more difficult for those individuals whose physical body has been assaulted by the ravages of disease, illness and injury, and others who are emotionally, socially, spiritually or psychologically injured. It is likely that the majority of people who are in need of health care will need support in more than one of these areas at any one time. The people engaged in the practice of

healthcare could address any of these areas or a combination of these areas in the pursuit of human flourishing.

Examples of the contribution to human flourishing were most evident in the narratives of the district nurses. The district nurses referred to healing, empowering, working in partnership with the patient, and being on a journey of learning together. It is worthwhile referring back to the excerpt from the transcript of DN 18 as an illustration of the idea of flourishing:

DN 18 24-34

Healing it healing it would be satisfying but I think as a district nurse we're looking you've got to have a degree of flexibility you've got to be aware of all the factors that go towards healing and the fact I have a number of people that still want to be out on the farm working (AC mm) and I know that if I said to them you've got to stay at home you've got to rest your leg we would probably heal that but that would be no quality of life for them (AC mm) so I have to be quite flexible there and look at what their lifestyle is (AC mm) so their lifestyle and their quality of life means that yes we go and dress the leg so many times a week but once we've gone they go out and work on the farm (AC mm) so we know that is contrary to good healing so there's a bit of a balance between what's good for the patient and what is right to heal an ulcer.

This district nurse's description of what is good for the patient is not congruent with what might heal the patient's ulcer. It is difficult to imagine how someone on a farm might flourish if they are unable to get out and work on their farm. The district nurse is contributing to human flourishing here by working in partnership with the patient and by understanding the unique needs of this particular individual.

The GPs' focus on disease and illness could be another example of the contribution to human flourishing albeit in a more select way. The GPs referred to the variety of illness and disease they come across in their work and they seemed to value being able to diagnose and identify significant and serious illness. When significant and serious illness was absent from their surgeries they were frustrated and GP 6 summed this up with "oh my god that was a nightmare god knows what was going on in you know three quarters of those cases" GP 6 19-20. The GPs did not specifically refer to the satisfaction gained from *curing* disease and illness, the satisfaction was associated with the challenge of identifying disease and with the

diagnostic process. One could argue that the identification of disease is the first step towards cure or disease management and therefore human flourishing is dependent upon this activity. Whilst there were examples in the GPs' transcripts of a focus on helping patients, working with families and building relationships with people over time, there was a distinct focus on the diagnosis of illness and disease. The focus on getting the diagnosis right rather than on working towards a cure or treatment is illustrative of the egocentric perspective of the GPs which is in some ways accordant with the narratives of the nurse practitioners.

The findings of the holistic content analysis pointed to the nurse practitioners' focus on themselves as being significantly different to the focus of the district nurses (on patients and families) and was perhaps more congruent with the focus of the GPs (on disease, illness and diagnosis). The holistic form also pointed to generally positive trajectories in the narratives of the nurse practitioners in comparison to the less positive trajectories of the district nurses and GPs. The nurse practitioners talked about their personal development, their ability to use their skills to the full, their ability to work autonomously and the satisfaction they gained from working at a strategic level. All of these factors point to human flourishing on the part of the nurse practitioners themselves. MacIntyre (1999) suggests that flourishing depends upon successful engagement in a practice and he also suggests that the goods internal to a practice are only available to those who engage fully in that practice (MacIntyre, 1984).

There is little evidence in the categorical content of this study to suggest that the nurse practitioners contributed to human flourishing. Indeed it is difficult to determine from the transcripts of their interviews what the purpose and goals of nurse practitioner practice might be. There was a hint from some of the narratives of the participants that holistic care was important but whilst two of the nurse practitioners focused on the social and psychological aspects of patient care, one nurse practitioner focused on patients with multiple disease processes. There was also a hint that they enjoyed the problem solving process and getting the diagnosis right, but this could be related to a sense of personal accomplishment rather than any concern for the patient. The narratives of the nurse practitioners seem to point to a lack of purpose and goals and yet interestingly, they seem to be flourishing both

personally and professionally to a greater degree than the district nurses and GPs. A possible explanation for this finding might be that the nurse practitioners are engaged with pioneering practice and as such they are lacking the structure of the more established practices. The question remains whether they might develop new purposes and goals in time or whether, as the role of the nurse practitioner becomes established, the goals and purposes that were evident in the narratives of GPs or district nurses might be embraced by the nurse practitioners.

It is interesting to note that even in the apparent absence of obvious purposes and goals, the nurse practitioners certainly seemed to be flourishing. From a MacIntyrean perspective a person who is flourishing would be expected to be fully engaged in their practice. Full engagement in a practice relies upon working towards the standards of excellence of that practice. It is therefore worthwhile exploring to what extent the participants of this study engaged in the pursuit of the standards of excellence.

Pursuit of the standards of excellence

The pursuit of standards and excellence was evident in a number of the narratives both at a personal and a professional level. In the section in the categorical content entitled “discourse with the self” a number of the participants referred to the development of clinical competency, and in “discourse with society” a number referred to the development of their profession. The GPs referred to clinical competency in relation to the diagnostic process, raising issues such as history-taking skills, consultation skills and physical examination skills. The district nurses referred to their clinical competency in wound management and their skills in palliative care. The nurse practitioners talked about their diagnostic skills, their knowledge development and their clinical skills. There were examples of contributions to the development of the profession across all three groups in relation to contributing to the education of others. The pursuit of the standards of excellence at both a personal and professional level is indicative of those practitioners who are fully immersed in their particular practices. Perhaps the most notable issue in relation to the standards of excellence were those participants who did not refer to clinical competency or did not refer to development of the profession. These participants provide examples of those who are not fully engaged in their practices

and as such, according to the MacIntyrean argument, the goods internal to their practice are not fully available to them. As the majority of the participants in this study did refer to clinical competency and professional development as being meaningful aspects of their work I have chosen to refer to those who did not mention these issues in the categorical content analysis, as deviant cases.

Deviant cases

May (1998) suggests that in every body of interview material there are individual respondents who somehow do not fit with the rest of the group. There can also be examples of sections of transcript that somehow seem to deviate from the rest of the material. The analysis of deviant cases can assist in the analysis of the remainder of the data by providing a counterpoint that ultimately enriches the interpretation of the rest of the data. In this study there were examples of participants whose narratives did not fit with the remainder of the sample, most notably the transcript of DN 10.

DN 10 did not talk about clinical competency, or personal development and she very briefly talked about being an educator for students. This seems to suggest a general lack of engagement in the systematic extension of the standards of excellence of district nursing. Full immersion in the practice of nursing would require the practitioner to contribute to the development of the standards and to strive towards excellence; without such activity the internal goods are not fully available and consequently the individual cannot flourish fully. It is accepted that all of the participants in this study will carry out a number of practices in their lives. MacIntyre (1999) suggests that in order for a human being to flourish, their life as a whole must flourish; therefore one might expect that a nurse who is not flourishing as a nurse would not be flourishing generally. Miller (1994) suggests that practices should be in harmony with the person's life and with the community as a whole; if they are not, they become discordant. The excerpts of the transcript of DN 10 that appear on page 163 of this thesis reveal the level of disharmony in the life of this participant. This suggests that she may not be flourishing. A nurse who is not flourishing and who is not immersed in the practice will not be able to help others to flourish. It is perhaps not surprising, therefore, to find DN 10 having problems with access to patients' homes, not working in collaboration with other members of the primary health care team, and telling the patient what she will and will not do (see

excerpts from her transcript on page 163).

A similar comment can be made about GP 2 whose transcript seems to suggest that she is not flourishing. GP 2 was the GP who stated that she kept thinking about all the things she did not enjoy about her work and that, when asked, she said she would not choose to go into general practice again. GP 2 is also the participant who made numerous changes to the transcript, and the holistic form also had an overall negative trajectory. GP 2 did talk about the meaning of clinical competence but she did not refer to contributing to the profession, educating others or developing professionally in any way. Once again the general disharmony in her narrative and the disharmony I felt during and after the interview with her (as was revealed by excerpts from my reflective diary) point to a general lack of flourishing for this GP.

I referred to other examples of incongruent sections of transcript as I presented the findings of this study. GP 9, GP 17 and DN 3 all had narratives that were described as neutral because they were both positive and negative in reasonably equal amounts. It was interesting to find that these three practitioners also did not comment on contribution to the development of the profession and hence from a MacIntyrean perspective they were not flourishing and were not fully engaged in their practice. NP 7 was found to share a number of values with the district nurses. I pointed out a comment from the GP in her practice that seemed to suggest that she was not able to carry out the role of the nurse practitioner fully. DN 5 used “you” and “we” more frequently than any of the other practitioners, which I suggested could be linked to the fact that we carried out the interview in the coffee room. Her choice of the coffee room for the interview is perhaps in itself revealing as she might have chosen such a location to avoid having to share her personal feelings. The value of these examples of outliers or deviant cases is that in many ways they help to explain many of the issues raised by the remainder of the study. This is particularly so in the examples of the respondents who did not appear to be flourishing in their practice. The goods internal are not fully available to such practitioners, however the goods external are.

The goods external

The external goods are not definitive of particular practices. Goods external are those rewards that can be achieved by a variety of means and not simply by engaging in a practice and therefore people who are not fully engaged in practices still have access to those rewards (for example the deviant cases in this study). MacIntyre refers to these goods as those rewards that are contingently attached to practices by “accidents of social circumstance” (1984 p.188). Examples of external goods are money, status and prestige. Status can be achieved by engaging in the practices of medicine and nursing and this was mentioned by two of the participants in this study:

DN 8 193-198

... that lovely feeling of when you're in the village I mean two or three years down the line and suddenly you start to feel that you're part of the community (AC mm) because you've got to know so many families (AC mm) they never forget ... and that just takes a while to start to feel part of that community.

GP 15 109-111

I actually like that I like being part of the community when I'm wandering around people know me as the doctor I don't mind it at all (AC mm) so those are the good parts of the job.

Engaging in a practice gives these participants a sense of status in their local community and they suggest that they enjoy having this status. Status, like money and prestige, is an external good and therefore it can be achieved by engaging in a practice or it can be achieved in other ways such as being born into the Royal family or, in some cultures, simply by being old.

A further example of an external good achieved through the pursuit of practices is financial reward. It is interesting to return to the transcript of GP 15 who said:

GP 15 128-138

They can only give us money on something they can measure so everything's based on measurements (AC yeah) and they think that that equates to quality but it's purely quantitative it's there's no way I can measure a good consultation with an upset person a patient a parent (AC no) a child don't get any points for it I can't get any money for it therefore (AC mm) I can't show I'm good at it (AC mm) all I can show is

I can measure a blood pressure and the cholesterol the blood count and peak flow and thyroid function every so often and whatever (AC yeah) and if I don't do that I get penalised.

At first sight one might conclude that GP 15 is only interested in those activities that can provide him with financial reward. However, a closer inspection of this excerpt reveals the tensions that exist between practices and institutions, referred to by MacIntyre as the “corrupting power of institutions” (1984 p.194). MacIntyre suggests that institutions are concerned with the pursuit of external goods, in acquiring money and other material goods, and that they are structured in terms of status and power. Practices rely on institutions for their survival but their ideals and creativity are vulnerable to the competitiveness of the institution. Practices rely on the virtues of courage, justice and truthfulness to resist the corrupting power of the institutions. Yet there is a complex relationship between the practices and the institutions. The institutional forms that are the social bearers of the practices need to be sustained for practices to maintain integrity. The practices need institutions and the institutions need practices. Hence GP 15 describes the tension he feels when he is forced to meet targets, the attainment of which will determine his salary and hence contribute to the achievement of external goods, when these targets are incompatible with his notion of what it means to be a good GP.

The district nurses consistently referred to palliative care as being meaningful to them. This was related to the sense of satisfaction gained from being involved with patients and families at such a significant time in their lives. The appreciation and feedback that are features of work in terminal illness were important to the district nurses. The district nurses and the nurse practitioners talked about being valued and being of value as being meaningful to them. A number of the nurse participants referred to nursing as a two-way process whereby the nurse gained as much from the patient as the patient gained from the nurse. The satisfaction associated with being valued and receiving feedback could be viewed as an example of an external good. Satisfaction is a reward that can be seen as an accident of social circumstance that is attached to the work of nursing. MacIntyre suggests that someone who achieves excellence in a practice also derives pleasure from that achievement. To aim for excellence is also to aim for pleasure. A problem arises when the aim is the pursuit of pleasure in its specific sense rather than the pursuit of

pleasure as a consequence of engagement in a practice. The participants in this study highlighted aspects of their work that were meaningful to them and described the satisfaction they gained from engagement in those aspects of their work. Hence working autonomously (valued by all the practices) and operating at a strategic level (particularly valued by the nurse practitioners) are also examples of external goods.

The embryonic role of the nurse practitioner

The focus of this study was to determine to what extent nurse practitioners shared the values of medicine or nursing. I used GPs to represent the values of medicine and district nurses to represent the values of nursing and nurse practitioners working in a primary care setting to represent the values of nurse practitioners. During the analysis of the findings I pointed out that the GPs may in some ways be different to doctors who practice elsewhere and referred to Greaves (2004) who suggests that the GP has resisted the Cartesian dualism associated with the work of hospital medicine. Equally, district nurses not only work in different ways to their colleagues in the hospital setting (Blackie, 1998), they also see themselves as being different and repeatedly pointed to their work in the community as being preferable to working in a hospital setting. Nevertheless, the findings of this study would suggest that the district nurses described examples of meaningful practice that were significantly different from the GPs and both were different to the expressions of meaningful practice from the nurse practitioners. The nurse practitioners used pioneering language which pointed to the embryonic nature of their work and they talked about the boundaries of their role, acceptance, recognition and respect which were not issues for the other participants. The nurse practitioners used the first person narrative more than the other two groups; this was congruent with the holistic content of their transcripts which focused on personal development and autonomy. There were a number of examples of the nurse practitioners combining the responses of the district nurses and the GPs so that their perspective seemed to be something of a hybrid of the other two practices. The categorical form of the narratives demonstrated the way in which the nurse practitioners used storytelling to convey their messages as did the district nurses when there were no examples of storytelling in the narratives of the GPs. Examples of excerpts from the narratives also revealed the way in which nurse practitioners, like the district nurses, are bound to the traditions of nursing.

The nurse practitioners are pushing at the boundaries of nursing and, as the boundaries move, some of the content of the work of nurses is merging with the content of the work of doctors. If, as Wainwright (2000) suggests, human flourishing is a core concern for nurses, it seems that in focussing on the boundaries of nursing the nurse practitioners have lost sight of some of the core of the practice of nursing, namely the holistic care of patients and families and concern for human flourishing. The district nurses are closer to the centre of nursing and therefore remain more closely associated with its goals and purposes. The nurse practitioners are flourishing as individuals because they are gaining personal satisfaction from engaging fully with their practice, they are pioneering, they are pushing the boundaries and they are changing the shape of nursing practice.

Summary

The literature review which was conducted at the start of this thesis outlined the studies of nurse practitioner practice that have been conducted to date in the UK. A number of descriptive studies have been conducted on single practitioners (Stilwell et al., 1987; Salisbury and Tattersell, 1988; Reveley, 1999) followed by descriptive studies of larger numbers of nurse practitioners (South Thames Regional Health Authority, 1994; National Health Service Executive, 1996) and more recently, two large randomised controlled trials that compared the work of GPs with the work of nurse practitioners (Kinnersley et al., 2000; Venning et al., 2000). The studies to date seemed to suggest that patients were more satisfied with nurse practitioners than they were with GPs and Kinnersley et al. (2000) found that patients were significantly more informed about their illness when they consulted with a nurse practitioner. I have already highlighted the methodological problems associated with adopting a randomised controlled trial to explore differences between practitioners and the findings of the Kinnersley (2000) study (that there were three practices where patients reported greater satisfaction with nurse practitioners and seven practices where there was no difference) demonstrate these difficulties. I have also highlighted the problem of the use of patient satisfaction scales to compare nurse practitioners and GPs when patients' prior expectations of the consultation have not been taken into consideration. Rashotte (2005) explains that we have come to know the nurse practitioner as a tool or instrument of the health care system and our focus has been

on efficiency, safety, and effectiveness. The research to date has helped to articulate to others what the nurse practitioner role entails, however, it has not attended to the human experience of being a nurse practitioner (Rashotte, 2005).

Rashotte (2005) suggests that we need to engage in dialogical forms of research, such as the methodologies grounded in reflective questioning, in order to understand what it means to be a nurse practitioner. Through the exploration of meaningful practice with nurse practitioners, district nurses and GPs this study has made a contribution to our understanding of the nurse practitioner role on a deeply personal and human level. From the participants' descriptions of meaningful practice I was able to learn something about the things they valued, and from this I was able to explore the content, traditions, purposes, goals, internal and external goods of their practices. The form of the narratives and the use of storytelling as a means of communication revealed the extent to which the nurse practitioners shared the traditions of nursing with the district nurses. In contrast, the content of the narratives suggested that the three groups of participants in this study had divergent sets of values. There seemed to be a clear difference between the GPs and the district nurses whilst there were a number of examples of the nurse practitioners combining the values of the other two groups. The nurse practitioners were focused on their own personal development and achievement whilst the district nurses were focused on patient relationships, patient care and families. The GPs seemed to focus on disease and illness and were particularly interested in diagnosis. The GPs' personal satisfaction in achieving a correct diagnosis seemed to be consistent with the personal satisfaction associated with working as a nurse practitioner. The nurse practitioners appeared to be personally flourishing in their roles, they all had positive narrative trajectories and described their work as being at the forefront of nursing, shaping the future, pushing at the boundaries and paving the way for others.

If the nurse practitioners are personally and professionally flourishing to the extent that seems to have been revealed in this study, MacIntyre might suggest that they are fully engaged in the practice of being a nurse practitioner. It was difficult to determine what the purposes and goals of being a nurse practitioner might be and yet the purposes and goals of the GPs and district nurses seemed to be evident and consistent. The GPs' purpose seemed to be the identification of disease and illness

and the district nurses' purpose seemed to be care for patients and their families. The district nurses' purpose seemed to be most closely associated with the concept of the promotion of human flourishing and it was difficult to find examples of contributions to human flourishing in the transcripts of the nurse practitioners. I have attempted to explain the nurse practitioners' lack of purposes and goals and their focus on themselves as a consequence of their embryonic and evolving role and I have suggested that this might change over time. This finding poses a challenge for future research into the nature of nurse practitioner practice which could explicitly explore the nurse practitioners' views on their unique contribution to health care. As Rashotte (2005) has suggested, nurse practitioners might have come to view themselves simply as tools of health care as a result of the dominant discourses of economics and scientific imperialism. Further research should therefore aim to determine whether nurse practitioners consider themselves to contribute in unique and meaningful ways to the care of patients and should attempt to uncover the complexity, ambiguities, strengths and weaknesses of the role.

Limitations of the study

Throughout this study I have pointed out the potential limitations of this work. Prior to selecting a methodological approach I realised that my membership of the group of nurse practitioners could be problematic if I were to study any issues related to the role of the nurse practitioner. It is for this reason that I chose an autoethnographic approach whereby my perspective has been shared with the reader alongside the data from the study and a discussion of the findings. Readers can return to Diagram one (page 79) which provided an overview of how to establish the credibility and plausibility of postmodern ethnography through subtle realism and the use of the ethnographic imagination and to Table one which outlined Brewer's (1994) injunctions for good practice in ethnography as providing a standard for the ethnographic community. Schwandt (1997) states that verisimilitude is the relationship of a text to the agreed standards of a particular interpretive community. Having addressed Brewer's injunctions for good practice, I have demonstrated that this is a robust and rigorous study. Nonetheless it is worth noting the weaknesses in this study to enable the limitations to be addressed in subsequent work.

In the review of the literature I suggested that gender could have an impact on

the expression of values and the stability of values. Rokeach (1973), Furnham (1988) and Grundstein-Amado (1992) all suggested that there might be differences in gender. In addition Cooke and Hutchinson's (2001) study revealed significant differences between male and female doctors. The sample selection for this study was not gender specific. I asked each practice to nominate a doctor, district nurse and nurse practitioner who might be willing to be interviewed and therefore I had to accept whoever volunteered. At the outset I was concerned that very few people would be interested in being interviewed and for this reason I did not want to put restrictions on sample selection in terms of gender. The result was that there was a single female GP and none of the nurses were male. It might be reasonable to suggest that the emergent findings are related to a gender divide rather than a division based on membership of a particular practice. Interestingly there was only one occasion where the female GP shared a particular perspective with the nurses. Conversely there were many examples of GPs and nurses sharing perspectives with each other where one GP might have expressed a different opinion to the rest of the GPs which seemed to be more congruent with the nurses and vice versa. The gender divide may not be as significant as membership to a particular practice but in view of previous research pointing out that this could be an issue in the study of values, the lack of female GPs and male nurses in this study could be seen as a weakness.

Implications for future research and practice

The findings of this work raise a number of questions that would be worthy of further study and they also raise a number of implications for clinical practice.

Implications for future research

Given the potential difference between work in primary care and work in secondary care in the UK, it would be interesting to carry out the same study in the hospital setting engaging with hospital nurse practitioners, hospital nurses and hospital registrars or consultants. The literature would suggest that there could be more evidence of a Cartesian dualism divide in hospital medicine and it would be interesting to discover whether the same might be said of nurses in the same setting.

Referring back to the limitations of this study, it would be valuable to repeat this work with a sample that was mixed in terms of gender. It would be interesting to

interview a greater number of female GPs and to interview male nurse practitioners and district nurses.

GPs, district nurses and nurse practitioners seem to have different views of the team. It would be interesting to explore this further and to consider what impact this might have on the delivery of health care by a particular team.

This study highlighted a lack of clarity with regard to the purposes and goals of nurse practitioners. I have suggested that this might be due to the embryonic and pioneering nature of their work. It would therefore be interesting to conduct the same study in the United States where the nurse practitioner role has been established since the 1960s to explore whether, as the role becomes more established, some clarity of purpose is gained. Equally this same study could be conducted here in the UK in twenty years' time to explore in what ways the contents, goals and purposes of each of the three practices had evolved.

A number of the participants in this study referred to the ways in which they valued working in the community. This was often compared to work in secondary care where the participants felt there would be less autonomy in their roles. It would be interesting to explore degrees of autonomy in both primary care and secondary care further.

In the categorical content analysis of this study it was revealed that the nurse practitioners did not seem to consider the impact of families on the health of the patient. The GPs and district nurses were both concerned with families and saw the family as an important focus of their care. It would be interesting to explore what impact such differences in focus might have upon the patient experience. This could be explored by interviewing patients and their families who had been involved with nurse practitioners, GPs or district nurses.

Finally, it would be interesting to explore the question of whether nurse practitioners share the values of nursing or medicine through the lenses of different methodologies. A feminist or hermeneutic phenomenological perspective would provide contrasting epistemologies from which to explore the nature of nurse

practitioner practice. Issues of social class and professional status could be explored through a critical social theoretical perspective which could explore the differences in professional socialisation, education and power between medicine and nursing that were highlighted in the literature review for this study. Increasing the diversity of methodological approaches to the same problem could help to deepen our understanding of the nurse practitioner role. This study has provided only a fleeting and incomplete glimpse of the nature of nurse practitioner practice, however, the issues that have been raised are significant and important and are worthy of further study.

Implications for practice

The findings of this study suggest that nurse practitioners focus more on individual patients than they do on families. Interestingly, in the domains and competencies for nurse practitioners outlined in the Royal College of Nursing guide to the nurse practitioner role, under the title “The nurse-patient relationship”, there is not one reference to the family (Royal College of Nursing, 2002). The Nursing and Midwifery Council’s “Domains and competencies for registering nurses working at a level beyond initial registration” has been presented for consultation and awaits NMC approval; under the title “The nurse-patient relationship”, the first competency is “Creates a climate of mutual trust and establishes partnerships with patients, carers and families” (2004 p.12). The findings of this study, in conjunction with the NMC proposal, might suggest that a focus on the family should form part of the nurse practitioner curriculum. Indeed in the United States, where the role is more established, nurse practitioners who work in primary care are often qualified as “Family nurse practitioners”. A brief internet search found that the Family Nurse Practitioner programmes at Gambling State University, Wagner College New York and Baylor University Texas all had specific modules devoted to the family. The College of Nursing at Ohio State University listed “Family nurse practitioner essential skills” and the first skill was to: provide health promotion & primary health care for individuals in the context of their families (Ohio State University, 2005). Nurse practitioner programmes in the UK have been accredited in accordance with the Royal College of Nursing domains and competencies of nurse practitioner practice and are therefore likely to be missing a focus on the family in their curricula. A recommendation could be made for nurse practitioner programmes in

the UK to consider including modules on family theory as they develop their curricula in the future.

A second recommendation based on the findings of this study concerns the concept of teams in primary care. The narratives of the participants of this study would suggest that GPs do not include other members of the primary health care team in their view of the team and that nurses do not include the doctors in their view of the team. It seems that a divide exists here which may be caused by the natural employee/employer relationship in general practice. However, when one considers the nature of the work of a health care team one might suspect that working together as a whole would have benefits for patients and their families. A recommendation could be made that primary health care teams should come together to share their perspectives and their views in an effort to encourage cohesion and greater understanding of each other's roles in the team.

Concluding comments

This thesis commenced with a personal narrative. It was included to provide the reader with an understanding of the personal and particular perspective of the author of this work. "Right hand turn, left hand turn" (page 22) reveals the strength of feeling I have regarding my role as a nurse practitioner. It shares with the reader my link to the nursing community and the enjoyment that I achieve from the autonomy associated with the nurse practitioner role. I gain satisfaction from making decisions about blood results, writing prescriptions and from advancing my medical knowledge by working so closely with my GP and nurse practitioner colleagues. The opening lines of this thesis provide even more insight into my belief that I am a nurse and I always will be. The strength of feeling that I have regarding the nursing contribution to patient care and how that differs to the medical contribution, drives me to protect the time I spend with patients, resisting pressure from others to get up to the same speed as the doctors.

At the start of this study the aim was to examine whether nurse practitioners share the values of nursing or medicine. Having conducted this research I found that the nurse practitioners in this study seemed to share some of the values of the nursing group and some of the values of the medical group and yet they also seemed to value

their own personal and professional development more obviously than any of the other values they discussed. The analysis of holistic content revealed that the doctors valued illness and disease, the district nurses valued patients and families and the nurse practitioners valued their own development and personal achievements. I was surprised to find the lack of purpose and goals in the nurse practitioner narratives which contrasted with the consistency in purpose and goals for each of the two more established groups. After revealing my own perspective in “Right hand turn, left hand turn” my view of the nurse practitioner has taken a U turn. In the words of Denzin and Lincoln “The process of analysis, evaluation and interpretation are neither terminal nor mechanical. They are always emergent, unpredictable, and unfinished” (1994 p.479) and so the exploration continues. My current view of nurse practitioner practice, like the reader’s, is likely to take many more turns as our understanding of the practices of nursing and medicine continues to evolve in the postmodern world.

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Appendices

Appendix 1: Ethical approval for the main study

Morecambe Bay 

MORECAMBE BAY LOCAL RESEARCH ETHICS COMMITTEE Primary Care Trust

Chair: Dr J Shakespeare

Administrator: Mrs C Martin

Direct Line: 01539-797859 : Email: christine.martin@mbpct.nhs.uk

Date: 12 September 2003

Our ref: JS/CM/MB230

This study no. should be quoted
in all future correspondence.

Name Alison Crumbie

Address



Research Project Approval

Re: **MB230 To what extent do Nurse Practitioners, General Practitioners and District Nurses Share Values?**

Thank you for letting me have your amended consent form which satisfied the concerns of the Committee. I am happy to give Chair approval for you to proceed with the study and wish to advise you of the following:

- (a) your responsibility to notify the MBLREC immediately of any information received by you or of which you become aware which would cast doubt upon, or alter, any information contained in the original application, or a later amendment application, submitted to the committee which would raise questions about the safety and/or continued conduct of the research
- (b) the need to comply with the Data Protection Act 1984
- (c) the need to comply, throughout the conduct of the study, with good clinical research practice standards
- (d) the need to refer proposed amendments to the protocol to the MBLREC for further review and to obtain MBLREC approval thereto prior to implementation (except only in cases of emergency where the welfare of the subject is paramount)
- (e) the requirement to furnish the MBLREC with details of the progress of the research project periodically (e.g. annually) and of the conclusion and outcome of the research project and to inform the MBLREC should the research be discontinued or any subject withdrawn altogether.
- (f) It has been agreed that the Local Research Ethics Committee for Morecambe Bay along with East and West Cumbria will accept each other's decisions as being a joint decision, therefore this approval also covers East and West Cumbria.

Signed

Dr J Shakespeare, Chairman Morecambe Bay Research Ethics Committee

Date: 12 September 2003

Trust Headquarters, Tenterfield, Brigsteer Road, Kendal, Cumbria, LA9 5EA.

Tel: 01539 797800 Fax: 01539 726687

www.mbpct.nhs.uk

Chairman: Dr. Robin Talbot

Chief Executive: Leigh Griffin

Appendix 2: Ethical approval for the pilot study

North Cumbria Local Research Ethics Committee
Trust Headquarters
Chorley & South Ribble District General Hospital
Preston Road
CHORLEY
Lancashire

Telephone/Fax: 01257 247140
E-mail: Mary.Sykes@LTHTR.nhs.uk

22 October 2003

Ms A Crumbie
Windermere Health Centre
Goody Dale
WINDERMERE
Cumbria LA23 2EG

Dear Ms Crumbie

Re: ***To what extent do nurse practitioners, general practitioners and district nurses share values?***
LREC ref: NCLREC.2003.10.LLREC.1

The North Cumbria Local Research Ethics Committee has considered in full the locality issues relating to the above application.

The issues reviewed were as follows:

- the suitability of the local researcher
- the appropriateness of the local research environment and facilities
- any specific issues that may relate to the local community

The North Cumbria Local Research Ethics Committee has no objection to the research being conducted within its boundary.

Yours sincerely

E. Mary Sykes

E Mary Sykes
Administrator
North Cumbria Local Research Ethics Committee

Copy: Ms C Hornby, R&D Co-ordinator, North Cumbria Primary Healthcare Trusts
Dr J Shakespeare, Chairman, Morecambe Bay Research Ethics Committee

Members of Executive Sub-Committee who reviewed the locality issues:
Dr B Stanley (Chair) Rev Prof J Beazley Dr C Jones

Dr N Calvert

Appendix 3: Participant Consent Form

PRIFYSGOL CYMRU ABERTAWE
Ysgol Gwyddor Iechyd
Parc Singleton, Abertawe SA2 8PP



UNIVERSITY OF WALES SWANSEA
School of Health Science
Singleton Park, Swansea SA2 8PP

Participant Consent Form

Exploring the values of district nurses, nurse practitioner and general practitioners

Consent to audio tape recording for research purposes

You have agreed to participate in a study which is exploring the values of district nurses, nurse practitioners and general practitioners. Your interview will be recorded on an audio-tape. The recording will only be heard by people involved in the analysis of the data which includes the researcher and her academic supervisor. In the presentation of the findings the researcher may use some direct quotes from your interview. Should anything arise during the course of the interview that you do not wish to have recorded please ask the researcher to stop the tapc. After the interview the tape will be transcribed and will be sent to you for your comment. You will be able to alter the transcript if you choose to do so. The subsequent analysis will also be sent to you for your comment.

I confirm that I have read and understand the information sheet for this study and have had the opportunity to ask questions. I understand that I am free to withdraw my consent at any time without giving any reason.

Participant's Name.....

Signed.....

Name of person taking consent (researcher)

Signed.....

Date.....

Thank you for your time and co-operation.

Pennaeth yr Ysgol · B.F. Green · Head of School
Tel 01792 295789 Fax 01792 295487 www.healthscience.swansea.ac.uk

Appendix 4: Information about the study

PRIFYSGOL CYMRU ABERTAWE

Ysgol Gwyddor Iechyd
Parc Singleton, Abertawe SA2 8PP



UNIVERSITY OF WALES SWANSEA

School of Health Science
Singleton Park, Swansea SA2 8PP

Exploring the values of district nurses, nurse practitioner and general practitioners

Information about the study

This research forms part of a doctoral programme of study being carried out through the University of Wales Swansea. The aim of this work is to explore the values of nurse practitioners, district nurses and general practitioners. Values can be difficult to describe, they are linked to ideals beliefs and meanings and tend to influence our choices, behaviours and actions. These issues will be explored with you in an interview.

If you consent to be involved in this study you will be asked to nominate a time and place that is suitable for you to be interviewed. The interview will be recorded on an audio-tape which will subsequently be coded and anonymised. You can anticipate that the interview will last a maximum of one hour. The tape will be transcribed and the transcriptions and the subsequent analysis will be sent back to you for your comment. The recording will only be heard by people involved in the analysis of the data which includes the researcher and her academic supervisor. In the presentation of the findings the researcher may use some direct quotes from your interview. Audio-tapes and transcripts will be stored in a locked cupboard, accessible only to the researcher and will subsequently be destroyed in accordance with the data protection act.

The sample will be selected from practices across Morecambe Bay Primary Care Trust. All practices that employ and use the services of a nurse practitioner will be approached for this study. A nurse practitioner, district nurse and general practitioner will be interviewed at each of the participating practices. It is anticipated that this research will contribute both locally and nationally to the exploration of the diversity of roles in primary care.

If you have any further questions about the study I will be happy to discuss this with you prior to the interview.

Alison Crumbie (Researcher)
Windermere Health Centre
Goodly Dale
Windermere
Cumbria

Tel: 015394 45159
Email: Alison.Crumbie@gp-a82046.nhs.uk

Pennaeth yr Ysgol · B.F. Green · Head of School

Tel 01792 295789 Fax 01792 295487 www.healthscience.swansea.ac.uk

Transcript Check

Please answer the questions below and return the form in the envelope provided

	Yes	No	Comments
Is the transcript a true record of events?			
Is there anything you would like to add?			
Is there anything you would like to delete?			

Signed _____

Date _____

Transcript Summary Check

Please answer the questions below and return the form in the envelope provided

	Yes	No	Comments
Is the summary a fair reflection of the values, ideas and beliefs you referred to in the interview?			
Is there anything you would like to add?			
Is there anything you would like to delete?			

Signed _____

Date _____

Appendix Seven: Amended Transcripts and Transcript Summaries

Pilot Interview 1 GP

1 AC Basically what I'm doing the whole sort of aim of the study is to interview GPs
 2 nurse practitioners and district nurses and I'm looking at em ideals beliefs and
 3 thoughts about your role erm so it's looking at the three groups' values about what
 4 they do (MM right) it's very broad erm the idea is the interview lasts for an absolute
 5 maximum of an hour but probably a bit less than that (MM yes) erm and it's very
 6 broad very unstructured and it's just guided by your responses so it feels it might feel
 7 a bit awkward at times just er because there aren't a whole lot of questions to ask it
 8 just goes with whatever you respond with (MM right) erm at any point you can stop
 9 the tape and say I don't want to I don't want this recorded or please erase what I just
 10 said erm and also when I we've finished I'll transcribe it and send it to you if there's
 11 anything you want deleting again that's fine erm and then after that I'll analyse it and
 12 look for values and beliefs about your role send it back to you and again you can
 13 comment or change anything if you want to. So that's the essence of what it's about
 14

15 MM Fine sounds like hard work for you Alison (both laugh)
 16

17 AC [consent form signed and passed across] Erm that's great thanks and I'll hang on
 18 to that thank you. So er oh and I'll just, I'll get this out because you might mention
 19 one or two things that I'll jot down and er return to later on. So erm the question is
 20 can you tell me what you find most meaningful in your work as a GP?
 21

22 MM Personally as a GP er the starting point is I'm a doctor (AC uhum) and why do I
 23 enjoy general practice and why do I do it erm instead of being a consultant or
 24 hospital doctor of some kind and it it's the personal contact with the patients that I
 25 enjoy (AC right) and that's the main the main plus of general practice as far as I'm
 26 concerned (AC uhum) er so that's very much how I see it. There are other things
 27 which you could mention in passing for example there is a lot of variety in our work,
 28 when you speak to hospital colleagues er I suppose chest physician for example er
 29 they're more or less dealing with the same thing day in day out a lot of them are
 30 describe actual boredom (AC uhum) with their role colleagues and friends that I
 31 know from when I was a student speak to them a lot of them er describe the
 32 dreariness whereas in general practice it's always different there's something
 33 different every day in your surgery in the patients you see different problems to
 34 address so there's a rich variety of medicine (AC mmm) er so that's that's very
 35 stimulating that's er important I think er to have that professional variety and
 36 stimulation (AC mm) and challenge there all the time erm but the main but behind
 37 that I think the main thing for me is personal contact with the patients really is seeing
 38 people sometimes for years and years through a lot of their life cycle (AC uhum)
 39 and having some long term relationship er which I think leads in a lot of cases to a
 40 build up of trust and er mutual resp mutual respect which I think is very valuable
 41 almost completely disappeared from the hospital kind of setting in a lot of ways these
 42 days (AC mm) that's er that's my main er reason for doing it besides the money of
 43 course (AC right) (both laugh)
 44

45 AC Right can you say a little bit more about that about the patient contact?
 46

47 MM Well erm a lot of our patients a lot of our patients for example are very simple
 48 people they are not sophisticated they're not highly educated er quite a lot of them
 49 have are people with learning difficulties (AC mm) and that means in a lot of ways in
 50 a modern society they are quite vulnerable er and er (pause) one thing is
 51 communication. Although I am separated from them by education er it is I find it
 52 relatively easy to communicate er to not just to communicate understanding but also
 53 to communicate their our common goals as the doctor and the patient and to reach
 54 some kind of agreement about the way forward er and so I'm thinking of one
 55 particular lady at the moment I don't want to give a lot of clinical details to you (AC
 56 mm) but erm er it's quite pleasant to be able to go to someone's house that you've
 57 known for a long time when perhaps they've received a rather serious diagnosis and
 58 be able to discuss with them the way forward despite their confront their fears erm
 59 about the future but also emphasise explain the treatment and emphasise the need
 60 despite the fear to persist in their own interests (AC mm) and get sorted out (AC
 61 mm) er a lot of a lot of there's a lot of misinformation these days which people find
 62 very confusing erm but when you're in a position where you've been around for a
 63 while then you are accounted perhaps to media information in terms of people see
 64 the media as having authority something on the BBC they take it often as to be the
 65 truth (AC uhum) see it on television telly can be very seductive er being being a
 66 figure in the community who has been around for a while you can be accounted to
 67 that in terms of explaining the truth to people (AC uhum) and so I think that's er
 68 that's an important thing. And then it comes down to I suppose personally I believe
 69 in quite simple values truth, honesty and this kind of thing so I think these simple
 70 values do come out a lot in our dealings with the patients people know that you are
 71 someone who isn't going to tell them something that's not true that you are honest
 72 person (AC mm) I think that's very important er and er there are threats to that and
 73 things like Shipman and that have destroyed a lot of done a lot of damage but people
 74 don't associate I hope they don't anyway in most cases you with that and I think they
 75 do there is an important line of communication that I have there (pause)

76
 77 AC You mentioned about being a figure in the community can you say a bit more
 78 about that?

79
 80 MM Yes I mean I don't actually live in O I live a few miles outside O but I am well
 81 sort of known by everybody I've been here for nineteen years erm so I'm people er if
 82 they've got any sense don't want to deal with me because I'm a doctor they want to
 83 be in a like all of us we don't want to be in illness long it's not a common sense
 84 dictates that you don't want to be ill you want to avoid doctors if you can and I think
 85 it's a perfectly admirable idea personally I don't believe in this medicalisation of
 86 everything I think it's a retrograde step becoming retrogrades step in some ways so I
 87 feel erm that when people do need to see me they are more in the extremes
 88 experience of life they are not in the hum drum middle bit of life where things are
 89 going along quite happily they are more in the extremes of their life you're seeing
 90 people who are more vulnerable as I mentioned before but also most stressful and
 91 most worried time of their life and in situations where they don't fully understand
 92 what's going on so er because it's a small community everybody knows you most
 93 people a lot of patients call me by my first name (AC mm) and I call them by the first
 94 name (AC mm) and I er regard that as a good thing I think it's a bad thing if you call
 95 them by their first name and they don't call you by your first name it's a bit unequal
 96 but I think er it you know on the whole it indicates a level of er trust er er through

97 you and support (AC mm) (pause) er the erm most important area that we have a
 98 long term relationship with patients these days is in palliative care terminal care care
 99 of the dying er that's where we have the more prolonged and more intense
 100 relationships with patients still erm most other specialities now are increasingly
 101 taking the patients over more we do do shared care schemes in some specialities but
 102 in palliative care er we still have a large role to play that doesn't mean there aren't
 103 other services for people in palliative care as you know there are lots (AC mm)
 104 palliative care consultant at KL Dr K er McMillan nurses but for example in O the
 105 McMillan nurses only visit once a week at most so most of it is left to us and the
 106 community nurses to deal with these people so it is a time when you do develop do
 107 do a lot of doctoring for people and develop quite close relationships with them and
 108 try and provide a lifeline to address their fears and problems as they arise (AC mm)
 109 and erm a lot of outsiders are surprised when you tell them that in fact you find
 110 palliative care tends to be quite an enjoyable part of most GPs most people GPs I
 111 think that I've spoken to say the same they see it as a very positive thing they're
 112 doing although your dealing with someone who eventually will die (AC mm) er
 113 that's a very positive thing because you can actually act as a doctor er a lot of the
 114 problem with general practice I think is because of the rise of specialisms your role
 115 as a doctor is reduced erm but in palliative care you are allowed to act as a doctor
 116 (AC mm) and to address the medical social and psychological er needs of the patient
 117 (AC mm) erm at times

118
 119 AC Can you explain that a bit more about being able to act as a doctor and what that
 120 means?

121
 122 MM Erm er it has a lot of aspects but erm er (pause) when you're trained as a doctor
 123 er it's a long training and you come away from it eventually you qualify as a doctor
 124 and then you go through other pre reg houseman and then you train er a GP in my
 125 case I did a lot of hospital medicine before I became a GP at the end of that time you
 126 come away with a lot of knowledge and skills and attitudes as a gen as a general
 127 practitioner er a lot of er you're not in a lot of ways you are not allowed to use these
 128 knowledge skills and attitudes because the management of the patient is taken away
 129 by secondary care er and so in a lot of cases you might know how to manage
 130 diagnose carcinoma cancer of the prostate (AC mm) or someone who has had a heart
 131 attack (AC uhum) but the management is taken over by the hospitals (AC mm) and
 132 your job is not really medical in that sense erm the previous erm er Secretary of State
 133 said the GP's role was to was to help patients navigate the health care system (AC
 134 mm) I would regard that as a very secondary role. I think it is important people do
 135 find health service (AC mm) er erm confusing and difficult to latch on to and to find
 136 a way through I think it is important to help people to get to where they need to go in
 137 the health service but I certainly wouldn't by any means regard that as my primary
 138 role er and I think my primary what I'm trained to do is to be a doctor to use the
 139 skills of being a doctor er examination er history taking diagnosing treatment seeing
 140 people in their social and psychological setting (AC mm) that's my primary role er
 141 and my primary job is to is to try and fulfil as much of that as possible erm but I have
 142 to be careful that I am not giving people an inferior service and in a lot of ways now
 143 if I was to treat every diabetic or everybody every heart attack at home I would be
 144 giving people an inferior service. So I've become deskilled I've been told that I
 145 mustn't use my skills to exercise my skills to treat these people in the interests of
 146 these patients and that's right in most cases not in all cases but in most cases that's

147 right but in palliative care the because the prog the final prognosis is already
 148 predetermined (AC mm) the limits on what I can take care of are wider and also
 149 because there aren't enough people in secondary care to look after dying patients at
 150 home (AC mm) especially in an isolated place like this when you are so far away
 151 from a hospital people prefer your care your low tech care to the care they receive
 152 from the palliative care team in the hospital (AC uhum) McMillan nurse coming
 153 once a week whereas you can pop in five times a week if necessary (AC mm) six
 154 times a week if necessary and but there still is a big role for you to do doctoring,
 155 (AC mm) little changes in treatment little diagnoses along the way er settle little
 156 crises symptoms that are arising (AC uhum) manage it that way. So it is more
 157 fulfilling because you are being skilled my personal view is that skills er in any
 158 occupation I think the exercise of skills is the prime er er prime satisfaction in any
 159 job or even in human activities I think my view is that in our society that knowledge
 160 is overplayed erm knowledge is now freely available on the internet (AC mm) but
 161 it's the skill of using knowledge that's er that gives the benefit to people (AC mm) er
 162 and my own experience I spoke of my training as a doctor and when we were
 163 students at some stages we were crammed full of knowledge facts (AC mm) but you
 164 quickly realise a third of them are wrong the facts that you were given a third of them
 165 are wrong a third of them are out of date and of the other third you probably only use
 166 a small percentage of anyway (AC mm) so my own view is that knowledge is is not
 167 erm an important as important as it is made out to be (AC mm) perhaps in society
 168 and people in gen but skills in the broadest sense the exercise of skills gives most
 169 reward (AC mm) er and I have a friend who is a prison governor he's very very one
 170 of his big things is rehabilitation of prisoners er it's his life's work really to improve
 171 prisons and he has the same view in the kind of setting prisoners that are caught are
 172 usually the ineffectual ones that are not the guys in suits who make millions out of
 173 the thing er people on the streets who have a low level of education a low level of
 174 skill in the general sense of the term (AC mm) but also in specifics like reading and
 175 writing and so on. Er giving people skills er whether they are the bottom end of
 176 society criminals petty criminals, moderately sized criminals, giving people skills
 177 ennobles them and erm you talk about professional life in terms of knowledge skills
 178 and attitudes you can't change it's very hard to change people's attitudes but by
 179 giving people skills you can change their attitudes and so the skills to me are a
 180 central thing and I came to reflect that in my own performance when we've
 181 discussed these things in the past and found that that's what I think the exercise of
 182 skills is the it the ennobling part of of your life really (AC mm) as a professional
 183

184 AC Mm Is there anything more you'd like to say about that? (pause both laugh)
 185 about the skills?
 186

187 MM Er well skills in the broadest sense (AC mm) we're not talking about necessarily
 188 manual skills although they can be important there's a there's a sort of tradition a law
 189 within medicine about skills that perhaps people don't talk about things like being
 190 able to give injections give intravenous injections put up drips (AC mm) do suturing
 191 er these are practical skills (AC mm) but there are much broader skills particularly
 192 the thing that's emphasised in primary care is communication skills and I think that's
 193 right erm. I was interested that er my son is just going to university and I understand
 194 that the government I didn't realise the government have set standards for university
 195 education now undergraduate education besides having standards for primary and
 196 secondary education they've set standards and one of them is communication skills

197 (AC mm) er and I think that's right I think communication skills are important. It
 198 sounds like the government are probably er from what I've heard have got a similar
 199 idea because again the things they talk about in terms of what they're wanting in
 200 higher education are skills like numeracy a skill basically rather than knowledge so I
 201 think they reflect what I'm saying I found in my professional life as well so erm I
 202 think erm in the broadest sense of skills in terms of being able to perform (AC mm)
 203 [someone at the door – sorry sorry about that] having erm knowledge er that you can
 204 perform that can alter how you perform (AC mm) which isn't the same as just having
 205 knowledge (AC mm) gives you is skilling and is a fulfilling and also effects your
 206 attitudes (AC mm)

207
 208 AC That's helpful that's good. Just to go back right to the beginning (MM yep) one
 209 of the things you said right at the start apart from the relationship with patients was
 210 about the variety (MM uhum) in general practice and that was valuable to you. (MM
 211 yep) Can you say more about that?

212
 213 MM Er as I mentioned before I don't think I can add much more to what I said but
 214 erm I'll try the erm when I've spoken to consultant colleagues a lot of them
 215 consultants are erm a lot of them are very bright men and women very intelligent
 216 (AC mm) very high performers who've sailed through school A levels university
 217 courses been stars among their peers and a lot of them when you speak to them when
 218 they become a consultant they seem to change they seem to there seems to be no
 219 challenge left in the job as far as they see it. Now that might be partly because they
 220 are very intelligent and they are just not moving forward but I think it is also because
 221 the job becomes fairly routine most of the time for them and the thing I always say I
 222 discuss this a lot with students the students we have and erm the thing I always say to
 223 them if I said to you chest physician then you could more or less fill in his timetable
 224 for the week you would know he was doing bronchoscopies (AC mm) probably one
 225 day a week one half day say, he would be doing ward rounds three or four days a
 226 week he would be doing sort of out patients three or four times a week he'd have a
 227 lung function session. You could more or less predict what he would be doing and
 228 where he would be (AC mm). My job is er I feel I have more variety to it than that.
 229 Although I do surgeries every day I see lots of different cases in the surgeries and er
 230 when I go and visit people the problems can be can range tremendously from
 231 exquisitely medical type problems to social problems sometimes the underlying
 232 problem is non medical at all debt or some obscure worry that totally surprises you
 233 erm one of the techniques we have in primary care is which I've been doing a few
 234 more in the last few years is often asking when you've seen the patient and you've
 235 done your own sort of initial analysis is saying 'well what do you think why did you
 236 come and see me what did you particularly, what was in your mind?' and even after
 237 all this time I'm often astounded by what they come out with (AC mm) I'm amazed
 238 by their idea of what's wrong with them er or what the treatment involves is often
 239 quite quite and that's if nothing else it's entertaining to have some to have this sort of
 240 latch on people (AC mm) there's this other dimension to it which again in a hospital
 241 setting you wouldn't get. (AC mm) In a hospital setting it's history diagnosis this is
 242 the treatment what do you think about I mean there is this move for what they call
 243 concordance (AC mm) going on but it is still very limited whereas I think we as
 244 communicators in general practice tend to look more to see the patient's view of
 245 things (AC mm) and that provides another dimension another level of
 246 unpredictability and erm surprises and enriches the job (AC mm) so that's why I

247 think we have variety and erm sometimes you're not aware of these things but for
248 example when you have students sitting in with you and you're perhaps reflecting
249 more on what you're seeing it's not just the daily grind so you're aware more and
250 you sit back at the end of the surgery and you discuss cases you've seen together and
251 you realise there's immense variety (AC mm) of cases (AC mm) that you've seen
252 (AC mm)

253
254 AC Excellent is there anything more you'd like to add to all that you've said?

255
256 MM So the initial question was what again?

257
258 AC It was about what you find most meaningful in your work (MM uhum)

259
260 MM Well I mean there are other aspects to general practice sort of being in a
261 partnership in business working with a lot of colleagues here in the surgery now
262 we've always been sold as being part of a team but it is more so these days to be
263 quite frank with you I find these of secondary importance they're often a source of
264 frustration er in your work er so I think there's less reliable positive enjoyment in a
265 lot of these roles er a lot of them are more difficult interpersonal relationships with
266 colleagues which er themselves have their own agendas and pressures which I think
267 makes which personally I don't find so easy (AC mm) er so I'd say that's not a side
268 of it these are not sides of it that I would have such positive feelings about all the
269 time (AC mm) than I do about the actual business end of the job

270
271 AC Right the business end of the job is more positive is that what you're saying or

272
273 MM When I say business end I mean the doctoring (AC oh I've got you yes) I
274 apologise (AC yes) the business the financial side (AC yes) of it is look at in this
275 practice er we're quite lucky really in that we're able to set policy and the details are
276 worked out by our fantastic staff E and colleagues (AC mm) who are able to so in a
277 lot of ways we are able to act as an executive and decide policies and delegate a lot
278 of the detail side of that which is a great help (AC mm) because it's not a side you
279 want to get involved with too much

280
281 AC Mm I see yes there's that part of it and then the partnership side which was about
282 relationships

283
284 MM Yes again if you speak to most GPs probably the same as me that this is often
285 the most difficult part most GPs would quite frankly admit this to you that
286 partnerships are the more difficult part you are dealing with people who all have their
287 own vested interests and having to compromise and erm sort of sort things out and
288 that tends to be more difficult the relationship with the patient is much more direct
289 (AC mm) and much more a contractual relationship based on their needs er so that's
290 easier to follow I think (AC mm) OK

291
292 AC Is there anything more you want to add?

293
294 MM No that's all thanks Alison

295
296 AC Thank you very much

Transcript Summary

Pilot Interview 1 GP

This transcript suggests that MM finds the personal contact with patients a most important and valuable part of his role as a GP²⁴. He values seeing people for years and years throughout much of their life cycle³⁶ and developing long term relationships with them³⁹. He values developing trust and mutual respect with patients³⁹. He feels it is important to communicate effectively with patients and to determine common goals and agreement about the way forward⁵². He likes to work with patients he has known for a long time⁵⁵ and believes it is important for people to see him as a true and honest person.

MM believes the most important long term relationship is in palliative care⁹⁶, he enjoys doing a lot of doctoring for people and developing a close relationship with them¹⁰⁵. He feels he has a large role to play in palliative care¹⁰⁹ and finds this a very positive aspect of his role. He feels that in palliative care you are allowed to act as a doctor to address the medical social and psychological needs of the patient^{113 143}. He values being able to perform his role as a doctor which includes examination, history taking diagnosing and treatment, seeing people in their social and psychological setting¹³⁷. In areas other than palliative care he feels he has become deskilled as other specialties have taken over¹⁴³. He feels that the long training to become a GP equips the doctor with knowledge, skills and attitudes and in many situations you are not able to use these knowledge, skills and attitudes because care of the patient has been taken over by secondary care¹²⁴.

MM believes that the variety in general practice is very enjoyable²⁷ and that it's important to have professional variety, stimulation and challenge^{32 33 35}. He feels being able to exercise skills is a prime satisfaction and by "skills" he means the ability to use knowledge for the benefit of people¹⁵⁹. He doesn't value knowledge and facts, knowledge is freely available and facts are often wrong¹⁶⁰. Skills such as communication and numeracy are valued above knowledge¹⁹⁷ and he believes giving people skills ennobles them¹⁷⁴. Communication skills are most important in primary care^{194 186}. He believes that having skills is fulfilling and that it effects your attitudes and how you perform¹⁹⁹. MM has a sense of accountability to the community particularly in interpreting information released by the media, he values explaining the truth to people⁶⁵.

MM believes in equality and believes if you call a patient by their first name they should call you by your first name. He feels this is also an indication of trust⁹². He feels it is important to help patients navigate the health system but he sees this as a secondary role¹³². He doesn't believe in the medicalisation of everything⁸⁴. He finds partnership frustrating at times with difficult personal relationships and people pursuing their own agendas²⁵⁹. He believes many of the patients are vulnerable⁴⁹ and feels communicating understanding and equipping patients with skills is important.

(The small numbers refer to the line of the transcript where the idea can be found)

November 30th 2003

Pilot Interview 2 NP

1 AC This research is erm very qualitative (ML yes) so er what I'm looking at are
 2 values ideas beliefs thoughts about your role (ML yes) and about you know your
 3 work er and it starts with just one question and then you know you answer it as you
 4 feel fit er and then the rest of the questions will just be guided by whatever you say
 5 (ML yep) so it might feel a bit strange at times (both laugh) but er just you know if
 6 you want to erm delete anything or if you say oh no that wasn't right I want to go
 7 back (ML yep) then feel free to do that erm and the way the research works is erm
 8 after today I'll go away and transcribe it all and send it to you (ML yes) and again if
 9 there's anything there that you think oh no that's rubbish (ML not what I meant) then
 10 you can do you change it. And then I'll analyse it erm and then send you the analysis
 11 saying you know this is what I think it looks like (ML yes) and again you'll be able
 12 to change it (ML yep) if you think it's not right. So today really is the first step in the
 13 process. Erm and I'm just going to get out a piece of paper here because if you say
 14 something that I think I'd like to go back to that I'll just jot it down as we go along
 15 (ML yes) OK So erm the question is 'what do you find most meaningful in your
 16 work?'

17
 18 ML (Pause) I think what I would say is the satisfaction of being able to see
 19 somebody from start to finish and actually complete that episode of care whether it's
 20 within the practice or referring on and following up after that and I think it's getting
 21 that element of completeness that I didn't used to have (AC right) does that make
 22 sense? (AC Yes can you expand on that a bit more?) ML I mean from my own point
 23 of view because the role's been a progression over the last fifteen years from coming
 24 in as a brand new qualified nurse into general practice I didn't work in hospital after
 25 qualifying I came straight here as a treatment room nurse and sort of evolved right
 26 through fifteen sixteen years of working here and so a lot of it is like a natural
 27 progression you're sort of learning all the time what you know and your role is
 28 expanding with that. But up until being able to undertake the physical examination
 29 and assessment skills then there was always that cut off point that that's it that's as
 30 far as I can go, I know what needs to be done but I'm not equipped to do it (AC
 31 uhum) so developing that hands on aspect and those techniques a step further and
 32 also the referral aspect there's things that I would have seen as a practice nurse
 33 because we've always been the first point of contact that I would see somebody for
 34 instance somebody with a breast lump I know what needs to be done but never felt
 35 able to do that or referral wise wouldn't have been accepted in the past (AC uhum)
 36 so being able to do that step as well you feel you're actually giving that patient a
 37 better service because everything is being done by one person you're not having to
 38 bring them back to somebody else for something that you know needs to be done but
 39 just don't feel confident or competent to be able to complete (AC uhum) I think the
 40 prescribing is going to come into that even more because you're actually doing that
 41 little bit extra as well (AC uhum) I think yes maybe with it being sort of that
 42 progression I've felt that I've broken down another barrier I've moved on another
 43 level. That's maybe sort of I don't know if that sounds sort of like a self satisfied
 44 thing I don't know but from my professional point of view then I do feel that I'm
 45 offering much more and the patients' benefiting because of that (AC right)

46
 47 AC Again can you say a bit more about that perhaps about what ways the patient's
 48 benefiting?

49

50 ML Firstly accessibility most days people will be able to if it's a day I mean if I've
51 got a diabetic clinic then that probably is slightly different but if I've got days that
52 I'm doing the nurse practitioner surgeries that are like open access most people can
53 get same day appointments so accessibility has improved. It may be that all the GPs
54 are booked up so it's another alternative for patients to be seen that same day and
55 that's been acceptable and the way patients have accepted it it's been wonderful as
56 well there's people what is nice is when they come through the door they say they've
57 asked for a doctor's appointment but no doctors are available so I've come to see you
58 and I don't know whether you're going to be able to help' and when you are actually
59 able to help that's a lovely feeling. In some ways when that happens you think you
60 feel a bit of a barrier at first because you know they've said you're second choice
61 you're second best if you will and that probably in some ways makes you more
62 determined that I'm going to get to the bottom of this problem one way or another
63 (AC aha) as well and usually there are very few things that I've come across that I've
64 not felt I've been able to deal with but I feel like totally like a fish out of water so
65 most things I can go so far with and so from the patient's point of view it has
66 improved same day access. From a practice point of view the urgent extras that the
67 doctors were seeing at the end of surgeries has reduced because my appointments are
68 available so the majority of my appointments are booked, they're not specifically left
69 for same day appointments but tend to be maybe about 50% will be same day booked
70 (AC uhum) and you tend to find because of the nature of same day booked
71 appointments the biggest proportion are minor self limiting illnesses that I am more
72 than capable of dealing with (pause) the patients get easier access, the GP workload
73 to a certain extent even though there are six doctors and only one of me it has made a
74 difference to their work load and that again improves morale within the practice
75 because you making life a bit easier for everybody (AC mm) erm what else? I've lost
76 me thread totally now (laughs)

77

78 AC In the midst of all because you've just given a wonderful description of how your
79 role contributes (ML yes) what would you say you enjoy most about your day to day
80 work?

81

82 ML What do I enjoy most? I enjoy being able to complete an episode of care and
83 when somebody's come in with a problem that I do enjoy it it's probably a self
84 satisfying thing when they think I'm not going to be able to help them and I do, (AC
85 right) it's quite a nice feeling that you know. Part of that probably is because I've
86 lived and worked in the same area for a long time so obviously patients have seen me
87 working in one role and are quite surprised to see you doing something else
88 particularly like as a treatment room nurse and a practice nurse wearing uniform and
89 then suddenly you're not in uniform (AC mm) and that you get you actually do get a
90 different response to people they do respond differently to you in that way rather
91 than when you're wearing uniform. That's something that I've felt at first when I
92 first qualified I still wore uniform for a while (AC right) and that definitely made a
93 difference coming out of uniform (AC uhum) because that in a way it made the
94 patients realise that I was a different kind of nurse but you still I do still do get a few
95 that will come in 'so you training to be a doctor then?' (AC laughs) that always is
96 going to happen – you see I've gone off at a tangent again (AC OK it's OK both
97 laugh) it's like total waffle. Erm (pause) I enjoy helping people (AC aha) what has
98 surprised me when I first started I really felt out of me depth with the mental health

99 issues (AC right) and that's something that I find whether it's because patients
100 perceive that as a nurse you have more time and in some ways I do have more time
101 because my appointments are fifteen minutes appointments if somebody comes in
102 you know there's a huge amount of depression in O (AC mm) and if you do get
103 somebody that comes in I feel that I can give them that time (AC uhum) and I'm
104 really sort of amazed at how you know I can feel it within myself how my old
105 communication skills and things like that are improving all the time. And I used to
106 feel the minute somebody came in with a mental health problem that I'm out of my
107 depth here I can't cope with this whereas now I'm happy to discuss medication
108 counselling and things and I think and what makes you realise that yes I must be
109 doing a good job is when people come back to you (AC mm) that's a nice that's a
110 nice feeling when you see somebody you've whatever problem it may be and
111 something else crops up and they come back to you and they ring up and they'll ask
112 to see you rather than (AC mm) being offered it as an alternative (AC mm) so that's
113 a satisfying feeling and I think you know all reception have noticed that they've
114 commented on me after a while of doing this patients do actually ask for you (AC
115 uhum) rather than it being a case of filling up an appointment and do it that way so
116 that's

117
118 AC Yes like you said before they erm they are told they can come and see you
119 because they can't see a GP (ML yes) and so it's very different when they ask for
120 you

121
122 ML Yes that's right and you know that's the way you know you do feel you know I
123 must be doing things well (AC yes and can you – sorry go on) you do I mean I've
124 had er without being too specific, I've had a couple of patients that I've seen recently
125 chronic bronchitics that I've actually initiated new treatment and got a vast
126 improvement and these are people that have had years and years of poor management
127 (AC mm) and one who could only get half way up the stairs before she had to stop
128 for breath, now she can get all the way up the stairs and they come in and say 'thank
129 you (AC mm) you've done a good job' yes (AC mm) so that's particularly when it's
130 been a long term chronic problem and I think along to that is having that extra bit of
131 time with people (AC uhum) that you don't feel that you've got the pressure of ex
132 amount of people waiting out in that waiting room and you know you've only got six
133 minutes with this patient (AC uhum) that you don't have time to get you've got to
134 treat the presenting problem and you don't necessarily get that and I think that's
135 maybe where what I do to a certain extent differs I've got that extra time (AC mm)
136 and it may be that you know the patients like that so that's why they why they come
137 back to me because all across the board the majority of patients perceive nurses as
138 having more time (AC mm) than doctors do so that's quite I enjoy having that time I
139 hope that never gets taken away (AC yes) yes (AC mm) because you think fifteen
140 minutes appointments it sounds like excess but it's amazing how you manage to fill
141 it (AC mm) but you know hopefully that will continue it's working so far

142
143 AC Yes so can you explain a bit more then about erm about that time and erm what
144 you enjoy about having that extra time with patients

145
146 ML I think you feel less because you've got you know you've got that extra time you
147 feel less pressured into say cutting corners not doing things thoroughly I feel as
148 though I've got that time to be able to do a full examination (AC mm) take a

149 thorough history and I think if I didn't have that amount of time, I mean obviously
 150 the more experience you get you'd be able to do that much quicker and more
 151 focussed than what even myself would have done two years ago (AC mm) so you
 152 can focus on things that bit more (pause) but I think part of this is probably sort of
 153 living and working in the same town is knowing that little bit more about people's
 154 families and because obviously that's all having an impact on their health so you
 155 know you feel you can look into that side of things a bit more (AC mm) there are
 156 occasions when you know people just want to come in they want to deal with the
 157 presenting problem and they want to go but I think that's part of the skill you
 158 develop is being able to pick up who wants that and who wants to spend a bit more
 159 time and that probably comes back to the mental health thing. I never thought I
 160 would enjoy mental health as much as what I have done (AC mm) because it was
 161 always even you know sort of during training something that I really felt quite
 162 frightened of (AC uhum) so that's erm yes that's definitely an interesting part (AC
 163 mm) and that's I think that's where that time comes into it but as I say it allows you
 164 to be thorough without feeling pressurised to be moving on to the next patient (AC
 165 mm) a lot of that may be comes from because I've done a lot with the diabetic care
 166 (AC uhum) and that's something that you know there's a lot of family issues and
 167 things surrounding that and I do still enjoy doing the chronic disease as well as the
 168 acute things (AC uhum) I think the patients like familiarity of seeing the same person
 169 and all that goes with that as well
 170

171 AC Mm right so you started off by talking about the complete episode of care and er
 172 you also talked about the mental health point of view so again it sounds like a
 173 complete picture that you're talking about erm is there anything more that you would
 174 say you value in what you do day to day anything that springs to mind in terms of
 175 you know giving you enjoyment or giving you meaning in what you do?
 176

177 ML I think erm (pause) professional wise, I feel proud of what I've achieved (AC
 178 aha) especially you know I mean because when I started the circumstances that lead
 179 to me working as a practice nurse as a treatment room nurse because I'd just had my
 180 son you know I was single parent so I came into it totally unprepared (AC mm) and
 181 to now look back at what I was then to where I am now that sense of achievement is
 182 (AC mm) you know we're not talking about your contact with patients just from a
 183 personal point of view to have got through all that educational side of it and to have
 184 done that is yes is quite a proud feeling (AC mm) and it spurs you on to do more, you
 185 know I've just done the prescribing course, you do that and you think right well what
 186 shall I do next (AC aha) it's maybe the motivation is I suppose is what I mean isn't
 187 it? From actually going into that educational side of things has motivated me to do
 188 more (AC uhum) since finishing that I've done the Warwick diabetic course and then
 189 now the prescribing course and I come out of one and I think right that's it (AC
 190 laughs) and then it's 'what shall I do next?' (AC yes) so my own professional
 191 development is quite satisfying (AC mm) yes. I don't know if that's what you (AC
 192 yes absolutely yes) laughs
 193

194 AC Is there anything else that erm you would to say gives you that feeling?
 195

196 Pause
 197

198 ML There probably is it's just coming up with it

199

200 AC Yes (pause) And to a point I mean if we don't cover everything in this interview
201 that's fine because you can jot it down when I send it back to you (ML yes) so it's
202 not that I'm not searching for anything in particular (ML laughs) but just giving
203 you a chance to say anything that you feel is of value

204

205 Pause

206

207 ML I'm sure there is

208

209 AC To look at it from the other perspective is there anything that er you don't enjoy
210 about what you do?

211

212 ML I think the main thing is not so much saying I don't enjoy which is again going
213 back to the prescribing is the frustration that I felt from that point of view that you've
214 seen somebody that you've made a clinical decision you know what treatment is
215 needed but you just can't just do that last little bit (AC aha) so that's a frustration
216 rather than and that again from your patients' point of view can delay them getting
217 medication. Most people I mean I've never come across any problems most people
218 are pretty happy to come back and pick prescriptions up but there are times that I'll
219 be seeing people and there isn't a doctor in surgery so they have got to come back if
220 they need but that's a down side but that I know is going to improve (AC uhum) erm
221 occasionally with referrals particularly if it's two week rule referrals that they'll send
222 them back and say this needs a doctor's signature and things like that it's a bit
223 frustrating but that's about role recognition I think (AC uhum) that still there's a lot
224 of places that don't understand what we're about (AC mm) and when anything like
225 that does come back, it's just a case of er the doctors don't necessarily see these
226 patients they're happy within our own practice I feel that the doctors have confidence
227 in the decisions I make (AC uhum) and will countersign things like that without any
228 problem. The other thing with that that is not accepted is x rays (AC right) but most
229 things referral wise there's never any problem with (AC uhum) and I suppose the
230 other thing that's a bit frustrating as well is with referrals I don't know whether this
231 happens everywhere or what there is you can do about it is that the letters come back
232 to the GP first (AC mm) so you feel yes you're doing this completely but you're still
233 sort of pushed to the sideline a little bit from that point of view (AC uhum)
234 everything obviously gets passed on to me but you're not the first person to see
235 what's happened to that patient next (AC mm) so that's a bit frustrating (AC uhum)
236 but again I'm sure in time things like that are going to change (AC uhum) I suppose
237 it's up to us to get out there and change it (both laugh) Erm erm but no I can't I don't
238 think there's anything that I can say I don't enjoy about it (AC mm) no

239

240 AC OK that's great. Is there anything more that you'd like to add to what you've said
241 so far?

242

243 ML I don't know half of what I've said I've just sat here and waffled (laughs) I don't
244 think there is (AC no) I can think about it (pause) but I must admit I'm surprised how
245 well it's been accepted (AC uhum) how patients have responded and been more than
246 happy to but I still think that you know there's a lot of people out there that still
247 know me as the little girl that grew up in O (AC right) you know because that there's
248 people that either they'll come to see me that I went to school with or there's people

249 that know my parents and they'll probably still see me as their little girl (AC uhum)
250 and maybe don't appreciate what has gone in to getting me to the position that I am
251 now (AC mm) but I'm quite happy to tell them if they want to know (both laugh)

252
253 AC But from what you were saying that's not stopping them from coming to see you

254
255 ML It isn't no no I mean maybe that's something that maybe I just wondered what
256 because there's people that I've grown up with that now come to see me in this role
257 (AC aha) and you know when you go out there do they think 'blimey I remember her
258 when she was at school she wasn't that clever' (both laugh) but I mean I don't I've
259 never seen it as a problem it's just something you think I wonder what people do
260 think (AC mm do you sorry go on) we all like to think people think well of us don't
261 (AC mm) we but then again they wouldn't come back to me if they didn't think I was
262 doing a good job so I think I do yes yes (pause)

263
264 AC Thank you

265
266 ML I hope that's alright I feel like I've just talked a load of rubbish

267
268 AC No you haven't

Transcript Summary

Pilot Interview 2 NP

This transcript suggests that ML finds being able to offer patients a complete episode of care is very satisfying^{17 81}. Being able to refer^{18 30} and do physical examination and assessment²⁷ allows her to complete an episode of care with a patient. Previously there was always a cut off point²⁸ and she felt ill equipped to proceed further²⁹. As the patient only has to deal with one person she now feels that she offers a better service³⁵ and that she has broken down another barrier and moved onto another level⁴⁰. She feels frustrated when she is prevented from offering a complete package of care due to prescribing^{211 214} or referrals not being accepted (for example the two week rule referrals)²¹⁸ and feels this is due to a lack of recognition and understanding of her role²¹⁹. Letters come back to the GPs²²⁷ and she finds this frustrating as she feels she is pushed to the side-lines²²⁸.

ML says that patients sometimes consult with her because they are unable to get an appointment with a doctor⁵⁶. She says that when she is able to help in this situation it is a lovely feeling^{57 84}. She sometimes feels there is a bit of a barrier because she is second choice or second best⁵⁹. But that makes her more determined to get to the bottom of the patient's problem. She feels it is wonderful the way patients have accepted seeing her⁵⁴.

ML says that she enjoys helping people⁹⁶ and she feels that coming out of uniform made patients realise that she was a different kind of nurse⁹³. She feels her role has made a difference in the practice as it has reduced the workload of the GPs improving morale and making life a little easier for everyone⁷³.

ML feels that her communication skills are improving all the time¹⁰⁴ and is now more confident to work with people who have mental health problems¹⁰⁵ and enjoys working with this group of people¹⁵⁶. She feels she must be doing a good job when people come back to see her¹⁰⁷ and says it is a nice feeling when people specifically ask for an appointment with her¹¹⁰. She enjoys doing the chronic disease¹²⁶ as well as the acute things¹⁶³ and enjoys having extra time to spend with patients^{127 132 135}. As she has the extra time she feels less pressured to cut corners¹⁴⁴ and feels able to do a full examination and thorough history¹⁴⁵.

ML feels proud and satisfied¹⁸⁶ with what she has achieved professionally^{173 177 179} and feels that having got through all the educational side has motivated her to do more¹⁸³.

(The small numbers refer to the line of the transcript where the idea can be found)

November 30th 2003

Pilot Interview 3 DN

1 AC So here we go erm It's looking at erm what you value about your role what your
 2 ideas and beliefs are about your role and about your work in general and erm so I'm
 3 interviewing people across the primary health care team so looking at GPs, nurse
 4 practitioners and district nurses and it's er a slightly unusual erm interviewing
 5 technique so I'm just going to ask you one question and then we'll just go with
 6 whatever you say in response to that (MI mm) so it might feel a bit odd you might
 7 think I don't have any more to say but just go with whatever comes into your mind
 8 and feel free to say whatever if there's anything you think 'oh I wish I hadn't said
 9 that' just let me know and we'll just erase it but equally when we've finished I'll
 10 transcribe it all and send it back to you and if you want to remove anything fine or if
 11 there's something you think of 'oh I wish I'd said that' then you can add it
 12 afterwards (MI right). So really this is just sort of the first step in the process (MI
 13 yes) so I'm just going to get a piece of paper out here in case you say something and
 14 I think 'oh I must remember to go back to that' erm I'll just jot it down as we go
 15 along, I'll just get a pen here we go and I'll just grab my coffee as well (both laugh)
 16 so we can sip as we go along. And there's no sort of time limit except I do say
 17 absolute maximum of an hour because most people have got a lot of other things
 18 pressing on them in the day so maximum of that but you know it might be twenty
 19 minutes or forty minutes whatever you want OK

20
 21 MI So what is your background are you nurse practitioner?

22
 23 AC Yes I am working at W that's where I do half of my week (MI right) and then the
 24 other half I do a bit of work at H surgery (MI right) in the middle of the area (MI
 25 nice place) yes erm and then er in fact the district nursing team there are brilliant real
 26 combination of roles erm and then I do a little bit of work helping practices with
 27 audit and things like that and the rest of the time I'm studying so that's my
 28 combination. Erm so the question is 'what do you find most meaningful er to you in
 29 your work?' What gives you most meaning?

30
 31 MI Probably having control over the patients I mean the GPs the role has changed so
 32 much because everybody's under so much pressure aren't they of patients and time
 33 (AC mm) and erm we do a lot more chronic disease management and erm sort of in
 34 the when I first started on the district we just did what we were asked to do basically
 35 (AC right) you know the doctor would ask you to go and do a blood pressure and
 36 then somebody would ask you to do a diabetic blood or this blood or whatever
 37 whereas now erm I don't know whether the others have mentioned to you about the
 38 integrated records we've got (AC no) well we've got integrated records now
 39 computer records where we all put our consultations on so we've got free access to
 40 the patients that we're looking after (AC uhum) we can see at the touch of a button if
 41 they're diabetic if they're anaemic if they're should be having this checked or that
 42 checked (AC right) and when we're due if we're asked to go and do for instance
 43 somebody comes out of hospital or somebody falls and we just get asked to go we
 44 can have a quick look and you know see if there's anything that sort of relates to that
 45 (AC mm) it has helped a lot (AC mm) it's also helped a lot in sort of the
 46 management of the case load because erm you know we can try and encompass
 47 everything in a few visits rather than you know you could go and visit one patient
 48 and give them a three monthly B12 for instance and then the next minute the doctor

49 would ask you to go and do a blood or a blood pressure (AC mm) or you know
 50 whereas you know when we're sort of erm got our own registers round at the office
 51 that say six monthly this or three monthly that or (AC right) and try and link them all
 52 in together (AC aha) you know we make it's obviously a longer visit (AC yes)
 53 because we're doing a lot more when we go (AC uhum) erm I'm trying to think what
 54 else what else might the flu vaccines for instance (AC mm) we try to encompass
 55 other things in with that (AC mm) should they be having yearly bloods checked for
 56 hypertension treatment or all these type of things and try and interlink it and the GPs
 57 more or less sort of not exactly given us total control but have more or less said if we
 58 feel there's something appropriate that should be checked rather than keep going to
 59 them every five minutes shall we check this blood shall we check that you know
 60 they've more or less said you know if you think something's appropriate (AC uhum)
 61 you know to just do it (AC right) for their patients

62
 63 AC right and that's a change isn't it? (MI uhum) Aha so can you say a bit more about
 64 that erm you started off with saying erm the control that you have

65
 66 MI Well you feel as though you're involved more in the care (AC right) it's a bit
 67 more like beforehand a bit like task orientated your job (AC uhum) whereas it's more
 68 holistic now and looking at everything all together and doing everything that's
 69 appropriate at the same time well it's also better for the patient as well you know
 70 there's nothing worse than someone asking for a blood test and then you know then
 71 next the practice nurse practitioner K asks for a diabetic check that kind of thing (AC
 72 mm) so you'd have to go and do the bloods again (AC right) erm I mean in the
 73 practice they still tend to be a bit more oriented to diabetic clinic hypertension clinic
 74 that type of thing (AC mm) they may come to diabetic clinic and then come to have
 75 their INR done the next week (AC mm) that type of thing but they're trying to sort of
 76 it's been more difficult in general practice because the turn over is a lot faster isn't it
 77 (AC mm) they maybe haven't got time to analyse quite as much as we would have
 78 (AC mm) erm it's sort of erm I don't know I think a lot of it is to do with respect as
 79 well (AC right) you know S and I have both been district nurses in L now for over
 80 ten years (AC mm) and I think over time the GPs get to respect your judgement as
 81 well (AC mm) I don't know whether you've found that (AC mm) elsewhere

82
 83 AC Yes You've been around for that length of time (MI uhum) right OK so you want
 84 to say anymore about that?

85
 86 Pause

87
 88 MI Erm I can't sort of think off hand you mean to do with erm the control

89
 90 AC About the respect side of things

91
 92 MI I think over time as well when you've worked in an area the population get to
 93 respect you as well

94
 95 Pause

96
 97 AC mm because they've known you for some time aha right is there anything more
 98 along those lines? (Pause) That's fine if something springs to mind you can bring it

99 back later. So erm so that's great I got I understand that erm you enjoy that erm
100 control that involvement in er sort of decision making

101
102 MI It's to do with job satisfaction

103
104 AC Yes so can you say a bit more about what erm gives you particular job
105 satisfaction?

106
107 MI In our particular role?

108
109 AC Yes yes what other things?

110
111 MI Erm well we've done quite a lot of work on leg ulcer management (AC uhum)
112 and tissue viability that's my little speciality that I enjoy the most (AC uhum) erm
113 and I think er we've had quite a lot of work now where the GPs and the practice
114 nurses they now feel it's sort of more our role set up a leg ulcer clinic and erm erm
115 we sort of got the GPs know that sort of we've done a lot of work in leg ulcer
116 management and they refer patients for our advice (AC right right) so that's sort of
117 they've given us that that er role if you will

118
119 AC Aha as your area (MI mm) of expertise (MI uhum)? Right and you said that
120 gives you satisfaction is that right

121
122 MI Well also because when you get good results. In the past you know because
123 we've had all this recent research well it's not recent ten twenty years of research
124 when I started over ten years ago we had lots of leg ulcers on the case load patients
125 never healed erm and I mean now we get them healed (AC mm) and it's nice to be
126 able to say to patients you know you know we'll get this healed (AC mm) and to be
127 able to say we that we will when you know years ago we couldn't really (AC mm) so
128 you get a lot of job satisfaction and knowing that patients are going to be happy as
129 well

130
131 AC mm yes so is there any more you can say about that part of your role?

132
133 MI Well it's also now increased into we're doing a lot more preventative (AC right)
134 erm when we're seeing patients for other reasons as well we get them into
135 compression hosiery we get them assessed and get them into compression hosiery
136 before ever start getting ulcers

137
138 AC right so you get patients referred to you for that do you?

139
140 MI Erm yes and no usually they get referred to us if they've got a very nasty varicose
141 eczema or oedematous legs or leaky legs (AC right) or maybe they may have been
142 referred for something else and when you're assessing them you notice that they've
143 had problems in the past or varicose veins or healed ulcers in the past (AC mm) and
144 maybe they're not wearing compression hosiery to prevent recurrence so then we
145 would advise them or try and encourage them to have hosiery

146
147 AC Right so that's the preventive side of it aha right OK so erm so just to take a step
148 back again to the broad area of your work erm and you've already said quite a few

149 things that give you job satisfaction or give you meaning erm is there anything else
150 that you want to say?

151

152 MI Yes palliative care (AC right) caring for patients at home erm if erm if they
153 choose to die at home

154

155 AC Right and can you explain a bit more about that?

156

157 MI Erm well generally patients erm we've got a very good McMillan nurse who gets
158 to know the patients very well but over time we try to establish you know before
159 hand that the patients what the patient's wishes are what the relative's wishes are
160 (AC mm) erm and if possible if they want to stay at home you know we will look
161 after them at home or we have got you know some quite good facilities around here
162 at the local hospital (AC right) so quite a lot of them it's sort of like the next step
163 really to the hospice the hospice is quite a long way off (AC mm) for people visiting
164 from here (AC mm) whereas the community hospital erm it's really the next best
165 place to being at home if you will (AC mm) it's the general hospital so patients
166 usually usually they say they don't sort of say for definite they want to stay at home
167 always but we always sort of let them know what's available and usually there's
168 always plenty of beds at the cottage hospital (AC right) and patients can usually be
169 admitted at last minute notice (AC mm) and we've also got nurse led beds at the
170 hospital we're allowed we've got a nurse led bed criteria (AC OK) I mean we don't
171 admit a lot of patients but erm if we have to for some reason we can do that (AC
172 right) erm I can't remember what all the criteria are but it's to do with rehabilitation
173 and erm erm management of wounds (AC mm) and palliative care erm (AC mm)
174 there's there's I think there's five criteria for nurse led admission

175

176 AC OK right so erm what would you say about palliative care that you find is most
177 valuable or that you enjoy?

178

179 MI erm just being able to give the patient the best possible care that you can give
180 them really (AC mm) the nursing care side of it and erm and the symptom control
181 (AC mm) because often in the general hospitals they haven't the time (AC right)
182 probably although we haven't got a lot of time but we try to allow time more time
183 (AC mm) especially you know cus it's the last few days and it's the last they can
184 possibly have isn't it? The last of your care that they can have (AC mm) so we try to
185 prioritise really really strictly when we've got terminal patients and give them as
186 much care as we can possibly give them (AC mm) and if that means four visits or
187 more then we'll try and do that (AC mm) it's quite good here because we're local
188 we're quite central quite often patients are just down the road (AC uhum) which is a
189 lot of areas haven't got that service really cus the patients they've sent us are so far
190 away in rural areas

191

192 AC mm and that's because the community hospital's right here (MI mm) right right

193

194 MI Sometimes your patients are within walking distance

195

196 AC Mmm Oh I see for you you mean from here (MI mm) I see yes yes right

197

198 MI I mean when they're when the patient's in the community hospital unless they're
199 nurse led we really don't have a lot of dealings although if we've had long a lot of
200 input with the patients we do tend to visit them anyway (AC I see) because they're in
201 our vicinity (AC yes right) you know we have erm we have weekly meetings at the
202 hospital anyway with the social workers and erm the hospital and the CPN team to
203 discuss discharges anyway (AC right) and any problems we've got with anybody
204 (AC right) so I mean we're often on the ward, it's our base, the hospital's our base
205 (AC uhum) but we're not exactly on the ward but we're in the hospital (AC right) but
206 of course if they're nurse led well we have to have not daily input but we have to
207 have input into their care (AC mm) we have to sort of manage the care (AC right) we
208 don't give the care

209
210 AC right yes you're overseeing the care (MI mm) right interesting. So erm what do
211 you think it is about palliative care in particular you find satisfying?

212
213 MI I think it's probably just erm allowing the patient to go through a peaceful death
214 really and erm (AC mm) well as nice as possible really I know death can't be nice
215 (AC mm) and supporting the relatives and informing them of what's going to be
216 happening and then erm offering all the services that are available because there are
217 quite a lot of things that are available to help them (AC mm) you know hospice at
218 home and McMillan nurses (AC mm right) I think it's just seeing that they're
219 comfortable and peaceful and (AC mm) it's very difficult to explain really (AC mm)
220 what it is

221
222 AC Yes sometimes it is difficult to put these things in words (MI calming and)
223 (pause) AC yes so you helping calm the situation? (MI right) and is there anything
224 more about palliative care you'd like to add? (MI Erm) (pause) that's fine as I say I'll
225 send you the transcript and if there's anything you want to add you can. Erm so again
226 back to your general role is there anything else that you would say you find you
227 know that is most meaningful to you?

228
229 MI Probably just learning new skills and and I don't know really but we've got a lot
230 more clinical skills than when I first started we erm you know we a lot of patients
231 had to come to surgery because we couldn't do ear syringing and we couldn't do this
232 and we couldn't do that whereas we've all been trained in ear syringing and zoladex
233 implants (AC mm) and all these extras male catheterisation of course which and the
234 flu influenza vaccine (AC mm) and all these types of things so you know it's
235 increasing our role really because a lot of other areas have taken a back step if you
236 will we've now got a lot more support workers for mental health and erm erm the
237 medicines management is a lot different now I mean we used to do a lot of medicines
238 management which of course there was no other way round it but of course we
239 realised you know we had to do it because there was no other way the chemist I
240 mean I sort of got that implemented myself because we realised you know it wasn't
241 acceptable what we were doing medication administration for patients who were
242 unable to manage their own really from their bottles (AC right) erm and I sort of got
243 it implemented and in the end they ended up having a study erm we used to have I
244 don't know how many cus when the study first came out they took ten ten of our
245 patients off us and then increased it to fifteen so I mean we must of have nearly well
246 I think we had nearly twenty patients that we used to go out every week and fill
247 Dossette boxes (AC Oh I see) you know because they were incapable of that

248 supervision of medications really (AC mm) which I mean it wasn't really acceptable
 249 (AC mm) because we were in theory breaking the law but there was no they were
 250 doing it around the county I don't know what (AC mm) you've come across
 251 anywhere else erm and then of course we realised in the bigger cities and around
 252 about you know that chemists were doing it (AC mm) and they could were doing.
 253 Anyway I think some money came I think erm I think its from the HAZ (AC oh yes)
 254 because I'd been trying quite a bit of problems trying to negotiate who was going to
 255 pay (AC mm) you know and the chemist the chemist would erm the chemist said she
 256 would do it if she had weekly scripts and the GPs didn't want to do weekly scripts
 257 (AC right yes) a bit of backwards and forwards and in the end it came this money
 258 came for this study (AC right) so we could actually give them ten patients first so of
 259 course we gave them the ten with the most medications (AC right) which made it
 260 better and then increased it to five more so that was fifteen and when this study
 261 eventually finished erm all the patients went back went on to paid so the R worked it
 262 out it was going to cost £3 a week for them to do it and they all pay now £3 a week.
 263 And if patients need management of medications we just say well you know that is
 264 what you have to have (AC mm) and we really don't do them so we don't do any
 265 now (AC mm) just in an emergency of a weekend or (AC mm) until it could get
 266 started (AC mm) so there's quite a lot of things in our practice that have changed
 267 (AC mm) but then there's a lot of more different areas where we're involved now
 268 (AC right yes so) so the role's changed quite a lot (AC uhmm) erm and I think also
 269 with just generally where we used to do seemed to appeared to be doing a lot of task
 270 orientation (AC mm) erm I feel personally that you get more involved generally with
 271 the patients and the visit is more meaningful in that you do a more intense visit if you
 272 will (AC mm) and then your maybe staff nurses or health care assistants will follow
 273 up what you've assessed but then anytime you go do you know what I mean (AC
 274 mm) the visits take longer because you're doing a better job basically (AC mm) at
 275 the visit if you understand what I mean (AC yes yes) whereas people were running
 276 round like headless chickens trying to do all these tasks (AC uhmm) and maybe not
 277 sort of involving the carers or family or

278
 279 AC Erm and when you say you have quite a meaningful visit, are there some that are
 280 more meaningful than others and if so can you put your finger on what the difference
 281 might be?

282
 283 MI No I think they're all the same really I think back that erm erm I mean the first
 284 visit I think probably sometimes the first visit until you get to know the patient unless
 285 you know the patients of old which quite often you do (AC uhmm) erm I think it
 286 gives you a lot of job satisfaction just with having to go in and have the time to
 287 assess the patient properly and to make sure that even though you've just gone just
 288 specifically for one thing erm you know quite often you know there might be three or
 289 four things (AC mm) that nobody else (AC mm) has sort of thought of or picked up
 290 on or you know in the hospitals now they still tend to send you out to do a wound
 291 check or something like that when it's more than that really (AC mm) isn't it because
 292 I mean they send them out that quick now from hospital often they've got more than
 293 that wound

294
 295 AC Mm right so you find that most of your visits have that level complexity?
 296

297 MI Especially when they're elderly if patients are very are a lot younger generally
 298 erm they generally you know not as complex (AC mm) maybe because they haven't
 299 got much history much medical history but generally the ones that we see (AC
 300 uhum) have a history of other things (AC mm right right)

301
 302 AC So to look at it from another point of view is there anything that you would say is
 303 not enjoyable or you don't like in your day to day work

304
 305 MI Erm just inappropriate referrals I find annoying (AC aha) which we still get a lot
 306 of erm although erm they are really very good here erm I think the problems stem
 307 from the general hospitals in they get a bit blinkered that it's all district nurses and
 308 everybody seems to refer everything to district nurses (AC mm) where it could be
 309 health visitor or practice nurse or erm I mean they still refer patients for sort of erm
 310 maybe they've been and had a little op on their arm and maybe they just live round
 311 the corner and they're asking the district nurse to go and they might be twenty or
 312 (AC mm) twenty years old and could walk round (AC aha) things like that.

313 Sometimes all the politics and everything all the policies that people are trying to to
 314 you know it's so different now in that everything's going on and trying to implement
 315 this and this and this and sometimes you can get bogged down in meetings or people
 316 wanting you to attend this and that (AC mm) single assessment is the thing at the
 317 minute (AC mm) and you know constantly and they're trying we're trying to have a
 318 pilot in L or C with managing social and health care together and you know there's
 319 all these things on the agenda and sometimes you feel as though you're getting
 320 bogged down trying to keep up (AC mm) that's the hard that's the hardest part (AC
 321 mm right so) and also staffing levels can sometimes be a problem (AC mm) we don't
 322 have you know people at the moment we're struggling with staff sickness erm and I
 323 mean sometimes we feel as though we don't get the support because because of the I
 324 think it's the budgets and more money and never any money to pay not enough
 325 money to pay (AC mm) the really so that can be very frustrating when you're short
 326 staffed (AC mm) because if you get used to doing a complex visit and then you
 327 suddenly find you haven't got the time to do it (AC right) I mean the jobs have
 328 changed as well in that we have extra roles to do now I mean S does the
 329 determinations for the nursing care for the local home (AC mm) the nursing care
 330 level (AC right) and I also do cardiac rehabilitation (AC OK) the heart manual so I
 331 mean they're all extra (AC mm) sometimes it's quite difficult trying to juggle fitting
 332 these extra things in (AC mm) into the case load (AC yes) because you keep getting
 333 these extra jobs but nobody extra to help you do it (both laugh) that's one of the most
 334 frustrating parts.

335
 336 AC right yes I could imagine so you've got all these extra skills and who helps you
 337 with that yes yes Is there anything more you'd like to say about what you do and
 338 what you find enjoyable in what you do?

339
 340 MI Erm just erm having contact with with a lot of other professionals and day to day
 341 contact with a lot of people here we've got quite a good working relationship with
 342 the doctors and the practice nurses and social workers you know we've got quite a
 343 good general team in L (AC mm) erm everybody sort of works really well together. I
 344 mean I've worked in other areas er when I first qualified I had to go and work in W
 345 and when I did nurse er practitioners training I was in E er and they're very team
 346 orientated here and we they don't see their practice nurses and I mean you can help

347 each other so much really (AC uhum) when you've got a close working relationship
 348 (AC mm). I know the mental health team well and the social workers you know they
 349 say other areas you know they don't work like we're working (AC right) I think
 350 that's why I suppose it's very difficult as well because in other areas there's that
 351 many different teams whereas we're an isolated area here and there's just one
 352 practice and one district nursing team I know we take outlying patients some from B
 353 and from B but very few (AC right) so erm I mean all the information's there erm I
 354 mean I do feel this integrated record has helped a lot (AC mm) that was part of the
 355 erm pilot when er become PMS here (AC OK) that was one of the areas they looked
 356 at (AC right) integrated patient records (AC aha) erm and most people write their
 357 consultations on there now from the McMillan nurse to the health visitors (AC mm)
 358 school nurse the health visitor assistant, all the district nurses the midwives the
 359 doctors the practice nurses (AC mm) there's only social services really that aren't on
 360 there the CPNs write on (AC right) psychiatric nurse and all the (AC uhum) all the
 361 other people that sort of come to the practice smoking cessation (AC right) so you
 362 can see exactly what's happening and I mean you can see if patients have got
 363 appointments to see the doctor (AC mm) you can see if they've got appointments to
 364 see anybody else (AC mm) so erm just simply from if you've got a referral (AC
 365 uhum) or somebody rang you'd want to see do they generally go out can they get out
 366 when did they last ? (AC mm) when did they last have their bloods done when did
 367 they last have their blood pressures done (AC mm) all these types of things it all
 368 helps in their care

369
 370 AC mm right so the integrated record is almost a sign of the integrated team erm yes
 371 and so

372
 373 MI The doctors can see exactly what we're doing we can see what they're doing (AC
 374 yes) and they can see when we're next going and (AC mm) and you know we work a
 375 lot in that you know if they know we're going they don't go they'll go another day
 376 (AC right) so as we're not all going together (AC yes aha) so I think that's helped a
 377 lot in patient care (AC mm) as well as the management of our time (AC mm) and
 378 resources as well

379
 380 AC mm that's great. Is there anything else that springs to mind about your work?

381
 382 MI I think the general size of the caseload sort of tends to generally be bigger
 383 because we're doing this chronic management (AC right) so I mean in the past I
 384 think it'll change across the board in the long run when everybody they're trying to
 385 get these records everywhere aren't they? (AC mm) but I mean in the past we were
 386 always told you know you had your episode of care erm and then you had to get
 387 them off the case load but really in an ideal world that isn't ideal because they are
 388 chronic disease management they're always on your case load really you should be
 389 sort of there for them (AC mm) if they need you in between times (AC mm) and er
 390 they sort of need to be in an ongoing program to know that when you're next seeing
 391 them (AC mm) so they are still do you know what I mean they're still on your case
 392 load (AC mm) rather than in the past you would take them off and then K would
 393 refer you again (AC right) do you know what I mean as if it was a new patient again.
 394 I mean that has quite a lot of erm you know to do with the data (AC aha) in the past
 395 they would be classed as new patients I think there's a lot of I think there's a lot of
 396 work to be done on that really because erm I know you're doing a full assessment

397 again every time you see them but erm really they're still your chronic disease
398 management patients do you know what I mean (AC mm) whereas every three
399 months they were being classed as a new patient in the past which has got
400 implemented for your data (AC right) how many new patients you see and erm (AC
401 mm yes) it's a bit awkward really

402
403 AC Again it's a sign of change

404
405 MI So you see the Korner data they say it's meaningless anyway don't they (AC yes)
406 I don't know why I mean we don't do a lot for the Korner data because erm K takes
407 it off all our consultations off there yearly so she can see how many new patients
408 we've got how many erm consultations we've had and where they've been referred
409 from so she I mean we don't fill anything in now (AC mm) for the data she gets it off
410 at the end of the year (AC uhum) I mean I can look there now and search for the
411 statistics and see how many patients I saw whenever (AC right) June or October (AC
412 uhum) or (AC right) so I mean she can get all that data off there just at the touch of a
413 button

414
415 AC Mmm So that saves all that form filling in yes which I'm sure is a great relief

416
417 MI That's it I mean we used to have to put on how long we were with patients but
418 apparently that's one of the things that they don't want to know (AC mm) there was
419 minimum things that they actually wanted to know. We used to fill in all kinds of
420 things on these papers (AC mm) and all practically they want to know is how many
421 new patients you've seen over the year and how many new episodes of care you've
422 got and who has referred them (AC right) and all they want to know for the referrals
423 are is it a consultant is it a GP or other. That is all they want (AC right) it doesn't
424 matter whether it was a social worker or they referred themselves (AC mm) there's
425 just those three referrals (AC mm) they want. (AC right) So there's a lot of work
426 goes into it (AC sure) for what they want off it. (AC yes) That used to be very
427 frustrating but of course we don't have that now (AC mm) you know constant having
428 to send forms back in or register the patient or (AC mm) you've completed the care
429 and they needed registering again that's dreadful (AC mm) we used to get well you'll
430 have seen them reams of paper (AC oh yes) thankfully that's one thing less that we
431 don't have (AC yes) (both laugh)

432
433 AC Thank goodness for the computer eh?

434
435 MI I mean there was a lot of worry about the computer when we first I mean the
436 doctors were quite wary of it going out from here because it had been such a small
437 practice and access to it and you know patients and erm (AC mm) patients and staff
438 are patients and all this but there's a strict confidentiality code and we went through
439 we had a K did a training pack she did a training package for us (AC right)
440 everybody had to go through it (AC mm) and of course I mean you'll work with
441 them in your practice do you? (AC mm) You get your passwords for it every month

442
443 AC That's right yes. You actually you have this computer based (MI at L hospital)

444 got you right

445

446 MI We have district nurses have one the health visitor has one erm there's one in the
 447 hospital on the ward (AC mm) although they tend not to use it but the GPs use it in
 448 the hospital for out of hours erm in patients they see so they need one there and
 449 they've just they've just put one in the clinic at L hospital for the midwives (AC
 450 right) the midwives have them as well upstairs in our offices but they needed one in
 451 the clinic situation (AC sure right) because they struggled for space and I think erm
 452 I'm almost sure the CPNs the elderly mental health CPNs have one at the jubilee
 453 centre (AC OK) so they've put links out there (AC right)

454
 455 AC So it truly is integrated

456
 457 MI Yes McMillan nurse usually comes to our office to put hers on or here (AC
 458 uhum) when she's here she'll just comes ??

459
 460 AC Right right And presumably you have to come back and put the information on
 461 after you've seen the patient

462
 463 MI Yes that's the only trouble I mean in an ideal world I mean we have sort of talked
 464 in the future about lap tops and all this but you run into all kinds of problems with
 465 that as well. I mean generally what we do now is er we look on the computer for the
 466 patients we're going to before we go (AC uhum) to check where we're up to and
 467 what's happening erm the GPs if they get erm a visit a request for a visit they do a
 468 print out but I mean we didn't really you couldn't do that for the numbers of visits
 469 we're doing every day (AC uhum) plus you'd have the problems of disposing of the
 470 printouts and sometimes if we've got a very complex case I might get one to do some
 471 you know so as I've got it with me but very very rarely I don't think I've done that
 472 more than two or three times (AC right) we generally have a good look before we go
 473 (AC aha right) and it tells you gives you access to who's in the house if they're on
 474 their own (AC mm) really vital information (AC yes great)

475
 476 AC So is there any more you want to say about your role or particularly about what
 477 you enjoy or value about what you do

478
 479 MI I don't know I just enjoy it all really it's just the frustrations sometimes (AC mm)
 480 but it's all mainly political or managerial it's not really to do with the patients (AC
 481 mm) I don't know if that's just me (both laugh) yes erm (pause) when I did erm my
 482 district nursing fortnight whatever it was in my training I didn't like it at all (AC
 483 right) district nursing (AC aha) it's funny isn't it? (AC yes) I wouldn't have thought
 484 that I would have sort of done it I was quite pleased I did in the end

485
 486 AC What made you make the move to district nursing?

487
 488 MI Erm I think well what happened I was working erm at F well GH (AC mm) on
 489 nights (AC uhum) just two nights a week when the children were little (AC uhum)
 490 erm and then er of course general hospitals are so far away from L travelling well not
 491 so far but they are (AC yes) for work when you've got a family (AC aha) erm
 492 anyway there was the C became a nursing home at about the same time after I'd gone
 493 back after having my second child (AC mm) C just registered as a nursing home and
 494 they were wanting staff er somebody that I knew in the village worked there (AC
 495 mm) and she said 'oh we need some nurses do you want to come' and all this erm I

496 think it had become such a bind piling the children off to me mums (AC mm) going
 497 back for them and getting everything ready and plus I nearly had an accident coming
 498 home one morning after night shift I thought I'm going to have to do something
 499 different here so I went to the nursing home (AC uhum) I was there I think just over
 500 twelve months and then the erm job came up on the district on the evenings (AC
 501 right) six to nine (AC aha) evening service so I decided to apply for that so that's
 502 where it started (AC right) just doing the twilight service

503
 504 AC aha so that would have been a community nurse yes

505
 506 MI Evening staff it was an E grade post (AC aha) on evenings

507
 508 AC Right and how long ago was that

509
 510 MI That was '91 (AC OK) but it sort of escalated fairly quickly with it being a small
 511 area quite soon even when A was quite small you know you had to help out, could
 512 you help in the day and do this shift and that shift and then it just escalated really and
 513 then ninety four one of the staff nurses went to do her district nurse training so I did
 514 relief on the days so er A had just gone to school I think he'd just be five and erm
 515 and then of course the year after it came out that if we didn't go that next year if we
 516 didn't apply that next year to go it was really my last chance or else I would have to
 517 do my diploma first and it was going to be the degree program (AC yes) so I really
 518 had to apply to get in to do the diploma (AC right) there and then and thankfully I
 519 mean I would say no I can't do that I can't do that but I've got a very very good
 520 family

521 and me mum and I mean she knew how much I enjoyed me job and she said oh you
 522 can you can now so I mean she sort of had the children while I was away and helped
 523 out a lot (AC mm) erm and I went away and did it you see (AC mm) did the course.
 524 That's how it started

525
 526 AC Aha right you sort of evolved into it yes

527
 528 MI I sort of settled in straight away from the beginning really from the beginning
 529 (AC aha) and then erm yes I still love me job

530
 531 Interruption with phone call wrong room (both laugh)

532
 533 AC Yes so you love your job

534
 535 MI I do

536
 537 AC Do you think if I asked you the question what does it mean to you to be a district
 538 nurse as opposed to any other nurse that you might have been how would you answer
 539 that?

540
 541 MI I don't know really erm I think it's more sort of like a figure head isn't it
 542 somehow. I don't think it is as much so now because erm when I think of the district
 543 nurse when I was little you know everybody ran to the district nurse's house or they
 544 rang for the district nurse (AC right) she was like erm somebody in the area in the
 545 community that everybody knew and sort of respected if you will I don't know really

546 if that's true nowadays (both laugh) I think it is to some extent (AC right) especially
 547 in smaller areas I don't know because I mean there's quite a lot now isn't there about
 548 whether they should be wearing uniforms and but I think sort of takes away the
 549 identity of a nurse doesn't it (AC mm) or people see you and it's hello nurse hello
 550 nurse you know they all know who you are and in a small town like this (AC yes
 551 right) I mean that gives you quite a bit of er satisfaction as well really I think (AC
 552 mm) just all that knowledge and who you are (AC mm) I think you have usually
 553 been involved with most people's families over time (AC mm) and I suppose the
 554 longer that you're here that will be the same (AC mm). It's like Mrs L our manager
 555 you know she's been here for years she was district nurse before that she was
 556 practice nurse here then she was district nurse you know everybody she's like erm I
 557 don't know like a figure head to everybody we all know who she is do you know
 558 what I mean (AC mm yes) so maybe I might be like that in twenty years (both laugh)
 559 I don't know I don't know (AC yes) I think erm I think as long as you can give good
 560 care and everybody respects what you're doing I think that's the main thing and I
 561 think it's important you know they're quite strict now aren't they on people's
 562 conduct and what you're doing out there I think it is very important (AC mm) for
 563 people to be able to say it's no good to say oh she did this or she did that (AC mm
 564 yes I'm sure you're right) it's a bit like L police or the local bobby or the doctor or
 565 these type of people (AC mm So) I mean people do respect the nurses in hospitals as
 566 well mind but I think there's that many of them (AC mm) I suppose they tend to
 567 relate more to the ward sister don't they (AC uhum) or somebody that's in charge
 568 (AC mm) it's because of the physical numbers of them really probably (AC aha) so
 569 that's the same sort of feeling isn't it as the district nurses (AC yes) people do know
 570 me by name (AC right)

571
 572 AC Before we finish is there anything else that you can think of that you would like
 573 to add

574
 575 MI I should really have tried to prepare a bit more but I've just come back yesterday
 576 from a holiday you see (AC oh that's fine) and I just got me letter yesterday and I
 577 never had a lot of time yesterday and I thought I'll just go with the flow of what's
 578 asked

579
 580 AC Yes and actually that's great this is what this is all about it's just what you feel
 581 at the time and if you prepare too much you would probably come with script ready.

582
 583 MI I think the main thing is about value (AC mm) sometimes in the past we we've
 584 maybe sort of as a sort of district nursing team felt sort of more valued by the trust
 585 than probably by the practice (AC uhum) but I think as time goes on when they get to
 586 know your practice and how you work then you seem to get a lot more respect and
 587 value from like the GPs (AC right) although sort of generally I think the feelings
 588 generally are which is understandable that their staff are sort of just that little bit
 589 better than we are (laughs) I mean I don't know if that's come across before but I
 590 think that's the general feeling although I feel personally that I'm respected quite
 591 well here (AC mm) by the GPs (AC mm) but not everybody feels like that

592
 593 AC mm so when you say value erm can you just explain that a bit more
 594

595 MI I think mainly that's to do with erm with quantities rather than qualities of care
596 because I think sometimes I think it might be a lot to do with not really
597 understanding sometimes understanding the role properly (AC your role? OK) in
598 that erm you know in a clinic situation says in here they can see sixty patients a day
599 or what have you (AC OK) sixty that would be totally impractical you know maybe
600 maybe if we see ten or twelve or sometimes more of course I mean ideally it's not
601 ideal to see too many (AC mm) well to give quality care it isn't but it's all to do with
602 the difference of care isn't it in the clinic situation and patients just coming in for like
603 one thing (AC mm) erm and I think sometimes you sort of just sometimes feel you
604 know maybe they feel you're not seeing enough patients (AC mm) but I think I think
605 since we've had this I think it's erm I think its changing because they can see how
606 thorough that we're working (AC mm) you now erm the practice nurses put very
607 little on well they haven't the time have they? (AC no) whereas when we're
608 constantly assessing obviously our staff nurse and health care don't put a lot on cus
609 they you know maybe they just put that they changed a dressing because they're
610 following our care but when we come to put a full assessment on especially if there's
611 lots of problems (AC mm) sometimes you can write three pages (AC mm) so erm
612 I'm in there following up care or they're following us then they can see you know
613 how much we do (AC mm) what we're asking or checking out on (AC uhum) so I
614 think it is I think it is improving but generally I mean that's been the feeling here
615 since before I came back erm you know that they always seem as if they value their
616 nurses more than the community nurses (AC mm) but that's because they are their
617 staff isn't it? It's different. I think maybe if they are talking about GPs employing
618 their own district nurses aren't they? (AC uhum) maybe that might be different (AC
619 mm) but that's just something very very minor (AC right) it isn't a major issue (AC
620 uhum)

621

622 AC Right great OK is there anything more before we switch the tape off?

623

624 MI I don't think so (AC OK) I've talked enough I think

625

626 AC That's brilliant A thank you

Transcript Summary

Pilot Interview 3 DN

This transcript suggests that MI likes being involved in patient care, likes to know what's going on and to be able to make her own clinical decisions³¹. She likes to be efficient in what she does⁴¹ and gets frustrated if the system results in inefficiency. MI values holistic care, doesn't like the task oriented approach³⁵ and enjoys having the freedom to make decisions about patient care. She says this makes her visit to a patient more meaningful²⁷⁰, she values having time with a patient to carry out a proper assessment²⁸⁶ and doesn't like to see patients as an "episode of care"³⁸⁶.

MI enjoys her specialty in leg ulcer management¹¹¹ and gets satisfaction from getting good results when treating leg ulcers. She likes to get things healed and to let the patient know that it can be healed¹²⁶. She values the fact that this makes patients happy¹²⁹. She respects the research underpinning leg ulcer management¹²³.

MI values giving good care⁵⁵⁴ and enjoys the respect she gains from everybody by giving good care. She values being personally respected by the GPs and the local community^{79 536 580} and values wearing a uniform as a sense of identity⁵⁴³. She is aware people know her in the community⁵⁶⁴ and is aware of having to behave appropriately⁵⁵⁷.

She respects the wishes of patients and relatives¹⁵⁸ and respects the ongoing relationship with patients when they are admitted to the community hospital²⁰⁰. Palliative care is a priority¹⁸⁰ and her goal is to give the best possible care with control of symptoms for the last few days of the patient's life¹⁸⁴. She values a peaceful and comfortable death whilst keeping relatives informed²¹³.

MI enjoys working in a team³³⁹ and feels that you can help each other so much when you've got a good team³⁴⁶. She gets frustrated by the senseless filling in of forms⁴²² (although this is less of a problem now with data entry on the computer) and feels she gets bogged down with politics, policies³¹² and having too much on the agenda³¹⁹. She also feels there is a lack of support, a lack of staff and never enough money³²⁴ to provide enough staff. She values spending time with patients³²⁴ and values quality contact over quantity of contacts⁵⁹⁰.

MI was concerned about breaking the law in managing patients medications and so was actively involved in changing the system²⁴⁹. She values nurse prescribing and feels it gives her more control over care, more respect as a decision maker and more job satisfaction. Time spent with the family is more important than time spent travelling to work⁴⁸⁴ and MI values the support she has had from her family to help her in her career development and working life⁵¹⁶. MI enjoys learning new clinical skills²²⁹.

(The small numbers refer to the line of the transcript where the idea can be found)

November 30th 2003

Interview 1 NP

1 AC It's a very very informal style of research and basically what I want to do is just
2 chat with you about erm your ideas about your work (CA OK) er so er the main
3 question is 'Can you tell me what you find most meaningful in your work?'

4
5 CA Erm I think erm it's the challenge daily (AC uhum) er its given me I think doing
6 the nurse practitioner degree has er given me a whole new lease of life (AC right)
7 because erm I've done many things in nursing that I've really enjoyed but I think
8 before I did this I was becoming a bit not uninterested but it was a job (AC mm) and
9 after doing this it's it's given erm it's given me a challenge every day (AC aha) so I
10 think that's the main thing. I've forgotten what the question was.

11
12 AC (laughs) (CA laughs) it was 'what do you find most meaningful in your work?'

13
14 CA erm yes like I say it's the challenge (AC uhum) and I think probably erm the
15 patients seem happy with the consultations in the main (AC right) so that's to me is a
16 lot as well (AC mm) that they're satisfied (AC right) now I can't think of any way
17 else to answer that

18
19 AC Can you say a bit more about that?

20
21 CA Erm About consultations? (AC Yes or anything) anything about the job? (AC
22 aha)

23
24 CA I think I like the fact that I see the patients from the minute they come in with
25 their problem and nobody else has sent them to me (AC uhum) and they erm and I
26 have to diagnose (AC uhum) using all the skills we were given in college (AC uhum)
27 and I really enjoy that and I enjoy I really enjoy thinking I've done an examination to
28 the best of my ability (AC mm) and them saying they haven't been examined like
29 that before or something like that so that you know that you've done it to the best of
30 your ability (AC mm) Erm and I like the differential diagnosis I like it even more
31 now as I'm as I'm getting a little bit more erm what's the word? feel a little better
32 about seeing patients on my own (AC uhum) erm if I find out something and then it's
33 right and I've actually questioned somebody else and it is right it gives me lots of
34 satisfaction (AC mm) Er I don't think, I go back to the treatment room quite often
35 they ask me to go and do a blood test or whatever it is if it's been difficult or
36 somebody can't syringe an ear and will I go and have a look to see what I think just
37 anything (AC mm) and I don't want to go back down there I don't want to work in
38 that atmosphere I'm happier in here (AC right) in this room seeing people one to one
39 and hopefully having done my best for them (AC mm) rather than being sent things
40 and told what to do which I loved when I was doing it (AC uhum) I loved my
41 practice nursing and erm er and I liked running the clinics see I don't run clinics
42 anymore (AC right) erm so er I do miss that a bit but on the whole I like doing I'm
43 on what we call on call all the time so whatever comes in anything it comes to me
44 first and I either see it or if I don't think it's suitable I pass it on (AC uhum right)
45 I've gone off the tale a bit haven't I?

46
47 AC Not at all (both laugh) is there some more you can say about that?

48

49 CA Erm (pause) I'll just have to have a little think (AC that's fine that's fine) Er the
 50 way we actually erm we're actually trying out open access at the minute erm so the
 51 girls who work in the communication room there's about five lines coming in all the
 52 time they try to work to a protocol that we've devised to find out whether the patient
 53 can be put in with me (AC uhum) or if it's an ongoing problem well is it better they
 54 see their own GP or whoever erm and at the minute I don't really like people putting
 55 patients in with me I feel a bit out of control because I haven't triaged the problem
 56 myself (AC right aha) so that's that's but it might we'll see how it works (AC mm)
 57 so and the other thing is we're only doing half time doing that and the rest of the time
 58 we're back to our normal way of working (AC mm) and it would be better to either
 59 do it and go the whole hog and just do it (AC yes) or to stay as we were but it really a
 60 little bit so today is a day where we do it where they just send me things or (AC
 61 right) they'll put them in with me (AC uhum) erm but erm I was just getting into my
 62 stride knowing that in the morning I got a blank sheet and er it just starts the minute I
 63 walk in (AC mm) and yes I enjoy it and er I enjoy the feeling that I'm really not sure
 64 about what the patient's come with and erm and then going back to basics thinking
 65 right you know setting it all out in my on my paper and do a PQRST and (AC uhum)
 66 and erm and not being as frightened as I used to be (AC mm) of everything that came
 67 through the door (AC mm) because it is frightening (AC uhum) and erm er if you get
 68 something like a headache it's such er can be such a varied amount of things that it
 69 frightened me a first (AC right) but once you've gone through what it really couldn't
 70 be (AC uhum) or you know it's a lot more simple (AC mm) it's not as it's not as
 71 frightening (AC mm) erm yes (pause) do you want me to talk some more? (laughs)
 72

73 AC Yes, yes if there's more you want to say
 74

75 CA Erm I don't ever want to feel that I know the job (AC OK) I never have done in
 76 any of the jobs I've done but er I like the feeling that I come in and I'm wary (AC
 77 mm) er I'd rather feel like that than thinking oh well I know this now (AC mm) and
 78 erm I'm very well supported here (AC uhum) erm the GPs are all really good I think
 79 originally not everybody wanted me to do the course (AC right) I didn't know that
 80 till afterwards (AC Is that in the GP team) in the GP team (AC OK) I think they
 81 thought it was perhaps well why you know why do we need but the practice manager
 82 at the time and the senior partner really wanted a nurse practitioner for quite a long
 83 while (AC mm) now they absolutely think it's the bees knees everyone of them as far
 84 as I know (AC uhum) erm and I think it's a little bit like I don't know whether you
 85 experienced this but when we got the erm support care workers and they took some
 86 of our role (AC mm) you feel a little bit gosh my job's being eroded slightly (AC yes
 87 yes) and maybe they felt like that even though it's not (AC mm) but now they really
 88 erm they really like me being here and (AC uhum) er you can tell when you go off
 89 what happens you know like (AC right) please come back (both laugh) so it's quite
 90 nice and it's nice to know that they appreciate if not me but the actual job (AC uhum)
 91 and how much it's helped them out really (AC mm) having said that erm I want to do
 92 the diabetic diploma (AC uhum) and erm number one they don't want me to have
 93 any time out of surgery (AC right) erm and I keep saying well it's not just for me it's
 94 not just for me because I'm not very well up on diabetes because I've never had to
 95 deal I've never had to deal with them we've always had somebody here but I think in
 96 the future if we do have more open access my role will change slightly (AC uhum)
 97 and it would perhaps be better if there was another person to fulfil that diabetes slot
 98 if one of the diabetic nurses were off sick (AC mm) or anything especially with the

99 new GMS contract (AC uhum) but they've they now don't want me to move (AC
 100 right) you know and I expect perhaps how they were when I first started as a nurse
 101 practitioner (AC aha) they don't want the change (AC yes) but the benefits
 102 afterwards (AC yes) perhaps they can't see so that's up in the air at the moment and I
 103 feel I'm loosing some of my skills in just dealing with something like an asthma
 104 patient a review of an asthma problem I deal with their exacerbations (AC mm) er
 105 and I don't see them again (AC right) unless you know they're poorly you know I
 106 don't do the reviews I used to enjoy seeing how they were progressing and (AC mm)
 107 you know perhaps altering the treatment slightly perhaps when they were better (AC
 108 mm) or worse or whatever so I'm not sure if I'm I'm not sure if I'm I don't think I'm
 109 loosing skills but I think you know I just don't do that sort of thing anymore I just
 110 see the poorly you know walking poorly ones (AC yes right) but I do enjoy that as
 111 well (AC OK) (both laugh) Er I can't think of anything else just for a minute
 112

113 AC OK well to put it in a slightly different way erm is there anything that you find
 114 you don't enjoy or that frustrates you about what you do?
 115

116 CA Erm (pause) One little thing that frustrates me is erm I'm not on call on my own
 117 one of the GPs is on call as well but they change morning and afternoon because they
 118 don't like doing full days and I don't like it when they don't tell me they've gone out
 119 of the building because I feel insecure (AC uhum) er mainly because if I did need
 120 any help they're not there. If I had an emergency I don't know they've gone (AC mm)
 121 is this if they go out on a visit) they might go out on a visit or (AC right) so that just
 122 frustrates me if I ever leave erm the building (AC uhum) I tell the girls because you
 123 never know if somebody collapses and they're looking somebody's looking for you
 124 and I just feel that frustrates me a bit (AC mm) and they do it a lot (both laugh) they
 125 disappear (AC right) which I don't blame them because they're busy (AC sure) and
 126 their head's full of what to do next and they don't think well I've got to go and tell C
 127 I'm going but if they could just say 'Will you tell C I've left the building?' or (AC
 128 mm) 'does she need me before I go for anything?' (AC mm) I think I'd feel better
 129 (AC right) erm (pause) I can't think of anything else that frustrates me erm (pause)
 130 I'll probably think of lots of things like you say (AC yes) when you've gone erm I'm
 131 very reliant on the computer so that's frustrating if it's not working (AC oh yes) erm
 132 and it's just like you've had your arm chopped off isn't it (AC mm) because you
 133 haven't a clue because we're totally paperless (AC mm) you know we've got the
 134 notes stored away but er we (AC uhum) don't know whose coming or (AC mm)
 135 anything so I do find that and it does happen quite a bit (AC does it?) yes we're on a
 136 Torex system (AC aha) and it doesn't seem to be it's OK but we keep hearing how
 137 much better some of the other systems are (AC mm) from GPs that come in as
 138 locums (AC yes) they go oh (AC yes). Erm erm one little thing that frustrates me is
 139 that erm I don't like it when people just walk in in the room (AC mm) cus I wouldn't
 140 do it to other people who are consulting (AC mm) but people do it to me (AC so this
 141 is while you've got a patient in the room) yes yes (AC mm) erm but it's all petty
 142 stuff isn't it I can't think of anything major (AC no) that frustrates me (AC right)
 143

144 AC Just to go back right to the beginning when I asked what do you find most
 145 meaningful in your role (CA mm) the first thing that you said was challenge (CA
 146 mm)

147 So can you expand on that a bit more?
 148

149 CA Erm I think it's just the fact that we've become more autonomous and er we've
 150 we've not somebody's not telling me what to do (AC mm) I didn't realise how much
 151 I was told what to do (AC mm) because you don't think you are being but it's
 152 never your ultimate decision whereas it is more now (AC uhum) not all the time but
 153 most of the time you've decided that the patient has got a chest infection that needs
 154 this this and this (AC mm) you've decided (AC mm) and even if you don't write the
 155 prescription you write then do the prescription and it's signed and now erm unless I
 156 ask for help for their advice they don't ask me why they're signing a prescription
 157 (AC right) so really that you've had er autonomy with that patient for that time (AC
 158 mm) that's a challenge to me (AC right) that's a challenge that I that I think with our
 159 training and our backing and erm the clinical skills and the history taking you didn't
 160 realise at the time I didn't realise at the time that it was such good erm training (AC
 161 mm) because it's sunk in (AC mm) and so I can use I can use that with what's the I
 162 keep forgetting this word erm the knowledge that I'm doing the right thing (AC
 163 right) there's a word but I can't think what it is. Erm so so yes I just find I just find
 164 every day a challenge (AC aha) I do and I like I don't think oh gosh it's Monday
 165 back to work I really enjoy it (AC mm) enjoy being if I've got to go to work then I
 166 like doing what I'm doing (AC mm) Er it's a challenge when somebody else asks my
 167 opinion another nurse (AC mm) er because they and then they listen to it and go and
 168 work and go and work on what you've said what you advised even (AC right) and
 169 then I think afterwards ooooh I know I was right in what I said (AC yes) but you
 170 know yes (pause) I think that's it really (AC aha)

171
 172 AC OK (CA It's like dragging water out of) no not at all that's brilliant C. Erm again
 173 just to think about the er the question about what's most meaningful to you you've
 174 said a lot of things which are brilliant is there anything else that springs to mind
 175 about what you do that you enjoy or

176
 177 CA Erm (pause) apart from thinking that the some of the GPs didn't want me to do
 178 the role at first I have a sense because I do get on with everybody thankfully erm that
 179 one or two er staff couldn't actually believe that a nurse could actually see a patient
 180 (AC mm) instead of the GP (AC mm) nothing was ever said erm to my face (AC
 181 mm) but I knew underneath because I could sense erm er just with one or two people
 182 that that's how they felt and and er once I'd finished the training and I'd become you
 183 know they knew that right this is it she's out on her own now er again I could sense
 184 that because it's such a close community they've all got relatives that I might be
 185 seeing (AC yes) and I could see it them trying to be veered off in another direction
 186 (AC mm) Well it's lovely now because they're coming to me (AC mm) and I know
 187 that I've crossed that hurdle that they were unsure (AC mm) er it's erm it's such a
 188 close knit community that everybody seems to know a lot about everybody (AC
 189 right) and erm and er I'm sure I was talked about because I was it was a different role
 190 (AC sure) and they weren't sure about it and they'd always had the senior partner
 191 who isn't here now who was so well known to everybody that he was known on his
 192 first name by everybody (AC mm) erm and and he was the ultimate person (AC mm)
 193 you know there's nobody better than this person because they were just so used to
 194 him (AC mm) and it was getting other people to accept that you could see you know
 195 consult with them or any of the other doctors but especially me (AC right) and
 196 there's nobody else around at the minute there will be er because there are other
 197 nurse practitioners now in the area but there was nobody else in fact you know they
 198 are still unsure what a nurse practitioner is (AC uhum) so erm it's been a hard

199 marketing job (AC mm) and it's been hard not with all the staff but with one or two
200 who have been around for a long time (AC mm) and you know everybody's fixed in
201 their ways (AC sure) erm (pause) so it's meaningful I suppose that I feel I've crossed
202 a few bridges and erm and ended up OK (AC right) erm (pause) and some people
203 who I knew felt like that are actually coming to ask my advice now (AC mm) so
204 that's nice (AC uhum) so all these things I think are meaningful because er it means
205 you've you've erm (pause) you've been accepted (AC mm) in the role that you're
206 doing now (AC uhum) I think they accept me as me but they could only accept me as
207 me in the treatment room (AC right) and you know to do something else wasn't
208 acceptable to them (AC right) It's also meaningful because my colleagues are great
209 and I worked hard at that right from starting the degree (AC right) that they wouldn't
210 feel threatened or (AC mm) about this person suddenly looking different (AC mm)
211 and erm always asked their opinion on whether I should go ahead and do anything
212 (AC mm) so it was their they had input into what I was doing as well as me (AC
213 right) and so I find that lovely because we all we've all got different roles in the
214 practice (AC uhum) we've got erm diabetic trained nurse CHD trained nurse (AC
215 mm) erm well most of us have done COPD but we've got one who's just dealing
216 with COPD patients (AC right) and erm and then we've got two er nurses who erm
217 practice nurses but they do a lot of treatment room stuff as well two care support
218 workers so on the whole it's a nice team (AC yes) who are doing most things. And
219 the district nurses come and do our dressings (AC mm) we do do some obviously
220 because they're not here all the time (AC mm) but on the whole erm we don't see the
221 district girls a lot but we do see them daily just about half an hour 2 till half 2 (AC
222 right) so erm and they come and ask me they often come and ask me to give my
223 opinion on something that they're doing (AC aha) which is really which is really nice
224 (AC yes yes) and I also think that I'm perhaps easier to get to than a GP and they
225 don't feel like oh let's ask C (AC yes) and erm because I'm not a threat you know
226 I'm not going to say 'No' or 'I'm busy' (AC mm) or anything erm unless I am busy
227 (both laugh) erm but you know what I mean (AC yes) it's somebody they can
228 approach (AC mm) er not no you know perhaps. All the GPs are approachable but
229 sometimes you just feel like I wish I hadn't got to bother them because I feel like I'm
230 mithering mithering Northern word it means anxiously asking erm (AC yes I'm sure
231 it exists) (both laugh) mithering erm so I just I know by the look on their face if I say
232 yes I'll pop down I'll come and see you in a minute (AC yes) that they think 'oh
233 good' so that's nice that's a meaningful thing that people think they can come and
234 ask me (AC mm) anything really (AC uhum) erm (pause) it's become more
235 meaningful since nurse prescribing (AC right) (CA laughs) er especially it's just
236 lovely to see the patient and be able to prescribe something like something say it's
237 something simple like trimethoprim but you've actually dealt with the whole thing
238 (AC yes) yourself (AC yes) and you've not had to mither (AC mm) erm so that that
239 gives me a lot of satisfaction and I've found it has become even more meaningful
240 since I could to do basic things (AC mm) like that (AC mm) mmm I think erm I can't
241 remember who said it now on nurse prescribing course that we must make sure that
242 we weren't asked just to sign prescriptions, that hasn't happened to me (AC right)
243 mm I've not been I've not felt I've been used in any way (AC mm) erm I don't think
244 I would let that happen but nobody's come and said oh just write us a script out for
245 such a thing will you it's just not happened (AC right good) so that's nice (AC mm)
246 erm (pause) meaningful? (pause) erm I don't know whether the job's become more
247 meaningful since er my other half John came to work here because he's such erm to
248 everybody he's such a good source of knowledge and information (AC mm) erm not

249 just because I love him but erm it's just nice knowing he's there (AC mm) for me to
 250 go and just erm get a bit of back up on something or if I'm unsure about just
 251 anything really (AC mm) erm so I suppose its er it has become more meaningful
 252 since he's been here because he's and everybody says the same everybody tends to
 253 ask him (AC right) and it's very rare that he doesn't know something (AC mm) on
 254 any drug (AC right) so he's such a good source of information and (AC mm) so
 255 that's er I know it's made my job a lot I just feel a lot more confident that's the word
 256 (AC right) that's the word I was struggling with because I know that I can back
 257 myself up with him (AC uhum) sometimes more than the GPs because of his
 258 knowledge of medications (AC right) or if erm we get half baked packets of pills
 259 from Egypt or somewhere (both laugh) like this morning you know he finds out for
 260 us where they've come from and what they are and what the patient's been on (AC
 261 mm) because I haven't always got that knowledge of who to ring or (AC right) you
 262 know and that makes it more meaningful I suppose (AC aha)

263

264 AC Right and anything else you want to add about your day to day work?

265

266 CA Erm (pause) er I tend to (pause) if I'm really busy I don't write the notes up
 267 straight away (AC uhum) I make myself little notes and do it later and my time
 268 management's dreadful (AC right) I do admit it and erm so I do work overtime a lot
 269 (AC mm) which I don't ask for back because it's my fault because I can't fit
 270 everything I want to say on the computer in with a consultation (AC mm) and an
 271 examination (AC mm) and think about what the problem is and a prescription I can't
 272 always get it in quarter of an hour (AC right) and write it up because I write copious
 273 notes so that I don't miss anything (AC mm) erm so yes I have to that's something I
 274 have to get better at (AC aha) er some days I can manage it like this I knew you were
 275 coming so whether that's made me and I know I've got to be off on time tonight (AC
 276 right) and I've got all the notes written up (AC mm) from the morning (AC
 277 interesting) so that's interesting isn't it? (AC yes) So whether I, on a normal day I
 278 think I'll just have my lunch and when I get back it's like paddy's market (AC right)
 279 so I haven't had I've still got the morning's to write up and then it goes on and on
 280 (AC aha) so I know it's me er and I will work on it but I knew you were coming and
 281 er and er I've got to be off on time because I've got to go somewhere tonight (AC
 282 uhum right) erm I do find that difficult I don't know a better way round of writing
 283 notes er I know the GPs' are just very short and sweet but seem to say just what they
 284 want them to say (AC mm) but mine I've got to write loads down (AC mm) just to
 285 prove I've done it (AC mm) I can't just write 'chest clear' (AC right) I've got to say
 286 what I've found (AC yes) and er I've tried to shorten words but erm that the lungs
 287 did expand equally and that you know whatever (AC mm) I feel I've got to write it
 288 down so that if anybody looked at those notes (AC uhum) they knew I had done it
 289 properly (AC yes) er so I don't know how I don't know I've not questioned any other
 290 nurse practitioners or anybody who writes notes to see whether they all do it the
 291 same (AC mm) or not I don't know but that's what I do at the minute and er I don't
 292 know why I was telling you that but er it's me time management's got to get better er
 293 and I do get very tired because it's a long day I come in at eight and er it's quite
 294 often half six or seven when I'm going (AC right) erm so I do find that er quite a
 295 long day specially if you've been busy (AC mm) you know a long involved thinking
 296 about everything day (AC mm) and still writing notes I can't sometimes concentrate
 297 at the end to write them up properly (AC sure yes that's hard) but I know I'll have to
 298 get better but I don't know how I don't know how to do it (AC mm) but I feel

299 satisfied when I've finished (AC right) and I feel satisfied when I've finished and I
 300 know tomorrow I'm starting again (AC fresh) fresh that's nice (AC yes)

301
 302 AC So what do you think makes you feel satisfied what is it?

303
 304 CA I feel that I've accomplished something when I get through the day (laugh) (AC
 305 right) and that er I've done my best and er I've done it to the best of my ability at that
 306 time (AC right) and then I worry I worry and worry about things I've said to people
 307 or (AC mm) or if I've asked them to come back the next day because I was a bit
 308 worried about them to see whoever (AC mm) and then I worry about them all night
 309 until I know they've been in the next day (AC mm) erm or weekends I worry about
 310 people all weekend I can't wait to get in on Monday to see if they've been seen at
 311 Out of Hours or you know (AC yes) er (AC yes) but I do worry about them erm And
 312 another really nice thing is and I feel very very privileged is that erm I can discuss
 313 my day briefly at home (AC mm) with somebody who understands (AC mm) the
 314 place really (AC yes) we don't have to mention names of patients or anything but we
 315 can you know if something's bothered me or I feel really privileged that I can ask
 316 John (AC mm) at home (AC mm) or if he's not been in work for some reason
 317 because sometimes he does the B erm pharmacists (AC right) support pharmacists
 318 group (AC aha) and PCT work (AC aha) so he might have been to a meeting so he's
 319 home earlier (AC yes) and er he'll wait he gets up from what he's doing when I walk
 320 in and goes to stand in the kitchen where we have a quick our conflabs about bad
 321 days and he always says 'what sort of day have you had?' or 'what's happening at
 322 the ranch?' or something (AC yes) and if something's bothered me I can go 'blahhh'
 323 and I've unloaded it (AC yes) you know (AC yes) and he'd do the same to me but he
 324 doesn't do it as much it's me that does it (AC right) and er and once it's out it's
 325 halved then (AC yes) the problem's halved (AC yes) so I do feel privileged I try not
 326 to do it all the time but erm he's just such an easy listener and he'll just listen to me
 327 (AC mm) so I feel fortunate (AC mm you've got that support) I've got that support
 328 yes (AC yes) making me cry (both laugh) yes it's good (AC yes great) erm I just love
 329 it just enjoying it

330
 331 AC Your job?

332
 333 CA Yes and I've done so many things Alison that er I've loved them all I've always
 334 said I loved them I loved er I was a theatre sister for a long while at B (AC aha) and
 335 it were a little closed community and it was like a little family (AC right) and when I
 336 left B to come live up here I didn't want to do anything else (AC mm) because I
 337 loved the job (AC uhum) and previous when I first started nursing I did orthopaedic
 338 nursing first (AC right) and er it was on my CV and I was put on orthopaedic ward at
 339 the infirmary (AC oh yes yes) and god I hated it for a bit but then I got to love that
 340 but after a year I left. So wherever I've been I've actually grown to love it (AC mm)
 341 but I've not actually entered in to something that's given me such erm such er what I
 342 feel is a challenge every day (AC mm) they've all been er perhaps jobs you've got
 343 the training to do it and you've gone and done it whereas I can't explain what this is
 344 it's a challenge (AC right as opposed to a job?) yes (AC mm) yes erm so I'm very
 345 fortunate I've done lots and lots of different things and er erm hopefully erm I'll be
 346 able to retire although they might not let me retire might they not? (both laugh)
 347 hopefully I'll be retiring in four years after this and erm and if it carries on like this
 348 until the end I'll feel really fortunate (AC mm) that I'll be ending what has been a

349 great career to me (AC mm) lovely lovely love doing this er work er only doing this
350 sort of thing because it's new (AC mm) and modern (AC mm) and challenging and
351 erm you know it's at the front isn't it at the cutting edge of nursing (AC yes aha) and
352 with change everybody changing NHS changing and the way we working and
353 everything it's it's a new role to to deal with (AC uhum) new policies and new ways
354 and I just feel really chuffed that I've been included in it (AC mm) and got through it
355 (both laugh) got through the er got through the course (AC right) I mean that was a
356 challenge (AC yes) yes I just feel really privileged (AC mm brilliant) so

357
358 AC Is there anything else you want to add?

359
360 CA No (both laugh) I can't think of anything I probably will do like you say when er
361 you've gone

362
363 AC Yes you can always jot it down yes. Great thank you very much

The following comments were returned with the transcript check:

I find working with so many GPs interesting but their advice to me differs as they are individuals and this is often confusing

New nurse on team very demanding of my time and knowledge

My lack of confidence referring to the hospital for example

Transcript Summary

Interview 1 NP

This transcript suggests that CA has enjoyed many roles in nursing^{7, 332} however she enjoys the challenge of the nurse practitioner role more^{14,9,157,163} than any other previous role³⁴⁰. CA feels that the nurse practitioner degree gave her a new lease of life⁶ in her work. She enjoys the everyday challenge of problem solving and differential diagnosis^{62,63,29} and enjoys using her examination skills and problem solving skills to the best of her ability^{25,27,303,38,29}. She likes being the first point of contact for patients²³ and prefers to do her own triage rather than have other people doing it for her^{53,38,39,150}. She likes to deal with the complete episode of care for her patients and the nurse prescribing role has helped her to achieve this²³⁴. CA gets a lot of satisfaction from getting the diagnosis right without asking for help³¹ and she enjoys feeling confident in her role⁶⁵. She is also aware that she must not feel over confident and wants to remain wary about her abilities⁷⁴. One area in which she does not feel confident is in referrals to secondary care^{TS}.

CA used to work in the practice nursing team and in some ways she misses running clinics for people with chronic conditions⁴⁰. She enjoyed adjusting treatment and seeing people progress^{105,107}. She is concerned that she might be losing her skills in this area¹⁰² although she still sees people with acute exacerbations and enjoys this aspect of her work too¹¹⁰. CA likes patients to be happy and satisfied with what she has to offer¹⁶.

CA feels that her GPs are supportive of her role⁷⁷ and she is aware how her role might have had an impact on them both professionally and personally^{86,87}. One of her frustrations is being left alone in the building when she is on call¹¹⁸. She feels that there is a certain lack of support from the GPs when they leave the building without letting her know that they have gone^{124,127}. She finds working with a number of GPs interesting but also confusing as they offer differing advice to her^{TS}. Other frustrations are when the computer is not working¹³¹ and when people walk into her room during a consultation¹⁴⁰.

CA enjoys having autonomy^{148,156} in her role and enjoys making her own decisions¹⁵². She enjoys using the breadth of skills she has acquired including history taking and examination skills¹⁵⁸. A number of members of staff come to CA for advice, she likes people to ask her opinion¹⁶⁶. CA feels a sense of satisfaction that she has been able to prove her role to the local community and practice team^{198,200,203}. CA recognises the importance of good working relationships with her team and so she has worked hard at minimising the threat that her role could represent by including members of the team in decisions about her role^{207,211}. She likes to make herself available and easily accessible to the rest of the team and likes to offer support and advice when she can^{222,229}. However she can find that new members of the nursing team can be demanding of her time and knowledge^{TS}.

CA gains great support from the presence of her husband both at work and at home^{245,310,325} and values being able to off load her worries when she gets home³²¹. She prefers to work late²⁶⁶ writing up her notes from earlier consultations in the day rather than keep people waiting and get behind in her work. She writes copious notes because she doesn't want to miss anything²⁷⁰. She wants to provide proof that she has

been thorough. She would like to speed up and get more efficient at note taking²⁹⁴ and aims to do this in the future. CA worries about patients over night and over the weekend³⁰⁶. She would like to engage in further education⁹¹ for example the diabetes diploma and is keen to keep moving and changing in her role^{350,99}. She enjoys being on the cutting edge of developments in nursing³⁴⁹ and loves the challenge of her daily work^{297,163}.

(The small numbers refer to the line of the transcript where the idea can be found)
TC = Transcript check

February 13th 2004

Interview 2 GP

1 AC So thank you very much for agreeing to be interviewed erm it's a maximum of
 2 an hour but I'm finding most often it's more about half an hour forty minutes is
 3 about the time it takes and it's erm a very informal approach I'm really interested in
 4 just your ideas about what you do your work and particularly what you find most
 5 meaningful in what you do so (pause) (CR right) are you able to er can you tell me
 6 what you find most meaningful in your work as a GP?

7
 8 CR (pause) it depends on your interpretation of meaningful

9
 10 AC Yes you can substitute for meaningful things like what do you enjoy most what
 11 gives you most satisfaction erm what do you like about what you do anything er in
 12 that area

13
 14 CR I suppose I haven't given it a huge amount of thought except that when
 15 somebody asked me recently would I do it again I said no (AC laugh oh dear) (laugh)
 16 but that's perhaps for different reasons (AC aha) I don't like the word meaningful.
 17 (AC right erm do you find erm) I think what gives me the most satisfaction (AC
 18 satisfaction right) is the diagnostic process (AC OK) in terms of erm problem solving
 19 and working out what's wrong with somebody. (AC right) asking the appropriate
 20 questions (AC aha) and obtaining a good history (AC aha) to allow you to make a
 21 diagnosis (AC right)

22
 23 AC Can you say a bit more about er that process you know what it is that you find
 24 satisfying about it?

25
 26 CR well it's the problem solving aspect of it isn't it? (AC aha) And if I'm really
 27 honest I find the clinical aspects of that more satisfying than putting it within
 28 psychological and sociological contexts

29
 30 AC Right aha so the would I be right in thinking by clinical you mean disease (CR
 31 yes) process yes OK

32
 33 CR Yes rather than looking at a diagnosis in more of a holistic way Obviously you
 34 have to do that as a GP but I think what I actually find satisfying is diagnosis

35
 36 AC Right can you expand on that a bit more?

37
 38 CR in order to achieve that objective you have to be able to consult effectively (AC
 39 uhum) the consultation skills and communication skills that you use to arrive at that
 40 objective (AC aha) are obviously important (AC yes right right) so when that goes
 41 well that's helpful (AC aha OK) but obviously it doesn't always go well

42
 43 AC aha yes so erm to look at it from that perspective er the other side what do you
 44 find in your role that is frustrating or dissatisfying

45
 46 CR (Pause) dissatisfying you mean unsatisfactory (AC yes) (pause) when there isn't
 47 sufficient time to do the process in a proper considered way

48

49 AC Right so erm time constraints
50
51 CR Yes feeling rushed
52
53 AC Right is there anything else in what you do that you find frustrating?
54
55 CR (pause) (AC aha) frustrations about communicating with secondary care is a
56 huge issue for GPs (AC mm) I mean I spent this morning spending ages trying to
57 speak to somebody at the hospital (AC right) normally I would delegate that to one
58 of my staff but I was doing it myself because they were putting the Christmas
59 decorations up (laughs)
60
61 AC (laughs) priorities yes right and so that's a frustration to you yes
62
63 CR mm I hate wasting time
64
65 AC Yes anything else you said there were loads of things that frustrate you
66
67 CR Well I don't want to be too negative, (laughs) it depends what you mean There
68 are all sorts of things that don't go in the way that you'd hoped they would go. That
69 can be challenging as well as frustrating (AC uhum) erm
70
71 AC What sorts of things don't go in the way you hope?
72
73 CR Well if you encounter hostility, anger or outright aggression from the people that
74 you are dealing with, that's quite hard
75
76 AC Erm right OK (pause) If we go back to the positive things again apart from the
77 diagnostic the clinical diagnostic process what else do you find that you enjoy in
78 your role?
79
80 CR I enjoy having a relationship with my patients (AC aha) and fortunately if the
81 relationship's good they carry on coming to see you and if the relationship isn't good
82 they tend to go somewhere else (AC right) and see somebody else (AC self selecting)
83 That's quite satisfying as you are aware that patients have respect for you and put
84 value on your judgement and your opinions and the fact that you have erm a
85 relationship such that you can share treatment and management options treatment
86 options with them. (AC right right) I suppose the variety of presentations in general
87 practice must be the beauty of it really (AC mm) I mean I think it would be very
88 tedious sitting in a cardiology clinic seeing angina patients day in day out (AC aha)
89
90 AC Yes so variety is (CR yes) a good part of it (CR yes) Can you expand a bit more
91 on what you said about relationships with patients, the ongoing relationship?
92
93 CR Well erm (pause) in what in what way?
94
95 AC Erm well you talked a bit about erm the working together to come to an
96 understanding together so erm can you explain a bit more about how you do that and
97 erm what you find enjoyable about that process?
98

99 CR (Pause) well the feeling that you have a satisfied customer and one who feels that
100 their ideas about their illness have been explored and that you've looked at their
101 anxieties about their particular problem (AC right) I mean basic consultation skills
102 really (AC aha right) that's what you do in a GP consultation isn't it?

103
104 AC Right so by basic consultation skills what does that conjure up for you?

105
106 CR Well finding out why somebody comes to the doctor when they do come (AC
107 uhum) and what it is that drives them to seek medical care at this particular point in
108 time (AC uhum) finding out why they came this week and not last week (AC right)
109 what their worries are about whatever it is they've got

110
111 AC aha (pause) so it's exploring those things (CR yes) with them aha

112
113 CR Yes and being able to cover in consulting jargon their agenda (AC uhum) and
114 matching it with your agenda (AC uhum) of what you feel ought to be achieved in
115 the consultation in terms of health promotion data collection which of course we
116 have to do (AC yes) with all the computerisation

117
118 AC Yes right Is there any particular area of general practice that you enjoy more than
119 another area?

120
121 CR I have a special interest in dermatology but I'm not sure that's particularly
122 general practice I that's dermatology

123
124 AC Right erm a sort of special interest area (CR That's not what you mean is it?) No
125 no what I I suppose what I was meaning was is there any particular area that you
126 enjoy engaging with erm for example if it was dermatology seeing a patient with
127 eczema and er enjoying working through with them how to control their condition I
128 just wondered if there was any particular area that you think aha yes I really enjoy
129 doing that work?

130
131 CR (pause) a lot of the presentations in practice are quite similar really. We see an
132 awful lot of chronic disease (AC uhum) and we see a lot of acute problems with their
133 accompanying anxieties and uncertainty about what's wrong

134
135 AC yes so while there's huge variety there's a lot of elements that are the same

136
137 CR yes yes

138
139 AC Right OK

140
141 CR Sounds muddled doesn't it?

142
143 AC It makes sense yes. Is there anything else that erm you would say that you enjoy
144 about the role?

145
146 CR I keep thinking about all the things I don't enjoy (both laugh) working in a team
147 is part of general practice working with all the staff (AC aha) Delegating
148 appropriately is something that is very dear to my heart because I think that's a very

149 efficient way of organising services (AC uhum). In one sense a GP is a bit of a sifter
150 and filterer and doesn't actually do much apart from put the arrows in the right
151 directions (AC right) but I mean that in itself is a huge skill (AC mm sure) (pause)
152
153 AC So erm working in the team were you saying that's something you do enjoy?
154
155 CR I do I think that's an essential part of it isn't it? It would be very difficult to
156 perform the whole range of activities in general practice without having secretarial
157 support (AC erm) without having administrative support without having nursing
158 support (AC uhum yes) (pause)
159
160 AC OK you say negative things keep springing to mind (both laugh) do you want to
161 share some of those as well because it's an important part of how you see general
162 practice and your role
163
164 CR Well I particularly don't enjoy all the computer work checking of blood results
165 (AC yes) checking that people have reached targets et cetera (AC mm) I'm not
166 interested in that at all I'm afraid (AC mm so all the data) all the data (AC aha)
167
168 AC (pause) Right and anything else?
169
170 CR (pause) erm (pause) I don't know I find this a bit er a bit too soul searching really
171 (both laugh) for a Monday afternoon
172
173 AC Maybe it should have been done on a Friday afternoon (both laugh) (pause) Yes.
174 Well the way this works is erm I'll write up this transcript after we've finished (CR
175 mm) then if there's anything you wanted to add to what's on the transcript (CR mm)
176 then you can add that later on if you felt you know (CR mm) if there was something
177 that we'd missed (CR mm) or if there was something you didn't agree with (CR mm)
178 or wanted to remove that's fine (CR mm). So I shall send it back to you for your
179 comments. Yes so nothing else that erm springs to mind that you want to add at the
180 moment?
181
182 CR About what?
183
184 AC Either that you enjoy or that you don't enjoy about the role.
185
186 CR I've already said that we don't have enough time (AC mm) to do things properly
187 (pause) I don't like all the paperwork we have to do (AC mm) I don't like writing
188 reports and filling in forms (AC right) I'm not very interested in that (AC mm)
189
190 AC OK er just to put the question in a slightly different way now erm would you be
191 able to explain what it means to you to be a GP?
192
193 CR What it means to me (AC mm)
194
195 AC What being a GP means
196
197 CR (Pause) erm erm I don't really know what you're getting at
198

199 AC Erm do you have a picture in your mind about erm what the role of the GP
 200 means to you what it stands for or what it looks like how would you describe it?
 201
 202 CR (pause) It's a sorting and sifting job really (AC uhum) of in nurse practitioner
 203 jargon these undifferentiated undiagnosed problems that people have (AC uhum) and
 204 deciding whether anything needs doing or nothing needs doing (AC uhum) and who
 205 might do it best (AC right) The GP's role is deciding whether the presenting problem
 206 needs treatment, reassurance, (AC mm) referral or investigation
 207
 208 AC Right. Again that decision making (CR yes mm) problem solving yes OK and
 209 that to you encompasses the role?
 210
 211 CR (Pause) Well you could add in continuity of care and people developing a
 212 relationship with their health professional that's not necessarily a part of all roles as a
 213 GP (AC mm) it's a role in this practice as (AC uhum) people keep coming back.
 214 (AC right) You see families through various changes, pregnancies births young
 215 children older children teenage children (AC erm) marriages divorces and the social
 216 changes that go on in people's lives, running alongside with them (AC right) until
 217 they get old and get various diseases and eventually die and all the consequences of
 218 the bereavement. It's the whole process of working in parallel with (AC mm) what
 219 goes on in people's lives .
 220
 221 AC mm right and when you say particularly in this practice is that something that
 222 you've sort of structured you've
 223
 224 CR Well we run a personal list system (AC mm) with our own list of registered
 225 patients so (AC mm) they consult with us primarily (AC right) and they come back
 226 to us for follow up
 227
 228 AC aha and that's because you as a partnership have decided to run it in that way is
 229 that right?
 230
 231 CR Yes that's right
 232
 233 AC Yes OK and how do you feel that do you like it working in that way?
 234
 235 CR Yes I do (AC Yes OK) It means that you develop a good relationship with your
 236 patient. Although if there isn't a good relationship then (AC yes) the whole thing
 237 doesn't work.
 238
 239 AC Yes and that must be difficult sometimes yes
 240
 241 CR Yes I mean that is one of the problems of the system in the practice (AC mm)
 242 when the doctor patient relationship isn't very good we find that difficult to resolve
 243 (AC mm) in the partnership
 244
 245 AC mm and that's bound to happen from time to time
 246
 247 CR Yes
 248

249 AC How do you deal with that do you have patients changing er from one GP to
250 another within the partnership?

251
252 CR Well (AC is it OK) it's an area that's difficult to manage (AC mm) because some
253 doctors feel that the patients who are having difficulty forming a relationship with a
254 particular doctor will have a problem forming a relationship with any doctor (AC
255 Right yes)

256
257 AC Sure yes, I could imagine. But erm that goes really back to what you were saying
258 at the beginning about ongoing relationships and the relationship with the patient and
259 how important that is to you in what you do. Would that be accurate or a reasonable
260 thing to say (CR what) that the erm relationship with the patient is important to you
261 in your role?

262
263 CR Yes it is

264
265 AC Right OK is there anything else that you want to add at this point before we
266 switch the tape off

267
268 CR No I don't know (laughs)

269
270 AC OK that's great. Thank you

Transcript Summary

Interview 2 GP

This transcript suggests that CR enjoys the clinical aspects of being a GP.^{38,29} She particularly enjoys taking a good history²², using the diagnostic process^{20,23,29,38} and engaging in the problem solving process^{21,28}. The disease process³³ is generally more interesting than the psychosocial or sociological context²⁹. CR feels that the consultation skills and communication skills required to arrive at a diagnosis are important⁴³ and she feels frustrated when she is rushed and does not have enough time to carry out a consultation in a proper considered way^{51,203,57}. CR does not like to waste time⁷⁰ and therefore can get frustrated when trying to communicate with secondary care^{61,70}.

CR enjoys having a relationship with her patients^{231,257,88}. She feels that a good relationship results in patients returning to the same GP and this shows that they value her opinion and judgement⁹². This can lead to the sort of relationship where treatment and management options can be shared with the patient⁹² meeting both the agenda of the GP and the patient¹²⁶ during the consultation. CR likes to have a satisfied customer¹⁰⁹ and feels that this usually occurs when a patient feels that they have had their ideas about their illness explored¹⁰⁹. CR finds it is more difficult when consultations don't go as well as expected and patients are dissatisfied or angry.

CR enjoys the variety⁹⁵ and continuity of care in general practice and sees the GP as a sifter and sorter of problems^{165,220,225}. She doesn't enjoy computer work¹⁸⁰, checking blood results, aiming for targets, paperwork²⁰⁵, writing reports and filling in forms. She values being able to delegate to other members of the team as she feels this is the most efficient use of time. She values the contribution of other members of the health care team¹⁷² and feels it would be very difficult to run general practice without the support of administrators, secretaries and nurses¹⁷⁴.

(The small numbers refer to the line of the transcript where the idea can be found)

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Interview 3 DN

1 AC So it is erm simply a chat really about your work (CN OK) and your ideas about
2 your work erm so can you tell me what you find most meaningful about what you
3 do?

4

5 CN Are we talking sort of district nursing or my particular role within it? Probably
6 my

7

8 AC Your particular role so it's about you rather than

9

10 CN Yeah I mean I think probably the better part of my job is um probably sort of the
11 patient contact which (AC Right) is a typical nurse sort of answer isn't it? Umm
12 yeah I mean I'm obviously sort of a team leader so I obviously sort of enjoy sort of
13 the organisational skills (AC aha) and management skills to a degree but it's
14 probably patient contact still (AC OK) basic basic nursing going back really (AC
15 Right)

16

17 AC So can you explain a bit more about that, what you mean by that?

18

19 CN General general visits so I mean if I separate my job probably my role has
20 changed quite dramatically in the last probably the last three years let alone the last
21 ten (AC uhum) in that there's obviously much more management (AC Right) for
22 team leaders um a larger proportion of my day is spent actually in the office (AC
23 Right) which is not erm is probably not really what I most enjoy (AC mm) (both
24 laugh) (AC Right) erm it's changed because it's it it was it was always obviously part
25 of the role I mean if you're going to be a team leader you have to have some you
26 know some degree of your time is management but the emphasis the sort of probably
27 the percentage of management to actual going out doing patient visits (AC uhum)
28 and actual sort of on the ground hands on sort of work has changed quite
29 dramatically (AC Right) and I preferred the emphasis being maybe fifty fifty or
30 something but now it's almost it can be ninety per cent office and ten per cent patient
31 contact but that's the way nursing's gone (AC that's interesting) yeah yeah and I
32 think that's the same for probably I would say the majority of district team leaders
33 would say more than likely say the same thing (AC mm) there's much more in the
34 way of erm things that we would never do used to be used to be your manager's job
35 if you will sort of health and safety issues erm a lot of stuff has been passed down to
36 us rather than being dealt with by sort of top management which obviously are doing
37 other things (AC mm) it's just change (AC yes) that's all (AC yes) whether we like it
38 or not it's that's the role (AC yes) so

39

40 AC Right so can you say a bit more about er what you find most meaningful in all of
41 that?

42

43 CN I I mean the most meaningful thing I mean I quite like I quite like organising I
44 quite like sorting stuff out (AC uhum) I don't like having to do you know I mean the
45 paperwork has increased dramatically I'm not I'm not awfully I know I appreciate it
46 has to be done but that isn't my favourite part of the job I'd much rather go out do a
47 visit sort out (AC mm) plan the care sort the care out quite happy to delegate it erm
48 (AC yes) but I I prefer going out and actually you know I'd rather spend my morning

49 visiting people than spend my morning actually in the office sorting out (AC mm)
 50 but as I say it's the nature of the team leader's job (AC mm) you're obviously a
 51 problem solving erm yeah I mean it's the nature isn't it (AC mm) erm (AC yeah) but
 52 I'd prefer to go out and I prefer to go out and dress somebody's manky leg (AC
 53 right) sort a few problems out refer them to social services do whatever else I have to
 54 do and I can feel much more satisfied doing that than sitting in the office doing a risk
 55 assessment for health and safety or actually erm filling out other sort of paperwork
 56 (AC mm) that obviously you have to do.

57
 58 AC Yes So erm what is it about that patient contact that you think you really enjoy or
 59

60 CN It's probably quite satisfying (AC aha) I mean it's it's it's probably why we went
 61 into nursing in the first place (AC uhum) and I think you know if you can go out you
 62 can actually achieve something not necessarily make somebody feel better but in the
 63 greater terms if you can actually go out a dressing you know (AC mm) you're
 64 actually making some improvement to whatever condition you're there for (AC
 65 uhum) and I think that's just a nice you know I think probably ninety nine per cent of
 66 patients appreciate the visit (AC uhum) the care that they're getting and it's a sort of
 67 two way process really (AC mm) I think you can erm be there for a period of time
 68 even if there's even if you look at the other things like terminal care you're obviously
 69 not going to make you're not going to cure them are you (AC mm) you're never
 70 going to pull out but there's still satisfying in you know in making somebody
 71 comfortable you're making some changes in helping relatives cope that sort of thing
 72 (AC yes) it's just a it's difficult to identify any one thing really (AC mm) it's just
 73 nice to go out and feel that you've actually done something in the household (AC
 74 uhum) whether or not you're going to you know you're going to improve them or not
 75 but at least it's quite satisfying (AC mm) erm, and I think that just goes back to
 76 basic nursing care (AC mm) you know we all went into nursing maybe not modern
 77 you know maybe not the students we've got now they're obviously going in as
 78 nursing is now but I think those of us that have been around for a few years (both
 79 laugh) actually we went in to actually go we went in to sort of bath people and make
 80 them more comfortable (AC mm) and and you know just sort of basic care (AC mm)
 81 so I think it's probably just going back to that (AC mm) if I was going into this job
 82 now I would know that ninety per cent of my time would be in the office (AC mm)
 83 erm I would have very little patient contact all I would get was picking up the
 84 problems that other grades of staff aren't you know able to deal with (AC mm) and
 85 that might for me that might not be the job that I would choose to do now (AC right)
 86 the job's evolved (AC mm) and you have to you obviously have to evolve with it
 87 (AC mm) but if I'm honest if I was applying for the job now knowing exactly what it
 88 was I would probably stay at a lower grade (AC mm) because then I would I would
 89 have a bit more sort of hands on and erm (AC mm) but that life that's the way it is
 90 I'm not dissatisfied with it just (AC yes) if you stand back and actually look at it I
 91 specifically chose to stay in community (AC uhum) I think because within the
 92 hospital if you get up to sort of G grade sister's level you usually are very far
 93 removed you have been for a lot of years you were the old the nursing officer level
 94 (AC yes) who didn't see many patients and that was really I just thought that well I
 95 just felt that in the community you could achieve that sort of level within nursing but
 96 you still remained very much erm you know sort of hands on in the community (AC
 97 mm) you never er you never just sort of sat organising there was always a bit of the
 98 best of both worlds really (AC mm) but that emphasis has switched round and it

99 becomes very difficult to carry out that part of your role sort of the patient care part
 100 (AC uhum) and the admin (AC uhum) and sometimes I think the priority is for legal
 101 reasons whatever on the admin rather than the patient care (AC right) I find that I
 102 actually find that quite difficult

103
 104 AC Mm right. So within that other ninety per cent of what you do erm are there
 105 things within that that you find er satisfying or enjoyable?

106
 107 CN Probably the day to day erm I mean I'm obviously I mean I'm quite good at
 108 organising I can sort out allocating forty odd patients whatever (AC mm) forty odd
 109 visits a day erm you know it's a large team (AC right) so from a day to day
 110 organisational thing yeah I quite enjoy it it's quite nice to (AC uhum) sort it out
 111 know that everybody's doing what they're doing (AC uhum) problem solve within
 112 the team erm probably the bit that I don't enjoy is the is the sort of bit that we've
 113 inherited over the last few years (AC right which is) there's a huge emphasis and I
 114 appreciate there has to be particularly sort of health and safety issues particularly in
 115 this Trust I think they were very poor at health and safety and now we're bombarded
 116 with with improving it and I understand the reasons (AC mm) but whilst you're still
 117 trying to do the same job within the same hours to have all of these extra sort of
 118 admin things (AC mm) passed down to you can be quite can be quite frustrating you
 119 know I mean for instance a few weeks back I spent three hours printing off health
 120 and safety policies just so as I could put it in the relevant file (AC right) and I just
 121 find that such a waste of time (AC uhum) a secretary could have done that for me but
 122 the directive was that we had to have this particular file within our office (AC right)
 123 and I just think I'm being paid an awful lot of money it's not using any of my skills
 124 (AC mm) to print off and put paper in a file and that sort of thing I do I don't enjoy it
 125 (AC mm) (laughs) I don't enjoy it at all (AC yeah) but at the end of the day (pause)
 126 (AC that's part of the role) it's part of how it's become yeah (AC mm) and I think
 127 erm I don't think it's possible I mean it's nice to enjoy the job (AC mm) in every
 128 aspect but I'm sure everybody has little bits that are their least favourite (AC mm)
 129 and they're sort of the admin concerned with probably not what I sort of what I
 130 would consider day to day patient care organising the case load the extras I find it's
 131 difficult to fit them in (AC uhum) and we're being very pressured to fit them in (AC
 132 mm) and they're always on the sort of they're always last on the list because you
 133 know you've got to write such and such a person's notes or you got to put a
 134 computer entry in because you've just done the visit and by the time four o'clock
 135 comes round you still haven't done you know all these extra bits (AC yes) and it's
 136 that I don't I don't like that as much

137
 138 AC Mm So the priority there is doing the patient work first and then

139
 140 CN I think from the Trust the way nursing the way any profession has gone it's erm
 141 it's very much a litigation protection exercise to some degree more so than it was ten
 142 years ago twenty years ago whatever and again whilst I appreciate the reasons behind
 143 that erm it it's quite difficult to sort of think (AC mm) no I'm sorry I can't do that
 144 visit today because I have to do this paperwork (AC mm) and that's that's quite hard
 145 to do (AC mm) I think it's very difficult clerical help would probably make a
 146 difference (AC right) but that's probably in practice that's probably quite difficult
 147 because most of our work involves some sort of clinical background (AC right) so to
 148 get sort of clerical help erm it's probably possible for a lot of things (AC uhum) but

149 er for many the clinical comes into it all of our admin so it can be quite difficult for
 150 the none a none nurse to sort of be able to do it I think (AC mm) but it would be
 151 worth a try (AC yeah sounds like it yes) I think erm paperwork is the bane of our
 152 lives

153
 154 AC So is there anything else that you find meaningful in what you do anything that
 155 you enjoy or you find really makes you satisfied?

156
 157 CN Erm erm If we're looking at it I mean clarify it as types sort of terminal palliative
 158 care (AC uhum) it sounds quite perverse to say you enjoy it but I think that's actually
 159 it's quite very satisfying and it is satisfying to know that you you've actually gone
 160 out you've probably helped somebody's symptoms you know symptom relief you've
 161 actually you know good support for the family and with a bit of basic basic care (AC
 162 uhum) thrown in really erm and that I think is is quite quite satisfying

163
 164 AC Mm Can you say a bit more about that about you know explain a bit more about
 165 why you find that satisfying?

166
 167 CN I think again it's because it's very obvious that you are going in and making a
 168 difference (AC right) erm sometimes if we are going in and putting a dressing on
 169 somebody's leg obviously sort of from a wound care point of view we are making a
 170 difference (AC mm) but overall their life goes on in some respects their next door
 171 neighbour could put a dressing on their leg (AC mm) erm but sort of with the sort of
 172 palliative or terminal care it's much more it's much more obvious (AC mm) you
 173 know you're looking after generally very sick people (AC uhum) who aren't going to
 174 get better and it's quite nice to be able to sort of do do the physical things you know
 175 make them comfortable if if obviously in the latter days erm be involved in pain
 176 relief you know and obviously the family do find it quite a huge support to have
 177 nurses going in really (AC sure) and I think it's nice to have that there's a lot of time
 178 probably those visits take up more time than maybe you know you're average wound
 179 care not always but you spend a lot of time I suppose you get much more down to a
 180 personal level with them (AC mm) and as I say I think it's to enable somebody to
 181 stay in our case at home where they want to be (AC uhum) and to be able to sort of
 182 provide the services to keep them there I think is actually a good thing (AC mm) and
 183 I think it it's exhausting it can be quite draining (AC mm) erm but it's quite sort of it
 184 can be quite intense (AC uhum) sort of emotionally really but at the end of the day
 185 it's quite nice to think sort of if it wasn't for our nursing care and support they would
 186 have to go to hospital (AC mm) and that's quite I think that's quite satisfying to do
 187 that (AC yes) erm and a lot of it is a lot of it is emotional care I mean a lot of the time
 188 we might be going in and not actually carrying out any sort of procedure as such (AC
 189 right) we might just be going in as as support (AC uhum) and sort of problem solving
 190 type erm somebody to chat to and that's you know that's fine (AC mm) as I say I
 191 think that's probably the most favourite part I mean one care's good because you can
 192 go in you see you there's some some sort of satisfaction in being able to plan the
 193 right sort of care (AC uhum) see that the wound's improving know that you've
 194 actually done the right thing (AC right) and discharged them you know it's a period
 195 of care (AC yes) discharged them and that's successful it's got to be successful
 196 because (AC yes) they're off the case load so you can measure success very easily
 197 can't you (AC mm) erm yeah I've got people who are on the case load for years (AC
 198 right) I don't know sort of leg ulcer type wound care (AC aha) where you may not be

199 looking at sort of a cure as such (AC uhum) but again you're you know using
200 appropriate treatments appropriate frequency of visits etcetera (AC uhum) there's
201 there's you're obviously satisfied at at you know pitching that at the right level (AC
202 mm) whatever erm but I think erm I think the sort of the palliative and terminal bit is
203 probably if I had to change jobs and just choose one area that's probably something
204 that I would be quite keen on (AC right the palliative area yeah) yes I think so
205 because I think it's just quite erm it it's very I find it for me it's satisfying to go in
206 (AC mm) and feel that you know you have made not a difference to the outcome but
207 you have made a difference to to how you know patients themselves and their
208 relatives are sort of coping with the situation and (AC right) mm (AC yeah) (pause)
209

210 AC Can you expand on that a little more about that particular area?

211

212 CN I don't know (both laugh) erm

213

214 AC Anything more about you know your role in all of that and why you feel

215

216 CN I think you'd probably find I think you're using all your all of our skills are being
217 used (AC right) and I think I think whilst we all have to use communication we all
218 have to use erm you know our sort of listening skills our organisational skills but I
219 think it all comes I think it all comes together every visit maybe (AC mm mm) I
220 don't know it's difficult to sort of sit back and analyse it really (AC yes) if we have
221 erm we have had recently can come out and it's actually if you're doing that sort of
222 visit every day it's actually probably quite it's quite draining (AC yes) erm it's quite
223 draining (AC mm) supporting people totally (AC mm) there's a lot of there's a lot of
224 giving all the time (AC mm) erm but it just is er I just think it's actually enabling
225 people to stay where they want to be (AC mm) and I think you know we can do that
226 through our skills our nursing skills as well as our support counselling I mean we're
227 not counsellors but there's all those sorts of mixed skills (AC mm) coming into it I
228 think every visit needs it needs quite a lot (AC mm) it might just be going in 'how
229 are you' have a cup of tea and erm a bit of a chat but even so it it's something I think
230 it's something we feel we're giving them that they need (AC yeah) I don't know it's
231 it's difficult (AC sure) to er pin it down (AC But it's fascinating) and it may well be
232 just my personal you know my personal preference I don't know (AC but it is
233 fascinating what you've just said) I think it's when you get a concentrated period of
234 care (AC aha) I know we do for wound care we might be going to visit somebody on
235 a daily basis for six weeks erm but although we're looking sort of holistically at
236 everybody (AC mm) it it just seems to be just seems to be a little more obvious with
237 sort of terminal care (AC mm right) not every visit I mean if you have a wound that
238 you're seeing every day and OK you've gone in and you've assessed them and make
239 sure if they're elderly that they've got enough help in the house you make the
240 relevant you know referrals (AC uhum) do they need a bit of social service help do
241 they need meals on wheels if you've done all that on the first visit and they're ticking
242 over (AC mm) then often you may go in and erm you go in and do the dressing
243 procedure and ten minutes later you're out of the house which is fine that's good (AC
244 uhum) obviously if they need more from you you're there longer (AC yes) but a lot
245 of that is is specifically directed at you know a leg (AC right) you go and see the leg
246 (AC yes) and whilst I don't want to say well we're just going in to see that leg and
247 we're out we're not we're looking at the whole picture all the time (AC mm) but but
248 probably ninety per cent of the time you're just concerned with that particular wound

249 care and I think probably with palliative care you've got family members you've got
 250 all sorts it's quite sort of complex (AC sure) and I I think we take it for granted that
 251 we can go in and do that sort of (AC mm) visit but sometimes when when you look
 252 at other staff who are probably well not necessarily less experienced or who probably
 253 do find that difficult you appreciate your own skills more (AC mm) maybe erm and
 254 you sort of think well actually I'm not bad at that but it's quite nice to come out
 255 thinking actually I've done quite a nice job there (AC mm) because so often I think
 256 we we do it the other way we don't praise ourselves very often (AC uhum) I don't
 257 think. I think you sort of you come back and there's we're supposed to reflect on
 258 everything we do all this and it's very easy to come back and say actually I didn't do
 259 that very well (AC mm) and I think to a lot of nurses sort of reflecting on how
 260 you've done can be quite negative if you're not careful (AC right yes) erm it's very
 261 easy to say I did so and so maybe it was the wrong dressing or erm just that situation
 262 maybe if I hadn't said what I said you tend to be quite although you are reflecting
 263 and analysing and obviously you are looking at improving your practice next time
 264 (AC mm) it it can be quite negative (AC uhum) if you're not careful and I think with
 265 palliative care you're not going in to cure them you know (AC mm) hopefully you're
 266 going to you might not be able to help them with their symptoms (AC mm) erm
 267 they're going to die you might have very involved conversations about death and
 268 dying (AC uhum) you know but at the end of the day I think you come out and think
 269 well well actually yeah that was I think I've done quite a reasonable job (AC mm)
 270 and it's it's er I find it quite satisfying anyway (AC mm) draining (AC mm) I
 271 probably having gone back on what I said earlier erm I probably couldn't do eight
 272 visits a day I mean I couldn't (AC right) perhaps be a McMillan nurse maybe erm
 273 maybe at the end of the week that could be a bit (AC mm) bit exhausting (laughs)
 274 (AC yes I'm sure you're right) I mean I think just employing all of the skills and all
 275 of the experience that we've gained is actually quite nice (AC mm) erm

276
 277 AC Do you think there are any other areas of what you do that where you use all
 278 those skills in that way

279
 280 CN I think we probably do in every in every situation (AC right aha) I mean we're
 281 going out assessing people I mean it's you're assessing you're re-evaluating you're
 282 doing sort of holistic nursing assessments we are but erm I think you know for the
 283 periods in between if everything is going fine and erm er probably ninety per cent of
 284 our role is wound care so if we are looking at wounds it's improving you're just
 285 going in and using the same dressing you re-evaluate it (AC mm) it's all very it can
 286 be very sort of straight forward (AC uhum) and very not normal but it it becomes
 287 sometimes not terribly challenging I mean I can drive round and I can do ten visits I
 288 can change a dressing I can do it I can you know obviously (AC mm) you assess it
 289 and change treatments do whatever refer to GPs you do all that but it actually
 290 becomes quite easy (AC right) erm and I think probably for me I don't feel terribly
 291 stretched maybe I don't know (AC mm) whereas if you're going in and you're really
 292 having to draw on you know lots of things (AC mm) sort of practical skills as well as
 293 everything else it's it's just sort of a bit more challenging really (AC mm) and I think
 294 I think it's nice to have part of your day when you're not that challenged because you
 295 need you couldn't be challenged all the time (AC sure) you need you need that little
 296 bit of normality (AC yes) (both laugh) but but the satisfying bit for the visits that that
 297 you know have taken a while and have (AC mm) needed a lot of sorting out a lot of
 298 input you know I think it's quite good (AC mm) but I do quite like to going in to do a

299 sort of two minute injection and don't encounter any problems (AC yes) I mean
 300 that's nice (AC yes) erm but (AC right) I think I think that's probably my preferred
 301 bit (AC mm the palliative care bit) I think so yes

302
 303 AC Right and you said erm during your other part of your work away from patients
 304 (CN mm) you're erm using your skills all the time in what you do so are there
 305 particular things in that part of your work that you think oh yeah that's satisfying or I
 306 enjoy that

307
 308 CN I think probably as I said some of the organising you know (AC mm) I I'm fairly
 309 logical I can organise staff I can sort work out it's a huge geographical area that
 310 we're working in (AC mm) erm it's a large team there are sort of seven of us (AC
 311 mm) and to sort of allocate work looking at sort of skill mix looking at patient needs
 312 (AC mm) I think I I probably if I think about it I probably enjoy it because I don't
 313 find it difficult to do (AC right) erm it's quite nice to be able to sort of do it without a
 314 problem it's only until you see other team members struggling and you find that
 315 you've got six nurses in W today and I'm thinking I must be quite good at it because
 316 I don't do that (laughs) (AC right) you can sort of measure your own sometimes I
 317 think we take for granted our abilities and our skills (AC mm) erm and I think
 318 sometimes when when we measure it against somebody else who perhaps is much
 319 better at doing other aspects (AC right) it it's erm and it's the same for all of us I
 320 mean I erm there's there's things that I'm probably not as good at as some of the
 321 other team members (AC mm) and it probably works for them as well (AC mm) I
 322 don't know

323
 324 AC So you mean when you look at erm your own team and compare it with another
 325 team is that right?

326
 327 CN Probably our own team and looking at different members within the team (AC
 328 right) erm and I think we do I think we for a sort of a normal visit for us and we go
 329 into a household we go in we do whatever we have to do (AC uhmm) and we come
 330 out and I think sometimes we take take it for granted what skills we are using from
 331 the minute we get to the front door (AC uhmm) and I think particularly recently we
 332 have a sort of fairly new team member and that's presented some problems with sort
 333 of confidence (AC mm) and I think I think it's not until you're faced with that that
 334 you realise actually it probably does take quite a lot of knowledge quite a lot of
 335 confidence to walk in be able to look round be able to sometimes we might be going
 336 and don't actually know why we're there we might have had a very poor referral (AC
 337 right) and you're you're sort of gathering you're quietly gathering information (AC
 338 mm) you don't want to go in and say well I don't really know what I'm doing here
 339 (AC yes) cus patients will not be very confident in you and sort of just basic skills
 340 (AC mm) observational skills (AC mm) and I think somehow we take for granted
 341 (AC mm) and I think until we see people who perhaps aren't as good as that its it
 342 takes it takes something to stand back and think well actually you know we might be
 343 saying oh gosh why doesn't this person why can't they walk in why can't they see
 344 what to do why can't they talk to the patient whilst getting the dressing pack out (AC
 345 mm) why's it taking them so long (laughs) (AC right) why do they stand there and
 346 say I don't know what I'm doing (AC mm) you know and it's very frustrating (AC
 347 mm) but until you stand back and think well actually maybe we're being a bit hard
 348 maybe that's because we're actually quite good at that aspect (AC mm) and that's

349 not a skill that they've got yet (AC mm) and I think working within a large team erm
350 is perhaps in some respects easier than than just sort of a small team of one or two

351
352 AC Right in what way?

353
354 CN Well obviously you've got different skills within the team (AC uhum) you've got
355 different you've got different sort of characters within the team (AC right) erm and
356 people it's very good in that people handle the same situation differently (AC uhum)
357 and it's quite good erm it's quite good from a sort of support thing really (AC mm)
358 and I think that can it can highlight what you're not good at if you're not careful (AC
359 uhum) but it can if you're really and I think we do have to think harder I think we're
360 very as I said before I think we're very good at picking what we didn't do well (AC
361 yes) but if you beyond that it can actually pick out the things that you must be good
362 at but didn't realise it (AC right aha) and that's sort of satisfying within the day (AC
363 yes) and you sort of think well I didn't have you know simple things allocating work
364 erm I mean we cover sort of well we cover sort of S to S to H it's a huge area (AC a
365 huge area yes) you have to be fairly organised (AC mm) to sort out who's going
366 where (AC mm) erm and I suppose I do it and I don't even think twice about it and
367 then when I see somebody else struggling it actually although it's quite frustrating it
368 can be quite beneficial in that you think well actually I must be quite good at that
369 (AC right) I must be quite good because I don't have a problem with that (AC mm)
370 erm and whilst whilst it probably sort of it makes you think well you know you could
371 have seen you can obviously sort of say such and such a body is absolutely useless
372 can't even seem to manage to send the right people to the right places I think you can
373 turn that round and think well actually that must be something that I'm quite good at
374 and you know there are sort of probably four out of the six team members are
375 extremely good at it two aren't (AC mm) but it's not you know it's not any detriment
376 to them (AC mm) and I yes it is very difficult getting satisfaction satisfaction out of
377 the job is just such a it's such a variable thing (AC yes) and I do think it's difficult to
378 say I don't like this I do like that (AC mm) because just so many so many parts of it
379 can be satisfying (AC mm) I don't know (AC yeah) but I mean really in some
380 respects if somebody said to me I probably would erm I would think being a sort of
381 staff grade nurse from a pure day to day (AC uhum) probably is much more
382 satisfying because you're going out you're just doing your job and you're not
383 involved with all the admin (AC right) having said that you do sort of evolve don't
384 you and probably I would feel very frustrated (laughs) (AC If you were in that role)
385 yeah I probably would. It's nice to sort of think wouldn't it be nice to go out do as
386 you're told go off finish at the end of the day (AC uhum) don't have all this extra
387 admin to do just do your you know the admin concerned with your actual daily visits
388 all your daily work (AC mm) erm and then not have all this extra sort of
389 management type stuff that would be quite nice but on the other hand maybe maybe
390 that's too easy (both laugh)

391
392 AC And you said maybe frustrating?

393
394 CN Maybe very frustrating yeah

395
396 AC For what reason?

397

398 CN It's not challenging (AC right) I mean if I look back I mean I've had a lot of jobs
 399 I've worked in a lot of areas (AC uhum) and if I look back I've changed my job
 400 when the job becomes too easy (AC OK mm) if I've got bored and if it's not if it
 401 things become things become less of a challenge don't they (AC mm) if you've
 402 actually you've got all the skills needed to do that job you do it most of the time
 403 quite well (AC uhum) it can become quite boring (AC mm) for me erm and you just
 404 want a bit more (AC uhum) want to be stretched a bit more and if I look back that's
 405 when I've changed my jobs (AC right) (both laugh) so (AC yes) so probably at this
 406 time the fact that the job itself is is changing (AC mm) I don't have to go off and
 407 change my job I have to cope with the changes maybe that's maybe that a sort of erm
 408 maybe that's quite a good challenge really (AC mm) I might moan about it but it
 409 probably is otherwise I probably would have had to erm looked for something else
 410 (AC mm) probably most nursing most nursing areas are changing rapidly now (AC
 411 uhum) erm but I think certainly certainly community nursing is (AC mm) is one that
 412 there's a huge amount. (AC sure) It's difficult when you're not in another area to
 413 compare it (AC yes) but erm yes I think there comes a time in life it's not as easy to
 414 go and change your job (AC uhum) I was very fortunate in that I did it for a lot of
 415 years very successfully (AC right) erm yeah (AC yeah)

416
 417 AC Is there anything more you want to add at this point?

418
 419 CN No I don't think so I mean I don't I don't know it is difficult I find it difficult to
 420 pin point (AC It is difficult) what I like or (AC yeah) what I don't like really (AC
 421 yeah) but if I had to sum it up erm very briefly I'd have to say I don't like the
 422 paperwork (AC uhum) er and I do like the patient contact (AC uhum) erm (AC yeah)
 423 and that's a very sort of a very old fashioned nurse sort of thing to say (both laugh)

424
 425 AC That's brilliant. Erm what happens now unless there's anything more you want
 426 to say

427
 428 CN No it's difficult because I don't quite know what erm what sort of things that
 429 you're actually looking at erm

430
 431 AC Exactly what you've just said (CN yeah) that yes that was so rich er it was spot
 432 on erm so yeah unless there are other things you want to say

433
 434 CN No I think the more the more I think about it it's just the same things really (AC
 435 right) you could try to expand on on what gives you satisfaction and what doesn't but
 436 I think erm at the end of the day generally speaking even if you get a horrible visit
 437 patient complains you deal with it is sort of perversely satisfying really (AC yeah)
 438 erm some visits are absolutely awful (AC uhum) erm the palliative care side is a bit
 439 more you know it's a bit more holistic a bit more concentrated and it's easier it's
 440 easier to see going daily (AC mm) twice daily in the latter stages (AC mm) it it's if
 441 that's the sort of work that you can do it probably is it's probably satisfying for a lot
 442 of people (AC right) and the admin side isn't I think I could probably just keep going
 443 on about the admin side (AC yes) but but emphasising at the same that obviously for
 444 yeah professional reasons legal reasons there has to be an admin side (AC sure) has
 445 to be (AC mm) none of us (AC mm) none of us sort of we all know why we have to
 446 do it it just hits hard when erm paperwork in some respects paperwork has to come
 447 before the patient visit (AC yeah aha) for me anyway (AC aha) I'm sorry I have to

448 stay in the office today (AC yes) I've got to do the off duty (AC yeah) I've got to do
 449 the risk assessment I've got to do the audit that's come through from wherever (AC
 450 mm) erm I've got to sort of get everybody booked on the mandatory trainings (AC
 451 yes) that sort of aspect I don't I have to say I don't like (AC mm) If somebody wants
 452 to come and if one of the team members wants to come and take that over that's
 453 absolutely fine (AC mm) erm (AC right) I would much rather spend the day doing
 454 other things (laughs)

455
 456 AC Right. You just said a moment ago some visits are awful (CN yeah) what makes
 457 an awful visit?

458
 459 CN Erm For me an awful visit is probably either we're looking at we're probably
 460 looking at abusive aggressive type (AC right) relatives usually relatives rather than
 461 patients (AC mm) we're probably looking at we're probably looking at the complaint
 462 the rudeness the nasty situation rather than anything that's specifically (AC mm) erm
 463 a nasty visit I suppose you could be going into a house we do have houses where it's
 464 absolutely disgusting you wouldn't want to wash your hands in (AC mm) it's filthy it
 465 smells that I suppose you could say it isn't a nice visit but at the end of the day erm
 466 we are going in for a purpose so it's not I mean to me a horrible visit is one where
 467 probably you're not appreciated or it doesn't seem to be that you're appreciated (AC
 468 right) erm nothing but complaints nothing but erm you know we have had sort of
 469 aggressive behaviour off relatives (AC mm) and that you know is not a pleasant visit
 470 (AC mm) whatever you might be there for it becomes very unpleasant (AC mm) erm
 471 and I think that's something that we see perhaps a little bit more than we used to (AC
 472 mm right) (pause) and again in some respects people are much more informed aren't
 473 they people are much more questioning (AC uhum) erm people feel you know that
 474 they can now I don't know erm they can challenge but some people find it difficult to
 475 challenge in a nice way don't they (AC mm) it comes out as as abuse or or very sort
 476 of threatening manner (AC mm) which which maybe I think I suppose it must vary
 477 area to area I think we're very we're very safe environment in this particular area
 478 (AC uhum) erm violence and aggression that sort of stuff isn't something we come
 479 across very often (AC right) if I was working in the west end of M I probably would
 480 say something totally different (AC sure) so we are we are generally in a sort of
 481 pleasant area (AC mm) but the risk is probably greater now than it was I don't really
 482 know why erm and we do come across one or two people that seem to do nothing but
 483 complain (AC mm) about what we're doing and how we're doing it (AC right) erm
 484 and if the complaints are justified that's fine (AC mm) but just erm sometimes it's
 485 just a sort of hostile reception (AC mm) and I don't that's that's one of my not nice
 486 visits (laughs) (AC right yes) erm as I say I suppose you can have lots of boxes for
 487 not nice (both laugh) not nice because of the relatives not nice because the house
 488 smells (both laugh) (AC right) not nice because the patient's whatever (AC mm) the
 489 procedure's not terribly pleasant whatever (AC mm) but but for me I mean all of that
 490 is is just something that is just part and parcel (AC sure) it's the it's the visits I
 491 suppose it's the visits where we we decide I suppose we do have a few not often
 492 where it is not safe not safe as in physically not safe not safe for one nurse to go in
 493 erm not safe from a complaint point of view (AC mm) so we have to visit in twos
 494 (AC right) and I just find that just find that a bit sad really (AC mm) but that's it does
 495 happen and for me that's the visit I don't like doing I don't want to have to send two
 496 staff in just because (AC mm) there might be a complaint or I mean it could be erm it
 497 could be somebody who's perhaps you know suffering I don't know maybe a bit of

498 dementia or something (AC mm) it's not necessarily a wilful situation I mean we
 499 have we have situations where erm we've had one in the past where no direct
 500 accusations were made but it's like erm that nurse that came in that on my mantle
 501 piece that's missing now that sort of thing and it's not wilful it's (AC mm) it's a sort
 502 of age dementia type thing (AC mm) but again it puts staff in a difficult situation
 503 (AC sure) and you therefore have to those can be probably not that situation but
 504 aggressive (AC mm) erm complaining sort of people (AC mm) where you need a
 505 witness you need your solicitor to go with you (both laugh) (AC yes) it is erm for me
 506 not a pleasant visit (AC mm) but generally ninety nine probably ninety nine per cent
 507 don't come into that category (AC right uhum) erm (AC yeah) then again I suppose
 508 you can get some satisfaction out of being able to deal with the situation resolve it by
 509 sending two people in I suppose you can stand back and look at and if they really are
 510 aggressive you can go down health and safety routes (AC mm) you can actually do
 511 something about it you do get support from management now which erm maybe we
 512 didn't I think there was one culture not that long ago where we had to put up with it
 513 there was the patient's charter (AC yes) there's nothing there's not rights for nurses
 514 (AC yes) we were expected to put up with you know bad behaviour really (AC mm)
 515 whereas now I think we're not we can actually address it and be supported in it and
 516 that's quite a nice (AC uhum) and suppose that comes with health and safety risk
 517 assessments doesn't it which I hate doing (both laugh) probably a good thing coming
 518 out of that (AC yes it's interesting isn't it?) yeah (AC mm) so erm (AC yeah great)
 519 other than that I must like the job because I'm still doing it (both laugh) (AC yes)

520
 521 AC How many years have you been here?
 522

523 CN I've been here about seven and a half erm (AC right) about that now but then
 524 before that I worked in K for a couple of years (AC OK) erm that was with a and
 525 again it's the same thing you become very used to your job can do the job so why not
 526 why not go and do the next grade (AC uhum) because obviously you're ready to
 527 move on (AC uhum) erm which is obviously why I've taken this job that is ninety
 528 per cent admin (AC yes) and very little patient care (laughs) direct patient care (AC
 529 yes right) erm but er erm (AC OK) I think as I say I think it's probably quite nice that
 530 the jobs are developing rapidly (AC uhum) because it does it does mean that you do
 531 have to you do have to learn more skills (AC uhum) to cope with the job so that's
 532 probably actually we might not like all of it but it's probably quite a good thing (AC
 533 mm in that it) from a challenging point of view and it does keep you erm you can't
 534 stagnate I mean I know nurses shouldn't anyway and we don't (AC mm) but it it
 535 keeps stretching you there's yet more different aspects (AC mm) erm that will need
 536 that need sort of learning about (AC mm) and dealing with (AC mm) so er

537
 538 AC Excellent OK
 539

540 CN Otherwise I could go back to working in a shop or something (both laugh) (AC
 541 yes yes) so er (pause)

542
 543 AC Great is there anything more you want to add
 544

545 CN No I think that's it really (AC OK) I think again erm it boils down to the same
 546 sort of aspects (AC mm) that are enjoyable or not (AC mm) erm and there's there's
 547 apart from you know the evil paperwork you know most most sort of visits most day

548 to day things are not either wholly bad or wholly good (AC yes) there's there's
549 different bits that you can pick out really aren't there? (AC sure yes) erm you might
550 have a you know a very nice visit and some aspect wasn't quite so good or whatever
551 and vice versa (AC uhum) so and it it's I think we're probably we're probably quite
552 privileged in community and that's probably you know GPs general practice
553 whatever (AC uhum) in erm we are presented with such a wide variety of different
554 things (AC yes) requiring different skills. If you're working on a surgical ward you
555 become you become perhaps very limited I mean from a sort of professional skills
556 level (AC mm) we're dealing with just about anything that anybody wants to throw
557 at us (AC mm) erm you have to be you know you have to be good at dressings
558 injections you have to do a whole lot of of things and it's you know there's a lot of
559 variety (AC uhum) it doesn't get boring (AC mm) there's always something there's
560 always something slightly different to go out and do (AC yes) whereas as I say if you
561 want to concentrate on a particular nursing area within a hospital then you probably
562 wouldn't come across quite so much variety (AC mm) so you never quite know and
563 there's an element of surprise you never quite know what you're going in to when
564 you walk through somebody's door (AC uhum) (both laugh) (AC surprise shock?)
565 yeah whatever, wrong house (both laugh) yeah (AC yeah excellent) I think from a
566 community nursing point of view it's probably erm well obviously for me it's erm
567 it's the most challenging area (AC mm great) (pause) other than that (pause)

568

569 AC OK? (CN um) well thank you very much for your time that was great.

570

571 CN Prattling on about the same things really.

572

573 AC No no that was really good.

Transcript Summary

Interview 3 DN

This transcript suggests that CN enjoys patient contact^{12,8} more than the paperwork^{41,138,145,375,434} associated with her role. She prefers to go out and do a visit^{43,44} rather than spending most of the day in the office²⁰. She enjoys sorting out problems for patients⁴⁸ and gets particular satisfaction when she can see that her interventions have made a difference^{162,179,200,431}. She enjoys doing basic nursing care^{71,75,154}, making patients feel comfortable^{168,66} and contributing to an improvement in their condition^{59,60,66}. She particularly likes palliative care^{151,165,195,429} and likes to think that she has helped someone's symptoms¹⁵³. When patients are terminally ill CN likes to help them stay at home if that is what they wish to do^{174,179}. She enjoys supporting the relatives and helping them to cope^{67,169}.

CN enjoys challenge³⁸⁹ and whilst she would like to have a lower grade staff nurse role so that she could remain more 'hands on'^{374,88} with her patients she also enjoys the challenge of her organisational and team leader role^{389,523}. She enjoys being stretched³⁹⁵ professionally and enjoys being involved in change³⁷⁷. CN enjoys organising a large team^{104,301} and enjoys using her organisational and management skills¹¹. She likes 'sorting stuff out' and problem solving³⁹ within the team¹⁰⁶ and is happy to delegate tasks to other members of staff⁴³. She finds all the administration associated with her role frustrating¹¹³ and is particularly frustrated when she spends time carrying out tasks that could be done by administrative staff¹⁹. At these times she feels she is not using her own skills to the full. She enjoys the challenge of having to use all her skills²⁸⁶ on a visit for example in palliative care where she uses her organisational, communication and listening skills simultaneously^{267,210}.

CN is satisfied when patients are discharged off the case load as they have improved and no longer need the service and this can be seen as a measure of success¹⁸⁸. She enjoys organising³⁰¹ the staff but also wants to stay hands on with patients^{88,374}. She enjoys the wide variety of work in the community^{548,543} and enjoys looking at ways to improve practice²⁵⁶. She feels satisfied when she has done a good job²⁴⁷ and less satisfied when she feels she has not been appreciated⁴⁵⁷.

(The small numbers refer to the line of the transcript where the idea can be found)

Interview 4 NP

1 AC And so there's only really one question and then we just go with wherever you
2 want to go (QU Right) so it's very open and it's just about your ideas and your
3 beliefs about your work erm and so the opening question is 'what do you find most
4 meaningful in your work?'

5
6 QU Probably the autonomy of managing patients (AC right) looking after patients
7 care from the beginning to the end (AC right)

8
9 AC Do you want to say a bit more about that?

10
11 QU Bit more? Er taking more responsibility about that erm (AC mm) using the skills
12 that you've gained over the years and being able to implement them which I think
13 before you could do to a point but now I feel I can do a lot more and have perhaps a
14 bit more say in patients' care (AC uhum) not just in acute but in chronic disease
15 management because I think I've been a bit more accepted by the medics for my
16 skills as a nurse practitioner and implementing them into chronic disease
17 management as well (AC right)

18
19 AC Right do you want to carry on?

20
21 QU Can I elaborate on that? Erm (pause) ooh I think the degree helped because it
22 wasn't just the clinical examinations that I feel that I've evolved or developed I feel
23 that I've gained skills in er looking academically and clinically at aspects and making
24 er a judgement as part of the lead nurse as well that I'm now the lead nurse as well
25 and I look at things probably more objectively than I did before (AC right) about
26 how to do skill mix erm probably look more macro than I did used to I used to just
27 look at things micro at the particular patient rather than the whole issue (AC mmm)
28 of how we can manage health care (AC uhum) erm and accept other people's roles
29 and the roles that they may offer in health care and how they may offer different er
30 dynamics to the health care (AC mm) and respect where your limitations are and
31 where someone else has probably got better expertise (AC mm) than you

32
33 AC That's interesting yeah yeah so again can you expand on that a bit more?

34
35 QU Er ooh (pause) what generally skill mix or (AC yeah any of that) skill mix OK
36 I'm very pro skill mix I don't know whether that's a nurse practitioner role or
37 whether that would have evolved just because health care's evolved that way erm but
38 erm I find that that's the most cost efficient probably and the most practical for
39 health care. Within my team we have two phlebotomists two health care workers and
40 now taking another on health care worker, we've got two practice nurses and a
41 treatment room nurse who we've just taken on to fill that care gap as well and then
42 myself as the nurse practitioner (AC mm) and I think that team works really well
43 together erm er not just people at different levels we work across and help each other
44 in different areas and as people erm work longer in specific areas they gain extra
45 skills that maybe I've become deskilled at (AC mm) and you have to come to terms
46 with that and accept that they may have more knowledge about that and that's fine
47 because it's just such a mine field in the NHS (AC mm) to know everything so I feel

48 that's a positive side of things that we are actually saying it doesn't have to be done
 49 by a registered nurse but it can be facilitated by a nurse (AC mm) and I feel that's
 50 part of the skills that I learnt in the degree course (AC right) about looking at those
 51 aspects of facilitating care not just having to be directly involved (AC mm) although
 52 management's not my cup of tea but I do actually erm see the benefit to the patient
 53

54 AC right so that's working a different level (QU Yeah) OK
 55

56 QU What else can you say er (pause) erm skill mix (pause) I lost me train of thought
 57 there. Oh that was it I was thinking about chronic disease management one of the
 58 next things I'm going to do is that now we have three health care workers erm is
 59 because chronic disease management is a big area for GMS contract and we have to
 60 overview that erm that I'm going to give each health care worker the responsibility
 61 of each area so one will be responsible for respiratory one will be responsible for
 62 diabetes (AC right) and one will be responsible for cardiac and I feel from that side
 63 of things they feel quite motivated because they become to be seen as the person who
 64 is knowledgeable about that within the practice (AC uhum) and who everybody else
 65 can go to for any particular problem whether it be administrative or the process of
 66 how we manage people (AC mm) erm so we're working towards that we already
 67 have a health care worker who has done the diabetes and it's shown me that that is
 68 the way forward because if there's anything to ask about diabetes er she's the one we
 69 can always go anyone within the practice can go to her and ask 'where do we go to
 70 send this' or 'what do we do about that?' and I feel that only improves care and for
 71 herself I feel she feels a lot of job satisfaction from that as well (AC mm) erm so I'm
 72 working particularly towards the respiratory one now (AC uhum) and I'm hoping to
 73 train the health care worker to do spirometry and we'll work together on that (AC
 74 right) because that's very time consuming and I'm the only nurse who does the
 75 spirometries in the practice (AC mm) erm so yes so that's where I'm looking towards
 76 and I think that works really well both for the patient because they've got a point of
 77 contact and also for the rest of the health professionals because they've got a point of
 78 contact and I think a lot of the problem in the NHS is poor communication (AC mm)
 79 and if you've got someone you can refer to there who knows where to go for the
 80 answers they don't have to be a doctor or a qualified nurse they can be somebody
 81 who's just gained that expertise and that knowledge in that area
 82

83 AC Right excellent right anything more you want to add to that?
 84

85 QU Any more I want to add to that? Erm no I think that's the way it's going towards
 86 erm and I think that we should look more positively on the GMS contract because I
 87 think it will pull people up (AC mm) to give a similar standard of care (AC mm)
 88 albeit it might be ticking boxes for some of us but it will pull some of the practices
 89 up who haven't (AC mm) already got there and it's certainly making us look at it
 90 (AC mm) and had this not come about I may have not made that choice (AC right)
 91 but erm er practically speaking you think how do you manage this with the resources
 92 you've got (AC uhum) and therefore it drove me to make that decision (AC mm) erm
 93 and as I say I don't see that as negative cus I think it's actually come out better care
 94 (AC yes) and a better organised system (AC aha) for both patients and staff erm a lot
 95 of each of those chronic disease management areas don't need again a qualified
 96 member of staff but somebody who who knows the system (AC mm) erm what we're
 97 hoping to do is perhaps have some key worker above all that who will administrate

98 the organisation I'm hoping to have an administrative staff erm attached to the nurses
 99 basically (AC right) but this person will become the chronic disease management
 100 administrator and they will administrate how clinics are run every month (AC mm)
 101 and organise those (AC mm) just because of the massive turn over of patients (AC
 102 mm) erm and I find that very time consuming I'm not very practical (AC mm) my
 103 time spent trying to trawl through audits and things trying to identify who's not come
 104 (AC mm) and so on but that could be left to one person (AC uhum). The other thing
 105 that I'm trying to do from that is often patients will have more than one chronic
 106 disease management and rather than pull them in for one set thing try and pull them
 107 in to cover both areas (AC yeah) which is what I'm already trying to do now is to see
 108 people who have ischaemic heart disease who have a respiratory problem come to
 109 see me (AC right) rather than the other nurse cus she's not respiratory trained (AC
 110 right) and they then have a double appointment because a lot of what you're dealing
 111 with is crossing the same areas (AC sure) so you can deal with both things and you
 112 can deal properly with the patient and for the patient they're getting a full work out
 113 (AC uhum) and they're only coming once (AC mm) rather than coming back for
 114 these repeat annual reviews to different places with people's different views you've
 115 (AC mm) just got one person (AC mm) saying this is holistically how we should
 116 manage all your chronic disease management
 117

118 AC Mm yeah and you'd all be asking the same questions (QU yeah) so it makes
 119 efficient use of time (QU yeah) yeah right. Just to go back to the er beginning the
 120 first thing you said was about autonomy (QU uhum) erm and about managing the
 121 whole cycle of care. Can you say a bit more about that?
 122

123 QU Ok yeah erm I think it's having patients who see you about a perhaps an acute
 124 problem or whatever and you dealing with it using your skills to deal with that and
 125 make a judgement call and then to manage them and now with extended prescribing
 126 you can do the full circle (AC mm) without any other member of staff which I think
 127 has two fold thing one because you've actually completed the circle and secondly for
 128 the patient erm they I think feel more confident about you (AC mm) because they've
 129 not seen the doctor they've just seen you, dealt with the problem gone away if
 130 they're happy about that that's fine go away and if it's dealt with they come back
 131 again and see the nurse practitioner again (AC mm) because they didn't need to see
 132 the doctor and they're aware of that and I think patients see that now (AC mm) it
 133 takes time to gain that confidence (AC mm) erm so I quite enjoy that because you
 134 become a person in your own right I'm now Q the nurse practitioner so when people
 135 speak to me or they speak to the girls there is another Q in the practice who is a
 136 practice nurse (AC right) so they always try to differentiate between that (AC mm)
 137 usually it's because 'oh is it that big tall lanky one?' (both laugh) or some will
 138 address me as a nurse practitioner some wont I think actually some patients still
 139 don't know who I am actually (AC right) I'm just Q the nurse who's been here for a
 140 few years (AC mm) and extended her skills but the label 'nurse practitioner' perhaps
 141 has no bearing on them (AC mm) I don't think it's as important as we think that label
 142 it's just what you erm what you reflect I suppose what image you give to that patient
 143 and that assurity they have about your attitude and your behaviour when you're
 144 dealing with them (AC mm) is the thing that's important (AC uhum) for the new
 145 patient I think it's important to have a label some of the younger generation they
 146 know what a nurse practitioner is I think now (AC mm) but for the older generation
 147 they don't know (AC mm) I'm just sister who's been here for a few years and that I

148 can always come and talk to (AC mm) and say by the way this is a problem and you
149 deal with it (AC mm) and each time you do that they feel that they can come to you
150 more and more (AC yeah) because they don't know what your limitations are (AC
151 mm) erm but when you do present yes I'm limited by this they can then you can then
152 say look I think you need to see the doctor about that I don't see that as negative
153 either I think they actually think OK she knows where to draw the line (AC mm) and
154 she'll tell me when I'm right to go to the doctor (AC yes) that's not something I have
155 to worry about it's at the back of my mind (AC mm) so erm autonomy I think it's
156 nicer in the practice because I seem to get more respect from other members of staff
157 (AC mm) now certainly receptionists hold me as erm whether I like the title or not
158 like the super nurse the nurse who can do more (AC right) erm amongst my
159 colleagues not you know that's something I'm you seek out but it's there because
160 you know it is they often say 'oh Q can do that' it's not negative against other
161 practice nurses (AC mm) but it's they've just decided that I'm just that step higher
162 (AC mm) on my knowledge just probably just talking to me as well (AC mm) erm
163 it's like I had a health care worker who's training up coming sitting in one of my
164 surgeries (AC right) and er she was quite amazed at what I knew (AC mm) and she
165 said 'god you know so much' and you know I said you know it's just years of
166 experience and (AC mm) and so on but erm and that's quite nice and going to PB has
167 done me good as well because I've gone there and er you're not in your own
168 environment which you start to feel very comfortable with (AC yes) erm they don't
169 have a computer it's totally paper and I don't know anybody don't know the staff
170 don't know the system I don't know the patients and I'm just having to work totally
171 off my skills (AC mmm) and that's quite amazed me actually (AC mm) because I've
172 gone in there and made judgement calls without being in my own environment and
173 the comfort of that so my confidence levels probably not at it's best (AC mm) erm
174 not sure of the doctor don't know him just know he's another health professional
175 (AC uhum) er and certainly not knowing the patient and having nothing at all about
176 the patient (AC mm) except for what they tell me (AC mm) or what I glean from
177 them erm and I think that's been quite a boost actually for me because when you're
178 working in somewhere for a long time and you've worked there and progressed
179 gradually it's not like it's a switch is it (AC no) it's something that happens (AC
180 uhum) it you get better and better at it (AC mm) when I was first doing the nurse
181 practitioner role I was very nervous and now I'm fairly comfortable with it (AC mm)
182 I certainly for instance come back off holiday and when I came back off holiday I'd
183 be really nervous about 'Can I remember everything? Will I deal with this? Will I
184 forget key points?' (AC yes) and this time I come back off holiday I was slightly
185 apprehensive (AC mm) but within a patient or so I was back in in (AC mm) that
186 mode again erm. But going to PB that was my first day back I was quite nervous
187 about that because ooh can I do this but again within patients I mean the very first
188 patient I referred to the doctor and I felt apprehensive about doing that because I
189 thought 'I bet he thinks I'm a right one' because here we are with a nurse practitioner
190 don't know her from Adam and the first patient she asks me to look at (AC right) but
191 it was a judgement call that I felt needed I felt if I had total autonomy I would have
192 admitted them to hospital (AC right) er going to Benner I suppose at the time I was
193 thinking about it and I just wasn't happy with this patient (AC mm) I just besides
194 some clinical things that I wasn't happy about the patient was a child that I just
195 didn't think was well (AC mm) just not a well child and I wasn't happy (AC mm) so
196 I er and the patient had been the day before to the same service and had seen the GP
197 who had said erm oh go home continue with your antibiotics sort of thing so that

198 made me feel a bit anxious as well because I thought ‘they thought this was OK and
 199 I’m actually going to challenge this and say I don’t think this is OK’ (AC mm) and I
 200 don’t think the child had actually deteriorated so what I was seeing I think was what
 201 the GP had seen the day before (AC right) but the GP I confronted and asked to look
 202 at he agreed with me and we admitted him (AC mm) so I felt better about that erm
 203 but those sort of things are quite challenging still (AC mm) there’s still an air of
 204 uncertainty or still an air of challenging (AC mm) er probably the nurse practitioner
 205 role yourself and thinking ‘am I right here?’ (AC mm) ‘am I overstepping the mark
 206 or am I perhaps being what’s the word not confident er not assertive enough or not
 207 believing in yourself enough to make the right judgement’ (AC mm) erm but anyway
 208 and then after that I saw patients and it was fine and erm asked him to do
 209 prescriptions and so on and he was quite cool about it he was just like you made a
 210 good judgement call that’s fine and that was it. So when I came out of there I felt
 211 really quite pleased with myself (AC mm) because I thought you know I managed to
 212 deal with all those issues (AC mm) and it was totally on my skills (AC right) that I
 213 was able to do that (AC mm) and I’ve never really had or never really looked back at
 214 it and thought about that before (AC mm) what I’ve done that day was purely from a
 215 lot of knowledge (AC mm) experience and things that I’ve gained over the years that
 216 you just take very lightly (AC mm) and you think ‘oh yes I do know some stuff but
 217 not that much’ but actually when you look at that day you think ‘well actually yeah
 218 (AC mm) I can do a lot of things’
 219

220 AC Right and that was more obvious to you being in a different setting rather than
 221 being here? (QU Yeah) Yeah Would you get those experiences here as well
 222

223 QU Not the same degree I don’t think (AC right) because there’s all sorts of things
 224 going on in your head I think. In a way if I had something iffy here my head would
 225 probably say different things it would say well you know this patient so take
 226 something off that or I know the family or so and so is just dotting about so I’ll ask
 227 him to come and have a look in (AC mm) er or they’re very busy. I suppose that
 228 child if it had happened here I would have actually rung the nurse practitioner on the
 229 children’s ward having known her (AC right) and asked her advice (AC mm) and
 230 said I’m not happy would you have a look and we have done that before and she’d of
 231 probably said ‘yes send him in’ (AC mm) and then I would have just told one of the
 232 GPs what I’d done so maybe yeah I would have done that different but that’s
 233 working in a different Trust as well isn’t it (AC mm) and I don’t you know I’m not
 234 very sure PB they work slightly different than us (AC yes) again that’s not negative
 235 that’s just different points of view and opinions (AC mm) erm and you take the good
 236 or the bad from that don’t you (AC mm) I’ve learnt from that (AC yes) so (pause)
 237

238 AC Anything more you want to add to that (pause) about the autonomy?
 239

240 QU About the autonomy? (pause) Not really no I think that identified it mostly for
 241 me
 242

243 AC Right OK Well again going back right to the beginning one of the other things
 244 you said was about er having responsibility and that being an enjoyable part of your
 245 role. (QU mm) So anything more you want to add to that?
 246

247 QU Well I think it's having the responsibility of erm not only looking at your own
248 work but looking at other team members' work (AC mm) and how that can effect for
249 me probably mainly the practice because that's where I'm attached to erm so you
250 know constantly looking around me and being aware of what we're offering where
251 we've moved on from (AC uhum) and where we could move to (AC mm) and I feel
252 that's some of my responsibility as the lead nurse to make that (AC mm) erm and
253 some of the changes that have gone on have been because of myself (AC uhum)
254 which is quite nice because when you look back and you think well that wouldn't
255 have happened if I'd not said challenged things or said 'why don't we try someone
256 doing this?' For instance I got one of the health care workers to do stop smoking
257 clinic (AC right) and that was against some conflict from other members of erm the
258 primary health care team who felt it was their area erm but subsequently she took
259 that role on she did a very very good job (AC mm) and after that er they actually
260 went to her for advice which was quite nice for her and for me I felt a bit like well I
261 made that decision I know some people didn't like it but actually it worked it was the
262 right thing to do (AC mm) erm and it did work well (AC mm) er and if you think
263 about stop smoking and the cost of it and the advice that we're paying for certain
264 members to pay out if you can get a health care worker to do it then that's got to be
265 more cost efficient and you could even argue that you could have nearly two health
266 care workers to some other members of the team (AC mm) doing it and that's got to
267 be better (AC uhum) particularly if they're offering the same service (AC uhum)
268 which she was and if anything it was superior (AC right) because the patients knew
269 her as somebody else (AC mm) and could relate to her far easier than (AC mm)
270 somebody coming in cold (AC mm) so from responsibility I mean that's just
271 identifying one point but I've done other things and that's quite nice (AC mm) and
272 it's quite nice to sometimes when you have got time reflect and say 'This could be
273 better and how could we do it?' (AC mm) and I have er the position to make that
274 choice (AC mm) so yeah (AC right) I like that as well

275
276 AC So you've been able to make some changes happen (QU yeah) yeah excellent.
277 Erm another thing you said earlier on was about er respect from medics so do you
278 want to say a bit more about that?

279
280 QU Erm yeah I think since the nurse practitioner and the extended prescribing
281 because you're much more closely involved I felt doing that because you're
282 discussing clinical aspects at a greater level that I think I've gained their respect
283 more because they I don't know what they perceived or what they perceived my
284 knowledge base was but because you're being more open and discussing things
285 probably at a deeper level than I was as a practice nurse (AC uhum) erm er I think
286 that's lead them to er acknowledge where you are (AC mm) and where your level is
287 and probably have a better comprehension about who you are and what you are (AC
288 uhum) and from that er respect it enables them to off load more and feel comfortable
289 about that (AC mm) erm and also in some areas particularly respiratory they may
290 actually come to me for advice well they do they now send patients if they don't
291 know they just say 'will you just sort this out' (AC right) which I mean I have done
292 respiratory for years and I'm cardio-thoracic trained but I never got that as a practice
293 nurse and I'm getting that now (AC mm) and you have to wonder why (AC mm) you
294 know you can't say it's just another few years experience I think that's where I
295 would say it's different because one of my other colleagues is respiratory trained erm
296 well she's done the asthma diploma and they never refer to her (AC mm) even

297 though I constantly say there's her and I to refer to it seems to be like a mental block.
298 I don't think they do it nastily or pointedly I think it's just that when they think that
299 they think oh well send it to Q (AC mm) erm and erm from that it's a bit of a shame
300 because I think not that she's loosing the skills but she's not progressed or evolved
301 from that (AC right) but at the same way also realise if there's an acute respiratory
302 problem she can't deal with that (AC mm) which I can do (AC mm) which again
303 probably the medics see that as a positive thing that when you see them you're
304 already picking up any acute signs as well (AC mm) during the chronic consultation
305 (AC mm) and dealing with that (AC mm) so that might be an offshoot of that
306

307 AC mm (pause) right that's interesting yeah any more about the medics and the
308 relationship with them?
309

310 QU Anymore? I think it's improved it's been a hard slog (AC yeah) (both laugh) but
311 I think from having 50% of them not sure of me or should I say even against me I
312 know I've got all of them now they totally support the role (AC mm) erm and if I
313 was to leave I'm sure they would want another nurse practitioner (AC mm) without a
314 doubt (AC mm) erm I think what sums it up is the other week they were talking
315 about the holidays and erm the holiday rota and one of them said well we need to
316 include Q on this because when two of us are off that's bad three's bad or but if
317 there's two or three of us off and Q is off that's just a nightmare (AC mm) so we
318 think we should involve Q of which the practice manager said well that's fine but if
319 you do that Q is in with the nurses and then what should she do with the doctors or
320 the nurses who does she have her holidays with (AC You can't take holidays) (both
321 laugh) no you can't take holidays and seeing as half of you have children and Q has
322 it's going to be a big (AC yes) so anyway they went 'mm OK' but he was saying to
323 me you want to feel pleased because that was their view point (AC yes) that was like
324 OK holidays are bad we can deal with it up to this but we can't have Q off as well
325 (AC mm) so it's as if you've made ways forward because when you're not here they
326 go 'Where's Q?' (AC mm) and that's quite nice as well (AC yes yes) that erm they
327 see you in that equation now
328

329 AC mm yes that's interesting. (pause) Yes so to look now at this from another
330 perspective erm what are the aspects of your work that you don't find meaningful or
331 that er frustrate you or
332

333 QU Erm jiggling jiggling er being the lead nurse sometimes er if there's er someone
334 off sick or if someone's left or someone's like that (AC mm) it seems to be me who
335 has to take the slack (AC mm) erm and that can mean eroding the nurse practitioner
336 role because they can't get slots for certain members so they just stick it in my open
337 access and that's what happens (AC right) erm I'm probably as guilty because I take
338 that slack up because I feel that's my role to do that in the management point of view
339 (AC mm) erm not having enough time for er admin er but again that's my own short
340 fall because I hate paper work I hate admin erm anything to do with audits I'll do
341 anything but (AC really) yes I'll do them (AC yes) but I'd just rather see patients
342 (AC yes) and theoretically I should book sessions out of my surgeries (AC mm) to
343 enable me to do that or to certainly to do it better than I am doing but I wont do
344 because erm I'd rather not do it (AC right) so I make excuses for not doing it (AC
345 aha) I do do it but I know I'm guilty of probably not doing it as well as I should be
346 doing it (AC mm) and the pressure of that at the back of my head I don't like either

347 (AC mm) cus I'm a person that's quite organised I like to see things done and I tend
 348 to do things that I don't like first so that I can get them out of the way (AC right)
 349 otherwise it just hangs over me (AC mm) if I'm too busy and it hangs over me I find
 350 that quite stressful (AC mm) because I can't deal with it (AC mm) so that's the part
 351 that I don't like a part I don't like I think it's all management things really dealing
 352 with staff problems (AC mm) if there is any (pause) erm one of my colleagues is a
 353 bit challenged to the nurse practitioner role and I think she's never overcome it
 354 totally (AC mm) so there is times that erm I feel I have to be careful (AC mm) treat
 355 her with kid gloves and I don't like doing that because I don't think I'm being fare
 356 because I let her off the hook more than other people (AC mm) erm and I tend not to
 357 manage her I tend to shy away from it and let her do her own thing (AC mm) er cus I
 358 don't want confrontation (AC mm) erm yeah I'd have to say it's mainly paperwork
 359 that I'm a nightmare about (AC right) I just don't like it. I don't mind sorting rotas
 360 out and looking at that or looking at peoples' staffs' needs (AC uhum) that doesn't
 361 bother me it's really the audits and (AC mm) probably sitting down and thinking
 362 about things objectively and writing them down (AC mm) I can think of the ideas but
 363 somebody else has to write them down for me (AC mm) (both laugh)

364
 365 AC Yes that skill mix thing again

366
 367 QU Yes that's really the thing I don't like

368
 369 AC Right erm anything else that frustrates you or you find

370
 371 QU Frustrates me Erm (pause) yeah I've got a couple of GPs who still under estimate
 372 you or take over (AC mm) erm for instance if I'm setting up erm a process for
 373 respiratory like for instance we had a meeting not long ago about how we are going
 374 to meet the GMS contract and I did loads of as much as I didn't like it background
 375 work on how we should do it how we should improve the templates maybe where
 376 we're missing out like people doctors not completing templates and trying to get
 377 them to get on board they have to do that whether they like it or not (AC mm) er and
 378 I came up with a list of ideas after the practice manager said we were going to have
 379 an away day
 380 (AC uhum) and then doing it and then finding that the GP was responsible for that
 381 area just took over got his own paperwork didn't want to look at my issues (AC mm)
 382 and then came back and sort of said well the erm respiratory nurse in the area does
 383 this and the respiratory nurse in the area does the other and you're going 'yes that's
 384 exactly what we do' but he's not listened to you he's just gone off (AC mm) erm and
 385 not listened to you but I think he's guilty of that at some times but that really annoys
 386 me I find it demotivating and really frustrating (AC mm) because he doesn't he
 387 probably wouldn't do it to another colleague but he is doing it to me because I'm a
 388 nurse (AC mm) so

389
 390 AC Mm interesting yeah – is there anything more you want to add to either what you
 391 find frustrating or you enjoy about your work?

392
 393 QU No I can't think of anything else Alison

394

395 AC No? You've painted a lovely picture of what you do (both laugh) and also a
396 complete picture from the management point of view plus your clinical work. Yes
397 that's brilliant but nothing else you want to add?
398
399 QU No no
400
401 AC That's great Q Thank you

Transcript Summary

Interview 4 NP

This transcript suggests that QU enjoys having autonomy⁶ in her role as a nurse practitioner, she likes being able to complete a whole episode of care⁷ with a patient and enjoys having more say¹⁴ in the patient's care. She enjoys having more responsibility¹¹ and gains satisfaction from being able to use the skills she has gained over many years and being able to use them fully¹². Having gained academic and clinical skills from her degree course²³ she feels she now sees things from a macro perspective²⁶. She enjoys having responsibility for her own role as well as the work of others²⁴⁵ and she likes being able to reflect on the practice of the team and make suggestions for change²⁷⁰. She values other people's roles²⁸ and values the diversity that exists in her team^{79,104}. She values cost effectiveness³⁸ and efficiency⁷⁷ and so supports skill mix in the team^{36,49}. QU is aware that skill mix can contribute to motivation and job satisfaction^{63,71} in other members of staff and so she is prepared to challenge and embrace change in order to move things on²⁵³. She is prepared to accept conflict from other team members in order to make changes in the practice²⁵⁵. QU aims to empower other members of staff and likes them to feel satisfied²⁵⁸.

QU is aware of her limitations³⁰ and is prepared to share these with patients¹⁵⁰. She feels that sharing her limitations with patients results in the patient being more confident in her abilities¹⁵⁰. She is not too bothered about the title 'nurse practitioner' and feels that the patient gains confidence in her role by experiencing her attitude and behaviour¹⁴². QU values the patient's time and so aims to cover an assessment of two chronic diseases in one consultation^{112,128}. She likes to see a well organised system for both patients and staff⁹⁴. She feels that her own confidence as a nurse practitioner has increased since she has worked in the out of hours service in another primary care trust^{170,181}. She feels she has been becoming more and more comfortable in her role as a nurse practitioner²¹¹. She feels the autonomy she has in her role gives her more respect from other members of staff¹⁵⁶ and that managing the full cycle of care increases patient confidence in her as a practitioner¹²⁸. She occasionally experiences uncertainty when making a clinical judgement²⁰².

QU feels that she has worked hard at gaining the support of her medical colleagues³⁰⁸ and now feels that they totally support her role³¹⁰. She enjoys the fact that the GPs miss her when she is not there³²⁴. She feels frustrated and demoralised when one of the GPs does not listen to her ideas for change³⁸¹. She is keen to contribute to the new GMS contract³⁷² and values the idea of providing a similar standard of care across the NHS⁸⁷. QU prefers seeing patients³³⁹ rather than doing administrative work or audits³³⁸. She finds that paperwork, administration and audits hang over her and cause stress when there is not enough time to do them^{347,359}. She doesn't like all the management and having to deal with staff problems³⁴⁹ and prefers to avoid confrontation³⁵⁶ if possible. She feels frustrated when her nurse practitioner role is eroded because she is called on to cover the sick leave of other members of staff³³⁴.

(The small numbers refer to the line of the transcript where the idea can be found)

February 16th 2004

Interview 5 DN

1 AC Yes It's really what you find most meaningful in your work

2

3 QE Right I'll say now then. I feel as a district nurse in our role we get a lot of reward
4 from people because we erm see them every day in their own homes (AC right) erm
5 we do form a rapport with them some obviously are on our books for many years
6 many months and we do get a good relationship with them er we do view patients
7 holistically erm that means not just from the physical side the whole spiritual attitude
8 and everything erm we work well with GPs our communication skills erm do go that
9 far we work with health visitors (AC aha) nurse visitor for the elderly. I think I get a
10 lot of reward from my patients because I'm very keen on wound care and to see a
11 wound healing and leg ulcers healing I think is very rewarding from our point of
12 view. Er we do obviously keep updated we work we do lots of courses at M to do
13 this (AC mm) and to see a wound heal I think is very is a great bonus for us erm. I do
14 enjoy my work erm obviously patients value what we what we do they they listen to
15 us sometimes you can get one or two non concordant patients (AC right) but if you
16 sort of erm discuss things with them and explain the situation allow them to be a
17 little bit more empowered you can sometimes win them over and they will
18 understand that we are the ones with the knowledge more than them we do try and
19 share our knowledge with them and keep them informed give them a few informed
20 choices (AC aha) so as that they can obviously get a great deal out it themselves as
21 well (AC right) what other aspects do you really

22

23 AC Whatever else you want to

24

25 QE Erm I think

26

27 (Cup of tea being poured by someone who just walked in the room all three laugh,
28 person apologises and leaves)

29

30 QE We do a lot of work in surgeries too so we probably get we probably see more
31 younger people we do see young people on the community obviously and I think the
32 most of our clients are the elderly (AC mm) so that's quite I think you know we do
33 get a lot from that really but we do tend to see a lot of younger people but mostly in
34 surgery and because they are obviously they are younger we don't we only do tend to
35 see those that are strictly housebound erm we get a variety of different work we do
36 what you call the erm within the scope of professional practice more extended roles
37 (AC right) erm we tend to get a lot of bloods ear syringes erm pessaries erm oh
38 various other things Hickman lines we do a lot of work with cancer patients (AC
39 right) we hear from the McMillan unit so we obviously they liaise with us through
40 the liaison system. So I think our role has really changed over the years. Erm going
41 back to surgery I do think erm from a clinic point of view erm sometimes it's a bit of
42 a faster pace or a lot of the clients may may just be a one off visit so the relationship
43 you build up with them is just a one off really (AC mm mm) certainly for wound care
44 and stitches out you don't really need to see them again (AC mm) you have to give
45 them a lot of education handouts or advice so as that they can just ring us if they do
46 have a problem (AC right) and that's quite nice really because they sort of listen to
47 you and think you know they've learnt something (AC mm) and they see us as the
48 experts if you will really (AC mm) erm (pause) what else is that it?

49

50 AC Do you want to keep going?

51

52 QE Yes I can just keep going that's fine (both laugh) erm I think erm we do tend to
53 liaise a little bit with other obviously the multi disciplinary team (AC aha) we do
54 speak a lot with social workers because obviously they are the main assessors so
55 obviously if we come across any patient problems we do tend to liaise with them
56 quite a little bit erm we do tend to work with sometimes even the McMillan nurses
57 Marie Curie nurses we do have a big link with them (AC mm) erm on a day to day
58 basis the district nurses are based in a team we have a team leader and different
59 grades of nurses erm our work varies from day to day (AC uhum) we have we do
60 have the computer system where the patients are actually there for each day so we do
61 know who we are going to and they are printed out but obviously we are a twenty
62 four hour service so we obviously have the evening staff as well as the night staff
63 erm so it's like a continuing care erm I do feel erm (pause) what happens mostly is
64 when in a morning the phones ring we can often get different calls sometimes people
65 will just ring up (AC mm) you know 'will you come and see me my leg's broken
66 down or my wound's deteriorated' we're assessing on an ongoing basis really (AC
67 mm) it's not just a one off thing you know we don't just do a one off assessment and
68 think oh that's it now till goodness knows and it's an ongoing thing every day (AC
69 sure) and we evaluate wounds as and when and obviously in the earlier stages with
70 wound care especially if the wounds are quite nasty and quite have deteriorated we
71 do evaluate them pretty regularly maybe weekly (AC uhum) obviously as they do
72 progress we reduce it and reduce it (AC mm) sometimes if it's a long standing leg
73 ulcer because sometimes they can be there for years (AC mm) so they can become
74 monthly but you know we do erm obviously erm evaluate wound care quite regularly
75 really (AC mm) erm we do have a nurse visitor for the elderly that obviously works a
76 little bit not to say parallel to us she does a lot of the erm over seventy five checks
77 (AC right) so anything that she picks up on she'll liaise with us any other problems
78 erm she'll do a lot of the blood tests various things that they need and blood pressure
79 checks etcetera also we can also do them too but obviously she'll do them most and
80 all the inco assessments (AC mm) if they've got no other nursing needs she'll do
81 those too but we do incontinence assessments on patients with nursing needs too erm
82 so obviously our work does kind of liaise a little bit sometimes (AC yes) she can
83 communicate with us and we can pass things on to her (AC right) I think from a
84 health visitor's point of view unless it's a baby or a child obviously we have some
85 links and dealings with them erm we don't always we obviously work with them but
86 we don't sort of have a great lot of you know health visitor work apart from erm the
87 NVE is kind of linked in with the health visitor so unless they're with the elderly
88 yeah they do

89

90 AC NVE?

91

92 QE Nurse visitor for the elderly. (AC ah right) Like you say it's they like work for
93 the Trust (AC mm) and are assigned to GP's practices like we are (AC mm) so they
94 too visit the elderly (AC mm) certainly the over seventy fives and they're assigned to
95 the health visitors because obviously the G grade which is the highest grade is their
96 kind of leader if you will (AC yes) their team leader (AC yes) erm but from the
97 babies unless they are tiny babies we probably would have some connection with
98 them you know (AC mm) so yeah I think on a day to day basis our work changes
99 very quickly we have to be erm we do have mobile phones now where we have a

100 lone worker policy really (AC uhum) where erm erm from the work point of view
101 team leader or anyone else in charge knows where we are the patients are assigned
102 they know who's exactly in where and what we have the mobile phones for our own
103 safety (AC right) and obviously if you need to contact someone so we're really not
104 totally isolated like they used to be perhaps many years ago (AC right) erm the last
105 visit of the day the person going to do perhaps the diabetic for instance she will
106 phone in and say that I've finished at my client's house now and I'm on my way
107 home or whatever (AC mm) so we do know that that patient has left that client's
108 home so we know then she's safe from that home whatever happens on her way
109 home unfortunately we don't know then (AC right) from the working day point of
110 view (AC yes) we know that she's safe and everything else but it's quite safe really
111 (AC mm) it works quite well for different teams we do work for like you say
112 individually erm we have to be sort of the dynamic really we have to make decisions
113 choices decisions on our own erm obviously if we face a problem we do
114 communicate with the GPs as well as other team members for sometimes sound
115 advice (AC mm) we do empower patients so a lot of these patients who sort of think
116 'oh I want the nurse for this I want the nurse for that' we do try and educate them to
117 think perhaps you can do it yourself or the families to do it (AC right) and sometimes
118 families do want to be involved and are quite happy to do it (AC uhum) erm and I
119 think basically what you say really just erm it's quite interesting because it's never
120 the same from day to day (AC yes) it's not a mundane they're not mundane tasks
121 really or mundane jobs (AC mm) our work just varies (AC mm) you know we don't
122 know what we're going to get apart from the obviously scheduled visits we do know
123 but anything else differently and we make the choice decisions when we're going to
124 reduce visits, if they need increasing so obviously we're always there (AC mm) erm
125 at weekends we have like you say we work from QCC erm patients can always
126 contact us we've always got a contact sheet where there's our contact numbers
127 there's the evening staff contact numbers and the night staff so they're never without
128 anyone (AC mm) to ask for advice or even erm offer a call if necessary (AC right)
129 erm we have a lot with students we do take students out so a lot of us have got the
130 qualification of a mentorship where we erm have to be now for a lot of the students
131 to sign their competencies (AC mm) we sign a lot of the work that they do (AC mm)
132 so we tend to sort of have them with us for quite a spell maybe five to six weeks (AC
133 right) and we support them erm obviously know their own their own erm route and
134 what they're going to do (AC uhum) and what essays they have to do but we're there
135 to support them and give them any advice and any help they need in the community
136 (AC right) I think that's probably all really

137
138 AC Wow In all that you've said there I mean there's quite a breadth of different tasks
139 (QE Oh yes yes there is) that you do (QE yeah yeah) is there anything that you would
140 say you find most enjoyable or most meaningful in all of that?

141
142 QE Erm I think that knowing that you've gone into a patient's home especially if
143 they physically restricted housebound and they're lonely sometimes if you've just
144 made their day sometimes you're the only face they see (AC mm) erm sometimes as
145 I say especially at Christmas time for instance (AC mm) you know they're just happy
146 to see a face or somebody they know erm just to allay their anxieties basically (AC
147 mm) you know even if a wound isn't necessarily going to heal just to sort of keep
148 them informed all the time what you're doing and what choices you're making erm
149 and explaining what you're doing allowing them to sort of allow two way

150 conversation allow their we listen to them as much as they listen to them listen to us
151 rather (AC yes) because at the end of the day we're guests in their home (AC sure) I
152 think basically you know that you've made somebody feel happy and a little bit sort
153 of allay their anxieties (AC yes) I think that's good (AC yes) yes

154
155 AC right. Is there anything else that you would say that you find particularly
156 satisfying or

157
158 QE I think for terminally ill patients obviously that's a big part of our care as well
159 you get a lot of the terminally ill patients who do wish to die at home (AC mm) erm
160 obviously we do the best we can erm all the care they need we visit as necessary as
161 often as necessary along with all the carers perhaps they might have carers they put
162 two alongside us we've got the night staff the evening staff we all communicate well
163 on this area and think if the families know that someone is going in to make their
164 loved one comfortable (AC mm) it's all that they need sometimes (AC mm) we're
165 not just there to support the dying person we're there to support the whole family it's
166 a holistic thing really (AC yes) so I think you know that's very satisfying and
167 rewarding (AC mm) it's quite satisfying obviously very satisfying (AC mm) but it is
168 lovely to know that you've made someone comfortable so as that they can die (AC
169 mm) in the place where they've chosen to which is at home (AC yes) most of the
170 time (AC yes)

171
172 AC Can you explain a bit more about that about why that's particularly satisfying?

173
174 QE Erm I think because a lot of people don't want to be in a clinical setting (AC
175 mm) really they do want to be with their loved ones around them they want to be in
176 familiar surroundings in their own rooms knowing that they can just be at home in
177 the final weeks or days (AC mm) erm obviously their condition does deteriorate but
178 they know we feel satisfied knowing that we've satisfied them (AC yes) and
179 certainly satisfied that their loved ones like you say their husband wife or daughter
180 son anyone they live with we've made them feel happy and comfortable (AC mm) in
181 their last few moments really (AC mm) so the care we give is just general nursing
182 care erm obviously obviously they need all the appropriate equipment to make them
183 comfortable which we have the loan store where we keep all the pressure relieving
184 mattresses (AC right) all the things that we do need there to make them comfortable
185 (AC right) erm obviously any drugs that they need we set up syringe drivers (AC
186 uhum) obviously they've got the drugs to keep them pain free so the analgesia is
187 regularly updated all these questions are asked and we can tell just by looking at the
188 patient really whether they're restless whether they need doctor input and further
189 (AC sure) you know whether the drugs need increasing or what (AC right) I think
190 that in itself is just nice to know that we've made somebody (AC mm) in their final
191 days comfortable (AC yes)

192
193 AC OK is there anything else that you would say you know out of all that that you've
194 described that you find particularly satisfying?

195
196 QE Erm I think just the whole aspect of nursing and the care that we give really (AC
197 right) I think it's like you say that we've made people feel comfortable (AC yeah)
198 and know that they're happy at the end of the day knowing that everything's OK (AC
199 yes) with their dressings (AC right)

200

201 AC Right OK. You mentioned right at the beginning about being holistic and

202

203 QE That's right we're looking at the patient from a whole aspect not just physically
204 we look at them psychologically emotionally spiritually (AC uhum) so if you can get
205 all that into one (AC mm) you know obviously some people are very low in spirit
206 just being able to talk to them (AC right) you know perhaps being able to refer them
207 to a GP or to any erm other kind of professional in that route we can do so you know
208 (AC mm) we can perhaps identify it sometimes patients don't want to be don't want
209 you to fuss sometimes (AC mm) everybody's different (AC yes) but just sometimes
210 just listening to them can just be a whole open up a whole new world for them (AC
211 mm) you know it's they're quite happy with that (AC mm) sometimes
212 psychosocially areas with wounds especially they're afraid to go out some people
213 they don't like the thought of the smelly wound or a smelly leg or (AC mm)
214 obviously wounds when they exude they can have an odour (AC mm) and you know
215 yourself if you know you wouldn't like it yourself (AC mm) I wouldn't like it so I
216 know for a fact that any of my clients wouldn't like it so obviously the choice of
217 dressing that we make we do take all this into consideration (AC right) and just
218 making them know that you know there are dressings out there that can reduce odour
219 reduce all this problem perhaps make them you know even a situation where they
220 become more mobile (AC yes) those that can't walk we can refer them to the
221 appropriate place or the GP because they can get these little motor scooters (AC
222 right) so that they can get out and about erm so it's just general just making people
223 comfortable at the end of the day (AC mm) it's not always curative just making them
224 feel comfortable (AC yes) and knowing that we've satisfied them and we feel
225 satisfied (AC yes) that we've done our nursing duties in an appropriate way (AC yes)
226 professionally (AC right) yeah

227

228 AC To look at it from another perspective erm is there anything that you would say
229 you find frustrating or dissatisfying?

230

231 QE Er yes sometimes frustrating I think is more with the non concordant patients
232 (AC right) which we can't do anything about really you'll always get patients that
233 you'll put you know you'll do your dressings erm on certain clients and they'll take
234 them off when you've gone (AC laughs) or they don't like the look of it or they'll
235 pull it down (AC yes) and they wonder why the whole thing deteriorates (AC yes)
236 but like you say with good sound education sometimes you can make them hopefully
237 come your way of thinking in the end (AC mm) I think the other thing is lack of time
238 with patients if we're really really busy and lack of staff and that kind of thing it can
239 make staff moral show (AC sure) and I think you know our job isn't there just to rush
240 in and slap a plaster on somebody's bottom or leg it's there like you say to listen to
241 what problems they have to know what the diets like and have they got what's the
242 pain like and how mobile are they because that's all part and parcel of the healing
243 process (AC mm) it's not just what dressings we use it's what's inside the person if
244 things are treated systemically hopefully you know from a whole point of view,
245 things will improve (AC yes) you know I think that's the worst thing like you say the
246 non concordance if they really are that way and like you say lack of time (AC mm)
247 you know you do feel sometimes you're under pressure and I think that can
248 sometimes be it's not very rewarding in that area but I think that's not just in nursing

- 249 I think it's in every aspect of jobs isn't it really (AC mm sure) so that's the worst
 250 thing really
 251
 252 AC yes yes so it's when you're under pressure and er
 253
 254 QE yes yes so
 255
 256 AC Right erm you mentioned earlier on about having students out (QE right) how do
 257 you find that?
 258
 259 QE Oh I quite enjoy having the students (AC yes) I mean certainly nowadays they
 260 are very well educated erm they are very knowledgeable and they come out quite
 261 knowledgeable even when they first start obviously they look up to us more but I
 262 think it's a two way thing as well you know I think we learn from them (AC yes) and
 263 they learn from us (AC right) especially a lot of us nurses now it's an ongoing
 264 keeping updated so they're in on the essay writing and they know the skills and how
 265 to reference things I mean obviously I do it quite a lot so I've got used to it but for
 266 those that are a bit rusty because we can be can't we (AC mm) they're a great bonus
 267 and a great help to us there 'oh we do it like this perhaps I can help you' so I feel it is
 268 a two way thing with students (AC mm) not just you know I'm teaching them that or
 269 I'll show them that (AC mm) I really I do enjoy the students (AC mm) and I enjoy
 270 knowing that you've helped to sort of develop their knowledge as well (AC mm) erm
 271 and allowed them to become competent in the areas they want to become competent
 272 in (AC uhum) because at the end of the day they're going to be trained registered
 273 general nurses with a diploma or a degree (AC uhum) so you feel you've contributed
 274 to that (AC mm) it's quite rewarding (AC yes) yeah (AC right) yeah
 275
 276 AC It sounds from what you've said that you find quite a few aspects of what you do
 277 quite rewarding (QE Oh yeah) and satisfying
 278
 279 QE Yeah I think the majority of my work is (AC yes) you know I think most district
 280 nurses would probably say that (AC mm) I think the worst aspect like you say is
 281 perhaps the lack of time and if you're busy under pressure (AC mm) you know lack
 282 of staff sickness holidays and things that's when it becomes worse (AC mm) and
 283 people have left and they haven't been quite replaced (AC uhum) it does increase
 284 everything (AC mm) and the non concordance which isn't it's just patients are
 285 different aren't they (AC mm) you know they just feel they want to erm fiddle with
 286 the dressings (AC yes) or feel they can sort of if you say black they'll say white so
 287 that's what (AC yes) prolongs a lot of the healing really (AC yes) and that's the main
 288 things for me really (AC yes)
 289
 290 AC What do you think it is about erm you know when you're under pressure er
 291 because of lack of time or staff erm and you find that frustrating what is it about that
 292 that's frustrating to you?
 293
 294 QE I think with having to rush more because you can't you know you go into
 295 patients because a lot of our work is quite time consuming we've got some quite
 296 nasty dressings (AC sure) if you get new patients phoning in or new referrals from
 297 the infirmary or whatever the GP whatever (AC mm) and the bloods you just sort of
 298 feel you can't always you might miss out on something you know where the patient

299 might think 'oh the nurse is too busy today I'd better not tell her about me pain in me
300 other leg' you know (AC right) which probably could be something quite serious
301 well not necessarily serious but it could be something that could be related to
302 something else (AC sure) and you might miss out on something and because they're
303 too afraid to tell you (AC mm) erm and that is an area you don't want to feel you're
304 missing (AC mm) because you feel when you're with a client you want them to be
305 open with you and tell what is wrong with them (AC right) so that you can either
306 report back to the appropriate professional (AC mm) and perhaps you know
307 something could be changed something could be improved (AC mm) you know (AC
308 right) and I think with a lot of the wound cares we do feel we do try to educate as we
309 go along I mean from my point of view I always try to explain what I'm doing when
310 I'm working (AC uhum) so part of my conversation which I do feel is quite lucky
311 really I don't like to think that I come over as rushing if I am under pressure because
312 I always talk to clients when I'm doing my work so you get a lot of the information
313 from them as you're doing your dressings (AC yes) so erm as I think that's probably
314 quite a good bonus but sometimes if you are certain people are different aren't they
315 (AC yes) you know and if they do think you're getting your coat in a hurry because
316 you've got to get to your next client or whatever you've got to meet another nurse
317 you've got to be at the clinic you know perhaps we all for all the will in the world we
318 don't mean it maybe it does show (AC mm) sometimes (AC mm) but I do feel clients
319 will not always give you the information they should do (AC mm) if they think you
320 are under pressure (AC sure right) so

321
322 AC Right that makes sense and you mentioned earlier on about sometimes doing
323 work in clinics you're not always out in the community

324
325 QE No no we do erm we do do work in clinics (AC right) we have in our surgery we
326 have three in satellite area where we work in C and the other one we have erm two in
327 S erm we're an hour each time so we tend to get a lot of people who have had
328 stitches in (AC OK) those who can get out you know like little sebaceous cysts
329 removed or (AC mm) various things from the hospital where they've said on the
330 discharge letter the nurse whoever's discharged has said perhaps you can go to your
331 GP and have your stitches out in five days so we tend to get a lot of patients like that
332 (AC right) who are who are not house bound who can get to surgery (AC yes) so
333 that's quite erm different (AC yes) and quite interesting (AC yes) yeah so (AC right)
334 obviously because they're not housebound we obviously do see it's obviously more
335 appropriate to see them (AC sure) you know it cuts down on our work load in the
336 community (AC yes) for those that do need to see us really (AC yes)

337
338 AC So it's quite different to what (QE Oh yes) you do the rest of the time

339
340 QE We do get one or two people that erm with more acute more acute or chronic
341 wounds should I say who do like to come to clinic because I think it's a day out for
342 some people (AC right yes) but if they are mobile we do encourage them to come to
343 clinic (AC mm) obviously just post surgery somebody who's had you know been
344 discharged twenty four forty eight hours after a wound we wouldn't you know an
345 abdominal wound or something we wouldn't expect them to come to surgery (AC
346 no) even if they were young so obviously we do assess it each time as we go along
347 and the better they become obviously the more mobile they become if we do need to

348 see them they can come to surgery eventually (AC yes right) it's an ongoing
349 assessment all the time (AC yes) basically
350
351 AC OK is there anything more you'd like to say about what you enjoy (QE erm) or
352 find satisfying?
353
354 QE I think I'm satisfied with all I do really (AC right) I mean it's nice to work with
355 your colleagues it's nice when you've got good team dynamics (AC mm) being a
356 good team player and being flexible with one another (AC right) I think that's all part
357 of your working it's not just going out and nursing patients it's working with other
358 people (AC sure) and I think from my point of view I feel I get on with all different
359 members of the primary health care team (AC right) colleagues alike and that's
360 rewarding too
361
362 AC Because you've got your team here but you have links specifically to AS
363
364 QE Yes we are (AC yes) we're not based which perhaps is sad really because a lot of
365 the GP practices are based which I think is good better for communication in one
366 sense (AC mm) but obviously we've got the system computerised system we can
367 send them practice notes so the communication is always there (AC OK) and we can
368 phone them if needed and leave messages and vice versa if they need to speak to us
369 (AC right) so I think that's basically basically all really (AC right)
370
371 AC And when you do your clinics they are at AS
372
373 QE Oh yes they're at AS they're actually are in the GP practice so we do have access
374 to GPs if we need to see them
375
376 AC Sure so you get to see that lot that part of the team
377
378 QE Oh yes you do yes (AC yes right) yes
379
380 AC Anything else you want to add?
381
382 QE Erm Not really no (AC no OK) No. Is there anything else you want to ask?
383
384 AC No not at all no erm that's great so thank you very much
385
386 QE You're welcome

Transcript Summary

Interview 5 DN

This transcript suggests that QE finds the majority of her work as a district nurse rewarding^{275,350}. A most meaningful aspect of her work is going into a patient's home and knowing that she's made their day¹⁴². She likes to make patients feel happy^{150,196}, comfortable^{195,221} and enjoys being able to allay their anxieties¹⁴⁴. She gets a lot of reward from seeing people every day in their own homes⁴ and she enjoys the variety in her work^{117,118} it is never mundane. She views patients holistically^{7,201} and feels she builds up a good relationship and rapport with people^{5,6}. QE works within a team and values communication amongst members of the team^{9,54,112,160,355,364}. She values the team she works in and feels that there are good team dynamics³⁵¹.

QE tries to share knowledge with patients¹⁸. She always talks to them as she does her work³⁰⁸ and likes to keep patients informed about the choices she is making^{145,305}. She likes to feel that patients have listened to what she has said and have benefited from it^{14,47}. She likes to educate⁴⁶ both patients and their families so they are more able to look after themselves^{115,304}. She feels that patients see the district nurses as the experts⁴⁸ and sometimes non-concordant patients can be won over¹⁸ when they appreciate the expert knowledge of the district nurse¹⁸.

QE enjoys wound care^{10,11} and likes to see a wound healing she also enjoys working with the terminally ill¹⁵⁶. She feels her role is to support the whole family¹⁶³ and she feels that holistic care in terminal illness is rewarding and satisfying¹⁶⁵. It is particularly rewarding to know that she has enabled someone to die at home¹⁶⁶ and she wants to make the family as well as the patient feel happy and comfortable^{178,189}. She feels satisfied when she knows the patient is satisfied²²³ and she has done her nursing duties in an appropriate way²²³.

QE gets frustrated with non-concordant patients^{229,280}. She also gets frustrated with lack of time and being really busy or short staffed^{234,277}. She feels this is frustrating because she then cannot carry out her nursing duties, she doesn't have time to listen²³⁷, to assess the patient's pain²⁹⁵ or to assess their diet²³⁸. She feels when she is rushed²⁹⁰ she might miss something important^{294,298}.

QE enjoys having students^{255,265} and sees her role as supporting them in the community and providing any advice they might need¹³³. She sees their interaction as a two way process learning from each other^{259,264}. She sees students as a great help as they can contribute to keeping up to date²⁶². She enjoys knowing that she has helped someone to develop²⁶⁶ and feels that it is rewarding to contribute to their development²⁷⁰.

(The small numbers refer to the line of the transcript where the idea can be found)

February 16th 2004**Interview 6 GP**

1 AC The opening question and it is a very unstructured interview so we just go with
2 wherever you want to go erm what do you find most meaningful in your work as a
3 GP?

4
5 QN I (pause) I feel that I'm doing a worthwhile job (AC uhum) I think that's the
6 bottom line and yeah overall I do enjoy the job a lot erm I get a lot of erm pleasure
7 out of the interaction with patients I enjoy the intellectual challenge particularly of
8 the diabetes (AC mm) work that I do erm I enjoy keeping up to date I suppose as
9 with everybody I like the feeling of doing a good job (AC uhum) erm those are the
10 positives I suppose

11
12 AC Right can you explain a bit more about what you mean by that what do you mean
13 by doing a good job?

14
15 QN Doing a good job when I feel that erm on a more difficult case I've come up with
16 a diagnosis erm when I feel that I've helped my patients through a difficult time. I
17 mean I think doing a good job is erm is a very sort of nebulous thing that you can
18 only really get from gut feelings (AC mm) I mean we all go through surgeries when
19 we get to the end of the surgery and we think oh my god that was a nightmare god
20 knows what was going on in you know three quarters of those cases (AC mm). Other
21 times you go through surgeries where you know you feel you interact well with the
22 patients you feel that you are being useful to the vast majority of them (AC uhum)
23 and it's overall very satisfying and you haven't had too much time pressure and
24 stress (AC mm) and feel you've not kept people waiting and all the rest of it (AC
25 mm) these things are very nebulous erm how else doing a good job? I mean I feel
26 also that erm I try and practice very much evidence based medicine you know which
27 some people approve of and some people disapprove of prefer the old more old
28 fashioned approach to things (AC mm) if I'm able to apply evidence based medicine
29 and practice evidence based medicine during a surgery then I feel that I have been
30 doing my job properly (AC mm) and I get some satisfaction out of that (AC right)
31 particularly the diabetes side of things I mean I think it's easier to practice evidenced
32 based medicine in something like a diabetes clinic (AC right aha) rather than a sort of
33 more nebulous general surgery where you know quite a lot of things we do you know
34 it's hard enough to make a diagnosis never mind then practice evidence based
35 medicine on top of it

36
37 AC Mm yeah OK so you mentioned there er the difference between a surgery that
38 you feel erm goes really well and feels really satisfying and another surgery that is a
39 complete nightmare erm can you explain a bit more about that and maybe put your
40 finger on what the differences are there?

41
42 QN Erm time keeping's one of the things (AC uhum) if I'm running particularly late
43 then I find that stressful (AC mm) a surgery whatever's gone on erm I think having a
44 surgery with a significant number of the insoluble problems that inevitably present to
45 general practice if you like the heart sink type things (AC mm) that are defined I you
46 know a surgery that has more than it's fair share of those becomes a difficult surgery.
47 I mean I don't mind having the odd heart sink patient I think we all have to accept

48 that that's part of doing general practice (AC mm) but it is amazing how they seem
49 to cluster in surgeries (AC yes) and that can sort of make it quite you know you get
50 to the end of the surgery and you feel that really you've not moved anything (AC
51 mm) forwards erm those surgeries are few and far between but they do happen (AC
52 uhum) from time to time erm what else ah I think other stressful surgeries are
53 surgeries where erm perhaps you're on call and erm you have the pressure of feeling
54 you need to be in two places at once that's quite a sort of stressful. It doesn't
55 necessarily make it that you practice bad medicine or that you've done anything
56 wrong it's just that it has been you know you've felt pressure all the way through the
57 surgery (AC mm) so in that way it's quite stressful.

58
59 AC Mm OK you mentioned enjoying the challenge of diabetes is there anything else
60 that you would put your finger on to say you particularly enjoy that area of what you
61 do?

62
63 QN Erm yeah there's a couple of areas I'm quite involved in clinical governance and
64 sort of as an off shoot of that we've been looking very closely at cardiovascular
65 disease management so those sorts of things I enjoy being involved, the other sort of
66 clinical aspects that I'm particularly keen on is erm joint injections and
67 musculoskeletal medicine (AC mm) side of things which is an area that I've done
68 quite a bit of erm training and reading about over the last year or two (AC right) but I
69 enjoy that side of things.

70
71 AC Right OK So to put it in another way erm is there anything that you would say
72 you find frustrating in what you do or not satisfying?

73
74 QN Not satisfying erm (pause) what do I find not satisfying? Frustrating is when
75 patients present with multiple problems that they want sorting out there and then in a
76 short time and I'm trying to sort of move myself towards sort of saying right we can
77 deal with so many problems but you know we have a single appointment here you
78 know you have to come back (AC mm). That gets more difficult if you're already
79 running a bit late in the surgery you've kept people waiting you feel more guilty (AC
80 mm) in terms of getting people back and I find that feelings of frustration (AC yes) I
81 feel obliged to sort out the problems best I can in that time but I also feel that sense
82 of frustration (AC yes) rising so I feel time pressures quite quite a bit. Erm I also find
83 people erm returning with the same nebulous problems difficult to erm keep my
84 enthusiasm (AC mm) for erm I don't think I'm alone in feeling that and er you know
85 I have read a bit about how to deal with heart sink patients (AC mm) but I don't
86 think I'm particularly adept at doing it really (AC right) erm also sort of minor
87 frustrations things like erm people coming knowing they're going to have to be
88 examined with multiple layers of clothing on (AC yes) you know they're just sort of
89 little irritations it takes ages (AC well yes) to go through a fairly simple consultation
90 (AC sure) but they're just my irritations really.

91
92 AC But that would add to your problem of people waiting and er

93
94 QN Yes and I try I put extra spaces in my surgeries so my surgery actually goes on
95 for longer so I try I normally do run pretty close to time because I don't like I don't
96 like being late (AC right) I don't like keeping people waiting (AC right) erm and I
97 don't generally run particularly late but I do feel that pressure is there.

98

99 AC So when you say your surgeries are longer you mean than your colleagues?

100

101 QN Yeah like in my morning surgery I'll put four spaces in (AC right) I'll see the
102 same number of people (AC I see) but I'll start earlier and I'll finish later (AC right)
103 just that I feel more comfortable doing that (AC mm) rather than sort of saying oh
104 I'll just run late I still take the same amount of time seeing patients (AC mm) but I
105 will have kept people waiting (AC mm) which I don't like the feeling of

106

107 AC Mm right so that's your way of practising (QN yep) yeah OK. Erm to take a step
108 back a little erm perhaps back from the clinical work (QN mm) is there anything erm
109 in your role as a GP erm that you particularly enjoy erm perhaps at an organisational
110 level

111

112 QN Erm the clinical governance side of things (AC uhmm) is my like my
113 organisational input and I mean clinical governance does encompass a large amount
114 of sort of clinical practice (AC mm) erm from erm the sort of clinical areas there all
115 sort of. The clinical governance plan we've had here in N has been fairly similar for
116 the last few years to the clinical governance plan that is now set out along the lines of
117 the new contract there have been very few changes that we in N have had to make
118 (AC right) to change to the new contract clinical governance plan (AC mm)
119 following very similar targets and so on already and I've been involved with that
120 both at a local level in the practice and erm I'm on the clinical governance sub-
121 committee for N (AC right) erm so its been a clinical governance erm clinical targets
122 but there's also been the organisational targets that erm we've had for clinical
123 governance that have been broader have been broadened by the new contract er and
124 they've included sort of risk management ongoing training and appraisal that side of
125 things (AC mm) erm and you know that fits with my sort of way of looking at
126 practice as I said to you before I'm very much I like to practice evidenced based
127 medicine well clinical governance is looking at sort of are you meeting the evidence
128 based medicine (AC mm) targets (AC mm) erm I did a degree in health research
129 three or four years ago (AC OK) and so I sort of you know that was erm one way that
130 I got more into evidence based medicine if you like (AC right) and you know it's
131 nice to although I don't do any research work at the moment because I had to make
132 some decisions as to where my career was going (AC mm) erm having done that
133 research work it does mean that I maintain an interest in ongoing research
134 particularly in cardiovascular and diabetes areas I sort of try and keep as much up to
135 date as I can in those areas (AC right)

136

137 AC OK and again looking at it from er that perspective at the sort of more
138 organisational level is there anything there that you find frustrating or not satisfying
139 that you don't enjoy?

140

141 QN Erm the only bit of organisational that I'm on is the diabetes (AC yeah aha) LIT
142 and I suppose I find with all organisational aspects but particularly when you get up
143 at PCT level it amazes me and frustrates me how slowly things (AC mm) move
144 forward (AC mm) and you know I've been sort of chairing the precursor to the
145 diabetes LIT for two or three years I can't remember we have moved things forward
146 but we've moved things forward despite the PCT not with the thanks (AC mm) not
147 with the help of the PCT and things like getting BK the new diabetes manager (AC

148 mm) we erm by moving various budgets we already had access to we managed to get
 149 sixty thousand pounds for her post with (AC mm) we got seventy five thousand
 150 pounds from drug companies they decided within a week that they would give us that
 151 (AC uhum) getting the next fifteen thousand pounds from the PCT for a hundred and
 152 fifty thousand pound post took about nine months or (AC mm) something along
 153 those lines (AC mm) and you know you we nearly lost the drug company money as a
 154 result of that delay and it's just so amazingly frustrating (AC yes) no-one can make
 155 decisions and even now B's having difficulty sort of getting PCT to endorse her
 156 decisions so you know you put a manager in place and she can't she can't decide
 157 anything (AC mm) you know and I find those sorts of the bureaucracy of the NHS
 158 (AC mm) drives me bonkers whereas you know this practice we make a decision and
 159 it happens (AC right) you know because it's a small unit the PCT's so vast and
 160 bureaucratic and geographically spread I find that you know their decision making
 161 processes are very slow I find that frustrating
 162

163 AC Mm right. Anything else that you could add to that?
 164

165 QN The organisational side of things? No I don't think so I think here at this practice
 166 we we run a pretty erm we run a pretty sort of easy going practice we all pretty much
 167 think along similar lines (AC mm) we get on well we we most of us work in very
 168 similar sorts of ways we pride ourselves on clinical work clinical skills and we're
 169 very keen all of us are very keen to sort of erm to keep our clinical skills up to date
 170 and erm you know we all are keen on practising evidence based medicine erm so
 171 there isn't any great conflict in in the way it works I find that on a practice based
 172 level the organisational side of things tends to run very smoothly and we have a
 173 fantastic practice manager (AC mm) who will you know take things and run with
 174 them and you know only bothers us if there's something that we actually need to
 175 make a decision on he's he's been really good so our local on a sort of practice based
 176 organisational erm level I don't have any sort of major (AC mm) worries not at the
 177 moment anyway
 178

179 AC Right right that's interesting particularly with the new contract round the corner.
 180

181 QN Yeah I think I mean we're a PMS practice anyway so to some extent we're a
 182 little bit back from that (AC mm) but I think we're actually because as I said N
 183 already had the clinical governance framework which wasn't that different we were
 184 already working to the vast majority of these targets anyway the targets have moved
 185 they're slightly different (AC uhum) erm but it's nothing that's come out of the blue
 186 you know (AC mm) we were already the diabetes targets the cardiovascular targets
 187 they're all pretty much what we've been working to for three or four years (AC right
 188 that's terrific) I don't have any other major worries about practice
 189

190 AC Right anything else you want to add about erm you know what you enjoy about
 191 your work?
 192

193 QN Erm I do enjoy the interaction with with patients (AC mm) I I the yeah the time I
 194 suppose there's one time when I feel good and one time when I feel bad about things
 195 if I feel we're offering a good service here at LN then I feel really sort of you know
 196 proud (AC mm) to be part of it. Now there are times like last November there was a
 197 lot of viral infections going around this area we were very busy we were struggling

198 to provide what I felt was a good service I mean people were being offered
199 appointments but they weren't necessarily getting to the doctor they wanted to get in
200 straight away with (AC right) and we had sort of been able to provide a better service
201 before that people were sort of saying oh it's really difficult to get to see you. It only
202 went on for about three or four weeks but during that period I felt quite frustrated
203 that we you know that we couldn't offer a better service (AC mm) to people (AC
204 mm) and we weren't really offering a good service and it was only a short period and
205 it's a lot better now and I do feel the vast majority of the time we offer an excellent
206 service with excellent access (AC right) and I think you know I sort of have to
207 understand in my own mind that during a a time when there are a lot of viral
208 infections around you maybe have to lower your expectations slightly and just offer
209 the best service you can offer (AC mm). I find that a little bit difficult to do because I
210 do want to offer you know a really good service and feel proud that I am offering a
211 really good service or we are offering a really good service (AC right mm) I don't
212 think (pause) er another frustration is I suppose finding time to keep as up to date as
213 possible. I enjoy reading I enjoy keeping up to date erm you know with twelve hour
214 days four days a week and seven or eight hour day the final day of the week and
215 paperwork on top of that when you get home it's actually quite difficult to (AC mm)
216 do as much reading as as erm ideally would be (AC mm) done but I try and er pick
217 the stuff that I read and try and make sure I read the relevant stuff one of the
218 problems with that I suppose is that it means that I read stuff that interests me rather
219 than perhaps as much stuff as I should be reading (AC right) so er (AC yes) the
220 ischaemic heart disease and diabetes gets read (AC mm) and perhaps the gynae stuff
221 that I don't do as much with (AC mm) I have to make a special effort to try and keep
222 up to date with that but I do sort of try and watch erm for my own personal
223 development plan areas where I feel I'm a bit weak and not spending so much time I
224 don't see so much gynae for example (AC right) we have four female doctors here
225 (AC mm) so erm they tend to get the majority of the gynae (AC mm) so you know I
226 do have to try and put time aside on sort of study days (AC mm) to try and keep up
227 to date with that (AC right) but I think that's a question of self awareness and having
228 a think about your erm personal development plan (AC mm)

229
230 AC Right anything else you want to add?

231
232 QN Erm (pause) I think I feel very privileged to work as part of a good team really
233 (AC mm) you know I think if I wasn't confident with the team I was working with
234 that would be that would be difficult I do feel that we work as a team I mean as with
235 any team we have minor disagreements from time to time (AC uhum) but they are
236 only minor and we all tend to push in the same direction (AC right) and I feel that
237 you know everyone works really hard so you don't feel that erm you know you're
238 carrying anybody you feel everyone's (AC mm) everyone's working hard and got
239 their head down and I enjoy that sort of aspect of being part of a part of a group. I'd
240 find it very difficult working on my own I don't think I'd like that at all (AC mm)
241 although you know obviously six other people (AC mm yes) don't think there's
242 anything else I want to add (AC OK) Oh and we work in a lovely building as well I
243 suppose that's really positive. (AC Getting lovelier by the minute.) Yes bit of a mess
244 at the moment with the builders in (AC mm) bits from other people's rooms in here
245 but it's lovely I mean this is a lovely room to work in (AC yes yes) we're very lucky
246

247 AC Yes it does feel good yeah OK that's brilliant Q thank you.

Transcript Summary

Interview 6 GP

This transcript suggests that QN feels that his job is worthwhile⁵. He gets pleasure out of interaction with patients^{7,21,191}, enjoys his job⁶ and enjoys the intellectual challenge⁷. He particularly enjoys the intellectual challenge of diabetes⁸ and enjoys coming up with a diagnosis on a more difficult case¹⁶. He likes to keep up to date⁸ and enjoys practising evidence based medicine^{26,29,31,169}. QN likes to feel he is doing a good job⁹ and likes to feel that he is useful to the majority of his patients²². He likes to feel that he has helped his patients through a difficult time¹⁶. He feels he's been able to do his job properly if he's been able to practise evidence based medicine²⁹.

QN feels guilty when he is running late in a surgery^{43,79}, he doesn't like to keep people waiting^{96,105}. He puts extra sessions into his surgery to try to avoid running late⁹⁴. A significant number of insoluble problems in one surgery makes for a difficult surgery⁴⁴. He gets frustrated if patients present with multiple problems and they want them all addressed at the same time⁷⁵. Patients who are wearing multiple layers of clothing⁸⁸ also slow the surgery down and cause frustration. He finds it difficult to maintain his enthusiasm for patients who return repeatedly with the same nebulous problems⁸³. He also feels that a stressful surgery is one where he's also on call and he feels the pressure of needing to be in two places at one time⁵².

QN enjoys diabetes, cardiovascular disease, musculoskeletal problems and doing joint injections⁶⁴. He enjoys clinical governance¹¹² and enjoys working to targets and clinical standards¹²⁶. He maintains an interest in ongoing research¹³³ and enjoys reading²¹¹ particularly in the areas of cardiovascular disease and diabetes²¹⁷. He is very keen to maintain his clinical skills¹⁶⁸. He also tries to keep up to date in areas of clinical practice that he has less regular experience of such as gynaecology and has a personal development plan to make sure he covers these areas²²². He gets frustrated at not being able to find the time to keep as up to date as he would like²¹⁰.

QN feels proud of offering a good service to patients¹⁹³ and feels privileged to work as part of a good team²³⁰. He enjoys being part of a group²³⁷ and would not want to work on his own²³⁸. He wants to offer a really good service and to feel proud of it²⁰⁸ and gets frustrated when due to time pressures or overload of the system they are unable to do so¹⁹⁶. He feels there is no great conflict in the way the practice works¹⁷⁰ and values the role of the practice manager¹⁷¹.

QN gets frustrated at how slowly things move at PCT level^{142,153,159}. He finds the bureaucracy of the NHS frustrating¹⁵⁶.

(The small numbers refer to the line of the transcript where the idea can be found)

February 16th 2004

Interview 7 NP

- 1 AC So this is meant to be erm really quite open and quite informal (SM Right) erm
 2 and it really is a chat about your ideas about your role and your work (SM aha) and
 3 how you feel about it (SM aha) erm so can you tell me what you find most
 4 meaningful in your work?
 5
- 6 SM Erm making a difference I think (AC aha) to how erm people feel about their
 7 disease or problem (AC right) erm making them feel better about it or more er able to
 8 cope with it (AC right)
 9
- 10 AC Can you explain a bit more (SM elaborate) about that?
 11
- 12 SM (Laughs) erm (pause) I suppose I'd feel you start by ensuring that they
 13 understand what the problem is (AC aha) and then getting their perception of it. So
 14 for instance diabetes (AC yes) I had a guy this morning and just told him he is
 15 diabetic after doing a glucose tolerance test (AC right) erm so what do you already
 16 know, establishing what they already know and believe (AC uhum) and his first
 17 thing is 'I'm not going to be on insulin am I?' (AC mm) which is so you're the
 18 getting to know what their beliefs are and then helping them to adjust in some ways
 19 giving bad news but in other ways in giving good news you know it's very not mild
 20 diabetes but early (AC mm) we caught it early so the chances are much better and
 21 erm trying to get them to take ownership of it (AC right) (pause) I suppose you see I
 22 see myself as a facilitator to them (AC uhum) and that's what I find rewarding (AC
 23 mm) (pause)
 24
- 25 AC Right can you explain a bit more about why that might feel rewarding?
 26
- 27 SM Erm (pause) I try and always do as I would be done by (AC mm) and if I was in
 28 his position or anybody's position but to use him as an example erm how would I
 29 feel? And I would feel better by having somebody who I felt was in partnership with
 30 me and was supporting me (AC uhum) and appeared to understand so I gain a lot of
 31 not quite sure of the right word, I do know what the word is kudos I suppose (AC
 32 uhum) from erm trying to do as I would be done by (AC mm) what I think I would
 33 want in that situation and I mean it's backed up by you know a lot of the more recent
 34 thinking in for instance diabetes isn't it you know it's a partnership and you give the
 35 patient ownership (AC uhum) erm it's patient centred care and (AC uhum) so it's
 36 sort of evolves from that (AC mm)
 37
- 38 AC Can you (SM elaborate more – laughs) explain a bit more yes. There's so much
 39 in what you've said there
 40
- 41 SM Is there?
 42
- 43 AC Yeah if you could explain a bit more about that that would be great.
 44
- 45 SM About how I feel about my work or
 46
- 47 AC About what you find most meaningful what's rewarding satisfying enjoyable
 48

49 SM Yeah. (pause) Making them feel feeling as though you've made a difference (AC
 50 uhum) erm not so much physically I don't think a lot of it's not physical most of it's
 51 psychological (AC right) certainly in issues like that when it comes to the itsy bitsy
 52 venepuncture and the odd dressing then it's that can be as well you know the
 53 psychological support. There was a little old lady this morning who has had the same
 54 wound for nine weeks and I haven't seen it for three weeks and there was a vast
 55 improvement (AC mm) and to be able to say that to her and that was the most
 56 important thing to her it wasn't important that she came in had the dressing done and
 57 went out which could be seen as being the nurse's priority (AC mm) it was more
 58 important to her to be told how well it was doing (AC mm) erm so I suppose meeting
 59 people's what I perceive to be their needs (AC right) and erm trying to be sure that
 60 you've perceived their needs correctly that's the crux of it (AC mm) not to er try not
 61 to have preconceived ideas as to what they do need (AC uhum) and be sensitive to
 62 what each because everybody needs dealing with differently don't they (AC mm)
 63 and every diabetic has different needs (AC uhum) psychological needs I mean erm so
 64 I suppose to try and put it in a nut shell it's to meet that individual's holistic care
 65 needs but with a big emphasis on psychological (AC right) and how they cope with
 66 what's going on for them (AC right)

67
 68 AC At the beginning you mentioned about helping people to cope (SM mm) erm so
 69 can you say a bit more about that and how you go about doing that?

70
 71 SM (pause) A lot of it depends on how they see how they perceive what's going on I
 72 think as well as what else is going on for them (AC uhum) erm I talked to a lady this
 73 morning for instance who has erm from her perspective a very unloving vindictive
 74 relationship with her husband and that to her pervades everything in her life and her
 75 diabetes doesn't really matter (AC mm) (pause) for her with her I felt quite
 76 inadequate especially on the telephone in trying to do what I was trying to do in other
 77 words to control her HBA (AC right) I phoned her because it was up from the last
 78 reading (AC uhum) erm and so we checked through her diet on the last visit when
 79 she had the blood taken (AC mm) erm and her diet sounded fine but to her that
 80 doesn't really matter (AC mm) when I phone her about it this morning (AC mm) and
 81 that so helping people cope isn't a isn't an easy er target to have (AC mm) especially
 82 in a situation like that. But that's what I aim to do I think for instance the guy erm
 83 who's a new diabetic not so much giving information as trying to find out where he
 84 stands at the moment (AC right) I didn't feel I achieved it particularly with him cus
 85 I've only met him twice before and I don't think he was able to verbalise I felt
 86 anyway I perceived he wasn't verbalising how he really felt (AC mm) and he tried to
 87 appear a big brave man and I can cope with this (AC mm) whereas I don't think
 88 reading between the lines that that's how he really felt (AC right) so it's you can get
 89 muddled up in the nefariousness of it can't you but a lot of the time you are lead by
 90 how you feel that others feel (AC mm) or I think I am (AC right) and I'm aware that
 91 you becomes an unconscious thing the way that you approach them is lead by
 92 unspoken body language (AC uhum) erm and picking up things between the lines
 93 between what they say (AC mm) erm and I think that's building a relationship that's
 94 a lot of it that's at the bottom of a lot of it because it's very difficult to do it on a one
 95 or two meetings (AC mm) but getting to know that person and how they tick and
 96 how best to enable their care (AC uhum) (pause) (laughs)

97
 98 AC Right that's great yeah (pause)

99

100 SM I'm not sure how else to explain it

101

102 AC No that's fine erm so you've talked a lot there about the relationship erm with
103 patients and helping them cope (SM Yes) getting in tune with their needs (SM Yes)
104 is there anything else that you would add that you find meaningful or enjoyable in
105 your work?

106

107 SM Contact with people full stop really for me (AC right aha) and just the complete
108 diversity of how people view what goes on I enjoy their humour and you know the
109 way they look at things so differently (AC mm) erm I kind of enjoy making a mind
110 picture of what they're like at home (AC right) trying to think round or see round
111 how they are here (AC mm) erm specially with the older generation (AC uhum) I
112 think it makes quite a difference to erm to feel valued in the job that you do by the
113 patients and you get a lot of feedback in that way (AC right) in this job (AC aha) erm
114 I think it would be hard for instance to work in A&E erm where you've got drunks
115 and violence (AC mm) and erm nobody you don't feel as though anybody
116 appreciates what you're doing (AC mm) whereas I think in this kind of role you do
117 get a lot of appreciation and that helps you feel as though you're doing a good job
118 (AC mm) and makes the job so much more er doable I don't like that word but it
119 says what I mean (laughs) (AC right right yeah) so it's yeah I don't know how else to
120 say it really I just enjoy work (AC right) this work

121

122 AC Do you want to say a bit more about that about the erm feeling valued and the
123 feedback from patients that sort of thing?

124

125 SM Erm I think it's er it's more you know with the patients that you see on an
126 ongoing erm situation like the diabetics or the asthmatics (AC uhum) that you see on
127 a regular basis erm the one off consultations you don't have so much feedback from.
128 (AC right) (pause) It's nice to feel you make a difference you know it ties back to
129 what we were talking about to start with (AC mm) and to feel that they understand
130 that you've made a difference (AC uhum Right) mm

131

132 AC Anything else that you want to add to you know what you enjoy about your
133 work?

134

135 SM (pause) I don't think so (AC no) there will be when I read it back (both laugh)

136

137 AC Well to look at it from a different perspective then (SM aha) erm is there
138 anything that you would say you find not satisfying about what you do anything that
139 you feel frustrated about or erm you feel makes it less meaningful?

140

141 SM Erm Most days feeling as though you're in a terrible rush (AC mm) too much to
142 do and not enough time (AC right) erm I know myself that I need to address having
143 more administrative time (AC mm) in order to follow up you know referrals and erm
144 check back on things and contact patients by phone I tend to have a pending file (AC
145 mm) that's far too large (AC mm) and you just deal with the top uppermost things
146 and never get to the things at the bottom of the pile (AC mm) that's frustrating erm it
147 used to be more frustrating I I find I want more interface with colleagues it's quite an
148 isolated job or can be (AC right) mm and I think you've talked about the weekly

149 meetings (AC mm) that you get we don't and I think that would be er vital (AC mm)
 150 erm other things that I think need addressing are kind of on hold for the for the
 151 change in nursing (AC right aha) services that are due later this year (AC uhum) erm
 152 so lack of administrative time (AC mm) and time in which to review erm your
 153 services (AC mm) you know rehash stuff (AC uhum) there's a lot of things I want to
 154 do that I never seem to manage find time to do (AC right) because it much of the day
 155 is taken up by appointments (AC mm the face to face contact) yes yeah (AC yeah)
 156 erm so more interface with colleagues (AC uhum) it has improved I think with the
 157 use of practice notes and e mails. (AC mm) When I first came here eighteen months
 158 ago nearly two years ago they didn't use e mails at all (AC right) or practice notes
 159 and that's made communication a lot easier (AC mm) you used to find you'd be
 160 hanging about trying to catch a certain GP about a patient question (AC mm) and
 161 now you can just type it in and when they get time they type it back (AC uhum) erm
 162 but I think a more erm practice philosophy type meeting (AC mm) not every week
 163 but we don't have practice meetings (AC not at all?) Not at all (AC right) erm it's
 164 coming (AC mm) but it's taking too long (AC right) erm to be more involved in
 165 practice policy (AC uhum) I think (AC mm) so interpersonal relationships at work or
 166 professional relationships and erm more involvement in what goes on (AC mm)

167
 168 AC When you say inter-professional relationships at work do you mean erm more
 169 you want more of that (SM Yes) yes OK. Not that they themselves are frustrating it's
 170 that you'd like more (SM Yes) contact

171
 172 SM I don't know whether it's partly in erm historical you know what's happened
 173 before I came (AC mm) or whether it's just the partner's philosophy (AC mm) is that
 174 erm nurses haven't been involved in decision making (AC right) erm it's happened
 175 more in the last three four months certainly with the contract (AC uhum) but I think
 176 it needs to happen more than it already does (AC mm right interesting) so that's
 177 frustrating

178
 179 AC Is there erm anything else that you would say you found frustrating if you erm go
 180 back to patient you know the patient contact is there anything there that is

181
 182 SM No I wouldn't say so bar from wanting to do the prescribing course and feeling a
 183 bit hemmed in by not having done it (AC Right aha) that would give me more
 184 autonomy (AC mm) but it's on the cards for September cus the OU option (AC right)
 185 you know the (AC distance learning) distance learning option (AC right) you know
 186 so I feel as though that's been taken consideration of and is in the pipeline (AC mm)
 187 so it's not as frustrating then is it?

188
 189 AC Yeah cus you know something's happening

190
 191 SM Somebody's listened

192
 193 AC Yes that's good

194
 195 SM Yeah (AC yeah) So no not erm I don't think so apart from that. There's the odd
 196 you know clinical situation there was a guy this morning who's erm got venous
 197 eczema and he's seeing the arterial surgeons because we suspect there might be some
 198 involvement there and he's seeing the dermatologist so there there's some clinical

199 frustrations where you feel you've got a case that you can't really find a solution to
200 (AC right) erm I'm not alone in frustration with his case for instance because the erm
201 the other professionals he's been to haven't really come up with a solution either
202 (AC mm) erm so there are some (AC mm) you know little niggly clinical frustrations
203 but usually they get resolved don't they by asking an opinion of other people or
204 doing some reading (AC uhum) or finding out (AC right yes so) but nothing major
205 (AC no) the more major ones are to do with how things run here (Laughs)
206
207 AC Mm yes rather than the actual clinical (SM work) hands on (SM yeah yeah)
208
209 AC Yeah is there anything more that you'd like to say about your role and what you
210 enjoy about it?
211
212 SM Erm what I enjoy about it (AC mm) rather than what I would change in it?
213
214 AC Mm
215
216 SM Erm (pause) No I don't think so I enjoy it
217
218 AC You enjoy it all?
219
220 SM Yes I do (AC Yeah) Yeah (AC That's great)
221
222 SM I don't enjoy getting behind you know in time and you know when your clinics
223 are running late (AC mm) but that happens to everybody (AC mm) and I don't enjoy
224 having a big pending file (AC mm) but that happens to most people (AC uhum) (both
225 laugh) or feeling that you haven't got enough time to address everything you want to
226 but that happens to everybody (AC uhum) erm so no I don't think so
227
228 AC Right that's great thank you
229
230 SM That's not it is it? (AC Yes) Is it oh I should be saying a lot more then (both
231 laugh) I haven't talked for an hour
232
233 AC No no well an hour I put an hour there so you have an hour spare and then if you
234 talk for a long time you could do (SM It doesn't matter) yes and then you don't feel
235 pressured as well I've got to get on to the next thing so (SM Yes yes that's vital)
236 that's right. But you know some people feel more able to write some thoughts down
237 afterwards (SM right) and some people feel more able to speak it so it's totally you
238 know up to you (SM yes) You might feel that what you've said has captured
239 everything that you want to say (SM Yes) about what you enjoy
240
241 SM Feels as though I haven't said very much (AC yeah well) you know it's very
242 when you talk about such things it's quite nefarious isn't it (AC mm) you know it's a
243 sort of cloudy issue to get into words
244
245 AC Mm and yet you have also talked some bits about the nitty gritty of what you do
246 (SM mm) some of the hands on clinical stuff so (SM mm) yeah that's great but if you
247 feel like adding some more
248 SM I can do that can't I? (AC Yeah)

Transcript Summary

Interview 7 NP

This transcript suggests that SM enjoys her work^{119,214}. She likes to make a difference^{6,48,127} to how people feel about their problem, making them feel better about it or more able to cope^{7,65}. SM likes to help patients understand what their problem¹² is and tries to understand their beliefs, their perspective and what they already know about the problem^{13,16,18}. She sees herself as a facilitator²¹ helping people to adjust¹⁹. She likes to work in partnership²⁸ with patients trying to do to them as she would be done by^{26,31}. She feels that most of her work is aimed at psychological^{29,49} support aiming to meet people's needs and making sure she's perceived their needs correctly⁵⁸. She aims to be sensitive to the individuality of each patient⁶⁰.

SM enjoys contact with people¹⁰⁶. She aims to build relationships with patients so that she can understand them better and then know how best to enable their care⁹². She particularly enjoys the diversity of perspectives from different people¹⁰⁷. SM feels that appreciation helps¹¹⁶, she likes to get feedback from patients and likes to feel valued in her job¹¹⁰.

SM doesn't like feeling as though she's in a terrible rush¹³⁹, she doesn't like running late and getting behind in clinics²²⁰. She feels she has a lack of administrative time and time to review services^{150,223}. She would like more involvement in what is going on at the practice¹⁶⁴ and feels that it is frustrating not to be involved in decision making¹⁷⁴. SM feels that her role is quite isolated¹⁴⁶ and she would like more interface with colleagues¹⁵⁴. She feels frustrated with patients when there seems to be no clinical solution to their problems¹⁹⁷ but her most major frustrations are with the way things are run at the practice²⁰³. She has some frustrations at not being able to prescribe¹⁸⁰ yet as this would give her more autonomy but she felt less frustrated when she knew that someone had listened to her and she hopes to do the course in the near future¹⁸⁹.

SM also feels that having an impact on improvements in both indirect and direct care such as the use of evidence based practice and policy developments is most rewarding^{TC}.

(The small numbers refer to the line of the transcript where the idea can be found)
TC = Transcript check

February 16th 2004

Interview 8 DN

1 AC an informal interview erm and what I'm doing is asking people what they find
2 most meaningful in their work whatever their work is (SA uhum) and I'm speaking
3 to erm GPs nurse practitioners and district nurses (SA uhum) and just to get a sense
4 of whoever they are or whatever they do (SA mm) what they find most meaningful
5 erm and the link there I mean you've read the information and the consent form (SA
6 mm) er the link is to try and discover what people's values are what they believe in
7 what they enjoy (SA mm) what they find satisfying in their work that sort of thing
8 (SA right) so it's very broad and very informal (SA right OK) OK (SA yes) erm
9

10 SA So is that going to be a question answer or
11

12 AC There's there's just one question (SA right) erm and so the question is what is it
13 that you find most meaningful in your work (SA yes) and then however you answer
14 that or whatever you erm feel you want to say then we will just go from there so
15 there isn't like a set list of questions to ask (SA mm right) it is erm quite informal
16 (SA mm yeah) yeah
17

18 SA What I find meaningful in my work (AC yes) erm well particularly in the
19 community erm as opposed to the hospital it's being involved with the whole family
20 (AC right) social nexus of the family the total care including the family friends and
21 neighbours it's not just caring for the patient (AC uhum) erm I find that quite
22 satisfying. Things that I find fulfilling erm I enjoy palliative care and terminal care
23 erm the feedback that you get (AC right) erm for instance yesterday a lady who has
24 just come on our books who's she's palliative really erm she said 'I just want to
25 thank you (AC mm) because you really make a difference' I enjoy being able to
26 make a difference (AC mm) because some jobs it's I mean you some days you think
27 ah it's a busy day and things go wrong like any job (AC mm) but you just need one
28 patient to sort of feel better (AC yes) and that happens most days in this job (AC
29 mm) so making a difference is a good thing (AC mm) it's nice to be able to nurse
30 people in their own home if that's their choice if they're poorly (AC uhum) because I
31 think people thrive at home with being in the bosom of the family (AC mm) it's not
32 always possible erm so yeah I enjoy palliative care terminal care I enjoy being part of
33 the team (AC right) and I value the communication but I do have frustrations in that
34 department I think probably we all do (AC mm) erm and I think there's strengths and
35 weaknesses in different teams and I've worked in different practices and seen
36 different ways of working (AC right) primary health care teams operate in different
37 ways (AC mm) and I think the crux of things is good communication (AC mm) so
38 yeah I do have frustrations sometimes erm but that improves I think you just have to
39 keep (AC mm) chipping away at that issue (pause) the fact that you're always
40 learning (AC right) that's a challenge and I think the day that you feel that you've
41 learnt everything that you know everything that's the day that you should stop (AC
42 yeah aha) you're always learning (AC aha) erm students it's quite good fun having
43 students (AC mm) that's a two way process we learn from each other. It's interesting
44 to see how their training is obviously different to my training (AC mm) erm (pause)
45 can you give me any other ideas of anything else that you
46

47 AC Yeah you keep going because you've been coming up with quite a list of
48 different things that you enjoy

49
50 SA One of my favourite areas is er wound care (AC uhum) particularly interested in
51 wound care that's a particular erm I suppose passion really I enjoy healing wounds
52 the challenge and it's the research behind the wound care products it's the (AC mm)
53 but holistic care erm there was a time when I thought I would have liked to have
54 been a tissue viability nurse that was a real passion and actually specialising in one
55 area (AC right) erm and there have been times when I've thought of erm McMillan
56 nursing or tissue viability but for various practical reasons (AC uhum) I'm still a case
57 holder and (AC mm) erm changing jobs actually meant erm sort of re-establishing
58 that was new that was a challenge in itself to know a new practice and start a new
59 team (AC right) so I've just progressed with that but whether

60
61 AC Do you want to explain a bit more about the palliative care and terminal care and
62 what is it that you enjoy about that?

63
64 SA Erm I think it's seeing families and patients experiencing what we could call or
65 hopefully what we could call a good death if that is possible (AC mm) or as good as
66 we can make it (AC mm) to try and make sure that they have support erm and to
67 build up that relationship prior to the death erm so that they've got the trust (AC
68 uhum) it's interesting to compare areas I have actually got erm a family member erm
69 from a different locality from (AC mm) I've just been involved in setting up a
70 package of care for this person

71
72 AC This person's moved in temporarily to the area?

73
74 SA No no this is this isn't my locality here (AC oh I see) this is where I'm from (AC
75 oh I see) (AC right) and erm it's a gentleman that's got lung cancer (AC right) He
76 had no services no support (AC mm) and I could see and compare (AC mm) you
77 know the care that we give here erm so that's been interesting erm and to be able to
78 make a difference to him (AC mm) and to say to him well there are people out there
79 it's just tapping into the services and knowing who is there (AC mm) and now that
80 we've got his package of care set up erm I'm sure things will probably run smoothly
81 (AC mm) so that's that's quite interesting comparisons of different localities and
82 knowing what services are out there erm. I enjoy the interaction with the social
83 worker we do have good weekly communication with the social worker (AC uhum)
84 erm so that's again it's all down to communication isn't it (AC mm) erm being part
85 of the team in the actual practice it's variable erm we were part of the wider team in
86 that we had the health visitor and health visitor assistant er sharing in the office and I
87 actually found that quite helpful and supportive but they now actually operate from a
88 different office (AC mm) so that I feel has fragmented the team even more (AC mm)
89 erm and although I think people thought we would make an effort to meet we don't
90 (AC no) so I feel you know that's a loss really (AC mm) and I did enjoy that er
91 feedback (AC mm) erm particularly with the health visitor assistant who also deals
92 with the elderly (AC right) erm and I think for practical reasons you know you're
93 often perhaps not involved but you're aware of the patient that you've both been
94 involved with (AC mm) and it's just those one to one contacts (AC mm) you sort of
95 share information that are important (AC mm) erm so yeah I think the erm the idea
96 of the primary health care team is excellent but I feel you've got to be part of the

97 actual lets say the meetings for instance we work very independently here we're not
 98 invited to primary health care team meetings and I just feel that that's detrimental to
 99 communication (AC mm) I've worked in practices where they would have a monthly
 100 meeting and everyone was involved the social worker the CPN practice nurse
 101 everyone GPs and at the same time worked in another practice where there was no
 102 communication other than a one to one if you had a problem you went along and and
 103 I can see how (AC yeah) you worked better in the first situation (AC mm) but things
 104 can change (AC mm) hopefully

105
 106 AC Yeah It's interesting when you've had experience of other places (SA yes yeah)
 107 and being able to compare it in that way (SA yes)

108
 109 SA And actually looking at other practices I know the erm the other practice my
 110 colleague erm does have a very good working relationship but I think even within
 111 that practice there are differences (AC mm uhum) GPs work in different ways don't
 112 they? (AC mm) we all work in different ways but then it's nice to have an informal
 113 communication I mean it's quite light but erm in my mind it's less time consuming to
 114 have a set time (AC mm) when you communicate so erm yeah so that's that's a
 115 problem really I would say. (AC mm) At the moment I'm quite erm interested in
 116 trying to get the practice involved with the Gold Standards (AC oh yes) for palliative
 117 care (AC uhum) erm so I'm just planting seeds at the minute (AC right) so whether
 118 that comes to fruition we have a new GP at this practice who has apparently taken an
 119 interest so hopefully we will progress in that area (AC mm) with erm the help of the
 120 a new McMillan nurse coming next week. (AC uhum) working in a multidisciplinary
 121 way I find satisfying (AC uhum) but it's not consistent throughout (AC mm) the
 122 different team members (AC mm) for various reasons (pause) yeah (laughs)

123
 124 AC OK you also mentioned a bit about erm working with students and also for
 125 yourself learning new things (SA yeah yeah) in your work do you want to say a bit
 126 that and why that's enjoyable?

127
 128 SA Again I suppose because you feel that you're helping you're making a difference
 129 (AC mm) can be quite stressful because personally I haven't done a degree and I do
 130 sometimes think wow (AC mm) these students are coming through and they're you
 131 know they're so up to press with erm recent research etcetera but actually when you
 132 get down to brass tacks their erm their basic skills are erm basic (AC mm) so you
 133 forget I think the amount of knowledge that you have (AC mm) although you've
 134 been doing a job for years and you think it's second nature they're actually just
 135 taking on board a lot of those sort of basic skills (AC mm) I think you underestimate
 136 what you do (AC mm) you do teach in a day really don't you erm but I find it
 137 stimulating but stressful at the same time if you've got a busy caseload erm it's that
 138 sort of er doing two things at the same time (AC mm). I like to do things well I don't
 139 like to do three things half well (AC yeah) I find that frustrating (AC uhum) you
 140 know erm and I suppose the other thing now more and more IT skills are needed erm
 141 I didn't I didn't actually start out with IT skills so that's that's been a stress so there's
 142 a lot of stuff that you're picking up yourself (AC mm) and yet you get young
 143 students coming through and they're whiz kids on the computer and you think oh
 144 wow (AC yeah) so things like this lots of erm little stresses but your personal
 145 development obviously you know you try to move forward erm (pause) I feel I'm
 146 probably ready to start learning something new er but having had er a new case load

147 I've just really felt since I've been here which is quite a few years actually wanted to
 148 consolidate the team get to know my practice get to know my patients (AC mm) and
 149 concentrate on that really and we've had a lot of team changes in this practice so that
 150 can be quite stressful lots of changes actually erm I just feel as if we've now got a
 151 team that's settling down (AC mm) erm but that's true of all teams I guess you know
 152 (AC mm) mm (pause) is there anything else that you

153
 154 AC Yeah while you were you were just talking about some of the frustrations that
 155 you find (SA mm) I mean that's another way to look at what you value or don't value
 156 (SA mm) erm so is there anything

157
 158 SA Personal development I value (AC right) erm I think you you've got to progress
 159 you've got to learn I mean your code of conduct says that (AC uhum) I like to be
 160 learning and progressing (AC mm) so I have it frustrating because I've not done a
 161 course er proper academic study for a little while erm and I find it frustrating that I
 162 haven't done a degree (AC mm) I know I could have done it (AC mm) erm but
 163 having had a quite a erm demanding first nine years in practice I travelled erm for
 164 nine years to my work place seventy miles round trip (AC uhum) and I just didn't
 165 have the energy basically (AC I could imagine yeah) so I didn't I didn't really push
 166 myself there (AC mm) and I think when you start a case load you're erm again
 167 you're just consolidating (AC mm) and I think you really start learning when you
 168 start doing the job (AC mm) it's not like erm being in college is it? (AC mm) but
 169 then I think well I'm getting enough out of this job as long as I can do updates that
 170 interest me like palliative care wound care and that make a difference to practice
 171 maybe I just settle for that (AC mm) and just do a good job (AC mm) there's a lot to
 172 be said for doing what you do well (AC mm) so erm so yeah that has been a
 173 frustration really (AC mm) I know I could have done that degree (laughs) (AC yeah)
 174 mm

175
 176 AC Just to go back gain then to erm a couple of areas that you mentioned at the
 177 beginning you mentioned about wound care (SA yeah) that you find that very
 178 satisfying (SA yeah) can you explain a bit more about that (SA erm) and why it's
 179 satisfying?

180
 181 SA Well it's satisfying because you can see the progression in a wound (AC mm)
 182 erm and you can see the influences that you have directly and you can see an end
 183 result and it's a positive (AC uhum) mm and you do make a difference (AC uhum)
 184 leg ulcers that didn't used to heal you're using research and you're getting the leg
 185 ulcer healed (AC mm) erm I've got I've got a lady just recently and I said hopefully
 186 we'll be having you in your stockings for Christmas day I think we were four days
 187 out she got her leg ulcer healed just after Christmas (AC right) (AC yeah) I think
 188 sometimes if you're dealing with a lot of death although I say I like erm palliative
 189 care and terminal care erm sometimes it can get stressful (AC mm) so if you've got
 190 something like your wound care that you know you can see a wound heal and you
 191 discharge a patient (AC uhum) you know erm that's satisfying (AC mm) erm (AC
 192 It's like you've completed the episode) you've completed the episode yeah but
 193 hopefully we do that with terminal care and palliative care as well we go back and do
 194 a bereavement visit and there's that that erm (phone ringing) that lovely feeling of
 195 when you're in the village I mean two or three years down the line and suddenly you
 196 start to feel that you're part of the community (AC mm) because you've got to know

197 so many families (AC mm) they never forget (answer machine answering the phone)
198 and that just takes a while to start to feel part of that community and it's more like
199 neighbourhood nursing (AC yes) (AC mm) (AC right) (AC mm) to be part of the
200 locality (AC mm) erm certainly a while to feel that feeling in this practice erm
201 slightly different culture here I think as well (AC right) different culture (*answering*
202 *machine now taking message – audio tape switched off in case any patient details*
203 *were revealed*)
204

205 AC Yes so you were talking about feeling part of the community (SA yeah) here and
206 you feel it's taken three years
207

208 SA I think yeah yes I feel it's taken that erm cus it's a split practice that I have here I
209 have erm a smaller office I have two offices actually (AC Oh OK) so it's like a split
210 team if you will which has its erm inherent problems as well mm right so erm I
211 sometimes feel that I'm not quite in control you've got to delegate (AC mm) and I
212 think skill mix is an issue (AC mm) I've been trying to get an E grade within the
213 team (AC right) (AC mm) I feel from the point of view of the team that that's erm a
214 negative because erm the girls are working to E grade and really they're not being
215 recognised for that certainly the team that work in satellite site (AC mm) I would like
216 them to be rewarded for what they do (AC mm) (AC mm) erm but that's out of my
217 control really (AC mm) I actually worked as erm I worked as a staff nurse in that
218 practice years ago and erm the post then was recognised as an E grade post and I
219 actually was given an E grade . With supervision I know I'm here and I do supervise
220 (AC mm) I think it should be an E grade post (AC mm) so yeah that's that's an issue
221 really
222

223 AC Is there anything else that you would say you find frustrating or you know you
224 don't enjoy about what you do?
225

226 SA (pause) I've said a lot there haven't I? (both laugh) er I think I enjoy most of my
227 job apart from the things like the time constraints with the computer input and (AC
228 mm) that type of thing we seem to have more erm written work and it's the old thing
229 isn't it you came into nursing to put to be a nurse to do hands on (AC mm) and
230 you're doing more and more management (AC mm) although I enjoy the
231 management side I still enjoy the hands on (AC mm) and it's that sort of dichotomy
232 isn't it always (AC mm) erm but yeah most most of the job I do enjoy (AC mm) it's
233 just all those frustrations you know the skill mix a lot of things have improved you
234 know with perseverance you know since I've been here but I think most things I've
235 said really (AC mm) communication I think is the big one (AC mm) and the team
236 being part of the multidisciplinary team that could be improved (AC mm) (AC mm)
237 erm it's that thing we don't work for GPs we work with them (AC yes) but you need
238 to work with them don't you (AC yes yes) and feel more part of the team (AC mm)
239 yeah (AC mm)
240

241 AC So if we go back on the other tack of you know what you find meaningful and
242 what you enjoy about what you do (SA mm) the very first thing you said was working
243 with families (SA yes yeah) can you explain a bit more about why that is so
244 meaningful to you?
245

246 SA Erm because you see a patient not in isolation and that is more holistic care isn't
 247 it (AC mm) if you look at a patient psychologically physically emotionally spiritually
 248 that must involve the family (AC mm) well in most cases we're all part of a family
 249 so erm I think in hospital and I think that's the biggest thing the students mention
 250 when they come in to the community the first thing they say is 'oh it's so different
 251 walking into someone's home' (AC mm) it's that it's that being taken into someone's
 252 personal space that's of value (AC yes) and being trusted and erm I know in the
 253 community I find that very special privilege (AC mm) it's a privilege erm I think in
 254 hospital you know you put people into pyjamas and you put them into a bed and they
 255 become erm become a patient they're still a person (AC mm) they remain a person
 256 rather than a patient (AC mm) hopefully you deal with them (AC mm) on that level
 257 in their own environment so that's that's valuable (AC mm) erm and I mean we're
 258 privileged we you get so close to people erm (AC mm) and that I just find that's very
 259 special I feel very privileged to do that really (AC mm) and people say 'oh how do
 260 you do how do you do that job?' it's erm erm how can I explain it? (pause) It is a two
 261 way thing (AC uhum) I think in nursing it's the need to be needed as well isn't it
 262 (AC uhum) I think sometimes so although patients feel that they get something out
 263 (AC mm) of the service I think the nurses get something back (AC mm) erm and that
 264 making a difference and being needed perhaps is part of us as nurses (AC mm)
 265 perhaps that's an inherent part of a nurse I don't know (laughs) (AC yes maybe) yeah
 266 (pause)

267

268 AC So yeah anything else that you would say you enjoy particularly (SA Can't
 269 think) or you find satisfying?

270

271 SA Can't think of anything specific I'm just thinking of the particular things that I
 272 enjoy erm I quite enjoy the teaching the teaching side (AC uhum) yeah erm it's
 273 always nice to have done an assessment and done a teaching session with someone
 274 and then returning and find they've taken on board what you've said (AC mm) erm
 275 the sort of health education side of the job er (AC Oh teaching patients?) Yes (AC
 276 yes right) so you're teaching is such a big part of the role isn't it the patient (AC mm)
 277 the family the student the team erm so that side of things (AC uhum) sometimes you
 278 forget that you're a teacher you know and an assessor of students as well erm but
 279 yeah that's that's quite erm quite stimulating (AC mm) I enjoy the counselling side I
 280 do enjoy the counselling side of er the job erm (AC uhum) (pause) but not being an
 281 actual trained counsellor erm erm that's another area that I often think I could sort of
 282 branch out in but I do enjoy that side (AC uhum) it's such a multi faceted job really
 283 (AC mm) there's so many aspects to the job (AC mm) the job is the sum total of the
 284 whole (AC mm) and like any job there are parts of it that you enjoy and parts of it
 285 that you least enjoy and I think I've probably explained the bits that I enjoy best (AC
 286 mm) and the frustrations erm can't think of anything else really (laughs)

287

288 AC That's brilliant. (Both laugh) Well thank you very much that's great

Transcript Summary

Interview 8 DN

This transcript suggests that SA particularly enjoys being involved with the patient's whole family including friends and neighbours¹⁹. She enjoys being able to make a difference^{26,30} and feels that she just needs one patient to feel better in a day to make the whole days work worthwhile²⁸. SA likes to nurse patients in their own home because she feels this is where they thrive³¹. She enjoys palliative and terminal care²² and also enjoys wound care⁵³. She enjoys teaching patients and families²⁹⁹ and enjoys using counselling skills³⁰⁰. She enjoys seeing wounds heal⁵⁴ and enjoys using the research behind wound products^{55,196}. She feels satisfied when a wound heals and a patient can be discharged from the case load^{194,204}. In palliative care SA likes to build up a relationship with families so that they feel they have support⁷². She likes to contribute to families and patients by facilitating a good death⁶⁹. She values feedback from patients²³.

SA enjoys being part of a multidisciplinary team^{34,91,128}. She values communication in the team³⁴ and feels frustrated when communication does not work as well as it could³⁴. She feels good communication is important³⁸ and enjoys regular communication with the extended team⁹⁷. She enjoys interaction with the social worker⁸⁹ and enjoys sharing information through one to one contacts with the team¹⁰¹. She feels regular meetings are important¹⁰² and misses a number of the extended team since they have moved away to another office⁹⁷. SA is prepared to keep working away at an issue if she feels something needs changing (for example team communication), she perseveres to try to change things^{40,253}. SA is keen to introduce new standards of practice for palliative care¹²³.

SA enjoys having students^{45,290} and feels it is a two way process⁴⁵. She enjoys teaching and enjoys finding out that students have learnt from her²⁹⁴. She values continual learning⁴² and personal development and likes to keep learning and progressing^{155,169,170,171}. She enjoys making a difference for students¹³⁶ and finds students simultaneously stimulating and stressful¹⁴⁵. She finds the busyness associated with having students frustrating because she doesn't like to do things half well¹⁴⁹. SA finds it frustrating that she has not done an academic course for a while¹⁷² but enjoys doing updates that make a difference in practice¹⁸².

SA values being part of the local community^{209,211,214}. She values being taken into someone's personal space^{270,272} (their home) and being trusted²⁷¹. She feels privileged to get close to people²⁷⁷ and feels that making a difference and being needed is part of being a nurse²⁸³. She enjoys the hands on work with patients²⁵⁰ and also enjoys her management role²⁴⁹. She values the other nurses in her team and would like them to be rewarded with appropriate grades for their level of work²³¹. She enjoys most of her job^{251,245} but finds time constraints and the computer input frustrating²⁴⁶.

(The small numbers refer to the line of the transcript where the idea can be found)

Interview 9 GP

1 AC It's a really unstructured interview and erm basically what I would like to know
2 is what you find most meaningful in your work as a GP erm so
3
4 SR What's everybody else said? Money money (both laugh) No er what's most
5 meaningful (AC mm) erm well I think I can't say one thing certainly what appeals to
6 me about it if that's a different way of phrasing it I like I like looking after patients
7 I've been here three erm and a bit years so I've now defined I think quite ?? my
8 patients population I'm very sort of pragmatic young male GP so I deal with a lot of
9 elderly people with heart failure, ischaemic heart disease, prostate disease, chronic
10 lung disease (AC right) I don't get a lot of soft psychology (AC mm) a lot of
11 probably young people with depression anxiety I think they tend to go to my partners
12 I look after the S Home I've got twenty four people up there with an assortment of
13 chronic neurological conditions (AC uhum) some of which are very poorly on
14 ventilators and things at night (AC mm) and some of them are very well just in
15 wheelchairs or whatever erm so I like medicine but when I say medicine I like
16 pragmatic medicine I'd probably be like S you work with S don't you (AC ah yes)
17 I'd probably be that sort of from what I gather (AC yes) I like things that I can define
18 and I can deal with in medicine and I think that's what I've managed to do (AC mm)
19 and so that's what I like because with anything like that you get defined outcomes
20 (AC mm) which appeals to me (AC mm) so that I can look at my erm my heart
21 disease people and I can see their cholesterols dropping I can see their blood
22 pressures coming under control (AC mm) I can see population manager showing us
23 where we are (AC right) er so I like that. I've got quite a business head on me I think
24 (AC right) probably more than the other partners Dr P does that but I do quite a lot as
25 well so I quite like the concept of running our own businesses (AC aha) driving the
26 finances making it work quite like that. I dislike intensely staffing issues but don't
27 we all? You know we all have them we're very lucky we've got great staff and it's
28 running very well at the moment er I dislike in some ways being responsible for the
29 buildings (AC mm) all these things are distractions but I'm sure you hear endlessly
30 but we're trying to do the medicine which is about looking after patients and making
31 them better and really the strength really I think of what I try and do is the proactive
32 stuff (AC uhum) primary prevention or secondary prevention not you know not
33 really the other stuff and I find that my time is too often I'm sure everybody else says
34 to you finding out that the roof's leaking finding out that we've got staff off sick and
35 finding out that this hasn't happened and finding out that happened and our data
36 protection act isn't up to date and our health and safety isn't up to date and we
37 haven't got the right protocols to come through but that's what we all spend our lives
38 doing. (AC yes) So the plus side is what I do what I'm trained to do and what I like
39 doing (AC mm) the down side is the endless endless endless endless bureaucracy and
40 I'm sure that S and S say the same thing (AC mm) our practice meetings are now
41 really spent little bit about the new contract defining targets and how well we're
42 getting on with those and the rest is just about work sheets, tool kits, protocols,
43 coming in from the health authority which I feel is beginning to distract a bit from
44 the core of what we do (AC mm) whereas I'm one of the younger generation who
45 doesn't see general practice as we're working on it now continuing in the same vein
46 for the next after the next ten years or so (AC right) but I don't know that's just me
47 talking the future (AC mm) and I think I'd probably quite welcome to see all the

48 practices amalgamated purpose built centres (AC uhum) you know much better skill
 49 mix (AC mm) much better use of other people (AC uhum) less referring in to
 50 hospital and more keeping it in house (AC uhum) but it's not going to happen while
 51 we're working in this antiquated way isn't it (AC mm) working in three practices
 52 working from two practices in two buildings in V branch surgery in T another
 53 relatively small practice in G with a branch surgery in A (AC mm) three small
 54 surgeries just down the lake I know it's geography but that's really where the
 55 medicos are we're tied down by the fact that we're very much generalists (AC mm)
 56 in this part of the world I don't know what it's like elsewhere presumably if you've
 57 got a practice with twelve partners you can have an expert in prostate an expert in
 58 female health an expert in musculoskeletal but we can't we all just do (AC mm) what
 59 we've always done and I enjoy it I don't want to lose it but it's slightly frustrating at
 60 times (AC mm) you do find you do a bit of everything and nothing very very (AC
 61 mm) particularly well or particularly in depth (AC mm) but anyway (AC mm) but
 62 that's what I like I mean I suppose I've completely undermined just what I said
 63 because I quite like seeing lots of different people (AC right) and it suits me because
 64 as I say I like medicine and when I say medicine I mean you know archetypal heart
 65 disease not medicine from the global spectrum and that's what I deal with (AC yes)
 66 you know I think when I used to locum elsewhere in town centres I'd deal a lot more
 67 children with minor illness single mums with concerns you know all the things that
 68 tend to polarise that whereas our populations are old with multiple medical problems
 69 (AC uhum right) that you've got to get to grips with like the CH really (AC right)

70
 71 AC Can you say a bit more about that explain a bit more about where you started you
 72 talked about being very pragmatic and enjoying medicine (SR Right) can you explain
 73 what you mean by that?

74
 75 SR Er what I (pause) I suppose going back to the start I started life I did surgery for a
 76 little while but only very briefly only to SHO I never went very far up the ladder and
 77 I never really got into to it and I never felt that I was going to follow a career but
 78 (AC right) I did my FRS and got both parts I did all that and then I did some hospital
 79 stuff and then I've ended up here quite slowly and I'm happy I've ended up here
 80 slowly my personality though I think is quite black and white really (AC right) you
 81 know I don't get I do but I don't go for shades of grey you know and that's why I
 82 think working here suits me because I have an old group of patients predominantly
 83 old people (AC mm) with high blood pressure and heart disease they come to me
 84 because they don't know what to do I sit down and I talk to them I'm not I'm not that
 85 doctor centred and I'm not sit down and talk to them and I say I think you should do
 86 this and this and this and this for these reasons (AC uhum) and they'll take it on
 87 board usually because we're quite lucky they're quite an intelligent bunch around
 88 here and they know what you're talking about (AC uhum) they'll go away and
 89 they'll probably do it er and they'll come back at a pre date and they will come back
 90 at that date as they do (AC yes) and you can see what you've done and what you've
 91 achieved and what you haven't and I like that (AC yes) because I can see a defined
 92 benefit from what I've done (AC mm) er what I don't warm to is people who take a
 93 lot of time what I call black holes basically a lot of time trying to sort out their social
 94 their psychological their financial concerns you go round and round in circles (AC
 95 mm) and a year later you're still exactly where you started off you know (AC mm)
 96 headaches endless people with headaches and you go round and round they see the
 97 neurologist they have their scan they go on these tablets a year down the line they're

98 still having headaches (AC mm) and you look at them and it's not just headaches it's
 99 illness behaviour it's depression it's everything else and you try and get a route into
 100 these people and say look we should stop worrying about your headaches we should
 101 start talking about maybe your depression or maybe what else is bothering you and
 102 inevitably they end up back on headaches and I'm pretty quick to draw stumps on
 103 that one (AC right) which probably makes enemies to be quite honest but I'm pretty
 104 quick to say look you know we've done your headaches I've tried really hard for a
 105 year and got nowhere (AC mm) I'm not going to pursue these anymore (AC mm)
 106 sorry I just haven't got the time and the hours in the day (AC mm) I know you'd
 107 probably leave very dissatisfied but I think you know I've done what I can do (AC
 108 uh) I've protected myself (AC uh) because you know these people will devour
 109 you know you could spend hours going round and round in circles knowing that
 110 you're in the wrong domain (AC mm) half the time you're in completely the wrong
 111 place it's not the headaches it's your depression you need sorting out (AC right) you
 112 go round and round and you fail to persuade them that you're in the wrong area here
 113 and x number of pain killers is not going to cure the headache what you need to get is
 114 beyond that and back to the fundamental cause of the headache and you know the
 115 same rhetoric and tend to say look I can't help you in a nice way (AC yeah yeah) and
 116 I think that protects me. It's a bit off record this but you know we just lost a partner
 117 who just got devoured (AC mm) by demanding patients (AC mm) and you look at
 118 her patients and they were shocking they're a really difficult bunch and she spent
 119 hours trying to sort these people out (AC mm) and you just wont you will not sort
 120 them out (AC mm) because their occupation is not being sorted out to be here and
 121 since she's gone they've all disappeared none of them of died none of them have
 122 died of brain tumours they're all out there they're still functioning (AC yes) and I'm
 123 just not like that I'm just quite pragmatic you know (AC yes) I'm sure there are
 124 people who pick up the phone and I know they pick up the phone and say yes or no
 125 there's an appointment oh it's Dr R today oh no I'll be alright (AC laughs) that's fine
 126 isn't it it's fine it's a relationship if they don't think I can help them (AC yes) then
 127 I'm not going to help them (AC yes) that's fine

128
 129 AC People learn that don't they?

130
 131 SR They do and that sounds really awful and I don't mean to I don't mean to sound
 132 really miserable it doesn't happen very often (AC aha) but there's a bit of relief isn't
 133 there is you've tried and tried and tried for a year with these people and got nowhere
 134 (AC mm) what are you going to do you know? (AC mm) Sometimes you just have to
 135 say I'm just the wrong person (AC mm) for this particular problem (AC mm) and I
 136 think you know you need to be able to define this (AC mm) you know like anything
 137 we refer all sorts of people into hospital don't we you know there's nothing wrong
 138 with them we're not worried there's anything wrong with them but there's a time
 139 when you need someone else now to shoulder this burden to say there's nothing
 140 wrong with you (AC yes) that's why we send headaches because we know they've
 141 not got a brain tumour because they never have brain tumours but you just get a bit
 142 fed up of telling them I'm a bit worried that one day there is going to be one (AC
 143 that's right) and we have one we have one we've been telling them for ages and
 144 we've just realised they've got a flipping brain tumour (AC yes) so you know you
 145 share the burden but that's the way that's the way I work (AC mm) I know Dr I I
 146 think is quite similar (AC aha) Dr S is I think is quite similar Dr P I think she tends
 147 she has a lot more sort of she's been here longer so she tends to get you know

148 anxious old ladies who want a chat (AC mm) I don't mind chatting to anxious old
 149 ladies once a month that's fine (AC mm) so long as you know that's accepted that's
 150 what it is it is a chat for once a month (AC mm) we're not going to go back to the
 151 headaches because we've done that and not got anywhere (AC mm right) and there
 152 you go you're about to change lists now aren't you if you're registered with us (AC
 153 sorry?) you're about to change lists if you're registered with us (both laugh) that
 154 horrible that git (laughs) I do a lot of terminal care we've got the same as you lots of
 155 cancer (AC mm) lots of cancer and a lot of terminal care and basically we're busy
 156 we are (AC mm) we're not too bad at the moment but it's the same our time is
 157 stretched (AC mm) and stretched and stretched (AC sure) I delegate an awful lot of
 158 my stuff I get the district nurses and McMillan nurses to go in and do stacks look
 159 after H and I've got years and now I've got it quite taped really the staff know my
 160 angle on things (AC right) and where I'm coming from and what I'm going to do and
 161 what I'm not going to do (AC uhum) and they're very good and I think the patients
 162 are quite content they're quite content and one thing I am is pragmatic quite
 163 transparent and very uniform (AC right) you know I just do things I will do them that
 164 way on the whole a bit predictable if you phone me up they know what I'm going to
 165 say because that's what I'm going to say (AC right) obviously it's not absolutely but
 166 you know I tend to try and keep it that way (AC right) I'm busy I've got a young
 167 family at home I've got a wife that works (AC mm) you know I tear around this
 168 world at the moment (AC right)

169
 170 AC Erm You mentioned cancer there where does that fit for you in the business of
 171 the black hole

172
 173 SR Er It's not black hole is it? Certainly is no no not at all I actually we all do we've
 174 all got a lot because of the population (AC mm) I don't enjoy looking after people
 175 who are terminally ill I think but I do find it very satisfying to have you know for it
 176 to go well and for them to go well I think one of our perennial frustrations around
 177 here is that we have to admit so many people into the hospital and the hospice to die
 178 cus they're elderly they're living on their own there is no nursing bank or short term
 179 nursing beds there's no cottage hospital not that I want one don't want a cottage
 180 hospital thanks but there isn't anywhere so you take them so far down the line and
 181 then they get admitted at the weekend because there's nothing (AC mm) I know
 182 that's the thing about the national service frameworks and (AC mm) er the gold
 183 standards but that is a perennial problem for us and I can't see that's going to change
 184 but yet it is quite satisfying medically to look after someone who you diagnose their
 185 disease you see them through the surgery the trauma of it they become terminal
 186 especially if they're in their eighties (AC mm) they're usually quite easy to look after
 187 they're accepting they're you know ready to die (AC mm) and they die peacefully at
 188 home (AC mm) so yes I don't say that I enjoy that it's the wrong expression (AC
 189 yes) to use but it is satisfying (AC yes) I think we all do it and I don't think we're
 190 keen to let it disappear off to the McMillan completely (AC no) partly because we'll
 191 get deskilled and twenty four hour McMillan cover they talk about a lot of twenty
 192 four hour cover we've just got district nursing twenty four hour cover and that's
 193 whether or not it will stay (AC mm) anecdotally when I've used it it's been fine but
 194 they're very under-utilised at the moment (AC right) whether it will pick up with
 195 time we'll see but there seem to be two district nurses parping about a lot at night
 196 (AC mm) cus the co-op used to do it and we do nights on the co-op and you think
 197 well in the past I would have done that in half the time (AC mm) but you delegate it

198 don't you why work when you can get someone else to do it (AC mm) you probably
199 just say that'll be alright see it in the morning or (AC right) so so yes terminal care is
200 fine (AC aha) I wouldn't want to loose it definitely not but again sometimes you
201 have a run I've got five or six on the go at the moment and that's hard work (AC
202 mm) that's really quite difficult (AC mm sure)

203
204 AC The other major topic that you mentioned right at the beginning was about the
205 business side of things can you explain a bit more as to why you enjoy that what is it
206 that's

207
208 SR I don't know I suppose I've always been quite fiscally minded I always have
209 been (AC uhum) I'm not that bothered about money I drive an old car I really don't
210 care that much (AC mm) but it's part of it's part of running the practice isn't it (AC
211 mm) you know I think it's a barometer of the success of what you're doing as well
212 (AC mm) you know if you can see that you're hitting your targets for immunisation
213 which equates to money inevitably so the two are directly linked I'm not saying
214 we're just doing it for the targets we're not just doing it for the targets we're doing it
215 for the money but the two are part and parcel then clearly we're going well (AC mm)
216 you know you're meeting your targets you're getting your payments so by definition
217 things are going well (AC mm) you know if we have a dispensary if the dispensary
218 is running well you know the staff are content and not overworked you know the
219 through put is good the amount on the shelves are good you get this feeling it's a
220 representation of how things are going people are thinking about what they're doing
221 (AC mm) people are using things sensibly so that's really it I mean I don't see me
222 counting pennies you know I don't do any accounts Dr P does all the accounts (AC
223 right) so I'm not that bothered you know it's part of running it as a small business
224 (AC yes) I'm much more stringent about if people come to me for something like
225 they want a letter to go on holiday then I'll do their letter but they have to accept that
226 is a they have to pay for it in days gone by you used to just do these things but now
227 we think no you must pay for it (AC mm) you must acknowledge that is not part of
228 what I'm here for that's the main reason (AC sure) you know it's just accepted isn't
229 it you go to the doctors for bloody everything (AC yes) I'm sure S has his views on
230 this but they do they come to you with things that are completely out of your power
231 and they want you to sort it out you know I want to do this I want to do that (AC
232 mm) and I'll say you know fine so that's why it's not particularly financial

233
234 AC It's interesting though because it does mirror what you said about practice in that
235 that's very black and white the financial side (SR yeah yeah) whereas with staff it's
236 probably a little bit more grey

237
238 SR Yeah it is really and the trouble is with staff and I don't mean it now because
239 we've got a great bunch (AC aha) touch wood they're really good they're really good
240 but you are at the whim of people's idiosyncrasies their emotions whatever aren't
241 they that will not necessarily conform with you I know you're a GP partner and you
242 have the ultimate responsibility you're running this place you have to heat it and
243 light it so you have to make sure that things are at least you know your ethics can be
244 quite different from some of the staff we've had who clearly just turn up to earn the
245 money and if they don't feel like coming they don't come in (AC yeah) you know
246 because they get sick pay so why should they care (AC yeah) and that's at
247 loggerheads of the way that we work (AC mm) because if you're a partner you're in

248 business I mean it's not just partners the hoteliers have the same problems you know
 249 everybody has the same problems so you're then at loggerheads with someone whose
 250 work ethic reason for being here is very different from yours (AC sure) our reason
 251 for being here is to earn money I mean there's no silver cloud I'm not (AC mm) I'm
 252 here to earn money that's what makes me afford my house and my children and my
 253 wife and everything like that I happen to like doing what I do and so it's a good way
 254 of earning money (AC mm) if you take the money away I'm not here sorry you know
 255 (AC laughs) of course not (AC yeah too right) you know absolutely and if they tart it
 256 up so you find the penalty you're paying for your money you go part time you drop
 257 some hours we've already done it when JC left we've already dropped a day (AC
 258 mm) because we all said this is just getting too demanding now (AC mm) er and Dr
 259 S and Dr W have all got young children at home (AC uhum) Dr P hasn't and we just
 260 found you just chaise your tail and you never have any time to yourself (AC mm) so
 261 we said right we want some time out (AC mm) so we've taken a drop in salary to
 262 employ a partner more time but that's fine that's perfect (AC yes) you know it's well
 263 worth it (AC mm) everyday you're off you think this is marvellous (AC mm) but
 264 that's why I'm in it you know I'm not here because I'm on some pilgrimage to look
 265 after patients (AC aha) but I don't know many who are (AC no of course) some
 266 maybe but I don't think so (AC mm)

267

268 AC Is there anything else that you would say you don't enjoy about what you do

269

270 SR Errr I'm not that bothered about out of hours care (AC uhum) I do it we all have
 271 to (AC mm) I work for the co-op so I do it I do like I do like contractual obligations
 272 so I'm supposed to do an amount of hours so I make sure I get them done I don't find
 273 it satisfying (AC right) you know it's crowd control out of hours basically (AC mm)
 274 looking after people who have an assortment of illness you know they need to be
 275 seen they get seen they get sorted but as an exercise in satisfaction and money
 276 generating I don't think it's worth doing to be quite honest (AC mm) so maybe with
 277 the new contract I'll stop doing it (AC mm) I don't think I will completely to be
 278 honest because I don't think we'll be able to but I don't find that no I think that's just
 279 I turn up give a bit and go home (AC right) and that's the attitude most of us have I
 280 think because it's different it's a different relationship (AC mm) I think it's much
 281 better than the old system where you were expected to be on call one in four (AC
 282 mm) but I mean I know A still does her own on call (AC mm) but I think that's a
 283 financial and a geographical reason isn't it (AC yeah) she lives in V (AC that's right
 284 yes) it's not that arduous she's half time she has to get up every now and again
 285 whereas I live in E (AC mm) and it would be a big issue to drive backwards and
 286 forwards to and fro (AC mm) but I mean I'm there I don't really enjoy it I do it and
 287 completely accept that it's part of the job and I'll do it but I don't really enjoy it.
 288 Some people really like it (AC mm) and they like it because there are no staffing
 289 issues there's no ongoing care issues you sort the problem you go away you walk
 290 away (AC yes yes) we have a doctor who does it at night he loves it because he's
 291 spent thirteen years in practice fighting with staff and hassle and all the rest of it and
 292 now he doesn't (AC mm) turns up at ten o'clock and goes home at eight o'clock (AC
 293 yeah and that's the end of it) that's it so yes in due course it might well be a logical
 294 extension like he has done if you're winding down (AC uhum) cus it's hassle free
 295 (AC uhum) in terms of the hassle we don't like which I've just said is staffing and
 296 buildings (AC mm) and arguing with the PCT about things (AC mm) but it's not
 297 satisfying care (AC mm) it's money over care (AC yeah right) what else would you

298 like? (AC yep) That's about it really I feel feel er relatively deskilled at things like
299 HRT and gynaecology coils contraception because I don't do it but I don't mind not
300 doing it (AC mm) I mean I can get by (AC mm) but it's because they go and see the
301 female doctors that's fine (AC mm) but I don't see that as a big problem you know
302 it's just

303
304 AC Is that self-selecting on the part of the patient?

305
306 SR Yeah they always they always I think most ladies would rather go and see a lady
307 (AC mm) with those sort of problems rather than a young man to be honest (AC
308 right) I mean I get plenty of old ladies who don't give a dam (AC uhum) but you
309 know the contraception coils caps I couldn't fit them anyway I have no interest in
310 fitting them it so it's not an issue (AC right)

311
312 AC OK Is there anything else that you would like to add things that you enjoy?

313
314 SR Err what in medicine? (AC mm) blimey I suppose other things that I enjoy used
315 to do minor ops because I've done my FRS so I've done my but I do less and less I
316 do enjoy them but to be honest it's time constraints (AC mm) it's fiscal I can get the
317 same amount of money for freezing a verruca as I can spending forty five minutes
318 taking a sebaceous cyst off a scalp (AC yeah yes) so you know what do you do we're
319 busy we've got time constraints I send the sebaceous cyst to the hospital to be done
320 (AC right) and I do the verruca (AC right) I think it's a combination of pragmatism
321 financial planning there's no point in taking a lost leader is there really in this world
322 but it's sad because I quite like doing it (AC mm) but you know we are like
323 anywhere CH takes up a lot of my time you know (AC mm) one of the reasons I had
324 to go upstairs is because I had to phone about two patients they wanted to ask about
325 so (AC right) so you do find time is contracting here we've got the new contracts I'm
326 sure they're the same down the road (AC oh yeah) we're all busy on computers when
327 we're not in surgery or we're not visiting we're looking at refining data (AC sure)
328 and so yeah but it's all part isn't it between trying to strike a balance between the
329 clinical side and the business and the running side (AC mm) and use the general
330 impression that I think we all have now is at the current rate of change is the business
331 side and the running side is becoming dominant (AC mm) which is fine in the short
332 term but I think if it continues at that change in ten years it'll be I feel personally
333 unattainable (AC mm) these things a lot of the stuff that we deal with are things like
334 data protection and health and safety (AC mm) freedom of information act these are
335 legal these are in statute you know you've got to comply you can be prosecuted (AC
336 yes) so you can stick your head in the sand a bit and say I'm not doing it but really
337 you can at the moment because nobody gives a dam (AC mm) but in time they might
338 start giving a dam and then they'll say where is your policy on fire risk or whatever
339 (AC mm) and if you haven't got it they'll say we'll prosecute you (AC mm) and of
340 course the moment that starts happening to small practices we're all in the same boat
341 (AC yes) we'll all stick our head in the sand and choose what we need to do and
342 what we are doing but it would just make it unattainable because already we are
343 struggling a bit with matching our our incomings and our staffing costs I mean the
344 PCT are awful they only reimburse at sixty per cent (AC mm) so we can't really
345 afford to take on any more staff to do these things (AC mm) the only sensible way is
346 to amalgamate (AC mm) you know I don't know whether you know I'm sure when
347 HP goes whenever he's going to go they wont replace H I'm sure they'll say to S and

348 A would you take on another partner please (AC mm) to take up his work load,
 349 there's no way they're going to say yes have another partner another practice
 350 manager another nurse you know (AC no) of course they wont they'll say no you
 351 have to absorb and the logical corollary of that is really is eventually for us all to mix
 352 but that takes a huge amount of money to deal with the infrastructure (AC mm)

353

354 AC It's an interesting vision though

355

356 SR Yes it's happening all over the place isn't it? It's happening in BP all the little
 357 practices are closing and they're building primary resource centres they can afford
 358 them they've got ten or fifteen small practices dotted all over the peninsular (AC
 359 mm) why've we got a branch surgery in T? Because it's historical (AC yes) they love
 360 it and it's nice it's a nice place to work (AC mm) but it's not economic you (AC mm)
 361 can't justify it now (AC mm) everybody's got cars they go to Asda to do their
 362 shopping (AC yes) so why can't they get in the car and go to and a fair portion I
 363 think only two thirds of the population are ours the rest are coming through to the
 364 health centre or they go to E practice so you know I don't think it would be easy
 365 because you'd take a lot of disparate doctors with a lot of different interests pulling
 366 in different directions different aspirations stick them under the same roof and say
 367 you know we're very happy clappy we'll all work together (AC laughs) I can see
 368 phenomenal problems (AC yes) but I think it's the logical way it will have to go and
 369 if it's not driven by central government I think it will be driven eventually by other
 370 pressures that have been brought to bear (AC mm mm) you know and I think
 371 administration is one of those pressures (AC mm) one of those things that you feel
 372 about hospital consultants I know they don't have an easy time but at least if their
 373 clinic nurse goes off sick it's not them that's on the phone trying to find out a nurse
 374 or their secretary's not there it's not them that's phoning the agency saying look we
 375 need a new secretary otherwise we can't pack your letters today (AC yes) it's human
 376 resources do it for them (AC mm) and I think as we get busier and the demands get
 377 heavier and the demographics are changing aren't they I mean we're no longer
 378 archetypal male full time GP I mean I don't know many GP's that who are looking
 379 for full time jobs anyway (AC no) and the vast majority are going to be female
 380 having children having long you know career breaks (AC uhum) coming back to half
 381 time erm and we're going to have to address these things (AC uhum) and the only
 382 way you're going to address them is not being able to offer the same continuous
 383 continuity of care which I don't think matters with our patients although some people
 384 talk about it it doesn't matter does it you've got computers (AC mm) most of us are
 385 not stupid and can make up the difference you can pick up the towel it's not that hard
 386 (AC mm) erm and centralise services (AC mm) and this I know will be the death of
 387 the little GP's surgery but we've had the death of the post office the death of the
 388 corner shop you know it all happens (AC mm) it's all change I'm not one that's
 389 going to mourn it particularly (AC right) you know I'm really not because I think
 390 you know a lot of us look at this and think we can't I mean I'm thirty nine and I'm
 391 not prepared to work like this juggling (AC mm) all these balls until I'm sixty five
 392 (AC right) just can't happen (AC mm) just can't and there are more and more in the
 393 air all the time (AC mm) sounds awful but I'm completely content I'm very happy
 394 you know (AC mm) you just look into the future and you think I don't know what to
 395 do here I can't juggle all these things (AC sure) because you're going to start
 396 dropping things before long I spend my life telling patients they're juggling too many
 397 balls that's why they're not sleeping that's why they're depressed that's why they're

398 stressed out and you think well (AC So are you laughs) Of course so you look for
399 going half time or you know do what S does and do some endoscopy it's just a break
400 isn't it? (AC it is yeah) and it's time out. (AC mm) When you talk to S he says you
401 know he comes back and it's chaos because he's been out that day (AC mm) and
402 everybody wants you and there are all these things to answer (AC mm) but
403 nevertheless it's time out (AC mm) so er so I think you know you look for your
404 change things will change it's not too bad I think the difficulty is trying to marry up
405 patients expectations who still believe don't they in the main doctor and that doctor
406 will do this to us who think quite differently I think the young generation of GPs
407 think very differently to the DE sort of and when he left we got quite a lot of patients
408 that moved because they live up this end of the village and things that was an
409 opportunity to move fiercely loyal (AC yes) fiercely loyal you know (AC yes) all the
410 patients and that which is great but we just don't you know we're pragmatic about it
411 (AC sure) you know I can do blood pressure but so can the nurse or the nurse
412 practitioner can manage blood pressure (AC uhum) it's really not that it can be tricky
413 (AC mm) but it's not impossible (AC mm) I know I have the big certificates on the
414 wall and that all about me but it really isn't that difficult (AC mm) you have to get
415 over that (AC mm) it's only a bit of a skill mix people are still entrenched in what
416 they want (AC mm) Now I've talked an awful lot

417

418 AC Is there anything else you want to say?

419

420 SR Er Not really what have other people said is it along the same lines or not (AC
421 ooh) completely varied

422

423 AC Yes yes wide variety

424

425 SR I mean your premise is nurse practitioner are you looking for me to comment on
426 nurse practitioners?

427

428 AC No no this is about you

429

430 SR That's alright I mean I'm quite happy to I haven't got a I think they're fine (AC
431 laughs) we've got one we don't use as a nurse practitioner unfortunately (AC mm)
432 because we've got a historical mess (AC mm) in our nursing levels which is not our
433 fault and it's the way it's gone but it's a problem (AC mm) we've got three highly
434 trained very experienced highly paid nurses doing bloods in the morning (AC mm)
435 completely ridiculous but we don't have the scope to change these things do we (AC
436 mm) I mean if we start changing are you going to look at redundancies or are you
437 going to look at you know er changing job descriptions downing hours you're then
438 getting into massive legal (AC mm) and you know er employment law issues that
439 none of us are prepared to get involved in to be quite honest (AC right) the practice
440 that might emerge out the other side is a better more appropriately mixed cus that's
441 what everybody seems to talk about skillmixed practice with less qualified people
442 doing bloods and cervical smears and ECGs for us and the nurses doing dressings
443 and diabetes and asthma which would be marvellous but we're a long way from that
444 and none of us frankly are going to start taking that on (AC no) so we don't need
445 three big nurses so hands up who wants to loose their job you basically have to wait
446 for time and time and time until there's natural shedding and we can change it round
447 and we'll do it (AC yes yes) but there's this great hurry all the time isn't there you

448 know to do it to do it to do it one of our nurses will retire this year almost certainly
449 (AC mm) cus she's end of her contract at sixty six this year and when the PCT comes
450 and says can we just look at your skill mix for you in terms of what you're doing we
451 say well we don't need what we actually need is not you to tell us we know what we
452 need if you tell us how to do it (AC yes) you know they'll stop at that stage and say
453 oh no we can't do that that's employment law and that and that and the other but
454 we'll tell you what you need and you think well you know sucking eggs I know what
455 I need I need a health care assistant to do my bloods in the morning (AC uhum)
456 perhaps do the usual stuff perhaps not smears but whatever simple things B12
457 injections and you know immunisations and I need the health visitors taking
458 immunisations childhood immunisations because why are our nurses giving
459 childhood immunisations? (AC mm) Because it's historical it's the way it's done
460 (AC yeah yes) I don't need to be told this I need someone to go and do it someone to
461 go to (AC yes) the people that employ the health visitors and say your job is now to
462 give immunisations on these children (AC mm) but I don't care I really don't that's
463 fine I mean it works it works and we will fix it (AC yes) bit by bit by bit (AC over
464 time) when the opportunity arises (AC sure) you know none of us are going to start
465 you know thinking right we need to give it a great big shake and sort this out (AC
466 mm) because you don't (AC mm) or if you do you get a disaster we've tried it in the
467 past you end up with great dissatisfaction people are very unhappy they feel they are
468 not consulted and you wish you'd never started (AC mm) So so no so you know my
469 only sentiment is really and I think we all feel that and I'm sure you get the same you
470 just get this balance is wrong at the moment and it's just not but I'm sure you get that
471 from everybody (AC uhum). We're spending far too much time worrying about the
472 mechanics of running a busy GP practice and looking after these people and making
473 sure that we get paid for the item of service on time (AC mm) and that the contract is
474 sorted and that the building is sound and that we comply with this that and the other
475 regulation which I've got we should comply with them (AC mm) but you have to
476 learn three and three quarters of those lessons doing it (AC mm) with a large clinical
477 commitment most of us have got very heavy commitments outside the surgery you
478 know (AC mm) I get home and it's bath time it's a zoo (AC laughs) but you know I
479 don't take work home I never take work I have a rule I never take work nothing
480 fortunately we're computer based so I have a very good you know excuse never to
481 take work home (AC yes) because you can't take the computers home without the
482 computers you're lost (AC mm) you can't do anything kind of clinical or anything
483 but I never do I never take work home (AC mm) er I don't take it to the co-op
484 because I just find it annoying dragging bags of notes around the co-op but then
485 there's a lot of pressure on the day (AC mm) and the things that cause stress and
486 we've a fantastic practice manager (AC mm) I know you haven't got one at the
487 moment (AC no) god knows what you do without one in this day and age I'm sure
488 you'll get one you'll sort it out (AC Yes she's coming in a few weeks time) but it's
489 very difficult running a practice without someone like S (AC yeah) who's getting all
490 this stuff because the Health Authority send the emails firstly I never read them
491 because I just don't have time because I have enough emails about you know
492 practice notes (AC mm) and results coming down the screen Health Authority
493 writing to me saying you haven't filled in your tool kit for fire prevention well that
494 just gets stuffed doesn't it it just goes it just doesn't matter (AC mm) partly typical
495 because you know they never ask again ? I'm happy they're happy everybody's
496 happy (AC laughs) but what you do without a good practice manager heaven knows
497 (AC Oh yeah) she's very good she seems to enjoy it (AC mm) but there's a lot of

498 stress (AC It's a critical role isn't it?) absolutely and again almost too critical (AC
499 mm) because we're great but if you haven't got one (AC mm) I don't know what you
500 do (AC mm) I really feel actually if you don't have a good practice manager who's
501 got a good handle on all this legislation and where we're going you might as well
502 pack up and go home (AC mm) to be quite honest because the provision of the
503 medical care is just useless in the background of that (AC mm). I know the new
504 contract is supposed to address this and is supposed to be less item of service and all
505 the rest of it (AC mm) but still a considerable amount of stuff has to be done (AC
506 yes) you know it's going to get rid of some of it maternity and contraception
507 temporary residents and but you're still going to have to do your smears I suppose
508 that's not a big one immunisations (AC mm) there's a lot of other data that's
509 collected (AC mm) hopefully it will be collected by the computer so it's less
510 paperwork (AC mm) but I don't think any of us feel it's going to make a huge hole in
511 the paperwork we have (AC no) but the practice manager is the person who matters
512 if she went and we couldn't replace her with a good one who knew what was going
513 on in a practice of nearly six thousand whatever two hundred patients (AC mm) now
514 you'd be lost really (AC mm) you might as well pack up I'd probably go back to
515 being a locum to be quite honest if you couldn't replace her because the stresses
516 would just be phenomenal (AC mm) you'd have staffing issues paying the staff I
517 don't know how to pay the staff (AC right) I've got no idea how you pay the staff
518 (AC yes) I'd probably employ an accountant to do it for you (AC mm) but then that's
519 more cost isn't it? (AC mm) And the boat starts to get a bit waky shaky if you're
520 paying an account they charge for the annual accounts paying an accountant to do
521 your staffing costs (AC mm) so when I locumed I didn't have anything like I have
522 now but it was easy (AC yes) you turn up with your bag at nine o'clock (AC yes) see
523 the patients have your sandwiches and read a book in a nice car park with a decent
524 view (AC laughs) go back for half past two go home at five not very satisfying I did
525 it for two and a bit years and I was happy to get out (AC right aha) it just wasn't
526 satisfying earned me money and all the rest of it but sometimes you know not often
527 you think it's so easy (AC mm) they give you a cheque at the end of the week (AC
528 mm yes) you do your tax return is pretty straight forward it is very it's a nice way of
529 working (AC There's a balance) there is my wife's got she's a retainer at a practice
530 in E (AC mm) so she turns up which is great she does her surgery she goes home she
531 gets paid not brilliantly but we're not that bothered keeps her interested keeps her
532 knowledge up (AC right) she does one morning she does a morning and a full day
533 (AC aha) because I have Thursday off so she works she works Thursday so I have to
534 get the children and look after them (AC right) and er she likes it but she doesn't get
535 involved in admin she doesn't get involved in the practice she does it she's been
536 there long enough now to have patients that come back to her so she's happy (AC
537 mm) it's great but it's not you can't run archetypal NHS general practice on the likes
538 of that (AC no) someone's got to run the building (AC mm) you know she loves it
539 but she doesn't understand why I get short fused sometimes because we have all
540 sorts of hassle and I say yeah the patients don't hassle me (AC mm) I've been here
541 three and a bit years now (AC mm) I know what they come through the door with
542 they're coming for ? because I'm not I'm not like that either oh it's her again get out
543 in ten minutes (AC right) you know although it's quick it's the other hassles (AC
544 yeah) does that sound really depressing? (AC laughs no it doesn't) I don't think it
545 should be because it's not it's not it's pragmatic isn't it? You just can't do everything
546 anymore (AC sure) and now that we've got our touch wood we've got a very good
547 practice manager we've got really nice staff we're quite stable from that point of

548 view (AC mm) we have a dispensary the staff are great and they run a really nice
 549 show (AC mm) we're lucky same bunch as you've got we've basically got nice
 550 patients easy to deal with very appreciative a cross word is unusual and usually
 551 provokes a letter from one of us saying don't be cross again you know we're not
 552 wallowing in deprivation and (AC no) and drugs and alcohol (AC mm) we're not
 553 we're really not you know so yeah we're very fortunate (AC mm) our life is easy but
 554 from another point of view it is difficult (AC yeah). A lot of GPs who have nurse
 555 practitioners say well they're pretty much doing what I do to some extent aren't they
 556 I mean they work to more protocols but they're pretty loose these days (AC uhum)
 557 and the prescribing is limited but it's probably going to get more and more isn't it?
 558 (AC mm) but without all the hassle (AC yes) you know it's a bit like what my wife
 559 does she does a retainer (AC yes yes) and if you don't like what you're doing and
 560 you're not sure you refer up (AC mm) you know we've tried this a bit giving some of
 561 our nurses AO obviously nurse practitioner is very good (AC mm) so you ask them
 562 to see someone with a cut head they're coming down could you see it for me you are
 563 invariably asked to see it (AC right) you know because they are not confident or they
 564 don't want to take on that responsibility (AC yes) it's a cut head it's not rocket
 565 science this you know most mums will deal with a cut head but it's a mind set (AC
 566 yes) you know I don't have to take responsibility for this so why should I? (AC mm)
 567 I look at it and straight away say that's fine strip it put a bandage on it whatever and I
 568 think that to some extent it's not resentment I don't think but it could be irksome you
 569 think well that's dealable by a first aider (AC mm) you know why can't you deal
 570 with it? (AC mm) So you know you try to mix your use of individuals is quite hard
 571 (AC mm) AO is our practice nurse practitioner we try to give her things but actually
 572 the girls at the desk are so confused by which is what it's easier to give it to us to be
 573 quite honest

574

575 *Phone rings – short conversation*

576

577 SR Sorry (AC That's OK) er that's it really I think I'm on the whole quite relaxed
 578 pragmatic person (AC right) I'm here primarily to earn money (AC uhum) cus er you
 579 know being realistic. I've been here long enough to define who I am and what I am
 580 from the patient's respect which makes my life so much easier (AC right) you know I
 581 hear people hear them muttering in the corridors he's a git (AC laughs) but that's fine
 582 you know because maybe I am a git but then that's fine because I'm probably not
 583 going to address what they want me to address (AC sure) what I will try to address
 584 what I want to address because I think that's the right thing to do and that hasn't
 585 worked when they don't want it (AC yes) but certainly I've got well beyond the stage
 586 of getting vaguely concerned if someone doesn't like me or doesn't want to come
 587 and see me that's absolutely fine but it's a top tip because GG would be mortified if
 588 she heard someone was saying that about her (AC yes) really mortified how could
 589 they possibly and some of our staff get very upset when they hear people chuntering
 590 oh I don't like that receptionist she's really brusque and they go 'ooh' it's easy for
 591 me to say get it all the time it's just water off a duck's back (AC yes right) you know
 592 you get it in the partners I'm not seeing so and so again he was awful and I say fine I
 593 like him I work with him (AC mm) see what happened so I think that's where I'm
 594 coming from (AC right) but also you know like all of us we've got a five year plan
 595 here (AC aha) and you're looking to the future and thinking well this is fine at the
 596 moment (AC aha) we've got a new contract it's quite interesting (AC aha) it's got
 597 some potential but it's got some time to run and things have to I think things have got

598 to change a bit (AC mm) in a nice way otherwise we'll vote a bit with our feet if it
599 doesn't if it's getting worse then well my wife's a GP I could job share with her in
600 five years time (AC mm) there are all sorts of options aren't there (AC mm) you just
601 don't know what's going to happen really (AC no) but basically I enjoy it (AC yes)
602 better than hospital medicine which I did for quite a long time (AC right) but I like it
603 because it gives me more independence than hospital medicine (AC OK) I'm a very
604 independent person (AC yes) I like trotting around on my own (AC yes) doing all
605 sorts of things (AC yes) and I'm competent in my own abilities and confident in my
606 self belief if it doesn't work I move on (AC right) you know but it works (AC mm)
607 blimey (AC excellent) both laugh
608
609 AC Thank you very much

Transcript Summary

Interview 9 GP

This transcript suggests that SR enjoys pragmatic archetypal medicine like heart disease, prostate disease and lung disease^{9,63}. He enjoys working with patients who have problems that can be clearly defined and have clear objective outcomes¹⁵. He enjoys the proactive work of primary and secondary prevention. He likes looking after patients⁶ and making them better²⁹ and particularly likes to work with those who follow through the treatment plan and return for review⁸⁶. He likes to see what has been achieved by his interventions⁹¹.

SR doesn't like to work with people that he describes as 'black holes' the people with social, psychological and financial concerns⁹³. He doesn't attract many patients who have soft psychological problems¹⁰ such as anxiety and depression. He dislikes working with people who have long-term headaches and seem not to be improving despite treatment, particularly those who do not want to address their illness behaviour⁹⁰. SR enjoys doing minor surgery³¹³. He likes to be very clear where he can help and where he cannot help¹³⁶. He likes to be transparent, pragmatic and uniform¹⁶².

SR finds working with patients who are terminally ill satisfying particularly when things go well^{174,175}. It is satisfying to work with patients from diagnosis through surgery to the terminal stages of their disease and for them to die peacefully at home^{183,186}. He gets frustrated when patients have to be admitted to the hospice due to a lack of support locally¹⁷⁶. He is keen to hang on to his palliative care skills particularly as he needs them when working at night for the out of hours service¹⁸⁸. He regularly delegates work to the district nurses and McMillan nurses^{157,196}.

SR enjoys driving the finances of the practice²⁵ although he dislikes staffing issues^{26,34,512} and being responsible for the buildings^{28,34}. He feels that the bureaucracy^{36,39,42} and administrative side³⁶⁹ of practice management is a distraction from the rest of the work. He deals with practice notes and e-mails before dealing with messages from the health authority⁴⁸⁸. He feels the business side is becoming dominant and is unsustainable in the long run³²⁸. He sees running the practice as a barometer of success²¹⁰, hitting targets²¹¹ and receiving the financial reward for achieving these goals²¹². He feels too much time is spent worrying about the mechanics of running general practice⁴⁶⁸ and highly values the role of the practice manager^{482,493,496}.

SR enjoys working in general practice, he feels it gives him more independence⁵⁹⁶ than was possible in secondary care⁵⁹⁸. Patients are not a bother to him⁵³⁶. He likes the diversity in practice⁶² and enjoys being a generalist⁶⁰ but also sees value in better skill mix⁴⁸ allowing for expertise in specialist areas⁵⁶. He sees value in purpose built amalgamated practices with resident experts and less referral to secondary care⁴⁹. He feels continuity of care does not matter much for patients³⁸⁰.

SR's reason for being in general practice is to earn money^{4,250}, he is happy to embrace change and see general practice move on⁴¹³. He doesn't find working for the co-op satisfying^{272,286}, he feels it creates a different relationship with patients²⁷⁹. He also found locum work easy but not particularly satisfying⁴¹⁹. He feels skill mix can help

to address work load issues⁴¹². He prefers to avoid taking on the staff to look at skill mix and would rather let staffing issues take their natural course rather than get embroiled in employment legal battles⁴³⁵.

(The small numbers refer to the line of the transcript where the idea can be found)

February 16th 2004

Interview 10 DN

1 AC Where I'd like to start is to ask you erm what you find most meaningful in your
2 role. So it's a very broad question and it's quite unstructured this interview.

3
4 KL Well what do you see as meaningful I mean what might mean something to me
5 might not mean the same to you. You may not get the answer you want.

6
7 AC It's what it means to you it doesn't matter what it means to me so.

8
9 KL My role (AC yes) as a district nursing sister? (AC uhum) Well it's important
10 important to me (laughs) because if I don't get it right then I've I think I have no job
11 but erm I'm trying to think. Well I do view myself as a manager a leader and an
12 organiser of case load and staff (AC right) and supporting staff to do their job erm
13 don't know really I suppose it's a bit difficult I've never been faced with having to
14 analyse it (AC mm) Erm well I regard myself yes as a qualified nurse who has the
15 knowledge and experience of many years erm and it means that I can go into
16 situations I can assess observe and implement care as I feel appropriate erm is that
17 what you were thinking?

18
19 AC Mm yeah yeah do carry on

20
21 KL Erm you might have to lead me because I really don't know what it is and I don't
22 want to go off on a tangent

23
24 AC That's alright

25
26 KL Erm I see myself as an educator not just for student nurses and specialist
27 practitioners but to educate the carers and the public. I have very strong feelings
28 about not taking control of a situation even though I want to be in control (AC mm) I
29 want to be in control of my case load and how can I put it erm I want to be in control
30 of it but I don't want to go into people's houses and control them I want to create or
31 facilitate a situation where they can be in control but yet I can still do my work (AC
32 mm) is that making sense (AC mm) to you? (AC mm absolutely yes) and I must tell
33 you whether this is important or not but it's important to me I do not like work I do
34 not like work but I have never yet found a way that I could avoid working (AC right)
35 in order to live (AC aha) now the idea is I've found something that I'm very happy
36 and comfortable to do and feel very confident and probably the confidence has come
37 over the years (AC mm) so I do this erm work this nursing and I do it so that I can
38 feel comfortable and I can be yes I can be in control and can minimise the stress
39 levels that such an occupation can create and I want others to work like that with me
40 (AC mm) so in short people who often come here as relief nurses are very happy to
41 come here actually it sounds as though I'm blowing my own trumpet doesn't it? But
42 they are happy to come here because they say to the management you know the
43 higher management it's very well organised (AC mm) and it's well organised for a
44 reason (AC mm) because I'm not having any stress and no matter what comes any
45 petty situation erm it's got to be ironed out (AC mm) and it's not to fester (AC mm)
46 and you could say perhaps you consider me a control freak but I'm not in that sense
47 (AC aha) yes I do like to be in charge of the situation (AC mm) but I also like to
48 create a situation whereby people are comfortable and don't suffer stress

49

50 AC And when you say

51

52 KL You know people say things like 'oh we're very busy we're very busy' now
53 Alison when I look at what other people have to do (AC aha) I think god they're
54 making it difficult for themselves (AC mm) they're creating that busy state (AC mm)
55 and that will create stress and then you're no good to anyone you're no good to
56 yourself to your family to your patients your staff so that's that's really the
57 philosophy behind it

58

59 AC Right can you explain a little bit more about that erm

60

61 KL What do you want me to explain?

62

63 AC When you've talked about er control there I'm getting the feeling that you're
64 talking about control at an organisational level with the rest of your staff and perhaps
65 also control in terms of individual patients (KL uhum) and how you organise their
66 care (KL mm mm) so can you just explain a bit more about how you go about doing
67 that and what your approach is

68

69 KL I think it's going to be very difficult to explain because I think it now comes back
70 to your main theme about the values and what people expect (AC uhum) erm if I go
71 into a situation say for example let me think erm yes a patient was discharged from
72 hospital this week and social services rang me the week before 'what can the nursing
73 staff do?' this patient has a colostomy. The nursing staff erm my idea this is not me
74 I'm quoting the social worker 'I think that the nurses could go in erm daily or twice a
75 day to change the colostomy bag' I said 'now just a moment' I said 'no' I said 'we're
76 not prepared to do that' I said in fact what we are focussing on is educating and
77 creating some independence for these people 'oh right but you wont go in every' I
78 said 'we will probably go in every day for the first few days until such a time as one
79 of the carers or the family member is able to manage the stoma (AC mm) but we will
80 be focusing on education (AC mm) and support to that aim' 'so it wont be every
81 day?' I said 'it will not be every day for ever more' I said 'it will be every day for a
82 few days.' Now they obviously expected something different (AC mm) but they
83 weren't getting what they expected they were getting what I was prepared to give
84 them (AC mm) and we've been in and we've done that but unfortunately everything
85 fell down and the patient had to be readmitted (AC mm) it wasn't anything at all to
86 do with stoma care or management because we did exactly what we said we would
87 do and the patient's next of kin was very competent within three days to change and
88 care for the stoma (AC mm interesting) now does that answer the question?

89

90 AC Yes that's a very good example yes and you started off at the beginning of the
91 interview talking about your role as a leader as well (KL mm) er and then you talked
92 a little bit about control at that level so can you give an example of how that works or
93 explain that a bit further?

94

95 KL As a leader? (AC mm) Well I see I know myself, I know that I, this is terrible
96 you know because I've never had to discuss this really in great depth, or thought
97 about, I know myself I know my limitations and I know what I can do erm so I I sort
98 of erm lead the staff in as much that really by example perhaps by role model

99 whatever you perceive example role model erm and also I feel it's important when
 100 we say lead encourage them if they wish to develop further training and learn further
 101 skills I feel that's important to lead them to that (AC mm) now when it goes, now
 102 you're going to have to answer my question because I don't know what you mean by
 103 control at this level apart from the fact that I am there leading them setting examples
 104 hoping that they will follow hoping that they will trust me and rely upon me (AC
 105 mm) but having said that rely upon me not for to be dependent upon me (AC mm) I
 106 do believe in empowering them I do realise if you empower someone you cannot
 107 undo it (AC right) so it's a very fine art isn't it (AC mm) allowing them the freedom
 108 and to use their initiative and decide (AC mm) what they want to do and how they
 109 want to do it

110
 111 AC Mm mm interesting right so erm you've talked there about your philosophy
 112 really your approach (KL mm) erm in a sort of very global way which is brilliant it
 113 really sets the scene (KL does it?) It does yes it's excellent so out of all of that and
 114 out of the range of things that you do is there anything that you would say you find
 115 particularly meaningful or particularly satisfying or that you enjoy about your work?
 116

117 KL There is nothing that is very wonderful in that I get great satisfaction from this
 118 work because as I said earlier (AC mm) I do not like work (AC mm) the only
 119 satisfaction and something that's meaningful is if something comes along that is
 120 quite complex I like that very same day before I go home to get it sorted (AC right) I
 121 must have it sorted in my mind I must go home at five o'clock knowing that
 122 everything is in its place (AC mm) and it's ready for tomorrow even if there's a halt
 123 if you can understand what I mean if there's a halt in what I've been faced with it'll
 124 be carried over to the following day but it will be carried over and make it go to the
 125 following day in an organised way (AC mm) so that it is not stressful (AC mm)

126
 127 AC Right so you enjoy that challenge that complexity
 128

129 KL Well yes but I wouldn't say Alison that oh this means something to me I do not
 130 see myself as the answer as a Florence Nightingale I do not because I don't like this
 131 image of nurses as angels (AC mm) because come five o'clock I'm not interested
 132 anymore (AC mm) I don't care anymore (AC mm) I'm paid to care and my own
 133 individual code of practice code of conduct call it whatever you will I will I consider
 134 myself (laughs) I consider myself genuine and sincere and if I say I'm doing
 135 something I'll do something so consequently my own personality my own sort of
 136 erm code of practice will not allow me to erm deviate from that (AC mm) if I'm paid
 137 to do a job I will do it (AC mm) till five o'clock or whatever (AC mm) and then it's
 138 home time yes I have worked over when things have come along (AC uhum) and
 139 I've thought I'm not leaving that till tomorrow well I'll come now and sort it out (AC
 140 mm) but I do not think I am the answer to nursing (AC no) I do not think I'm
 141 indispensable (AC mm) I mean graveyards are full of indispensable people aren't
 142 they (AC mm) but I've never been one of those who I just wonder now because as I
 143 hear myself and as you listen to me I wonder if perhaps I come over as a very smug
 144 individual but I'm not I am content within myself (AC mm) and there's nothing in
 145 this job that will give me how can I explain? I'm not living for this job (AC right
 146 mm) I'm working doing my best because of my own personal code of practice
 147 conduct or whatever contract and then of course I'm contracted by the NHS to do it
 148 so I'll do it to the best of my ability (AC mm) but it does not erm I'll just give you an

149 example I don't know whether this is what you want to hear but I'm going to tell
 150 you. Sometimes you go to people's houses and they'll say to me 'oh Sister H you're
 151 so kind' now I know I'm not kind (AC mm) I'm not a kind person or 'you are very
 152 sweet' I know I'm not sweet I know my personality (AC right) does not come over
 153 as sweet and I say to them but I'm paid to do this 'ah but there are ways' now
 154 possibly there are different approaches and manners and attitudes but I know I'm not
 155 kind (AC mm) and I don't like people to be dependent upon me (AC mm) and I'm
 156 pretty well aware when I'm being manipulated

157
 158 AC Right when you're being manipulated by patients

159
 160 KL Patients yes (AC OK) I think it's probably a bit more difficult it doesn't come
 161 quite so easily if it's staff who are trying to manipulate me (AC right) but eventually
 162 it twigs and I think 'aha'

163
 164 AC Can you give an example of that?

165
 166 KL (pause) I can't really but I'll have to think very hard there have been occasions
 167 manipulated when it comes to sort of like erm off duty and erm it's a long long time
 168 it was when I was in hospital that I probably have to go back that far about being
 169 manipulated by staff in as much that they are saying things nice things to you and
 170 you know I you know it's very good to work with you and this that and the other
 171 'can I have this day off' a bit of flattery to get something they want (AC right) it
 172 doesn't happen very much here (AC yes) because there's not many people there's
 173 only me and one qualified nurse and erm part time community support nurse (AC
 174 mm) so if they are trying it on I'm probably a bit slow (AC right) to pick it up with
 175 staff but having said that I don't think it's happened here I can't think of an example
 176 I can only think of when I was in hospital (AC mm) and management tried to
 177 manipulate you as well you know to do something that they know you're not very for
 178 example erm I can only think of when I was a ward sister and they had a policy of
 179 putting up extra beds and taking on as many admissions as they could and I would
 180 protest against this because I thought health and safety you couldn't possibly nurse
 181 people safely and comfortably in the confined spaces and then there was 'well we'll
 182 give you more nurses we'll give you more nurses' fine but when I wanted more
 183 nurses when the ward was at you know easily erm spaced and you could get to
 184 people, couldn't get them to suit their needs their political needs then they would get
 185 me more nurses (AC right) and that's what I would I perceive a manipulative act (AC
 186 right right)

187
 188 AC And you feel sometimes that happens with patients as well

189
 190 KL Oh yes patients can do that you know. 'Well the hospital said that you would
 191 come along and you would do this and you would do that' well you know the
 192 hospital have a different view point from what I have but I'll come along and have a
 193 look there's no guarantee that I'll do it (AC mm right) and then you know they try I
 194 suppose manipulation might be the wrong word but they try very hard to get what
 195 they think they should have and they're very surprised to find that they can't get it
 196 (AC mm) for example erm hospitals will refer patients for installation of erm eye
 197 drops well I wont put eye drops in (AC mm) I'll go and assess first visit (AC mm)
 198 see what they can do and we have some eye drop appliances and I'll teach them

199 because I reckon if they can fasten little buttons on a shirt or a blouse use a knife and
200 fork they can surely put some eye drops in with some education and support to that
201 aim. It might mean that we go three times but eventually we wont be going at all (AC
202 mm) however, you try to introduce that erm and people are not wanting that because
203 they're wanting the nurse to visit (AC mm) complain to your managers now if your
204 managers are strong enough you're fine but if they can't deal with a complaint (AC
205 mm) then you have to go back in and do it (AC mm) at the whim of the patient (AC
206 right) now I think I don't know whether that's what you want to hear or not but I
207 don't like (AC mm) that if er management are and my experience of nurse managers
208 is not very good really (AC mm) I have experienced bullying
209

210 AC Right in fact there was a quit a national case here wasn't there? (KL Yes there
211 was) some years back yeah (KL mm mm) Right
212

213 KL And I experienced it in the year 2000 when I went to W I applied for erm a
214 nursing co-ordinators post which was H grade which was a form of management and
215 I had my own ideas how I wanted to do things and I was quite prepared to discuss
216 with managers above me how I wanted to do things but they weren't particularly
217 interested in me and they would have meetings and exclude me (AC mm) so much so
218 that my manager was across the corridor and she would erm have a meeting with the
219 administrative staff have a meeting with the health visiting co-ordinator and shut me
220 out (AC mm) well to me that is bullying as well you don't have to be physically
221 abusing or verbally abusing someone but to exclude them is a form of bullying (AC
222 mm) so I was unhappy and I came back here (AC right) the staff in W as far as I
223 know were quite happy with what I was doing (AC mm) people like myself were
224 happy (AC mm) with what I was trying to do (AC right) but the management weren't
225

226 AC Mm so you felt strongly enough about that to move back here
227

228 KL Yes I did (AC mm right) because they don't want people like me (AC mm).
229 That's how I saw it (AC mm) because possibly they would regard a personality like
230 me as confrontational now I don't think I am but if there's anything if there's a grey
231 area and some doubt over anything I can't pussy foot around it Alison (AC right aha)
232 oh no it's got to be in the open there are ways and means of bringing it out into the
233 open (AC mm) for example we've had erm in the past incidents of abuse erm and a
234 family once told me that they'd witnessed the son had witnessed the father hitting the
235 mother who was senile she was dementing (AC right) and I went and this might help
236 you I don't know whether it will but I'll give it to you erm I was already involved
237 with this family and I went in one day and the husband wasn't wasn't looking very
238 pleased and I'd been told about this incident the GP had been told about this incident
239 and he said 'oh well we'll just you know we'll just sort of watch it don't think it's
240 anything to worry about' well quite frankly it is and it can be (AC mm) if it's ignored
241 (AC mm) and erm I went into the situation I was doing what was I doing oh it was in
242 the days when we were bathing (AC right uhum) that's a sore point but anyway
243 that's beside the point for the minute yes I was in bathing this lady and erm her
244 husband wasn't very happy this day and I asked him you know what's the matter
245 you look down 'oh it's hard work and all this carry on' now we did have social
246 services involved so I said to him 'is it really frustrating for you' 'oh it bloody you
247 know bloody well is bloody well been up all night with her' I said 'have you ever felt
248 that you wanted to hit her?' I just came out with it (AC right) so he burst into tears

249 (AC mm) I said 'have you hit her?' he confessed he had I said well now we can do
 250 something about it (AC mm) I said I'll tell social services 'oh I don't want' I said I'll
 251 tell social services and then we can increase some care (AC mm) and that's what I do
 252 (AC mm) I went sort of whether it's acceptable or not I don't know (AC mm) but it
 253 never happened again and they got more care in the home (AC right) now yes I
 254 suppose you could say that's meaningful (AC mm) I'd done my job (AC mm)

255

256 AC Would you does that give you a sense of satisfaction at all?

257

258 KL Mm mm yes I'm satisfied I've done it (AC mm) but I'm not how can I put it
 259 Alison doesn't I'm not sort of 'oh god I've done a wonderful job' (AC no no) I just
 260 know I've done my job (AC mm) I've done what I believe is acceptable to these
 261 people and what society would perhaps expect from a person like me they wouldn't
 262 want a person like a nurse to ignore things would they (AC that's right) or would
 263 they? (AC well) you see

264

265 AC Yes it depends who they are (KL mm) doesn't it? (KL yeah) To look at this from
 266 a slightly different angle is there anything that erm you do in your day to day work
 267 that you would say frustrates you or

268

269 KL Yes there are things I'll tell you what frustrates me and you might laugh if the
 270 telephone erm is out of order which it was the other week I can't stand that (AC mm)
 271 if we're sitting at the computers and you know doing our erm journals and what have
 272 you and the IT you now put such emphasis on how important it is as part of our
 273 record keeping and the damn thing crashes now that frustrates me (AC mm) yes it
 274 does

275

276 AC Yes I could imagine (both laugh) right

277

278 KL Can you why do you say that?

279

280 AC Oh because I've had the same experience

281

282 KL That's the only thing that frustrates me erm perhaps I can't think of anything
 283 even if we go to someone's house and they're not in then I won't get myself worked
 284 up over it I think oh well I'll just leave them my card and that's it it's in their hands
 285 now

286

287 AC Mm right what about in the sort of day to day things that you do with patients is
 288 there anything in that that you know you would say you enjoy or find frustrating?

289

290 KL Not really I don't think there's anything that I'm unhappy about or frustrated
 291 about with patients (AC uhum) sometimes perhaps if people go on and on about
 292 things but then I make allowances I mean when I'm in that situation they might tell
 293 me three times what they've told me before but I just take it as part of the job (AC
 294 mm) you're going to hear it again before you go home so so what? (AC uhum) I
 295 don't profess to be an angel love I just and pardon me for calling you that because
 296 somebody said to me the other day they don't like to be called love (both laugh) so I
 297 don't know whether that's what you want to hear

298

299 AC Yep all of that has been very useful what you've said so far it's been terrific
300
301 KL Well if I think about it if I reflect upon it Alison I think it's a bit sort of self
302 focused isn't it and you might wonder why but I can give you an answer (AC OK)
303 for many many years it's only since ninety eight that we've actually merged P
304 merged with WL (AC right) prior to that I was working on my own as a district
305 nursing sister and midwife so it would all be focussed on self
306
307 AC Right what here on your own?
308
309 KL Not in this building in my house it was then the nurse's house
310
311 AC Right I see so you'd be quite used to working (KL on my own) as an individual
312
313 KL But I can work within a team now I think I'm a fairly good team member but I
314 don't know what my staff would think (AC mm) I think they're happy you'd have to
315 see if you wanted to explore that but erm and then living in a place like this. Now I'll
316 tell you something yes yes it is self focussed there's no doubt about it erm I find this
317 community very small community and I put it on a par with Alabama Mississippi
318 (AC right) that type of attitude those type of bias and prejudice comes through as far
319 as I'm concerned (AC mm) because I'm not from here so I've had difficulties over
320 the years because I'm not from here
321
322 AC You're an off comer right?
323
324 KL Call me what you will but I'm not from here and quite frankly I have no regrets
325 (AC mm right) quite happy to have come from where I have
326
327 AC Right so erm when you say Mississippi Alabama you're meaning like the racial
328 prejudice that they have there
329
330 KL Mmm because my partner erm he died ten years ago he was a foreigner a
331 European foreigner and my friend now is a European foreigner but we've had some
332 verbal attacks
333
334 AC Mm from people in this community
335
336 KL Local youths. Because it all started and it has played a big part in my life I can't
337 deny it though I try and not to think about it a great deal. There's a play field there
338 and goal posts nearly thirty yards from our sitting room so you can imagine what
339 would happen with footballs et cetera and erm a few years ago my dog my border
340 collie had to be put down and I had a new dog (AC mm) a german shepherd cross
341 (AC right) she wasn't quite like the border collie and I've had lots of trouble so that
342 sticks, a myth has fast become a reality about my dog and myself (AC mm) so I have
343 to come to terms with that this is how they feel about me. I have been told by
344 someone locally that I'm not right in the head I'm mental and my my reaction was
345 that is your opinion and I walked away (AC mm) and I find I've just got to ignore
346 these things and get on with it
347
348 AC Mm does that have an impact on your your work as a district nurse?

349

350 KL Erm one particular family I've been advised never ever to go in to by a solicitor
351 because whatever I do I put my work my career whatever you perceive it to be in
352 jeopardy could do (AC mm) it perhaps would never be right so management knew
353 about it and it was arranged if I had to go in another nurse from another area would
354 have to go in and I would have to go to her or his area (AC right) which I would
355 quite willingly do (AC right mm) I can cope I can rise above things

356

357 AC Mmm but it sounds like it's hard

358

359 KL It is hard sometimes (AC yeah) it's not easy to do. I once parked my car in a
360 place I thought I was quite in a sensible place but apparently I'd parked it at an angle
361 in front of a building near the horse market down there and there was a garage here.
362 Well I didn't realise that obviously erm the garage doors I was I thought I wasn't
363 blocking it but however I was and I was visiting a patient and a woman who owned a
364 pub just round by the horse market there well on the main market street came to the
365 patient's house banging on the door and I'd actually finished and I was going out and
366 she shouted at me she said 'a woman like you should not do a thing like this we
367 would expect more from you you know' I never answered back and there was a milk
368 van and a milk boy driver you know erm two men who had a garage were looking
369 and a group of about half a dozen people and she was shouting (AC mm) I was
370 obviously on duty in uniform but I didn't react I just got in my car (AC mm) and
371 moved it and went away (AC right) and then as I was going away she was shouting
372 'you're bloody ignorant' (AC mm) I thought you can't do anything with people like
373 that (AC mm) just get away (AC mm)

374

375 AC This is a small enough community for that sort of incident to

376

377 KL Now maybe this is not what you are you are wanting but this is what some of
378 these people expect locally (AC uhum) and I know that erm I can't give them what
379 they want. Sometimes I give them what they need but erm I've been classed as aloof
380 and difficult (AC mm) but

381

382 AC But you cope with it

383

384 KL I do I have to do I put it down well this is the way I am and I'm just different and
385 as long as I don't harm anyone and do my job to the best of my ability so what's the
386 problem? You know when I've finished work I enjoy my own life quietly I don't go
387 interfering with anyone (AC mm) unless I'm asked to (AC mm) don't go knocking
388 on the doors and saying 'how are you?' you know that's probably a big fault I don't
389 know but erm it's been interesting I'm not sorry I came here and I'm not sorry I do
390 the work I do. It can be very lonely sometimes (AC mm) like I'm on duty this
391 weekend (AC mm) erm but I'll manage I know I will erm but there'll be no nurse to
392 talk with if there's a little problem or a little concern I'll just have to go through with
393 it

394

395 AC Deal with it yourself (KL yep) yes

396

397 KL Mm self manage self reliant really (AC mm) but not to the degree where I would
398 exclude others (AC mm) you must appreciate that (AC mm)

399

400 AC Yes (pause) is there anything more you'd like to say about that?

401

402 KL I don't think so because as I listen to myself I really think as I said earlier I think
403 it's focusing on myself and I don't know whether it's what you want

404

405 AC That's what this is all about it's about you and how you feel about your work

406

407 KL Well I'm happy to do it and I'm happy to be paid at the end of the month? (AC
408 yes) But yes I do I do respect people and I er and that's another thing you see talking
409 about respect you go into other people's houses and I have a habit of addressing
410 people as Mister Miss or Mrs 'call me Jenny' well yes I will call you Jenny but you
411 know I may slip back to Mrs Thomas because it's habit (AC mm) and there are even
412 people younger than myself I address as Mr and Mrs there are people who live next
413 door to where I live and erm a young couple I don't know them very well and I said
414 to them one Smith Smith he's called talk about building a wall because I wanted to
415 keep my dog you know within safe confines (AC mm) and erm I said to him one day
416 'Excuse me Mr Smith I'm thinking of building a wall' well I said I want to build a
417 wall have you any objection 'No no' and I didn't ask them to contribute or anything I
418 wanted to do it myself and he's younger than me but he didn't say I don't know his
419 first name he didn't say 'oh I'm Pete' or anything (AC right) you know I will not erm
420 sometimes I will call people by their first name and they will call me by my first
421 name but my usually my first introduction is sister L (AC right) Now some of my
422 colleagues I know don't like that 'oh there's no need for that' Well I think there is
423 (AC mm) initially (AC mm) then people can decide how comfortable they are with
424 you if they want to tell you to use their first name and you feel quite comfortable that
425 they're not going to sort of exploit that relationship then I say I'm K (AC mm) but I
426 suppose in a way I laid the ground rules (AC mm) for respect for each other (AC
427 mm) does that make sense

428

429 AC Mm it does yes (KL yeah) yeah

430

431 KL I don't want it to be too familiar (AC mm) but yes I accept there can be some
432 familiarity but er also respect (AC mm) there's got to be that (AC uhum) because
433 you may be treating someone or caring for someone you don't particularly like but
434 you've still got to respect them and give them (AC absolutely) you know shouldn't
435 matter (AC mm) So is there anything else Alison? (both laugh)

436

437 AC Is there anything else you'd like add?

438

439 KL No because as I said earlier I'd just be going on talking about this and myself. No
440 I can't think of anything (AC OK) has it been relevant or irrelevant?

441

442 AC No absolutely relevant (KL Really?) yes yeah erm as I said what I'll do I'll write
443 all this down now (KL mm) and if you have some thoughts afterwards and think oh I
444 wish I'd added that then you can (KL mm)

445

446 KL I don't think so and I suppose really upon reflection it's probably the way you've
447 been brought up (AC mm) that makes you behave like you do and I'm just thinking I
448 might say something now that when I was a little girl if things if I went home to tell

449 my mother you know I'd fallen out or somebody had fallen out with me and I would
 450 be upset she would simply say and I can see her now 'rise above it' she would say
 451 just 'rise above it' (AC right) and I remember there was one instance where she said
 452 come on I'll show you how to bake some cakes or do something I said 'oh no
 453 mummy I'd rather go upstairs and read' (AC mm) I didn't want to do things like that
 454 (AC mm) but I think that's erm that comes from the way I've been brought up and to
 455 have respect for others and what sticks out in my mind about having respect for
 456 others is when I was having a birthday party I've told several people this, I had erm
 457 set the table out for my little friends right and we were having bananas and custard as
 458 a pudding and I was putting these bananas in the bowls and what have you and there
 459 was one bad banana you know it wasn't bad but it was going you know how they
 460 brown (AC yes yes) and I gave it I put it into another plate. And mother came she
 461 was looking at it and she said 'who's having that banana?' I said 'I'm not' she said
 462 'you are' she said 'you don't give your guests a bad banana you can have it' and I
 463 had to have it (AC right) and I think upon reflection that's where I'm coming from
 464 and that's why I am like I am

465
 466 AC Mm so some of the lessons from childhood (KL mm) follow all the way through
 467 (KL mm)

468
 469 KL And in fact I'll tell you something now I really didn't want to go on about this
 470 but I have had problems at home with the dog at home and youths and what have you
 471 and the police and we finished up erm twice in Kendal magistrates (AC mm) with the
 472 police trying to seek the destruction of the dog the second time er my solicitor said to
 473 me 'I've had enough of this' she said 'we're going for trial she said because I think
 474 this is a vendetta' (AC mm) and she also said to me 'the trouble with you K is you
 475 have' what did she say erm 'a different value system'

476
 477 AC Interesting (KL mm) and what do you think she meant by that?

478
 479 KL I think she's right I think she's right because I think that does stem from how I
 480 was brought up because even though I might challenge people if they are doing
 481 something they shouldn't to my property I do not go out and swear at them (AC mm)
 482 I go out and ask them what on earth are you doing (AC mm) of course I get back chat
 483 and what have you and I ask them not to do it otherwise it will give me no option
 484 than to tell the police 'oh go on tell the police' and things like that but I don't sort of
 485 go out and swear at them (AC mm) and my friend not my present friend he said this
 486 to me but that's the only language they understand K I said well I'm sorry I can't do
 487 it (AC mm) I can't shout at somebody (AC mm) and swear at them publicly I can't
 488 do it (AC mm) (laughs)

489
 490 AC Just like with your parked car you just go quietly away (KL mm) yes

491
 492 KL I'm not don't misunderstand me I don't go to ground I mean if someone decides
 493 to pick on me I'll stand my ground (AC mm) and they may regret it (AC mm) they
 494 may well regret it (AC mm) but you know left alone I'm alright but if they start
 495 poking at me they may regret that (AC right) yes (AC mm) and that's probably
 496 where I'm coming from and why I do what I do and why I behave like I do (AC mm)
 497 and why I behave like I do so there you are Alison. (AC mm)

498 AC Thank you very much.

Transcript Summary

Interview 10 DN

This transcript suggests that KL carries out the role of district nursing sister because first and foremost it is a job¹⁰. She does not like the concept of 'work'³³ and doesn't live for her job¹⁴⁴ but she realises that there is no other way of living comfortably without seeking work and having a clear conscience^{TSC}. She is happy, comfortable and confident³⁶ doing this job³⁵ and chose to do nursing because she wanted to do something useful^{TSC}. She sees herself as an educator for students and the public²⁶. She does not want to take control of a situation²⁸, she prefers to create a situation where the patient feels empowered and in control³⁰. She likes to educate patients to create independence⁷⁶ and she does not want people to be dependent upon her¹⁵⁴.

KL likes to be in control of her work situation to minimise stress levels¹³⁸. She would like others to work in the same way³⁹. She likes to lead by example and sees herself as a role model⁹⁸. She likes to be in charge of a situation⁴⁷ and to get things organised and sorted before the end of the working day¹¹⁸. After five o'clock KL switches off and recharges her batteries for the next day.

KL does not believe that she is indispensable¹³⁹, she is self reliant³⁹³ and prefers to be left alone⁴⁸⁹. She believes in empowering staff¹⁰⁶ and likes to encourage them to develop and do further training¹⁰⁰ but she also believes that there is a fine balance because once they are empowered there's no turning back¹⁰⁶. KL does not like to be manipulated by management, staff or patients¹⁵⁹.

KL likes to meet problems head on and doesn't like to 'pussy foot' around grey areas^{1228,252}. She gets frustrated if the computers or telephones go down²⁶⁸. She acknowledges that she may not like some of the people and patients she is working with but she appreciates her duty of care toward them and remains respectful of their situation and needs^{TSC,404,430}. This attitude she feels comes from her childhood experiences⁴⁵⁹.

KL finds great satisfaction in acting as a mentor to students and specialist practitioners^{TC}. She finds reward in knowing that she can facilitate the students' development by linking practice and theory in the clinical setting^{TC}. She is happy to do her work and she is also happy to be paid at the end of the month⁴⁰³.

(The small numbers refer to the line of the transcript where the idea can be found)

TC = Transcript check

TSC = Transcript summary check

March 9th 2004

Interview 11 NP

- 1 AC It is a very unstructured approach this (KI mm) erm and what I'm interested in is
 2 what you find most meaningful in your work as a nurse practitioner erm so whatever
 3 whatever springs to mind for you
 4
- 5 KI I should have had some thought on this one (pause)
 6
- 7 AC It's OK gut reaction's fine (both laugh)
 8
- 9 KI Say it again
 10
- 11 AC What do you find most meaningful in your work (pause) and if that word
 12 meaningful is difficult then things like what do you enjoy what do you find most
 13 satisfying rewarding (pause)
 14
- 15 KI I think it's the personal development and it's the ability to be able to manage a
 16 patient's clinical situation and develop your management skills generally I think
 17 because of what's happening to me in this practice do you want me to go over that?
 18
- 19 AC Mm yes do you want to explain that a bit more?
 20
- 21 KI Erm to be involved in the planning of moving premises which I was (AC uhum)
 22 to be involved in development of the nursing team erm to be considered as an adviser
 23 to management issues with other staff including reception and dispensary staff (AC
 24 right) erm so it's not just you being a nurse managing patients chronic disease or
 25 abdo pain or it's the whole global situation (AC mm) of running a general practice I
 26 think (AC right) It's a bit like I can only compare it to where you get to sister level
 27 and managing a team there and then you're involved in the management structure as
 28 well (AC mm) in hospital that's how I compare it and I think you bring to general
 29 practice because of your past experience a lot of those skills which you develop in a
 30 different way and that medical team have not developed on occasions because they
 31 don't have that management structure as they train and as they work because they
 32 don't have anybody telling them what to do (AC right) so what I get out of it I think
 33 are those personal development things that I feel involved that I'm valued erm that
 34 you make a difference to every single patient you see even if it's just they leave with
 35 a smile (AC mm) I think that's what it's about all nurses should do that but I think
 36 you do it on a different level as a nurse practitioner because you have more input
 37 (AC right) and you have more out put
 38
- 39 AC Can you explain that a bit more?
 40
- 41 KI Erm you don't have to refer to to another person always you can deal with the
 42 situation and you know when your boundary's there that you don't deal with it you
 43 pass it on (AC mm) so it it broadens how you talk to the patient your communication
 44 skills your collaboration with the other team members erm you depends how far you
 45 want to take how you develop because some people probably wouldn't push the
 46 boundaries as far as I do sometimes (AC mm) and yet I maybe don't push them as far
 47 as other people (AC right) so I'm a bit of a risk taker sometimes (AC uhum) which is
 48 scary (AC mm) but then we're all here taking risks aren't we? (AC mm)

49

50 AC Are you able to explain a bit more about erm what you said about working with
51 the patient erm and the clinical aspect?

52

53 KI It broadens your horizons doesn't it it broadens your ability to see the patient as a
54 whole although you think you do it as a practice nurse (AC mm) or a sister on a unit
55 or a sister on a ward at that level you're constantly having somebody else to take the
56 final decision or somebody else to make the management plan (AC uhum) whereas
57 now I do it myself (AC mm) and if I'm not clear about that then I'll go and discuss it
58 with one of the GPs (AC right) so it's the whole broadening of what you glean from
59 the patient how you go about it how you examine them how you convey your
60 empathy how you decide what happens to that patient when they leave when you
61 bring them back where you refer them to is it appropriate is it not appropriate it's that
62 broadened out isn't it? (AC mm) (pause)

63

64 AC So it's working in a different way (KI completely) to how you used to work

65

66 KI You don't think you do it (AC mm) because as a practice nurse you think you do
67 a good job and you do do a good job (AC uhum) but you make a huge leap (AC mm)
68 and it's difficult to explain it (AC mm) because I come from completely different
69 angle now to what I did twelve years ago (AC right) but again I think it's that how to
70 you know like C'll ask me how to manage a situation which she did this morning and
71 it was about one of the patients who has got metastatic disease not wanting one of the
72 district nurses to go because he doesn't get on with them and it was how we were
73 going to approach the district nurse team without offending them because it was the
74 case holder that they didn't want in the house and I said well I think you've got to
75 say to the patient you know I take on board what you're asking me to do but she is
76 the case load holder and that I need to inform her but it doesn't mean that they will
77 never come to you (AC mm) because I said you cannot cause antagonism between us
78 and the district nurse team (AC mm) you need to make it clear to the patient that you
79 can't betray them (AC mm) and yet you're going to be the mediator to for them to
80 have what they want (AC mm) and so you know you learn that don't you (AC mm)
81 that's something that comes with the expanded role I think (AC mm) not just the
82 clinical situation

83

84 AC Right yes it's at a broader level

85

86 KI Mm (AC yes) much much broader (AC mm) (pause) I can't think of another
87 example (pause) off the top of my head (AC right) only sitting in meetings and
88 cringing when some of the practice nurses speak

89

90 AC Oh dear. Right. Anything else that you would say you find satisfying particularly
91 satisfying or rewarding in what you do?

92

93 KI (pause) worrying (AC laughs right) some of it's worrying (AC aha) don't have
94 sleepless nights but have had (AC uhum) erm (pause) the hurdles you have to get
95 over the difficulties with referrals but I'm quite broad shouldered now erm that's the
96 down side of it

97

98 AC Do you want to say a bit more about that?

99

100 KI The downside is the just I think the naivety of often (pause) the multidisciplinary
 101 side of it not being aware of the role of the nurse practitioner (AC mm) and because
 102 we live in er a population where there are few of us it's much more difficult I'm sure
 103 than it could be in Thameside or London (AC mm) or Birmingham or wherever so
 104 our hurdles we're having to get over somebody else will have had years ago we're
 105 just having to influence it here (AC yes) and we have to influence it in a subservient
 106 manner sometimes (AC mm) just really to get round to what we want (AC mm)
 107 which doesn't bother me because I'm just here to do my work like anybody else. It
 108 used to bother me (AC right) because I didn't understand why people just couldn't
 109 accept you know here doing a different role but still working for the same end for the
 110 patient (AC mm) but that doesn't bother me anymore (AC right) I just think pah

111

112 AC So do you have ongoing battles with that still?

113

114 KI Not anymore (AC right) I used to get abusive letters from the consultants (AC
 115 mm but that's stopped now?) Mm it's stopped (AC right) erm but I mean the good
 116 things I think are the things I've said the fact that you can run your surgery without
 117 having to ask anybody else what do I do about this erm not every surgery but you
 118 know twice a week maybe now I need to discuss somebody (AC mm) whereas at the
 119 beginning you shake when somebody sits down and you wonder what's going to
 120 come out of their mouth (AC yes) (both laugh) you think oh my goodness (both
 121 laugh) (AC yes) but there isn't that feeling now (AC right right) and there shouldn't
 122 be should there really? Erm I'm a cynic because I've been in the game too long so
 123 the political awareness side of it and the pharmaceutically corrupt side of it erm (AC
 124 mm) I tolerate (AC mm) because the new contract is just really getting towards the
 125 stage that teachers are at where they need to get they're scoring academic
 126 achievement and we're getting to a tick box situation and it worries me because at
 127 the end of the day we shouldn't be just ticking the templates we should be thinking
 128 about the patient (AC mm) and it worries me some people will only (AC mm) do that
 129 and not think about the individual (AC mm) sat there so the political awareness is a
 130 bit cynical (AC mm) but it would be whichever government was in because I'm
 131 coming to the second time round with some of these things (both laugh) and I just
 132 think oh here we go again mm more change I think I remember this before

133

134 AC Starting to make your self sound very old K

135

136 KI Mm been in the NHS a long time (AC mm). Erm (pause) the other things I don't
 137 know (pause) I like the fact that I think we're leading the way forward for nurses and
 138 I feel it's like I said to you before I wish I was ten years younger because I just think
 139 we're on the brink (AC mm) of something better (AC mm) and if I worked until I
 140 was seventy I would never be out of work (AC mm) and it's exciting for me but for
 141 some it will just be go in earn your salary go home (AC mm) (pause)

142

143 AC And you're saying that's not how it is for you?

144

145 KI No I don't think about the salary to be quite honest (AC mm) I just think about
 146 the work (AC right) the money's good (laughs) at the end of the month but it doesn't
 147 ever enter my head about should I have had a pay rise this year (AC right) what's
 148 anybody who else is whoever's working as a nurse practitioner elsewhere getting

149 (AC mm) doesn't bother me what anybody else is getting (AC mm) I reasonably
 150 negotiate my salary and there was a situation when I first qualified where they asked
 151 me what I wanted and I said well I'm not going to negotiate my salary with you I'm
 152 going to expect you to give me what you think I deserve (AC right) I wasn't prepared
 153 to sit down (AC mm) and you know justify what I did they knew what I did they'd
 154 trained me (AC mm) and that's the way it's been since (AC mm right) erm what else
 155 (pause) I don't know I can't think of anything that I haven't covered.

156
 157 AC One of the first things you said was about patients leaving here with a smile on
 158 their face

159
 160 KI Yeah feeling better

161
 162 AC Yeah can you say a bit more about that what you mean by that?

163
 164 KI Just making a difference but I mean we all should make a difference shouldn't
 165 we? It's them feeling more less anxious erm more a structured outcome erm not a
 166 dependence because I don't like them to be dependent but erm to feel I suppose
 167 empowerment is the word isn't it really (AC mm) that they feel they own part of
 168 what's gone on (AC mm) erm and that it isn't just me sitting here saying this is what
 169 we'll do erm this is what's happened to you you know it's got to be an explained
 170 situation it's got to be an agreed outcome erm and that they feel they less anxious
 171 when they leave and as if something's happening and even if it's a poor outcome that
 172 they feels somebody's supportive if they want or they're helping them to sort it out
 173 or the way forward I think (AC mm) (pause)

174
 175 AC (pause) So they are your aims when you see somebody for a consultation?

176
 177 KI Everybody yeah (AC right) yeah I don't like people to go out feeling angry or
 178 upset you know they don't go out upset. If we're upset in here then we get round the
 179 upset and then they go out (AC right) even if they're upset that I've said you know I
 180 think this is probably not a good outcome or I'm suspicious or (AC mm) you know
 181 the way you phrase it really (AC mm) and that they have access to you because I
 182 often say you know if you get home and you think about something that you should
 183 have asked then ring or come again you know it's that sort of not feeling cut off (AC
 184 mm) whereas I think sometimes some GPs might do that they seem to keep people
 185 here more than nurses do (AC mm) I think people keep them a bit closer than er than
 186 GPs do (AC mm) it's the familiarity I think. It's difficult here because it's a
 187 community small community if you're in a city it would be a different relationship
 188 wouldn't it? (AC mm) or in the town (AC uhum) because you don't know your
 189 population so well whereas you know who's related to who more or less here and
 190 you know who's friendly with who (AC mm) and if you get it wrong in this small
 191 rural community you might as well leave (AC right mm) because it's Chinese
 192 whispers (AC mm) and if you you've got to make sure you that is quite a pressure
 193 (AC mm) because you haven't got room to error for error or to upset anybody (AC
 194 mm) you have to erm because they'll come in and say oh so and so said they'd been
 195 to you for this and you were you know you did this and so I thought I'd come that
 196 sort of Chinese whispers (AC right) or they'll come to you and say oh I'm not going
 197 to see them again you know they did this to whoever (AC mm) whereas you don't
 198 get that in a larger community do you?

199
200 AC Mm I don't know don't know whether or not that would happen in cities
201
202 KI It would do in a street I think (AC mm) wouldn't it?
203
204 AC You probably get pockets of communities in cities (KI mm) yeah but then it's
205 easier for them to nip off to the next GP (KI mm) whereas here they can't can they?
206
207 KI They've no choice (AC no) so you have to have that good rapport (AC mm right)
208 which is a pressure sometimes (AC mm) and you see when I made my transition
209 there's lots of stuff written about that isn't there from practice nurse to nurse
210 practitioner I didn't find it as hard as possibly they did.
211
212 AC Right and by 'they' you mean the patients?
213
214 KI Patients (AC mm) but then the patients still say to you 'well what are you doing
215 now oh you're a doctor now?' no and then we go into explaining you know (AC
216 mm) well what's C then? (AC right) It's defining the difference (AC mm) and it's
217 quite difficult to explain to the lay person especially if you know you have to phrase
218 it in ways that they'll understand it (AC yeah) and depends on how much knowledge
219 they have of the health service and nursing and (AC sure) any structured
220 establishment really
221
222 AC And do you think your community's getting to understand that now?
223
224 KI My role? (AC mm) Erm yes I think people choose people do choose definitely
225 who they see (AC right) but again that that that I think is over the years as well they
226 knew me before I was this person now (AC mm) so again it's a personality thing I
227 think as well isn't it? (AC mm) Whereas if I left and somebody from I don't know
228 Newcastle came here hadn't lived here before I don't know how that would adjust
229 (AC mm) how they would adjust you know (AC mm interesting) it would be
230 different wouldn't it? (AC yeah) mm (pause) it would be interesting (pause)
231
232 AC Is there anything else you can think of that er you find rewarding in your work?
233
234 KI I don't know there must be things but I can't off the top of my head (AC no?) I'll
235 go home and I'll think tonight I should have said that to Alison
236
237 AC You can always jot things down er because I'm going to send you the transcript
238 erm and then if there are things you want to add you can (KI mm) or things you want
239 to take away (pause)
240
241 KI No I can't think of anything off the top of my head. Because I haven't singled out
242 certain things I've singled out broad issues really
243
244 AC Mm that's that's fine
245
246 KI Erm No I don't think so Alison
247

248 AC Just then just to look at it from the other perspective you already mentioned
249 about erm getting frustrated over the referrals (KI mm) previously (KI mm) is there
250 anything else that frustrates you in what you do?

251
252 KI Erm not being able to sign a path form and get my blood results back (AC mm)
253 erm because I don't if the results are back who's seen them what's happened to the
254 patient I haven't time to chase after everybody (AC right) erm not being able to refer
255 to x-ray which you're not going to do unless you desperately need to erm the physios
256 dieticians, opticians, CPNs all those that group of people are fine (AC mm) erm x-
257 ray's the issue really I think you know I rang for I rang for a result for a lady who
258 really is not well of her lumbar spine x-ray I referred her I got one of the GPs to sign
259 the form she had an osteoporotic risk she's diabetic nephrotic syndrome dreadful
260 back pain erm and it came back that she had a crush fracture of L3 and L4 when I
261 rang for the result they wouldn't tell me they needed to give the result over the phone
262 to the doctor. So I had to get P out of his surgery I had the lady sat in with me wait
263 for him to come out in between patients to take this off the phone (AC oh) I wasn't
264 best pleased (AC I bet) because I just thought well P wasn't either (AC mm) you
265 know it wastes everybody's time (AC mm) and it's it's it's their bureaucracy (AC
266 yes) but little things like that don't help you to function (AC no) and for the patient
267 it's not efficient (AC no) it looks bad you know it undermines it makes it look as if
268 you're undermined (AC mm) erm and basically all they told P was it hasn't been
269 reported on the radiologist hasn't reported it but it's showing this (AC right) and so
270 he just said that back to me (AC mm) but you know (AC mm). So those little
271 frustrations (AC yes) everybody else is fine I think (AC mm) path lab is a nuisance
272 definitely erm but I think they're the main two (AC mm) the consultants are fine now
273 (AC mm) they write back to me most of them (AC right) a lot of them don't but I
274 think that's just they look on the hospital notes and say it's doctor whoever (AC yes
275 yes) and dictate it to them (AC mm) but I don't have the same hassles I used to have
276 with them. Erm there was an occasion where this is about three years ago where all
277 my letters were going to be audited by a nurse who had a post at T who was less
278 qualified than me (AC mm) and that rattled me a bit (AC mm) but I thought blow
279 you so I just never said a word and I just carried on doing what I was doing

280
281 AC And did you get any feedback?

282
283 KI I've never had any in three years.

284
285 AC Oh there you go the audit must have been alright (both laugh)

286
287 KI But it's chalked up I've got letters to prove they said they would feed back to me
288 (AC mm) and they never have (AC mm) and I've kept every erm critical letter in a
289 file (AC right) and I've kept letters from the radiographers who said they came here
290 to speak the radiologist came here to speak to the partners about three or four years
291 ago and said he would set up some guidelines for my referrals and I've never heard
292 peep (AC mm) but I've got it in writing (AC mm) so if there's ever any come back
293 say well we did ask you (AC mm) and you didn't do anything and I'm not chasing
294 you (AC yes) but I have to function

295
296 AC So those are the things that (KI Frustrations) yes

297

298 KI Patients and management and access to the GPs is not a problem (AC mm)
299
300 AC It's more systems things that
301
302 KI Bureaucracy (AC yeah yeah) that's what it is (AC right)
303
304 AC Is there anything else you want to add?
305
306 KI No no (AC OK) I can't think of anything
307
308 AC That's brilliant K thank you

Transcript Summary

Interview 11 NP

This transcript suggests that KI likes being able to manage the whole episode of care with a patient¹⁶. She runs her own surgeries¹¹⁶ and she likes to make a difference with every single patient^{34,164}. She feels that her nurse practitioner role has made her more able to see the patient as a whole⁵⁴ and has also enabled her to make final decisions about the management plan⁵⁶. If she is unclear about a decision she will discuss this with one of the GPs^{57,118} but most often she finds she does not have to refer to others and she is able to manage the whole situation⁴¹.

KI feels that her extended role has changed how she communicates with patients⁴² and also has changed how she collaborates with other team members⁴⁴. She enjoys having involvement in practice management²⁰, development of the nursing team²¹ and management of other groups of staff²². She has a role in helping the nursing teams to work smoothly together⁷³. She feels that her nurse practitioner role has resulted in her own personal development^{15,33} including development of management skills¹⁷. She feels that it is the whole picture that makes her work meaningful²⁵ rather than just the clinical work with patients.

KI likes to push the boundaries⁴⁶ and enjoys being a risk taker⁴⁷. She likes to be involved in leading the way forward in nursing¹³⁷. She has had to address a number of barriers⁹⁴ to her role particularly with referrals to consultants. She tries to influence the system to achieve what she needs to function effectively in her role¹⁰⁵ and she feels she has developed broad shoulders to be able to cope with the barriers and hurdles^{95,110}. KI says she is cynical about the political and pharmaceutical influences on general practice¹²². She does not subscribe to the tick box approach of completing templates and working towards the quality criteria of the new contract¹²⁷. She feels that she should be firstly interested in the individual patient¹²⁷.

KI doesn't want patients to leave her room angry or upset¹⁷⁷. She wants to empower patients¹⁶⁷ and does not want them to feel dependent upon her¹⁶⁶. She wants patients to feel supported¹⁷² and to feel that they have access to her when they need it¹⁸¹. She likes patients to feel familiar¹⁸⁶ and feels that the relationship that has built up over a number of years has an influence on the way patients make choices regarding who they want to consult with²²⁵. KI is aware of the importance of the small rural population and realises there is no room for error in such a close knit community^{190,193}.

KI gets frustrated with not being able to sign path forms and get path results back²⁵¹. She also gets frustrated with not being able to refer for x-rays²⁵⁴. She feels that these barriers make it difficult for her to function effectively and this results in wasting time for the whole team²⁶⁴. This is not efficient for patients either²⁶⁶. She is particularly frustrated at not being able to accept x-ray results over the telephone as she feels this again is a waste of time and also undermines her role²⁶⁰.

KI does not carry out her role solely for the salary¹⁴⁵. She is not particularly interested in comparing her salary to that of other nurse practitioners. She does not want to negotiate her salary with the GPs and expects them to make an appropriate decision about her wage¹⁴⁵. She does feel valued³³.

(The small numbers refer to the line of the transcript where the idea can be found)

March 14th 2004

Interview 12 GP

1 AC It's erm unstructured in that (KN mm) erm we just start off with one question
2 (KN mm) and then really go with wherever you want to go with. And the question is
3 what is it that you find most meaningful in your work as a GP?

4
5 KN (laughs) Wow. Seeing patients I suppose (AC right) and that's why I think most
6 doctors erm go into medicine in the first place because they like people perhaps (AC
7 mm) and that's certainly the most meaningful aspect of general practice for me erm
8 face to face patient contact erm and obviously the more paperwork one does the
9 more things that pull you away from that erm the more frustrated one gets and the
10 lower the morale of the profession which I think probably accounts for the fairly
11 parlous state of morale in general practice overall although I have to say our practice
12 is I think a pretty happy practice and I don't feel too depressed really (AC right) I
13 mean you keep reading these things about how awful it is in general practice and no-
14 one wants to be a GP anymore I can understand that but this is a really nice practice
15 and a really nice area it pays reasonably well I don't have to work my socks off (AC
16 mm) erm it's a very pleasant place to be (AC mm) so

17
18 AC Do you want to explain a bit more you started off by talking about the patient
19 contact do you want to expand on that a bit more?

20
21 KN Erm it's nice to build up a relationship with people and that's the big strength
22 obviously of family medicine the ongoing familiarity with patients and again that's a
23 nice thing about this particular practice it's a particularly stable practice in terms of a
24 patient base so people tend to come to the area and stay or don't go away in the first
25 place so (AC mm) and obviously there's a turnover but it's lower list turnover than
26 many practices erm so I've been here fifteen years now and erm have had fifteen
27 years of a relationship with some patients (AC mm) so you can see the Mums I can
28 look back and think about ones who I was doing antenatal care for and now they've
29 got adolescent children and so it goes on (AC mm) so that's that's very rewarding
30 (AC mm) and erm good old fashioned family medicine really (AC right, right)

31
32 AC What more would you like to add to what you find meaningful in your work

33
34 KN Erm I suppose I ought to say one very big thing for me is as a Christian erm I
35 feel that this is what I should be doing (AC uhum) and it's erm er it's an erm a very
36 important part of who I am and er I feel quite certain that this is where God wants me
37 to be doing what God wants me to do (AC mm) which obviously adds a very major
38 element of certainty to it as well (AC mm) and not just within the practice but other
39 things within the area and where I am and what I'm doing so so that that is another
40 important part of job fulfilment job satisfaction (AC mm)

41
42 AC Right so you feel like you're in the right place

43
44 KN Yes mm

45

46 AC Yes yes right is there anything else that gives you particular satisfaction about
47 what you do about what you enjoy?

48
49 KN Erm education clearly is an important part (AC uhum) for us erm having been
50 involved in various different aspects of erm education for different parts of the
51 primary health care team K may have said that I was her mentor erm so that was
52 interesting (AC right) I'm still not sure what a nurse practitioner is (both laugh) I'm
53 not sure she's sure either I'm not sure anyone is (AC yes good question) erm that's
54 not to say she's not an essential and very valued part of the team which she clearly is
55 but erm hard to define exactly what she is (both laugh) apart from wonderful in one
56 word K's wonderful erm but education's important and challenging and refreshing
57 and stimulating (AC mm) erm and so medical students ask 'why? what are you doing
58 that for?' which is always a useful question to make you think 'well why am I?' (AC
59 yes indeed) erm and er keep you up to date (AC uhum) erm as a partnership we get
60 on very well we have our ups and downs have our niggles (AC uhum) but er the five
61 of us are professionally close although not personally that close we socially we
62 socialise a bit but not a huge amount (AC mm) I get on very well with the other full
63 time male partner which is very nice er the youngest partner so he's very much
64 complemented the practice team (AC mm) but we're very different people but we get
65 on very well erm so just the whole teamwork thing really is good the ancillary staff
66 are for the most part of very high standard practice manager's fantastic so I consider
67 myself very fortunate to work where I do really (AC mm)

68
69 AC Right so it sounds like you've got a good network and a good (KN mm) team
70 here yes (KN definitely) Is there anything more you'd like to add?

71
72 KN I think that covers most of it

73
74 AC Right the things that you enjoy? (KN mm) Right mm thinking of it from a
75 different perspective then (KN mm) what are the things, you mentioned at the
76 beginning about paperwork erm (KN mm) effecting morale (KN yes) frustrating
77 you, erm what other things are there that you find frustrating or not satisfying?

78
79 KN Erm I'm sure that for everybody really the major frustration is time (AC uhum)
80 and rationing erm that one never feels that you have quite enough time to give to
81 people really er because it's an open ended cheque book isn't it really how much
82 time you give to the NHS when you could spend your every working minute in here
83 but I've got a family too (AC mm) and I don't want to, but within a standard working
84 day erm there are always immense time pressures so that that can be frustrating but
85 that's er that's the NHS isn't it? (AC mm) Erm what else frustrates me? Erm
86 constantly changing demands in terms of fill this form in achieve that target do the
87 other (AC mm) now we've changed our minds we'll do something else (AC mm) a
88 sense of I suppose a loss of control isn't it we think we know what's best for our
89 patients and don't take kindly to somebody outside telling us what's best for our
90 patient so that tends to frustrate and demoralise (AC mm) erm unrealistic
91 expectations I suppose I mean erm the er this forty twenty four forty eight hour
92 access targets erm which really just further fosters further unrealistic expectations
93 that you know right I've got a boil on my no not a boil on my bum that's an acute
94 thing, I've got a pain in my knee that I've had for a month (AC mm) I'm fed up now
95 I want to see a doctor today (AC mm) well why? Why not in a week (AC mm) why

96 not you know why do they have to be seen in that time and so you change your
 97 appointments systems to allow for that and effectively what we're saying to people is
 98 now is we have virtually no routine appointments (AC mm) because they're all
 99 urgent ones (AC mm) so the ones who want to er come about their chronic disease
 100 processes or their long term mental health things it becomes increasingly difficult for
 101 them to plan any sort of follow up (AC mm) so there's then the half past eight in the
 102 morning telephone lottery (AC mm) can you ring up and get your appointment made
 103 for that day or the next day is it a day when doctor K's on duty taking the telephone
 104 calls because I want to see him (AC mm) so expectations generated by government
 105 can make it erm I think difficult to do the job well in a way that you want to (AC
 106 mm) erm and as I say it generated unreasonable expectations in the public erm for
 107 them to be seen instantaneously (AC mm) which is fine in an open ended system but
 108 clearly it's not open ended it's rationed and therefore if somebody's being seen that
 109 day then somebody else isn't going to be (AC mm) and so how do you ensure that
 110 the ones who are seen that day are seen appropriately and I think previously we did
 111 offer a very effective system where we had a lot of routine appointments and some
 112 urgent ones and we would always squeeze in the urgent ones you know the ear aches
 113 the boils on the bums (AC mm) and they will be seen erm but the ones that really
 114 didn't need to be seen that day could wait a week (AC mm) and that's not going to
 115 harm them (AC mm) so that's a particular problem at the moment I think and
 116 frustrating for everybody not least the patients because they can't get an appointment
 117 with me it's two and a half weeks for a routine appointment with me at the moment
 118

119 AC It sounds in your situation as though the targets have almost caused you to take a
 120 step backwards in terms of service

121
 122 KN And I think that's what most GPs feel at the moment (AC mm) twenty four hour
 123 access has been a disaster for for most patients with most problems really (AC not
 124 very helpful) no (AC mm)

125
 126 AC And also links with what you were saying about control because you don't have
 127 control over that somebody else is telling you (KN that's right that's right) mm yeah
 128 that's hard (KN mm) When you were talking about pressures of time (KN mm) how
 129 do you given that you've got a finite amount of time in the day how do you sift
 130 through what it is you pay attention to (KN mm) and what you don't?

131
 132 KN Erm (pause) well obviously inevitably you prioritise clinical demand first of all
 133 erm so erm experience as a GP erm is very important in terms of spotting the things
 134 that really need immediate attention and I suppose it is just a gradual wading through
 135 of the things that have to be done now and then the lower and lower priority things
 136 erm until you run out of time and go away leaving things left behind on your desk
 137 not done till the next day (AC mm) or the next week or what have you erm but then
 138 that's triage isn't it really that's in the broadest sense that's medicine (AC uhmm) erm
 139 dealing with the priorities and then if you've got time left over dealing with the other
 140 things (AC right) I don't like having a desk that's buried under things so I will tend
 141 to stay late and make sure that the referral letters are done and pathology results are
 142 (AC mm) seen because I get stressed if that's all sitting there looking at me (AC mm)
 143 erm but then the family life suffers of course because you don't get home and don't
 144 see the kids for their tea (AC sure) you know (AC mm) but er (AC it's that balance)
 145 yeah I think I strike it most of the time (AC uhmm)

146
147 AC So it's that clinical stuff that you see as (KN mm) the priority (KN oh yeah
148 absolutely) What about all the other incoming policies and procedures and
149 population manager and all of that
150
151 KN Well designate and delegate as much of it as possible to erm our very good
152 ancillary staff or our nurse practitioner (AC right) or our er practice nurse so a lot of
153 the clinical governance stuff chronic disease management targets and things erm I
154 don't have to do very much to (AC mm) or very much for thankfully (AC mm) and
155 we have within the practice different areas that the partners are responsible for so
156 obviously I'm responsible for training as the GP trainer and er the other full time
157 male doctor he and I have been the main two in terms of training teaching the
158 medical students (AC right) erm and I am the mentor for the erm GP trainee at the
159 moment (AC right) so I have had perhaps most out of any of the partners to do with
160 the teaching and training and then the other area of responsibility I have is the
161 dispensary (AC mm) and looking at the running of that erm which is important
162 financially (AC uhum) and then the other partners have their own various other areas
163 of responsibility and it works fairly well really and we've got one very much a
164 completer finisher doctor who is very good at the clinical governance side of things
165 (AC mm) so we leave her to worry away at that (AC right) and she does it very
166 efficiently well I don't know about efficiently but very thoroughly anyway (AC mm)
167 how does one define efficiently? She spends a lot of time on it (AC right) and does it
168 very well (AC aha) erm and that's fine so (AC mm yes) but again it's down to having
169 a good team a good partnership team really (AC yes)
170
171 AC Right is there anything else you would like to add that erm you can think that
172 you enjoy about your work?
173
174 KN No I think that's
175
176 AC Covered it? (KN mm) And anything extra that you don't enjoy?
177
178 KN (pause) no not really (AC no) Mostly the pros very much outweigh the cons (AC
179 mm) so
180
181 AC That's terrific (KN mm) well thanks very much

Transcript Summary

Interview 12 GP

This transcript suggests that KN enjoys face to face contact with people⁸. The most meaningful thing to him in his role as a GP is seeing patients⁵. He likes building relationships with patients over a number of years²¹ and enjoys having familiarity with patients^{22,27,29}. He likes the practice and the geographical location of the practice^{14,16} and says he enjoys good old fashioned family medicine³⁰. Being a Christian is important and he feels that he is where God wants him to be³⁴, this contributes to certainty in his life and work.

KN feels that education is important, he finds being involved in education challenging, refreshing and stimulating^{50,56}. He likes being challenged by students and enjoys having his own practice questioned⁵⁸. He likes to keep up to date⁵⁹. KN values teamwork and the variety of people in the practice team^{65,169}. His areas of responsibility in the team include education and the dispensary¹⁵⁸ and he is happy to delegate responsibility for clinical governance and chronic disease management targets¹⁵⁰.

KN likes people⁷ and gets frustrated when the demands of paperwork¹⁰ reduce the amount of time he can spend with patients⁸⁰. He also gets frustrated at the constantly changing demands in general practice and the subsequent loss of control⁸⁸. He feels demoralised by someone from the outside telling him what is best for his patients⁹⁰. He feels the unrealistic expectations of immediate access to medical care have resulted in a less than satisfactory service for patients with long term conditions⁹⁰. NHS Direct has contributed to these expectations^{p1} and he feels that this has had a negative impact on the service he can offer to the routine patients⁹⁰.

He likes to clear his desk at the end of the day by completing referral letters and viewing pathology reports¹⁴⁰. He feels stressed if things pile up on his desk¹⁴². However, his priority is clinical demand¹³² and he aims to balance this with family life^{83,144}.

(The small numbers refer to the line of the transcript where the idea can be found)
(PI = Post interview)

June 2nd 2004

Interview 13 DN

- 1 AC So this is a really unstructured interview (MD Right OK) erm there's only one
2 starting question and then we just go with wherever you want to go from there so I
3 don't have a list (MD Great) of questions to ask you. (MD OK) Erm have you seen
4 the information and the consent form and everything about the study?
5
- 6 MD Erm yes I think I've got the info is that what you sent me (AC yes) in the letter
7 yes (AC yes the two sheets) I have to say I did read it when I received but I haven't
8 actually read it since
9
- 10 AC That's fine so long as you've got an idea
11
- 12 MD Yes yes
13
- 14 AC So my opening question is what is it that you find most meaningful about your
15 work?
16
- 17 MD Ooh. Well there's a great variety of things but I think probably the overriding
18 thing is my ability to make a difference to somebody who has some sort of problem
19 or difficulty (AC right) erm obviously health related because of the er the remit that
20 we're in erm but I think that's probably the overriding thing that I that I can
21 hopefully make a difference to them and help them in some way
22
- 23 AC Right yes, can you explain that a bit more?
24
- 25 MD Erm (pause) I think probably erm with the training that I've done and the
26 knowledge that I've accumulated over the years erm somebody with a a health
27 problem be it that they've got a wound or they're looking after a relative who needs
28 caring for I can go in and assess the situation sit down and talk to them and try and I
29 suppose get hopefully get down to their level but that they see me as someone they
30 can access for information about how to deal with the situation that they're actually
31 in or to do part of that care for them ultimately I suppose overriding our remit is that
32 we will try and help them to be as independent as they can be (AC aha) erm and I
33 just think the interaction with the patient and their family is the thing that I enjoy the
34 most really and where I think I can I can make a difference to them. (AC right). Is
35 that sort of?
36
- 37 AC Yes and can you explain a bit more about that about the interaction and what that
38 means to you?
39
- 40 MD Erm think it's er can be quite challenging at times erm (AC uhum) Many there's
41 just so many different situations that you can find your self being asked to erm help
42 with really (AC mm) and sometimes I think it's it's a journey of learning together
43 because I may not have all the knowledge that I actually need to deal with in that
44 situation erm and so it's a matter of sometimes the patient educating me erm in some
45 way maybe around the difficulties that they're actually having and not so much about
46 the disease processes if they will I suppose a lot of it really is is that it's not so much
47 the element of the disease processes as the encumbrances that that gives them and the
48 difficulties in maintaining their day to day life (AC right) and erm I suppose we are

49 trying to help them to erm maintain as full a life as possible really (AC mm) so it's
 50 not just about going in and doing a wound dressing which you know might be where
 51 our expert knowledge lies but it's also anticipating and erm finding out how that
 52 actually effects the rest of their life (AC right) and trying to help them deal with
 53 those difficulties (AC uhum) I suppose there's an awful lot of problem solving (AC
 54 uhum) involved which means that we have to communicate an awful lot erm the
 55 amount of help and guidance and assistance we can give somebody depends on how
 56 they communicate with us (AC uhum) erm but also the effectiveness of what we do
 57 and suppose the effectiveness of the information we get from patients depends a lot
 58 on how we tackle things and how we can actually draw things out of the patients as
 59 well

60
 61 AC Right aha yes so that communication's really important

62
 63 MD It is it is yeah (AC yes) erm because you do you do end up in situations where
 64 erm you sort of have to say to people I can only help you if you can tell me what is
 65 happening to you and how this is actually effecting you (AC uhum) erm particularly
 66 things issues I tend to have to use that really around issues of pain relief and things
 67 like that erm if patients don't actually tell us (AC uhum) that they are in pain and
 68 how much pain they are actually in erm we can't do anything to address that (AC
 69 sure) erm if they wont admit to having any pain sometimes we can tell (AC uhum)
 70 by the way that they act and their expressions (AC mm) and the non verbal things
 71 that are coming across that they are in pain but if they wont acknowledge that there's
 72 not an awful lot that we can do apart from giving advice and explaining that they
 73 need to sort of try and be open but that we can see that they are in pain and we can
 74 give them some information then but ultimately it's up to them to open up (AC yeah)
 75 and acknowledge that and then we can try and address it in some way (AC right
 76 right) I seem to have gone off the track (both laugh)

77
 78 AC No at all no that's been brilliant and you've explained a lot about erm you know
 79 working with the patient (MD mm) and what you see (MD mm) as important in that.
 80 At the beginning you said there's a whole variety of things that er are meaningful to
 81 you in your work (MD right) so what are some of the other things that?

82
 83 MD Some of the other things are erm around team working with the other team
 84 members as well (AC right) erm not just in our in our own little team but in the wider
 85 sort of primary health care team erm the trust that we have in our little team that
 86 we're in erm I suppose that comes from working together knowing each other's
 87 strengths erm I suppose sharing again sharing the same values looking at the you
 88 know we're all working towards the same ends really and the same goals we all want
 89 to maintain the same standards and improve (AC uhum) really erm that that is
 90 meaningful to me there's an awful lot of support within the team and within our sort
 91 of nursing network in the environment that we work with so like from the other
 92 district nursing teams as well we are very (AC right) supportive whether that is true
 93 of all areas I'm not sure but certainly erm here erm within our teams in this area I
 94 feel that is it's very strong and it's it's really good to know (AC mm) that that
 95 support is there it makes it easier to ask for help erm (AC mm) and you know that
 96 people will help you if they can you know we're all under a lot of pressures and erm
 97 I I think that's really important (AC mm) and that's one of things that is really quite

98 meaningful because it's not just about looking after the patients it's looking after
99 each other as well isn't it?
100
101 AC Yeah aha (pause) and you mentioned the wider primary health care team then as
102 well so do you mean within this within the practice here
103
104 MD Yeah within the practice erm and also I mean there are also other professionals
105 outside of the practice such as OTs and physios (AC mm) erm I think on the whole
106 erm you can access an awful lot of help and information (AC uhmm) and them as
107 well although you don't tend to know them quite as well on a personal level (AC
108 right) which erm I think if you know people on a more personal level or you perhaps
109 see them everyday and you interact with them everyday then yes you build up a
110 better relationship but working relationships with other professionals erm yeah you
111 can you can (pause) I don't know where I've gone now (both laugh)
112
113 AC You were saying about
114
115 MD It is it is very good you can people are always willing to offer advice if they
116 possibly can you know if you're stuck (AC mm) but again it's reliant on you actually
117 (AC mm) tapping into that and admitting that is it admitting I don't know asking for
118 advice (AC mm) and clarification and things which I think sometimes we're not
119 always good at doing (AC right yeah) (both laugh) we like to I don't know whether
120 it's erm people see it as admitting a weakness if they have to go and ask (AC mm)
121 for help or not but erm you don't learn if you don't ask (laughs)
122
123 AC And erm again you mentioned a broad variety of things so what other things do
124 you find meaningful in your work?
125
126 MD (pause) erm (pause) to me it again it's the feedback that you get erm from the
127 patients and from your staff and other members of staff if you if they can see that
128 you're doing a good job that you've done a good job that you maintain it's just
129 getting that positive (AC mm) feedback about what you're doing (AC mm) erm I like
130 to I like to know that I'm you always set your own standards don't you? And I
131 always strive to maintain those standards regardless of any other pressures that might
132 be brought to bear at the time erm and I think when you can actually complete what
133 you wanted to do erm that you've made a good job you've achieved your goals (AC
134 uhmm) and you know you've done a good job do you know (AC mm) what I'm
135 saying that its really meaningful to me (AC right) erm it's also a source of frustration
136 if you can't actually achieve what you're wanting (AC mm) to achieve for whatever
137 reason erm it's difficult to think of examples really erm (pause) I suppose one of one
138 of the big areas that that we do we do quite a lot of terminal care (AC mm) and I
139 really enjoy that sort of work which sounds strange and a lot of people sort of 'how
140 can you enjoy doing that?' But in that environment you're in a position to really
141 make a big difference but again it's going back to the supportive thing sometimes it's
142 not a lot of the physical things that you actually do it's the way you interact and
143 support the patient and the family (AC mm) that makes the biggest difference (AC
144 mm) and erm in a lot of respects it's about just being there and allowing people to
145 talk about their fears and concerns and yes you've got some expert knowledge so you
146 can actually assist in that way (AC mm) erm and access resources and things to help
147 I think the biggest part of that comes from support and it is very erm sometimes it's

148 quite humbling to be in that environment (AC mm) if you will erm I think it's er a
 149 privilege (AC mm) to be able to support somebody in the very emotional stage erm
 150 and to be not even to be thanked afterwards but you can just tell how appreciative
 151 families are erm (AC mm) of the support that you've given them and that to me is
 152 one of the most they don't have to say it they don't have to give a card (AC mm) or
 153 whatever you can just you can tell that you just being there has made a big difference
 154 to them (AC mm) erm and that is a very meaningful part (AC mm) of my job really
 155 (AC right) erm and I think with it being a privilege I think it is a privilege that we
 156 can do that that we are allowed to do that it doesn't doesn't always work out as you
 157 would like it to because of the other restraints and you know resource issues and
 158 things like that but I think so long as I feel that I have made I have done the best that
 159 I could given all of the circumstances then (AC right) erm yeah

160
 161 AC So what are some of those constraints erm that make it difficult for you to
 162 achieve what you want to?

163
 164 MD Sometimes it's erm accessing resources and that may be erm extra staff erm (AC
 165 mm) getting extra care in for the families even sometimes if perhaps they want to go
 166 into the hospice and there aren't any (AC mm) beds erm or conversely if they
 167 desperately want to stop at home but there just isn't that support network available
 168 erm it could be any number of reasons (AC mm) it could be from a staffing point of
 169 view erm getting packages of care in it could be that the family aren't in a position
 170 aren't actually able to erm be there for that patient so sometimes sometimes they
 171 don't have any family at all who can be with them and in that instance that is very
 172 difficult (AC mm) to be able to allow somebody to be able to stop in their own home
 173 (AC mm) so erm it is a source of frustration but I would really well I would hope
 174 anybody would really try very hard to get things in place (AC mm) erm if it doesn't
 175 work out then yeah it is a source of frustration but if I know that I have explored
 176 everything that I possibly could think of to try and enable that to happen then that's
 177 that's as much (AC yes) as I can do (AC yes) I know that I've done the best I could
 178 (AC mm) in that situation (AC right) erm (pause) (AC yeah) so sometimes you can't
 179 get the equipment you might need (AC right) erm maybe because we haven't got it
 180 or it might be you know might be we have got it but it's all in use or (AC yeah yeah)
 181 it's just resources are always finite they're not (AC yes) so you can't always rely on
 182 the things that you really need to be there (AC mm)

183
 184 AC A little while back you mentioned er you said I've got my standards that I work
 185 to (both laugh) can you explain a bit more about that?

186
 187 MD (pause and laugh) We have set standards and procedures and erm I think if we're
 188 all truthful we all have our own standards I suppose that we aspire to (AC right) and I
 189 suppose a lot of it might be about thinking how would you want yourself to be
 190 treated (AC mm) in this situation how would you want people to deal with erm deal
 191 with you in this situation? And I suppose a lot of that I suppose that's your yardstick
 192 (AC mm) isn't it that you would like to treat people as you would want to be treated
 193 yourself or you would want another member of your family to be treated and I
 194 suppose I suppose that might be the level that I (AC mm) look to sometimes perhaps
 195 it's a little bit unrealistic erm maybe (pause) you have to you have to you've always
 196 got to relate that however to what the patients actually say they want that can't be
 197 your overriding because that may not be what they want (AC sure) erm I suppose

198 there's two things working side by side there (AC mm) erm because we do listen to
199 what the patients want (AC mm) and I suppose that's another aspect if that doesn't
200 fall in with what I would want then I take my level from them (AC mm) if you do
201 you understand what I mean (AC mm) erm so long as that is acceptable practice (AC
202 yes yes) it's er I'm not thinking of any one situation really it's difficult to erm
203

204 AC You are suggesting that you would want to be listened to (MD yes yes) if you
205 were the patient or if it was your family
206

207 MD Yes and I suppose that's around not being judgemental (AC mm) and erm
208 letting your own values erm not contradict but erm cause problems you know if your
209 own values don't fall in line with what somebody else's do then erm you've you've
210 got to work in conjunction with with the family (AC mm) you can't be judgemental
211 because of the way the way somebody lives (AC yes) isn't the way that you would
212 live that's their choice and erm I think I'm going to put myself on the spot now I
213 suppose you within certain limits you've got to accept that obviously if the way
214 they're behaving or the way they are living is going to actually be detrimental to
215 somebody else then obviously we've got a duty (AC mm) to address that (AC sure)
216 erm but sometimes people live their lives differently everywhere don't they erm so
217 we've got to be aware of that and we've got to work within that (AC mm) not putting
218 our own values on them (AC mm)
219

220 AC Yes it's very complex isn't it?
221

222 MD It is yeah it's not just very cut and dried (AC no no) but you are I think however
223 hard you try you are always in some way influenced by the way that you would like
224 (AC mm) things to be (AC mm)
225

226 AC And you have an idea of what that might be for yourself (MD Yes) AC yeah
227 (MD yes yes) right. When we were making the tea you said that you felt passionately
228 about the leadership thing (MD laughs) erm do you want to explain a bit about that?
229

230 MD Yeah erm it's very simple really. I think at the moment within the NHS I think
231 the patient appears in quite a lot of instances to be being erm invisible really they
232 seem to be a commodity rather than people erm there's an awful lot that we hear
233 about targets and you know all the NSF we've got to reach all these targets (AC mm)
234 and it's all very task oriented a lot of the work we do now and somehow erm the
235 patient seems to have been moved out of the centre if you will and the task has
236 become the overriding aim or the target has become the overriding aim and the way
237 that the patient feels and erm I suppose it's all about the patient experience and and
238 about what is happening to them seems to have just disappeared and they've been
239 taken out of the circle you know (AC right). The leadership thing is about I suppose
240 to coin a phrase going back to basics and erm bringing the patient back into the
241 centre and realising they are a person and actually listening (AC uhum) not just is it
242 listening to hear or (AC right yes) you know you can listen without hearing can't
243 you? (AC yes) Really listening and hearing (AC mm) what the patient is saying to
244 you. You always hear these stories of erm that erm you know the nurse came in and
245 looked round and I don't think they've even seen me (AC mm) you know they just
246 got on with the task. The one that I like is the advert there's a man in the hospital bed
247 in all the plaster and the nurse comes in and puts the strawberries down (AC oh right)

248 on the bed table at the end and he obviously can't reach them (AC uhum) and comes
249 back 'oh you don't want these' and takes them away (AC yes) you know there's no
250 thought that well actually he can't get them himself (AC mm) erm and the leadership
251 thing is about really bringing the patient back into the centre of things (AC mm) and
252 thinking about how what we do effects them but also about listening to what it is that
253 they actually want erm I think one of the not one of the biggest things but one of the
254 things that I remember about nursing early on was around a little old lady who I can't
255 remember the exact details but there was something about her going into hospital and
256 she didn't want to go into hospital erm people kept saying oh she's not going to go
257 she's not going to go but when somebody actually sat down with her and talked to
258 her actually talked to her she was actually worried about who was going to look after
259 her dog while she was away (AC yes) but nobody had actually (AC mm) sat down to
260 talk to her about it (AC mm) so they got the dog sorted out and she was quite happy
261 to go in for whatever procedure it was that she needed (AC right) you know and that
262 to me just makes me you can overlook so many things (AC mm) if you're not careful
263 and the leadership thing is about bring back awareness (AC mm) because it's
264 probably one of the you know we all wanted to help people and make a difference
265 when we came into the NHS I would say you know (AC mm) the main things that
266 people would say 'I want to help people' erm and yes but it's also about
267 rehumanising it as well (AC mm) somehow (AC right) (pause) and again it is about
268 listening to a lot of the things that patients want are about erm well the problems the
269 things that worry them most are quite often the impact that their illness or treatment
270 is going to have on the rest of their life (AC mm) I think that perhaps we see it more
271 in community (AC mm) or within primary health care than they do in hospitals
272 because they've already been taken out of the day to day environment (AC yes) erm
273 and they're not allowed to carry on with their normal day to day living if you will but
274 when we're dealing with people in their own homes they may still have jobs to go to
275 they've still got family to think about (AC mm) erm you know I just think about if I
276 was having some form of treatment where I was told oh no you can't have a bath or a
277 shower for you know until this wound's healed up I'd be I'd be appalled that would
278 be the one thing that would worry me more than anything you know (MD laughs)
279 (AC yeah yeah) and yet sometimes things can be addressed so simply just by putting
280 a waterproof dressing on something you can then have a shower (AC sure) but
281 sometimes we don't think to explore that sort of thing (AC mm) and the program is
282 showing also that it doesn't matter what your job is you can be a porter or a domestic
283 or whatever we all have a responsibility to making that patient experience a good one
284 (AC mm) erm you know even if its just sitting down with somebody and saying is
285 there anything I can help you with is there anything that you would like me to do or
286 need me to do it it just makes it much more human and that you are wanting to do
287 something (AC mm) you know you're not just looking over them to see what the
288 next job (AC mm) is to do (AC mm right)

289
290 AC What do you think are going to be the challenges in facilitating that as you take it
291 out to other members of staff?

292
293 MD Erm (pause) I think the challenges are probably going to be the ones that
294 challenge everything in that 'oh you know we've not got a lot of time' although
295 that's a very difficult argument to bring in because it's not difficult you know I'm
296 thinking it's not difficult to do to make those little changes I think it's sometimes it's
297 just a way of erm you've got to keep reminding yourself during your day to day work

298 right OK let me just think about the patient now (AC mm mm) erm we're all
299 pressured for time and it is very easy to just look at what jobs need doing (AC mm)
300 and sometimes we get on with our jobs without actually talking to the patients and
301 erm working with them and explaining to them what it is we can do or what we're
302 about to do (AC mm) and erm and I think we're very good at keeping quiet while we
303 go about our business (AC right) erm it's it's all revolves around communicating and
304 ensuring that people have understood and that you have understood (AC mm) them
305 (AC mm) before

306
307 AC So you think others might feel that the time is going to be the barrier to actually
308 doing that?

309
310 MD I think so plus I think that the the way that they've learnt to practice (AC mm)
311 it's not a big change that needs to take place but it's a different way of thinking (AC
312 sure) really (AC mm) it's not really going to take up anymore time (AC mm) in fact I
313 could see that in some instances it would actually save time (AC mm) erm because
314 you wouldn't get people who are reluctant to it may help in situations where people
315 are reluctant to undertake erm a certain treatment that was going to be beneficial for
316 them because they might not fully understand how it's going to help them and what's
317 going to happen (AC mm) erm I mean it doesn't always take a long time to
318 communicate (AC yes) it lessens the anxieties (AC mm) if you will sometimes or
319 allows people to erm open up and say what their anxieties are so that you can (AC
320 mm) help to address them or try and reassure them that actually it's going to be OK
321 (AC mm right right) so I think I think one of the challenges one of the other
322 challenges because I've just done one of the programs is that erm I don't know
323 whether it's an embarrassment thing that erm you know maybe because they're
324 changing the way that they interact erm other people might think what's got into
325 them (AC right) erm I was just thinking of a comment that somebody made about
326 erm because it's about trying to recreate a positive atmosphere as well so (AC mm)
327 we do an awful lot of good work that we aren't good at acknowledging (AC mm) we
328 acknowledge the things that we don't do well but we don't do an awful lot about
329 acknowledging the things that we do do well (AC mm) so perhaps a change in
330 culture might be begin to congratulate people if they've dealt with a situation well or
331 you know they've had some success somewhere erm and I suggested that they might
332 like to think about every day within their workplace finding something that they
333 could congratulate somebody on (AC right) which ended up with er you know a bit
334 of a wide eyed 'what are they all going to think if I start doing that?' (AC laughs)
335 well just try it (AC yes) and you'll be amazed at the difference (AC mm) that it can
336 actually make to the environment (AC mm) erm you know they go away happy you
337 go away happy because you've made them happy by congratulating them it doesn't
338 take it doesn't take anything

339
340 AC Mm yes it's interesting isn't it because it's asking people to change behaviour
341 and that's incredibly difficult

342
343 MD It is it is difficult yeah but it's not big changes that need to be made (AC no) and
344 I think they're positive changes as well (AC mm yes)

345
346 AC Yes that sounds like a really interesting project (MD mm) yeah. So just to go on
347 a slightly different angle here (MD laughs) would you say there's anything about

348 your work that you don't enjoy or that you find dissatisfied about (MD erm) or gets
349 you frustrated?

350
351 MD (laughs) frustrations erm I mean I suppose the same difficulties that people have
352 that other people other professionals have not only in the NHS but in other erm work
353 environments as well erm the constraints that are put on you through erm perhaps
354 poor staffing levels perhaps erm inadequate skill mix erm lack of resources can can
355 go on really (both laugh) (AC right) erm I mean that's around the sort of erm what do
356 they call it like the establishment type (AC mm) issues really erm it is a source of
357 frustration in some respects I don't know whether you become a little not resigned to
358 it but you do try and adapt to the different pressure that you work under but I think
359 when you are under a sustained pressure from poor staffing levels and difficulties in
360 getting supply staff and things like that erm it can be quite wearing at times (AC
361 mm) and I think it becomes wearing because you're trying to protect that having an
362 effect on the care that you give (AC mm) the patient so you don't want that to effect
363 the care that somebody receives (AC mm) erm which can be like to view it as
364 challenging (AC mm) (both laugh) (AC right) erm it can be a challenge (AC mm)
365 yeah erm other frustrations are probably when you can see that a certain path in the
366 care of somebody would probably meet the outcomes in that it might actually say for
367 instance in wound care if you are wanting to put a certain treatment on that wound
368 that you know would be the best but the patient is actually resisting going down that
369 route because of a variety of reasons and you can understand their reasons (AC mm)
370 but sometimes you think well erm sometimes you've got to sort of compromise and
371 in the long term this would actually improve things so much more quickly (AC mm)
372 erm and and that can be a frustration but it's a frustration that you've got to be
373 careful that you don't pass that on to the patient if you will (AC mm) erm you can
374 only try and be objective and give the explanations (AC mm) as to why you feel that
375 treatment would be best there's always other options they may not be the best option
376 but if that again there's a lot of things come in to play there because if you erm
377 persuade is persuade the right it might be the right word to use say for instance you
378 can persuade a patient to try a course of treatment (AC mm) they may not actually
379 totally comply with it (AC mm) so in that respect you'd be better going for
380 something else that they are going to comply with (AC mm) so it it's all I suppose
381 it's all about negotiating and being able to weigh up the pros and cons (AC mm) and
382 again I suppose that would only come out of good communication (AC mm) with the
383 patient and being able to identify that the best treatment as you see it may not be the
384 best treatment for them (AC right yes) erm (AC mm) so I suppose it can be (AC mm)
385 frustrating and I think when patients constantly erm complain about something but
386 whatever advice you give them they wont actually take it on board or do anything
387 (AC mm) about that problem that they are complaining about (AC mm) erm that is
388 frustrating (AC yes) as well (AC yes) but you can only try (both laugh) (AC yes keep
389 trying) yeah and approach it from different angles but you know (AC mm) erm you
390 still get people who are stubborn and don't have any real erm reason to be that
391 stubborn (AC mm) I don't know (laughs) (AC yeah) erm (pause) the example around
392 that that I could give you is a patient that erm complains of pain and you can give
393 them advice about how they might be able to reduce that pain either by analgesics or
394 by erm adjusting their perhaps their way of life you know perhaps around to do with
395 mobility erm resting and exercise and things like that but if they don't take that on
396 board they don't want to take their tablets they don't want to stop what they're doing
397 but they will still complain (AC mm) about the pain erm what more can you do (AC

398 yes) what more can you do? (AC yes) erm (AC mm) it is frustrating but you can only
399 keep giving the same advice (AC aha yeah)

400
401 AC Is there anything else that you would say you find frustrating or that you don't
402 enjoy about what you do?

403
404 MD Erm (pause) sometimes I think erm I can get frustrated by the not just the
405 demands of the job but the erm I'm sort of going away from patient things now and
406 to the work environment trying to fit everything in (AC mm) you know work and
407 home and all the rest of it (AC mm) it sometimes can turn into a big juggling act you
408 know (AC right) and trying to er keep everything moving (AC mm) (MD laughs) I
409 don't know whether I bring some of that on myself because I like to I wouldn't say
410 erm no I think for my own development I have an awful lot of interest areas if you
411 will but then I think that's part and parcel of the job if we just stuck to our job and
412 didn't erm go to I'm thinking of the different groups that I'm actually in and the
413 different things that I'm doing along side the district nursing jobs that I do (AC
414 uhum) I think they are all part and parcel such as the district nurse development
415 group and getting involved with er record keeping (AC mm) and things like that erm
416 we need to do that (AC mm) that to me is part of the job but actually trying to fit it
417 all in (MD laughs) (AC yes) can become difficult sometimes (AC yes yes) erm and
418 sometimes you can find that one impinges on the other (AC mm) erm and then you
419 start getting your home life sort of impinging I suppose you know (AC mm) well
420 you're stopping on to do this but then you've got to get home to sort the kids out then
421 you're doing the shopping and who's making the tea (AC right) (MD laughs) you
422 know so erm yeah I don't know whether that's a frustration or a bit of an anxiety I'm
423 not sure (both laugh) (AC right) but it all makes for an interesting life I suppose
424 (both laugh)

425
426 AC Yes I bet you don't get bored

427
428 MD (laughs) not very often no (pause)

429
430 AC So is there anything else you want to add about you know what you enjoy and
431 what makes you

432
433 MD What makes me get up in the morning?

434
435 AC Yes what makes you tick in this job yeah

436
437 MD I just I just enjoy it really (AC mm) I enjoy all the things that I've said I enjoy
438 erm I do enjoy I enjoy the challenge (AC right) that the job presents and I enjoy the
439 variety (AC uhum) within the job as well (AC mm) erm and that can be the variety of
440 things that we do (AC mm) erm it's the variety of the people (AC mm) that we come
441 across (AC mm) and deal with the variety of experiences that that they've had and
442 that you find out about (AC mm) erm (pause) I think yeah the challenge erm I enjoy
443 being having autonomy I suppose (AC uhum) or a form of autonomy within the job
444 (AC mm) I think the district nursing I want well yes perhaps it is unique erm you get
445 such a good variety you can work on your own erm you're working as part of a team
446 and that can be small intimate district nursing team it can be within the (AC mm)
447 wider primary health care team (AC mm) and erm in a lot of it you are your own

448 boss (AC mm) you are the decision maker in that area or certainly as a team leader I
449 am the decision maker although they all all the other members of the team do make
450 decisions as well (AC mm) but erm you know I admit people to my case load and
451 work with them (AC mm) to decide what care they are going to have and erm
452 working in partnership with the patient and things like that it's I enjoy that
453 environment (AC mm) it's not everybody's cup of tea which is (AC mm) good I
454 suppose (both laugh) because we'd all be vying for all the jobs wouldn't we (AC
455 yeah) erm but yeah plus obviously you've got the erm the independence of actually
456 you've got an office but you can get out you're not restricted to being in a hospital
457 (AC mm) or you know there's such a lot of variety within the job (AC mm) erm and
458 that in itself when we talk about challenges again I think we've probably touched on
459 it can be a challenge in that erm you're not confined to say medicine or surgery or
460 (AC mm) you get the whole complete gambit of things as GPs do (AC yeah) and that
461 that can be a challenge (AC mm) because you're trying to give advice perhaps to
462 people (AC mm) on areas that you perhaps don't have an awful lot of knowledge or
463 you know so you need to go on and find out about things (AC mm) yeah so (AC
464 yeah) I enjoy that (AC yes) I enjoy that

465
466 AC That's great anything else you want to add (both laugh)

467

468 MD No I don't think so

469

470 AC No OK well that's brilliant thank you

Transcript Summary

Interview 13 DN

This transcript suggests that MD values making a difference to someone who has a need^{18,21,34}. She enjoys interacting with the patient and their family³³ and enjoys working in partnership with them⁴⁴⁷. She views her work with patients as a journey of learning together⁴² where she might learn as much from the patients as they might learn from her⁴⁴. She tries to get down to the level of the person she is helping to provide information²⁹ and to help them to be as independent³² and to maintain as full a life as possible⁴⁹. MD is not so much focussed on the disease process as on the resulting encumbrances for the patient^{46,48} and how it effects the rest of their life⁵².

MD sees communication as instrumental in impacting on the effectiveness of her work^{56,64}. She aims to communicate with people and to ensure they have understood³⁰¹. She believes this involves not only listening to the patient^{239,265} but also hearing what they have communicated^{239,241}. She focuses on the patient and not just on the job or the task at hand^{285,297} and wants to place the patient in the centre of focus in her work^{233,264}.

Teamwork is important⁴⁴¹ to MD both the smaller immediate team^{82,83} and the wider Primary Health Care Team⁸⁴. She feels that support within the team is important^{89,96} and that taking care of team members is important⁹⁶. She feels that her aim to maintain standards and improve^{88,128,129} is shared with her team. She tends to abide by the standard 'how would I want to be treated in this situation?'^{187,190} but also realises that her own wishes may not be congruent with the patients'¹⁹⁶. She aims to work in conjunction with people and not be judgmental so long as the patient is not having a detrimental effect on someone else²⁰⁸.

MD enjoys terminal care¹³⁶. She feels that in terminal care she is in a position to make the biggest difference¹³⁸ and feels that it is particularly meaningful to know that you have made a big difference¹⁵¹. She sees interacting with the family and supporting them as the most crucial part of her role in terminal care¹³⁹. She feels it is a privilege to assist and support someone in their terminal illness^{145,153}.

MD feels frustrated when she is not able to access resources be it staff, equipment, family or packages of care for patients who are terminally ill¹⁷³. This is frustrating because it prevents her from providing the best possible care^{173,350}. Patient resistance to treatment³⁶⁴ and constant patient complaints³⁸¹ can also be frustrating when patients have been offered solutions to their problems and have chosen not to accept advice or act on advice. Overall demands on time can be frustrating resulting in juggling and home and work life commitments⁴⁰¹. The problem with this is that it results in not having adequate time to spend with patients at times when they need her⁴⁶⁸.

MD values learning from others¹¹⁹ and values positive feedback from patients and from staff¹²⁴. She is prepared to ask for advice and support when she needs it¹¹⁵ and finds that knowing she has done a good job is really meaningful¹³³. She sees getting involved in various development groups as an important part of her job⁴⁰⁹. She generally enjoys all of her work⁴³², she enjoys the challenge⁴³³, the autonomy^{438,442} and independence⁴⁵⁰, the variety of people she works with and the variety of things that she does^{434,440,452}.

The small numbers refer to the line of the transcript where the idea can be found May 19th 2004

Interview 14 NP

1 AC As you know this is a really unstructured interview and it just starts with one
2 question and then erm we'll go from there wherever you want to go (MW right) so
3 the opening question is what do you find most meaningful in your practice as a nurse
4 practitioner?
5

6 MW Most meaningful? (AC mm) Erm (pause) I think for me very definitely there's
7 two things (AC aha) erm one is from the patient's side of it of being able to erm
8 translate information for the patients erm and even though you may have had a sense
9 that somebody's had exactly the same consultation with a doctor or even with
10 another health professional sometimes just going through it at a different speed or
11 using different words or sometimes just the informality of it means that the same
12 message is put across but it's taken or received differently (AC mm) so I actually it's
13 it's the almost like the go-between element of translating health professional jargon
14 into meaningful language really and then the other thing about it is from my point of
15 view that I just thrive in this culture I'm you know I've been away done lots of things
16 dabbled in lots of things and yet I always come back to the same thing because it
17 gives me a tremendous amount of buzz in my life erm it it's meaningful for me and
18 allows me to carry on and work
19

20 AC Mm do you want to explain that a bit more?
21

22 MW (laughs) erm yeah I mean general nursing some people are I think what they call
23 nurse nurse touchy feely kind of people who like to do tasks and clean people up
24 and but that's not me and so I didn't quite fit there and then I went to midwifery and
25 again quite enjoyed it very meaningful time for people but there was an enormous
26 task element to it (AC mm) that still wasn't very meaningful and yet then I jumped
27 from there neonatal intensive care because I went the other way and decided right
28 maybe it's relationships I'm not good at therefore we'll go to technology. Enjoyed
29 the technology because it stimulated my brain but felt something was missing then
30 jumped to primary care and I just love the wealth of you know types of people that
31 you see the interactions that you have erm the fact that it's not the same thing the fact
32 that it stimulates your brain all the time (AC mm) that it's you can jump from a
33 mental health problem to erm you know asthma (AC mm) and that there's so much
34 complexity around it and it stimulates my brain in trying to understand things unpick
35 things put the pieces together erm (AC mm) and that whole picture (AC mm) is just
36 so rich (laughs)
37

38 AC Right right can you explain any more about that picture and about the things that
39 you particularly enjoy?
40

41 MW Erm yeah I like I like the different types of people and it never ceases to amaze
42 me in your consultation there are certain consultations where you know it's been a
43 good consultation you almost feel the hairs on the back of your neck stand on end
44 (AC mm) because you know for that one second or for that one minute you've
45 actually touched something (AC mm) and you may never be able to say what it is
46 you've touched or what impact you've really had but you feel you've had an impact
47 or made a difference to somebody's life (AC mm) and those are few and far between
48 but when they happen they carry you along for a good period of time (AC mm) and

49 then of course there's the bad consultations that you have that you acknowledge are
50 bad consultations but then when you actually start to reflect on them they give you so
51 much opportunity to develop yourself that that's almost as rich again (AC mm) I
52 mean fairly recently I had my first ever complaint about a consultation and from a a
53 technical erm point of view or from a medico legal point of view there was no
54 problem at all it was completely safe practice but the one thing the patient had picked
55 up on was that she felt I'd erm linked on to a mental health issue (AC mm) and when
56 I reflected on that because at first you go through the 'I got it totally wrong and I
57 didn't know I'd got it totally wrong why had she made this complaint' but when you
58 actually reflect on it and you actually start to think about all the you know how was
59 that patient booked in in the morning and her expectation hadn't been to see me erm
60 then because it was a patient that I didn't know I was new to the practice and because
61 she'd got a previous history of something you then start to think 'oh did I pick up on
62 that because it was (AC mm) mentioned before and if I'd have known the patient I
63 would have trusted my own instincts and things' so you start to unpick it and those
64 are the things that give you the richness then because it builds you into a richer
65 stronger person for the next consultation along (AC right) and you don't get that in
66 any other form well I didn't in any other form of nursing role (AC mm) it's that
67 continuous learning cycle (AC mm) that's enriched by life itself (AC mm right)

68
69 AC So this area is particularly er good for you (MW yeah) and exactly what you do
70 in this area (MW mm) yes right. At the beginning you started talking about er
71 translating for patients (MW mm) erm can you explain a bit more about that?

72
73 MW yeah I think erm I mean it's changing now because I think in the past you know
74 doctors were respected citizens of the community and everybody just took what the
75 doctor or the lawyer or the church man said implicitly without any discussion
76 whereas now people are starting to question things and therefore we're getting a new
77 breed of doctor who may be just as good a communicator as some of the nurses out
78 there but certainly when I was training good communication in doctors wasn't wasn't
79 always there (AC mm) or whether it maybe it's just the pressures of work that
80 changed in terms of they were so much more busy that they didn't have the time to
81 stand and talk with the patients so therefore the nurses were always the better
82 communicators but even in general practice you know you get so wrapped up in
83 jargon seeing things day after day that maybe you do just assume that people know
84 what you mean (AC mm) by the language that you use or that they will just comply
85 because for goodness sake they've come here and they were expecting something so
86 here it is they've got something (AC mm) you know whereas it is more you
87 experiment more now with asking patients about what it is they want what their
88 expectations are erm you know and the hidden agendas in the consultations you
89 know. Only the other day somebody came through and essentially it looked as if she
90 was coming about her chest the whole of the first ten minutes was about her chest
91 and then we got onto so what impact is it having on your life and actually the reason
92 she had come was the stress incontinence and probably wouldn't have mentioned it
93 until you know or maybe would never have mentioned it but because we asked a
94 question about you know impact on her life out comes well actually that was the
95 impact and that's what made her come (AC mm) so she really wasn't bothered about
96 her chest did she need antibiotics was it bacterial viral all that went out the window
97 despite having gone through it (AC right) it was really what we going to do about the
98 stress incontinence because since I've been coughing more frequently

99

100 AC yes yes so that's about your history taking and (MW mm) yeah excellent. Erm
101 when you think you've been talking a lot about erm your role in the practice and
102 your sort of day to day contact with patients and what you enjoy about that is there
103 anything else you know on the broader scheme of things that you particularly enjoy?
104

105 MW Beyond the patient contact? (AC mm) Oh yes yeah I mean as I say I've worked
106 around a lot of practices and had different roles it sounds like I'm a bit of a flitter
107 here (both laugh) but each practice each job that I've gone to I've always tried to
108 build in something different something you know that would stretch me erm and
109 initially when I was doing this it was very much focussed on chronic disease and the
110 next place that I worked at I focussed very much on acute medicine and here I've
111 picked up management in that I have complete responsibility for the quality and
112 outcomes framework erm and do an awful lot of the practice management nurse
113 management erm even receptionist training erm and more and more getting involved
114 in business things (AC mm) and maybe looking at you know partnerships with
115 practices. Erm initially that was my main intention for getting back into practice was
116 I decided I wanted to put roots down and be attached to a practice instead of an
117 employee erm because employees move around all the time and I felt that the one
118 thing that the GPs strength was in being static (AC mm) and getting to know their
119 patients (AC mm) and whilst I needed to move around for a period of time to build
120 up my skill and to supplement perhaps what I didn't have that junior doctors got I
121 needed to move around but now I want to know the patients I want to know the
122 history I want to know who their families are what the accommodation they live in is
123 like without it being mindless information erm so I looked very much towards a
124 partnership thinking that's a way of doing it things have moved on and lots of people
125 aren't looking for formal partnerships because it means buying into buildings
126 committing cash but you can have informal partnerships (AC mm) erm and I think
127 maybe that's the way to go and be an associate partner in that you have a fair share in
128 the decision making about the practice's development the services the resources erm
129 but not necessarily buying into a property (AC right) you know (AC mm) erm and
130 not having the out of hours (both laugh) (AC yes) I mean I did think about doing
131 home visits and things like that but the more I actually think about it you are out
132 there on your own it is very difficult to actually get somebody admitted even from
133 the surgery when you ring in and you know that you know you want them in it
134 takes a lot and without formal tools of assessment to just rest purely on clinical skills
135 I think it would take a lot to get an admission so I think you'd be practising unless
136 the current climate changes a lot I think you'd be practising on the line and find it
137 quite stressful (AC mm) so I don't tend to do visits (AC mm) although I know other
138 nurse practitioners do (AC mm) but there again maybe they're not doing acute visits
139 maybe they're doing visits to review somebody's chronic disease or things like that
140 (AC mm) in which case that's different (AC mm) but you know I just feel that yes
141 somebody that I think is in acute heart failure if they're in the surgery and I've got all
142 the tools like the ECG (AC mm) I could argue my case with anybody to get them in
143 but just examining in the home (AC mm) and still wanting to get them in I think I'd
144 you know find that stressful (AC mm)

145

146 AC So that's one of the points where you draw a line for (MW yeah) what you do
147 (MW yeah) right

148

149 MW I do have definite lines around what I do and don't do in practice I don't get
 150 involved at all in erm increasing and increasing pain relief (AC right) erm I just don't
 151 think those kind of patients because one they could be abusing the system and two I
 152 tend to think that if they are needing increasing and increasing pain relief then they
 153 need the continuity of care with a health professional that is seeing them through
 154 whatever episode is requiring that increase pain relief so seeing somebody as a one
 155 off same day access is not the place for those patients to be (AC mm). I don't get
 156 involved with erm I'm just trying to think the other things don't tend to do an awful
 157 lot of mental health (AC right) I'll see again acute situations mainly because I'm not
 158 mental health trained but I'll see acute situations and I'll refer them onto appropriate
 159 services or encourage them to make a contact with their preferred GP (AC uhum) but
 160 again I mean I think some of that is the fact that I only do three days and somebody
 161 with a mental health problem there probably does need again that continuity of care
 162 (AC yes) you know that can access you whatever day (AC yes) erm but I mean if it's
 163 a crisis intervention situation then same day access yeah that's not a problem (AC
 164 mm). So yeah I guess it's the things around continuity of care which is the very
 165 reason that brought me into the practice (laughs) (AC right interesting yeah laughs)
 166 the things that I've avoided are the things that I actually came into the practice but
 167 again it's because I'm not fixed here and not full time I think

168
 169 AC Yeah or because you value those things so highly you want those things for those
 170 patients and when you can't deliver it (MW yeah) then you don't do it (MW yeah)
 171 yeah

172
 173 MW And I think it is the continuity of care that when I first started as a nurse
 174 practitioner I worked in a practice where I had been a practice nurse for eight nine
 175 years and very much took for granted a lot of information that I knew (AC mm) and I
 176 also worked with GPs who would say 'oh by the way Mrs so and so do you
 177 remember Mrs so and so she's got the daughter with the' you know (AC mm) and
 178 they knew very much erm the infrastructure of that family. I took it for granted then
 179 you move away and now that's the bit that I think (AC mm) you know is the
 180 important thing really (AC mm) which makes a farce really of all the out of hours
 181 ideas and the credit card business where people's information is stored and they'll
 182 just access any health professional (AC yes) (laughs) (AC yes interesting) (pause)

183
 184 AC When we were making the cup of tea you were talking about erm being involved
 185 in education (MW uhum) with students erm where do you fit that on on all the things
 186 that you enjoy (MW mm) and things you find meaningful?

187
 188 MW Yeah I mean it is meaningful and I hadn't realised perhaps how meaningful I
 189 mean the other day I was thinking I've got an opportunity to get involved with
 190 training as we were discussing and at first I thought oh it's too much hassle I'll just
 191 walk away from this one because I knew this was probably an opportunity that
 192 another practice would pick it up and the more I thought about it at first I was a bit
 193 territorial this is my idea this is my bid why should somebody else take it away from
 194 me but then I actually started to think about it in terms of you know I'm not a
 195 visionary or a leader in certain respects but I have come through an awful lot of
 196 experience and that maybe other people could benefit from that (AC mm) you know
 197 and therefore it's a bit like if somebody hadn't believed in me in the first place to
 198 allow me to develop into what I am and given me a leg up on the way then maybe I

199 wouldn't be here now (AC mm) I know I wouldn't be here now and therefore there's
200 a certain debt isn't there? And I mean the piece of research that I did for my masters
201 erm actually looked at evolving advanced roles and I actually concluded that
202 research with the fact that you know for each species that dies off a more butterfly
203 beautiful species will emerge so much stronger and braver than we were so it is a bit
204 like yeah we've done well for ourselves now but if we are going to shape the future
205 then we really need to give people a leg up to get to where we are so that they can
206 build further (AC mm) and the nurse practitioners in ten years time will be doing so
207 much more than we do (AC mm) but if we don't give 'em a hand (AC mm) then they
208 aint going to get there (AC mm) (laughs) so it's a bit like yeah it's time to pay back
209 in a way give them the benefit of your experience and save them from making some
210 of the errors (AC right aha) you know the things that like I say that I walked away
211 from that I took for granted somehow if you could give them that (AC mm) you
212 know they wouldn't go wandering around milling around they'd be a lot more
213 focussed about where they are going (laughs) (AC mm right right)

214
215 AC OK is there anything more you want to say about what you enjoy and what
216 makes you feel satisfied about what you do?

217
218 MW Erm (pause) no not really I think it is it's the patient feedback it's the you know
219 like I say living for the one or two cases that you think yeah I've really made a
220 difference today (AC right) to that person (AC aha) erm (pause) or even you know
221 the consultation where you have a really good laugh with somebody (AC yes) and
222 you think if nothing else we've had a good laugh (AC yes) put a few tales to rest (AC
223 mm) so yeah it's interacting with people (AC mm)

224
225 AC So to go off on another tack (MW laughs) erm what are the things that really
226 frustrate you in your role or the things that make you angry or not satisfied (MW
227 right)

228
229 MW The prescribing at the moment very definitely for me (both laugh) (AC right)
230 only because I'm trying to navigate this stupid course (both laugh) (AC right) and I
231 wouldn't mind except I wanted to do the course because I feel that I do have a deficit
232 in my knowledge about pharmacology but the course is just not living up to that
233 expectation (AC mm) and whilst it's a necessary hurdle that I know I have to jump
234 because we keep getting hurdles to jump I actually feel that my time would be far
235 better spent doing a full twelve months pharmacology degree or something if
236 necessary (AC mm) you know because that would actually address my needs but erm
237 the course is it's a paperwork hurdle it is literally you know putting together yet
238 another portfolio and after a while you've written so many that you can virtually lift
239 one from the other to the other erm and it actually hasn't expanded my knowledge in
240 any way because even the activities that are in the workbook whilst they might be
241 pertinent to somebody who has never actually done any kind of evaluating of clinical
242 evidence erm or any kind of formal study you know then maybe it's pertinent you
243 know but it's not addressing my needs (AC mm) and therefore it's a nuisance value.
244 And the fact that I'm then going to have to mess about with different coloured papers
245 between the printers for the things that I can and can't do you know (AC yes) I just
246 think it's a nightmare (both laugh)

247
248 AC So do you think it will even be a nightmare even when you're prescribing?

249
250 MW Yeah I'm hoping (AC mm) I'm hoping that maybe somebody can you know
251 take the blinkers off my eyes (laughs) and show me how really useful it could be
252 (AC mm) and I could see that maybe if I was more involved if I was a nurse
253 practitioner who had more of a role in chronic disease management I could see that
254 maybe that would be quite useful (AC yes) but I don't do an awful lot of chronic
255 disease management now the way that we're setting up the practice because it's a
256 training practice is that my role will very definitely be acute same day medicine (AC
257 right) and I'll do the organisational systems and the training and the support of the
258 people doing the chronic disease but I won't be seeing the patients with chronic
259 disease (AC right) so therefore you know there's a limited window (AC mm) for me
260 to actually use it but there's always another hurdle and I'm just hoping that the next
261 hurdle will be a little lower and a little less useless (both laugh) as we actually get the
262 full BNF and to be honest with you I know they keep saying about nurse prescribing
263 and everything but I wasn't one of the people who said that all nurses should
264 prescribe when the vote came out (AC mm) I said no there are definitely some
265 people that I would find dangerous (AC mm mm) prescribing so in a way I've
266 probably shot myself in the foot it's probably people like me that made the system
267 you know as it is (AC mm) but it worries me that there are people out there that this
268 course would stretch and yet it's not stretching other people (AC mm mm) you know
269 and somehow I think there needs to be two levels to it (AC mm right) so yes
270 prescribing very definitely frustrates me (AC right) erm and I was a little frustrated
271 about you know admission criteria into the hospitals and everything and referrals but
272 actually for me that's changed quite drastically over the last twelve months in that
273 most of my referral letters now aren't challenged in any way well none of them are
274 challenged and I have had some referral letters addressed back to me personally (AC
275 mm) erm and when I've rung through with admissions because it's been a training
276 practice some of the GP registrars have rotated in or the house officers have rotated
277 into the hospital to the unit that I've been ringing so they actually know me (AC
278 excellent) and I'm beginning to develop a network now (AC right) and I think that
279 was the other thing that I was missing one of the things that I took for granted you do
280 need to be within a network (AC mm) it makes it an awful lot easier (AC mm) erm
281 and somehow if we could network all the you know clinical nurse specialists with the
282 nurse practitioners (AC mm) then I think that would be a very definite advantage
283 (AC yes) you know (AC yes right)

284
285 AC So previously getting people admitted was a frustration (MW yeah) but not
286 anymore?

287
288 MW No (AC no) it seems to be a lot smoother. Again whether it's that or whether
289 it's just that I've become more assertive. I mean I had some clinical supervision the
290 other day and actually I was told that yes I am becoming more assertive (AC
291 interesting) in my consultation skills (AC mm) erm that I was dealing with some of
292 the things that would phase registrars (AC mm) now I would argue that I was
293 probably dealing with them maybe because what you don't know doesn't worry you
294 (both laugh) (AC yes) and maybe they just knew a bit more but yeah I mean some of
295 the I don't tend to see I think sometimes you tend to set off and you just see coughs
296 colds you know (AC mm) the routine things that the doctors don't want to see that
297 can be very well managed by a nurse but I do tend to get a good range of things erm
298 and I'm reactivating some of the skills. I mean again previous surgery I used to do an

299 awful lot of women's health and I was out doing a bit of education erm did acute
300 medicine for a while so when I came back here I didn't really re-instigate a lot of
301 women's health because I felt I'd been out of it for a while (AC mm) but again over
302 the last three or four months I've started to expand that again thinking well yeah OK
303 I feel a bit more secure now erm (AC mm) your basic skills never leave you (AC
304 mm) and providing you're actually practising under limited conditions with back up
305 you can then start to advance your skills again which is what I'm doing (AC right)
306 and I think that'll fill quite a niche within this practice as well because at the moment
307 we only have one female partner (AC mm) and she also does sessions at the hospital
308 so she's not always here (AC right) so there is a role for that (AC mm)

309
310 AC Right that's good. Anything else that frustrates you or gets you angry?

311
312 MW Erm no attitudes have changed (AC uhum) I mean there's always doctors that I
313 mean sometimes I think when the new house officers come in they're a little
314 surprised at who and what I am (AC mm) or what I do (AC mm) and the other day I
315 was asked to do erm an ECG which I really didn't bother about you know I was
316 actually in the middle of a consultation when the phone rang and I was asked to do
317 an ECG so I was very polite and said yes I'll just finish my consultation I'll come
318 down and I'll sort it out, what's the patient's name and I'll collect him and
319 everything and erm it turned out that erm the house officer was actually supervised
320 by one of the doctors and he hadn't realised that I was a different kind of nurse (AC
321 mm) and just thought 'I'll get the nurse to do that' but when the doctor had come
322 through and said 'well why aren't you doing the ECG yourself?' 'Oh I've asked the
323 nurse to do it' so she came flying through apologised to me profusely (AC right) and
324 said 'I think he should be in here get him in here' (laughs) (AC right) and so it was
325 quite nice because it was a bit like you know in the past that would have just
326 happened all the time (AC mm) you know the nurse's role isn't as important you just
327 get on with it and it was actually quite nice that she actually thought to say 'no he
328 should be doing this you know he's new in and he needs to realise that you do these
329 tests yourself' (both laugh) (AC yes) so it was quite nice I thought yes attitudes are
330 changing (AC mm) so that's good

331
332 AC Anything else you want to add at all?

333
334 MW No I don't think so (AC no OK) I'll probably think of loads later

335
336 AC That's brilliant M thank you

Transcript Summary

Interview 14 NP

This transcript suggests that MW thrives in the culture of primary care¹⁵. She gets a buzz¹⁷ out of working in this environment and finds it stimulating^{32,34}. MW loves the wealth of types of people and the varied interactions^{30,41,221} in primary care and particularly enjoys certain consultations when she feels she has touched something, had an impact or made a difference in somebody's life^{43,217,TC}. Change is part of the culture of primary care, there is a lack of hierarchy and a sense of freedom which appeared to be lacking in secondary care^{TC}. MW doesn't want to vegetate, feel devalued or suppressed and she found that primary care allowed her to develop self confidence and clinical abilities^{TC}.

MW feels that when a consultation does not go well this is an opportunity for reflection and an opportunity to build into a richer stronger person for the next consultation^{50,64,216}. She sees her work in primary care as a continuous learning cycle⁶⁴, indeed each job she has had previously she has tried to build in something different that would stretch her¹⁰⁷. She has moved around to build up her skills¹²⁰ and now wants to remain static in one place to build up longer term relationships with patients¹²¹. For this reason she is interested in partnership in the practice¹¹⁴ so that she can have a more stable relationship with the practice team and can have a fair share in decision making about the practice's development¹²⁷.

MW enjoys being able to translate health professional's jargon for patients^{7,13}, creating an air of informality and working with patients at a different speed to other health care professionals¹⁰. She doesn't do home visits because it feels like this would be practising on the line^{135,143} she also doesn't get overly involved in mental health¹⁵⁶ issues and with people who need increasing levels of pain relief¹⁴⁹. The reason for this is because such patients need continuity of care^{152,160,163,171} and as MW is not full time at the practice she is unable to provide that continuity for patients.

MW enjoys being involved with student education¹⁸⁶ and feels that others could benefit from her experiences¹⁹⁴. She feels indebted to the people who have helped her along the way¹⁹⁸ and feels that in order to shape the future she needs to help others in a similar way^{202,207}.

MW feels frustrated at having to do a course that is not addressing her needs^{233,240} and is not expanding her knowledge²³⁶. She is frustrated because the course is not living up to her expectations²²⁹. She was also frustrated by having problems with referrals and admissions to hospital²⁶⁸, however, this is no longer a problem and no longer a frustration. She has found that developing a network with other health care professionals has made life a lot easier²⁷⁷ which links to her decision to become more stable in a practice and pursue a partnership.

MW enjoys laughing with patients²²⁰. She feels valued in primary care and has a sense of being in control^{TC}. She feels she has done well for herself²⁰² and achieved a great deal, however, she is also acutely aware of her own limitations¹⁴⁸ and will not use clinical skills unless she is feeling secure and confident about them³⁰⁰.

The small numbers refer to the line of the transcript where the idea can be found TC=Transcript check
May 18th 2004

Interview 15 GP

1 AC This interview is very informal erm and basically what I'm interested in is
2 anything that you find meaningful in your role as a GP erm so very broad question
3 and we'll just go with wherever you want to go from there

4
5 MA Can you just explain that to me again and the question?

6
7 AC What do you find most meaningful in your role (MA meaningful) as a GP (MA
8 OK) so what is it what is it that makes you tick that you enjoy?

9
10 MA A couple of things one er big aspect is the actual family medicine being
11 involved with the whole generations of grandparents parents and grandchildren
12 children knowing the dynamics of the family and therefore knowing how illness fits
13 in to that which I don't think anyone else within the medical field knows what's
14 going on really in a family. Hospital doctors the nurses specialists just don't know
15 because they're not involved so in terms of what I find interesting about that
16 compared to being a hospital doctor for many years you know I did specialities in
17 hospital for much more than I've only been a GP for a few years that's a more
18 rewarding part of the job so following people through times of problems be it serious
19 illness or serious psychological illness or whatever (AC mm) I also quite like being
20 the first port of call because that's what makes the job interesting the fact that any
21 single day any patient can come with any problem so it is actually still quite
22 challenging although there are some really negative aspects of the job particularly
23 paperwork like the demands on my time its massive (AC mm) in the end my primary
24 role is to be the first doctor somebody sees or the first medical person somebody sees
25 and then to decide is it serious or not if it's serious what might it be and who might
26 be the best people to help us (AC mm) and that's something that I know I'm quite
27 good at I've always been quite a good clinician picking things up (AC mm) so that's
28 one thing I like (AC mm) you know when you compare you know I've been
29 qualified fourteen years my rate of diagnosis of serious problems I know it seems to
30 be quite good (AC right) compared to some of my colleagues having worked with
31 them I know when people come in my door as a rule I try to take them seriously as
32 possible and but I have the power a way to bring them back if I'm not sure what it is
33 leave it a little while or I could refer on straight away I like being able to do that (AC
34 uhum), that's quite challenging (AC mm) as a doctor so although some doctors are
35 very stuck in their routine and er they're not really enjoying their work I do actually
36 enjoy my job a lot I'm not saying, it's a very hard job it's much harder than I thought
37 it would be and much harder longer hours much more paperwork than I ever
38 imagined with demands and targets but I put all that to the back and I make that my
39 lowest priority the paperwork is my lowest priority (AC right) that's not what effects
40 my patient management (AC mm) so I put that at the end of the day or the end of the
41 week but each day I try and give the people who come in my room you know a good
42 deal for what they get you know (AC mm) and I think that erm that my role in the
43 practice and as a GP means that I do do that I give them a good time I do over run if I
44 have to I try and sort things out not let thing linger (AC mm) you know quite
45 proactive people tell me that patients (AC right) I try and sort it out I don't like to
46 leave things (AC right) so that's how I feel anyway

47

48 AC Can you explain a bit more about giving erm a patient a good deal and what you
49 mean by that?

50
51 MA When you know that they've waited to get an appointment and they've got ten
52 minutes on the slot and then they come in and their life is in complete crisis erm I try
53 to er certainly give them their full ten minutes and longer if necessary so sometimes I
54 ask them to book a double appointment for next time if I know it's going to be
55 complicated (AC mm) I try not to leave lots of things left I try to sort out erm you
56 know physical complaints or problems and not say I'm sure this will just get better or
57 whatever (pause) so I you know I inject joints I take my own blood I do a lot in the
58 consultation I don't just say well come back for a blood test and we'll see if that'll
59 show anything I do the test there and then (AC mm) which knocks me back a minute
60 or two (AC mm) erm I you know do a lot of minor operations so I remove things that
61 people have got so you know when I say I give a good deal I think I try and resolve
62 something rather than just bringing it back for another day or another person (AC
63 mm) but by doing that of course I put more pressure on me because I end up seeing
64 more patients or for longer

65
66 AC Right but it's a balance (MA yes) that you've come to

67
68 MA Well it is I worked at the practice longer than anyone else there are four of us
69 four partners but I do actually do more shifts here because we've all got outside
70 interests (AC mm) so I have more slightly more patient contact than any of the others
71 (AC mm) which means that I have a bigger number of people on my books in a way
72 (AC right right) and if you look each year that I've been here I've only been here
73 three years I see the most patients (AC mm) that's not because I'm working harder
74 it's just the other doctors have got these other things that they do (AC right) in terms
75 of teaching and outside commitments but that means I've got more people on the go
76 at one time (AC mm) I've got more problems but but I do erm know that patients do
77 like to come back to a doctor that they find they think is sympathetic but also not just
78 a good listener but actually does you know what they want or if it's appropriate (AC
79 mm) they feel they can come and ask me to refer them I would never I don't think I
80 would ever block somebody asking for a second opinion (AC mm) whereas I know
81 other doctors do that (AC mm right) yes

82
83 AC Is there anything more you'd like to add about what you enjoy about your role
84 because you said at the beginning that you really do enjoy it

85
86 MA I do enjoy it (AC yeah) because I've done a lot of things in my career already
87 you know I was a military doctor for ten years and I travelled the world and have
88 done all sorts of exciting things so I do get bored very easily I have to move on (AC
89 right) I'm the sort of person that easily gets bored and one that worried me about
90 coming into general practice I came in to it because I wanted to be a family doctor
91 and I wanted to have a better work life balance than I did as an A&E specialist but
92 what did worry me was that I would actually become bored I thought perhaps most
93 GP problems would be very minor and routine and although there is a high number
94 of patients with that there is also certainly within a week every single week I see
95 some very serious illnesses or I help diagnose or spot something that's critical or
96 crucial and that that is what makes the job interesting (AC mm) and that is absolutely
97 no doubt that it's better than I thought it would be I didn't expect perhaps so many

98 people to turn up with so many interesting or unusual or serious illnesses (AC mm) at
 99 the GP surgery but they do you know with lumps bumps pains whatever so you got
 100 to be completely on your toes and I actually quite like that it's actually quite
 101 stimulating challenging and I'm not bored by it which I thought I might be (AC
 102 right) I like being my own boss as a GP in the end I can within reason within the
 103 partnership work the shifts days hours mornings lates whatever I can swap around to
 104 sort my personal life out erm you know which I just couldn't do in a hospital (AC
 105 mm) where the patterns are set so I already have a slightly better working day than I
 106 used to have because I aim to finish at a certain time in order to get home to be with
 107 my baby you know (AC right) which I could never have done as a hospital doctor I
 108 can only do that because I've organised to do that here (AC uhum) and you know my
 109 patients know that I have a young daughter most of them and they don't expect me to
 110 work all the hours god sends (AC mm) and a lot of them ask me about it I actually
 111 like that I like being part of the community when I'm wandering around people know
 112 me as the doctor I don't mind it at all (AC mm) erm so those are the good parts of the
 113 job

114
 115 AC Right anything else you want to add to the (MA good parts?) good parts
 116

117 MA No that's it I think (AC uhum) might think of some later
 118

119 AC Right well you mentioned right at the beginning (MA yeah) about the bad (MA
 120 yeah) parts (MA yeah) and you said some things (MA yeah) you know drive you
 121 nuts (MA yeah) like the paperwork (MA yeah) do you want to say something about
 122 that (MA yeah)?
 123

124 MA I think there's been an exponential increase in the amount of paperwork even in
 125 the three years that I've been doing the job I went away for a two week skiing
 126 holiday just two weeks ago and I came back and there was eighty three documents
 127 waiting for me to read eighty three because I counted them sixty four medical type e
 128 mails had been sent to me in a two week period (AC mm) and these were directives
 129 quite complicated letters new policies (AC mm) you know it's it's gone absolutely
 130 mad and of course the contract for doctors has been changing in the three years I've
 131 been doing it and the newest contract has just come through and that's target driven
 132 it's completely target based (AC yeah) the government can only encourage us to do it
 133 by financial reasons and they can only give us money on something they can
 134 measure so everything's based on measurements (AC yeah) and they think that that
 135 equates to quality but it's purely quantitative it's there's no way I can measure a
 136 good consultation with an upset person a patient a parent (AC no) a child don't get
 137 any points for it I can't get any money for it therefore (AC mm) I can't show I'm
 138 good at it (AC mm) all I can show is I can measure a blood pressure and the
 139 cholesterol the blood count and peak flow and thyroid function every so often and
 140 whatever (AC yeah) and if I don't do that I get penalised. So the paperwork plus the
 141 solicitor's letters and the amount of government paperwork required for people who
 142 are off sick is just mind blowing and the majority of it is completely and utterly erm
 143 could be done by any member of staff it doesn't have to be a doctor (AC mm) except
 144 they request a doctor to do it it's nearly always copying from notes (AC mm) it's not
 145 it's very rarely a personal opinion it's just literally factual base reporting (AC mm)
 146 erm but every single day we have several of these and there's nothing that's built in
 147 the day time wise to allow you to do that there's nothing that's built in the day time

148 wise to allow you to deal with the email (AC no) in a previous doctor before e mail
 149 came on a doctor could only do so many patients in a surgery and so many home
 150 visits and that was the day full (AC yes yeah) and it was booked in but now on top of
 151 that we get email email requests for patient erm wanting to ring them back or
 152 whatever and there's just no time built into that (AC mm) so you do that on top of
 153 your normal day (AC mm) and the paperwork is well every doctor I think complains
 154 about it but it really is incredible (AC mm) the number of directives and things that
 155 change and yet actually very few of them have any real clinical meaning of change
 156 much anything that we do day to day (AC right)

157
 158 AC And how do you prioritise which ones you're going to address and which ones
 159 you're going to leave? (MA Right well) because presumably you can't look at them
 160 all

161
 162 MA No well we have to read everything so eventually you do (AC right) but the erm
 163 prioritise it in terms of I do urgent things on the day as in urgent referrals I have to do
 164 it by the end of that day, routine referrals I do at the end of the week I just pile them
 165 all up on a list on the computer the computer stores it all, the paperwork to read I do
 166 at the end of the week, the paperwork to complete I do letters for people when it's
 167 regarding mortgages life insurance first because people actually rely on that and then
 168 I do government paperwork for people who are on long term illness or solicitors
 169 letters that comes last because that's not actually effecting someone's life it's just
 170 simply a paper exercise that the lawyer or the social security want (AC right) so that
 171 becomes a low priority (AC aha) things like cancelled insurance or holiday insurance
 172 and house insurance that has to be done more urgently because people are relying on
 173 that (AC mm) for their money back (AC mm) erm and then after that sometimes I get
 174 through to the audit things but er it's difficult because in terms of prioritising the
 175 most important thing is patient care usually and patient care is patient contact not
 176 paperwork (AC mm) but I have to do it we share a personal assistant at the practice
 177 all four of us just this one secretary so (AC right) it simply wouldn't be possible for
 178 her to do it for us she does what she can (AC mm) if I had an actual personal
 179 assistant or proper secretary just for myself like I did have in the army I could give
 180 probably at least fifty per cent of the work straight to her (AC mm) or him (AC mm)
 181 oh and when we're filling out a report when it's taken off the computer there's
 182 absolutely no reason why it couldn't be done by her and I just sign it (AC yeah) but
 183 she can't do that on top of all her other jobs and three other doctor's work (AC mm)
 184 there's no system in place for me to have each of us we don't have the money or
 185 resources to fund individual private secretaries (AC mm) and I don't think most GPs
 186 do (AC mm) so just got to do it (AC yeah)

187
 188 AC And you mentioned the targets (MA yeah) erm you're not (MA elated by them)
 189 driven by them? Is that right? (Both laugh)

190
 191 MA On an academic front there's the targets are difficult to argue against you know
 192 if you take them as individually as stroke or diabetes or blood pressure targets
 193 they're basically usually on evidence based medicine good evidence based medicine
 194 on what would be ideal treatment for an individual patient so on it's own the target is
 195 fine (AC mm) and I would be sounding like I was erm fighting against something
 196 that specialists and other experts were saying was the right thing to do so I'm not
 197 against the idea that patients should or we should strive for certain targets but the

198 problem is that our patients are so individual (AC mm) that to fit them into protocol
 199 target boxes is difficult we're also very busy and there's not much evidence that
 200 actually pushing a target to its limit will actually help an individual so much that
 201 chasing their cholesterol or their blood pressure for a certain target when they're
 202 already on treatment (AC mm) to show that we've met a certain level when in fact
 203 you look at the statistics and the numbers needed to treat to improve the life
 204 expectancy of a single person it is difficult to justify (AC mm) so much emphasis
 205 being put on those targets (AC mm) and yet it's the only way we are going to be
 206 measured in the future is the targets (AC mm) so you know I accept that they're there
 207 now you know and I don't have much choice but I don't think it's reasonable to be
 208 carrying especially a very elderly person who is not on a current drug that the current
 209 target says really you should be on this drug and it might slightly improve their
 210 outcome of a certain problem in several years when they're already ninety or late
 211 eighties I just think it's probably not the best thing to do (AC mm)

212
 213 (interruption for ECG machine)

214
 215 AC Right yes so we were talking about the targets and how it doesn't reflect
 216 qualitatively what you do

217
 218 MA Erm it might reflect certain things like outcomes death mortality in certain (AC
 219 mm) conditions but that's going to take years to show up isn't it (AC yeah) from now
 220 but my experience of patients are if you were more honest with them and said if I
 221 give you this drug for your cholesterol it might decrease your chances of having
 222 something in the next ten years by a certain (AC mm) if we really were more honest
 223 I think a lot of them would actually not choose to take it (AC right) because of the
 224 actual benefit isn't very very high (AC mm) some of them would but it's not
 225 presented like that it's presented erm you should really take this treatment this is
 226 what most experts agree (AC mm) so anyway I do try and stick to the targets but it
 227 doesn't measure quality it just doesn't measure whether a very upset person who's
 228 life's in crisis or a patient with er certain psychological illness has had a good
 229 consultation (AC mm) forty per cent of our work is psychological (AC mm) and that
 230 can't be measured all they can measure is our suicide rate our rate of prescribing of
 231 antidepressants whether we record suicidal idea or not (AC mm) and erm you know
 232 if I ask every single person who I know very well has anxiety 'do you think you're
 233 going to kill yourself?' it's just not appropriate in certain circumstances (AC mm)
 234 like it's not appropriate to ask a person who has come in for one problem which
 235 might be very very personal and serious then oh by the way I notice you're not
 236 taking your inhalers at the moment that might be a problem for a different time and
 237 yet according to the target it might look bad if we hadn't checked their peak flow
 238 (AC mm) if we didn't check the blood pressure of somebody who we know to have
 239 high blood pressure but actually they came in because they've got piles or depression
 240 (AC mm) yet it's forcing us into consulting in a different way (AC mm) it's actually
 241 altering the relationship we have with people (AC mm) if we try and match the
 242 targets (AC mm) now some doctors I believe are just going to say 'I'm not doing it'
 243 (AC right) 'See what they do to us' what can they actually do they're short of doctors
 244 (AC yes) we could have as a group of doctors have said we're not willing to er enter
 245 this way of working (AC mm) but er anyway we have accepted it so we've got no
 246 choice (AC yes yes it's here yeah) but I don't think it's what patients want I don't
 247 think they want to be a target I don't think they have any idea that's what we're

248 doing actually I think it's alright to say to them your blood pressure's high and it
249 probably is better if we treat it because that would probably stop you having a stroke
250 or a heart attack or it'll certainly help do you understand that and if we try this drug
251 and they agree to go on the treatment erm and the same with if your cholesterol is
252 high if you're at high risk and that's reasonable as an individual but when we're now
253 chasing and writing to people in order to get our numbers up (AC mm) in order to get
254 our pay up it all seems very clinical and it seems very it's a it's a little bit like the
255 parents who are refusing to have their children vaccinated and then throw back the
256 fact one of the reasons those doctors want our children to have that MMR is because
257 they get paid for it (AC mm) it puts us in a difficult position (AC mm there's a
258 tension there) yeah it's a real problem and er if I've got if I put a lot of people on
259 statins who were never on them before just because they did have a stroke thirty
260 years ago and now it's shown that probably is they probably should be a on a statin
261 that is literally what we're doing we're going round nursing homes (AC mm) it's
262 absolutely ridiculous to me to be starting drugs on people who are at the end of their
263 life who are stable a drug which we then have to take a blood test after a few weeks
264 (AC yeah) just doesn't seem right that part and that's been a real shock to me
265 because when I came into general practice only a few years ago there was no hint
266 that that's how the whole job was completely altered (AC mm) it wasn't target
267 driven when I started three years ago (AC right that's a rapid change isn't it) and the
268 group of people who negotiate that contract have completely altered the way we
269 work (AC mm) we're no longer working as individual doctors I understand why they
270 hope that the quality of care will be standardised through the country (AC mm) they
271 say that those targets are the minimum that a good doctor would be achieving and I
272 accept that and in fact most good doctors were auditing themselves or were being
273 checked and were trying to do the best for patients so they were probably meeting a
274 lot of the targets when they've been tested a lot of them have met them previously
275 we were close to meeting them before we even started (AC right) but in order to
276 actually meet them we have had to go round nursing homes putting people on statin
277 drugs like I said it's not just (AC mm) and when you get there there's a load of other
278 GPs doing exactly the same (AC mm mm) and that little old lady and little old man
279 that we've started those drugs on they weren't unwell (AC mm) they had been stable
280 for twenty years (AC mm) and yet surely our time would be better spent on the ones
281 that are currently coming in with new problems and yet we can't even match the
282 demand of patients you know they can't get appointments (AC mm) so the targets
283 have been brought in quickly, sold to everybody as this is the best way forward
284 without much research or evidence to back that up (AC mm) they're best practice
285 medicine I accept that but whether taken as a whole change in the way primary care
286 doctor works or primary care doctor and nurses work because a lot of the targets can
287 and will be met by nursing staff (AC uhum) in special clinics but if I was a nurse and
288 I was literally being asked to meet certain targets I would wonder is it the right thing
289 as well I'd want to challenge it (AC mm mm) is it really erm work just bringing in
290 fifty people with high blood pressure, checking them again and then altering their
291 drugs because they're a few millimetres above (AC mm) what is currently the target
292 and yet in a few weeks or if on a different day it was tested it wouldn't have been
293 high (AC uhum) it's really difficult and yet the day you record it if it's above you've
294 missed your target that looks bad (AC yeah) you get financial penalty (AC yeah) you
295 know if there were no finances involved in it that might be a more honest way to do
296 it but then they've said they wouldn't be able to get people to agree to them and they
297 wouldn't be able to push it through which is actually in a way the whole proof of

298 why it's not a good idea the only way they can make us do it is they've made it (AC
 299 mm) a financially based target (AC uhum) and er you know if you when we've done
 300 patient satisfaction surveys in this practice which we have done and they do them
 301 every year the majority of patients in this practice are very happy we don't have any
 302 outstanding legal claims there's never been a claim for medical negligence in this
 303 GPs surgery for the last ten years (AC right) you know it's an incredibly nice place
 304 to work (AC mm) and yet suddenly a new contract's come out which is driven by
 305 targets and it's changed everything (AC mm) you know we now have a different
 306 computer system to measure the targets we're being pushed with lists of people (AC
 307 mm) that are not meeting the targets (AC mm) I'd just like to know who really who
 308 really thought that was the best way forward in medicine tick box medicine as far as
 309 I'm concerned (AC mm) it's it's not what I'm supporting (AC yes) and yet on
 310 another side of my character me as a doctor when I was an A&E doctor I still work
 311 in A&E once a week and I was an A&E registrar for a few years I know that
 312 protocols and targets specially in resuscitation are crucial to make sure that everyone
 313 is a similar standard (AC mm) I follow resuscitation guidelines in trauma and cardiac
 314 and I know that means that most people will stick to what's best (AC mm) best level
 315 of care (AC mm)

316
 317 AC So so what's bothering you here is the way it's er altered the way you work

318
 319 MA It's because in a critical life saving treatment to follow a certain protocol is
 320 probably the best approach (AC mm) to make sure that in an emergency everyone
 321 follows the same, in general practice each individual consultation can not be boiled
 322 down to that it's just so varied people come in with lists of problems (AC yes) and
 323 they come in with complicated problems plus complicated interactions both in their
 324 personal life their job and the drugs that they take (AC yeah) and they just do not fit
 325 into the single boxes that they're being asked to (AC mm) and it's altered the way we
 326 work or it's going to (AC mm) it only started on the first of April (AC yes) and so far
 327 I haven't done a single clinic yet but I'm about to start special clinics and I don't
 328 mind doing them (AC right) I'm going to do cardiac and stroke clinics and I'll have
 329 longer consultations and that'll be good (AC mm) so there'll be some positive sides
 330 I'll have more time to do that but I'll have less time to do the other things (AC mm)
 331 but whether those clinics will mean that my patients will in the end be any better off I
 332 think it's doubtful (AC mm) it's doubtful (AC mm interesting)

333
 334 AC Just to go back a step (MA yeah) when we were making the tea (MA yeah) we
 335 were talking about your role erm (MA yeah) with students (MA yeah) and with
 336 registrars (MA yeah) erm how does that fit into your picture of what you enjoy and
 337 what you don't

338
 339 MA yeah well one of the things that attracted me to this practice when I was looking
 340 was that it was known to be the biggest training practice in town (AC mm) of which
 341 all three partners here are all trainers of doctors and one the senior partner here is
 342 very high up in the medical school and he's a post graduate sort of like an advisor in
 343 general practice he chooses who can train as GPs so we've got a very big training
 344 role (AC mm) and I knew when they took me on they asked me if I would interested
 345 in training medical students as my personal role and I that's one of the things that I
 346 came to do and I knew that we would also train house officers and registrars and my
 347 role in that is one day per week I will be in charge of training the registrar and one

348 I'll be in charge of training the house officers so two days of the week are taken one
 349 day I'll be training the medical students so three days out of five I'm doing
 350 supervision of a trainee of one description (AC right aha) be it a student a young
 351 doctor or a trainee GP and we all share that burden (AC mm) and that involves hands
 352 on alternative checking consultations and seeing patients with them and it also
 353 include teaching as in actual set tutorials (AC mm) of which we do at least one every
 354 week plus sharing home visits (AC mm) and that's actually nice because we're
 355 talking about young enthusiastic usually new people who are joining the profession
 356 (AC mm) with you know fresh ideas and newly trained but er the problem with that
 357 at the moment is that also the encroachment of the new targets and the amount of
 358 time I'm having to spend to match demand is it cuts into the amount of time we have
 359 to train (AC uhum) because it is time consuming training (AC mm) we can see much
 360 less patients with trainee doctors (AC uhum) because they take longer (AC mm)

361
 362 AC So it's an extra pressure on your time

363
 364 MA It is you could say they're an extra doctor so added together in the end overall
 365 we probably see about the same number as we would if they weren't here (AC uhum)
 366 we certainly don't see more because they're here (AC no) because we as individuals
 367 see less people because every third slot in our day is taken up by going in to
 368 supervise (AC right) instead of it being a patient for ourselves we're going in for ten
 369 minutes or twenty minutes (AC mm) with the trainee (AC mm) but it's good to know
 370 we're training doctors (AC yes) training people who are going to take over from us
 371 when we retire (AC yes) and someone's got to do it and a lot of people just don't
 372 volunteer to do it (AC mm) it's not very popular it's not very well financially
 373 rewarded in terms of time and it is time consuming and if you are busy already
 374 people won't take that burden on so I'm quite happy that this practice does it and I'm
 375 you know certainly enthusiastic towards it

376
 377 AC Mm and equally you describe it as a burden and a pressure

378
 379 MA There is definitely a pressure and erm it is a burden when things are looking bad
 380 it's not a burden when things are looking good (AC right yeah OK) I think we're
 381 intending to train nurses as well here so there's going to be even more trainees (AC
 382 uhum)

383
 384 AC Is there anything else you would like to add about erm the things that frustrate
 385 you or you don't enjoy about your work

386
 387 MA Erm (pause) I think if we're talking about things that are frustrating perhaps the
 388 it's not primary care that's frustrating it's the primary care secondary care link the
 389 hospital referrals and admissions there's a major problem with acute admissions to
 390 hospital (AC mm) because there's never any so often there's never a bed to acutely
 391 admit (AC mm) which is very frustrating patients are sat at home waiting for phone
 392 calls for beds to become available and also the erm waiting times at the hospital
 393 generally are not too bad apart from psychology, neurology and physiotherapy which
 394 are an absolute disgrace you know they're bordering on a year to be seen which is
 395 totally unacceptable but for most surgical medical complaints the waiting time is not
 396 bad but what is bad is then the time it then takes for us to find out what actually
 397 happened (AC mm) you know the hospital letting us know the hospital do tests and x

398 rays and get blood results and they don't forward them back to us even though we
399 have a linked system (AC mm) just because somebody doesn't tick the right little
400 forwarding box to forward and then the patients come here expecting that we would
401 know what their results were (AC mm) that's just simply an administrative thing it
402 could be sorted tomorrow if someone could do it (AC yes) it is a bit of a frustration
403 but er it is better than it was we certainly get more results on directly from the
404 internet linked results system (AC mm) that's about it I think (AC right) in terms of
405 frustrations (AC good)

406
407 AC Anything else you want to add in terms of what you enjoy?

408
409 MA Enjoyment (AC yeah) I've said about the varying nature of the job I enjoy being
410 a family doctor for the whole family (AC mm) I enjoy being my own boss I enjoy
411 working in a small team (AC uhum) I didn't mention that I'm lucky that I get on well
412 we get on well as a little group of doctors these particular doctors it's the doctors that
413 would er if you didn't get on with your partners it would be a problem (AC mm) and
414 yet most practices I know have got conflicts (AC mm) interpersonal (AC mm)
415 conflicts (AC mm) they're not very there's not much interpersonal conflict here
416 thankfully (AC that's good) yeah which means sharing the workload is better (AC
417 mm excellent) OK

418
419 AC Well thank you very much for your time

Transcript Summary

Interview 15 GP

This transcript suggests that MA primarily enjoys his role as a GP because he enjoys family medicine and being involved with generations of the same family^{10, 407}. He enjoys his work³⁵ and enjoys the role⁸⁵. He came into general practice to be a family doctor⁸⁹ and to get a better work life balance⁹⁰. He likes knowing how illness fits into the family structure and believes that no-one else in the medical field knows what is going on in the family in the way that GPs do¹³. He likes being the first port of call for patients^{19, 23} and believes that the variety of patients and problems⁴⁰⁶ makes the job interesting²⁰ and challenging²¹. He likes to follow people through serious physical or psychological illness¹⁸ and he asks patients to book a double appointment if they have complex problems and need the extra time⁵³.

MA feels that he is quite a good clinician²⁶, he has a good rate of diagnosis with serious problems²⁸ and every single week he spots something that is critical or serious⁹³. He feels he could get bored easily⁸⁷ but because people turn up with interesting and unusual serious illness⁹⁷ you have to be on your toes and he finds this stimulating and challenging and not at all boring⁹⁸. When people walk through his door he likes to take them as seriously as possible³¹ and to give them a good deal⁴¹. He will run over time if necessary because he likes to deal with problems and not let them linger^{43, 57}. He feels he is proactive⁴⁴ and a good listener⁷⁷ and would never block someone who asked for a second opinion⁷⁹.

MA feels that being a GP is a hard job with long hours and lots of paperwork³⁶. Patient care and patient contact are the highest priorities¹⁷³ and paperwork and targets are the lowest priority^{36, 174}. When it comes to paperwork urgent referrals are prioritised followed by anything that might effect a person's life such as mortgages, and insurance^{166, 170}. Audit is the lowest priority¹⁷². He finds the link between primary and secondary care frustrating because so often there are no beds for acute admissions³⁸⁵ and communication between primary and secondary care is poor³⁹³.

MA feels the current contract is target driven and quantitative and that a good consultation cannot be measured and rewarded¹³³. He is not against the targets as he feels that they are based on good evidence based medicine^{191, 195} but the problem is that individual patients do not fit into protocol boxes¹⁹⁶. He is worried that the targets are forcing him into a different approach to consultations^{238, 266, 323} altering his relationships with people²³⁹. He doesn't think that this is what patients want²⁴⁴. MA feels that it is totally ridiculous to be starting someone on drugs when they are at the end of their life simply to meet the targets^{208, 259, 261}. He feels that actions driven by the targets may not be the best approach for an individual patient²⁰⁸ and that in general practice individual consultations cannot be boiled down to a protocol^{318, 322}. He feels that forty per cent of his practice is psychological and the targets do not reflect this²²⁶.

MA was initially attracted to the practice he works in because it was one of the biggest training practices in town³³⁶. He enjoys being involved in training because it brings him into contact with young enthusiastic people who are joining the profession with fresh ideas³⁵¹. He is enthusiastic towards training^{367, 372} but also acknowledges it is a burden on his time^{357, 370}. He enjoys working in a small team⁴⁰⁸ and says as a little group of doctors they get on very well together⁴⁰⁹. He likes being

his own boss^{100,407} and likes the freedom to fit work around his personal commitments¹⁰¹. He aims to finish at a certain time so he can get home to be with his baby¹⁰⁵. He likes being part of his local community and people knowing him as the doctor¹⁰⁹.

The small numbers refer to the line of the transcript where the idea can be found
June 16th 2004

Interview 16 NP

1 AC It is very unstructured (HV right) we just start with a very broad question and
 2 basically we just go from there with whatever you want to talk about. So the first
 3 question is er what do you find most meaningful in your work as a nurse
 4 practitioner?
 5

6 HV Most meaningful erm (pause) probably now that I've gained extra knowledge I
 7 can see the patients from start to finish so I treat them more holistically and I can
 8 continue the care and have a decision in the care and the outcomes really because
 9 before what I would actually do would was just maybe erm find something like just
 10 say to use as an example hypertension somebody with high blood pressure and then I
 11 would have to refer it back to ST whereas now I would continue the care and maybe
 12 discuss treatment because I can't prescribe erm with him but I can follow the care
 13 through or if it's something like cardiac patient I would come in I would diagnose
 14 they've got angina and send them off rapid access and I can do that now all myself
 15 which I feel is more fulfilling for me (AC mm) because I get to continue the care
 16 through (AC right) erm that's probably what I find personally (AC right)
 17

18 AC Do you want to explain a bit more about all of that?
 19

20 HV Erm I used to feel very not annoyed but that there was something missing I
 21 didn't with the patients I didn't get the patient contact either because I'd just see
 22 them once and off they'd go and I wouldn't find, it's more rewarding for me now
 23 because I find out how they've got on and with the treatment and I bring them back
 24 and review them and you know if they've got any problems I can start putting things
 25 in like social services and and also the home care you know you can look you can
 26 look at the problems that they have the sort of more holistically really I can't explain
 27 it sorry (AC no that's great) erm I'm not just it's not just a one off consultation
 28 anymore I can see them lots (AC mm) and lots of times and get involved and pick
 29 up and get to know them better (AC mm) which I found when I was I hadn't done
 30 the nurse practitioner I was just seeing them as the practice nurse odd times and I
 31 would think 'how's Mrs so and so doing?' (AC mm) and unless you looked in the
 32 notes you'd not find out but now I know how she's doing and other problems will
 33 crop up in the meantime and er (AC right) I can deal with those and get on and do it
 34 (AC right) and I don't feel erm I think I've gained more confidence with doing the
 35 nurse practitioner course (AC mm) and my knowledge is better (AC mm) and I think
 36 I think a different way as well (AC mm) probably better at problem solving than I
 37 was before (AC right) so er I think you do actually once you do your degree you
 38 think differently (AC mm) than and you can't don't think I could go back now to
 39 being a practice nurse I think I would feel that there was something missing (AC
 40 right) so if I had to cut myself off and say oh well that's only my task off you go (AC
 41 mm) you go back to see ST I mean I do still refer patients back to ST especially
 42 things like men with sexual problems because I think it's best that ST actually
 43 examines them (AC mm) because with just being a single handed GP (AC mm) erm
 44 and just me here but er you know a lot of things I totally solve myself really (AC
 45 mm) and help patients (AC mm) so erm. And I like to go out as well and see patients
 46 in the community there are times that I go out (AC right) if they find that it's hard to
 47 get into surgery I go out to see them (AC right) which is quite nice which I didn't do

48 before (AC mm) so I can continue the care at home (AC mm) so (AC right) it's
49 (pause)

50
51 AC Right so what group of patients do you do that with?

52
53 HV Erm it's usually erm patients that are disabled or elderly er that can't actually
54 get into surgery to erm it's it's more for sort of chronic disease management where
55 patients can't get into the surgery and we need to look after them so to still look after
56 them like doing like with diabetes (AC right) patients with diabetes (AC right yes)
57 (both laugh) to be politically correct (AC yes) and like I've got gentleman who lives
58 out in the wilds and he's had a erm cerebrovascular accident bless him and he can't
59 get in he's got no family (AC mm) and I go and visit him erm look after him so he's
60 not he's not missed really (AC right) and he gets the same care as everybody else
61 (AC right yeah) so cus I think quite often especially I think in nursing homes as well
62 sometimes patients tend can be forgotten (AC mm) it's er I visit a gentleman in a
63 nursing home in PR sometimes and you know just so everybody's looked after (AC
64 right)

65
66 AC And when you said earlier that you think you think differently can you explain
67 that a bit more?

68
69 HV Erm I suppose I've got more knowledge about different conditions now (AC
70 uhum) erm I'm very very aware that I need to keep up to date all the time (AC mm)
71 especially for sort of legal reasons erm and also for the best care for your clients that
72 are coming in as well (AC mm) I don't know how to explain it really I think doing
73 the nurse practitioner course just it makes you more analyse that's it makes you
74 analyse things more I think (AC right) that's the word (AC mm) you look at things
75 differently and you look at things I think you are questioning things all the time (AC
76 mm) and if I don't think that something's a certain individual has had good care or if
77 I don't agree with the care they've had I will actually speak out and say (AC right)
78 (both laugh) militant (AC right)

79
80 AC So it's made you militant too

81
82 HV No but I just no I will question things (AC mm) I wont just allow people now
83 just to say 'do this' because if I don't think that's the best care then I will speak out
84 and say things (AC mm) and I think I'm able to do that now because I've got more
85 knowledge (AC right) and I do I can actually how can I put it I suppose with
86 conversations now I'm able to whereas before I probably wouldn't question the GP
87 now I'll say well you know if you do this this'll happen and if you don't do it this'll
88 happen and (AC mm) why have you done that and things and I'll question things like
89 that (AC mm) so (AC right) its er he'll probably wish I'd never done it (both laugh)

90
91 AC Yeah so what else do you find meaningful in your work?

92
93 HV Erm just being in contact with people seeing them it's nice that in general
94 practice I think that you see patients or clients erm over years don't you you get to
95 know them (AC mm) erm it's hard sometimes to not to be friends with well to detach
96 yourself and not become friends with them because you've got to always be
97 professional (AC mm) and especially with me because I live in the community as

98 well erm you've got to be so careful (AC mm) you can't really get close to people in
 99 one aspect you can see them for their health care I think over the years but you can't
 100 get close to people in the community because and they ask you questions (AC mm)
 101 so you've always got confidentiality (AC mm) erm I like all sorts of things really I
 102 can't really say that there's one particular thing that's I mean I like looking after erm
 103 chronic disease people with chronic diseases because I get to know them erm there's
 104 lots of different things I've never really sat down and thought about it really (AC
 105 mm) what's meaningful (pause) so it's nice as well when people come back and say
 106 and thank you (AC mm) that they've actually you've got somewhere with them with
 107 the treatments and things (AC mm) you've improved their quality of life I think
 108 that's nice (AC mm) you know and they'll actually thank you or even thank you just
 109 for listening to them and (AC mm) erm it's you know that's a nice part of it erm (AC
 110 mm) so (pause)

111
 112 AC Right what about erm beyond the sort of patient contact you know face to face
 113 the extra things in your role because we were just talking about your working day
 114 being half a day of clinical and half a day of admin time (HV yeah) or other stuff that
 115 you do so what about the sort of other stuff?

116
 117 HV Erm well most of the other stuff is really erm looking at well it's referrals doing
 118 your referrals it's continuing if you need to refer anybody to a consultant and things
 119 so it's referral letters (AC mm) erm it's going reviewing clients' records to make
 120 sure that you've given them the correct care and reviewing the medication and things
 121 like that I also do things like admin in the surgery erm I do things like erm the
 122 accounts (AC right) and things like that (AC right right) so that all comes into it and
 123 the staff sometimes I'm with the student medical students erm teaching them about
 124 things and that takes help them with doing things that they need to do with like
 125 SWOT analysis and things like that (AC right aha) erm sometimes liaising with other
 126 erm health erm professionals like the district nurses or practice meetings it can be a
 127 wide range of things (AC mm) that I do in sort of admin time (AC right) erm I've not
 128 sort of set I mean the only thing I've got to do practice notes that anything that's
 129 come through from the GPs or receptionists about certain individuals I've got to deal
 130 with I've got to do my letters (AC mm) and after that it's really anything in the
 131 practice erm sort out for the smooth running of the practice it could be things like
 132 ordering nebuliser anything really (AC right) there's no sort of set pattern (AC mm)
 133 sort of for those hours really (AC right) resuscitation training you name it (AC right)
 134 (both laugh) it goes on and on

135
 136 AC And where do you fit all that in the sort of grand scheme of what you really
 137 enjoy about your work?

138
 139 HV Erm I wouldn't say it's high on my priority list (AC no right) (both laugh) er I
 140 think probably I prefer to be with in with individuals (AC mm) and that type of my
 141 job really more than the admin side of it (AC right) and I have thought about doing
 142 other things rather than general practice like McMillan nursing or things like that

143
 144 AC You've had thoughts about it

145
 146 HV I have thought about it

147

148 AC Oh I see right

149

150 HV Moving on from general practice (AC mm) so I don't know (AC mm) it's still in
151 the pipeline really (AC right) so but no admin's not my most favourite thing (AC no
152 OK) (both laugh) so (AC interesting) doing staff wages is not the height of my week
153 (both laugh) so (AC right)

154

155 AC And what about your involvement with the students like the medical student?

156

157 HV Oh I enjoy that (AC right) yeah yeah erm and sometimes I think it depends on
158 the student's personality really sometimes they'll prefer I think to ask me rather than
159 prefer to ask ST (AC right yeah) and er you know they ask me all sorts of things it's
160 usually about chronic disease (AC aha) and I quite enjoy that that's quite nice keeps
161 me on my toes (AC right) and up to date with practice (AC mm) so and they've just
162 been studying about this because they've actually just qualified and they're just
163 doing their twelve months after (AC uhum) they actually do their exams before they
164 come here so they're up to date with all the latest practice (AC yes) so it's quite nice
165 to have them to talk to (AC mm) so (AC right)

166

167 AC You mentioned the thing about McMillan a moment ago (HV yes) erm is that
168 because you perceive that you would enjoy that better for some reason are you able
169 to put your finger on why you think that way?

170

171 HV Erm I think yeah er I keep thinking back to when I worked in the hospital (AC
172 mm) and erm I don't know really whether that's my personality the more sort of
173 dependent on you know your care and things I don't know so

174

175 AC What the patient being more dependent on you? (HV yeah) oh I see than they
176 would be in general practice? (HV yeah) right

177

178 HV So I'll have to think about it (AC mm) I'd get too involved I think I should give
179 up nursing full stop (both laugh)

180

181 AC And that's hard for you is it drawing that line?

182

183 HV It is yeah (AC yeah) I get too attached to people (AC mm) and er I think that's
184 probably that's me I think I've got to detach myself (AC right) from patients things
185 sometimes because I do get especially when you've been seeing people for years and
186 years (AC mm) you get attached to them and then if something happens to them
187 which it will do if they've got a chronic disease (AC mm) I find it quite upsetting
188 (AC mm) so

189

190 AC And that must be particularly tricky living here in this community

191

192 HV Yes small community

193

194 AC Yes where you would know everybody

195

196 HV So (AC mm) that's one of the downfalls I think (AC mm) (pause) but then again
197 I suppose it depends how you view things if you're doing something for someone

198 even though they're so ill you can er even if you can't do anything with medications
 199 and things you can still do sort of physical things for them (AC mm) and you know
 200 get social services to come in and help them in that way (AC mm right) so

201
 202 AC Anything else that you can think that you enjoy about your work?

203
 204 HV Mm (pause) enjoy (pause) probably lots of things but I just can't think of them at
 205 the moment erm it's nice to go off and do things like study days (AC mm) er and
 206 meet other health professionals I enjoy that it's nice to be able to chat now to the GPs
 207 on a more equal basis (AC mm) that's erm quite nice I don't feel inferior anymore
 208 and sometimes they actually ask me for advice (both laugh) or ask me to teach them
 209 how to do something (AC right) that's quite nice (laughs) (AC right) for my ego
 210 anyways erm there's lots of things I enjoy about it er (pause) it's hard to pinpoint any
 211 particular thing that I think patient contact's the big thing for me rather than er

212
 213 (interruption for delivery of lunch!)

214
 215 HV Erm I can't say there's anything I dislike really I don't like doing the well they
 216 don't bother me that much the accounts is not a big thing on my agenda but I can't
 217 say there's anything I don't like really (AC right) in my job that I do (AC right) so

218
 219 AC OK well that was going to be my next question actually is there anything that
 220 erm frustrates you or you get you know where you feel frustrated and are not able to
 221 move on with your work

222
 223 HV Erm I think there was in days sort of when I first started my nurse practitioner
 224 course there was then erm but now I think probably not saying I've learnt to cope
 225 with things and reason things so I put things a different way whereas I would go in
 226 and say erm you know I think this I don't agree with that and I would get upset about
 227 it I don't now I go around it different ways (AC right) so erm so I don't get frustrated
 228 the same probably probably it's experience isn't it (AC mm) I've got more
 229 confidence that's probably it (AC mm) cus when you're not confident and you're
 230 trying to put an argument forwards but now I'm more confident and more question
 231 (AC mm) more practised questioning everything (laughs) (AC right)

232
 233 AC And more able to put your argument forward

234
 235 HV Well yes (AC yes) yes so

236
 237 AC Right so previously that frustrated you that you couldn't (HV yeah) get your
 238 message across

239
 240 HV Couldn't get my message across (AC mm) and you know when I thought you
 241 know sometimes when you have a sixth sense about things and and everyone thinks
 242 you're mad and you know and then but now I probably put it across better (AC right)
 243 so (AC mm) you've got to talk their language to get anywhere (AC uhum yes right)
 244 (both laugh) learnt from experience (AC yes) but there's not really that much that
 245 frustrates me I suppose other things that are not sort of political things when people
 246 come in and they need urgent care and they can't get you know it's four months
 247 before they get radiotherapy or (AC mm) things like that money sort of that type of

248 thing that frustrates me sometimes (AC mm) and you know it's great to have a gold
249 standard where they go to hospital and are seen within two weeks but then if
250 nothing's happening after that for weeks on end (AC mm) that's just more distress
251 (AC mm) you know how I feel that's what frustrates me I suppose (AC right) more
252 than anything things like that (AC mm) things like sometimes we've just been told
253 by I mean I'll have to say this the pharmaceutical advisor that we should swap
254 everybody over from pravastatin to simvastatin (AC mm) and that to me is not
255 ethical because if patients have been controlled on that drug which one of them is
256 supposed to have the least side effects why go and upset the apple cart and I just
257 sometimes this upsets me sometimes (AC right right) because he's not looking at the
258 you know person that's taking the medication it's just everything is money orientated
259 (AC mm)

260
261 AC So it's about saving money?

262
263 HV And I know the health service has not got a pot of gold at the bottom of the
264 garden and we should be aware of it but erm fair enough now to put everybody on
265 simvastatin that's coming through but when we first started pravastatin (AC mm) was
266 just the drug so that's that (AC yeah) you know and I don't think you should just
267 keep swapping patient's medication just to save a few pounds every five minutes
268 that's just my personal thought (both laugh) (AC yeah) so that's what sometimes
269 frustrates me (AC right) it's things like that (AC yes) yeah

270
271 AC So these are the things that are sort of outside of your control (HV yeah) yeah
272

273 HV And another thing that I've just thought of (both laugh) what really bugs me is
274 when people still insist on calling me a practice nurse (AC right) (laughs) it's really
275 petty but I think I've done all these years of studying please give me my correct title
276 (AC yes) isn't that stupid?

277
278 AC Is this patients or other health care professionals?

279
280 HV It's other health care professionals (AC right) so

281
282 AC They are probably mystified by what the title means

283
284 HV Yeah probably so (AC yeah) but that's just how I feel (AC mm)

285
286 AC But yeah that irritates you

287
288 HV Yeah sometimes (AC yeah) but there's not really it's mostly sort of political
289 things that are it's things like you know people not getting their correct care or (AC
290 mm) lack of resources or money and those type of things really (AC mm) frustrate
291 me more than anything (AC mm) erm I mean things are improving though so erm it
292 just be nice if they went that bit further wouldn't it? (AC mm) like now they've got
293 system where everybody's referred for a two week referral but they've got to have
294 the resources at the end (AC mm) of it to continue it through (AC mm) so (AC yeah)
295 that's what frustrates me I suppose

296
297 AC Mm anything else that you can think of?

298

299 HV I wish I'd had these questions before (both laugh) I could have thought of them
300 all not really not just off the top of my head (AC no) so er (AC no) I've got a good
301 working relationships with everybody and I couldn't say there's a particular person
302 or anything that I do in my work that frustrates me (AC mm)

303

304 AC So good teamwork

305

306 HV Yeah (AC mm yeah that's good) I think that's important as well otherwise you'd
307 get extremely stressed (AC mm) so it's er it's quite nice really and I have always
308 sadly the district nurse that used to come in she's actually left now but we had such a
309 wonderful working relationship (AC mm) with her erm and the health visitor erm the
310 only problems is that our practice lies on the boundary of three different areas (AC
311 mm) so we've got different district nurses for different areas and that is erm
312 sometimes difficult to get everybody together to discuss things (AC mm) we've had
313 problems with that before communication problems (AC right) which I highlighted
314 in my degree (both laugh) and things have been sorted out (AC right right so there
315 was an outcome) yeah finally (AC right) so er RT got in touch with PR and said that
316 they must because we never used to get any feedback off the district nurses (AC mm)
317 so they now get in touch with us (AC mm) so that's improved things there as well
318 (AC right good) so er quite a happy little bunny really (both laugh)

319

320 AC That's great that's great

321

322 HV Nothing really bothers me so

323

324 AC Aha OK Erm just one other thing you were talking about you know being in this
325 community and (HV yeah) am I right the sense that I got from what you were saying
326 was that sometimes that's a little bit difficult in terms of your relationships with
327 people (HV yeah) erm how do you feel about living right in here or would you have
328 preferred to have lived outside somewhere and come in to the community?

329

330 HV Erm I think I probably in hindsight would prefer to live outside the area (AC
331 right) so

332

333 AC Yeah so a bit more anonymity

334

335 HV Yeah (AC yes) I think so but at the time it was necessary for us to live here
336 because of the on calls (AC yes) but now it's not (AC mm) and I think it definitely
337 would have its benefits (AC mm) to living outside so (AC right interesting yeah) its
338 er you've always got to be on your guard not to say anything to anyone (AC mm I
339 could imagine) and my family as well I think erm would have they didn't actually go
340 to the local school not that I felt there was anything wrong with the local school but I
341 thought they would probably have been kept an eye on (AC right) (laughs) so with
342 ST as well you see (AC of course) so we moved them up to the school at BP (AC
343 mm) so at least they could be their own little people (AC yeah) fight when they want
344 to fight (both laugh)

345

346 AC Yeah do all that stuff that kids do

347

348 HV So no I think it definitely would have been better to lived out of the area really
349 (AC right) so (AC right OK) I think you're quite isolated when you live in the area
350 within this community because you can't be friends with anyone and (AC mm)
351 because of the sort of professional boundaries really (AC mm) and also it's it's
352 worked sometimes where neighbours have felt that they should have different care to
353 everyone else (AC yes) which I'm totally against everybody's treated the same (AC
354 yes right) so to turn up and just expect to be seen without phoning for appointments
355 and things (AC mm) it's er you know that's not on really

356
357 AC Mm must be hard to deal with

358
359 HV Certainly is try not to upset anybody (AC yes) yeah I think I would have
360 preferred to live outside (AC right) so

361
362 AC Is there anything else that you want to add to the things that make you such a
363 happy bunny? (both laugh)

364
365 HV Erm gosh I'm sorry (AC oh no it's fine) (pause) I just enjoy my job really (AC
366 mm) it's hard to put things on (AC mm) I've no dislikes or anything about it (AC
367 mm) so er I think I think becoming a nurse practitioner has actually helped me do
368 that because I did actually I felt more frustrated before I was a nurse practitioner that
369 I couldn't get my ideas across or erm I think you gain some respect from doing the
370 course (AC mm) er and also I find that it's been hard going sometimes people don't
371 actually know what I actually do but I find people that will come in for things like
372 chronic diseases will suddenly ask me about something acute and I've sorted them
373 out sounds awful doesn't it sorted them out but I've dealt with the problem and
374 they've then realised that oh gosh you know (AC yes) and they've come back time
375 and time again and now that they actually come back to see me rather than go to see
376 (AC mm) the GP (AC mm) so er that's quite rewarding so (AC mm) people actually
377 want to see you (AC yeah) its er but no there's nothing really I enjoy it all really (AC
378 right that's great) but the biggest thing for me is actually being able to see people and
379 talk to them and (AC mm) that sort of I would hate just to be in admin (AC mm) it's
380 the people the contact with the people that I enjoy that's the biggest thing for me (AC
381 mm) so (AC right) and getting to know them individually and what they like what
382 they don't like (AC mm) and er and it helps then because you pick up if there's if
383 there's any problems you know I saw a gentleman that I've known for years this
384 morning and I knew there was something wrong his wife's dementing bless her (AC
385 mm) but I was able to pick that up (AC mm) because I've been you know been in
386 close contact with him for the last few years (AC yes) his mood was different and
387 things like that (AC mm) so no I enjoy everything so (AC mm that's great) sorry to
388 be so boring (both laugh)

389
390 AC That's brilliant H thank you

Transcript Summary

Interview 16 NP

This transcript suggests that HV generally enjoys her work^{361,383}. She enjoys seeing people from start to finish and making decisions about their care⁷. She feels that this allows her to treat people more holistically^{6,25} and she finds this personally more fulfilling¹⁴. She is now able to follow people up after their initial consultation and this allows her to think of their wider needs and to arrange for home care or social services if they need them²⁴. She enjoys being able to solve problems herself and this is different from her previous role as a practice nurse where she had to pass people over to the GP for their ongoing care⁴³.

HV values good teamwork³⁰² and would prefer to be with people rather than doing administrative work¹³⁷. HV enjoys being in contact with people^{91,208,376} and enjoys building relationships with them over a number of years⁹². She likes getting to know them individually³⁷⁷. She enjoys working with people who have chronic diseases¹⁰⁰ and will visit people in their homes if necessary. HV values having feedback from patients when they return to say 'thank you'^{103,106} and likes it when people come back to her for further consultations³⁷¹.

HV gets frustrated by delays in the system that slow the progression of patient care^{248,290}. She also gets frustration when financial constraints result in patients having to alter their medications²⁶¹. HV believes in treating everybody equally and gets frustrated when neighbours expect special treatment at the surgery³⁴⁹.

HV feels that being a nurse practitioner has made her question things more⁸⁰ and has made her more analytical⁷². She is aware she needs to keep up to date⁶⁸ and enjoys going on study days where she can interact with other health care professionals²⁰². HV likes being able to chat to the GPs on an equal basis²⁰⁴ and enjoys working with the medical students¹⁵⁴. She gets frustrated when people (particularly health care professionals) refer to her as a practice nurse rather than a nurse practitioner after all her years of extra work and study²⁷⁰.

Interview 17 GP

1 AC It's very unstructured and erm so we just start with one open question and really
2 go from there with whatever you want to talk about (HT Yep fire away) erm so the
3 question is what do you find most meaningful in your work as a GP?
4

5 HT Erm try not to be too flippant the actual patient care is probably the most
6 important bit erm I would enjoy the actual management of the practice if that was my
7 job that bit cus there's so little time to do it all being squeezed in erm than the sort of
8 sitting back organising a practice population like diabetes going through it all sorting
9 that out which I would find very satisfactory it's just an add on lump that doesn't get
10 done (AC mm) erm and it's that erodes the job satisfaction but basically the bottom
11 line is patient care (AC mm) I do enjoy it when I have to do it (AC right)
12

13 AC Do you want to explain a bit more about what it is about patient care that you
14 enjoy?
15

16 HT Erm it's it's the whole aspect seeing the patients coming in erm trying to make a
17 diagnosis the challenge of making a diagnosis the actual contact with them
18 addressing their fears their concerns their illness investigations etcetera organise
19 doing just the whole thing for it erm and (pause) there's even satisfaction in
20 obtaining a you know an unpleasant diagnosis (AC mm) just as part of the jobs work
21 done erm but that's transient
22

23 AC Right so actually coming up with the diagnosis is satisfying is that?
24

25 HT Yes (AC yes) basically just all those aspects of patient care hands on getting
26 stuck in doing for that patient you know from the time they come in the door to going
27 out hopefully treated or coming back and follow up etcetera
28

29 AC Mm right so the whole picture
30

31 HT Mm it's that clinical picture really
32

33 AC Yeah OK. Anything more that er you enjoy about your work?
34

35 HT Right leaving the drug addiction side out of it?
36

37 AC No whatever yes
38

39 HT Well the drug addiction side certainly is very satisfying and in many ways you
40 get more positive feedback there than you do from primary care at least you get some
41 successes there erm you do in primary care but they're not so obvious and they're not
42 so dramatic (AC mm) probably a bit more transient in the drug clinic though erm
43 (pause) as I say the the admin as into the finances all the rest of it that I find very
44 tedious but actual sort of trying to develop patient care on the practice basis would be
45 very nice if the time was there to do it (AC mm) instead of being a neglected task
46 that tries to get squeezed in (AC mm)
47

48 AC So that time pressure is a frustration is it?

49

50 HT That's the biggest problem yeah (AC mm)

51

52 AC Right you were going to talk a bit about the drug addiction service there (HT
53 uhum) and you said that you found some of that quite satisfying but it's transient can
54 you explain what you mean by that?

55

56 HT Er basically you take a chaotic drug user straighten them out just on to
57 methadone and you see a dramatic change in their affect the way they look
58 everything their clothes you know (AC mm) they've got a bit more affluence
59 everything else erm but there's big change in them and then of course you get them
60 off the drugs there's a huge amount of self satisfaction etcetera there but of course
61 it's a relapsing condition (AC mm) same as smoking alcoholism obesity (AC mm)
62 erm and there's a tendency for them to relapse which is a shame but it's it's so
63 satisfying because the change is so dramatic (AC mm) it's incredible when you see
64 what how they are when we first start with them and then a few years down the road
65 you see the difference (AC mm)

66

67 AC So it's quite a long term picture

68

69 HT Drug addiction is it's a very long term process (AC mm) OK someone coming
70 they're wanting rapid help come off drugs etcetera er the success rate with that is
71 probably quite poor (AC mm) and it does take a repetitive getting involved working
72 with us erm and moving on (AC mm) and that takes time takes years (AC mm)
73 (pause)

74

75 AC Right right back to your work here as a GP (HT uhum) you've mentioned what
76 you find most satisfying is your interaction with the patient and this sort of whole
77 picture from start to finish erm is there anything else you'd like to add to that?

78

79 HT Not really I mean that's that's the key part of it for me er it's an essential part
80 obviously (AC uhum) erm in many ways I'd love to be in a practice where a lot of
81 the more day to day chronic disease management etcetera was done by er practice
82 nurses nurse practitioners and I was dealing with the more complex er (AC mm)
83 clinical situations you know perhaps with half an hour per appointment or something
84 (AC mm) to really work the patient instead of a quick ten minutes and get them out
85 the door (AC mm) erm that's something that would be nice but it's not achievable in
86 this practice as it stands (AC mm) if some of erm a neighbouring practices retired or
87 something we get a chance of some patients then it's more achievable (AC right)
88 whether it'll ever happen (AC mm)

89

90 AC Right and so you would enjoy working with complex patients?

91

92 HT Yes I think so because certainly if you take a complex patient and manage them
93 in ten minute consultations brief consultations looking in the notes (AC mm) quick
94 look before the appointment you're getting snap shots of them you're not getting the
95 overall picture (AC mm) and really if if someone's not been properly sorted or even
96 if they are say the diabetes where there's multiple facets that have got to be
97 addressed you can't just walk in sit down quick look at the screen and see the patient
98 do the best for them (AC mm) you have to step out summarise the records work out

99 what you're goals are I suppose you'd better discuss that with the patient that's (AC
 100 mm) politically correct would be erm but then work with all of that instead of just
 101 what they're here with today etcetera (AC mm) and that's where the big loop holes
 102 are in our quality and outcome data is we haven't been looking at the bigger picture
 103 we've been just looking at where they are at now and when they last had a blood test
 104 done oh it's been three months repeat it now (AC mm) rather than picking up the
 105 larger scale (AC mm)

106
 107 AC It's interesting that you feel population manager reflects that

108
 109 HT It does (AC mm) just looking at it then the (pause) you can see the things that
 110 we're consciously aware of all the time like TFTs erm for our hypothyroid patients
 111 erm you can certainly see the ones that we're not recording you can also see the ones
 112 that we haven't been addressing like microalbuminuria in diabetes (AC mm) erm but
 113 other cases where erm just we're not consciously say checking everyone I suppose
 114 microalbuminuria is a bad example because we haven't done it but erm where we
 115 should be looking at the whole mass doing an audit saying right everyone with erm
 116 heart disease how many of them are on beta blockers and making you know a push
 117 along that line (AC mm) that sort of thing is not happening (AC mm) and that's all
 118 down to time for the administration etcetera (AC mm) it's got to be done (AC mm)
 119 (pause)

120
 121 AC It has yeah so the er complex patients that you mentioned what is it erm how
 122 would you describe that complexity and what is it you enjoy about that?

123
 124 HT Erm it's probably more of a mental thing than anything else it's tying in er all the
 125 minutiae of patient care social life clinical results of investigations etcetera putting it
 126 all together erm maybe going for a diagnosis that hasn't been made (AC uhum) erm
 127 maybe polypharmacy comes into it looking at the number of patients who are on
 128 multiple drugs (AC mm) I mean just these ones who are on different things for ankle
 129 oedema and a calcium channel blocker (AC mm) etcetera erm trying to sort of go
 130 through all of that and probably as a team not just as an individual make sure you're
 131 getting the pharmacist to go through the erm polypharmacy and just see what's what
 132 perhaps giving them an overview of the patient so they can look at it (AC mm) see
 133 what their problems are related to that erm and just try and do a better job than you
 134 can do in a brief ten minutes (AC mm) it takes a good while and in practice it
 135 probably should be done with all patients with chronic disease (AC mm) once a year
 136 or so erm to do it once a year is achievable but to do the first run through would
 137 probably take a few years (AC right) and that's a snag (AC yes) something I want to
 138 do with the drug team and it's something I'm trying to get going but secondary care
 139 computer systems are not brilliant there are actually four different systems in use in
 140 the drug team (AC mm) which none of them interact with the others so you can't
 141 actually use them for effective data storage (AC mm) you can't introduce a new one
 142 because it wouldn't be popular (AC right) utter garbage (both laugh)

143
 144 AC So when you say you're trying to do that with the drug team you mean have
 145 longer appointments?

146
 147 HT No just review every single client

148

149 AC Review everybody right
150
151 HT Do a full on summary (AC right) erm and the few I've done certainly you can
152 throw up some erm rather startling results (AC mm) that sort of totally go against
153 where things are you do it see them every two or three months erm I see them every
154 couple of weeks but never looking at the overall picture never auditing say all the
155 drug screens etcetera seeing what you're actually getting from that tying that in with
156 what they're saying and sometimes it's er completely different to what you think's
157 going on (AC really interesting mm) (pause)
158
159 AC So anything else that you'd like to add that you enjoy about your day to day
160 work?
161
162 HT Erm going home (both laugh)
163
164 AC Well that's important
165
166 HT Yeah (AC yeah) going home at the end of the day or the night erm that's it by
167 and large really (AC aha yeah)
168
169 AC So to look at it in a slightly different from a different angle erm what is it in your
170 work that frustrates you that you get fed up (HT OK) with or?
171
172 HT Erm the hours are too long (AC aha) er Mondays and Tuesdays are typically
173 seven to sevenish erm and that's it just intrudes too much on the family life erm the
174 time constraints even despite the long hours are very much there erm I could reduce
175 those if I gave up the drug addiction work and just worked five days a week but then
176 I've still got to be here eight thirty to six thirty eight to six thirty anyway (AC mm)
177 so there's no advantage erm the sort of admin things that have to go up to the PCT
178 the financial management and all that side that's I find very tedious (AC mm) I'd
179 happily loose a lot of that because we're meant to be loosing a lot of that with new
180 GMS (AC mm) we'll see
181
182 AC Time will tell mm (HT mm) right anything else that frustrates you?
183
184 HT No it's all that sort of admin erm managing staff contracts and all the rest of it I
185 suppose also the ineffectual nature that happens with the guidelines where you have
186 NICE guidelines British Hypertension Society guidelines and local guidelines erm it
187 would be so nice to have NICE involved with the individual people involved and
188 coming up with UK guidelines (AC mm) and that would be make life a lot simpler
189 (AC mm) er alternatively if the local guidelines were produced secondary and
190 primary care sitting down together would come out like your ACE twos how often
191 should we be screening them (AC yes) for U&Es etcetera rather than some advice
192 that the majority of the UK health professionals think is garbage coming out from
193 NICE (AC mm) not that that happens I'm sure (both laugh)
194
195 AC Yes so clearer guidance would help
196
197 HT Yep it would simpler guidance (AC mm) so that you're not trying to work out
198 whose is the most up to date etcetera and which we should be doing er like the

199 British Hypertension Society one that came out in the BMJ and then it's just sunk
 200 (AC mm) most clinicians don't seem to be using them (AC mm) 130/80 for diabetes
 201 and lower cholesterol target it doesn't seem to be taken on board by any GP that I've
 202 spoken to anyway (AC mm) erm I don't know if secondary care are using them at all
 203 locally (AC mm) erm and that sort of thing if it was in local guidelines and instead of
 204 getting guidelines coming out from orthopods now someone else then to have a book
 205 that would come out once a year with all the updates in would be lovely

206
 207 AC Yes wouldn't it just

208
 209 HT Referral guidelines (AC yes) and working practices that they want great (AC
 210 mm)

211
 212 AC Yes we were talking earlier before we started the interview about frustrations
 213 with things like work at the level of the diabetes LIT (HT uhum) erm do you want to
 214 say anything about that at all?

215
 216 HT Yes it does seem to be a lot more talk than action going on (AC mm) I accept
 217 that some of the action is happening behind the scenes but certainly a lot of it is cost
 218 limited and therefore the stumbling block is that er whatever needs to be doing wont
 219 be done because there is no funding for it like the dietetics where they fail to meet
 220 every single target that's been imposed erm and that's with the current workload and
 221 the workload is going to go up enormously with statins erm and cholesterols (AC
 222 mm) with diabetes and they're going to fail more and more and the budget isn't
 223 going up podiatry work's been year on year reduction in budget erm and that's that's
 224 just silly (AC mm) but that's the PCT

225
 226 AC Mm so it's the budget that you see as the constraint

227
 228 HT Erm that's what is given as the constraint but I don't know where the money
 229 actually goes to (AC mm) enhanced services three and a half million for the PCT I
 230 think there's only about two hundred GPs (AC mm) I don't know how many of them
 231 are going to be getting an average of seventeen and a half thousand (AC mm) erm I
 232 don't think we'll be getting very close and if most people aren't then I'd like to know
 233 where the funding is actually going to (AC mm) so that's that's interesting thought
 234 (AC mm) (pause)

235
 236 AC Anything else that you can think of that er frustrates you in your day to day
 237 work?

238
 239 HT I suppose it's the secondary care aspect as well (AC right) the long waiting lists
 240 erm the absence of services like erm psychology neurology (AC mm) just not being
 241 able to access them (AC mm) erm to have e mail access of consultants in a more
 242 fuller fashion would be very helpful (AC mm) erm in theory once they've got full
 243 data transfer that'll be better but just to be able to send a letter up to a consultant by e
 244 mail saying like the diabetic possible diabetic we discussed earlier erm is this does
 245 this patient need metformin or hypoglycaemics or should she be left as she is is she
 246 even diabetic (AC mm) and just without them even having to see the patient just get
 247 a feedback as part of a routine management that would be good (AC mm) very very

248 useful and especially getting it turned round in a week or so instead of a month like it
249 is with a letter to the consultants
250
251 AC Yes so communication with secondary care (HT yeah) yes and waiting times
252
253 HT It is also would be nice to get feedback on like referrals if we do a referral and
254 they feel that this was an inappropriate referral most of them will just go in do what's
255 what and send them back they wont actually give you some feedback like saying OK
256 we should have seen this patient six months ago (AC mm) or there's no need to see
257 them erm you've done everything or whatever or you know whatever (AC mm) it
258 erm it would be nice because that I think would improve everybody's care (AC mm)
259 and we should feedback to them when they come up with something which we
260 regard as garbage and refer you know send it back
261
262 AC Yes in an ideal world (HT mm) yes
263
264 HT You would need to exclude litigation though from
265
266 AC Yes yeah anything else that you can think of?
267
268 HT Er that covers most things
269
270 AC Aha right and have we covered the breadth of things that you enjoy about your
271 work do you think?
272
273 HT Erm I think so part of what's missing in a single handed practice is working with
274 colleagues (AC mm) that's that's something which would have been nice to have
275 done more of erm that's single handed life (AC mm)
276
277 AC Yes OK that's great thank you

Transcript Summary

Interview 17

This transcript suggests that HT enjoys patient care^{5,11} and contact with patients¹⁷. He enjoys the challenge of making a diagnosis^{17, 124} and even when the diagnosis is an unpleasant one there is a satisfaction in getting it right²⁰. When working with patients he enjoys addressing their fears and concerns^{18,26} and putting the whole picture together including their social life, clinical investigations and polypharmacy¹²⁴. HT particularly enjoys the mental challenge of this process¹²³.

HT finds working with people with drug addiction satisfying because it is possible to achieve some dramatic and obvious successes^{39, 62}. Success is less obvious in primary care. He likes to have plenty of time to deal with complex clinical situations and values the input of others in the primary care team in this process⁸¹.

HT finds lack of time a frustration. He would quite enjoy practice management if he had enough time to do it⁶. He would also enjoy developing patient care in the practice if it were not for time constraints⁴⁴. He gets frustrated with long hours¹⁷¹ and he finds this intrudes on family life¹⁷². He enjoys getting home at the end of the day^{161,165}.

Tedious administration work is frustrating^{176,183} and HT gets frustrated with the numerous clinical guidelines that are published¹⁸⁵. He gets frustrated with long waiting lists and the absence of certain services such as neurology and psychology in the area. HT would value feedback from consultants on the appropriateness of his referrals²⁵⁰. He values working with colleagues although this feature has been missing for some time as he works in a single handed practice²⁷⁰.

Interview 18 DN

1 AC So it's a very unstructured interview erm and we just start off by asking you er
2 what do you think is the most meaningful thing to you in your work as a district
3 nurse?
4

5 HW I suppose erm patient satisfaction really achieving and that covers a variety of
6 things whether it's satisfaction in as much as you've healed a wound or whether it's
7 purely making them comfortable if you're dealing with palliative care you know a
8 whole range of things so that you sort of come out and think yes I did that to the best
9 of my ability and I've achieved something there and they're satisfied with that.
10

11 AC Right can you explain that a little bit more?
12

13 HW In a whole I suppose yes take an example of a leg ulcer erm I mean obviously
14 we can deal with leg ulcers over a matter of weeks a matter of months or a matter of
15 years (AC mm) we do have a number of patients (AC mm) and it's really very
16 rewarding to know that whatever you're doing is probably the right path it may not
17 necessarily mean that you're going to heal them every time but it means that you're
18 actually doing carrying out the treatment to the best of your ability er bringing in all
19 the other resources that are available as well to meet that patient's need.
20

21 AC Right right OK and you said with erm with somebody with a leg ulcer for
22 example healing it would be very satisfying
23

24 HW Healing it healing it would be satisfying but I think as a district nurse we're
25 looking you've got to have a degree of flexibility you've got to be aware of all the
26 factors that er go towards healing and the fact I have a number of people that still
27 want to be out on the farm working (AC mm) and I know that if I said to them
28 you've got to stay at home you've got to rest your leg we would probably heal that
29 but that would be no quality of life for them (AC mm) so I have to be quite flexible
30 there and look at what their lifestyle is (AC mm) so their lifestyle and their quality
31 of life means that yes we go and dress the leg so many times a week but once we've
32 gone they go out and work on the farm (AC mm) so we know that is contrary to good
33 healing so there's a bit of a balance between what's good for the patient and what is
34 right to heal an ulcer (AC right) and that is all part of the patient satisfaction isn't it
35 you can't go in and lay down the law and say this is what we're going to do it's
36 probably a lot easier in hospital because the patients do actually give themselves up a
37 little bit don't they? (AC uhum) and so here I am make me better. In the community
38 they have a lot of say in their care which is great (AC mm) and it means that they can
39 say oh yes I know you're doing that they but I also need to be out in the fields doing
40 some things (AC mm) so there has to be that flexibility
41

42 AC And you have to be OK with that
43

44 HW Yeah you do you have to fit in with that and that's really I quite like that I quite
45 like being flexible and able to say yes I understand that I understand what your needs
46 are in life (AC mm right) and you know so that's part of the job as well (AC right)
47 you know actually understanding what is a priority to my patient (AC to them yeah)
48

49 AC Can you explain a bit more about that patient satisfaction you said you know
50 other areas apart from wound management?

51
52 HW Yes I think you're also looking at not just wound management but possibly
53 talking about palliative care which is obviously something that we are looking at and
54 not just there talking about erm obviously erm patients with cancer but looking at
55 patients with CVA with chronic conditions (AC mm) which are obviously coming to
56 the end of term of their life and there it's really rather nice to be involved in
57 providing nursing care but also providing equipment to ensure that that end stage is
58 not ? but is an experience that isn't dreadful (AC mm) it means making that end
59 stage easier for them (AC mm) and so getting some degree of satisfaction in that way
60 (AC mm) so that you know whatever they are going for in life erm we're able to help
61 them with it.

62
63 AC Mm right can you think of any other things that are meaningful to you in your
64 work?

65
66 HW Yes teamwork (AC right) teamwork is the other thing I would certainly look at.
67 I work with a very big team here and I think it's really quite important that we work
68 together and that's not just the district nursing team but the multidisciplinary team
69 (AC uhum) because that's the only way you can achieve all the things you want to
70 achieve by working alongside other people (AC right) erm you know if you go out
71 there on your own there are so many things that we need to call in to aid people in
72 their own homes (AC mm) and you can't do it on your own so it's working alongside
73 a social worker or physio or another member of the team because everybody in the
74 team has something to offer (AC mm) although I'm the sister it doesn't mean that I
75 know everything everybody else has done different courses and they all bring
76 something special to the team (AC mm) so it's really nice to work together and to
77 bring out all the various skills (AC right) and there's also the fact that with team
78 work there's also you're with people isn't it (AC mm) I think as a nurse you've got
79 to be person a people person (AC yes) you've got to be able to work with them er
80 and as much as being a district nurse it's great being out on your own in the car but
81 you're dealing with people in between (AC yes) so there is that element of teamwork
82 (AC yes)

83
84 AC So you like that balance

85
86 HW I do yes (AC yes) I rather like that yes it's really rather nice and I think having
87 done it for so many years that sort of worry about being back on the ward I might
88 find that sort of feeling a bit claustrophobic whereas I know that I have a big team to
89 work with and I can call upon them all but (AC mm) at the same time I'm setting off
90 and doing things on my own (AC mm) quite a lot. Saying that we do have a lot of
91 students throughout the year so we do have people with us each day (AC right right)

92
93 AC So you're involved in teaching

94
95 HW We are yeah very much (AC yes) certainly we have a lot of diploma and degree
96 course students coming out at the moment and of course along with that we do take
97 students from other disciplines, social work students come out with us (AC right) and
98 physio students and also the general practice medical students (AC right) come and

99 spend some time with us as well so we spend a lot of time talking in the car (both
100 laugh) (AC yes) and the odd day when you're not is rather nice (AC yes)

101
102 AC And how do you find the teaching side of it and having people with you?

103
104 HW I think that is good it is good for the team in that it does make you think about
105 what you're doing all the time. It's so easy with any job isn't it to sort of get into to
106 a rut and say this is what we do and this is how we do it whereas it's also very
107 important that we do have research based practice and we're actually up to date with
108 changing ideas in nursing and medicine and it does keep you on the ball having
109 students there (AC mm) they constantly ask questions and needing to know what
110 we're doing and being able to teach them in that area (AC mm) so you know it's
111 refreshing having students here because they do bring new ideas as well (AC mm)
112 they do keep us up to date as well as us trying to ensure we're involved in their
113 teaching (AC right) and the patients rather like having students (AC right) which is
114 nice (AC yes) they're very used to the nursing team (AC mm) although it's quite big
115 they're used to who normally comes to see them but they like to have a new face as
116 well so it's nice to have somebody else in the car (AC mm) and it's rather nice to
117 discuss things as you're going around (AC mm) you know to actually talk things
118 through yourself because we all have to question what we're doing on a daily basis
119 (AC mm) whether it's 'oh should I have said that?' erm you know it's rather you can
120 think that yourself but if you've got somebody with you who was there at the time
121 you can say 'what did you think about that? Was that right? What would you say'
122 (AC mm) it's rather nice to have somebody else to talk that through with

123
124 AC Yes and get their opinion

125
126 HW Yes that's right

127
128 AC Is there anything else that you can think that you particularly enjoy about what
129 you do?

130
131 HW Enjoy in nursing well I mean there's the patient contact I mean that's the other
132 thing we talk about making people satisfied being satisfied but certainly the patient
133 contact I think to actually be a nurse you've got to enjoy dealing with people haven't
134 you (AC mm) so I think the contact there is really rather nice (AC mm) erm and I
135 also you know I rather like actually coming in and sorting things out I do quite like
136 the administration side as well certainly in my position being able to ensure that the
137 team is well organised and all the patients are sorted you know there's that aspect of
138 my job as well the administration side which yeah is fine it can be a bug bear
139 sometimes can't it as any job can when you've got lots of bureaucracy and
140 paperwork but again that can be OK (AC mm) I don't mind that it's not too bad

141
142 AC Right what's that balance like for you the administration and patient contact?

143
144 HW I think as a district nurse it's not it's not too bad I think I probably wouldn't I
145 find that I don't have enough time for the administration (AC mm) because there still
146 needs to be because it's quite a big case load I need to be out there seeing the patients
147 as well (AC mm) we've had a bit of disruption with the team at the moment well
148 certainly it's settling down now (AC mm) but over the last six months or so we've

149 had a big change over of staff and so it's really important for me to look at clinical
150 supervision and be involved in the day to day management and ensure that
151 everybody's quite happy with the job they're doing and training the new staff as well
152 (AC right) so that's very much out there with the patients (AC right) so it so maybe
153 there's not quite as much time as I'd like to do the administrative side but hopefully
154 once you've got the staff sorted out and get back to a normal team that should help
155

156 AC Right so when you've got that all piling up what do you prioritise what you're
157 going to do first in terms of the admin side or?
158

159 HW In terms of the admin or the patient the patients are the priority (AC yes) every
160 time and it just it does mean that the admin does get taken home (AC right) where it
161 can be (AC right) you know obviously if it's to do with the computing (AC mm) then
162 that does need to be done as well so that would come next I suppose patients
163 prescribing and making sure that everything is there for the day to day management
164 and to make sure that whoever's going in next will be able to carry out jobs that they
165 need to carry out and then the computer because of course we're all computerised if
166 everything isn't put on there and up to date all the visits are haywire we don't know
167 where we are so yes all the other bits of paperwork such as the notes and things yeah
168 they do get taken home to be written (AC right, right) which is we're all at fault for
169 that aren't we (AC laughs) but there you go (AC It spills over doesn't it?) It does and
170 something has to give so there we are.
171

172 AC Is there anything else that you can think of?
173

174 HW I'm sure that there's lots that I can think of once you've gone (both laugh)
175

176 AC It's always the way.
177

178 HW Yes it is isn't it yeah I mean the job itself I enjoy the locality of this job (AC
179 mm) working in the rural area but town as well you've got a nice mix (AC mm) I've
180 worked in inner cities before (AC right) so I've been able to look at the comparision
181 er and the job's the same wherever you go (AC mm) you've always got the different
182 types of people erm ah but it's the location's lovely on a summers day we're in the
183 country it makes it wonderful (AC yes) you know that's a rather nice aspect of the
184 job as well (AC yes, right)
185

186 AC Do you actually live in this area?
187

188 HW No I live just outside about fifteen miles away.
189

190 AC So you're outside of your locality.
191

192 HW Yes that's right.
193

194 AC How do you feel about whether you could live within this area?
195

196 HW Yes I always think it's probably a nice thing that I don't (AC mm) because I'm
197 sure there would be that facility for patients to call upon me (AC mm) as I know they
198 do with our one staff in particular who is well known to local people and lives here

199 and they call upon her quite a lot (AC right) so in that respect particularly as we do
 200 have a twenty four hour service now in this area so it's really nice that we ensure that
 201 that's that they know that is the area to call and not (AC mm) the people who aren't
 202 working (AC mm) and so it makes it much easier for me because I'm out of the area
 203 and certainly I don't give telephone numbers the telephone numbers are the service
 204 not mine (AC right, yeah) I think that's important I think you've got to have that old
 205 cliché the work life balance (AC mm) you've got to have that and I think you can
 206 only enjoy it if you can enjoy your own life as well (AC mm)

207
 208 AC Yes interesting.

209
 210 HW I do enjoy the autonomy as well of district nursing I think it's rather nice that
 211 erm the experience that I have particularly in areas such as wound care and palliative
 212 care that I can go in and make decisions about (AC mm) how I'm going to deal with
 213 these wounds that I can go and do that rather than I know in hospitals they are very
 214 much limited to their prescribing whereas of course with nurse prescribing it's really
 215 rather nice (AC mm) I'm not limited by what the pharmacy are going to provide I
 216 can look at a wound assess what it needs and take it from there (AC mm) that's
 217 rather nice.

218
 219 AC And so you write your own prescriptions now.

220
 221 HW I do yes (AC yes) which it it's much better (AC yes) you know and it saves time
 222 (AC mm) and whereas before it's very much a case of right you know effectively
 223 writing the prescription and the GP signing it (AC yes) or you wouldn't actually
 224 write it you'd just ask for it (AC mm) and er yes because the GPs do leave wound
 225 care up to us (AC mm) the vast majority of the team have been on wound care tissue
 226 viability courses or leg ulcer management courses (AC right) it just means that you
 227 know we know what we're doing (AC yes) you know carrying out doppler
 228 assessments and looking at leg ulcers you know district nursing has changed
 229 immensely over the last few years (AC mm) certainly since I've been doing it for
 230 fifteen years it has changed immensely you know the whole team are now involved
 231 in stripping down dialysis machines and setting them up for patients (AC mm) our
 232 auxiliaries are involved with giving insulin you know we've taught them day to day
 233 management of insulin and diabetes (AC mm) and it means that they feel as if
 234 they've got a role to play as well (AC mm) rather than just being a bath nurse which
 235 they were when I first came here (AC mm) so we're seeing the team dynamics
 236 changing which is good (AC mm) we're seeing actually using the staff skills
 237 effectively (AC uhum) to make sure that the patients cus we've got a very old
 238 population here you know it's very aged (AC yes) so there are quite a lot of demands
 239 and increasingly ever increasing demand really (AC mm) so it's nice to be able to
 240 meet that demand and use the team that you've got (AC mm)

241
 242 AC And using that breadth of skills

243
 244 HW It is yes it is (AC yes) because they're all do have that and it's a shame where
 245 some of our auxiliaries were purely expected to bath people (AC yes) you know they
 246 do have the knowledge (AC yes) and if you can you know give them a little sense of
 247 self worth and confidence (AC uhum) they're so much better for it (AC mm)

248

249 AC You mentioned when you started talking about autonomy there you mentioned
250 both erm wound care and palliative care (HW yes) so what about your role in
251 palliative care?
252

253 HW In palliative care I think my role runs very much more along dealing with
254 looking at what is needed there erm whether it's time to set up syringe drivers
255 whether it's time obviously I'm not necessarily going to prescribe that that's the GP
256 but it's very much going in to say this is the stage we're at now (AC mm) this is
257 where we need to be and then managing that er and obviously looking at erm
258 working alongside outreach teams (AC mm) working closely with them and yes you
259 know we have a decision to make you know (AC mm) whether it's appropriate (AC
260 mm) so that's an interesting aspect.
261

262 AC And you get satisfaction from making those sorts of decisions?
263

264 HW You do you do because you're the one that's going in on a day to day basis or
265 you're one of the team that are (AC mm) you know you generally know that patient
266 quite well by that stage (AC mm) you know whether they're uncomfortable you
267 know whether the drugs are a bit too much if they're making them dopey or you
268 know if it's not enough (AC mm) and so you know it's nice to be involved in some
269 sort of decision making (AC mm) rather than just going in and doing.
270

271 AC Yes right. Anything more that you can think of?
272

273 HW Goodness (laughs) erm I think we've covered most of the things Alison (AC
274 OK) I think probably as I say I'll think of lots of things later on once we've finished
275

276 AC To look at it from a different perspective then (HW yes) is there anything that
277 you find frustrating in your role as a district nurse or anything that isn't satisfying in
278 what you do?
279

280 HW I think probably a frustrating aspect is the expectation that we will respond to
281 absolutely everything straight away (AC mm) because we are a hospital without
282 wards effectively aren't I know these terms that are used (AC mm) and it's very
283 much a case that it is expected that referrals will be made and we will pick them all
284 up (AC mm) and maybe sometimes I think it's we need to actually say look we can't
285 do this (AC mm) you know and in the past we have developed waiting lists for
286 various things but it's very much a case of 'oh the district nurse will do that' (AC
287 right) if the chiropodist goes on holiday the district nurse will do this (AC yes) and if
288 somebody's away on holiday practice nurse is away the district nurse will fit those in
289 and you know we haven't got an endless resource of people (AC mm) there's only so
290 many hours in a day and I think you know when it comes to holiday time my staff
291 have to be on holiday as well (AC mm) and I find it just a bit annoying that it is
292 expected that we will pick up the short fall (AC yes) of other areas (AC yes) you
293 know and we do get that and I think that that's frustrating to the whole of the team
294 (AC mm) because when it comes down to it that patient needs the treatment (AC
295 that's right yes) and in the end you say I can come yeah put him in (AC yes) and you
296 do but it means that you're running around and it probably means that you're not
297 giving the best quality of care that you would like to give (AC mm) so I do find that

298 frustrating but you know we can't put a limit on it (AC mm) although I suppose you
299 probably could but it would be very difficult to actually make limits all the time

300

301 AC It's erm a lack of understanding on other people's part is it (HW that's right) as
302 to what they can refer to you?

303

304 HW Yes yes and we do try and ensure that people know if there are problems
305 generally it's the fact yeah they can refer these people to us but they can't expect
306 them to be seen this afternoon or you know they can't expect us to just pick up
307 everybody's short fall (AC yes) erm just because somebody's away on holiday (AC
308 yes) this is the thing it's understanding that we have a limited time as well (AC yes)
309 just as everybody else does (AC yes, right) it's a big resources problem isn't it really
310 (AC mm) patients in the wrong places.

311

312 AC And then the concern for you is that you end up giving less quality care.

313

314 HW That's right yes because you're running around trying to fit everything in trying
315 to meet all the needs of all the patients referred to you erm and yes as I say in the
316 past we have developed a waiting list primarily for things like ear syringing
317 incontinence assessments which is a shame (AC mm) it's a shame that they do
318 become the poor relations don't they (AC mm) I mean to somebody whose got
319 bunged up ears and they can't hear anything that's very important to have their ears
320 syringed (AC yes) but they will move further down the line (AC yes) somebody else
321 will be seen first (AC yes, right) I think that's probably the prime er frustration (AC
322 mm) in that yes it's erm knowing just how much is expected. I mean certainly things
323 like one of the local GPs decided to opt out of taking warfarin levels wont do INRs
324 so the Trust had to pick that up came to us and said can you do this (AC I see) and
325 you know we're quite happy to go out and do domiciliary visits but it meant that we
326 then had to sort out erm more time (AC mm) so I was able to negotiate some extra
327 hours for our staff (AC mm) so that it meant yes we can do a clinic here (AC mm)
328 but then what was frustrating was that the patients come here and complain because
329 they don't want to be seen at that time they used to be seen at nine o'clock these little
330 things are a bit frustrating aren't they (AC yes) you are bending over backwards to
331 help other people (AC mm) to make sure that you know there is they do have access
332 to the service and their blood can be taken they're not happy with it.

333

334 AC Yes that's hard.

335

336 HW I think the other area of frustration while I'm thinking about it is the abuse of the
337 system again it's not that can be I've found it mainly in this area more than in cities
338 where I've worked this is an area where a hairdresser in the clinic it would be fine
339 (both laugh) you see what I mean (AC yes) because they're more than happy to go to
340 the hairdresser but they can't come to us (AC right) we have to go to them or when
341 we say can we come on Thursday 'Oh I'm going to the hairdresser that day you'll
342 have to come later' (AC right) one of my nurses this morning was met by 'I'm for a
343 late call this afternoon' as the lady got in the car and drove away to the hairdressers
344 (AC mm) and that's an abuse of the system (AC mm) but it's very difficult here
345 because they're they do sort of they're of an age group that they expect that the nurse
346 will call (AC right) and again that is something that we're working on it's something
347 that we need to sort out (AC mm) it's doing it gently isn't it?

348
349 AC Yes (laughs) retraining
350
351 HW It is yes you know there is a clinic here and they can come here (AC mm) but no
352 they're not prepared to do that (AC mm) we find quite a lot are prepared to wait in
353 for us to come (AC mm) and that's a frustrating part of the service.
354
355 AC Yes how do you deal with that when you've got a patient whose
356
357 HW Well we do and I mean it's very difficult I mean it's you look at a number of
358 them and eventually you I mean one of my colleagues this morning was saying to a
359 lady you know she phoned up and said the nurse hasn't been and she said well we
360 came yesterday 'oh I was at the opticians' so you can get to the optician but you
361 can't come to the clinic she said 'oh no I can't' (AC mm) and so we do gradually
362 work on them so you know we do have a clinic (AC mm) and you know I'm sure
363 you'll be able to get there and we can make a time so that you know some of them
364 we will never get anywhere with (AC right) but I think initially I think from day one
365 when we first go in I think we need to actually say that we do visit people that are
366 housebound and once we get this wound a lot better you can come to us (AC mm)
367 and I think if you start that from the beginning (AC mm) you know sow the seeds
368 then maybe you can move on that (AC yes) but it is frustrating.
369
370 AC I could imagine (both laugh) yes like the lady at erm our surgery who demanded
371 a home visit for travel vaccines because she was going to Nepal (HW yes) She was
372 going to Nepal but couldn't get to the surgery
373
374 HW This lady who went to the optician goes to Pompey every year (AC yes, yes)
375 OK you look at her and she does look very frail but if you can travel to Pompey
376 every year and you can nip out to the opticians one day you can come here (AC You
377 can come to the clinic yes) but it's expected of district nurses (AC mm) and it's very
378 much because it's an elderly population it's an image of what your district is (AC
379 mm) and what they do (AC mm) I think we have got rid of the image of the bath
380 nurse now, it's taken many years and people do understand that we will not go round
381 and bath them but it's it's still getting them to come and take responsibility (AC yes)
382 for their own treatment (AC yes) and to get to appointments (AC mm)
383
384 AC Anything else that you find frustrates you or?
385
386 HW No not that I can think at the moment.
387
388 AC No OK. Anything else that you want to add about what you enjoy I know we've
389 covered a lot of areas.
390
391 HW We have haven't we yes can't think of anything at the moment Alison.
392
393 AC No OK right well that's brilliant thankyou.

Transcript Summary

Interview 18 DN

This transcript suggests that HW enjoys achieving patient satisfaction^{5,131}. This can be achieved through making a patient feel comfortable⁷, healing a wound^{6,24} or working to the best of her ability^{8,18}. She feels that doing the best for a patient's wound does not necessarily mean healing it¹⁷. HW values the patient's quality of life and tries to be flexible, adjusting the care she gives to help meet the patient's individual needs^{29,40,45}. HW values people having a say in their care and feels it is important to understand what the patient's priorities are⁴⁷, she likes to be guided by the patient's goals⁶⁰.

HW enjoys being involved in palliative care and aims to make the patient's end of life as easy as possible for them⁵⁵. HW enjoys having autonomy²⁰⁹ particularly in clinical areas where she can make her own decisions²¹⁰. Palliative care or wound care are examples of areas where HW has some autonomy. She likes to be involved in decision making²⁶⁶.

HW values teamwork⁶⁵, she enjoys working alongside others⁷¹ and likes to be part of a multidisciplinary team⁶⁷. HW believes that all team members bring something special to the team⁷⁴. She enjoys being with people⁷⁷ but also enjoys being able to get out into the community on her own⁸⁸. She feels this is a good balance⁸⁸.

HW enjoys having students around. She feels that teaching the students is good for the team¹⁰³ because it makes everyone think. She feels that research based practice and keeping up to date¹⁰⁶ is important and having students helps to bring in new ideas¹¹⁰ and keeps the team on the ball¹⁰⁸. HW feels it is important to question what you are doing on a daily basis¹¹⁷ and feels that clinical supervision in the team is important¹⁴⁸. HW likes change²³³.

HW enjoys patient contact¹³⁰ and enjoys dealing with people¹³². She also enjoys the administrative part of her role^{135,139} and enjoys making sure that the team is well organised¹³⁶. However, patients are always the priority¹⁵⁸ and if necessary she is prepared to take the paperwork home¹⁵⁹ to make sure that the district nursing team is well organised and continues to run smoothly¹⁶⁹. HW enjoys working in a rural area^{178,182}. She feels that the work life balance is important and therefore gives patients the telephone number of the district nursing service and not her own²⁰⁴.

HW believes that it is important that everybody is happy in their job¹⁵⁰. She works to give members of staff self worth and self confidence²⁴⁵. She feels it is important to use staff skills effectively²³⁴. She gets frustrated when people make too many (inappropriate) demands on the district nursing service²⁸⁶ and also gets frustrated when people prioritise the hairdresser over their health care needs³³⁴.

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