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Nurse Practitioners: Redefining Occupational Boundaries?

An Ethnographic Study.

By

Thomas David Barton

Submitted in candidature for the degree of Ph.D. at the School of Health Science,
University of Wales Swansea

Doctor of Philosophy

Supervisor : Professor David Hughes

School of Health Science
University of Wales
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October 2005

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ABSTRACT

This research project investigated aspects of the cultural and professional perceptions and experiences of individuals involved in the organisation, education and practice of the clinical role of the nurse practitioner. The study also examined the implications of that clinical role for the stability and nature of occupational boundaries, specifically the boundary between the professions of nursing and medicine.

The project's focus on occupation, profession and culture ran a natural course in directing the methodological development. That development was grounded in the qualitative paradigm, and in concepts of cultural (anthropological) investigation. Practitioner ethnography was the methodological approach utilised in the design of this research project and it is evident throughout the data and findings.

Over a two-year period, a sample of student nurse practitioners who were undertaking a clinical degree programme, was observed. Data were also collected from other individuals involved in the degree programme: teachers, physician mentors and senior academics. No predetermined framework or structure was imposed on the data prior to the analysis. The data were systematically analysed and structured, leading to the inductive identification of sub-themes. These were refined to five broad interconnected transition themes. These themes were then further structured and analysed by comparing and contrasting them within the conceptual framework proposed by Van Gennep (1960) in his work on the symbolic rite of passage.

Finally, four broad processes emerged that reflected the events observed within the data. The theoretical framework of transitional rite of passage was used to conceptualise the findings regarding the lived experience of the sample. The findings have revealed that the overall sample experience took the form of a rite of passage and that this process was central to the evolution of new career structures and identities associated with advanced nursing practice. Overall, the nurse practitioner degree programme involved a series of transitions and reappraisals of identity, but ultimately it left them located within the nursing profession.

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CHAPTER ONE

THE INTRODUCTION

1.1. INTRODUCTION

> *"A defining characteristic of a nurse practitioner is their autonomy of decision making, and their ability to see that decision through. That means you have to have a certain authority to do things, and part of that authority is inside you and in the way that you think - you just do it. But also there are quite important structural constraints that formalise the amount of authority that you have."*
>
> *Senior Academic - G2 Data Segment - 2nd Interview Data*

The above data extract comes from an interview conducted late in this study. It directs attention to core issues that are the focus of this research, and it points to the array of complex social and cultural interactions that are associated with the development and activity of nurse practitioners. In this research project, I have investigated the cultural and professional perceptions and experiences of individuals involved in the development, education and practice of the clinical role of the nurse practitioner. The study examined the implications of that clinical role and its affect on the stability of occupational boundaries, specifically the boundary between the professions of nursing and medicine. The broad research aims were:

a) To examine the experiences and perceptions of a diverse group of individuals involved in a nurse practitioner degree programme.

b) To examine the evolving nurse practitioner role and identity, and its affect on:

- Professional structures and concepts
- Occupational boundaries

c) To consider how transitional experiences compared and contrasted with the concept of a rite of passage.

Later in the thesis (chapters two and three), I consider in detail the professional debates and theoretical issues that have arisen from uncertainties over the development of the nurse practitioner role, arising as it did from a complex social and cultural situation. Those reviews provide a background for the eventual findings and discussion in this study. However, to guide the reader, and to provide a baseline, I will now outline the key features of a nurse practitioner role, this description based on evidence and opinion from the more recent literature (Trnobranski 1994, Williams and Valdivieso 1994, Rasch and Frauman 1996, Hunt 1999, Pearson and Peels 2002b). A nurse practitioner is an experienced qualified nurse who carries out a specific advanced clinical nursing role either in a primary healthcare setting, or in a secondary healthcare setting. Nurse practitioners build on their existing theoretical nursing knowledge, and use their established clinical nursing skills in combination with additional clinical skills and knowledge traditionally associated with medical practice. The skills adopted from medicine, and used by nurse practitioners, are those of physical assessment, pathological diagnosis, and clinical patient management. This combination of skills enables a significant degree of autonomous clinical decision-making and independent patient management (Lindeke and Canedy 1997, Hicks and Hennessy 1998, Pearson and Peels 2002b, Royal College of Nursing [RCN] 2002). I have used this broad role description as a baseline throughout this thesis when discussing and analysing student nurse practitioners' clinical development.

The literature revealed that nurse practitioners had presented many challenges to professional boundaries and to the social and organisational structures associated with them (Vayda 1965, Bates 1970, Marchione and Garland 1980, Bennett 1984,

Stilwell et al 1987, Brown 1995, Castledine 1995, Cahill 1996, Ashburner et al 1997, Campbell-Heider et al 1997, Walsh 1999, Brown and Draye 2003). The development of the nurse practitioner role had also been subject to considerable research on the specifics of its clinical outcomes, and its client and user acceptability (Stilwell 1988, Greenhalgh 1994, Hill 1994, South Thames Regional Health Authority 1995, Sakr et al 1999, Venning et al 2000, Lattimer et al 2000, Kinnersley et al 2000, Shum et al 2000). However, fewer studies had investigated the specifics of the social and cultural change, and the professional challenges associated with the introduction of the nurse practitioner role (Bousfield 1996, Svensson 1996, Allen 1997, Williams 1999, Offredy and Townsend 2000, Brown and Draye 2003).

In this study, data were collected and analysed with a focus on the social and cultural transitions that were experienced by students, educators and clinical mentors involved in an education programme that sought to develop a nurse practitioner role. From June 1997 to July 1999, I studied a sample of student nurse practitioners, teachers, academics and physicians who, to varying degrees, participated in a clinical degree programme (B.Sc. (Hons) Nurse Practitioner). During that period, I was one of several lecturers involved in the degree programme, and my role as the researcher in the data collection was consequently a fundamental research design issue. I consider that design issue at length later (chapter four, sub-section 4.2.4. p.79-87 / chapter eleven, sub-section 11.3.1. p.405-409). However, I acknowledge from the outset my specific interaction with the sample and this is reflected in the use of a practitioner ethnographer (participant observation) approach (chapter four, sub-section 4.2.4. p.79-87).

In keeping with an inductive design, no predetermined framework or thematic structure was imposed on the project design, or on the data, at the outset of the analysis. Once collected, data were systematically analysed, that process leading to the induction of sub-themes. Further analysis of these sub-themes led to the identification of five broad interconnected transition themes (chapter one, section 1.2. p.8). These five transition themes were then structured within the concept of a rite of passage as proposed by Van Gennep (1960) (chapter three, section 3.3. p.63-70). Finally, four thematic processes emerged (chapter ten, section 10.3. p.366-367). Although the study results could be viewed as expected in the light of existing and well-established social transitional theory and negotiated occupational boundary theory, some findings were original in the context of a highly specific sample experiencing an intense programme of clinical education over a two-year period.

1.1.1. The thesis structure and presentation

This thesis is divided into five broad areas. These are as follows:

1) The first three chapters provide the reader with a conceptual basis to the research itself, its fundamental aims, design, and theoretical background. Chapter one identifies the particular focus of this study, outlining the main aims, essential structure, presentation and design of the research. Chapter two reviews the literature, firstly outlining the systematic retrieval and critique of the literature, and secondly focusing on the general historical background of nurse practitioners and their relevance to more recent healthcare service developments. Chapter three

reviews the theoretical framework, broadly outlining the social, cultural and occupational theory that provides a basis for this project, and specifically describing the concept of the rite of passage and its role in the research design.

2) Chapters four and five consider in detail the methodology, method, and analysis. Chapter four considers the specific development of the project in terms of the methodological and design considerations, and profiles the study's sample. Chapter five details the data collection and the process of analysis.

3) Chapter six reviews the educational context in which the study took place and the structure of the nurse practitioner degree programme from where the sample was drawn.

4) Chapters seven, eight and nine present discussion of the data and the findings, each chapter being concerned with one phase of the rite of passage (the separation phase, the transition phase, the incorporation phase).

5) Chapters ten and eleven complete the study. Chapter ten completes the analysis and summarises the data findings, including a description of four processes that link the findings to the research aims. Chapter eleven concludes the research and provides a final critical review of design issues.

Throughout the thesis, I have used textual data extracts to highlight or clarify specific findings or points of interest. However, the reader will note that the bulk of my data are presented in three main data chapters (chapters seven, eight and

nine). All data extracts are italicised for ease of identification. However, where I have added later explanatory notes to data extracts, these notes are non-italicised. When dialogues are reproduced in data extracts, individuals are referred to by letters, or by numbers, to anonymise responses. All data extracts can be traced back to the source transcripts for verification.

I also draw from the literature throughout the thesis as is required to understand specific issues, although chapters two and three deal specifically with the main body of the literature. Chapter two reviews the literature that considers the history of nurse practitioners, whilst chapter three reviews the literature that provides theoretical background to the study.

I have, where necessary, cross-referenced general and specific areas of discussion throughout the thesis. For example, if an issue has been broadly discussed elsewhere in the work, I have cross-referenced to the chapter, the general section or sub-section, and to the page ranges. Alternatively, where an issue has been specifically discussed or highlighted elsewhere in the work, I have cross-referenced not only to the relevant chapter, to the section or sub-section, but also to the specific page(s), Figure, Graph or Grid.

In the following three sections of this introductory chapter, I provide further detail on the background and structure of this research project, and I discuss some of the ideas and concepts that arose in the early stages of design and development. The intention of this is to provide the reader with an outline of the research design

before the later more detailed discussion on the literature, methodology, analysis and findings in subsequent chapters (chapter two to chapter eleven).

1.2. THE RESEARCH PROJECT

Qualitative research is not only complex but also diverse, and it encompasses different methods and philosophies used in exploring aspects of human activity (Silverman 1994). The qualitative traditions within sociology, anthropology, psychology and philosophy, each have methodological features that display differences and similarities.

In this research, I have used an in-depth qualitative investigation. The approach adopted was ethnography (specifically practitioner ethnography) and I deliberate on the rationale for that choice in the methodological discussion (chapter four, sub-section 4.2.4. p.79-87). Thus, this project had a methodological direction at its outset and it will be seen that this guided the development and refinement of the specific research concepts and design.

This research project explored, by qualitative longitudinal participant observation (practitioner ethnography), the experience of a small group of individuals involved in nurse practitioner education in the United Kingdom (UK) during the late 1990s. I collected data over a two-year period from a sample of student nurse practitioners, educators, physician mentors and senior academic staff involved in a clinical degree programme (B.Sc. (Hons) Nurse Practitioner). Data collection commenced in June 1997, just before the students' formal commencement of the nurse practitioner degree programme, and ended at their completion of studies

with the degree programme two years later in July 1999. Thus, the data collection followed a well-defined start-point and end-point, and this dictated in part the eventual chronological presentation of the findings in the main data chapters (chapters seven, eight and nine).

At the outset of the research project, and in keeping with the methodological principles of ethnography, I imposed no pre-conceived thematic or conceptual structure on the overall design of the analysis of the data. Thus, an essential feature of the early analytical process was an evolving systematic inductive data mapping and coding that sought for commonalties which led to the induction of sub-thematic frameworks. As these sub-themes arose from the data sets, they were refined and revised and aspects of social transition became evident as a defining component of the sample's experience. Thus, this early data analysis led to themes concerned with transitions. Throughout this thesis I have termed these as transition themes. Five transition themes were identified: social transitions, professional transitions, clinical authority transitions, clinical knowledge transitions, and clinical skills transitions. These transition themes revealed social and cultural experiences that had affect on the entire sample, and although they were distinct, they were also intrinsically connected. However, it became clear that these transition themes required further structuring to enable a logical presentation of the data and findings. Reviewing the literature on social transitions identified Van Gennep's (1960) concept of a rite of passage as a theoretical model that facilitated the clear presentation of the data.

Incorporated in Van Gennep's (1960) transitional model of a rite of passage were three phases: the separation phase, the transition phase, and the incorporation phase. Consequently, the concept of a rite of passage gave structure to the nature of social transitions that occurred when persons moved from one social status to another. Social transitions defined the boundaries between social statuses, provided a licence for social movement, and mandated changes in social status within a society or culture (La Fontaine 1985), and this was reflected in the five transition themes identified in the research.

Utilising the concept of a rite of passage as a framework gave an encompassing structure to the thematic data analysis and presentation. Once this structure had been adopted, the relationships between the phases of a rite of passage and the five transition themes were mapped out (chapters seven, eight and nine). Following this, the final analytical stage arose in the form of four broad thematic processes, which are detailed in the discussion chapter (chapter ten, section 10.3. p.366-367).

This thesis reads much like a diary or story, as ultimately the chronology was a significant aspect of the experience of the data collection and its presentation. However, that presentation also arose because of an evolving analytical process and structure. I now outline further the project's design, and the particulars of the early conceptual development.

1.3. DEVELOPING THE RESEARCH QUESTIONS

My early thinking on this research project was illuminated by, and grounded in, the following data and observations:

> *"If people's health needs are complex, and the knowledge base that is drawn on to solve those needs is complex, then by definition you will not get it all in one person - you will need a team. Each of those people ought to be able to bring to the shared problem, shared goal, whatever it is that they have. But the relationship in what they bring should be equal and be respected. So the relationship between the nurse and doctor should be, when we are both working with the same patient, that nurses have knowledge and skills, and doctors have knowledge and skills, and they are equally important but different. The relative importance of any of them at a given point in time will vary."*
>
> *Senior Academic - F2 Data Segment - 2nd Interview Data*

> "A crucial issue at the present time is whether these professionals (nurses and doctors) must vigorously define their claims on particular techniques and procedures, or whether they can work together as true professionals to determine who can best assume responsibility for a particular aspect of a patient's care at a given point in time."
>
> (Darnell 1973 p.498)

This data extract, and Darnell's (1973) comment, reflected on an ideal and mature condition for the relationship that could, or should, exist between the healthcare professions of nursing and medicine. However, other literature suggested that the reality of that relationship was not ideal (Ryan 1996, Cahill 1996). This discrepancy seemed to me to call for an in-depth study of the experiences of clinicians and educators directly involved in multi-professional healthcare, and of those individuals engaged in negotiating a social order at the boundary of the healthcare professions.

In a study focused on nurse practitioners and the challenge they posed to the traditional boundary between nursing and medicine, data on the perspectives of those involved would be essential. The study would need to find out how front-line actors regarded boundary challenging, and boundary maintaining, activities. The data would need to be collected through close engagement with those involved, particularly given the constant changes that were occurring at this occupational boundary (Friedson 1970, Bennett 1984, Hughes 1984, Wright 1995, Read 1998). For example, Svensson (1996) viewed the traditional image of a stable and unchanging professional boundary as an outmoded idea from the days of the historical domination of medicine over nursing. He argued that such static modelling did not reflect accurately the newer dynamic and the social subtleties of negotiations that were superseding earlier traditional perceptions of professional boundaries (Friedson 1970, Hughes 1988, Porter 1991). Svensson's (1996) new perspective was important for the nurse practitioner role, as the role was a mix of medical and nursing skills, and this posed a particular challenged for both professions in their boundary negotiations. That challenge suggested that the nurse practitioner was active in renegotiating the relative contributions of the traditional occupations of nursing and medicine within that known hierarchy (Smith 1995, Chapman and Purushotham 2002). If that were true, and if the nurse practitioner role was to be successful, new occupational structures would be required to enable the successful negotiation of a new social order at the professional border (Allen 1997).

My involvement with a nurse practitioner degree programme had prompted my thinking on these issues and this resulted in the beginnings of this research

project. My role as a university lecturer brought first contact with the nurse practitioner programme in the early 1990s by way of a minor teaching contribution. That simple beginning evolved into a permanent and significant teacher role as part of the teacher team. Such intimate involvement with an advanced clinical nursing programme inevitably resulted in a developing interest in related issues of nurse practitioner education. As the nurse practitioner degree programme actively included physicians as mentors, this led to questions on the professional boundary between nursing and medicine, and on the occupational status, identity and professional role of the nurse practitioner. Searching the literature revealed a complex history and a spectrum of professional, political and lay opinion regarding the nurse practitioner role, ranging from the commendatory to the hostile (Wright 1995, Fulbrook 1995, Wallace and Gough 1995, Castledine 1996, Cahill 1996, Kitson 1996, Williams 1999). It was during this period of reflection that I made two observations.

First Observation: Why did some physicians appear to view nurse practitioning negatively, whilst others viewed them positively?

> *"I think there is resentment from doctors towards nurses. It's a fairly heavy resentment from doctors towards nurse practitioners getting a clinical qualification which, although it's a B.Sc., it is nevertheless a clinical degree. Then they take over the role of the doctor! You see this is where the boundaries need to be defined."*
>
> *Physician Mentor - E1 Data Segment - 2nd Interview Data*

> *"I don't want to overplay it, but you very much see them* (nurse practitioners) *more as colleagues in healthcare. And that is not only formal protocols which we have set down; it's where humans work together isn't it?*

They are making decisions that you would be making if you had seen the patient. It has to be respected hasn't it?"

Physician Mentor - D1 Data Segment - 1st Interview Data

These data extracts revealed a diversity of opinion. From the early stages of the study it seemed that physicians perceived the advanced clinical nurse (in this case a nurse practitioner) who used clinical skills that had traditionally lain within the domain of medicine, in one of two ways. Firstly, nurse practitioners could be perceived as a threat to medical authority and status, and thus they were a threat to medical autonomy and to the medical dominance of healthcare (Wilson et al 2002). Secondly, nurse practitioners could be perceived as a welcome new resource, a pair of hands to assist in an over-stretched healthcare service (Lattimer et al 2000, Kinnersley et al 2000, Venning et al 2000). Why different physicians adopted one particular view over the other was not immediately clear.

Second Observation: Why did nurses also appear divided on the development of nurse practitioners?

"They are the great white hope, aren't they - nurse practitioners? Nurse practitioners seem to be the answer to every problem going."

Student Nurse Practitioner - G2 Data Segment - 2nd Interview Data

"Other barriers are the barriers from nursing colleagues (as well as from medical colleagues) who are resistant to the idea of nurse practitioner for one reason or the other. Perhaps it is just because they feel threatened or because they disagree with it. In a lot of cases it's just down to ignorance. They don't understand what the idea of the nurse practitioner is all about."

Student Nurse Practitioner - D1 Data Segment - 2nd Interview Data

These data extracts revealed the conflicting perspectives that I had observed in the professional nursing literature. This led to other and more specific areas of enquiry. For example, the title 'nurse practitioner' (a title unregulated by the nursing profession) appeared to be an important factor. Also, the specific nature, scope and regulation of the nurse practitioner role were undecided, and were open to varied interpretation. Perhaps a most significant issue was that the nurse practitioner role had incorporated traditional medical skills. The inclusion of such skills gave rise to some fundamental objections and difficulties in accepting the activity of nurse practitioners within the professional domain of nursing (Dodds 1991, Cahill 1996, Jones 2003). Nevertheless, and in complete contrast, there was evidence of positive views that saw the development of nurse practitioners as expanding professional nursing boundaries (Castledine 1998, Maclaine 1998, Hicks and Hennessey 1999). Again, why different nurses adopted such contrasting views was not clear.

Seeking some shared core value system appeared to be a useful starting point in the study. What common (shared) ground (if any) did these two professional groups have? In a resource-limited healthcare service that clearly had enough work for its entire professional staff, it could be expected that shared skills existed. However, this was a simplistic view of a complex healthcare organisation that had multiple hierarchies and many professional groups. Thus, the question remained; could core values be identified that directed all healthcare professional actions? Additionally, were different interpretations of those values a result of the multi-professional and multi-cultural nature of a healthcare service where occupational boundaries were constantly changing?

"It would be facile I think to say that the end point is good patient care, and that it's for the sake of the patients, that is bandied around so much. But of course, there is an element of truth in this, in so far that we are all potential patients and it behoves us to contribute to a system that is efficient, caring, and compassionate. I think those core values are shared of course by doctors and nurses, but the treatment and interpretation of those values is different, although again one could argue that because of boundary changes it's not so very different."

Senior Academic - G2 Data Segment - 2nd Interview Data

This data extract emphasised that differing perspectives of professional views of core values were influenced by occupational boundaries. For example, Walby and Greenwell (1994) saw both medicine and nursing as aspiring to high professional and moral standards. Consequently, it could be expected that altruism was a core value that most doctors and nurses would identify with (Barber 1963). However, by virtue of both professions seeking high moral standards, and in regard of their intimate relationship, medicine and nursing created particular tensions and negotiation needs at their professional border. Examination of medical and nursing altruism could therefore reveal differences in professional behaviour, status and aspiration. New variables affecting the relationship between medicine and nursing, such as the introduction of nurse practitioners, could give rise to new interpretations, to new common values, and to new social structures. Dingwall and Lewis (1985) highlighted this:

"Professionalising occupations are a zone of transition, a point of change from which new social forms are emerging."

(Dingwall and Lewis 1985 p.6)

One alternative interpretation of the professional boundary challenge and the emergence of new roles lay in an early and somewhat radical idea. Marchione (1980) proposed an explanation for the confusion and debate on nurse practitioners that was evident in the United States of America (USA) during the 1970s (chapter two, section 2.3. p.28-33). She suggested that nurse practitioners were a new, evolving, professional group that was distinct and separate from both nursing and medicine. Thus, it was not possible to view nurse practitioners solely in terms of nursing, or view them solely in terms of medicine. Attempts to confine, or define, the activity of the nurse practitioner within either domain were thus likely to fail as nurse practitioners had borrowed from both previous professions, were using medical and nursing skills and knowledge, and had subsequently evolved into a new healthcare worker:

> *"I see them as being a new profession, carrying some of the elements of nursing and some of the elements of medicine."*
>
> *Physician Teacher - D1 Data Segment - 1st Interview Data*

Data extracts such as this complemented Marchione's (1980) view of American nurse practitioners as a professional group who had achieved levels of autonomy and prestige comparable to that of other clinical professions such as medicine. However, the lack of a recognised clinical hierarchy within nursing was a fundamental organisational problem for their career development and clinical recognition and authority. That underdeveloped clinical hierarchy within nursing in the USA during the 1970s and 1980s was later mirrored in the UK during the 1990s and was a fundamental problem for nurse practitioner role development observed in this study (chapter ten, sub-section 10.3.2. p.374-381).

Marchione's (1980) suggestion of a new emerging profession was not conclusive, and any answers offered were at best controversial and uncertain. However, many similar ideas were found elsewhere in the literature:

> "Nurse practitioners combine nursing and medical functions and provide nursing services in a manner that surpasses the effect of medical and nursing services provided separately."
>
> (Sultz et al 1983 p.139)

> "The relatively new role of the nurse practitioner has been, and indeed continues to be, fraught with ambivalence and reluctant support from nursing and medicine, the two professions that it attempts to bridge, and from the clients that it attempts to serve. These factors have contributed toward the creation of a marginal professional role, a role in which the nurse practitioner is caught between the two cultures of nursing and medicine. A marginal role is one in which an individual occupies the social space between two cultures, tenuously affiliated with both but a fully incorporated member of neither."
>
> (Bennett 1984 p.147)

These views both complemented and contrasted with Marchione's (1980) thinking. They acknowledged the marginal place of the nurse practitioner, a cross boundary utilisation of knowledge and skills, but they did not describe the nurse practitioner role as an emergent profession. Such issues remain unresolved and they are still debated.

Thus, my early thinking on my prospective research project rested on several broad general observations. For example, it was evident that both medicine and nursing had a history of a unique and close professional relationship, and that they shared a relatively benign value system (Porter 1998), but despite this there were

political and economic issues that influenced both professions that could not be wholly ignored (chapter two, section 2.3. p.35-36). The development of nurse practitioners was in part a response to those issues, and this had resulted in polarised professional opinions regarding their need and use in healthcare. The literature described nurse practitioner activity (chapter one, section 1.1. p.2), and gave evidence to perceptions of transgression of the professional boundary between nursing and medicine. That transgression was an issue in an already complex healthcare service.

From this confused picture, it was difficult to chart a clear path ahead. However, I observed that knowledge of the lived experience and perceptions of nurse practitioners, or of their academic and clinical mentors, was generally limited. Although social transition, rite of passage, and professional boundary negotiation were theories that were available and tested in other contexts, they were mostly untested in the context of a nurse practitioner role. Thus, this lack of information on the experiences of those guiding, developing and enacting the nurse practitioner role suggested a need for research. That need resulted in the development of this qualitative investigation into the lived reality of nurse practitioner students, their teachers, and their clinical mentors.

From that basis, this research project evolved. At its outset, in the developmental stage, my thinking focused mostly on functional and deterministic issues, reviewing the role and history of the nurse practitioner. However, as the project developed and progressed, I developed a more flexible and discriminating approach, providing not just an empirical narration but also a theoretical

perspective on the sample's experiences. This perspective was grounded in my data. The project examined the clinical professional structure of nursing, and examined the professional (occupational) boundary between nursing and medicine. It looked at how these structures and boundaries were influenced by the evolution of the nurse practitioner role.

1.4. THE PROJECT DESIGN

I conclude this introductory chapter by briefly outlining the methodology, data collection process, chronology, and profile of the sample in this research. These issues are revisited in depth in chapters four and five.

1.4.1. Introducing practitioner ethnography

This sub-section considers the fundamentals of the methodology used. Ethnography is an approach by which a culture is described (Fetterman 1998), and Hammersley (1992) described the main elements of ethnographic analysis:

> "Sensitising concepts and models that allow people to see events in a new way. The value of these models is to be judged by others in terms of how useful they find them."
>
> (Hammersley 1992 p.15)

This approach suited my study. It was a philosophical foundation that would underpin an immersion into the lived experience of a group of individuals. Hammersley and Atkinson (1995) summarised this applicability:

> "The ethnographer participates, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions; in fact collecting whatever data are available to throw light on issues with which he or she is concerned."
>
> (Hammersley and Atkinson 1995 p.2)

This observation accords with the main design features of this research. This project used practitioner ethnography, an approach embodied in my dual role as a researcher and a member (practicing teacher) of the nurse practitioner degree teaching team. Practitioners undertake research to advance their own knowledge and practice (McLeod 1999). Shaw (2002) furthered this, seeing practitioner research as advantaged over more traditional research approaches that treated data too rigidly, stifling cross-professional dialogue and resulting in a passive relationship between social research and clinical practice. Shaw (2002) observed that practitioner research enabled alternative styles of practice inquiry that provided perspectives other than that of deductive thought on associations found between theory and practice. The unique position of the practitioner researcher, both in terms of methodological design and in terms of critical review, is reviewed in the methodological discussion (chapter four, sub-section 4.2.4. p.79-87).

1.4.2. The research design - the timescale, data collection tools, and the sample

In this sub-section I outline the main features of the data collection process and the research sample. An important aspect of an ethnographic approach is the way it can influence the design of data collection. Hammersley (1990) saw ethnographic data collection as:

> "Unstructured in the sense that it does not involve following through a detailed plan set up at the beginning; nor are the categories used for interpreting what people say and do pre-given or fixed. This does not mean that the research is unsystematic; simply that initially the data are collected in as raw a form, and on as wide a front, as feasible."
>
> (Hammersley 1990 p.2)

The data source for this project was a part-time degree programme, a B.Sc. (Hons) Nurse Practitioner, run from a Health Science department in a provincial University in the UK. The basic research design, data collection tools, and timescale are summarised in Figure 1.1. (p.21)

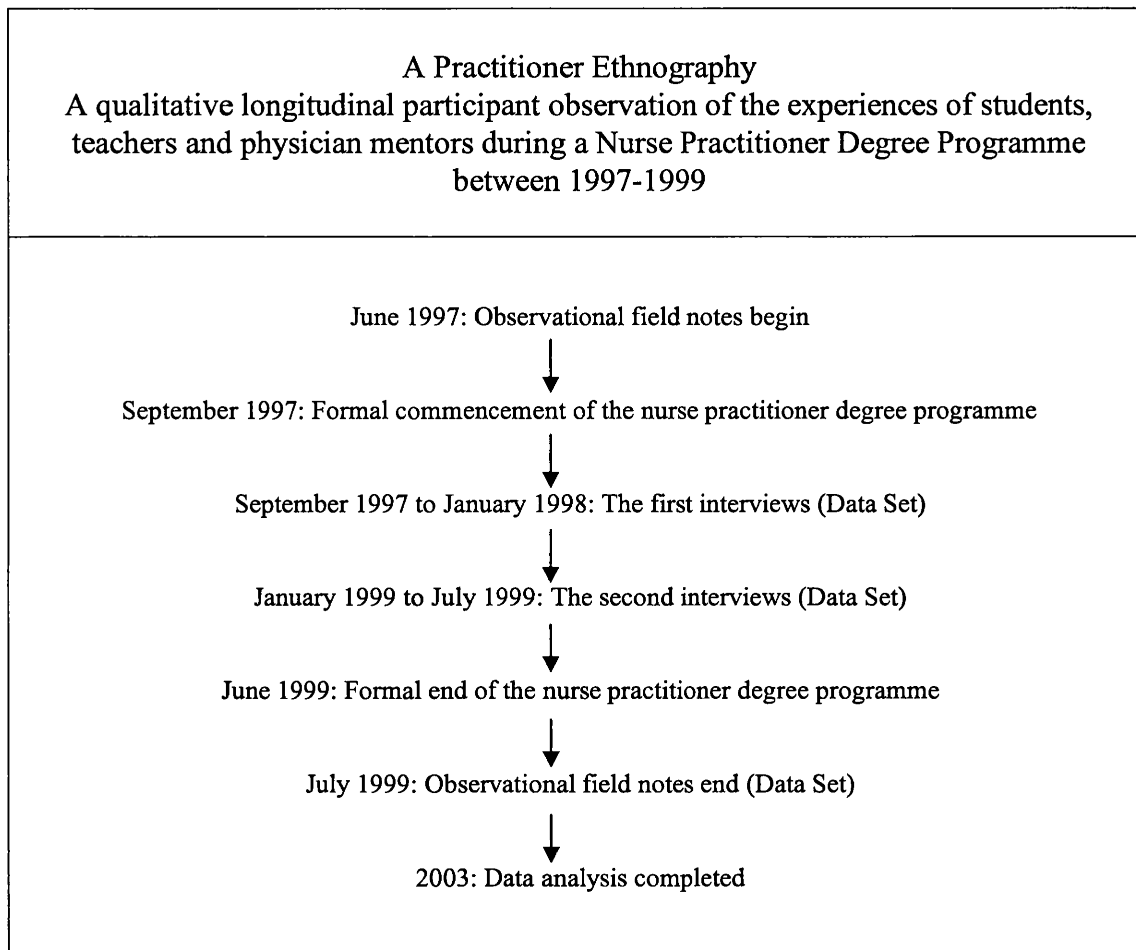


Figure 1.1. The research design - data tools and timescale

The data collection process began in June 1997 and it was completed two years later in July 1999. Interviews and observational field notes were the two data collection tools used, and these were structured around the chronological delivery of the nurse practitioner degree programme.

The sample were interviewed at the outset of the degree programme and then were interviewed again at the end of the degree programme (Figure 1.1. p.21), thus providing two data sets that enabled comparative and longitudinal assessment of experiences. These data sets were analysed by use of both latent and manifest content analysis, and these analysis methods are described in detail in the methodological discussion (chapter four, sub-section 4.2.7. p.94-97). I also observed the sample's experiences throughout the nurse practitioner degree programme, recording and collating data with field notes. This provided a further data set (Figure 1.1. p.21) that was analysed by use of latent content analysis (chapter four, sub-section 4.2.7. p.94-97). This process of observation arose in part from my natural exposure as a teacher to the student group during formal taught and clinical sessions. I also recorded other formal and informal student, staff and professional meetings and encounters. These field notes provided an uninterrupted chronological record that facilitated structure and comparison with the two sets of interviews. The analysis of the data commenced in 1998 and it was finally completed in 2003, and this is described in detail in the analysis chapter (chapter five).

The sample was initially comprised of a cohort of students, their clinical mentors, and the teaching staff. These individuals were interviewed and observed over a two-year period. Toward the end of the study, senior academic staff were also included in the interview sample (chapter four, sub-section 4.3.4. p.104). The sample is outlined below (Figure 1.2. p.23), and is later profiled in more depth (chapter four, section 4.3. p.102-104)

The Sample at the outset – June 1997	The sample at completion – July 1999
• 10 Students • 5 Physician Mentors • 3 Educators	• 9 Students • 4 Physician Mentors • 3 Educators • 3 Senior Nurse Academic Staff

Figure 1.2. The Sample

In this introductory chapter, I have outlined the basic structure and intent of this research project. I have reviewed the aims and questions that arose in the early thinking and development. I have also introduced the methodology, the process of data collection and analysis, the sample, and the chronology of the project. The following chapter considers the systematic search and critique of the literature and the history and development of nurse practitioners.

CHAPTER TWO

THE LITERATURE REVIEW

2.1. INTRODUCTION TO THE LITERATURE REVIEW

Although I follow the common practice in qualitative research of drawing selectively on relevant literature throughout the thesis, this chapter, and the following chapter, contain more focused literature reviews of two areas that are important to the study. This chapter explores the literature on the historical development of nurse practitioners in the UK and the USA, including some material on more recent developments. Chapter three reviews the literature relevant to the social and cultural theories that underpin the thesis. As background to the literature reviews, the present chapter begins by discussing the method employed in the literature search, and my rationale for including or excluding particular materials.

2.2. SEARCHING THE LITERATURE

Throughout this research project, from the inception of the original ideas in 1997, to the completion of the written thesis in 2004, the literature had been extensively explored. During this time, numerous literature searches were performed, and a wide variety of literature sources and reference items were accessed. The intention of this prolonged review was to further my knowledge, and enable analysis, on the broad social, cultural, professional, methodological, and conceptual issues that emerged during this research project, and to take account of the new literature in a rapidly developing field.

Search criteria varied in accordance with the particular needs and stages of the project. However, all the literature searches were undertaken using explicit search strategies and criteria, and all were defined by the scope and boundary of a search enquiry. Key words, terms, themes, topics and questions were used as appropriate, and inclusion and exclusion criteria were decided in advance.

Inclusion and exclusion criteria varied on specific points: publication dates, literature types, language, national or international literature, time-period, theoretical context, and professional context. Thus, inclusion and exclusion criteria were tailored to the needs of a specific literature search during a stage of the research. For example, a selected time-period would vary according to the focus of a particular search. A narrow timescale was used (1980 onwards) when searching for literature on recent strategic events in UK nurse practitioner development. A much longer timescale was used (1940 onwards) when searching for literature on concepts of professional socialisation. The result of this specific but variable criterion is a literature reference list (references, p.414-435) that ranges by date from the mid 20th century to the present day. Exclusion criteria were also varied according to the particular focus of a literature search. An example of this type of search criterion was the exclusion of quantitative literatures when searching for information on qualitative analysis techniques. Another general category excluded was non-English language papers or publications, due to the lack of a translation resource.

Literature search tools used included a broad range of resources. First line searching was via electronic databases. Examples of these were the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medical Literature On-Line (MEDLINE), and the Cochrane Library. However, I found that no single electronic database was comprehensive. Thus, second line searches included manual hand searching in libraries, internet sources, unpublished sources, following up items in the reference lists of already identified publications, and supervisor recommendations. Items of literature identified varied from research papers, opinion papers, books, reports and other diverse documentation, publications, and internet sources. All search results were carefully reviewed and cross-referenced with the predetermined search criteria. When potentially useful and relevant literature sources were identified, they were recorded and catalogued.

Literature sources were recorded in a customised computer database in full electronic form, and, where necessary, hardcopies were obtained and catalogued. Within the database, I created key fields for recording a unique identification code, the title, source (journal, publisher), author and date of the publication. Each database record had other fields available for the recording of detailed notes and the complete electronic text when available. When hardcopies were retrieved, these papers were catalogued and filed for ease of later retrieval.

Once a literature item was identified as of possible interest, I reviewed the content via available abstracts, editorial review and, in most cases, the full content. Following

review, the literature item was catalogued into broad thematic categories that facilitated logical electronic and manual filing. The categories were flexible but fell broadly into three areas, these being methodology, social theory, and nurse practitioner practice. These categories were further divided into specific sub-categories, examples of these being socialisation, profession, role, method, education, history, occupational boundary, and advanced practice. Additionally, I graded each literature source in terms of its general relevance or application to the research (or aspect of the research) by using a simple scale from one to four (where one indicated a literature of major interest and four indicated a literature of minor interest). That grade was assessed by using the search criteria that had identified the literature and comparing and contrasting this with the outcome of the review. However, if I concluded that a literature source offered little to the research it was not graded.

Just less than one thousand items of literature were identified from searches during the research (1997 to 2004). Following review approximately three hundred items were found to have little application to the research, and consequently they were not graded; these literature items were removed from the active records and archived. Six hundred and thirty seven literature items remained active on the database at the time of the completion of the study. These varied in type and focus, and by using the database sorting facility I could search records by category, by grade, or by both. This enabled me to focus selectively on literature sources and items specific to the varied theoretical, methodological and professional focuses of this research. However, not all literature items in the database were directly referenced in the study.

On completion, two hundred and forty references had been graded as literature of major interest or application, and all these are cited within the thesis.

2.3. THE LITERATURE REVIEW

The following section specifically considers the historical and more recent development of nurse practitioners and advanced clinical roles in the nursing profession. For the purposes of this thesis, this review aims to provide a background to the professional context of the research aims. As such, the review focuses on related professional developments in the USA and UK. However, I acknowledge that many of the professional developments highlighted in the review have also occurred elsewhere in the world (Offredy 2000, Ketefian et al 2001, Pearson and Peels 2002a, Vincent 2002).

From the historical perspective, the development of advanced clinical roles in nursing arose from the introduction of the specialist nurse in the USA. This title (specialist nurse) and its associated diverse roles were identified with individual nurses who had advanced clinical nursing expertise and skill (Hamric and Spross 1989). These specialist nurse roles were first documented during the late 19th century (Manton 1971) and they were increasingly evident in healthcare practice in the USA during the 1930s and 1940s (Peplau 1965, Storr 1988). However, during the 1960s clinical nurse specialists were widely introduced into the American nursing profession (Storr 1988, Hamric and Spross 1989, Fenton 1992). This 80-year development of the specialist nurse in the USA was mainly an uncontroversial one and reflected a general

perception of the clinical nurse specialist role as one that lay within the domain of nursing practice. Thus, the clinical nurse specialist role presented no threat to the established order and stability of the boundary between nursing and medicine. In contrast, the introduction of the nurse practitioner role in the USA in the late 1960s, founded to an extent on the principles of the specialist nurse concept but also incorporating traditional medical skills, was to have considerable impact on professional boundaries.

The origins of the nurse practitioner role lay in the work of Ford and Silver (1967) and their implementation of a new primary healthcare paediatric nurse practitioner role in 1965 in the USA. During this development of nurse practitioner practice in the USA, Zola and Croog (1968) commented on the professional status of nursing at that time. Zola and Croog (1968 p.15) described nursing as having an uncertain professionalism, and that this was an "age old question" that was difficult to resolve as the role of the nurse "would not stand still long enough". However, this role mobility also suggested that the professional nurse of that time was adaptable, and accommodating of new role developments. Thus, nursing was an occupation well situated, and well motivated, to extend its professional identity and authority, and Dingwall and Lewis (1985) observed that enhancement of professionalism was possible if a profession could:

> "Reconstruct its license and win acceptance of an enlarged mandate."
> (Dingwall and Lewis 1985 p.6)

Ford and Silver (1967) had sought to extend the nursing profession's mandate by their introduction of an advanced clinical nursing role that explicitly used traditional medical skills. However, this transgression of the occupational boundary between nursing and medicine disturbed some professional contemporaries who saw this as profoundly harmful to traditional nursing practice (Fondiller 1995). Some also viewed it as detrimental to the development of a unique occupational identity that would enhance the professional status of nursing (Shaw 1993, Wuest 1994, Deloughery 1995, Lorentzon and Bryant 1997). These views reflected nurses' preoccupation during the 1960s and 1970s with their professional identity, and their preoccupation with nursing having a greater autonomy (and thus distance) from the traditional dominance of medical authority. This wish to distance nursing from medicine underpinned and directed much of the prevailing nursing ideology of the time (Walby and Greenwell 1994), although that ideology conflicted with the introduction of new clinical roles that had a significant component of medical skills associated with them. Thus, the introduction of nurse practitioners was a controversial and challenging development affecting nursing and its relationship with other healthcare professions (Fondiller 1995).

The development of nurse practitioners in the USA arose not only in response to a professional innovation but also in direct response to other social issues of the time:

> "Several social phenomena of the 1960s provided impetus for the nurse practitioner movement. Health manpower shortages especially of paediatricians and family practice physicians, lack of primary healthcare for many rural and urban poor populations, escalating healthcare costs, and the

desire of nurses to achieve professional autonomy were stimuli for the nurse practitioner movement."

(Marchione and Garland 1980 p.37)

These social, economic and professional causes all had their part to play in the development of the nurse practitioner role during its introduction into clinical practice in the USA in the 1960s. During the 1970s, the nurse practitioner concept gained considerable momentum and support in the USA, but it was a development with associated difficulties. Marchione and Garland (1980) had observed a proliferation of education programmes for nurse practitioners (they estimated more than five hundred) that arose during the 1970s. This typified an unregulated and fragmented expansion of the nurse practitioner role in the USA. It would take time before research would give basis to the new role (Lawrence 1976, Lewis and Cheyovich 1976), and it was not until the 1990s that regulation and standardisation of nurse practitioner education became more widely introduced in the USA (Campbell-Heider et al 1997):

> "There is now standardisation in terms of educational and certification requirements for NPs in the United States. National certification for NPs is available for the areas of pediatric, family, adult, geriatric, school, women's health, and acute care."
>
> (Campbell-Heider et al 1997 p.338)

However, Campbell-Heider et al (1997) also noted that inconsistencies remained and that barriers to nurse practitioner practice persisted despite the efforts to regulate and standardise nurse practitioners' activity in the USA:

> "Individual state nurse practice acts dictate the degree of autonomous practice of NPs in terms of prescriptive privileges, reimbursement, and independence. The 50 states vary greatly in terms of title protection, authority over practice, autonomy of practice, and prescriptive privileges."
>
> (Campbell-Heider et al 1997 p.339)

Thus, the certification and regulation of nurse practitioners in the USA during the 1990s was still being developed (Hodnicki 1998, Styles 1998). By the early 2000s regulation was more established, although it remained a complex process (Ponto et al 2002). Today, to become a licensed nurse practitioner in the USA, the candidate must first be a registered nurse (RN) and meet several other criteria. Requirements to become a registered nurse vary between states, and may include an associate degree in nursing (ADN), a Bachelor of Science degree in nursing (B.Sc. Nursing), or a nursing diploma programme. In most cases, the B.Sc. Nursing is a minimal requirement for prospective nurse practitioners, and some states require this. Once registered as a nurse, the prospective nurse practitioner must then further complete a state-approved advanced training programme, most usually a Master level degree. These programmes normally specialise in an area of clinical practice such as hospital medicine, women's health or family practice. After completing advanced education programme, the nurse practitioner then has to be licensed by the state in which they plan to practice (Ponto et al 2002).

Thus, the USA state boards of nursing regulate nurse practitioners, and each state has its own licensing and certification criteria. In general, these criteria include completion of a recognised specialist-nursing degree programme (usually a Master

level degree programme) combined with evidence of appropriate clinical experience. Because state board requirements differ, nurse practitioners may also have to fulfil additional requirements, such as certification by the American Nurses Credentialing Centre (ANCC). These license periods vary in duration between two years and three years. After receiving state licensing, the nurse practitioner can also then apply for national certification from the American Nursing Association (ANA) or other professional nursing boards such as the American Academy of Nurse Practitioners (AANP). This rather complex process is evident in the guidelines on advanced practice nursing outlined by the American Association of Colleges of Nursing (AACN 1999):

> "The Advanced Practice Nurse is an umbrella term appropriate for a licensed registered nurse prepared at the graduate-degree level as either a clinical specialist, nurse anaesthetist, nurse midwife or nurse practitioner. Advanced practice nurses are professionals with specialised knowledge and skills that are applied within a broad range of patient populations in a variety of practice settings. All advanced practice nurses should hold a graduate degree in nursing and be certified. Each existing and future professional nursing speciality-certifying entity must meet uniform national standards when certifying nurses for advanced practice."
>
> (AACN 1999 p.130)

Thus, it is evident that the introduction of nurse practitioners in the USA, and the related regulation and standardisation of advanced nursing practice that had commenced in the late 1960s and early 1970s, was still developing and topical in the 1990s and 2000s (Dunn 1997, Hodnicki 1998, Ponto et al 2002). Unsurprisingly aspects of the USA experience, exampled by the complex social background and the subsequent early lack of regulation, were mirrored in the UK in the 1990s and early

2000s as nurse practitioner roles, and clinical nurse specialist roles, became widely implemented in clinical practice (Trnobranski 1994, Hicks and Hennessy 1998, Hunt 1999, Carnwell and Daly 2003).

The introduction of nurse practitioners into the UK can be identified with the pioneering work of Barbara Stillwell in the late 1980s (Stilwell et al 1987, Stilwell 1988). Stilwell introduced a nurse practitioner role into her own area of primary healthcare practice in response to social pressures in the UK that had been observed by Ford and Silver (1967) twenty years earlier in the USA. Stilwell (1988) viewed the nurse practitioner role in the UK as similar to the role that had developed in the USA, a role undertaken by an experienced nurse who would use existing nursing skills in combination with health assessment and diagnostic skills in autonomous patient management. Stilwell's work provided a basis for future UK nurse practitioner role competencies. Those competencies were based on consultancy skills, disease screening, physical examination, chronic disease management, minor injury management, health education, and counselling (Stilwell 1984). To prepare nurses for this expanded clinical role Stilwell promoted an apprenticeship model based on goodwill and collaborative time spent with clinically active medical physicians. During this clinical mentorship, the novice nurse practitioner observed and participated in consultations and learnt skills and techniques of medical history taking and physical examination (Stilwell 1988). Later I describe this apprenticeship model of education, and consider how it has influenced the development and

education of nurse practitioners in the UK (chapter six, sub-section 6.2.6. p.141-142 / chapter ten, sub-section 10.3.1. p.367-374).

The clinical potential of nurse practitioners was not lost on senior nurses, physicians or resource-minded policy makers in the UK (Ewens 2003). In response to the Stilwell's development of a model of nurse practitioner practice in the UK, and following the Department of Health (DOH) 'Cumberlege Report' (DOH 1986) that recommended the introduction of nurse practitioners into primary healthcare, the RCN introduced the first formal education programme for nurse practitioners in 1990. As the 1990s progressed, and in quick response to the RCN initiative, universities around the UK franchised and developed undergraduate and postgraduate programmes to facilitate nurse practitioner roles. The universities also initiated research investigations into the effectiveness of the product of these education programmes (Gibbon and Luker 1995, Woods 1999, Reveley and Walsh 2000). As with the earlier North American experience, this rapid development was professionally unregulated and this extended the debate on nurse practitioners and their implication for the future professional identity of nursing (Woods 1997). That professional dialogue became increasingly complex, and it was influenced by the political and economic agendas occurring in the UK at the time. Finally, hesitancies and uncertainties on the part of the United Kingdom Central Council for Nursing Midwifery and Health Visitors (UKCC), characterised by its refusal to clarify the issues of advanced and specialist practice, added to this problem of the regulation, development, and use of nurse practitioners (Castledine 1996, Maclaine 1998).

Thus, there were many issues and influences on the development of nurse practitioners in the UK. Demographic changes, reduction in junior doctors' hours, UK National Health Service (NHS) reorganisation and the professionally unregulated development of nurse practitioner education programmes, were all issues that had affect on nurse practitioner development (Jenkins-Clarke and Carr-Hill 2001, Daly and Carnwell 2003). A result of this was that by the late 1990s the regulation and use of nurse practitioners in the UK remained an uncertain issue (Read 1998, Williams 1999). However, more recently the introduction of the Nurses and Midwives Council (NMC) in 2002 and the subsequent implementation of a new professional nursing register may eventually lead to some control. A current indication of future regulation is the work of the RCN that has developed baseline clinical competency standards along with a framework for education programme approval (RCN 2002). Those competency standards were developed in collaboration with the National Organisation of Nurse Practitioner Faculties UK (NONPF-UK), and these have been implicit in the NMC's work on advanced nursing practice. Finally, there can be no question that nurse practitioners in the UK have already established a clinical role that is advocated by policy makers, employers and educators (Jenkins-Clarke et al 1998, Hicks and Hennessy 1999). However, the future of their professional identity, and their possible affect on traditional professional roles and boundaries, both remain contentious (McGee 1996, Caroll 2002, Rosen and Mountford 2002).

In this chapter, I have outlined the systematic method used to search the literature. I have also reviewed the literature regarding the historical development of nurse practitioners in the USA and the more recent development of nurse practitioners in the UK. In the following chapter, I continue the literature review and consider the theoretical literature on professions and professional identity, and the theoretical framework of Van Gennep's (1960) rite of passage.

CHAPTER THREE

THE THEORETICAL FRAMEWORK

3.1. INTRODUCTION TO THE THEORETICAL FRAMEWORK

In this chapter, I review the theoretical literature which provided a basis for this thesis, and which underpinned the analysis of the respondents' experiences. The chapter is divided into two sections. Firstly, I consider a range of sources from social theory that informed aspects of the analysis. Secondly, I turn to the specific framework that has been used to order the findings of my study: Van Gennep's (1960) model of the rite of passage.

3.2. SOCIAL THEORY

At the beginning of this thesis (chapter one, section 1.1. p.1) I presented a data extract that that hinted at the autonomy of the nurse practitioner in clinical decision-making. However, that data also pointed to the wider structural constraints that determined authority and the consequent ability of the individual to negotiate power to make decisions. As this research examined the experiences of nurses and doctors involved in the educational development of nurse practitioners it was necessary to review the theoretical concepts associated with this. Among these were the concepts of occupation and profession that underpinned the intimate and long-established relationship between medicine and nursing. Additionally, at a more fundamental level, the social theory of organisations (particularly healthcare organisations) and the division of labour had relevance. This section (chapter three, section 3.2. p.38-63) reviews in detail these aspects of social theory.

3.2.1. Social constructs, organisations and culture

Societies, and social order, arise from a matrix of component organisations. This is a principle on which all social construction is based. Organisations structure our society, define our social order, give foundation to our culture, and provide us with a mechanism for diversity (Kanter 1988, Peters 1989, Handy 1990). It follows that organisations are not just theoretical concepts that allow us to understand the world but are real and complex social composites of individuals.

Porter (1998) discussed how seminal theorists such as Emile Durkhiem, Karl Marx and Max Weber developed models of social and organisational structure that sought to explain societies and their behaviour. However, it is not the intention here to explore these theories in any depth. It is sufficient to say that analysis of these various theoretical models suggested that social structure was intricate, difficult to define, and most importantly was constantly evolving and changing. The array of organisations and social groups that comprised social structures was subject to constant forces of change as society continuously redefined its needs, wants and goals.

Weber (1947) viewed the cultural characteristics of organisations as fundamental in the ordering of society. He described a model of three authority structures that ordered society: the traditional class hegemony, the charismatic religious organisation, and the rational legal bureaucracy. Weber (1947) saw the rational legal bureaucracy as a form of organisation that was most efficient in ordering a modern society, and as able to meet society's constant demand for change and restructuring. His view is today borne out by the status of the rational legal

bureaucratic organisation as the prevailing form of organisation found in western capitalist society. Organisational bureaucracies exist in multiple forms and styles and have a wide range of characteristics dependent on their structure, intent, and social context. They are the basis of modern social order and regulation, and they define occupations and social roles. These bureaucracies are, to varying degrees, inter-dependent as they interact with each other in a constantly changing way, and relationships between organisations have emerged, and boundaries have evolved.

Organisations all have common goals, which are structured through implicit and explicit regulation (Fayol 1949). Thus, the origins, development and ordering of organisations was central in understanding their social purpose, and in understanding the context and regulation of their membership. This gave basis to the examination of the individuals within organisations, for they constructed and maintained the social order and purpose of organisations. The interpretation of the role and function of individuals allows us to examine specific organisational and occupational roles in a wider social context. We may wish, for example, to analyse a clinical role undertaken by a doctor or nurse, but if we do not attend in that analysis to the context within which that role is undertaken then any conclusion will be incomplete. No organisation exists in complete isolation from others, and thus no individual exists in such a state either. In a social analysis (such as the examination of the experiences of the sample studied in this project), it is crucial to acknowledge the social context and its influence on the individuals involved:

> *"Nurse practitioners are being driven by market forces; like nurses they are cheap. And they are also driven by consumer demand like, 'I can't get an appointment with a doctor for a week.' There is a sort of cumulative effect*

of all of that. I think that the role of the nurse practitioner was clearly defined for me by the Royal College of Nursing in its original intention, but then things change and it's not so clear now. Practice has changed. The government's proposals, where does the consultant nurse come into all of this? And it's all been complicated by the UKCC definitions of specialist practice. What is a specialist practitioner, as opposed to a nurse practitioner, as opposed to a clinical nurse specialist? It's a whole melting pot of different things."

Senior Academic - G1 Data Segment - 2nd Interview Data

This data extract revealed the extent and diversity of the social context that could be implicated in an analysis of nurse practitioners. However, a useful starting point in conceptualising this complex situation was a review of the nature of organisations.

Organisations may be classified by their particular cultural characteristics. For example, Handy (1985) identified four main general organisational cultures: power cultures, role cultures, task cultures, and person cultures. Handy (1985) viewed the UK NHS as a role culture, a typical large and inflexible bureaucracy. However, since that time there have been legislative changes that have sought to change the healthcare service culture to a more responsive task orientated organisational culture (DOH 1998). Because of these changes, Savage (2000) observed that the UK NHS had become an organisation increasingly concerned with culture. This was also reflected in policy thinking where organisational efficiency, healthcare service delivery and quality of service delivery were all linked. A consequence of these changes was the development of open, non-hierarchical, and responsive styles of management that led, according to Manley (1997), to the development of new clinical practice roles (a central theme in this work).

The task-orientated organisational culture suggested by Handy (1985) was a model that could fulfil in part the demand for a more responsive UK healthcare service organisation. The conceptual implication of that will be touched on shortly in the following sub-section (chapter three, sub-section 3.2.2. p.42-46). However, the relevance of cultural change was also important to this research as the changing nature of the UK healthcare organisations (structures and cultures) formed the social milieu in which the data collection in this research took place. Culture is a powerful phenomenon, particularly in a study that has adopted an ethnographic approach. Thus, organisational cultures were important considerations in this research. Savage (2000) viewed culture as a concept both within and beyond anthropology, as culture simultaneously affected and reflected recent healthcare policy and strategies. It is now important to relate this discussion to the analysis of the healthcare service organisation in the UK, and to the relationship between the healthcare professions.

3.2.2. Culture, management and the professions

The NHS in the UK is an elaborate rational legal authority style organisation that is a composite of a multitude of smaller organisations. The structure, grouping, culture and management of these smaller units are equally intricate, and this complexity is reflected in the nature of the healthcare professions. Analysis of the UK NHS organisation is consequently a difficult undertaking. It is only relevant here in terms of providing context to the structure and function of that organisation as it relates to the data and findings of this research. For the purpose of this study, whilst there were many possible theoretical models that could be

applied, I have considered only two. These are the organisational models (theories) of Fordism and Post-Fordism (Walby and Greenwell 1994).

The term Fordism is descriptive of Henry Ford's mass production techniques and principles of organisational monopoly in the USA car industry in the 1920s (Walby and Greenwell 1994). Post-Fordism described the subsequent challenge to Fordist production principles that placed more emphasis on flexible and diverse multi-organisational production approaches. Generally, these organisational models reflected a transition from one phase of capitalist development to another, but they have also been used in the analysis of the multiple composite organisational structure of the NHS (Walby and Greenwell 1994, Wright 1998, Savage 2000). As conceptual tools, they facilitated reflection on more recent features of the relation between the healthcare professions and the NHS organisation in the UK.

In its most literal sense Fordism is a theory that sees occupational effort (production) as task driven, each task defined and undertaken by a worker specifically trained for a particular duty within a single organisation. If this model were applied in healthcare, the resultant organisation would attend to tasks, those tasks undertaken by workers with specific roles, and social, cultural and political pressures would drive production outcomes. However, we know that healthcare organisations use professional groups whose agenda is at odds with such a focused production driven approach. That failure to match a basic organisational management theory to a professional group's organisational attributes is evident in the healthcare professions' problematic interface with the UK healthcare service

structure. Using medicine and nursing as examples, we find professionals educated by their respective professions in wide-ranging clinical skills. These broad skills, applied in the healthcare context, fulfill multiple outcomes and demands. This is a principle, a foundation of professional education that is rooted in the development of a professional generalist who may later specialise. But, if a healthcare organisation used Fordist principles, it would need specialists as primary clinical workers, who would focus on particular tasks that would be completed within a managed time schedule. If this were the case, the organisational needs of a Fordist healthcare bureaucracy would appear to be at odds with the professional aims and attributes of the healthcare professions. Dingwall and Lewis (1985) outlined a model of that potential professional / bureaucratic conflict (Figure 3.1. p.44).

Potential conflict areas	A Fordist healthcare bureaucracy requirement	The healthcare professions expectations
The Tasks	Partial and interdependent with others	Complete, sole work
The Training	Short, within the organisation, a specialised skill	Long, outside the organisation, a total skill
The Legitimation for Action	By following the rules	By doing what to the best of their knowledge is correct
Organisational Compliance	Is supervised	Is socialised
Loyalty	To the organisation	To the profession
Career	Ascent in the organisational hierarchy	Often no further career steps in the organisation

Figure 3.1. A model of professional / bureaucratic conflict
(adapted from Dingwall and Lewis 1985 p.178)

Fordist principles may, or may not, be at work in the UK NHS organisation, but the potential conflicts outlined in Figure 3.1 (p.44) accord with conflicts observed later in the data from this research. As will be seen, the analysis revealed the

sample attempting to reconcile clinical roles into a mismatched, or underdeveloped, organisational structure (chapter ten, section 10.3.2. p.374-381). It was in this context that Friedson (1970 and 1972) and Johnson (1972) both suggested that listing the functional requirements of a bureaucracy against the attributes of profession was an analytical process that was mostly unhelpful in modeling the relation between the two. They suggested that the context in which occupational groups sought the status and privilege of profession, and the constraints that regulated that goal, as the more useful defining features of the relationship.

Contrasting with the above analysis is the Post Fordist perspective, a perspective also known as flexible accumulation (Walby and Greenwell 1994). Flexible accumulation is characterised by the use of adaptable labour resources in responsive organisations. This construct, if applied in a healthcare context, would see clinical services and contracts provided flexibly from many sources, organisations, or professions, which dealt with social healthcare. This service-centred approach would be responsive, differentiated and flexible. If this were the case, it would have implications for enabling the development of new clinical roles. Wright (1998) observed that the introduction of more flexible approaches in the UK healthcare service organisation would make way for the development of new roles. These new roles could operate across previous professional boundaries, and would be responsive to new circumstances. Earlier I noted the increase in nurse practitioner roles in the UK during the 1990s and early 2000s (chapter two, section 2.3. p.35). This may evidence to some degree cultural changes in organisational management structures in the UK healthcare service of

that time, and the development of new management approaches that sought to resolve shortages of clinical expertise by enabling new nursing roles. Nurse practitioners were an example of this, their development of advanced clinical skills allowing them to be deployed in a wide-range of settings to meet new needs in healthcare practice.

Finally, in conclusion of this sub-section, Fordism and Post-Fordism are organisational models that enable a particular view of the relationship between the structure and intent of an organisation. They also enable a view of the expectation of professionals who contribute to the organisations function. It is possible that the major organisational changes within the UK healthcare service since 1990 represented some form of transition between Fordist and Post-Fordist principles. However, it is not the intention of this thesis to promote any theory or construct over another in the analysis of the UK NHS organisation. The objective has been to place the professional, clinical and organisational relationship observed in the data within the changing cultural organisational context of the time. This theme of the organisation of professional work in healthcare is considered in the following sub-section.

3.2.3. The occupational division of labour and the healthcare professions

The concept of the division of labour, outlined by Weber (1947), is fundamental to understanding professions. Consider a simple example that illuminates that concept in a healthcare context. The public views hospitals as physical entities, organisations in their own right. They are a place, a building, with a particular characteristic function associated with illness and health, often imbued with traits

such as friendly, cheerful, forbidding, and efficient or disorganised. Departments are individual geographical and organisational structures within the greater whole. Within that broad social construct of the hospital, individuals are identified with particular hospital areas. Examples would be medical ward nurses, casualty department doctors, and X-Ray porters. However, in reality, these individuals may also answer to wider occupational grouping, such as the nursing profession, the medical profession, or to the senior hospital management, and they are only nominally linked with hospital departments.

A hospital only exists and functions because of the integrated labour of many occupational groups that are all individually structured and regulated in multiple ways. Thus, although we can view a hospital as a singular organisation, it is in fact composed of multiple organisations. Without the work of many occupational groups, it could not function as a hospital. Consequently, the occupational groups involved in a hospital (a healthcare organisation), be they professional or otherwise, structure its general purpose. Each occupational group is itself dependent on some form of orderly structure, purpose, management, function and resource (Fayol 1949, Handy 1990). Some of these groups are established (traditional professions) whilst others are comparatively new and emergent, direct organisational products of the modern healthcare service industry and of new healthcare related technologies. Of these diverse occupational groups, some will be managed and regulated locally within a hospital organisation, and others will be subject to alternative professional regulation.

Thus, in simple terms, a hospital is an organisation that functions (and is characterised) by the principles of the division of labour. The regulation of that division of labour is diverse; it includes professional regulation, trade union regulation, and employment regulation. Consequently, all groups and individuals find themselves bounded by a network of order, contractually accountable in some form to the hospital organisation and to the wider healthcare service. It is the relative occupational status of these groups and their place in the organisational hierarchy that is of most interest here in this study. For example, many of these occupational groups find themselves ranked low in a professional status hierarchy that is dominated by the traditional healthcare professions, and regardless of the relative contribution of any group, a network of occupational boundaries arises.

It is the historically older professions that are more autonomous, more powerful and influential, that provide a central focus for the study of occupational boundaries in this study. These older healthcare professions, specifically medicine and nursing, control the division of healthcare labour and specialisation. They adopt closure approaches that limit their membership, and thus create occupational monopoly and scarcity (chapter three, sub-section 3.2.4. p.51). In addition to this, the dependence of healthcare delivery on more than one professional group is a pivotal issue, as labour division within a singular complex organisation has implications for authority and control. It was thus important to consider the nature of professions and the manner of their regulation, and I review this now in more depth.

3.2.4. Profession - reviewing the concept

The concept of profession has many connotations: for example, the division of labour, trait theory, moral order, bureaucracies and class structure (Dingwall and Lewis 1985). Dyer (1988) offered a functional checklist of professional behavioural traits:

- The professional is engaged in a social service that is essential and unique
- The professional is one who has developed a high degree of knowledge
- The professional must develop the ability to apply the special body of knowledge that is unique to the profession
- The professional is part of a group that is autonomous and claims the right to regulate itself
- The professional recognises and affirms a code of ethics
- The professional exhibits a strong self-discipline and accepts personal responsibility for actions and decisions
- The professional's primary concern and commitment is to communal interest rather than merely to the self
- The professional is more concerned with services rendered than with financial rewards

(Dyer 1988 p.2)

Thus, important defining features of a profession emerged that were characterised by a high occupational status (Haralambos 1995). High occupational status was also associated with high socio-economic status, and this served to create subordinate positions for other occupations in the hierarchy. That occupational hierarchy included other occupational groups, such as skilled workers, semi-skilled workers, and unskilled manual workers, and this offered one way of understanding the place of professions in society. However, it gave little help in understanding the intrinsic nature of professions as organisations that were both influential and yet regulated. Barber (1963) considered that professions possessed four functional social service characteristics that set them apart from lower order

occupations and afforded them their status and reward. These characteristics were:

- The possession of a body of systematic and generalised knowledge that may be applied to particular problems
- The concern and altruism for the community and its needs
- The internal regulation based on ethical principle, regulation and education
- The social recognition, status and reward

(Barber 1963 p.671)

This is a very similar model to that offered by Dyer (1988) (chapter three, sub-section 3.2.4. p.49). Indeed Porter (1998) indicated that there were numerous models of professions and that they all had some similarity and some contrasts. These models were generally useful as a means of undertaking analysis of professional function and role. They enabled scrutiny of professions' behaviour, how they ordered and defined their social function, regulated their membership by management of knowledge and education, and sought social reward.

However, there were challenges to these traditional models of profession. Parry (1976) saw professions as primarily concerned with their own interests and own membership. This self-interest model saw professions preserving their high social status (and economic reward) through restricted professional entry, by restricting service supply, maintaining high demand, and actively furthering their image of being unique in their social service. This polarity between the traditional view of professions providing an altruistic community service, and the alternative perspective of market protection of their own wealth and status, was demonstrated in Illich's (1990) critique of the medical profession. Illich (1990) saw the medical profession as contributing little to public health. Contrary to its claim to be able

to identify, diagnose and treat the causes of ill health, Illich (1990) claimed that medicine used its status to obscure other reasons for the trend of improvement in social well being (e.g. improved housing conditions and improved social amenities).

It was evident that both the altruistic community service and the self-interest theories could be used in the analysis of professions. Both theories certainly demanded further inspection of how professions maintained their identity, directed their function, delineated their goals, and identified and regulated their membership. Equally, the view of any profession as a regulated functional occupation led inevitably to the view of the boundaries that separated it from other occupational groups. If a profession had developed an identity that supported its unique aims, then it would also require some form of boundary mechanism that would prevent incursion from elsewhere. It is the concept of social closure that provided the means by which professions supported themselves within the greater array of social structures. Weber (1968) described the phenomenon of social closure as a process that any organisation or social group employed to preserve its identity. Occupations used social closure to protect their boundaries, maintain their internal organisation, and oversee whatever social advantage they had. Berlant (1975) and Porter (1998) viewed this as particularly applicable to groups that laid claim to professional status, and reviewed methods by which the traditional professions of law and medicine created their monopolies. I consider further this concept of professional closure later in this chapter (chapter three, sub-section 3.2.6. p.55-58).

Perhaps the most useful and responsive perspective of professions for this thesis was that proposed by Johnson (1972). Rejecting the traditional notion of a profession as a concept defined by specific attributes, Johnson (1972) stated:

> "A profession is not, then, an occupation, but a means of controlling an occupation."
>
> (Johnson 1972 p.45)

A consequence of this for any organisation was how the boundaries between occupational groups were controlled.

Professions, whilst having some common features (Porter 1998), are not identical and may have particular characteristics that reflect their place in the wider organisational structure. For example, Walby and Greenwell (1994) indicated that some professional groups were more self-contained than others were. Teaching was an example of a profession that operated mostly unilaterally and with minimal occasion to work inter-professionally. However, in healthcare there were numerous professions all working together, this making the issue of boundary negotiation more evident. Thus, the history, regulation and relative position in the hierarchy of these professional groups determined how they viewed and negotiated the boundaries that separated them, and how they collaborated in effective and efficient healthcare service provision. I consider this issue of professional boundary in more detail in the following sub-section.

3.2.5. Professional boundaries in healthcare

Change in the nature of the healthcare professions may result when boundary redefinitions and new divisions of labour occur. Such events do not necessarily

occur quickly but may evolve over time and thus their development may not be immediately apparent, or may be difficult to predict and visualise. There is evidence to support the fluidity of occupational and professional boundaries and the reallocation of labour and tasks between them. In regard of the healthcare occupations, Hughes (1984) stated:

> "As medical technology develops and changes, particular tasks are constantly downgraded; that is, they are delegated by physicians to the nurse. The nurse in turn passes them on to the maid. But occupations and people are being upgraded, within certain limits. The nurse moves up nearer the doctor in techniques and devotes more of her time to supervision of other workers. New workers come in at the bottom of the hierarchy to take over the tasks abandoned by those occupations that are ascending the mobility ladder. Others come in outside the hierarchy as new kinds of technology (photography, electronics, physics) find a place in the medical effort."
>
> (Hughes 1984 p.307-308)

Here the uncertainty of the nature and evolution of professional roles in the healthcare context was exposed. So much of the effort that had been devoted to precisely defining the nature of healthcare occupations had overlooked this uncertainty. Traditionally accepted occupational roles could thus mislead not only the layperson, but also members of the professions, into a belief that professional roles could be defined, or indefinitely preserved. Hughes (1984) saw the structure of professions (such as nursing and medicine) as undergoing constant change, and it was at the boundary of these professions, at the point of their meeting, where this was most apparent. Allen (1997) saw blurring at the nursing and medical boundary as inevitable, this because the traditional imagery of the diagnostic physician and the caring nurse was a division of labour that was no longer sustainable in meeting the needs of modern healthcare. The introduction of

new diagnostic technologies that were used by nurses, and the adoption of pastoral complementary therapies by physicians, were simple examples of role changes within these professions. Such thinking was not new. Bates (1970) had provided a physician perspective on the blurring of the nursing medical boundary, had commented on the traditional care and cure domains of nursing and medicine, and had observed that neither was mutually exclusive.

Such debate, it may be argued, lacked focus on the central issue of healthcare provision. Radcliffe (2000) suggested that the boundaries between professional groups were irrelevant as long as healthcare services were responsive and efficient. Radcliffe (2000 p.27) also argued that any boundary conflict between medicine and nursing was an "irrelevant, unsophisticated squabble" and one that distracted from patient care. This argument, whilst an effective strategy in side stepping a difficult debate, lacked insight into how these professions provided healthcare, and how their labour was divided. The data I collected in this project revealed the allocation and management of workload between professional groups as an important area of negotiation for the sample. Reed (1998) stated:

> "When questions are asked about how to achieve health and to give effective and efficient care, other questions will follow about which professional groups are best suited to meet these objectives. These questions are being raised at a time when the boundaries between healthcare professions have become a topic of ongoing debate."
>
> (Reed 1998 p.90)

Thus, there was a need to examine the negotiation of the division of healthcare labour. Darnell (1973) reviewed the development of physician associates in relation to career opportunities for nurses in the USA, and identified two features

of medical teamwork (which perhaps now would be referred to as healthcare teamwork). These two features described the negotiating process within such a relationship. The first was a division of labour in which complex professional roles would be split into less difficult, simpler and more manageable units of labour. The second was a synthesis of these new simpler units of labour into a new functioning system.

Darnell (1973) further discussed how such a process of reduction and synthesis of workload would rest entirely on a co-operative professional dialogue between the two professional groups. If this was in anyway to be successful, it should result in fully shared medical responsibility. Thirty years later the issue of legitimate authority remained a central theme in the data when examining the professional boundary between these two groups. It is now important to further this discussion by considering in more detail the specific nature and relationship between the medical and nursing professions.

3.2.6. The medical and nursing professions

I now review the fundamental nature and culture of the traditional healthcare professions. McCormick (1979) saw the differences that distinguished healthcare professions from other professions as characterised by their intimate involvement with the public, the roles that they had in public health, and the nature by which they were controlled and regulated.

Historically medicine had been the patriarch of the healthcare professions. It had maintained this position in many ways, but had primarily sustained this by the use

of professional (social) closure (chapter three, sub-section 3.2.4. p.51). Whilst this afforded a well-defined structure to healthcare delivery for a considerable time, it had also imposed an inflexible organisational hierarchy. Medicine had influenced many healthcare professions' development by carefully controlling the division of labour. This had most impact on nursing as in the professional hierarchy nursing was dominated by medicine. In addition, the boundary between the two professions was controlled by medicine. Hughes (1984) viewed this control as associated with the types of tasks that each profession traditionally focused on, medical tasks perceived as high order, nursing tasks perceived as low order.

It is at the occupational boundary that the concepts of professional monopoly and closure come into sharp focus. Aspects of professional monopoly arose from the descriptions of professional behaviour that were discussed earlier (chapter three, sub-section 3.2.3. p.46-48). The creation of scarcity (a social service that is essential and unique), the monopolisation of supply (a group that is autonomous and claims the right to regulate itself), and the restriction of group membership (controlled internal regulation and education), all illuminated aspects of monopolisation (Berlant 1975). This professional closure was commonly observed in the medical profession, and was also observed in other less dominant healthcare professions. For example, nursing restricted and controlled access to its professional status and privilege. However, nursing also actively sought the professional status and privilege of medicine. Porter (1998) described this as dual closure. Nurses were seeking a redefinition of professional status and function that would both maintain their existing professional status, and extend their

privilege by negotiating access to professional medical status. Witz (1992) saw this as evidence of an occupation who had not gained full professional status, but who wished to do so.

When a profession such as nursing is successful in negotiating access to more dominant profession such as medicine then redistribution of resource, status and authority occur. The findings in this research revealed aspects of that process of redistribution. That analysis offered a challenge, as it presumed a certain absorbed self-interest on the part of nursing (apparent in its quest for professional recognition), that should be contrasted with the social context. That context was the scarcity of medical practitioners, and this was a problem practicably resolved by boundary changes and the introduction of new clinical roles. Thus, there was an economic and political imperative in the equation of professional closure.

Recent history has seen a diminution of medical dominance in the healthcare professions. This has been due to several key factors: political, social and professional (Kaufman 1996, McCartney et al 1999). Equally, nursing had selectively delegated many of its traditional domestic tasks to other groups lower in the healthcare hierarchy, and had increasingly aspired toward more technical higher order roles and greater professional status. Bowler and Mallick (1998) acknowledged these changes but also noted that medicine was continuing to maintain strict boundary demarcations, this justified by reasons of professional maturity, legislation, litigation and tradition. If medicine saw the expansion of nurses' clinical practice best regulated by them, and if such expanded roles were undertaken by individuals trained and monitored by a doctor, then this thinking

would maintain professional closure and protect professional identity. However, in the context of the other economic and political imperatives highlighted above that sought new roles and greater flexibility in other healthcare professions, there was clearly a potential for professional conflict. There would be opposition to nursing rising to a more equal standing with medicine, as medicine sought to protect its traditional dominance. Gibbon and Luker (1995) saw this opposition to any boundary redefinition that was not ultimately controlled by the medical profession as a significant obstacle in the expansion and development of new clinical nursing roles.

The emergence in nursing of clinical specialists and nurse practitioners has given the most tangible and visible evidence of a profession that was expanding into new territory. However, in a profession that until very recently had little clinical career structure, understanding those new roles has proved difficult. It is now pertinent to complete this review of social and professional theory by focusing on its application to more recent role developments in the nursing and medical professions.

3.2.7. Professional identities and developments in the 1980s and 1990s

Offredy (1998) has highlighted important structural issues that affected the development of new roles within the nursing profession in the UK:

> "The evidence would appear to suggest that the development of new nursing roles and responsibilities associated with higher level practice in the UK needs to be accompanied by the appropriate legal framework and policy infrastructure if the development is to succeed. This is particularly so in relation to changes in the interface between nursing and medicine."
>
> (Offredy 1998 p.19)

The data from this research has pointed in the same direction; it has demonstrated a perception of occupational roles that traditionally, and structurally, divided these two professions. This is evident in the following data extract:

> *"I still think nursing is to do with nurturing and caring. Medicine I think is about curing."*
>
> *Student Nurse Practitioner - A2 Data Segment - 2nd Interview Data*

Perceptions such as these would inevitably influence boundary relationships between nursing and medicine. Later in the analysis chapter (chapter five, sub-section 5.4.3.1. p.118-120), I describe the findings in this research that revealed the sample's traditional perceptions of the occupational roles of the nursing and medical professions.

Consider further these traditional professional stereotypes. The nature of medicine historically rested on its foundation as a typical profession, self-regulated, autonomous, providing a unique public service based on a unique body of knowledge, and having high social reward and status. That perspective persists, although I have already alluded to its possible deconstruction. However, let us for the moment accept that medicine is a profession that has a long history that has led to an elaborate and powerful internal structure based on well-ordered hierarchies of generalism and specialism. The place of the medical student, house officer, general practitioner and specialist consultant, are all well established in this intricate occupational structure. Medicine is self-regulated by the General Medical Council (GMC) and is further arranged into other semi-autonomous and professional component organisational groups such as the Royal Colleges, the

Medical Schools, and the British Medical Association (BMA). Lines of communication are well established, professional etiquette is powerful, and medicine had long seen itself as the patriarch of healthcare provision (Witz 1992).

In contrast, nursing, although having a prolonged historical background equal to that of medicine, has until recently been viewed as a younger and less mature professional group that was still developing a clinical career structure (McGee et al 1996, Woods 1997, Radcliffe 2000, Fletcher 2000). Historically nursing had a somewhat idiosyncratic and underdeveloped structure for an occupation that chose to call itself a profession. Nursing had lacked autonomy, had an ill-defined membership, an ill-defined body of knowledge, and it did not have the social status of medicine. In the UK the formation of the UKCC (DOH 1979), replacing the older General Nursing Council (GNC) that had existed since 1919, led to changes that addressed some of these issues. The UKCC actively sought a greater professional recognition for the nursing in the UK by the creation of a comprehensive active register of membership, and by establishing a code of conduct with related mechanisms of professional governance. More significantly, it reviewed and changed the processes of traditional vocational nurse education, taking it into the higher education arena. It is also important to acknowledge that, during this time, nursing had developed a well-defined hierarchy of non-clinical managers and educationalists. This non-clinical nursing hierarchy arose from a long history of NHS management and educational restructuring (Ministry of Health [MOH] 1947, MOH 1949, RCN 1964, MOH 1967, DOH 1972, DOH 1979, DOH 1983). However, all these had failed to address the limited clinical career structure of nursing.

Thus, before the organisational and structural changes during the 1980s and 1990s, nursing in the UK lacked a well-developed clinical hierarchy. In the most basic sense clinical roles were defined by nebulous titles, some regulated and others not. Examples of these were student nurse, enrolled nurse, registered nurse, staff nurse and sister or charge nurse. An important example of an attempt to structure clinical nursing came with the introduction of the clinical re-grading exercise of 1988. This was introduced just before other NHS reforms came into place in the 1990s (Holliday 1995), and it was an attempt to provide an efficient clinical structure which failed because employers manipulated it to control costs, ignoring the clinical rationale for the change. However, its failure acted as another spur for nursing to seek a wider and more professionally relevant structure of clinical career development.

Three other important professional developments for nursing in the UK occurred during the 1990s: the Scope of Nursing Practice (UKCC 1992), the Specialist Practice Award (UKCC 1996), and the Higher Level of Practice (HLP) framework (UKCC 1998). These paved the way to the evolution of a more refined clinical hierarchy in nursing and mirrored the parallel uptake of specialist titles by nurses (Read 1998, Daly and Carnwell 2003) and the proliferation of clinical programmes for qualified nurses that sought to develop specialist and advanced skills. There was also a political will to support such developments, this apparent in the Government's promotion of consultant nurses (Waller 1998).

Hockey (1983) highlighted a paradoxical situation during the early development of specialist and advanced nurses in the UK. Whilst it was evident that the UK healthcare service needed and wanted specialist and advanced nurses, it misunderstood the nature of those roles due to the lack of a legitimate clinical career structure to accommodate them. That problem persisted throughout the 1990s. However, a clinical career structure for nursing was developing internationally, and this structure could be identified from the research on nurse practitioners and their place in nursing (Offredy 2000, Ketefian et al 2001, Pearson and Peels 2002a). Yet, in the UK, early research had focused mostly on client satisfaction and workforce resource implications of nurse practitioners (Spitzer and Sackett 1990, South Thames Regional Health Authority 1995). There had been until more recently, limited UK research on the specific nature (identity) of the nurse practitioner role, or research on the perception of those individuals developing (or in possession of) the clinical skills outlined in the introductory chapter (chapter one, section 1.1. p.2). Thus, in the 1990s in the UK, the nurse practitioner role, and its implication for the nursing and medical professions, remained ambiguous and poorly understood.

This ambiguity about the role of the nurse practitioner in part prompted the development of this research project. How the nurse practitioner role was being developed, and the social and cultural experiences of individuals involved in that process, was an area open for further investigation. As findings emerged from this project, Van Gennep's (1960) theory of social transition became an important tool in structuring the data presentation. Later I explain in detail how this model was used and how it became a fundamental part of the process and findings within

this research (chapter four, sub-section 4.2.2. p.75-77 / chapter five, section 5.1. p.105-106 and section 5.5. p.127-130 / chapter seven / chapter eight / chapter nine / chapter ten, sub-section 10.3.4. p.391-397). However, in the next section of this chapter I specifically discuss theoretical aspects of Van Gennep's (1960) model of a rite of passage and its broad application to this research as an analytical tool.

3.3. A RITE OF PASSAGE

This study examined the experiences of individuals involved in developing nurse practitioner roles. Those experiences were linked to social and cultural transitions. Earwaker (1992) described social and cultural transitions as more than simple changes that individuals experienced during minor adjustments to new situations or new events, but as a complex of processes that led to socialisation into significant new roles. This observation underpinned how the rite of passage (Van Gennep 1960), as an analytical tool, and as a theoretical construct, became important to this research and its findings. A rite of passage may be defined as an event in which an individual passes from one condition of life experience into another, from one stage of life or state of social status to a more advanced one. Rite of passage is referred to throughout this thesis but its theoretical basis is explored in depth in this section. Later, the three main data chapters (chapters seven, eight and nine) review in detail, and at length, the data and the transitional phases of a rite of passage: the separation phase, the transition phase, and the incorporation phase.

The concept of the rite of passage was not formally integrated as a structural part of the research until the later part of the data analysis in 2003. That inclusion was

a result of a staged process of reflection. Firstly, it had become clear that the data presented a complex web of interactions, it was unwieldy, and there was a need for a more structured framework (chapter five, section 5.1. p.105-106). Secondly, and as a direct result of that realisation, several theoretical constructs of social transition were reviewed and considered (Van Gennep 1960, Becker et al 1961, Woods 1999, Glaze 2002). All were found to have similarities. However, careful consideration pointed to Van Gennep's (1960) seminal theory of the transitional rite of passage as that most applicable to this study and this was later borne out by its congruence with the study's findings (chapter ten, sub-section 10.3.4. p.391-397).

Van Gennep (1960) described two main types of rites of passage. Firstly, there were rites of passage that accompanied the progress of a person from one social status to another in the course of his or her life. Secondly, there were rites of passage that marked recognised points in the passage of time (new year, new moon, solstice, or equinox). Today, in general scholastic use, the term rite of passage is usually confined to the former type. It is important personal life events, or life crises, that denote a rite of passage.

Van Gennep (1960) noted that whilst one expected (and found) the content of social transitions to vary from society to society, a characteristic of social transitions was that their form or pattern was universal. Societies that were completely separated from each other used near identical formal rites of passage that facilitated a change of social status for individuals and groups. These rites of passage validated an individual's change in personal status. Examples would be

life-transforming events such as marriage, parenthood, and bereavement. However, a rite of passage could also highlight other important life events, such as academic graduation or achieving formal membership of an occupational group or profession.

Crossing social boundaries is often an inevitable consequence of social change, and these boundary transitions, if unregulated and unconfined, can challenge social status or order. However, a rite of passage permits boundary transitions whilst preserving aspects of social stability and organisational regulation. A rite of passage eases the transition of groups, or individuals, at key life stages, into new status and new roles. As an individual's position in a society necessarily changes over time in response to gaining new skills, abilities, status and wisdom, it is the formality of a rite of passage that permits such transition whilst simultaneously validating the stability and order of existing social cultural structure. Thus, the social and cultural acceptance of a rite of passage avoids interpersonal or group conflicts and resistance or resentment of new social statuses. If new transitions arise, then border conflicts may occur between organisational groups or professional groups. Consequently, negotiation is a necessary part of any new transitional process.

In general, a rite of passage is seen as an event that not only defines wider social constructs but also enables social innovation; it demarcates boundaries between the old and the new. When fully assimilated into a society a rite of passage enables transitions of social status, without challenging the underlying symbolic structure of that society. Van Gennep's (1960) model is characterised by a

separation phase (when the individual is removed from his or her previous state), a transition phase (the liminal phase when the individual is in a social limbo), and an incorporation phase (when the individual is reintegrated back into society in a new state).

A rite of passage reveals aspects of change in status, and is essentially symbolic. It can be marked by elaborate ceremonies or simple practical events depending on the nature of the transition (Draper 2003). For example, Froggatt (1997) saw that particular phases of a rite of passage would be more prominent according to the type of life event. The separation phase would be prominent during bereavement, the transition phase prominent in new parenting, and the incorporation phase prominent in marriage. The role of the rite of passage associated with these transitions was concerned with reducing their potential harmful effects on the individual and on social order. However, this view of a rite of passage as a process involving three distinct phases need not follow in the linear way described. It is possible that there will be significant events, markers and themes that could occur at any time in any rite of passage. For example, in this project the final objective structured clinical examination (OSCE) represented a decisive initiation of the rite of passage and of the of students' overall experience (chapter nine, sub-section 9.7.1.1. p.335-336).

Turner (1969, 1979 and 1982), a cultural anthropologist, explored this notion of the rite of passage as a complex, and sometimes contradictory, model. He had studied different societies around the world, mainly in non-western societies, much of his own work in central Africa during the 1950s and 1960s. Turner was

particularly interested in the roles of social symbols that enabled any society to make sense of its members lives. He examined rites of passage and rituals, their symbolic meanings, and their role in specific social situations. For example, societies are ordered to include organisational structures dependent on distinct symbolic social groupings (gender groupings, social status groupings, occupational and professional groupings). Turner's (1982) view was that during a rite of passage, and particularly during the transition phase, such distinctions become ambiguous, and individuals find themselves living outside the normal organisation and values of the social system. In the transition phase of the rite of passage, the individual joins with other initiates, and new symbolic forms of social groups emerge. This fellowship, sharing, or communitas, has its own structure, although its purpose is anti-structural (Turner 1982). By this it is meant that communitas appears where normal social structure does not (where social structure is defined as the arrangement of social positions or status). Turner (1982) explained his concept of communitas:

> "I have used the term anti-structure, to describe both liminality and what I have called communitas. I meant by it not a structural reversal but the liberation of human capacities of cognition, affect, volition, creativity, etc., from the normative constraints incumbent upon occupying a sequence of social statuses."
>
> (Turner 1982 p.44)

During a rite of passage, established orders fail to operate but new orders can evolve. It is this experience of liminality (derived from the Latin limen - meaning threshold) that provides us with the view of the social borders crossed during the rite of passage. In liminality, individuals and groups are stripped of previous status, reduced to a uniform condition, this enabling a process of new socialisation

and the acquisition of new status and power. The characteristics of liminality are inevitably ambiguous as the social system of classifications that are normally used in situating organisations and groups are gone. The liminal individual, or group, is in limbo, neither here nor there, and unconfined by conventional regulation or custom. In this situation, communitas arises and Turner (1979) outlined its purpose:

> "Undifferentiated, egalitarian, direct, extant, non-rational, existential, I-Thou. Communitas is spontaneous, immediate, concrete, not abstract. It does not merge identities; it liberates them from conformity to general norms, though this is necessarily a transient condition if society is to continue to operate in an orderly fashion."
>
> (Turner 1979 p.150)

A rite of passage reflects transitions through a multitude of social structures. In this study, it was the social borders that existed between healthcare professions that were of interest. These presented particular barriers, as social mobility between healthcare professional groups was relatively uncommon. Although these boundaries were often difficult to define, as they were subject to constant change, they were nevertheless maintained by a complex order of negotiation and regulation. An individual crossing a professional boundary (without agreement) ran the risk of censure due to a social or cultural transgression. Such boundaries were formidable, but as Svensson (1996) suggested they were not absolute, and they were open to particular levels of cross-border negotiation. Using the model of the rite of passage to structure the data enabled examination of that negotiation process at the professional boundary.

It is important now to distinguish between the concept of a rite of passage and a ritual, as they are often considered as synonymous. Van Gennep (1960) compared the structure of rituals with the structure of a rite of passage, and concluded that they often shared similar features (periods of segregation from everyday life, liminal states of transition, and reintroduction to society with a new status). However, a rite of passage has been shown to be a purposeful process that affected the ordering and evolution of social order. Thus, it is an analytical concept, a tool that facilitates investigation of social transition. In contrast, whilst rituals are often associated with a rite of passage, they are best defined as aspects of a prescribed formal behaviour that have no direct determined consequence. Ritual action is often symbolic, it asserts something about circumstances or surroundings, but it is not necessarily purposive. A ritual action does not necessarily seek to maintain or alter the social world, it simply highlights an aspect of it.

In this research, the phases of a rite of passage have been used as an analytical tool, they illuminated aspects of the sample's lived experience and have tied the data sources systematically together. However, the use of the concept of the rite of passage in this way is not above criticism. For example, Gluckman (1962) asserted that a rite of passage was sacred and thus could exist only in societies with strong charismatic religious structures. The difference here is informative; it is the use of the model as an analytical tool that is important, rather than its symbolic content. In this study, the model of the rite of passage was approached in the context of a cultural investigation; it facilitated answers, reorganisation, and reinterpretation of the data in a way that produced a meaningful whole.

It is important to consider the difference between what I have identified as social transitions and what I have defined as a rite of passage. Are these mutually exclusive or was there a link between the two? I suggest that they are intimately related. A rite of passage is a process of events that individuals experience as they undergo a change in social condition. It is thus indicative of social transitions that individuals experience as they pass from one event to another. Transitions are thus necessarily components of a rite of passage. For example, an individual may change from a state of being stressed to not being stressed. That is in itself a personal transition, but it does not indicate a major life change or a rite of passage. In this study, an example of a transition would be the proficient acquisition of a clinical skill. In itself, this is not indicative of a major change in social status. However when several related transitions occur they can become a feature of a wider change - or a rite of passage.

La Fontaine (1985) believed that a rite of passage could define boundaries for initiates in gaining new status within a society. The designated officiates were legitimated through their ability to bestow traditional knowledge and skills which enabled the correct performance of the new role. Esoteric knowledge and related complex skills were thus components of a transition to new social status. In the case of student nurses and student doctors such social transitions took place within well-established social and cultural constructs. In this investigation of nurse practitioners, the social transitions that took place were in an unfamiliar social construct. The nurse practitioner students were not merely experiencing

transitions in their own profession but were trying to incorporate other transitions from another profession.

This chapter has outlined the theoretical background of concepts of social theory and rite of passage that arise throughout this project. I now move on to consider the methodological and analytical design considerations (chapters four and five).

CHAPTER FOUR

THE METHODOLOGY

4.1. INTRODUCTION TO THE METHODOLOGY

This chapter is divided into two main sections. Firstly, I discuss the methodological issues and specific design considerations of this research. I focus particularly on the use of practitioner ethnography and on the data collection and analysis techniques. Secondly, I examine the profile of the sample of students, physician mentors, teachers and academics used in this research project.

4.2. THE METHODOLOGY AND RESEARCH DESIGN

Throughout the following section, I review in depth the nature and rationale of the methodological design of this research project. The aims of the study were:

a) To examine the experiences and perceptions of a diverse group of individuals involved in a nurse practitioner degree programme.

b) To examine the evolving nurse practitioner role and identity, and its affect on:

- Professional structures and concepts
- Occupational boundaries

c) To consider how transitional experiences compared and contrasted with the concept of a rite of passage.

The research design had to underpin and reflect the study's aims. Thus, the following sub-sections (chapter four, sub-section 4.2.1. to sub-section 4.2.9. p.73-101) consider the specific areas of the project's methodology and research design.

4.2.1. Qualitative research

Qualitative research involves the investigation and interpretation of individual, group or organisational behaviour and the interpretation of human experience (Porter 1996). Thus, the qualitative researcher is an observer and interpreter of social and cultural behavior. Porter (1996) saw qualitative research as founded on four levels of understanding: ontology (what is reality), epistemology (what counts as knowledge), methodology (how can we understand reality), and methods (how can evidence be collected about reality). These levels of understanding are apparent throughout this study: the study explored the reality of the sample's lived experience, determined the sample's knowledge, and explored the methodological rigour where important design issues arose. Thus, the qualitative paradigm defined the principal methodological approach within this study. This approach further focused on concepts used in cultural (anthropological) investigation.

Fossey et al (2002) described a paradigm as an order of ideas, a worldview, within which a set of assumptions, research strategies, and criteria for rigour were shared by a collective of researchers. Fossey et al (2002) linked this perspective to qualitative research methodology and to the research community that sought to generate knowledge on human experience:

> "Qualitative research aims to address questions concerned with developing an understanding of the meaning and experience dimensions of humans' lives and social worlds. Central to good qualitative research is whether the research participants' subjective meanings, actions and social contexts, as understood by them, are illuminated."
>
> (Fossey et al 2002 p.717)

Qualitative research methodology has developed different methods and philosophies, and all are used in investigating the many aspects of human activity (Silverman 1994). I therefore acknowledge that the different qualitative traditions of sociology, anthropology, psychology and philosophy, each support their own methodological approach and display differences as well as many similarities.

The theme of methodological diversity was evident in Steven's (1998) exploration of the nature of nursing knowledge. Stevens (1998) questioned whether nursing knowledge was specific to nursing, or whether it was knowledge that was common to all the healthcare professions, and used by nurses in a particular way. The first premise would define nursing in terms of its fundamental nature, whilst the second premise would influence nursing in its investigative methodologies. The literature indicated that the second premise was the more likely of the two (Moore 1990). Consequently, some nursing researchers had used specific methodologies to help them explain (and defend) how nurses used shared knowledge (Morse 1991, Baker et al 1992). The suggestion that any specific methodology gave basis to the nature of nursing was also a suggestion that methodological diversity revealed limited research rigour within the profession. However, and in complete contrast, Nolan et al (1998) viewed methodological purism as potentially flawed and confining in healthcare related research, and Beattie (2002) observed that nurse researchers had recently begun to broaden their methodological options. This suggested a developing professional confidence that supported diversity in qualitative methodological approaches in nursing research. Finally, Johnson et al (2001) saw rigid conformity to any specific research approach, and restriction of methodological diversity, as lacking in investigative

rigour. In this view, methodological variety was not only acceptable, but also necessary. Thus, my decision to ground the study within a particular methodological approach required explanation (Maggs-Rapport 2001), as it was a methodological choice linked with the nursing profession's identity and status (chapter two, section 2.3. p.30).

This methodological debate was a broad acknowledgment that qualitative research was complex, and that methodological choice was difficult. Consequently, the choice of methodology required careful consideration and planning so that the eventual outcome would reflect relevance and purpose (Forbes and Griffiths 2002). It was clear that my methodological rationale had to be carefully outlined. To that end, this project's focus on occupation, profession, and culture, ran a natural course in directing methodological development, and I consider this next.

4.2.2. Social Anthropology - the nature of culture, transitions and rite of passage

I have already indicated (chapter one, sub-section 1.4.1. p.19-20), that it was within social anthropology that this project naturally developed, and that it was the concept of culture that was most commonly associated with the research aim. No singular definition or interpretation can adequately define the concept of culture (Surber 1998). However, Friedman (1994 p.720) offered the following broad definition of the concept as "the attribution of a set of social behavioural and representational properties to a given population". Baillie (1995) observed that culture rested on an assumption that any human group together for a period of time would develop a culture, whilst Savage (2000 p.231) described culture as

"concerned with ascribing difference or otherness". This difference, or otherness, formed a basis to the investigation of the cultural evolution, experience, and nature of the nurse practitioner.

The work of Becker et al (1961) and Melia (1979) had provided methodological direction for the examination of processes of professional socialisation. More recently, Holland (1999) had examined the lived experiences of pre-registration nursing students during their education, and had focused specifically on processes of occupational socialisation and transition. Holland (1999) noted that these transitional processes correlated with the construct of a rite of passage identified by Van Gennep (1960), where a rite of passage was defined by transitional phases of separation, transition and incorporation (chapter three, section 3.3. p.63). For Holland (1999), these transitional states were important in establishing the cultural system and rules that the students were orientating toward in their socialisation into professional nursing. In her view, the examination of the cultural experience of the daily world of nursing activity was underdeveloped. She saw this as a demand to establish firmer links between the practice of nurses and the science of anthropology. That this view did not necessarily acknowledge earlier work on professional socialisation (Hughes 1959, Becker 1961, Melia 1979 Hughes 1984) is perhaps an issue for critique elsewhere than in this study. More importantly, it was a call to adopt a suitable methodology that facilitated examination of social and cultural transitions. This was central to my project, as part of the investigation pivoted on the meeting point of the two similar, and yet disparate, professional cultures of medicine and nursing. Thus, I used the social and cultural construct of a rite of passage both as an analytical tool and as a

framework for the data presentation, and this is discussed in more detail throughout chapter five. Having outlined a rationale for the use of social anthropology, I now discuss ethnography as a methodological approach.

4.2.3. Ethnography as a research methodology

Anthropological ethnography developed from the early work of Malinowski and Radcliffe-Brown (Baillie 1995). This development influenced social ethnography and the methodological approach that later emerged from the Chicago School of Sociology during the 1920s and 1930s (Smith 1988). Today anthropologists selectively use ethnography in the study of race and culture, whilst social scientists use it to study cultures in the context of complex organisations and occupational structures (Laugharne 1995).

Jokinen et al (2002) outlined that the place of ethnography in the qualitative paradigm reflected the common philosophical foundation of that discipline:

> "The general purpose of a qualitative research process is to understand and interpret people's experiences and reality from their point of view."
>
> (Jokinen et al 2002 p.166)

Laugharne (1995) furthered this, and described three features of ethnography that were shared with other qualitative methodologies. Firstly, there was naturalism, a process of studying people within a natural setting and limiting the affect of the researcher on the natural world being examined. Secondly, there was holism, a gestalt issue where the group was known to be more than a simple product of its individual members. A philosophy diametrically opposed to reductionism it accepted the complexity of social organisation and order. Thirdly, and finally,

there was culture, a purposeful concept in maintaining group identity. On the specifics of culture, Laugharne (1995) stated:

> "Culture is recognised as being purposeful and useful for the maintenance of identity in a group. Culture can be defined as those aspects of society, which are part of the common beliefs, customs and traditions of that social group. These common traditions and beliefs are learnt by members of a group over time. Culture can also be associated with many different levels of society, including racial, ethnic, and sub-cultural, or even within institutions or smaller groups. The process of identifying and describing these common beliefs, customs and traditions is central to the ethnographer's work. By discovering how a social group understands its world and the common meanings that the group shares, understanding of the group is more effectively achieved."
>
> (Laugharne 1995 p.47)

Thus, ethnography arose as a methodological approach from the science of anthropology and was used in investigating a broad range of human activity. Genzuk (2003) suggested that whilst ethnography was commonly associated with exploratory research, its flexibility also enabled it to draw from other qualitative and quantitative approaches. Ethnography was a versatile tool that could range in its use from evaluation of aspects of cultural learning through to the testing of propositions. Despite that versatility, when comparing different views and perspectives, consistency in the definition of ethnography as an investigative approach was evident (Leininger 1985, Hammersley and Atkinson 1995, Martens 1998):

> "The ethnographer documents, describes and analyses physical, cultural, social and environmental features as those factors influence people's patterns of living."
>
> (Leininger 1985 p.36)

> "The ethnographer participates, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions."
>
> (Hammersley and Atkinson 1995 p.2)

> "One strength of ethnography is its use of a wide range of sources of information (or data). For instance, observing, asking questions and examining documents all are accepted ways to gather information. Ethnography has been found to be especially useful in describing processes for which little is known and in developing theory."
>
> (Martens 1998 p.342)

Finally, Hammersley (1992) saw ethnography as functioning at different levels. At one level, it enabled insightful descriptions. At another level, it enabled application and testing of established social cultural theories. Ultimately, it enabled development of theory. Thus, as a research methodology, ethnography was the broad and flexible tool, which if tailored correctly, could achieve the research aims of this project.

4.2.4. The range of ethnographic methodology

Practitioner ethnography is the specific methodological approach used in this research project. It is a design feature that is significant to the project, it is evident throughout the data and findings, and it reflects the flexibility of the ethnographic approach. This sub-section reviews this methodological flexibility and discusses the relationship of practitioner ethnography with participant observation and reflexivity. Hammersley (1992) saw such comparisons as illuminating more than purely methodological issues:

> "Research must be judged not just in terms of its validity but also on the basis of its relevance to practical concerns."
>
> (Hammersley 1992 p.137)

It is from the concern of practicality that the practitioner ethnographer contrasts with the more traditional approach of the specialist researcher in conventional ethnography (Hammersley 1992). In simple terms, practitioner ethnography is a related and extended concept of participant observation. Thus, whilst specialist ethnographers inevitably interact with the sample and data, they are not practitioners in the field and have limited (or no) previous knowledge or experience of that reality. Specialist ethnographers are characterised by social scientists such as Hughes (1959) and Becker (1961). In contrast, practitioner ethnographers are members of the group being investigated; they are more than just participants, they live (and have lived) the experience that they seek to investigate. What is important for the practitioner ethnographer is the nature of the research, and the particular dynamic between the data, the self, and the relationship with practice. I will now detail the methodological and reflexive implication of the range of participant observation for both practitioner and specialist ethnography.

Firstly, participant observation is considered as a technique. Simply described, it is a feature of ethnography, an intimate process of data collection in which the researcher (the participant observer) has a number of potential options. Hammersley and Atkinson (1995) described participant observation as ranging from the complete observer (a researcher who has no personal contact with those studied) to the complete participant (a group member who also undertakes the

research). This suggested that the researcher should use one type of observatory process. However, acknowledgment of the dynamic nature of participant observation required a more refined perspective of the role of the fieldworker (the researcher). In this more responsive view, the type of participation arose from the methodological foundation, and from either the observer's role as a specialist researcher, or the observer's role as a participant in the setting under investigation.

Secondly, practitioner and specialist ethnography can be considered as methodological approaches. Hammersley (1992) saw the selection of practitioner or specialist ethnography as influenced to an extent by the assumption that all research should be relevant to all practitioners. He examined this issue of research relevance by contrasting the more traditional values of ethnography with newer emergent ones. The traditional specialist ethnographer, regardless of his or her degree of participation, was a specialist observer who integrated himself or herself into the lived world of the sample, and interpreted data from that perspective. Hammersley (1992) observed that this type of specialist participant observation yielded results that were indirect and general, and this laid it open to claims of irrelevance and a lack of practical application to problem solving. In contrast, the practitioner ethnographer was a member of the investigated phenomena, a practitioner in the field, a reactive part of the event with insider knowledge and an historical perspective. The research outcomes were more direct and specific and they would address practical problems. Ultimately, Hammersley (1992) argued that both were of equal value, addressing different aspects of a wide research agenda where outcome was essentially relevant when viewed in terms of its context. He observed that whilst there were clearly differences

between the two approaches, rigid distinctions were unhelpful as many who undertook such research activity would have dual roles (be at once practitioners and specialists). Thus, the use of practitioner ethnography or specialist ethnography rested not on so much on the characteristics of individual researchers but more in the context of the investigation.

In any ethnography, the reflexive relationship of the specialist ethnographer or practitioner ethnographer with the sample will raise questions about subjectivity and objectivity (chapter eleven, sub-section 11.3.2. p.409-413). Genzuk (2003) saw the ethnographer having to balance the lived insider perspective against that of participant observer role. Those contrasting positions reveal a marginality that not only enables the researcher to understand the experience, but also to describe the experience for others. For example, specialist research ethnographers are initially outsiders, are naive observers (Atkinson 1979), who will have to develop a relationship with the sample they are investigating. They have to move in from the outside, and the stranger to the sample must become a friend to the sample (Hammersley and Atkinson 1995). Thus, the specialist researcher is at risk of going native. However, the marginal position of the practitioner ethnographer is quite different. Influencing that position of marginality is an involvement with the data that is rich with a subjectivity of actions, interactions, emotions, culture, symbols and rituals (Morgan and Drury 2003).

The next issue to be considered is practitioner ethnography. I have already acknowledged (chapter one, section 1.1. p.3) that the data collection process in this project arose from my open involvement with the sample (student nurse

practitioners, physician mentors and teachers). I undertook that participant observation by keeping observatory field notes and using a planned schedule of audio-taped interviews over a two-year period (chapter one, Figure 1.1. p.21). However, it is important to understand that I was more than just peripherally involved with the nurse practitioner degree programme. I was a member of the teaching staff and an authority figure, intimately involved in the sample's educational experience, and I had extensive insider knowledge of that social order. My relationship with the sample was significant, and it marked the methodological design as one of practitioner ethnography. It is however important (from the methodological perspective) to understand that my practitioner ethnographer role arose from my involvement with the degree programme as an experienced educator, and that no confusion arises from any inference that I was a nurse practitioner. I was not a nurse practitioner, and nor were any other members of the teaching team. This particular issue is considered in the description of the nurse practitioner degree programme (chapter six, sub-section 6.2.6. p.141-142) and emerges again later in the discussion chapter (chapter ten, sub-section 10.3.1. p.367-374).

My marginal position as a practitioner ethnographer was marked both by chronology and by situation. Chronologically, and despite my previous experience with the nurse practitioner degree programme, I had few insights at the time of the data collection of the eventual structure that was to emerge. In that sense, I was a naive observer (Atkinson 1979). However, I was also a naive (novice) ethnographer, and the process of methodological design and data collection reflected that situation. The complexity of the eventual analysis and

findings represented an extended period of personal development that followed the completion of the data collection in July 1999. Thus, I was initially defined by practitioner ethnography as an experienced practitioner (member) of the sample, but equally I was defined as a naive observer and naive ethnographer. That position was not static and would change over time. This brings into focus the crucial feature of reflexivity in this research:

> "A reflexive researcher is aware of the ways in which self affects both research processes and outcomes, and rigorously convey(s) to readers of research accounts how this happens. Thus the researcher's self is brought to the foreground of reader's attention."
>
> (Manias and Street 2001 p.239)

Reflexive researchers are aware of the connection between their intimate understanding of the research aim and their relationship with the research sample, and they consider how this may affect the outcome. Reflexive researchers acknowledge their own cultural values whilst examining and evaluating the cultural values of others. Indeed Hammersley and Atkinson (1995) viewed multiple cultural challenges to the researcher as an enabling process in the understanding of the culture of the group examined. Laugharne (1995) indicated that researchers' self-awareness of their own belief system, and how that may differ from that of those being studied, would enable a richer analysis and discourse.

However, there are other interpretations, albeit somewhat subtle variants, that can be used to explain reflexivity (Pellat 2003). This is perhaps indicative of the nature of reflexivity as a responsive concept that acknowledges the interpretation of cultural and social context and the articulation of a lived experience (Coffey

1999). It is this articulation (a process of story telling), that is fundamental to reflexivity in the research process. In the ethnographic account, the researcher seeks to tell the story in such a way that the experience of the individual, or the social group, becomes a living and credible entity that serves to further our understanding of that social cultural construct. Hand (2003) emphasised how this story-telling approach made the reflexive ethnographer visible and interactive in the research data:

> "The positivist emphasis on objectivity has meant that researchers have often tended to write themselves out of the text in the belief that to do otherwise would somehow contaminate the data. Qualitative approaches, however, acknowledge that the researcher and research cannot be meaningfully separated, and that neutrality is impossible. Researchers both influence and are influenced by, the process of engaging in research."
>
> (Hand 2003 p.18)

In this project, the use of practitioner ethnography was reflected in my role as a member of the nurse practitioner degree programme's teaching team. That placed me in a position that opened the way for a particular kind of reflexivity. As the data were collected, it was undeniable that I was at once an influence on the sample, and equally that the sample influenced me. The politics of the university department, staff relationships, wider political agendas, were all issues that influenced the data collection and its interpretation. Thus, I was not isolated from the world in which I lived. I had to develop means to engage in a reflexive process that facilitated interpersonal interactions with the sample that influenced the reality, and explanation, of my world and the data that I collected. That process of reflexivity was particularly evident to me at the outset of the research, and that required the development of relationships and understandings with the individuals (the sample) identified within the project. I had also to undergo a

personal process in which I developed a research persona that was separated from my educational role. The entire sample were aware from the outset that the project was taking place and that I was not only collecting data but also continuing in my role as a team teacher. However, that self-conscious relationship quickly resolved into a mutual understanding with the sample, which was revealed in the following data extracts:

> *"I joined the students in the coffee room. They were generally cheerful, but there was an underlying tenseness following recent exams. They question me on my research and I saw no value in being secretive. They asked 'had they changed,' and I said I thought they had. They were surprised by this and asked in what way. I said I thought they were more knowledgeable and confident. This led to some derisory comments."*
>
> *Field Note Entry - February 1998*

> *"It is equally interesting to note how readily they chat about all sorts of things whilst I am there, apparently knowing that although I am part of the teaching team, when I have my 'little book' I am a different person and can be ignored."*
>
> *Field Note Entry - September 1998*

> *"They* (the students) *are not concerned that I am there at all apparently, and I act as a model (manikin) for clinical demonstrations and examinations. There is much hilarity at my expense!"*
>
> *Field Note Entry - August 1997*

Nevertheless, these data extracts do not do fully illuminate all the aspects of the reality of my involvement with the nurse practitioner degree programme. Interpersonal, management and educational issues arose with the teacher team, and despite my role as a researcher, my membership of that team inevitably resulted in particular involvement with such issues. These events will become more transparent during the detailed analysis in the main data chapters (chapter

seven, eight, and nine). However, I highlight the issue here with a data extract that was recorded early in the observational notes following correspondence with an occasional teacher team member:

> *"I was actually very upset by this episode, coming as it did after a fairly long hard stretch through marking and exam boards. Everything seemed to be going OK. The letter I received from a colleague was unexpected and I am afraid only furthered my anxiety. I also felt very personally upset, which I reflected in my reply."*
>
> *Field Note Entry - August 1997*

The recording of such events was important. It revealed that I was interacting in all aspects of the day-to-day life of the nurse practitioner degree programme, interacting with its management and delivery, and interacting with the sample's experiences.

Having reviewed certain issues concerning ethnography and its reflexive component, I will now discuss in the next sub-section the nature of ethnographic data.

4.2.5. Ethnographic data

Laugharne (1995) saw the researcher as the primary tool in ethnographic data collection. Ethnographers involve themselves in the natural environment investigated, in the lived world of the sample, and in ways that enable data collection from a range of possible sources. The data sources may be accessed using techniques commonly used, such as field notes observation, interviewing, videos, and audio-tapes. Less commonly used data retrieval techniques include

archive reviewing, gathering of life histories, case studies and the examination of artifacts (Martens 1998).

As ethnographers immerse themselves into the respondents' world, they aim to objectively explore data, and yet simultaneously acknowledge their intimate involvement with the data. Ideas and theories arise from participation and observation, and investigation of ethnographic data may be "both empirical and inductive in nature" (Laugharne 1995 p.46). Ethnographic data enables interpretation of the cultural system from which it was derived, giving meaning to the lived reality of the individuals within that culture. Anderson (1996 p.66) saw this as an "exchange of symbolic connotations and patterns of interpersonal interactions", and described ethnographic data as rooted in method and revealing in description. The place of the researcher(s) in this process is thus central.

Whatever sources of data are explored, the researcher remains the primary data collection instrument in an ethnography (Baillie 1995, Choudhry 1998). Jokinen (2002 p.167) saw the ethnographer as having to develop and nurture a relationship with the sample and "become a part of the sub-culture being studied". Leininger (1987) furthered this, seeing the relationship between the specialist or practitioner ethnographer and the sample as typified by a stranger (non-member) to friend (member) continuum. Thus, an ethnographer's developing relationship with the world of the informants will enable acquisition of emic ethnographic data. Pike and Harris (1990) saw the emic perspective as an intrinsic cultural distinction that was meaningful to the natural world and members of a given society. It follows that the members of any culture (including the ethnographer), are those most able

to judge the validity of an emic ethnographic description. This contrasts with the etic perspective that Pike and Harris (1990) described as reliant on extrinsic concepts and categories that have meaning for scientific observers. The scientists are thus the sole judges of the validity of an etic account. Having outlined the nature of ethnographic data, I now turn to the project's chosen data collection tools in more detail.

4.2.6. Specific data collection methods in this research

In this sub-section, I consider in more depth the data collection tools used in this research. Whilst the course of any ethnography cannot be predetermined, this does not mean that researcher activity is unstructured (Baillie 1995). Equally, a demand for structured research methodology must not be confused with structured or unstructured data collection tools.

Pretzlik (1994) indicated that qualitative data collection tools could be structured or unstructured. They may be deductive and predictive, based on known theories, or alternatively they may be inductive, interpretive and theory generating. Thus, the ethnographer must carefully examine the most appropriate and responsive data collection tools. For example, the use of quantitative data collection tools (e.g. highly structured interview questioning or structured questionnaires), would be an unsuitable technique in illuminating social and cultural human activity (Burden 1998). More relevant would be the range of observational techniques. Participant and non-participant observation enables ethnographers to collect either unstructured or structured data that subsequently they can order in a systemised and logical way. Observational data collection techniques are thus in one sense

immediate and responsive as they record human activity as it occurs, but they are also methodical and reflective as data analysis may occur at a later time. Participant and non-participant data collection techniques are commonly used ethnographic tools, but a range of other data collection tools may also accompany them. For example, subjects may be interviewed singularly, they may be interviewed in groups, or subjects can be specifically targeted to gain insights into their lives (Berkwits and Inui 1998). Using a range of data collection tools will lead to a variety of different data sets from the same sample group, and this enables analytical contrast and comparison. For the purposes of this study, I have used two traditional data collection tools: participant observation and semi-structured interviews. These tools gave rise to data sets that, when analysed (chapter five, section 5.3. p.111-115 / chapter five, section 5.4. p.115-127) led to the induction of provisional conceptual frameworks (sub-themes and themes). Figure 4.1. (p.90) outlines the path of that inductive process.

<table>
<tr><th>Initial Data Collections</th><th>Primary Analysis</th><th>Initial Induction</th><th>Later Analysis</th><th>Second Induction</th></tr>
<tr><td colspan="5">→ →
The Direction of Data Collection and Analysis</td></tr>
<tr><td>June 1997 – July 1999
Field Notes
(data set)</td><td>1999-2000
Latent Content Analysis</td><td>2000
Induction of the Sub-theme from the analysis of the Field Notes</td><td rowspan="3">2002
Comparative Analysis of Sub-themes</td><td rowspan="3">2002
Induction of five Transition Themes</td></tr>
<tr><td>September 1997 – January 1998
1st Interviews
(data set)</td><td>1999-2000
Latent Content Analysis</td><td rowspan="2">2000-2001
Induction of the Sub-theme from the analysis of the Interviews</td></tr>
<tr><td>January 1999 – July 1999
2nd Interviews
(data set)</td><td>2001
Manifest Content Analysis</td></tr>
</table>

Figure 4.1. The induction of themes and sub-themes

In the following sub-sections, I describe these data collection tools, their testing and development. Later, in the analysis chapter (chapter five) I further this with a detailed review of the data sets, their collation, ordering and conceptual mapping.

4.2.6.1. Field notes

The field notes provided an uninterrupted chronological record that facilitated triangulation and comparison with the two data sets from the interviews (Figure 4.1. p.90). From June 1997 to July 1999, I regularly attended lessons, discussion groups, and meetings with the sample. At all of these I made handwritten notes, observing the participants involved, noting conversations or issues that arose, and recording my personal impression and reflection. In addition I made similar records of serendipitous events and chance meetings. All of these notes were later transcribed and coded. Consequently, field notes varied in length and detail. At the completion of the data collection (July 1999), the field notes were collated according to their place in the chronology and this is discussed in the analysis chapter (chapter five, section 5.3. p.111-115). The field notes are not reproduced in full in this thesis and are only drawn on selectively, but an example entry is presented in Appendix A. Figure 4.1. (p.90) outlines how the field notes data set gave rise to a sub-theme that was then further refined with the sub-theme that arose from the analysis of the interviews. This led to the induction of the five broad transition themes (chapter five, section 5.5. p.127-130).

4.2.6.2. Semi structured interviews

The interview is an important and flexible data collection tool in ethnography. Interviews can take place formally, informally, or even spontaneously. Barriball and While (1994) observed that the format of interviews could vary, ranging from structured to unstructured, and also noted the value of data collected by interview when it was triangulated with data from the researcher's fieldwork. This tailoring of data collection tools toward a common research theme enables the generation of comparable and contrasting data sets.

In this project, all the respondents (students, teachers and physician mentors) were interviewed during the beginning months of the nurse practitioner degree programme (September 1997 to January 1998) and then again in the final months of the nurse practitioner degree programme (January 1999 to July 1999) (chapter one, Figure 1.1. p.21 / chapter four, Figure 4.1. p.90). This facilitated longitudinal assessment of experience. Thus, there were two sets of interviews (the first interviews and the second interviews). During the second set of interviews, senior academic staff were recruited to the sample (chapter one, sub-section 1.4.2. p.22-23 / chapter four, sub-section 4.3.4. p.104).

On average, each interview took twenty to thirty minutes to complete, and all the interviews were recorded on audiotape for later transcription. The interviews were semi-structured, and in both sets of interviews, I used an identical set of questions to prompt responses. Nine questions were used (Appendix B). The first three questions prompted the interviewee's opinion and definition of nursing,

medicine, and nurse practitioners. Questions four to seven prompted the interviewee's opinion on professional roles and inter-professional relationships. Question eight explored the interviewee's personal experiences of the nurse practitioner degree programme, and question nine explored any general views or opinions. Although the nine interview questions provided direction, the semi-structured approach allowed respondents to discuss any issues that arose during the interview. Thus, this simple interview schedule was designed around four general topic areas:

1) Concepts of the healthcare professions (nursing and medicine)
2) Opinions on role(s) and relationships
3) Personal experiences and opinions
4) The prospective (long term) view

The interview schedule was initially tested with two members of academic staff who were not involved with the nurse practitioner degree programme, but were aware of the development and education of nurse practitioners. The schedule was found to be acceptable, and within the qualitative ethnographic context of this research, the semi-structured interview schedule allowed for the collection of valid data. Reliability was a less certain issue as the nature of the data collection arose in a dynamic and changing social milieu (chapter eleven, sub-section 11.3.2. p.409-413).

Following detailed analysis of the data sets from the interviews, a sub-thematic framework emerged. That framework was then compared and contrasted with the sub-theme that arose from the field notes, and this led to the induction of five transition themes. This process is outlined in Figure 4.1. (p.90) and is further

described in the analysis chapter (chapter five, sub-section 5.4.5. p.125-127 / chapter five, sub-section 5.5. p.127-130).

This completes the description of the data collection tools used. In the next sub-section, I describe the methods of data analysis used with the data set from the field notes and the data sets from the interviews.

4.2.7. Techniques of data analysis

Methods of data analysis are considered in detail in chapter five, but are outlined in this sub-section as this is important in describing the sequential and logical planning that was undertaking in designing the research project.

The analysis of qualitative data is an intricate process:

> "Reviewing, synthesizing and interpreting data to describe and explain the phenomena or social worlds being studied."
>
> (Fossey et al 2002 p.724)

Tesch (1990) furthered this, seeing qualitative data analysis as grouped by content, discovery and meaning. Consequently, as with all other aspects of the methodological and method design, it was the appropriateness, choice and rigour of the chosen analytical technique(s) that was important. In this project, it would be the analysis of the data for content that would give meaning to the cultural experience of the sample. The analysis sought for common or reoccurring issues within the data set from the field notes, and within the data sets from the interviews. This analysis was a prolonged process of transcribing, comparing, categorising and grouping text, and that ultimately led to the induction of sub-

themes and themes (chapter four, Figure 4.1. p.90). The need to reduce data to manageable units, to reveal outcomes and results, or to develop theory, was thus crucial.

Content analysis was the tool of analysis used in this project. Content analysis was responsive to the context of the data and was flexible in its application to the analysis of qualitative data that arose from field notes or interview transcriptions. Cavanagh (1997) observed that there were no universal rules in the use of content analysis. Nevertheless, content analysis, in a most basic sense, was an analytical tool that arose from a methodological process. The type of content analysis used arose in response to the inductive or deductive nature of the methodology. Babbie (1995) described two fundamental types of content analysis: manifest content analysis and latent content analysis. Both were similar and yet distinct, and this was an important issue in the analysis of data in this research.

Manifest content analysis is a process of reviewing textual material for, "words, phrases, descriptors, and terms central to the phenomenon under study" (Field and Morse 1985 p.103). Identification of a conceptual framework is necessary for manifest analysis to be used, and that framework should have been systematically investigated before the data collection to facilitate its application in the analysis of the data. By using this framework, textual data can be grouped into units of meaning, into categories, into sub-thematic groups and eventually into themes. Holsti (1969) outlined the characteristics of manifest content analysis. These characteristics included explicitly formulated rules and procedures, systematic category construction, and exclusion or inclusion based on consistently applied

rules and generalisations to theoretical models. Thus, manifest content analysis is a highly structured process. It has objectivity and therefore has procedural reliability.

Alternatively, latent content analysis is a process of interpretation of meaning within textual material (Woods and Catanzaro 1988). Thus, latent content analysis of qualitative data is an inductive process that leads to coding and categorising of events as they arise, with subsequent comparison with other coded text. Thus, the themes and theory derived arise from the analysis, not from previous frameworks or concepts imposed on the data. The nature of latent content analysis facilitates a flexible approach in the development of research findings. It requires immersion in the data by the researcher so that emerging themes and theories can be refined. Latent content analysis is therefore a systematic process used to analyse unstructured and diverse data. It has a measured credibility because of the dynamic response to any underlying meanings in the data. However, latent content analysis can be viewed as lacking some degree of reliability because of the subjective nature of the coding systems developed.

Within this project, latent and manifest content analysis were both selectively used in the analysis. Latent content analysis was used to analyse the data set from the field notes (chapter five, section 5.3. p.111-115), and to analyse the first data set from the interviews (chapter five, sub-section 5.4.3. p.118-123). The field notes were catalogued into a diary that spanned the period from June 1997 to July 1999. That diary was then examined using latent content analysis, and this led to

the induction of a sub-theme. With the data set from the first interviews, the latent content analysis was staged. Initially a simple word search exercise was undertaken, this followed by a detailed thematic content analysis. The sub-thematic structure that arose from this analysis of the first interviews was then used in the analysis of the second interviews (chapter five, sub-section 5.4.4. p.123-125), this characteristic of manifest content analysis.

By comparing and contrasting both the sub-themes derived from the field notes and the interviews, a thematic structure of five social transitions emerged (Figure 4.1. p.90). In the next stage of analysis these five social transitions where structured in the light of the known social theory of a rite of passage (Van Gennep 1960). This lengthy comparative analysis finally led to the emergence of four processes. The unfolding of the data analysis is detailed throughout chapter five.

4.2.8. The validity or trustworthiness of ethnographic data

Having outlined the analytical tools in the previous sub-section, I now consider the validity of ethnographic data. Maggs-Rapport (2001) saw issues of validity as simply grounded in the premise of credibility. If the consumer of the research saw nothing credible in its findings, then its validity was in question. It was therefore important that the researcher established that credibility. Three activities are used in establishing credibility (Lincoln and Guba 1985): prolonged engagement, persistent observation, and triangulation. Prolonged engagement facilitated the process of relationship building between the researcher and the informants and it enabled an evolution of a shared perception that would not be possible by brief contact alone. It followed that persistent observation was also an

integral part of the first process. It was not sufficient for the researcher to have a prolonged data collection that required only superficial contact with the sample. Persistent observation enabled the immersion of the researcher into the world of the respondents. For the practitioner ethnographer in this research, prolonged and persistent engagement was an inherent part of the relationship with the sample.

The process of triangulation (the use of multiple measures and data sources) was the third and most complex of these validity activities, and was a fundamental issue at the research design stage. Triangulating data collection to give foundation to validity was viewed positively in the literature (Woods and Catanzaro 1988, LoBiondo-Wood and Harber 1990, Hammersley 1992, Denzin and Lincoln 1994, Silverman 1994, Fetterman 1998). That positive view saw triangulation as a methods process that supported both the valid interpretation of the data as it arose, and the valid interpretation of data in later comparative analysis. In a more critical light, Silverman (1994) viewed triangulation as a cumbersome process that could disrupt the developing perceptions of the researcher as they tried to move between the different contexts of diverse data collection methods. As data arose in the context of a lived reality, Silverman (1994) considered any attempt to validate that from a different context or viewpoint as potentially flawed. In this view, each data package was a discrete entity in its own right. However, Baillie (1995) opposed this perspective, seeing multi-method triangulation as a process rooted in the holistic philosophy of ethnography, and as providing a valid and broad perspective that enhanced credibility of findings. From this perspective, practitioner ethnographers are advantaged by their intimate insights of the lived reality that allow them to move

with relative ease between different data collection methods and make more contextual judgments on different data perspectives. Finally, validity may be judged by the involvement of other insiders and outsiders (Maggs-Rapport 2000) who will be party to the ultimate interpretation of the data (chapter eleven, sub-section 11.3.2.2. p.412-413).

This study has used two data collection tools applied over a long timescale (Figure 1.1. p.21 and Figure 4.1. p.90). Data were collected from several groups of individuals who comprised the overall sample, all of whom had a common experience in their involvement with nurse practitioner education. The resulting data sets were used in the induction of sub-themes. Details of that process are found throughout the analysis chapter (chapter five).

This sub-section has outlined the principles of validity that are important to the data collected in this study. In the following and final sub-section of the methodology and design description, I review the fundamental issues of access and ethics that related to the data collection and its analysis.

4.2.9. Negotiating access and the research ethic

Collection of qualitative ethnographic data requires that the researcher have access to the field. Hodgson (2002) saw this as one of the most challenging stages of a social and cultural research project. Issues to consider when designing a project that required fieldwork were ethical, organisational and methodological. I considered each issue carefully in this project design.

Ethical Considerations

- Before data collection commenced, detailed planning enabled departmental and professional ethical approval to be achieved (Appendix C).
- From the outset of the research in June 1997, an agreed principle was that the study would be fundamentally overt, and the activity of the researcher would be explicit.
- The prospective sample was comprised of the nurse practitioner students, the teachers, the physician mentors, and the senior academics (Fig. 1.2. p.23). I personally saw each individual to request his or her inclusion into the study sample.
- The recruitment of the sample began in June 1997 and included the nurse practitioner students, the members of the teacher team, and the physician mentors. However, it is important to note that the inclusion of the senior academics and new physician mentors occurred in 1999 (chapter four, sub-section 4.3.2. p.103 / chapter four, sub-section 4.3.4. p.104).
- Regardless of the time of recruitment to the sample, each individual received written and verbal information on the research project prior to his or her inclusion into the sample (Appendix D).
- The timescale, research aims, and data collection methods were fully explained to each potential sample recruit. Anonymity was assured (Appendix D).
- All participation was voluntary, and individuals were clearly informed of their right to refuse their inclusion to the study sample (Appendix D), and of their right to opt out of the study at any time. Hodgeson (2002) described this as unwieldy but consistent with moral imperatives.

- Written consent for inclusion to the sample was required from each individual respondent, and this was recorded and filed.
- No individual refused inclusion into the study. Equally, no recruited member of the sample requested withdrawal from the study, although the sample population varied because of one student leaving the degree programme, students changing their physician mentors, and the later inclusion of the senior academics.

Organisational Considerations

- The academic role of the researcher as a teaching team member enabled ready access to the students during their normal daily schedule in college. This access was subject to the ethical requirements outlined above.
- Interviews with students were at a time convenient to them, and that did not interfere with teaching time.
- Interviews with academics and physician mentors were arranged in their place of work and at their convenience.

Methodological Considerations

- My specific occupational role as the researcher of this project had influence on the sample's relationship with me. That dynamic (as a practitioner ethnographer) was one of reflexivity and consideration of this was a fundamental design issue (chapter four, sub-section 4.2.4. p.79-87).

This completes this section on the methodology and design issues. In the next section, I discuss the profile of the research sample.

4.3. THE RESEARCH SAMPLE PROFILE

A cohort of students, their clinical physician mentors, and the teaching staff, initially comprised the sample that was studied. These individuals were interviewed and observed over a two-year period (1997-1999). Toward the end of the study, senior academic staff were also included in the interview sample. The sample members were selected purposefully as a direct result of the research design and due to their involvement in the nurse practitioner degree programme. Each group within the sample is described in the following sub-sections.

4.3.1. The students

The ten students who commenced the nurse practitioner degree programme in September 1997 were purposefully recruited to the sample. They all expected to undertake the programme on a two-year part time-basis. There were nine females and one male in the student sample with an age range from the late 20s to early 40s. All were qualified experienced nurses who fulfilled the admission criteria to the nurse practitioner degree programme (chapter six, Fig. 6.1. p.140). Eight students had level one and level two credit points and two students were already qualified nurse graduates. Four students were employed in primary healthcare settings whilst the other six were employed in secondary healthcare settings. Ten student interviews were undertaken during the first set of interviews. One student withdrew from the degree programme in December 1997; the remaining nine completed their studies in July 1999, although only eight students were interviewed at the second set of interviews, as one student was unable to agree a convenient interview time. All the students agreed to the ongoing observational

presence of the researcher (myself) throughout their studies on the nurse practitioner degree programme.

4.3.2. The physician mentors

Recruitment of physician mentors to the study was purposeful. I personally contacted each physician mentor and all agreed to be interviewed. However, due to the difficulties that many of the physician mentors had in finding available time it was not possible to interview them all.

During the first set of interviews, only five physician mentors were available. Of these five physician mentors, three were physicians from primary healthcare settings and two were physicians from secondary healthcare settings. Equally, at the second set of interviews, only four physician mentors were available, two physicians were from primary healthcare settings and two physicians were from secondary healthcare settings. Of these four physician mentors at the second set of interviews, two had taken part in the first set of interviews and two had not previously been interviewed as they had taken up mentor roles later in the nurse practitioner degree programme. All physician mentors interviewed at both the first and second sets of interviews were male, and their ages ranged from the mid 40s to mid 50s.

4.3.3. The teacher team

The teacher team was a small group purposefully selected; three individuals were approached and were available at both first and second sets of interviews. The three teachers were also observed in teaching interactions with the students. Two

of these teachers were nurse lecturers, one with a particular interest in community and child studies, the other with a particular interest in interpersonal skills teaching and counselling. The third teacher was a practicing medical general practitioner, with a particular role in teaching physical assessment skills. All teacher team members interviewed were female aged in their mid 40s.

4.3.4. The senior academics

Following the first set of interviews, and the subsequent analysis of these data, I decided to interview senior academic staff who had been influential in the nurse practitioner degree programme development (chapter five, sub-section 5.4.1. p.116). These individuals were purposefully selected to participate in the second set of interviews. Three senior academic staff were identified and interviewed. All were female and aged in their 50s.

This concludes the chapter in which I have described and discussed the methodological and design issues. In the following chapter, I review the detail of the data analysis, its development and evolution. I also describe how that analysis led to the presentation of the findings in later chapters.

CHAPTER FIVE

THE ANALYSIS OF THE DATA

5.1. INTRODUCTION TO THE ANALYSIS OF THE DATA

This chapter reviews in detail the data collection and process of analysis that evolved from the research design (chapter one, Figure 1.1. p.21). Firstly, I consider the concept development that took place in the early part of the data analysis. Secondly, I consider the general analytical processes that where used with the data set from the field notes and the two sets of data from the interviews. This will demonstrate how the analysis led to the induction of two sub-thematic frameworks. I explain how these sub-themes led to the induction of five transition themes: social transitions, professional transitions, clinical authority transitions, clinical knowledge transitions, and clinical skills transitions. Although these five transition themes structured the data, they were unwieldy and difficult to present. Van Gennep's (1960) rite of passage provided a model that enabled a coherent presentation. Thus, finally, I explain how the introduction of the rite of passage model gave structure to the findings that unfold in the chapters which present the main data (chapters seven, eight and nine), and how that led to the four broad thematic processes presented in the discussion chapter (chapter ten, section 10.3. p.366-367).

Important features of the analysis were the systematic data collection, concept development, mapping and coding of data, sub-theme induction, and theme induction. The process of data collection and data analysis was prolonged, and that timescale is

outlined below in Figure 5.1. (p.106).

The Field Notes **Collection and analysis** **1997 - 2000**	**The First Set of Interviews** **Collection and analysis** **1997 - 2000**	**The Second Set of Interviews** **Collection and analysis** **1999 - 2001**
Field Notes Data Collection June 1997 – July 1999 Field Notes Analysis September 1999 – April 2000	First Interviews September 1997 – January 1998 First Interviews transcribed February 1998 – January 1999 First Interviews Latent Content Analysis February 1999 – January 2000	Second Interviews January 1999 – July 1999 Second Interviews transcribed February 2000 – January 2001 Second Interviews Manifest Content Analysis February 2001 – December 2001
Ongoing analysis - 2002 The data sets from the interviews are compared and contrasted The sub-theme derived from the field notes is compared and contrasted with the sub-theme derived from the interviews Five transition themes are inducted from the sub-themes from the interviews and field notes **Ongoing analysis - 2003** Applying the rite of passage as a final analytical structure Induction of four thematic processes		

Figure 5.1. The data analysis timescale

5.2. THE DATA ANALYSIS - CONCEPT DEVELOPMENT

In this section, I describe how concepts emerged from a provisional and simple process of data analysis, and how those concepts were later refined. Those concepts were concerned with the professional identities of nursing and medicine, and the emerging professional identity of nurse practitioners.

This concept development began at the very beginning of the research with the two observations that I discussed earlier in the introductory chapter (chapter one, section 1.2. p.12-14):

a. Why did some physicians appear to view nurse practitioners negatively, whilst others viewed them positively?
b. Why did nurses also appear divided on the development of nurse practitioners?

These observations appeared to pivot on a lack of agreed occupational and professional definitions of nurse practitioner activity that would be acceptable to all. That thinking pointed me to the study of the professions of nursing and medicine. It seemed that clarification of the activity of the nurse practitioner should be preceded by clarification of the activity of nursing and medicine. For example, I was anecdotally aware that there were many traditional perceptions of nursing and medical professional activity. That impression would later be substantiated by the analysis and its findings, and this is typified in the following data extract:

> *"I think I am old fashioned, well I am old fashioned. When I first started, coming from a medical background - well doctoring was doctoring and nursing was nursing. Nursing, that was the care of the patient. From the medical side of things we* (the doctors) *would come and direct treatment."*
>
> *Physician Mentor - A2 Data Segment - 1st Interview Data*

Thus, in 1997 I reviewed the most imponderable issues of the nature of nursing and medicine, and began to reflect on how nurse practitioners compared with these traditional professions. Recent professional guidance on the development of advanced nursing roles (International Council of Nurses 2002) was not available in

the UK in 1997. Then there was confusion and uncertainty over nurse practitioners and their relative status within both medicine and nursing (Fulbrook 1995, Brown 1995, Peysner 1996, Dimmond 1998). This was revealed by data that arose from this research:

> *"I think the first and most important thing to get done is to make sure everybody knows what these things are* (nurse practitioners)."
>
> *Physician Mentor - G2 Data Segment - 2nd Interview Data*

> *"Well to begin with, you have got to sort out the title* (nurse practitioner). *It has got to be a protected title. If that doesn't happen there is going to be so much confusion in the profession about what it is. So that's an anxiety I have really, that people understand and appreciate what the title means."*
>
> *Student Nurse Practitioner - G1 Data Segment - 2nd Interview Data*

> *"When it's taken on board country wide, nation-wide, these entities of qualified nurse practitioners that are coming out, then people will understand more what they are? That's the big problem we have at the moment, actually understanding what they are."*
>
> *Physician Mentor - G1 Data Segment - 2nd Interview Data*

These data extracts typified the uncertainties that abounded at that time, and they explain why I had focused at project's commencement on a central question. What were nurse practitioners? Could they be defined, or would that be an impossible task in the light of the unresolved debate on the nature of nursing and medicine that preceded it? To that end, I commenced my analysis by subjecting the data set from the first interviews to a basic and provisional concept analysis. That analysis sought to ascertain the sample members' perception of the traditional clinical and professional roles of nursing and medicine, and their perception of nurse

practitioners. The specifics of that early analysis I review later in this chapter when describing the overall analysis of the data set from the first interviews (chapter five, sub-section 5.4.3.1. p.118-120). However, as a concept development exercise, that first analysis revealed that the respondents (students, teachers and clinicians) described nursing in terms of caring, described medicine in terms of diagnostic skills, and described nurse practitioners as a blend, or hybrid, that drew from both medical and nursing characteristics.

This initial analysis served its purpose in concept development. It made a provisional distinction between the sample's perception of the clinical role of the nurse practitioner and the traditional clinical roles of nurses and doctors. I then progressed to a more detailed and prolonged analysis of the transcripts of the first interviews, and that process is detailed later in this chapter (chapter five, sub-section 5.4.3.2. p.120-123 / chapter five, sub-section 5.4.4. p.123-125). This more detailed analysis revealed data that supported the initial concept development findings on the sample's perceptions of nurses, doctors and nurse practitioners. The sample's views were traditional, and this was revealed in the following data extracts:

> *"I always thought of nursing as caring for people and helping to alleviate their problems."*
>
> *Student Nurse Practitioner - A1 Data Segment - 1st Interview Data*

> *"A doctor's main objective is to assess somebody and make a diagnosis and prescribe treatment."*
>
> *Student Nurse Practitioner - A2 Data Segment - 1st Interview Data*

As the analysis of the data sets from the interviews progressed, it became apparent that those traditional perceptions of nurses and doctors changed little during the two-years of the nurse practitioner degree programme (1997-1999). The analysis also confirmed the general perception of the nurse practitioner role as one that combined aspects of medicine and nursing, and that view was apparent in the following data extract:

> *"A nurse practitioner operates in that particular grey area between nursing and medicine. I think nurse practitioners are taking on some of the competencies and tools that had been the preserve of medicine and they are using them within their practice of nursing. So ideally it becomes a synthesis of the two."*
>
> *Nurse Teacher - A3 Data Segment - 1st Interview Data*

This general view of nurse practitioners was contrasted by some variations between the groups within the sample (students, teachers and physician mentors). For example, the students and nurse teachers viewed the nurse practitioner role from a nursing perspective, and that view was evident in the following data extract:

> *"I see a nurse practitioner role as being based and rooted in the nursing role, but as extending and creating something new from that. They are much more self-directed."*
>
> *Nurse Teacher - A3 Data Segment - 1st Interview Data*

In contrast the physicians viewed nurse practitioners from a medical perspective and saw them acquiring and using very specific clinical skills that provided for, and were directed by, physicians. This physician view was evident in the following data extract:

"We see a nurse practitioner as someone who will be seeing emergencies, a role with some form of triage and supervising certain clinics. We would hope to use her as a morning and evening support for the surgeries."

Physician Mentor - A3 Segment - 2nd Interview Data

In summary of the concept development exercise, this first analysis underpinned important features of the prolonged data analysis that followed. Those provisional concepts are outlined below:

- The sample had clear views of medical and nursing roles from the outset of the research project
- Those views were traditional - a care and cure perspective
- The nurse practitioner role was viewed as a synthesis, or hybrid, of the traditional medical and nursing roles
- The nurse practitioner role was interpreted by different groups in terms of their own professional background

Having identified these provisional perspectives, I now move on to consider firstly the more detailed analysis of the data set from the field notes, and secondly the detailed analysis of the data sets from the interviews.

5.3. THE ANALYSIS OF THE FIELD NOTES

One of the data collection methods in this project was the explicit observation of the sample by myself as a practitioner ethnographer using field notes as a data-recording tool. A total of fifty-five individual field notes records were made between June 1997 and July 1999. I achieved this by reviewing the students' timetable weekly and attending taught sessions on a regular basis. During the course of any observed session, I would join in discussion and interact with the group. I made handwritten

notes that I transcribed, dated, and coded immediately afterwards. In addition, I also made records of teacher team meetings, academic and clinical meetings, meetings with national network fora, and any other serendipitous events when they occurred.

Following the end of the students' studies with nurse practitioner degree programme in July 1999, the field notes were catalogued. This was facilitated by mapping out the entirety of the field notes chronologically. The field notes are not reproduced in full in this thesis, as that would have been prohibitive and unwieldy. They are used selectively in the text as is appropriate and illustrative to issues that arose. However, an example of a singular field note entry is provided in Appendix A.

Initially, the field notes presented a simple diary that focused on the sample's experiences from my first contact with them in June 1997 and the degree programme completion in July 1999. However, between September 1999 and April 2000 this diary was subjected to a detailed latent content analysis. Commonly arising issues and concerns were identified, and I benchmarked these as emerging data groups. The chronological map that emerged from this analysis enabled a clear view of events over the two years of data collection.

5.3.1. The resume of the field notes - a timescale of stages and issues

Figure 5.2. (p.113) on the following page gives an overview of the important points in the chronology as they arose from the analysis of the data from the field notes:

Date	Issues – Concerns
June 1997	The teacher team – first meetings First student contacts
July - August 1997	Early professional networking The teacher team - tensions and the researcher The researcher and reflexivity
September 1997	The teacher team - teaching strategies The first morning The first mentors meeting
October 1997	A clinical skills map
November 1997	A developing group dynamic The teacher team - further tensions
January 1998	Second term – settling in The first stage report Late January – anxieties
February 1998	Early identity issues The teacher team - master class
March 1998	Clinical skill and clinical confidence
April 1998	The second stage report The second mentors meeting
May 1998	End of year one student evaluation First year OSCE examination
June 1998	The third mentors meeting
September 1998	Starting the second year Student reflections Summary at the halfway point Consultant nurses Returning to study
October 1998	The other research The third mentors meeting
November 1998	The teacher team - continuing tensions Reflexivity revisited Many teaching sessions Research awareness
December 1998	Emerging - the seeds of a new identity Physician teachers and advanced nursing students
January 1999	Anxieties and group dynamics
February 1999	On the boundaries - new professionals - old benchmarks
March 1999	The teacher team - further tensions Refining the new roles The Mock OSCE - clinical examinations
April 1999	The final countdown
May 1999	The Final OSCE Awareness The OSCE itself The OSCE Viva - A power struggle The Failure
June 1999	The Final Evaluation
July 1999	Wider events

Figure 5.2. The field notes time map

The inductive latent analysis of the data from the field notes (chapter four, sub-section 4.2.7. p.94-97) revealed three significant data groups or categories, and these I identified as the teacher team, the student group, and myself (the researcher). Each group revealed particular features of commonalty within the data. This framework was an important provisional sub-theme structure arising from the analysis of the field notes, and it is outlined below in Figure 5.3. (p.114).

The Teacher Team
Interpersonal tensions Protecting the image and power of the team Innovations, ideas and influences Internal recognition and wider networking Physician teachers / nurse practitioner teachers / nurse academics Defining the standards
The Student Group
Professional identity The use of titles Traditional images and uniforms New vocabularies Finding and knowing the professional boundaries The journey through medicine Nursing exploiting medicine and / or visa versa The employers agenda The primary / secondary healthcare divide The emerging role Learning fundamental adult learning skills Learning a new language Learning to link new clinical skills and theoretical knowledge The crucial role of, and relationship with, clinical mentors Establishing and benchmarking new levels of clinical skill Novice to expert - unexpected variables The need to pass the programme Group dynamics Discovering interpersonal and group tensions The nature of the group support mechanism Developing personal agendas
The Researcher
As the member of the teacher team and my relation with others The data collector Learning the nature of reflexivity The other research project

Figure 5.3. The field notes sub-theme framework

This completes the review of the analytical process undertaken with the field notes. The field notes sub-theme framework was used later in the next stage of the analysis. It was compared and contrasted with the sub-theme derived from the data analysis of the interviews (chapter five, section 5.5. p.127-130) and this inductive process led to the synthesis of the five transition themes (chapter five, section 5.1. p.105-106). I move on now to review in detail the processes of analysis undertaken with the two data sets from the interviews in chronological order (the analysis of the first interview data set followed by the analysis of the second interview data set).

5.4. THE ANALYSIS OF THE INTERVIEWS

Two sets of interviews were undertaken. The first set of interviews began in September 1997 at the beginning of the nurse practitioner degree programme, and it was completed in January 1998. The second set of interviews began in January 1999 toward the end of the nurse practitioner degree programme and was completed in July 1999 (chapter one, Figure 1.2. p.21 / chapter four, Figure 4.1. p.90, chapter five, Figure 5.1. p.106). The nature of the interview schedule, and the sample profile, have both been outlined in the methodology chapter (chapter four, sub-section 4.2.6.2. p.92-94 / chapter four, section 4.3. p.102-104). All interviews were audiotaped and I personally transcribed them. Transcriptions included the detail of the entire dialogue between the interviewer and the respondent during an interview. This required discretion and anonymity in the use of textual segments in the final data presentation. An example of an interview transcript is given in Appendix E.

5.4.1. The two sets of interviews

In the first set of interviews, I undertook eighteen audio-taped interviews between September 1997 and January 1998. These interviews were with ten students, five physician mentors and three members of the teacher team. In the second set of interviews, seventeen audio-taped interviews were undertaken between January 1999 and July 1999. These interviews were with eight students out of the remaining nine in the sample (one interview included two students, and one student, whilst willing to be interviewed, was unable to agree a convenient interview time), four physician mentors, three members of the teacher team, and three senior nurse academics. The number of interviews undertaken is outlined below in Figure 5.4. (p.116).

First set of interviews – started September 1997 and completed in January 1998	Second set of interviews – started January 1999 and completed in July 1999
• 10 Student Interviews • 5 Physician Mentor Interviews • 3 Educator Interviews Total 18 Interview Transcripts	• 7 Student Interviews (8 students in total as one interview combined 2 students together) • 4 Physician Mentor Interviews • 3 Educator Interviews • 3 Senior Academic Interviews Total 17 Interview Transcripts

Figure 5.4. Two sets of interviews

The senior nurse academics were purposefully included in the second interviews following the analysis of the first interviews and the provisional analysis of the field notes (chapter four, sub-section 4.3.4. p.104). Those analyses had indicated that a broad and objective perspective would be a useful contrast with some of the more focused data arising from the participants involved in the nurse practitioner degree

programme. The data from the senior academic interviews were used to refine and highlight findings in the study. However, I emphasise that the senior academics were not directly involved in the experiences outlined in the phases of the rite of passage (chapters seven, eight and nine) as they were not direct active participants in the nurse practitioner degree programme itself.

5.4.2. Analysing and coding the interview transcripts

Two basic content analysis techniques were used in the review of transcribed interviews:

a) The identification of significant recurring words or phrases. I have outlined the importance of this preliminary analytical tool in the analysis of interview transcriptions already in this chapter (chapter five, section 5.2. p.106-111). The specific outcome of this simple word search exercise is reviewed further in this section (chapter five, sub-section 5.4.3.1. p.118-120).

b) The identification of commonalties or sub-themes. These arose as general concepts within the interview transcripts. They were identified when a conceptual feel to a group of words, topics or generally related statements arose. For example, the identification of statements such as "nurse practitioners are found in **primary care**" or "they are restricted in their practice in **secondary care**" would be nominally identified (coded) with a general sub-theme on clinical areas and perceptions of role. An example of an interview transcript with coding is given in Appendix E.

Textual segments are reproduced throughout this work to illuminate findings as they arose from the analysis. All textual segments have been catalogued and coded and all can be traced back to the source transcripts for verification. The transcripts and textual data catalogue are not reproduced in the study in full, as this would have been prohibitive. However, an example of an interview transcript is given in Appendix E.

5.4.3. The analysis of the data set from the first interviews

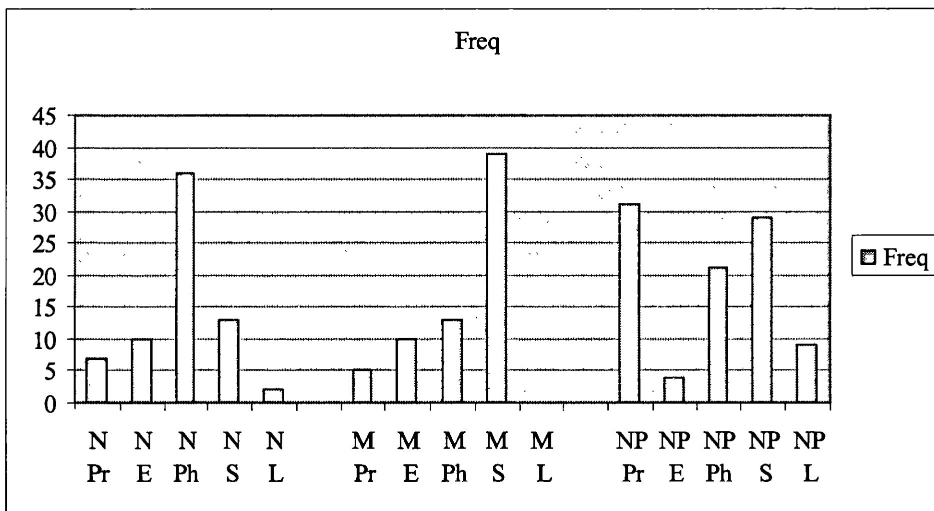
This analysis sub-section is divided into two. Firstly, I describe the preliminary word search exercise. Secondly, I describe the more detailed thematic latent content analysis.

5.4.3.1. A preliminary word search exercise / analysis of role perceptions

A preliminary data analysis exercise commenced a process of concept development (chapter five, section 5.2. p.106-111) and provided a basis to the later more detailed analysis. During the first interviews the members of the sample were prompted to give their definitions of medicine, nursing and nurse practitioners. These data then led to a word searching exercise that reviewed the three definitions offered by all respondents. I grouped together recurring words that arose in the interview transcripts on each of the three definitions. Five general topic areas emerged from the groups that reflected the traditional care and cure stereotype of nursing and medicine:

- Professional (Pr) - words that related to professional issues
- Educational (E) - words that related to educational issues
- Philosophy (Ph) - words that related to aspects of professional philosophy
- Skills (S) - words that related to specific professional clinical skills
- Levels (L) - words that related to levels (hierarchies) of professional / clinical practice

This facilitated an early feel for the respondents' perceptions of the clinical roles enacted by nurses, doctors and nurse practitioners. The frequency of the word count was collated (Graph 5.1. p.119).



Graph 5.1. The word search exercise
N = Nursing / M = Medicine / NP = Nurse Practitioner
PR = Professional / E = Educational / Ph = Philosophy / S = Skills / L = Levels

This data revealed a number of points. For example, when defining nursing the respondents alluded frequently to philosophical issues, and words such as caring and curing featured in the transcripts. In contrast, the definitions of medicine focused on specific diagnostic clinical skills, and words such as diagnoses, prescribing and treatment predominated in the transcripts. Finally, when defining nurse practitioners,

the respondents combined the aspects of clinical skills and philosophy and included a notable reference to professional issues. The main relevance of this preliminary exercise was its development of concepts that formed a basis for the more detailed process of latent content analysis.

5.4.3.2. The latent analysis of the data set from the first interviews

Latent content analysis was used with the transcripts from the first interviews (chapter four, sub-section 4.2.7. p.94-97). Dividing each transcript into seven sections eased this analytical process. The first section comprised the first three questions on the interview schedule and the following six sections corresponded with each subsequent interview question (Appendix B). As each section of a transcript represented the response to a particular question, this facilitated logical sequencing. However, the analysis was flexible and I accepted that data on a developing sub-theme could potentially emerge anywhere within an interview transcript.

Following the detailed review of the interview transcripts, textual segments were identified and a sub-thematic framework emerged. This is outlined on the following page (Figure 5.5. p.121).

Interview Schedule Question(s)	Reoccurring issues identified from the detailed analysis of the transcripts
Q.1,2,3 Definition of nursing, medicine and nurse practitioning	Initial Themes from Word Search (Prof. Educ. Philos. Skills. Levels) Concepts of professional merging and emerging
Q.4 Perception of nurses role	Generalists and specialists Primary and secondary care
Q.5 Perception of nurse practitioner role	Role concepts on professional merging / emerging / submerging / separating and membership
Q.6 Perception of nurse / doctor relationship	Traditional and new imagery on traditional medicine and traditional nursing New nursing roles
Q.7 Perception of nurse practitioner / doctor relationship	Professional concepts on hierarchical positioning / social levelling / boundary distinctions
Q.8 Personal expectations	Personal attitudes and their relation to issues of knowledge / skills / experience / ambition and +ve -ve power
Q.9 General perception of future developments	Professional issues and their relation to issues on regulation / legislation / market / time / standards and education

Figure 5.5. The sub-theme framework derived from the analysis of the first interviews

Emerging issues were then further grouped, titled and coded. This enabled a systematic analysis of each transcript and the development of a coded textual segment data catalogue. This coding system is outlined in Figure 5.6. (p.122) and an example of selected extracts from a specific coded segment catalogue (Coded D2) are provided in Appendix F.

Sub-theme code and name	Issues	Code
A - Professional Definitions	Nursing Medicine Nurse Practitioner	A1 A2 A3
B - Professional Perceptions and Imagery	Traditional doctor and nurse (traditional stereotypes), new nursing roles, new images	B1
C - Healthcare Settings - Generalists and Specialists	Primary and secondary healthcare Generalists and specialists	C1 C2
D - Professional Identity and Boundary Conflicts	Merging / emerging / submerging / separating Membership	D1 D2
E – Hierarchies and Boundaries	Positioning / levelling / boundaries	E1
F - Attitude, Motivation, Power and knowledge	Ambition / positive and negative power Knowledge / skills / experience	F1 F2
G – Healthcare Professions and Healthcare Services	Regulation / legislation The healthcare market Standards / education	G1 G2 G3

Figure 5.6. The naming and coding of the sub-theme framework derived from the analysis of the first interviews

All the coded textual segments that were identified in an interview transcript were bookmarked and then copied into the appropriate coded data segment catalogue files. Grid 5.1. (p.123) details the frequency that individual coded textual segments arose in each transcribed interview. A simple estimation of consistency was then possible by cataloguing the frequency of textual segment identification, averages and standard deviations.

First Interviews - Frequency of Coded Segments																		
	Codes >>>>																	
Interview	A1	A2	A3	B1	C1	C2	D1	D2	E1	F1	F2	G1	G2	G3		Tot.	AV	SD
S1	1	1	1	1	2	3	2	1	2	1	0	0	1	0		16	1.14	0.86
S2	1	1	1	2	1	0	1	0	1	3	2	2	0	0		15	1.07	0.92
S3	1	1	1	2	1	4	2	3	4	2	3	0	0	0		24	1.71	1.38
S4	1	1	1	2	2	2	1	0	3	3	2	0	1	0		19	1.36	1.01
S5	1	1	1	2	0	4	3	0	4	4	1	0	1	0		22	1.57	1.55
S6	1	1	1	0	0	0	6	0	3	2	1	0	0	0		15	1.07	1.69
S7	1	1	1	0	0	3	2	0	4	2	0	0	1	0		15	1.07	1.27
S8	1	1	1	1	0	2	2	1	8	4	3	0	1	0		25	1.79	2.12
S9	1	1	1	0	1	1	2	0	8	7	2	0	0	0		24	1.71	2.55
S10	1	1	1	1	0	1	3	1	3	2	2	0	0	0		16	1.14	1.03
M1	1	1	1	2	2	0	5	0	10	7	3	0	1	1		34	2.43	2.95
M2	2	2	2	4	0	4	0	0	6	1	2	2	0	2		27	1.93	1.77
M3	1	1	0	1	1	3	3	0	7	7	3	1	2	0		30	2.14	2.32
M5	1	1	1	0	1	3	5	0	7	5	3	1	5	0		33	2.36	2.31
M6	1	1	2	2	1	7	4	0	9	5	5	2	3	1		43	3.07	2.62
T1	1	1	1	0	1	0	10	3	5	5	2	0	0	2		31	2.21	2.81
T2	1	1	1	0	1	4	6	2	5	4	5	2	1	3		36	2.57	1.91
T3	1	1	1	0	1	1	4	0	1	2	1	0	1	1		15	1.07	1.00
															Total	440		
Total	19	19	19	20	15	42	61	11	90	66	40	10	18	10	440			
AV	1.06	1.06	1.06	1.11	0.83	2.33	3.39	0.61	5.00	3.67	2.22	0.56	1.00	0.56				
SD	0.24	0.24	0.42	1.13	0.71	1.91	2.38	1.04	2.70	2.00	1.40	0.86	1.28	0.92				

S = Student, M = Mentor, T = Teacher

Grid 5.1. The data set from the first interviews – the frequency of coded segments

The figure shows how textual segments were allocated to emerging sub-theme codes and this led to a final catalogue of 440 segments of data from the first interviews.

5.4.4. The analysis of the data set from the second interviews

As with the data set from the first interviews, each interview transcript from the data set from the second interviews was reviewed in detail and identified textual segments

were carefully coded. I used the same semi-structured interview schedule used in the first set of interviews (Appendix B), and thus the general grouping of the questions and their analysis applied as before (chapter five, sub-section 5.4.3.2. p.120). Again, as previously, I accepted that data could emerge on developing sub-themes anywhere within a transcript. However, the difference within this analysis (of the second set of interviews) was the use of the previously developed sub-thematic framework from the analysis of the first interviews (chapter five, Figure 5.6. p.122). Thus, in this case, a process of manifest content analysis was used (chapter four, sub-section 4.2.7. p.94-97). The sub-thematic framework proved to be an effective tool in structuring the analysis of the transcripts from second set of interviews. As previously, identified textual segments were coded and bookmarked in each transcript and then were copied to the appropriate data segment catalogue files. As with the first set of interviews, this gave rise to a data grid. Grid 5.2. (p.125) details the frequency of coded textual segments identified in each transcribed interview from the second interviews. Again, this facilitated simple estimation of consistency by cataloguing the frequency of textual segment identification, averages and standard deviations.

Second Interviews - Frequency of Coded Segments																		
	Codes >>>>																	
Interview	A1	A2	A3	B1	C1	C2	D1	D2	E1	F1	F2	G1	G2	G3		Total	AV	SD
M1	0	0	2	9	0	2	8	9	13	4	3	2	3	11		66	4.71	4.39
M2	0	0	0	0	0	3	3	2	5	1	1	4	3	3		25	1.79	1.72
M5	0	0	1	0	0	0	3	1	4	2	0	1	3	1		16	1.14	1.35
M6	0	0	2	0	0	3	3	5	7	2	2	0	4	3		31	2.21	2.15
S2	0	1	1	0	0	3	2	2	5	4	3	2	1	6		30	2.14	1.88
S3 – S6	0	0	1	1	0	1	6	2	9	1	3	1	1	3		29	2.07	2.56
S4	0	0	1	1	2	0	5	3	3	4	3	2	2	2		28	2.00	1.52
S7	0	0	0	2	2	0	3	3	5	4	2	0	0	0		21	1.50	1.74
S8	1	1	1	3	0	2	3	2	6	3	2	3	1	3		31	2.21	1.48
S9	0	0	1	1	0	3	4	3	4	3	3	0	1	3		26	1.86	1.56
S10	0	0	2	1	0	1	4	4	6	4	2	1	4	2		31	2.21	1.89
St1	4	0	3	9	1	2	5	0	7	1	2	2	6	3		45	3.21	2.69
St2	0	0	1	1	2	3	7	5	6	3	1	1	2	6		38	2.71	2.37
St3	0	0	1	1	0	4	2	1	2	1	3	4	2	5		26	1.86	1.61
T1	0	0	1	2	1	8	0	9	7	1	3	6	2	8		48	3.43	3.39
T2	0	0	1	0	0	2	7	0	4	0	4	3	2	9		32	2.29	2.87
T4	0	0	2	1	0	2	4	2	3	2	3	3	1	4		27	1.93	1.38
															Total	550		
Total	5	2	21	32	8	39	69	53	96	40	40	35	38	72	550			
AV	0.29	0.12	1.24	1.88	0.47	2.29	4.06	3.12	5.65	2.35	2.35	2.06	2.24	4.24				
SD	0.99	0.33	0.75	2.80	0.80	1.90	2.08	2.64	2.60	1.37	1.00	1.64	1.48	2.93				

S = Student, M = Mentor, T = Teacher, St = Senior Teacher (Academic)

Grid 5.2. The data set from the second interviews – the frequency of coded segments

The figure shows how textual segments were allocated to emerging sub-theme codes and this led to a final catalogue of 550 segments of data from the second interviews.

5.4.5. Summarising the structure and analysis of the interviews

The analysis of the interviews was a complex and prolonged process that is difficult to visualise. Following the lengthy coding exercise undertaken with the transcripts of the interviews, both the first and second set of coded segments were then reviewed in

detail and were compared and contrasted. Features of that process are evident throughout the main data chapters (chapter seven, eight and nine) that outline the chronology of the data with the phases of the rite of passage. Figure. 5.7. (p.126) summarises the overall progression of the analysis of the interviews:

THE INTERVIEW DATA
First set of interviews Interviews commenced in September 1997 and are completed in January 1998 All first interviews are transcribed between February 1998 and January 1999 Analysis of the first interviews commences in February 1999 A) Preliminary word search – concept development - basic topic generation B) Detailed latent content analysis – sub-themes generated C) Textual segments coded and catalogued – analysis of the first interviews is completed by January 2000
Second set of interviews Interviews commenced in January 1999 and are completed in July 1999 All second interviews are transcribed between February 2000 and January 2001 Analysis of the second interviews commences in February 2001 A) Detailed manifest content analysis using previous sub-theme that arose from the analysis of the first interviews B) Textual segments coded and catalogued – the analysis of the second interviews is completed by December 2001
Ongoing analysis - 2002 The data sets from the interviews are compared and contrasted The sub-theme derived from the field notes is compared and contrasted with the sub-theme derived from the interviews Five transition themes are inducted from sub-themes from the interviews and field notes **Ongoing analysis - 2003** Applying the rite of passage as an analytical and presentational structure

Figure 5.7. Mapping the analysis of the interviews

I now conclude this sub-section on the analysis of the interviews. The analysis of the first interviews had three main outcomes:

- It facilitated inductive emergence of a sub-thematic framework.
- It provided a sub-thematic framework for the later manifest analysis of the second set of interviews
- It facilitated triangulation and comparison with the field notes data

Consequently, the analysis of the second interviews had two main outcomes:

- It built on the foundation of the sub-thematic framework by comparison and contrast with the data and findings from the first set of interviews
- It facilitated further triangulation and comparison with the field notes data

5.5. THE TRANSITION THEMES AND THE FINAL DATA MAP

The generation of the five transition themes (chapter five, section 5.1. p.105-106) arose from the comparison and contrast of the two sub-thematic frameworks derived from the analysis of the field notes and interviews. Initially I noted that data from both sub-themes were broadly correlating with concepts of social transition. Further scrutiny indicated that the data from the sub-themes were revealing specific aspects of cultural and professional transitions. I then cross-referenced data from both sub-themes and five broad transition themes emerged. Each of the five transition themes I then tested against both interview and field notes data sets, and I found that they correlated with data from both. Equally, as transition themes emerged, their synthesis from the two sub-themes was consistent. That correlation and consistency is evident in the data presentation throughout chapter seven, eight and nine. Thus, as can be

seen in Figure 5.8. (p.129) each sub-theme contributed in part to the induction of the five transition themes.

However, how this transition theme framework could then be used to present the data was problematic. For example the network of connections that existed between sub-theme and theme could be reviewed either individually (cumbersome) or chronologically (fragmented). The use of Van Gennep's (1960) symbolic rite of passage (chapter three, section 3.3. p.63-71) provided an analytical tool and logical structure for the data, enabling a systematic and detailed sequence of data presentation (chapter seven, eight and nine). Finally, four broad thematic processes arose (chapter ten, section 10.3. p.366-367). The totality of this analysis is most easily visualised in the final data map on the following page (Figure 5.8. p.129).

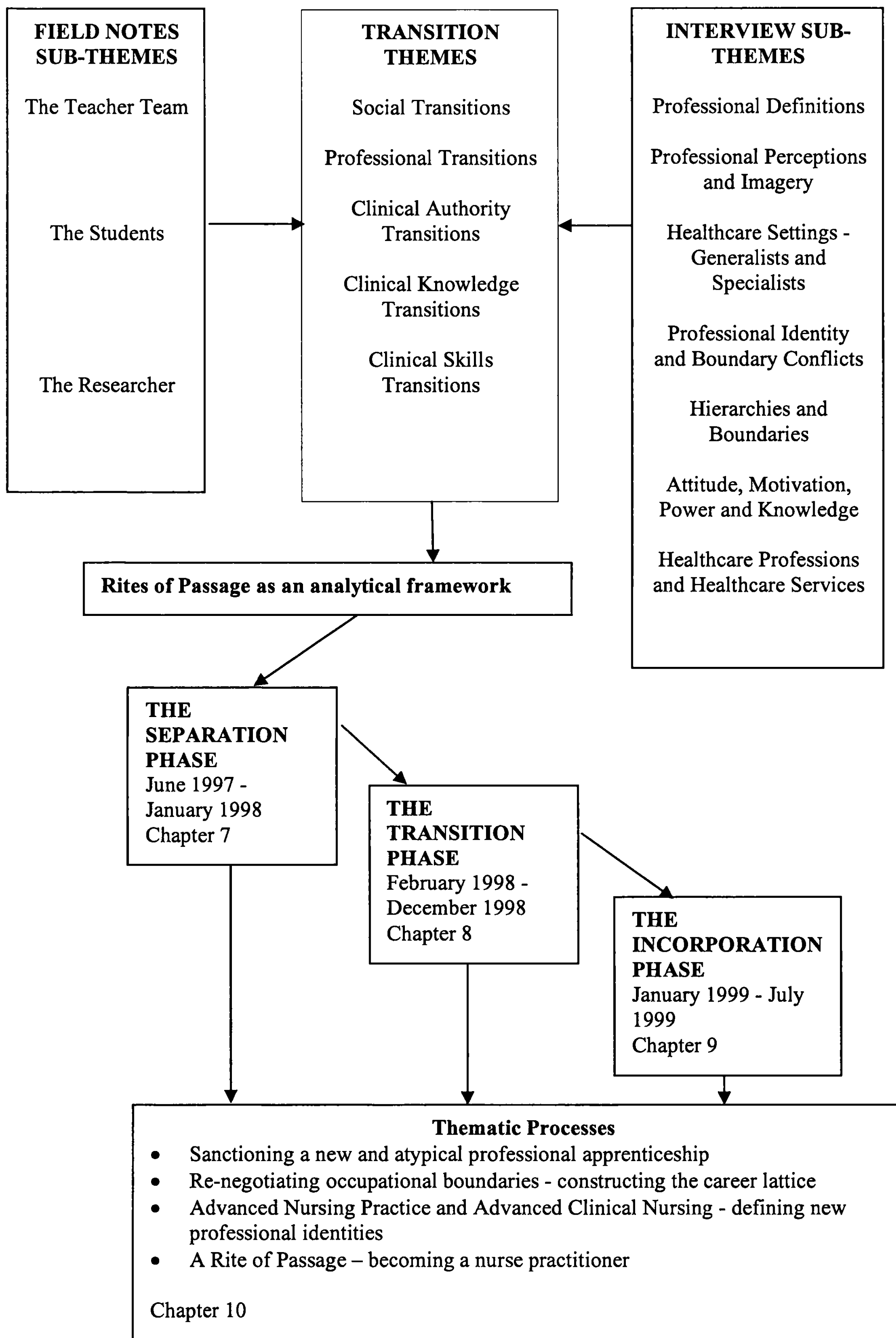


Figure 5.8. The final data map

This completes this chapter that has detailed processes of analysis. In the following chapter (chapter six) I describe in detail the education context of the nurse practitioner degree programme from which the data was collected. I also review related educational issues that give basis to events that arise in the main data chapters (chapters seven, eight and nine).

CHAPTER SIX

THE NURSE PRACTITIONER DEGREE PROGRAMME

6.1. INTRODUCTION TO THE NURSE PRACTITIONER DEGREE PROGRAMME

In this chapter, I review the educational context in which this research took place. I consider the organisation of the university department, and the organisation of the B.Sc. (Hons) Nurse Practitioner degree programme and its curriculum. I also review issues that arose from the degree programme design that give basis to events within the main data chapters that follow (chapters seven, eight and nine).

6.2. THE EDUCATIONAL CONTEXT

The nurse practitioner degree programme examined in this study was delivered within a Health Science department in a provincial university in the UK. In the following sub-sections (chapter six, sub-sections 6.2.1. to 6.2.9. p.131-147), I describe the general organisation of the department. I also discuss the history of the nurse practitioner degree programme, outline the curriculum structure as it was at the time of the data collection, and review some important related issues.

6.2.1. The University setting

The B.Sc. (Hons) Nurse Practitioner programme considered in this study was organized within a School of Health Science department. This department was part of a Faculty of Education and Health Studies at a provincial university and its origins lay in the national restructuring and assimilation of the NHS schools of nursing and midwifery into higher education in the early 1990s. As such, it was a relatively new organisation within a traditional university structure. Following that original merger, further restructuring occurred in 1997 that expanded the size

and activity of the department to a wider remit that encompassed philosophy, informatics, healthcare management and medical physics. The consequence of this was the establishment of a large university department that serviced a geographical region of rural areas and urban cities. The department ran administratively and educationally from several centres that met the needs of its main education programmes. As an organisation, it had professional links, and business contracts, with a number of NHS Trusts and Local Health Groups.

At the time that this research study took place (1997-1999), there were 140 academic and research staff with a wide range of clinical and academic interests within the department. There was 40 administrative staff supporting the department's academic activity. The department catered to 1000 full-time students and 2000 part-time students. From an organisational perspective, it was sub-divided into several academic centres, these managing academic programmes and grouping academic staff with common scholarly or clinical interests. These centres were dependent on considerable staff sharing between them. Additionally the department had a complex hierarchical structure based on diffuse management and committee regulation.

Nearly 80% of the department's funding was derived from healthcare education contracts with national government. In addition, contracts for post-registration education and training were in place with the local NHS trusts. Despite a considerable focus on the pre-registration preparation of nurses and midwives, the department offered education programmes at a post registration level for nurses and midwives and for other allied healthcare professions. These programmes ranged from certificate to post-doctoral studies. Thus, this organisation was not

unlike similar large university departments found throughout the higher education institutions in the UK.

6.2.2. Post registration modular degree - B.Sc. (Hons) Nursing

The department had since the early 1990s provided a generic post-registration modular B.Sc. (Hons) Nursing programme. As the 1990s progressed, this degree programme developed a modular pathway structure that facilitated a wide range of learning opportunities for students. These pathways met a range of theoretical and clinical needs (i.e. nurse practitioner, intensive care, elderly care, sexual health, and nursing theory). This general B.Sc. (Hons) Nursing award was validated with the university but also had approval from professional regulatory boards, meeting the requirements of the specialist practice award of that time (UKCC 1996).

There were several influences at work on the structure and development of this post-registration degree programme. Firstly, during the 1990s, any diploma programme for qualified nurses absorbed considerable student numbers. However, such awards were inevitably self-limited as the new generation of qualified nurses emerged with diplomas from their pre-registration studies (the Project 2000 diploma level programme). Thus, developments in post registration education began to focus on programmes leading toward the award of a degree. Influencing the development of these degree programmes were the demands from the funding clinical service managers that educational programmes for nurses should be designed to meet specific workforce needs. Secondly, the UKCC Specialist Practice award, and subsequently the Higher Level of Practice Project,

acted as important incentives in the development of clinically orientated degree awards (UKCC 1996, UKCC 1998). It was evident to the universities that the demands of the nursing profession for recognition of such specialist or advanced levels of clinical practice required equivalent levels of study at a minimum of degree level.

Post registration, part-time, modular academic awards are difficult to visualise. This becomes even more difficult when student applicants have existing professional qualifications and have undertaken other studies. For example, qualified nurses applying to study part-time degrees often had a variety of educational credits from previous studies. The university regulations that govern such flexible awards are complex and it is not the intention here to consider them at any length. However, certain points are important to give meaning and structure to the nurse practitioner programme and the eventuality of the sample's experience that is described in the main data chapters (chapter seven, eight and nine).

At the time of this research, an honours degree required the student to accrue 360 CAT credit points (CAT – Credit Accumulation and Transfer). In a traditional three-year full-time degree, this would equate to 120 level one credits in the first year, 120 level two credits in the second year, and 120 level three credits in the third year. However, for qualified nurses and their employers, part-time degree programmes would be the preferred option of further academic education. A qualified nurse could use a part-time degree programme to advance his or her career whilst maintaining their employment status and financial security. Equally,

employers did not lose an experienced clinical nurse from their staff rotas during the student's studies.

Within the credit framework, the following nomenclature was commonly used by nurse educationalists to define their programmes or modules: credit level one (certificate level), credit level two (diploma level), credit level three (degree level). Thus, access points to part-time degrees depended on what existing credits the individual nurse had, and this would define the length of prospective study. At the access point the student would be identified as having X credits at a particular level. Such terminology was actually somewhat misleading but provided a reference point for the level attained when a student accessed or exited without completion of a full portfolio of 360 credits.

Pre-registration nurse education programmes before 1991 (before the implementation of Project 2000 and integration with higher education), were recognised by higher education institutions as equivalent to 120 level one credits. Consequently, during the early 1990s there was a large population of qualified nurses who required additional studies at level two before progressing to level three. However, as the 1990s progressed, following the implementation of the new pre-registration diploma curriculum which included 120 credits at level 2 (Project 2000), that balance moved as the new generation of qualified diploma nurses entered the workforce and began planning for further study at level three.

6.2.3. The B.Sc. (Hons) Nurse Practitioner

In 1992, a nurse practitioner programme ran for the first time at this university, franchised from the RCN in the form of a two-year diploma course. In 1995, an option to extend nurse practitioner students' studies to degree level became available. In 1996, recruitment of nurse practitioner students to the diploma programme ceased, and by 1997 revalidation of the nurse practitioner diploma programme to degree level was finalised. Now integrated into the post-registration modular degree framework, the nurse practitioner profile of modules existed as one of several other possible profiles, or pathways, that made up the wider B.Sc. (Hons) Nursing. In September of 1997, the first undergraduate intake of nurse practitioner students commenced their studies. These students were part of the sample recruited to this study (chapter four, sub-section 4.3.1. p.102). However, it is important to remember that this was not the first student group to study on a nurse practitioner programme within this department. The new degree programme had arisen from the previous diploma programme, and had borrowed from the diploma curriculum. Equally, there had already been the experience of nurse practitioner students who had undertaken extensions from diploma to degree. Consequently, in 1997, the educational team involved in the course organisation and delivery had five years of nurse practitioner education experience available to them.

In 1997, the department was the sole provider of nurse practitioner education in the geographical region (chapter six, sub-section 6.2.1. p.131-133). Demand for the programme was consistent and educational evaluation pointed to generally good standards of teaching and student support from a diverse and multi-

professional course team. Additionally the nurse practitioner pathway received continuing franchise acknowledgement and approval from the RCN.

6.2.4. Designing the nurse practitioner programme

The design of the nurse practitioner degree pathway required all applicants to have an existing portfolio of 240 credits (120 at level one and 120 at level two). Thus, the two-year part time programme was structured around a module profile of 120 level three credits. The curriculum designers also stipulated pre-requisites that applicants had to achieve before access to the level three pathway. For example, they had to undertake 40 level two credits of research based study, and undertake 40 level two credits of human physiology based study. The requirement for study of human physiology arose from the experience gained from the earlier diploma programme that had shown that students needed remedial study in this subject before commencing detailed pathology and pharmacology studies. Consequently, applicants were required to undertake a human physiology module as a prerequisite to the level three pathway even if they had already achieved a full complement of level two credits.

To summarise, the curriculum designers took the following decisions with the new nurse practitioner degree programme that commenced in 1997:

- All applicants would be required to have worked in an area of clinical specialty (in primary or secondary healthcare) for a minimum of three years.
- All applicants had to have a full complement of 240 credits comprised of:
    - 120 level one credits.
    - 120 level two credits (of which 40 credits had to equate to research based study).

- All applicants had to undertake 40 credits of level two human physiology studies (with the exception of existing nurse graduates entrants who where required to undertake self-directed human physiology revision).
- All applicants must be able to identify a clinical physician mentor.

6.2.5. The curriculum philosophy, structure and delivery

The B.Sc. (Hons) Nurse Practitioner student handbook of 1997 stated the following:

> "This pathway is a clinical undergraduate degree for experienced qualified nurses. It facilitates the development of advanced and generalist clinical nursing practice that may be applied in a wide variety of clinical settings. The nurse practitioner practices and develops an advanced clinical nursing role based upon research findings. They operate clinically with high levels of independence and autonomy, work directly with their clients / patients for whom they conceptualise and diagnose problems, prescribe treatment within agreed protocols, undertake health education and therapeutic communication, evaluate the effectiveness of their treatment and communicate results as appropriate. The essential approach to clients is one of partnership, providing care in consultation with each client to provide for their physical, psychological, social and spiritual needs."
>
> (Thome and Barton 1997 p.3-4)

Thus, the overall structure of the curriculum focused on the development of advanced physical health assessment skills. Complementing this was development of interpersonal skills and in-depth studies in human pathology and applied clinical pharmacology. These all contributed toward the development of autonomous patient management skills. There was rigorous assessment of each module using traditional academic examinations coupled with examination of developing clinical practice skills. The assessment of clinical examination skills represented some of the more innovative areas of the nurse practitioner degree programme and included objective structure clinical examinations (OSCEs) and analysis of audio-taped, or video-taped, consultations.

The core curriculum of the level three pathway at that time (1997) was comprised of a compulsory portfolio of five modules:

• Clinical Assessment Skills 1	20 level three credits
• Clinical Assessment Skills 2	20 level three credits
• Consultation Skills	20 level three credits
• Research and Evidence Based Practice	20 level three credits
• Pathology and Pharmacology	30 level three credits

This left 10 additional level three credits identified as an elective choice (but in reality, this became a sixth compulsory module – Clinical Supervision). Figure 6.1. (p.140) and Figure 6.2. (p.140) summarise the overall modular design and mode of delivery of the B.Sc. (Hons) Nurse Practitioner in 1997. Figure 6.1. (p.140) on the following page outlines the admission requirements and the modular structure of the nurse practitioner degree programme:

Nurse Practitioner - part-time degree pathway (1997), a minimum two-year, maximum four-year, accruing 120 level three credits: 1 study day a week.

Admission Requirements:

Pre-requisites and modules:

- Level one – 120 credits
- Level two – human physiology module 40 credits (unless they were already graduates - in which case self-directed human physiology revision would be expected)
- Level two - research related studies totaling 40 credits
- Level two - 40 or more other credits
- All applicants must have worked in an area of specialty (in primary or secondary healthcare) for a minimum of three years
- All applicants must be able to identify a clinical physician mentor

Modules:

Level three credits - compulsory modules:

- Clinical Assessment Skills 1 – 20 credits
- Clinical Assessment Skills 2 - 20 credits
- Consultation Skills - 20 credits
- Research and Evidence Based Practice - 20 credits
- Pathology and Pharmacology - 30 credits

Level three credits - optional modules:

- 10 credits (Clinical Supervision strongly recommended)

Figure 6.1. Post Registration Modular B.Sc. (Hons) Nursing - Nurse Practitioner Pathway – admission and modules (1997)

Figure 6.2. (p.140) details the method of delivering the modules and the associated module assessment strategies within the nurse practitioner degree programme in 1997:

Nurse Practitioner Degree Module Delivery and Assessment 1997	
One day weekly. Three terms, Christmas, Easter and Summer	
Year One	**Year Two**
Clinical Assessment Skills One Assessed by OSCE (Objective Structured Clinical Examination)	Clinical Assessment Skills Two Assessed by OSCE (Objective Structured Clinical Examination) and an essay
Consultation Skills Assessed by audio or video tape analysis	Research and Evidence Based Practice Assessed by a research proposal
Pathology and Pharmacology (Over two years) Year 1 – Assessed by case study Year 2 – Assessed by written examination	
	Optional Module (Clinical Supervision) Assessed by essay

Figure 6.2. Post Registration Modular B.Sc. (Hons) Nurse Practitioner - The delivery of the modules and assessment strategies (pattern of delivery - 1997)

Having outlined the structure and delivery of the nurse practitioner degree programme, in the following sub-section I now consider an educational feature of this programme that had implication for the later findings of this study (chapter ten, sub-section 10.3.1. p.367-374).

6.2.6. A professional apprenticeship

A particular feature of this nurse practitioner degree curriculum was its apprenticeship structure. This apprenticeship concept becomes more apparent in the later detailed analysis and I consider it further in the discussion chapter (chapter ten, sub-section 10.3.1. p.367-374). This is not explored in depth here, but it is nevertheless important to give the reader some feel for this feature of the nurse practitioner degree programme.

The nurse practitioner degree programme was structured on a cognitive situated apprenticeship style of education (Stein 1998). This design had not been specifically imposed by the curriculum designers but had evolved naturally. Apprenticeship is commonly associated with the learning of practical skills within a structured training programme (Kidney 1998). However, in complex areas of professional learning, the more structured cognitive apprenticeship model is promoted. Cognitive apprenticeship is more than a basic training programme that enables rote skill acquisition, it is a curriculum process that develops structured thinking and complex skills acquisition. The process is described as a function of activity within a particular social context and culture; it is thus situated (Stein 1998). Consequently, the learning process combines both theoretical learning and situated learning.

In the nurse practitioner degree programme that is examined in this research, the expectation of the acquisition and use of advanced health assessment skills was situated in the reality of clinical practice. However, the degree programme had a structure that deviated from the expected cognitive professional apprenticeship education model in one important respect. The problem rested on an array of clinical outcomes that no one member of the teacher team was able to enact fully. In short, there were no nurse practitioners in the teacher team and the development of the role was consequently dependent on a partnership between the student, clinical physicians and the teacher team (chapter ten, sub-section 10.3.1. p.372).

In the two following sub-sections (chapter six, sub-sections 6.2.7. p.142-143 / chapter six, sub-section 6.2.8. p.143-144), I describe the membership of the nurse practitioner degree teaching team, and the team's relationship with the clinical physician mentors.

6.2.7. The teacher team structure

A core team of four lecturing staff coordinated the general administration of the nurse practitioner degree programme. Members of this team also undertook module leader roles. Additionally other lecturing staff from within the department taught on the programme, and expert clinicians were recruited on a sessional basis. Each student had an academic mentor to advise on aspects of academic development and each student had to identify a physician mentor in practice who would guide him or her on aspects of health assessment skills.

The course (teacher) team roles were as follows:

- **Programme Manager:** The academic manager of all the B.Sc. (Hons) Nursing degree programme pathways
- **Award Coordinator:** Responsible for the general overview and management of the nurse practitioner pathway
- **Module Leaders:** Responsible for the delivery and management of module content / examination setting and marking
- **Sessional Expert Teachers:** Academic and clinical experts were recruited as required to support aspects of module content
- **Personal Academic Tutors:** Each student had a personal academic tutor
- **Clinical Physician Mentors:** Each student had to identify a physician mentor in clinical practice

6.2.8. Clinical mentorship

Clinical mentorship was an important and integral part of the nurse practitioner degree programme. Thus, the clinical mentors (who were physicians) were a part of the sample in this research, and this reflected a unique feature of the degree programme in its relationship with medical practitioners. The students were required, by virtue of the nurse practitioner degree programme's pre-requisites, to identify a physician mentor (or mentors) who would assist them throughout their studies in their clinical skills development. Without physician mentorship and clinical supervision a student would not have been able to achieve the clinical learning outcomes of health assessment and diagnostic skill required by the nurse practitioner degree programme.

The use of clinical physician mentorship in the nurse practitioner degree programme had been tried and tested with the previous diploma groups and had proved to be successful. Clinical mentorship was two years in length, equivalent to the duration of the nurse practitioner degree programme. For students to have continuity, and to be able to assess their progress in clinical skills development, it

was important to have a named physician mentor who could retain an overview of the clinical training process. Students were also urged to negotiate three hours a week contact with the physician mentor. This was a difficult goal to attain and it was acknowledged that not all learning had to be with the nominated mentor, and that the mentorship load could be shared, if possible, with other physicians in the clinical area.

The process of mentorship was nominally divided into four phases. These stages were viewed as developmental, and their duration depended on the progress of the student. However, to achieve the learning outcomes, and to be able to pass the final OSCE examinations, the student needed to be working independently (but with supervision) for the last six months of the second year of the nurse practitioner degree programme.

The mentorship stages were as follows:

- Observation of the mentor in practice and detailed discussion
- Personal practice whilst being observed by the mentor
- Personal practice with occasional mentor supervision
- Personal practice with subsequent reports to the mentor

This model's application was dependent to an extent on the student's clinical environment, but it was broadly promoted for both the primary and secondary healthcare settings. I move on now to discuss further the implication of the primary and secondary healthcare issue for the nurse practitioner degree programme.

6.2.9. Student recruitment - healthcare sectors - specialists and generalists

In this sub-section, I briefly introduce two important concepts that later arise throughout the more detailed data presentation that follows in chapters seven, eight and nine. These concepts place the students in a cultural and clinical context.

Firstly, it is important to remember that recruitment of students was from both primary and secondary healthcare settings. Although the original target of the department's nurse practitioner programme had been primary healthcare nurses, it had become apparent that the clinical outcomes were attracting suitably able candidates from secondary healthcare settings. These secondary healthcare applicants fulfilled the programme's requirement that they be clinically experienced, and that they had worked in a specific clinical area for several years. Consequently, they were recruited to the nurse practitioner programme.

Healthcare sectors are an intricate concept but for simplicity sake, in this thesis, I use the traditional divide between the primary and secondary healthcare sectors. In this basic distinction, primary healthcare is the delivery of healthcare within the community, often based on the services of a small multi-professional healthcare team. The community healthcare centre stereotypically describes this as providing care to patients who live within their own home. In contrast, secondary healthcare is traditionally within the acute hospital service where a large multi-professional workforce offers complex clinical services. Secondary healthcare is often clinically specialised, and the patient population is cared for (mainly) on an

in-patient basis, removed from home and community. It could be said that in the primary healthcare setting the patients were generally well, whilst in the secondary healthcare setting the patients were generally ill. These are limited conceptualisations and there are many permutations of primary and secondary healthcare; for example, patients may be ill at home and well in the hospital. However, for the purpose of this study it is important to make this basic distinction because it had implication for the nurse practitioner students, as their client groups would have different profiles and needs according to the healthcare setting in which the nurse practitioner was employed.

Secondly, and related to this basic healthcare divide, were the other important concepts of clinical specialists and clinical generalists in healthcare. These important distinctions feature in the findings of this research (chapter ten, sub-section 10.3.3. p.381-391). I review them here to provide context for the reader when later considering the research data and findings in the main data chapters (chapter seven, chapter eight, and chapter nine). A simple view is that a generalist is a professional who delivers healthcare to a client group with a wide-range of actual or potential health problems, employing broad skills of health assessment and clinical management. The typical generalist is the general medical practitioner in primary healthcare, a clinician seeing many clients every day with diverse and undifferentiated health needs. Conversely, the specialist is a professional who has particular clinical skills, and manages a group of patients with very specific health problems or needs. The specialist role would be commonly associated with that of the hospital consultant. These are very broad

distinctions, and I acknowledge that specialists exist within primary healthcare and that generalists also have their place in the acute hospital setting.

The teacher team decision to accept candidates from both healthcare sectors would later give rise to considerable data on student's experiences and data on the influence of healthcare settings on developing clinical roles. I review this in detail in the research findings (chapter ten, sub-section 10.3.3. p.381-391).

In this chapter I have described and discussed the nurse practitioner degree programme, its setting and educational context. Using the transition phases of Van Gennep's (1960) rite of passage (separation, transition and incorporation) in combination with the five transition themes already identified, the data are now reviewed in depth in the following chapters (chapters seven, eight and nine). Each phase represented a snapshot of the data collection. Precise division between one phase and another was not possible, boundaries blurred as one merged into the next. However, noting that the degree programme spanned a two-year period from September 1997 to July 1999, it could then be said that the separation phase spanned approximately the first third of the degree programme (chapter seven), the transition phase the next third of the degree programme (chapter eight), and the incorporation phase the final third of the degree programme (chapter nine).

CHAPTER SEVEN

THE SEPARATION PHASE

7.1. INTRODUCTION TO THE SEPARATION PHASE

This chapter describes in detail the first phase of the rite of passage (Van Gennep 1960). Turner (1982) saw the separation phase as characterised by symbolic behaviour that represented:

> "The detachment of the ritual subjects (novices, candidates, neophytes or "initiands") from their previous social statuses."
>
> (Turner 1982 p.24)

Thus, the separation phase begins when an individual starts to disengage from his or her social, cultural or occupational setting. Segregation is a common feature of the separation phase, and is a process during which individuals experience events that remove their previous identities and separate them from their previous social statuses. Segregation may arise from a geographical move, such as the student leaving home to commence college studies. Alternatively, segregation may arise from a role change, such as the parent undertaking childcare for the first time. However, this process of social separation and segregation is not necessarily a well-defined process. Individuals experiencing the separation phase of a rite of passage may continue to have some contact with their previous life, and may not separate, or be segregated, completely from society. Consequently, a rite of passage often begins gradually, and with the expectation of a process of personal change that will alter individual's social status.

This chapter reviews the first phase of the rite of passage: the separation phase (September 1997 to January 1998). It examines each transition theme individually within the context of this phase. Where it is relevant, events from the immediate pre-course period (June to August 1997) are also included in the transition theme reviews. The structure of this chapter is as follows. Firstly, there is a summary of the general timing of the separation phase within the structure and chronology of the nurse practitioner degree programme (Figure 7.1. p.150) and an outline of the key conceptual links between the chapter's sub-sections (the transition themes and the data) and the elements of the separation phase. Following this there is a broad review of the main features of the separation phase. The main body of the chapter consists of the detailed review of each transition theme. At the end of the chapter, the data, findings and conceptual links of this separation phase are again summarised.

<table>
<tr><td colspan="6">The Rite of Passage - Transition Time Line – Separation

TRANSITION THEMES
Social Transitions,
Professional Transitions
Clinical Authority Transitions
Clinical Knowledge Transitions
Clinical Skills Transitions</td></tr>
<tr><td colspan="2">1997</td><td colspan="3">1998</td><td>1999</td></tr>
<tr><td colspan="6">July---Sept------------------------Dec--Jan--------July--Sept----------------Dec--Jan--------------------------July</td></tr>
<tr><td rowspan="2">P
R
E

C
O
U
R
S
E</td><td colspan="2">Academic Year One

Modules
Clinical Assessment Skills 1
Consultation Skills
Pathology and Pharmacology

Summative Assessments
OSCE 1, Essay, Video Tape Analysis</td><td>S
U
M
M
E
R

B
R
E
A
K</td><td colspan="2">Academic Year Two

Modules
Clinical Assessment Skills 2
Research and Evidence Based Practice
Clinical Supervisory skills
Pathology and Pharmacology

Summative Assessments
OSCE 2, Research Proposal, Written Examination, Essay</td></tr>
<tr><td colspan="2">The Separation Phase
(Chapter 7)</td><td colspan="2">The Transition Phase
(Chapter 8)</td><td>The Incorporation Phase
(Chapter 9)</td></tr>
</table>

Figure 7.1. The separation phase in context

Before discussing the data further, it is important to review and spell out the links between the separation phase of the rite of passage and this chapter's sub-sections. This chapter presents data that illustrate the five transition themes (chapter one, section 1.2. p.8. \ chapter five, section 5.1. p.105) as they occurred during the separation phase. The main concepts and relationships that are relevant to this phase

are outlined below in sub-section 7.1.1. (p.151-152) These are summarised again at the end of this chapter (chapter seven, Figure 7.3. p.205).

7.1.1. Conceptual links and relationships of the separation phase

Social Transitions – based on the experiences of the teacher team and the students

- In this transition, the teacher team data were characterised by interpersonal conflicts, personal beliefs and team closure. These data are linked with the broad issues of social relationships and processes of the separation phase.

- In this transition, the student data were characterised by clinical role duality, adversity, group cohesion, losing identity and finding communitas. These data are linked to the students' personal experience of discovering the social process of the separation phase.

Professional Transitions - based on the experiences of the teacher team and the students

- In this transition, the teacher team data were characterised by national events, conceptual ideas and the guiding of students to new roles. These data are linked to the wide processes that were motivating and driving the process of the separation phase.

- In this transition, the student data were characterised by the transition from professional nurse to student nurse practitioner, a process of losing identity and transgressing professional borders. These data are linked to the conflicts of role that arose as a result of the separation phase.

Clinical Authority Transitions - based on the experiences of he physician mentors

- In this transition, the physician mentor data were characterised by medical benchmarks and confronting authority challenges to the physicians' status. These data are linked to the process of authority separation and the separation phase.

Clinical Knowledge Transitions - based on the experiences of the teacher team and the students

- In this transition, the teacher team data were characterised by curriculum and teacher skill mix. These data are linked to the enabling of the process of role development during the separation phase.

- In this transition, the student data were characterised by new clinical knowledge and new language. These data are linked to the processes that allowed the students to accept the separation phase.

Clinical Skills Transitions - based on the experiences of the teacher team and the students

- In this transition, the teacher team data were characterised by the perceived high status of clinical skills and their professional ownership. These data are linked to the rationalising processes of the separation phase.

- In this transition, the student data were characterised by the defending and rationalising of border transgressions. These data are linked to the processes that defined and regulated the separation phase.

Having listed these concepts and relationships, the next sub-section provides a broad review of the main events of the separation phase. Following this review, each transition theme is examined in detail.

7.2. A BROAD REVIEW OF THE SEPARATION PHASE

I have identified the beginning of the separation phase with the formal commencement of the nurse practitioner degree programme in September 1997 and its end in January 1998. However, recording of field notes had begun in the pre-course period between June 1997 and August 1997, before the start of the new nurse practitioner degree pathway in September 1997 (chapter one, Figure 1.1. p.21 / chapter four, Figure 4.1. p.90 / chapter five, Figure 5.1 p.106 / chapter five, Figure 5.2. p.113). Those field notes included observations of encounters with some of the

prospective nurse practitioner students, and recorded teacher team meetings. These data are included where they are appropriate to the discussion of the separation phase.

Following the formal beginning of the nurse practitioner programme in September 1997, I commenced regular observations, and recorded and reflected on interactions and social relationships between the students, the teacher team, and physician mentors (chapter five, section 5.3 p.111-112). Also during September 1997 and January 1998, I undertook the first set of interviews and began to transcribe and analyse them.

The teachers, students and clinical mentors were all active in the separation phase. The teacher team members were establishing their control over the new nurse practitioner degree programme. Much of their attention was focused on providing a balanced structured curriculum, but they were also involved with wider professional developments and debates. An example of this was the teacher team's involvement with the RCN's developing national nurse practitioner education network. The students' experience of the separation phase was one of increasing role duality, finding themselves both as experienced professional nurses and novice nurse practitioner students. They were assessing new norms and negotiating identity issues. As the separation phase progressed, the students became increasingly aware of their potential professional border transgressions and developed means to defend their prospective nurse practitioner role. The physician mentors' experience was one of slow integration with the nurse practitioner degree programme during the separation

phase. They realised they had to sanction the nurse practitioner role as their students were beginning to develop new skills. They also began to evaluate the implication of this for their own professional role.

In this chapter's introduction, I have outlined the main chronology, events and experiences of the separation phase. I now consider each of the transition themes in detail.

7.3. THE SEPARATION PHASE AND SOCIAL TRANSITIONS

The social transition theme of the separation phase is divided into two parts. Firstly, I discuss the social experiences of the teacher team and researcher (myself). Social relationships link the separation phase to this discussion (chapter seven, sub-section 7.1.1. p.151-152). Secondly, I discuss the social experiences of the students. Their discovery of social processes links the separation phase to this discussion (chapter seven, sub-section 7.1.1. p.151-152).

7.3.1. The teacher team: social transitions during the separation phase

In June 1997, I observed a number of teacher team meetings that were held in preparation for the forthcoming academic year (1997-1998). These meetings established the management responsibilities within the teacher team following the restructuring of the nurse practitioner programme from diploma to degree level in 1997. The membership of the teacher team was quickly defined, and it met the academic needs of the nurse practitioner degree programme. However, observations during the pre-course period (June 1997) of the teacher team revealed an uneasy situation:

"There was a feeling of underlying uncertainty as to who has control of this new degree programme."

Field Note Entry - June 1997

"The outward appearance of a smooth and logical development of an innovative degree programme is very fragile."

Field Note Entry - June 1997

"(notes from a team meeting) - *X asked whether Y would be attending an exam board. This was met with a very awkward moment in which Y stated, quite seriously, that she was not sure that she had been invited. X and I tried to smooth over this by indicating that we assumed that the invitation to meetings was open to all. It was a tense hostile moment."*

Field Note Entry - June 1997

It was into this unsettled atmosphere that the new students were to commence their study. However, I observed that the students were unaware of any such difficulties and that they had a high expectation of the nurse practitioner degree programme as an efficiently run, clinically orientated, and professional course of study.

These early observations of the teacher team's concerns regarding the management of the nurse practitioner degree programme reoccurred in data that arose later in the study. For example, in August 1997 there were further references in field notes to problems within the teacher team when a sessional teacher unexpectedly decided to withdraw from the degree. Although this was resolved quickly, it revealed an underlying tension that was having an effect on the members of the teacher team who were attempting to develop and manage the nurse practitioner degree programme

whilst also promoting a co-operative and orderly image. These management difficulties were evident in the data extracts below that arose during the immediate pre-course period before the formal commencement of the nurse practitioner degree programme in September 1997:

> *"In addition the teachers are coping with interpersonal conflicts, and personal agendas, whilst trying to maintain a professional faculty approach."*
>
> *Field Note Entry - August 1997*

> *"I receive letter from lecturer Z. She stated that she was upset over various issues concerning our course planning, specifically the X component. She wished to withdraw from the course. The letter was jumbled and erratic. I wrote back indicating that I could not sanction any such decisions, as I was only a team lecturer. The matter was dealt with later by a more senior member of staff."*
>
> *Field Note Entry - August 1997*

In addition to these data, the analysis also revealed other anxieties within the teacher team. The aims of the nurse practitioner degree programme challenged assumptions on the relationship between the professions of medicine and nursing, causing the teacher team to re-evaluate its values and belief systems. For example, the nurse practitioner degree programme brought the teacher team into contact with both clinical physicians and clinical nurses. This presented particular challenges for the teacher team when dealing with issues of traditional professional authority. To meet the nurse practitioner degree programme's aim and philosophy, the teacher team had to reflect carefully on the relative contributions and traditions of the nurse and doctor relationship, and had to consider the future of that relationship. Such reflections were illustrated in the following data extracts:

"I think that the nursing profession has got a chip on its shoulder. If it were a man and wife relationship (nursing and medicine), *it would be pretty sick. When you think that they are joint partners in caring for sick people, it's pretty dismal."*

Physician Teacher - F1 Data Segment - 1st Interview Data

"My private vision is that all nurses in a sense should have the skills and competencies that a nurse practitioner has. That should be a part of basic nursing up to a point. Nurses could develop their interests to greater degrees, to advance further their level of practice. So, my vision is that every nurse would have the empowerment, the skills, autonomy and confidence that I see nurse practitioners have, and their relation with medical colleagues would be a collegiate one. That's my private hope."

Nurse Teacher - G3 Data Segment - 1st Interview Data

These data showed that that the members of the teacher team were mindful of the traditional relationship between the nursing and medical professions, and conscious of the implication of that relationship for nurse practitioner students. However, throughout the data collection period, the students appeared mostly unaware of such concerns within the teacher team. This revealed faculty (social) closure (chapter three, sub-section 3.2.4. p.51 \ chapter three, sub-section 3.2.6. p.56), which, I suggest, was not to protect the students, but to enable the teacher team's control of the students' learning experiences. In a degree programme that was potentially open to multiple challenges from a multi-professional audience, the teacher team concealed internal conflicts or hesitancies that could prove to be divisive. From the teacher team's perspective, it was necessary that they had full control and direction of the curricular process. Whilst the teacher team encouraged students and clinicians to negotiate individual clinical roles, alternative interpretations by students and

clinicians of the curriculum philosophy were discouraged as they could lead to confusion. This finding contrasts with observations toward the end of the incorporation phase, when the teacher team's authority over the academic programme was challenged (chapter nine, sub-section 9.5.2. p. 324-328).

This completes the presentation of this sub-section on the teacher team's social transition experience during the separation phase. In the next sub-section I review the students' experiences of the social transition theme during the separation phase.

7.3.2. The students: social transitions during the separation phase

Field notes data collection began in the pre-course period between June 1997 and August 1997 (chapter one, Figure 1.1. p.21 / chapter four, Figure 4.1. p.90 / chapter five, Figure 5.1 p.106 / chapter five, Figure 5.2. p.113). During this time, I recorded encounters with some of the students during their pre-requisite physiology module. I observed them as a small and relaxed group, although anxious over the forthcoming module examination results. There was a sense of impatience from the group. It appeared that the pre-requisite physiology module was considered a hurdle to overcome whilst waiting to access the main stream of the nurse practitioner degree programme. This view was an early acknowledgement by the students that the nurse practitioner degree programme would entail a process of professional change, this despite their existing professional status as healthcare professionals with life experience. They were novices to the nurse practitioner role and it was clear at the early stages of the data collection, during the immediate pre-course period (June 1997

to August 1997), and throughout the separation phase (September 1997 to January 1998), that they were aware that the nurse practitioner degree programme would be demanding:

> *"These students have already committed themselves to a protracted and difficult programme for which even at this early stage they are having to face stressful and difficult situations. There is a sense of purpose."*
>
> *Field Note Entry - July 1997*

> *"I think it is a new role* (the nurse practitioner role) *that has been only established for the last few years. I see it as taking an important role within the hospital and in community settings. I think it is a role that is going to expand. But how it expands I am uncertain, it depends on lots of things, and how the public and hospitals actually takes it on board."*
>
> *Student Nurse Practitioner - G2 Data Segment - 1st Interview Data*

These data extracts revealed the students' self-awareness of their prospective role change, and a consequence of that was their exploration of ways to ease their transition from professional nurse to student nurse practitioner. They inquired into the level of structured guidance that the teacher team would provide. In the immediate pre-course period (June 1997 to August 1997), they persistently asked for pre-reading lists and requested material for revision. This behaviour continued when the course formally commenced in September 1997 and was observed throughout the separation phase. In the early stages of an education programme, this revealed the students' transition and socialisation into the new education culture. New undergraduates need to discover the faculty rules, and yet will simultaneously begin to negotiate their own agenda with their teachers. These were certainly observable features of the separation phase, as the nurse practitioner students tested out the

unfamiliar ground ahead and began to leave behind older and more familiar social and occupational structures and values. For example, in the immediate pre-course period (June 1997 to August 1997), they were already anxious about their forthcoming studies, this evident in their demands for pre-course academic (tutorial) support. This apparent lack of personal confidence was an outward expression of their anxieties on entering an unfamiliar world, despite their eagerness to start the nurse practitioner degree programme. Thus, it is important to remember that whilst the students were active and experienced clinical nurses, they were also novice student nurse practitioners.

A focus of the students' self-perception at this early stage was their general uncertainty about the nurse practitioner degree programme's eventual outcome. They were starting a degree programme that they expected to be innovative and challenging, but a lack of clearly defined personal outcomes gave rise to individual hesitancies. That sense of facing the unknown was real for the students, and was paradoxically evident in their need to be confident in a future role that was threatening their existing identity. Hesitancy and anxiety of the unknown, coupled with acknowledgement of the tasks ahead, contrasted with the desire for the rewards of new status. These contrasting views in the face of prospective social transition were evident in the following data extracts:

> *"I will be honest with you. It is going to be much more than what I thought. I didn't really know what nurse practitioning was all about. So I did not come with a lot of ideas."*
>
> *Student Nurse Practitioner - F1 Data Segment - 1st Interview Data*

"I have told them (the student's employer) *that I need something more than just being a staff nurse, just doing the same job, because I don't want to waste all this. So I have a feeling that I need to negotiate with my nurse mentor and clinical mentor and see what's going to happen."*

Student Nurse Practitioner - F1 Data Segment - 1st Interview Data

"I would like my role to change actually. I was becoming bored, if that's the right word, with what I was doing. I was looking for something to change. But, I enjoy working with the people I work with now so really I have been given the best opportunity I could. I am still in the same environment and yet my role is going to change."

Student Nurse Practitioner - F1 Data Segment - 1st Interview Data

These data represented a view of personal change that the students anticipated and experienced in the separation phase. However, observation of the students indicated that they were changing as the separation phase progressed. By November 1997, the students' group identity was rapidly developing. They were busy in theoretical sessions, and I noted that they were quiet and focused. Interactions with the teacher team, and their developing skills of role-playing and seminar work, indicated a high level of involvement with the process and content of the nurse practitioner degree programme. They also continued to develop a student led agenda, and attempts at negotiating alternative ways to achieve learning outcomes were observable (for example, requesting set texts when teachers had left this option open). The students' demands did not detract from the nurse practitioner degree programme's progress and they seemed to meet the students' need to have some control over their study experience. Both the teachers and students were aware of these relatively minor negotiations, and I observed both making compromises to accommodate them.

During November 1997, one of the students began to absent from the nurse practitioner degree programme. This was the only male member of the student group. Over the following weeks, he repeatedly did not attend. I had noted that this individual had not fully integrated with the rest of the students from the outset. He had remained somewhat distant from the other students and did not participate well in group activities. This student withdrew from the nurse practitioner degree programme in December 1997.

The nine remaining students in the group developed a close supportive group relationship. They were working in a cohesive and cooperative manner and their hesitancies as novice undergraduates receded as their group identity matured. This was apparent in the following data extracts that revealed a developing student group identity:

> *"They are no longer working as though they are in a novice role, but more as though they are in a well developed professional role."*
>
> *Field Note Entry - November 1997*

> *"The session on abdominal examination progressed in a very flowing and natural way. The demand for personal body exposure* (the students practiced abdominal examinations on each other) *during class appeared to be no problem, despite some initial embarrassment."*
>
> *Field Note Entry - November 1997*

> *"There was a relaxed group work session. The group are establishing themselves. Individuals have established classroom territory, they are sitting in the same seats, they have having a coffee fund, and there is humour on who are the outspoken and quiet ones."*
>
> *Field Note Entry – December 1997*

"In class today, the teacher said to me that the students are a very good group, and that they are doing well. However, she says that they are under pressure because of forthcoming assignments."

Field Note Entry - January 1998

This developing group identity was an important feature of this clinical degree programme. The students' existing clinical experience was an advantage as it helped them to develop a learning style that was proactive and assertive. Following their original anxieties and fears, they had assimilated the unfamiliar academic demands of the educational programme by developing a coherent student group dynamic. Their ill-defined separation from their previous social professional identity balanced against the beginning of transition to new social status, and this gave an identity to the developing solidarity of the student group.

The developing social cohesion of the group was a precursor to a full communitas (chapter three, section 3.3. p.67), and this was a central feature of the separation phase. The students were on the edge of liminality, at the threshold of new identity, and increasingly marginalised from their previous professional role. Remaining partially socialised within their original area of clinical practice (as they did throughout the nurse practitioner degree programme), pre-communitas provided the bridge that enabled the beginning of transition into a later social limbo. The duality of role during the separation phase (continuing to enact an older role and yet negotiating a new one) would become an increasingly prominent feature later, when the students entered the transition phase (chapter eight, sub-section 8.7.1. p.265-268). This is relevant to the separation phase as role negotiation was an important feature of

the transition experiences that persistently arose in the data, particularly as the students' experience in clinical practice was socially unusual. There were few precedents for nurses making such social transitions whilst remaining in an otherwise unchanged clinical context. Thus, the context and drive for their social transitions arose directly from their negotiations with others in a social milieu that understood little of what was happening to them. This is a prominent finding throughout the separation phase and is a feature in the later transition phase and incorporation phase (chapter eight and chapter nine).

Finally, in the social transitions theme of the separation phase, it is important to give a balanced picture of the students' personal experiences. Although I had observed that they had progressed well in a relatively short period, they still had much more to achieve before the nurse practitioner degree programme's completion. This uncertain social position was summarised when the physician teacher explained to the student group her perception of their relationship:

> "(physician teacher's comment) *It is our mutual journey of the next two years."*
> *Field Note Entry - November 1997*

By January 1998, that journey had progressed, and examination nerves and anxieties over forthcoming summative assignments began to feature as part of the students' experience. Each week brought new events that would affect them, and in this changeable situation, their developing group cohesion was a means to facilitate the way ahead into the transition phase.

This completes the presentation of the social transition theme during the separation phase. In the next section, I discuss the professional transition theme during the separation phase.

7.4. THE SEPARATION PHASE AND PROFESSIONAL TRANSITIONS

The professional transition theme of the separation phase is divided into parts. Firstly, I discuss the professional experiences of the teacher team. Motivating professional processes link the separation phase to this discussion (chapter seven, sub-section 7.1.1. p.151-152). Secondly, I discuss the professional experiences of the students. Role conflicts link the separation phase to this discussion (chapter seven, sub-section 7.1.1. p.151-152).

7.4.1. The teacher team: professional transitions during separation phase

For the teacher team, the summer months were traditionally associated with academic administration, characterised by completion of the previous year's examination results, and preparation for the new student intake in the forthcoming academic year. However, between July 1997 and August 1997, the teacher team was also involved in wider professional developments. I observed teacher team members attending national meetings in August of 1997 where they met with colleagues from the RCN and with other teachers from nurse practitioner programmes elsewhere in the UK. The development of formal, standardised, nurse practitioner clinical competencies were discussed at these meetings. By the early 2000s, those competencies would

form the basis of the first national clinical standards for nurse practitioners in the UK. Thus, these professional network meetings between July 1997 and August 1997 represented an important milestone in the data. They marked the teacher team's exposure to the development of the UKCC's Higher Level of Practice (HLP) framework and the development of the National Organisation of Nurse Practitioner Faculties (NONPF-UK). The active part that the teacher team played in those developments influenced its perceptions of nurse practitioner education, practice and regulation.

Within the developing national fora there were debates on issues of title protection. Nurse practitioner was not a professionally protected title and any nurse could adopt and use it, regardless of his or her level of clinical skill or competence. This inevitably contributed to the widespread and ill-defined use of the title and this lack of professional regulation resulted in confusion amongst healthcare professionals, managers and employers throughout the UK. This confusion increased when the UKCC (1998) insisted that its higher level of practice framework, if it were to be meaningful, should be defined by a level of clinical competence and not by particular titles. The view was that the level of clinical competence should be formally assessed, and that such assessment should not be restricted by clinical titles. This view was borne out by the evidence of the Exploring New Roles in Practice Project (ENRIP) (Read 1997) that had revealed a confused situation of unregulated clinical titles in use by nurses in hospital settings. However, there was a problem associated with the UKCC's stance on this issue. Whilst there was sense in defending a

measurable level of clinical competence, that unfortunately had little bearing on the clinical workplace where multiple titles were already abundant and often used as measures of clinical ability. To introduce regulation of advanced levels of nursing practice would also require addressing an already developing situation that had arisen outside of professional control. Thus, the deliberations of the UKCC contrasted awkwardly alongside this workplace situation.

This preoccupation with titles mirrored the nursing profession's preoccupation with professional recognition and an enhanced occupational status. The title debate was not just an academic one, as titles already had been linked in some cases with job descriptions, wide clinical responsibilities, and enhanced clinical status and salary grades. Thus, the use of the title nurse practitioner would remain a core issue throughout the data collection period of this research (1997-1999). The data I collected at the outset of the study certainly revealed that the teacher team and students viewed the title nurse practitioner as associated with a change in professional status. That change in status arose from a role that incorporated clinical skills that were associated with traditional medical practice. In the separation phase, the data indicated that the status of the nurse practitioner arose from a new developing role that demanded greater clinical skill and authority from the nurse. That role was perceived as a transitional hybrid of nursing and medicine:

> *"We are told we will study at a certain level and we will be able to take our own decisions, and take responsibility for decisions, and possibly prescribe in the future."*
>
> *Student Nurse Practitioner - B1 Data Segment -1st Interview Data*

> *"My expectation and hope is that it* (the nurse practitioner degree programme) *will produce a nurse practitioner who is confident, competent, and who has an understanding of the different cultures of medicine and nursing and perhaps can be a bridge between them, be in that grey area in between."*
>
> *Nurse Teacher - D1 Data Segment - 1st Interview Data*

These data extracts revealed the professional role of the nurse practitioner in the separation phase as an emerging and developing one. The teacher team had to guide the students through this process, and its involvement with the national professional development of advanced levels of clinical nursing practice helped it to do this. I observed this as a two-way process. As the teacher team members learnt from the experience of delivering the nurse practitioner degree programme, they fed this back to influential and developing national nursing fora (the RCN network and the developing National Organisation of Nurse Practitioner Faculties NONPF-UK). These developing professional issues, occurring as they did at the outset of this project, also had inevitable consequence on the perceptions of the teacher team. Not least of these was a growing awareness of the wide political, educational and professional implications of the nurse practitioner role with its particular focus on a new level of clinical nursing competence. That the nurse practitioner role could enable the introduction of a new clinical hierarchy to nursing was implicit in the teachers' thinking, and in the students' thinking. Contrasting that was the hesitant response of the regulatory and strategic policy makers. The following data extracts revealed these perspectives of the development of a new clinical hierarchy in nursing, and the anxieties associated with the clinical regulation of such innovations:

"I think that they (nurse practitioners) *may well be working independently, be first line carers, have patients referred to them from other professions and build up their own practices. I expect a lot will work independently. I can see GP practices where nurses will be in partnership with general practitioners. I think they* (nurse practitioners) *will be leading the nursing profession clinically and therefore be nurse consultants eventually."*

Student Nurse Practitioner - G1 Data Segment - 1st Interview Data

"It will be very interesting to see what the UKCC has to say. I don't hold out any massive hopes that they will come out with anything desperately innovative. But, I hope that they come out with something a bit less half-baked than they usually do. Something that you can clearly say, 'this is it; this is how we see the (nurse practitioner) *role.'"*

Nurse Teacher - G1 Data Segment - 1st Interview Data

These data extracts illustrated that the teacher team was managing an education programme that was influenced by many professional issues. The national developments in nurse practitioner regulation reflected a time of considerable progress, and this was evident throughout the data collection. During the separation phase, as the teacher team members negotiated their own difficulties and philosophical reflections, they had also to be mindful of wider professional developments. Thus, the teacher team's professional transition revealed a process of separation, as the individual teachers began to develop a better understanding of advanced clinical nursing roles.

This completes the presentation of this sub-section on the teacher team's professional transition experience during the separation phase. In the next sub-section, I review

the students' experiences of the professional transition theme during the separation phase.

7.4.2. The students: professional transitions during the separation phase

In June 1997, a member of the teacher team observed the following during an evaluation session that marked the end of the previous diploma course:

> "(nurse teacher's comment) *I cannot deny the bits that the* (diploma) *students have taken from the doctors; I guess they are a bit of nurse and a bit of doctor all mixed up."*
>
> *Field Note Entry - June 1997*

This data extract revealed the uncertainty that the new degree students would face when they attempted to make sense of their future professional roles. Their nurse practitioner role development would take them into medical territory and this would lead them to question the nature of their traditional nursing background. The teacher team, which had previous experience of earlier student groups, anticipated a process characterised by professional conflicts and boundary negotiations, and expected that these would be most apparent in the relationship between the physician mentor and the student:

> *"What I notice at the beginning of the nurse practitioner course is the relationship between the mentor and the student is still very much one of two different cultures operating within their own boundaries. They are very reluctant and fearful to cross those boundaries (on both sides), but particularly on the nursing side. You get situations where the nurse will not approach their mentor to ask them for what they need, because that is not what happens between doctors and nurses. Nurses are told that they don't ask that sort of thing. So, I think that the relationship between physicians and nurses, however friendly, pleasant, and comfortable, is one of subordination. Where I really do*

see a change and a shift is to a more equal relationship with nurse practitioners."

Nurse Teacher- E1 Data Segment - 1st Interview Data

The professional boundary issues highlighted in this data extract were observed on the first day of the nurse practitioner degree programme in September 1997. I noted a sense of both anxiety and expectation amongst the students on that day. During an introductory address, the teacher team informed the students that they were on a journey that would result in them becoming professional nurse practitioners. Thus, the teacher team had set its agenda and explicitly laid claim to a view that the students would develop a new clinical role that would (or should) be different from their older (current) role. During a group discussion, the students gave their view of the prospective role that had been outlined by the teacher team. One stated that she hoped the nurse practitioner degree programme would:

"(student nurse practitioner's comment) *Enhance my practice and allow me to be a maxi nurse."*

Field Note Entry - Introductory Day - September 1997

Another observed of her current role:

"(student nurse practitioner's comment) *At the moment I am just a staff nurse."*

Field Note Entry - Introductory Day - September 1997

These data extracts typified comments from other students on that introductory day. This mirrored the teacher team's expectation of the students' transition toward a new clinical role, and their transition away from their current role. Those expected

transitions in role and identity raised some concerns. An example of this was anxiety regarding loss of professional identity, and this was evident in the following data extract:

> "(student nurse practitioner's comment) *It worries me, what will I be? Will I lose nursing?"*
>
> *Field Note Entry - Introductory Day - September 1997*

I observed that the introductory morning's discussion centred on issues of professional identity, and touched on the development and acquisition of new knowledge and language. This aspect of new knowledge acquisition focused particularly on medical issues, and the teacher team members actively promoted this theme of discussion. This was an indication that the teacher team was, from the outset, focusing on professional identity issues, and that these could influence the students' development. For example, the teacher team was quite open about the use of the traditional biomedical model in the curriculum structure, adding that this was enhanced, and complemented, by significant social skills content. However, it had to defend this in the face of some critical questioning from the students over the use of medical knowledge and skill. The teacher team countered this by suggesting that the mix of nursing and medical skills was a process tried and tested in earlier student cohorts and that it had enabled advanced clinical nursing practice. The teacher team also emphasised that it was advantaged by its multi-professional membership, and that it had used that diversity in structuring a learning process that promoted advanced clinical nursing competencies. Despite having alluded to a perceived strength in professional diversity, and following the suggestion that the nurse

practitioner was a hybrid of nursing and medicine skills, the physician teacher then stated that the nurse practitioner degree programme provided:

> "(physician teacher's comment) *A healing between nursing and medicine."*
>
> *Field Note Entry - Introductory Day - September 1997*

This contrasting statement pointed to a perception of an existing state of conflict between the two professions. Thus, there was also a view that the role of the nurse practitioner transgressed the professional boundary, and there was an expectation that it would meet with difficulties arising from identity conflicts and role redefinitions. To meet that challenge, it followed that the students would need to separate to some extent from their current professional nursing identities and actively explore the nature of the nurse practitioner role. That role was dependent on professional boundary negotiation and the following data extracts revealed the extent and expectation of that:

> *"They* (nurse practitioners) *wouldn't be fully doing doctoring work. But there would be areas where there would be a synthesis of medicine and nursing and that would be where aspects of nurse practitioning lie."*
>
> *Nurse Teacher - D1 Data segment - 1st Interview Data*

> "(On nurse practitioners using nursing and medical skills) *Specifically, there are the elements of caring that nursing carries, and there are more intuitive elements in that. From the medical angle, there is the scientific approach to diagnosis, management and treatment. I am sure as time goes on there will be a third element that will come out, which we can't yet see because there is not yet enough nurse practitioners at practice level. Something will evolve out of the marriage of those two elements."*
>
> *Physician Teacher - D1 Segment - 1st Interview Data*

With that expectation of change, I observed the students developing uncertainties and anxieties regarding their potential identity transition:

> *"I think it* (the nurse practitioner role) *looks more at diagnosing as well as still being a caring profession. I wouldn't like to see it move too far away from nursing. I think it should stay within the nursing scope. But obviously we will have an emphasis on diagnosis and curing as medicine does."*
>
> *Student Nurse Practitioner - D1 Data Segment - 1st Interview Data*

This uncertain state raised the question of personal motivation. During this professional transition of the separation phase, and considering nurses' wish to have greater professional recognition and status (chapter two, section 2.3. p.30), it was not surprising that a motivation was found in the desire for more clinical authority and professional recognition. Achieving that required the students to undergo transitions (transitions in knowledge, transitions in clinical activity). The following data extracts revealed the students' expectations of the transition to an enhanced professional status:

> *"More recognition for the job I am doing now, and to be more knowledgeable because I am being called to do work that doctors should be doing a lot of the time."*
>
> *Student Nurse Practitioner - F1 Data Segment - 1st Interview Data*

> *"I feel at the moment that I am doing the job but I am not qualified enough really. It's fine to be seen as an equal with doctors and to be able to converse with them, but I must have a qualification that matches up to their qualification, in fairness to them."*
>
> *Student Nurse Practitioner - F1 Data Segment - 1st Interview Data*

"I am rather hoping to move away from the blood taking and all those rather routine aspects of practice nursing and do the bits I enjoy more, which is getting down to the nitty gritty of what is wrong with the patient and what I can do to help the patient."

Student Nurse Practitioner - F1 Data Segment - 1st Interview Data

A particular feature of these data extracts was the inference that the students' motivation for greater professional status was driven by a perception that their existing clinical roles had already significant medical skills components to them, albeit skills that were neither formalised nor socially acknowledged. Thus, it seemed that during the separation phase that a motivation for the students' professional transition lay in the social status of the medical practitioner.

This completes the presentation of the professional transition theme during the separation phase. In the next section, I discuss the clinical authority transition theme during the separation phase.

7.5. THE SEPARATION PHASE AND CLINICAL AUTHORITY TRANSITIONS

In this clinical authority transition theme of the separation phase, I discuss the authority experiences that influenced the physician mentors. Thus, authority issues link the separation phase to this discussion (chapter seven, sub-section 7.1.1. p.151-152).

7.5.1. The physician mentors: clinical authority transitions during the separation phase

The physician mentors' role was critical to the students' acquisition and development of the diagnostic and autonomous nurse practitioner role. Developing advanced physical assessment skills, drawing selectively on knowledge of pathology and pharmacology, formulating a differential diagnosis and instituting appropriate patient management, were skills and behaviours that required nurturing in clinical practice. The teacher team had promoted the physician mentor as the clinical professional most able and available to do this. Although clinical mentorship by qualified nurse practitioners would have appeared an ideal solution, at the time of this research (1997-1999), there were few such individuals in clinical practice. Thus, the relationship between the students and their physician mentor was fundamental in clinical skills acquisition and role development.

However, there was also another important feature of the physician mentor and nurse practitioner student relationship. The goodwill and collaboration of the physicians in enabling nurse practitioner roles to develop was fundamental to the success of the nurse practitioner degree programme. In 1997, the nurse practitioner role in the UK was ambiguous, potentially threatening to medical authority, and it challenged traditional professional boundaries. If the nurse practitioner degree was to be effective in its translation into practice, it required a multi-professional endorsement. Thus, the inclusion of the physician mentors as clinical educators in the degree programme served two purposes: firstly, to nurture the clinical skills of the student

nurse practitioner, and secondly, to provide professional sanction to the nurse practitioner role (chapter ten, sub-section 10.3.1. p.367-374).

I observed that much was expected of the physician mentors. They were asked to disseminate their professional skills to another professional group, and also to give sanction to that new clinician and relinquish their sole ownership of those skills. This demand was a complete antithesis to the concept of professional closure; it was a request to purposively, and actively, open professional borders. Consequently, the physician mentors represented an important focus in terms of the motivations of the medical profession in either promoting or limiting the development of nurse practitioners on the degree programme. The data suggested some ambivalence at the outset of the degree programme:

> *"You would treat a nurse practitioner differently. We do treat nurse practitioners differently! We recognise a higher level of involvement, a greater degree of autonomy and decision-making; we have got to expect that. I don't know about the medical profession as a whole, whether it feels threatened - I doubt it. Most of them are delighted to have someone to share the burden with."*
>
> *Physician Mentor - F1 Data Segment - 1st Interview Data*

> *"I think some doctors are going to be easier than others. Some partners may not like it, or might not pass on or delegate jobs. As a profession, whether doctors will allow it to happen I don't know, because they may think that maybe they are going to be replaced in some way. Jobs are on the line! It will be interesting to see how things go over the next five years."*
>
> *Physician Mentor - F1 Data Segment - 1st Interview Data*

In these data extracts, the physician mentors reflected on the professional authority challenges made by nurse practitioners and the possible affect of these challenges on the professional border. Two closely linked and yet contrasting sets of issues arose from this. Firstly, the nurse practitioner required increased clinical autonomy and clinical authority in order to function effectively. Secondly, extending nurse practitioner authority depended on the sanction of the medical profession. If both were achieved (an increased clinical autonomy sanctioned by medicine), then the nurse practitioner would present a challenge to the perceived stability of the professional boundary between nursing and medicine. This would demand new thinking that would realign the traditional hierarchy and clinical authority regulation, and there was evidence of this in the data:

> *"These nurse practitioners are probably doing things that a doctor would do, exactly the same as a doctor would do really. I think that could be a problem really, whether she sits in the staff common room or in the doctors' sitting room - or whatever?"*
>
> *Physician Mentor - B1 Data Segment - 1st Interview Data*

Acknowledging nurse practitioners influence on workload, in terms of the sharing of clinical work, also revealed a potential threat to medical dominance of the healthcare professions. Finally, the physician mentors faced a professional demography that they could not ignore. This was a political and economic imperative as healthcare economists looked to nurse practitioners as a means to relieve the problem of physician shortages (Jenkins-Clarke et al 1998, Jenkins-Clarke and Carr-Hill 2001). The physician mentors were aware of this:

"I think we have to face up to the fact that recruitment in general practice is going down. Now whether that will change I don't know. A lot of young doctors are not really prepared to be committed to one area, in joint partnerships and getting financially involved in a practice."

Physician Mentor - G2 Data Segment - 1st Interview Data

Thus, the physician mentors foresaw the demand for alternative healthcare roles, and were party to the development of such a role in the nurse practitioner degree programme. Despite that apparent endorsement of the degree programme, the physician mentors had some anxieties regarding the nurse practitioner role. These anxieties were raised during mentor meetings arranged by the teacher team. The teacher team considered physician mentor meetings as an important component of the programme curriculum as they facilitated the exchange of ideas and concerns, and provided a means of developing a clinical network. Mentors attended these meetings at the university where they met with the teacher team and other students and mentors participating in the nurse practitioner degree programme.

It was during the first clinical mentors' meeting in September 1997 that some of the physician mentors' immediate concerns were raised. There was an interactive discussion, and they met and questioned student nurse practitioners and observed role-played clinical examinations. I noted that the physician mentors attempted to relate to their student's knowledge and skill development by using benchmarks from their own professional experience. The physician mentors explored with the teacher team the level and depth of knowledge and skill that their students needed. The teacher team explained that, although there was no intention to copy a medical

curriculum, it was helpful to use a knowledge benchmark with which the physician mentors were familiar. The physician teacher who was a member of the teacher team provided this benchmark:

> "(physician teacher's comment) *Teach them as if they were 5th year medical students."*
>
> *Field Note Entry –September 1997.*

I noted that the physician mentors appeared surprised by this, and indicated that they viewed this as a high standard for nurses. However, the influence of the physician teacher (as a member of the teacher team) proved to be an important connection to the nurse practitioner degree programme, and this influenced the medical mentors. There was no doubt that this physician teacher's opinions, and her clinical credentials from within the medical profession, were persuasive factors for the physician mentors. This is evident throughout the data and this particular episode had provided an early example of the influence that she had on her peers. I suspect that the physician mentors would have been less receptive to this comparative knowledge level of 5th year medical student had it originated from a nursing or academic member of the teacher team. However, the physician mentors' surprise at this suggestion, even from one of their peers, made it clear that they had already preconceptions of the nurse practitioner role.

I noted that the physician mentors' views of the nurse practitioner role fell broadly into two types: the view of the nurse practitioner as a mini doctor, and the view of the nurse practitioner as a traditional matron. The first view had appealing features for

the physician mentors. The nurse practitioner as a mini doctor, as a physician assistant, would be under the sole control of medicine, whilst freeing the fully-fledged legitimate doctor from mundane medical tasks. In this view, the physician mentors tacitly accepted the fluidity of the professional boundary but attempted to negotiate that boundary order in their own terms only. Whilst this model would give medicine complete control of the nurse practitioner, it would nevertheless represent a challenge to the closed membership of medicine. This challenge was acknowledged in the following data extract:

> *"So I think it will develop* (nurse practitioning*). It will reduce the work that you don't need a very experienced doctor to do. You can use somebody else who is equally, if not more capable, of doing that. Use them, and get the doctor to deal with purely medical problems. Like certain things that nurses used to do are now handed over to nursing auxiliaries. Taking temperatures, washing the patient, you know, traditional nursing that is now given to the auxiliary so nurses can be more scientific. Most house officer roles could be taken by nurse practitioners."*
>
> *Physician Mentor - B1 Data Segment - 1st Interview Data*

The alternative to this view was the second perspective, the view of the nurse practitioner as a traditional nursing role that was resituated in a modern context. In this view, evident in the data extracts below, the nurse practitioner would remain the sole concern of nursing, and nursing would remain as it always had, under the domination of medical authority:

> *"It's* (nurse practitioners) *getting back the old senior sister, the old night sister who (pause) - in the good old days (pause) - everything got run by them. Not exactly, but that's probably the best way that I can sum it up."*
>
> *Physician Mentor - E1 Data Segment - 1st Interview Data*

> *"So all the girls* (nurses) *know what she* (the nurse practitioner student) *is doing. If there is any problem with some chemotherapy, they can ask her, because they know she is doing this. Which is what you would do in the old days, you would go and ask the senior sister."*
>
> *Physician Mentor - B1 Data Segment - 1st Interview Data*

To understand the implication of these data further we must remember that the view of the nurse practitioner as a junior doctor was contrary to the nurse practitioner degree programme's philosophy that promoted them as advanced nurse clinicians. However, providing medical benchmark standards for the physician mentors (5th year medical student) was encouraged by the teacher team, as in 1997 there were relatively few clinical nurse practitioners, and no nationally agreed clinical competencies in the UK. Additionally, the view of the nurse practitioner, as either a mini doctor or matron, was familiar. If the first perspective of nurse practitioners as medically controlled assistants were true, then questions remained. How could nurse practitioners be measured, how should they be treated and how were they to be controlled? These were all issues in the physicians' minds. I noted that the teacher team offered little help, only providing conceptual rather than concrete definitions or clinical role descriptions. However, a question arose, what would happen if nurse practitioners did not come under medical dominion, what would happen if they challenged that control? In this eventuality, the physicians could use their second view of the traditional senior nurse or matron. They had encountered these role models during their time as medical students or junior doctors. This dated imagery of the matron was gender and age-related and did not reflect the current reality of the nursing profession (e.g. the reference to nurses as *"girls"*). Nevertheless by

identifying the nurse practitioner with the traditional nurse matron (a role that did not challenge medical authority), the nurse practitioner concept could be comfortably contained.

Thus, at this early stage of the separation phase the physician mentors were re-evaluating the professional relationship between the doctor and the nurse. Neither of the two models adequately addressed their need to find a place for the nurse practitioner in healthcare. The organisational and occupational definitions available to the physician mentors simply did not capture the totality of the nurse practitioner role.

The physician mentors were undergoing a process of authority transition that required separation from an older order. They had to re-evaluate and re-think traditions of authority and conceptualise new structures (advanced clinical nursing) that would allow for mutually acceptable border renegotiations, and this was evident in the following, and final, data extract of this sub-section:

> *"You do need a gate keeper to sort and sift. It's clear to me that, in a small town like this, lets say nine general practitioners for a population of sixteen thousand - who knows, in twenty or thirty years time there may be two or three primary healthcare doctors, and half a dozen nurse practitioners. The patients accept them, that's the other big thing. They seem to be accepted. There are no complaints whatsoever about seeing a nurse practitioner. Sifting and sorting, and making real decisions about who goes on for second opinions and treatment and so on."*
>
> *Physician Mentor - E1 Data Segment - 1st Interview Data*

This completes the presentation of the clinical authority transition theme during the separation phase. In the next section, I discuss the clinical knowledge transition theme during the separation phase.

7.6. THE SEPARATION PHASE AND CLINICAL KNOWLEDGE TRANSITIONS

The clinical knowledge transition theme of the separation phase is divided into parts. Firstly, I discuss the teacher team's experience of clinical knowledge transitions. Enabling processes link the separation phase to this discussion (chapter seven, sub-section 7.1.1. p.151-152). Secondly, I discuss the students' experiences of clinical knowledge acquisition. Accepting and managing the process link the separation phase to this discussion (chapter seven, sub-section 7.1.1. p.151-152).

7.6.1. The teacher team: clinical knowledge transitions during the separation phase

Clinical knowledge is a broad term, defined in this context as that theoretical knowledge required when enacting the role of the nurse practitioner. In the introductory chapter (chapter one, section 1.1. p.2), the role of the nurse practitioner was defined as health assessment and diagnostic skills used in autonomous patient management. The curriculum of the nurse practitioner degree programme reflected a modular content of interpersonal consultation skills and clinical supervisory skills, pathology and related clinical pharmacology, health assessment skills and evidence based research. The curriculum design gave equal importance to the varied aspects of the degree programme. However, the data indicated that the teacher team had noted

that the students concentrated on the health assessment skills and pathology and pharmacology theory within the degree programme; this focus on the medically oriented content, rather than on the humanist psycho / social and research content, of the nurse practitioner degree programme:

> *"I think that there is a danger that they* (examination and diagnostic skills) *can become the main focus of the course. I think that would be a pity. Because even in medical training I think it has been shown that just doing that is not enough. I understand why the students are so concerned with them because they are the newest thing, the most interesting thing and the most difficult thing. So, I sympathise with that. As a tutor I have to hold with the fact that they need both, the new skills but also the interpersonal bits. I have to have faith that those skills are actually important and underpin their practice in the future. I am concerned that sometimes we could run away as a course with the sexy skills of clinical examination, with your stethoscope, and our focus could become to medicalised."*
>
> *Nurse Teacher - F2 Data Segment - 1st Interview Data*

Recognition of this unequal emphasis was important. The teacher team had designed the curriculum to provide an even educational input from the various modules, this deemed as necessary to meet all the degree programme's outcomes. Formal examination and assessment of each module would ensure the students attended to all aspects of the nurse practitioner degree course. Nevertheless, the students devised their own agenda to manage what they perceived as priority knowledge and high status skills. They saw health assessment skills, founded on the traditional medical knowledge of pathology and pharmacology, as the more useful and important content of the nurse practitioner degree programme.

The nurse practitioner degree programme curriculum content requirement in-depth pathological and pharmacological theory and its application to a diagnostic decision-making outcome, and this presented a challenge to the teacher team in terms of content delivery and summative assessment. Much of that innovation would come from the use of integrated clinical examinations (objective structured clinical examinations - OSCEs) later in the nurse practitioner degree programme. Such clinical examinations had been widely used in medicine and nursing education previously. However, in the nurse practitioner programme, OSCEs made a particular contribution to the sample experience (chapter nine, sub-section 9.7.1. p.333-349).

The teaching of the clinical knowledge of pathology and pharmacology was organised by the teacher team members who called on science teachers within the department to help them with this content. Despite that departmental resource, the analysis suggested that the teacher team struggled to find an adequate level of clinically applied biomedical education for the students. Whist there was sufficient educational resource and expertise to provide the theoretical teaching, there was limited teacher resource in the clinical application of that knowledge. Application of such knowledge had to be current and clinically relevant, and although the departmental teachers who taught the pathology and pharmacology content were knowledgeable, they were not clinically active. This lack of specific clinical expertise was a feature of the teacher team profile, and a feature of the clinical apprenticeship structure of the nurse practitioner degree programme (chapter six, sub-section 6.2.6. p.141-142). These observations pointed toward a need to recruit

appropriate clinical experts (experienced nurse practitioners) to the teacher team who could apply their knowledge in a clinical context. It was also an observation that nursing, unlike medicine, had no equivalent formal clinical educational structure that could resource, or regulate clinical development meaningfully at an advanced level. This is reviewed in more depth in the discussion chapter (chapter ten, sub-section 10.3.2 p.374-381 / chapter ten sub-section 10.3.3. p.381-391).

Finally, a concern raised during this clinical knowledge transition was the relatively limited time-scale of the curriculum delivery. The data revealed a physician mentor view of the nurse practitioner degree programme as overly ambitious:

> *"The course needs to develop and one needs to ask a question. Is a one day a week course over two years sufficient? Possibly it is, I don't know, I would have to think about that."*
>
> *Physician Mentor - F1 Data Segment - 1st Interview Data*

I note three points in acknowledgment of the time limitation observed in the above data extract. Firstly, the student timetable was full and theoretical teaching commenced at the second study day in September 1997. For the teacher team, this reflected a normal pattern of curriculum delivery for a part-time academic programme, the essential difference on this occasion being the transition of the academic level from diploma to degree standard. Secondly, whilst the students were novice nurse practitioners (chapter seven, sub-section 7.3.2. p.160), they were also professionally and clinically experienced nurses. Thus, the students' existing clinical expertise was a consideration in their clinical development. Thirdly, the teaching

team emphasised the completion of the nurse practitioner degree programme as a beginning point in the ongoing development of advanced clinical skills, and encouraged all the students to continue with mentorship following graduation. The view that the nurse practitioner degree programme could not achieve everything in the time allowed is borne out by the study's later findings in chapter eight and chapter nine.

This completes the presentation of this sub-section on the teacher team's clinical knowledge transition experience during the separation phase. In the next sub-section, I review the students' experiences of the clinical knowledge transition theme during the separation phase.

7.6.2. The students: clinical knowledge transitions during the separation phase

From the outset of the nurse practitioner degree programme, the students had expressed their wish to develop and refine their knowledge base. This need was evident in their view of the nurse practitioner role as one that required advanced clinical decision-making, and this was clear in the following data extract:

> *"The main aim at the moment is to increase my knowledge. I really feel a lacking in some areas, especially in physiology and pharmacology. I find it frustrating when you're trying to understand what is going on with the patient, with treatment, or with blood test results, and you find that you haven't got quite sufficient knowledge to interpret this result, or to interpret that treatment."*
>
> *Student Nurse Practitioner - F2 Data Segment - 1st Interview Data*

This demand for more knowledge accords with observations of the students' pace of study as consistent and intense. By January 1998, following the first Christmas recess, the early data analysis revealed developing issues and changes that were arising from the students' knowledge transition and I summarised these points in my notes:

> *"The teacher team has a positive perspective of the student group's learning skills.*
> *The students have developed into a cohesive group.*
> *The student group are developing complex clinical abilities of health assessment and patient management whilst in the classroom setting.*
> *The student group is observably negotiating outcomes with the teacher team.*
> *The student group is complaining of a lack of time for adequate learning.*
> *The students are becoming anxious regarding forthcoming assignment work."*
>
> *Field Note Entry - January 1998*

This range of observations revealed features of the students' knowledge transition in the separation phase. For example, the students' developing classroom identity reflected their increasing separation from their daily occupational identity (chapter seven, sub-section 7.3.2. p.162-164). As that identity issue developed, it gave rise to the first expressions of anxieties, from the group as a whole, as well as from individuals. It was evident that these anxieties arose in part from the first forthcoming summative assignment work. However, further analysis of these anxieties revealed a more complex situation. In the earlier part of the separation phase the students had been mostly the passive recipients of new knowledge. I noted, toward the end of the separation phase, that this passivity appeared to be ending and they were now beginning to use this new knowledge in their clinical practice. The transition through new knowledge to new practice occurred with the advent of formal

examinations. As the students approached their first examination hurdle, a significant feature of their knowledge transition came into focus. I recorded evidence of this in January 1998, during a combined student and teacher group discussion on physiology knowledge. I observed both students and the teacher discussing concerns over a perceived inadequacy in nurses' physiological knowledge of human body systems:

> *"The student said, 'why haven't we been guided earlier into in-depth appropriate reading?' The teacher replied, 'you see, it's not just the reading, it's even the basic terminology you don't know!'"*
>
> *Field Note Entry - January 1998*

This data extract is drawn from a longer and more detailed exchange. When I compared this with other data I collected of the same time, it appeared to be contradictory. For example, the students had undertaken pre-course studies in human physiology, and my observations described students and teachers as engrossed in in-depth and intense episodes of questioning where the group displayed considerable understanding of advanced pathology. Points that I specifically recorded were depth, personal commitment, and language. For example, the data indicated that the students were materially advancing their knowledge to a new depth:

> *"It's difficult to articulate. This knowledge that they are learning is beyond the knowledge that an ordinary nurse uses."*
>
> *Field Note Entry - January 1998*

In respect of the students' personal commitment, the data indicated that the students were giving considerable commitment to their studies:

"Although the central nervous system is very difficult to grasp it is intriguing how hard they are striving to understand and learn."

Field Note Entry - January 1998

"(student nurse practitioner's comment) *I am even practising reflexes on my husband and children!"*

Field Note Entry - January 1998

How did these data equate with an observation of a student and teacher discussing misgivings concerning fundamental knowledge? The connection here is language and vocabulary. Language was an issue frequently observed in the data. It appeared that the students lacked fluency in the language they needed to communicate their knowledge:

"Without the right vocabulary they are blind. The students are learning medical vocabulary. I wonder if they will meld this with nursing vocabulary?"

Field Note Entry - January 1998

A precursor to the students' development of more advanced clinical skill was the acquisition of, and use of, new vocabulary rooted in the traditional biomedical sciences. It was this fundamental lack of fluency in biomedical language that was alluded to by the teacher earlier.

Although nurses commonly used fragments of the language of human physiology, pathology, and other related biomedical specialties in their day-to-day work, it was a limited vocabulary based on a limited knowledge of these sciences. For example,

nurses would frequently use terminology and abbreviation from the biological sciences in their written documentation. Whilst useful, it was not used in such a way that would develop fluency in that language. It was therefore interesting to note that the data revealed an expectation amongst the students that greater knowledge of biomedical science and fluency in its vocabulary would enhance the clinical role of the nurse practitioner by improving their ability to communicate with medical colleagues:

> *"I think doctors might identify more with nurse practitioners, because they have a similar sort of knowledge. Because they have more knowledge of pathology, they are speaking the same language."*
>
> *Student Nurse Practitioner - F2 Data Segment - 1st Interview Data*

Questions inevitably arose when considering such data. For example, if the language of the biomedical sciences was potentially of such benefit to advanced nurses, then why did nurses use it in such a limited and erratic way? I propose that nursing, in seeking its own identity (chapter two, section 2.2. p.30), had actively avoided acquisition of such vocabulary, as its use was synonymous with medical identity. If this were true, then nurses who adopted the language of the biomedical sciences ran the risk of medicalising nursing practice. This debate was reflected within the literature that considered the extent to which the biomedical sciences should be included within nursing curricula at both pre and post registration level (Courtenay 1991, Jordan 1994, Wharrad et al 1994, Wharrad et al 2001). The nurse practitioner degree programme that I have examined in this research had actively adopted curricular content that included in-depth biomedical science, and it expected

application of that knowledge in a diagnostic and health assessment context. The curriculum designers' claim was that this knowledge was used within the sphere of nursing based on the concept of advanced clinical nurse practice (chapter six, sub-section 6.2.5. p.138). The effect of this curriculum was an expectation of a level of fluency in biomedical vocabulary from the beginning of the nurse practitioner degree programme. Consequently, the students were disadvantaged in the separation phase by an underdeveloped biomedical vocabulary. Acquisition of that vocabulary became a primary focus of their learning needs as it would enable their use of biomedical knowledge.

Learning in a foreign language is perhaps a reasonable analogy for this vocabulary deficit. Bredo (1999, 2003) saw the acquisition of new language as more than just a means of mirroring another reality (if I talk nursing, then I am a nurse). New language promoted broader social coordination and adaptation. Thus for the students to make use of this knowledge, they would have to disengage from the traditional concepts of nursing knowledge that discouraged medicalisation, and actively engage and socialise with medical knowledge and language. That process was a feature of their socialisation, and was an integral part of the students' adaptation experiences. However, that process of separation from a nursing paradigm, and subsequent socialisation with a medical paradigm, would engender anxieties related to the students' professional identity as nurses. Further examples of this arise again later in the transition and incorporation phases (chapter eight and chapter nine).

This completes the presentation of the clinical knowledge transition theme during the separation phase. In the next section, I discuss the clinical skills transition theme during the separation phase.

7.7. THE SEPARATION PHASE AND CLINICAL SKILLS TRANSITIONS

The clinical skills transition theme of the separation phase is divided into two parts. Firstly, I discuss the teacher team's experiences of the educational provision of clinical skills. Rationalising processes link the separation phase to this discussion (chapter seven, sub-section 7.1.1. p.151-152). Secondly, I discuss the students' experiences of clinical skills acquisition. Rules that structured this process link the separation phase to this discussion (chapter seven, sub-section 7.1.1. p.151-152).

7.7.1. The teacher team: clinical skills transitions during the separation phase

As indicated earlier (chapter seven, sub-section 7.6.1.p.185) there was an observed tendency on the part of students to place particular emphasis on the health assessment and diagnostic skill outcomes of the degree programme. The students viewed health assessment skills as the core of their learning experience and as the feature that had attracted them to the nurse practitioner degree programme over other traditional academic degree programmes. Thus, the teaching of clinical skills was, from the outset, viewed by the students as of high status in their study experience. I noted that other content areas of the nurse practitioner degree programme were ordered by the students' perception of their clinical relevance to health assessment skills. Pathology and pharmacology were seen as important, consultation skills and clinical supervision

were viewed as relatively unimportant, and research was seen as an academic irrelevance. Thus, the teaching of clinical skills was a focus of the students' perception of their role development.

The influence of the physician teacher, as the clinical specialist in diagnostic health assessment, played a central part in guiding that process of clinical skills acquisition (chapter seven, sub-section 7.5.1. p.176-184). This teacher's influential role in this aspect of the nurse practitioner degree programme reflected her professional and cultural experience as a physician. Her influence on the teaching of clinical skills enabled two main outcomes. Firstly, it acted as a communication bridge between the physician mentors and the teacher team. Secondly, it provided the students with tuition from a clinical expert in traditional medical skills. However, it also inevitably reflected a particular medical bias. As the students actively engaged with medical knowledge to meet the nurse practitioner degree programme's clinical competencies, this professional bias of the physician teacher was arguably an advantage to the students in their transition through their clinical skills acquisition. This was particularly so if one contrasted the physician teacher's medical background with the nursing background of the remaining members of the teacher team, and the nursing focus of the wider department. Nevertheless, the teacher team's general skill mix, and the multi-professional team characteristic, provided (regardless of any other teacher team dynamics) a balanced perspective. That was useful for the students who were engaged in multiple skill transitions at the professional border between medicine and nursing.

It was important that the teacher team acknowledged its multi-professional profile, as those diverse skills contributed to the process and intent of the nurse practitioner degree programme and helped in developing the two-way exchange and cooperation between the physician mentors and student nurse practitioners. That collaborative exchange was a demand placed on the students by the curriculum throughout the separation phase, the transition phase, and the incorporation phase. The following data extracts revealed that the members of the teacher team were aware and responsive to the relationship between the two professions:

> *"I think medicine has underrated nursing for much too long. Hundreds of years probably. I also think nursing has underrated itself. Hence, the relationship has been quite top heavy and nurses have been directed by medics. Certainly, this is my experience in hospitals. Except when you are a junior doctor in which case your very much guided by the senior nurses. I think it's way gone time that the nursing profession stands on its own power, which is considerable, but it doesn't recognise it."*
>
> *Physician Teacher - F1 Data Segment - 1st Interview Data*

> *"I hope the relation between nurse practitioner and doctors will be one of mutual respect. I am not saying that doctors don't respect nurses and that nurses don't respect doctors, because I know they do. But, I think there is a lot of sibling rivalry. I would hope it would be one of 'this is what your good at and this is what I am good at, I can offer this to you and you can offer this to me.' It will be more of a partnership rather than a classical doctor / nurse relationship where one is superior and the other is inferior."*
>
> *Nurse Teacher - F1 Data Segment - 1st Interview Data*

Thus, aspects of the dynamic relationship between medicine and nursing were apparent in the views of the teacher team, and that would influence negotiations between students and physician mentors, and consequently influence new orders at

the professional border. I observed an example of the teacher teams' multi-professional influence in August 1997 when they met to review a developing conceptual clinical skills model for use within the curriculum. This model defined four domains from which a staged developmental process of skill acquisition and development could be used to assess and to measure the students' progress. These domains were:

- History Taking
- Examination Skills
- Patient Management Skills
- Reporting and Presentation Skills

Each domain of this model drew selectively on content from the taught modules that comprised the nurse practitioner degree programme. For example, patient management skills required students to develop and use consultation skills, pathology and pharmacology knowledge, health assessment skills, diagnostic skills, and evidence-based research. Each domain followed a staged process and a predictable chronology:

1) The Mechanical Stage: the early learning stage where clinical skills were practiced repetitively until they were automatically undertaken.

2) The Integrated Stage: the middle learning stage where clinical skills became refined and inter-linked with others.

3) The Diagnostic Stage: the final learning stage where clinical skills were refined and selectively used in autonomous patient management.

This model was used to manage the development and assessment of the students' clinical skills throughout their studies. The model was merged into a clinical skills map that outlined the varied components of the students' clinical learning experience. This map (Figure 7.2. p.198) was used by the teacher team to structure the students' skills transitions:

<table>
<tr><td>SKILLS OF
Health Assessment
History taking
Examination Skills
Interpersonal Skills</td><td>SKILLS UTILISING
The Pool of Knowledge
Biological Sciences
Therapeutics</td><td>SKILLS OF
Intuition
Intuitive Knowledge
Life Experience</td></tr>
<tr><td colspan="3">Rehearsing the Skills
Mechanical --- Integrated --- Diagnostic

Refining the Process
Diagnosis --- Investigations --- Management</td></tr>
<tr><td colspan="3">Determining the Outcome
Patient Management Skills
Reporting and Presentation skills</td></tr>
</table>

Figure 7.2. A clinical skills map

This completes the presentation of this sub-section on the teacher team's clinical skills transition experience during the separation phase. In the next sub-section, I review the students' experiences of the clinical skills transition theme during the separation phase.

7.7.2. The students: clinical skills transitions during the separation phase

In October 1997, I observed the students' first health assessment skills sessions. In these sessions the students had the clinical skills map outlined to them (Figure 7.2. p.198). This map drew comment from the students, as aspects of it were clearly medical in nature. There were several discussions on the use of medical skills in

nursing practice and it was evident that the students were concerned that the nurse practitioner degree programme would situate them in the domain of medical practice. This concern was raised several times in these early sessions, and this has been discussed earlier in this chapter (chapter seven, sub-section 7.4.2. p.172-173). I noted that the teacher team promoted its belief that the traditional medical model was more accurately described as a generic health assessment skills model, developed from a traditional medical model, but used in a different clinical and professional context. Whilst this appeared to address the concerns of the students, it also illustrated that the teacher team had to defend its position on this issue.

The transition to new clinical skills was an important component of professional identity separation. The students in one sense had freely elected to undertake that process of transition, by virtue of wanting the new skills and the associated status of the graduate nurse practitioner. They had effectively consented to the transition away from traditional nursing skills. However, when confronted with a model that had many of the familiar characteristics of medicine, this worried the students and caused concern that the nurse practitioner degree programme would take them unwillingly into a medical role. The teacher team insisted that this was not the case. Whilst it agreed the professional origin of much of their model arose from medicine, it believed that, within the nurse practitioner degree programme, it was a model removed from medical ownership. It was this assertion that returned elements of control to the students. I suggest that this was an important moment in the students' early separation experience.

An attraction of the nurse practitioner degree programme was the provision of clinical skills and knowledge to achieve diagnostic outcomes. However, this transgressed the professional medical border, and consequently could cause defensive reactions and censure from medicine and from nursing. Whilst students undertaking the nurse practitioner degree programme desired the skills that the curriculum offered, they had to be responsive to defensive challenges from both the nursing and medical professions. They had to be able to negotiate conflicts with their peers and their clinical mentors. Thus, it was important that the teacher team had responded to such threats. Equipping the students with a response to accusations of professional transgression had facilitated their ability to proceed with the subsequent processes of separation. Had this not occurred then students would have found it difficult to progress through the separation phase. That ability to defend professional boundary transgressions did not however suggest that the personal experience of such a transgression would be any less difficult.

During the separation phase (September 1997 to January 1998), I observed the students undergoing the process of acquiring and practising health assessment skills. They had invested a great deal of effort in this learning, and the data suggested that it was leading to greater confidence in these new skills:

> *"I watched them in class; they were in a quiet mood and were intensely absorbed with the taught content. They hesitantly interacted with the role plays, unsure of their abilities, particularly in diagnostic decision making."*
>
> *Field Note Entry - September 1997*

"At this time there is a feel of the students attempting to socialise themselves into a new decisive diagnostic role, it is an unfamiliar or uncertain area and they are unsure."

Field Note Entry - November 1997

"The physical exam routines are becoming very natural."

Field Note Entry - January 1998

These data extracts revealed an increasing fluency and development in the students' physical examination skills as the separation phase progressed. They appeared to be able to couple that clinical skills development with the theoretical knowledge they had gained from formal lectures. This prepared them for the difficulties of the next phase of the rite of passage, the incorporation phase.

This completes the presentation of the clinical skills transition theme during the separation phase. In the concluding section of this chapter, I summarise the data presentation and main findings of the separation phase.

7.8. THE SUMMARY OF THE SEPARATION PHASE

The separation phase of the rite of passage occurred between September 1997 and January 1998. However, there was some blurring at the beginning and end of the phase. The immediate pre-course period from June 1997 to August 1997 merged with the beginning of the separation phase in September 1997. Equally, at the end of the separation phase there was blurring with the beginning of the next phase of the rite of passage (the transition phase).

During the separation phase of the rite of passage, each of the five transition themes (chapter one, section 1.2. p.8. and chapter five, section 5.1. p.105) had revealed activity that involved, to varying degrees, the teachers, students and clinical mentors. For the teachers there were issues of the team dynamic, of maintaining closure and control over the programme aim, and of providing and maintaining a balanced structured curriculum. There was also a two-way interaction with wider professional developments and debates. The teachers were already socialised into their role as nurse practitioner degree programme facilitators, and they were catalysts in the students' passage through the separation phase. However, in this phase, separation experiences for them were mostly minor (or perhaps already very well established). It will become clear in the next chapter that the transition phase was a more prominent experience for the teachers. The students experienced a process of separation and role duality. They moved from being experienced professionals to novice student nurse practitioners. The students identified new norms and developed group solidarity, a pre-communitas. Within this pre-communitas, they assessed prospective identity issues and professional transgressions, they began to share their new clinical skills and defend their new role. The physician mentors engaged in the process of nurturing and sanctioning new clinical skills in their students. They had begun evaluating the impact that this would have on their professional status and consequently began to assess carefully the role of the nurse practitioner.

The transition experiences of the separation phase were broadly characterised by a socialisation with features of the medical profession, a socialisation with aspects of professional status, biomedical knowledge and vocabulary, traditional medical skills and advanced levels of clinical decision-making. Observing these trends revealed an emerging predicament. As I observed the students learning their new skills and knowledge, overcoming vocabulary deficits, dealing with identity issues and changes in their professional status, a notion emerged. I considered that the route to the nurse practitioner role, in part, occurred by a necessary passage through medicine. This idea is furthered throughout the two following data chapters (chapter eight and chapter nine) and is discussed in depth in the discussion chapter (chapter ten, sub-section 10.3.1. p.367-374 / chapter ten, sub-section 10.3.2. p.374-381). Thus, as the students endeavored to use new knowledge and skills, to make a transition to a new clinical role, they had to adopt transiently the culture of medical practice. At this point, the students would temporarily lose their nursing identity, enter liminality and embrace medicine. That sense of being on the threshold of something with promise and potential, and yet also facing many uncertainties, was revealed in the following data extract:

> *"I don't know where nurse practitioners are going but I think they are definitely going somewhere. They are not going to stop. It's not going to end here. I think if you look in the USA, there was something in one of the medical magazines just recently, where healthcare insurance companies are wanting to employ nurse practitioners to look after their patients rather than doctors. The doctors are not very happy about it. But then nurse practitioners can do it better and cheaper. I think it is on a progressive scale upwards. There is going to be more of us!"*
>
> *Student Nurse Practitioner - F1 Data segment - 1st Interview Data*

I conclude this chapter, which has presented a detailed analysis of the five transition themes within the context of the separation phase, with a concept summary (chapter seven, Figure 7.3. p.205). The summary lists the main issues that arose in the transition themes during the separation phase, and this correlates with the conceptual links and relationships of the separation phase provisionally outlined at the beginning of this chapter (chapter seven, sub-section 7.1.1. p.151-152). It is also linked to the summary of the transition themes data in the discussion chapter (chapter ten, section 10.2. p.355-366). The following chapter (chapter eight) will consider the detailed analysis of the next phase of the rite of passage, the transition phase.

- **Separation and Social Transitions**

The Teacher Team
(Conceptual links - relationships in the separation phase)
Conflicts, closure and control, re-evaluation of personal value beliefs

The Students
(Conceptual links - discovering the separation phase)
Engaging with separation, discovering new ground rules / one student leaves, developing the group agenda / clinical duality, professional nurse / student nurse practitioners/ the beginnings of solidarity in adversity, pre-communitas

- **Separation and Professional Transitions**

The Teacher Team
(Conceptual links – motivating and driving the separation phase)
Interacting with national forums and structures / the debate on titles and levels that define roles / guiding and influencing student perception / advanced clinical nursing, new hierarchies

The Students
(Conceptual links - role conflicts in the separation phase)
Becoming a professional nurse practitioner, an elevated status / formalising existing advanced clinical activity / fear of losing a nursing identity / the nursing - medical relation, conflicts and agreement / the transgression into medicine / the value of a multi-professional teacher team

- **Separation and Clinical Authority Transitions**

The Physician Mentors
(Conceptual links - authority challenges in the separation phase)
Imparting and evaluating clinical skills, medical benchmarks / sanctioning nurse practitioners as clinicians / perceptions of the new clinician, the mini doctor / matron / the challenge to medical authority and relinquishing medical dominance / connecting with the physician teacher

- **Separation and Clinical Knowledge Transitions**

The Teacher Team
(Conceptual links – enabling the separation phase)
Hard medical knowledge / soft nursing knowledge, maintaining the balance / an ambitious programme with limited time / the team / knowledge skill mix, applied clinical knowledge

The Students
(Conceptual links - accepting the separation phase)
Developing skills and a lack of time, passive recipients to active participants / new vocabularies, a socialising process

- **Separation and Clinical Skills Transitions**

The Teacher Team
(Conceptual links - rationalising the separation phase)
The high status of clinical skills / the multi-professional team, the physician teacher bridge / the clinical skills map

The Students
(Conceptual links - the rules of the separation phase)
Transgression into medical skills / concepts that defended the transgression process

Figure 7.3. Concept summary of the transition themes during the separation phase

CHAPTER EIGHT

THE TRANSITION PHASE

8.1. INTRODUCTION TO THE TRANSITION PHASE

This chapter describes in detail the second phase of the rite of passage. Van Gennep (1960) described the transition phase as a marginal or liminal period during which social and cultural events structured the subject's progress toward a new status. Turner (1982) further characterised the transition phase as that period when:

> "The ritual subjects pass through a period and area of ambiguity, a sort of social limbo."
>
> (Turner 1982 p.24)

This social limbo enables not only a passage to a new order but also the potential for social and cultural change. Prout (1989) observed that individuals within the transition phase simulated the tasks of their prospective role and new identity, playing out their future social or occupational reality. This role-playing was an artificial enactment, an exaggeration and parody of important features of the new role. It would enable the individual to rehearse in a practice environment, safe from the reality of the social responsibility that the new role would eventually entail. This role-playing feature of the transition phase was a fundamental part of the nurse practitioner degree programme and the communitas observed in this transition phase. Role-play not only allowed the students to practice clinical skills within a protected context, but also allowed them to have their clinical skills constantly assessed.

Assessment of clinical skills and of theoretical knowledge were important features of the rite of passage.

In the previous chapter (chapter seven), I described the first phase of the rite of passage: the separation phase During the separation phase, the loss of occupational identity stood as the notable experience for the student sample, and this was marked by the changing relationships between students, teachers and physicians. In this transition phase, the students' experience of marginality and associated communitas was notable, and this influenced the teacher team's experience and the physician mentors' experience.

This chapter reviews the second phase of the rite of passage: the transition phase (February 1998 to December 1998). It examines each transition theme individually within the context of this phase. The structure of this chapter is as follows. Firstly, there is a summary of the general timing of the transition phase within the structure and chronology of the nurse practitioner degree programme (Fig 8.1. p.208) and an outline of the key conceptual links between the chapter's sub-sections (the transition themes and the data) and the elements of the transition phase. Following this there is a broad review of the main features of the transition phase. The main body of the chapter consists of the detailed review of each transition theme. At the end of the chapter, the data, findings and conceptual links of this phase are again summarised.

<table>
<tr><td colspan="5">The Rite of Passage - Transition Time Line – Transition

TRANSITION THEMES
Social Transitions,
Professional Transitions
Clinical Authority Transitions
Clinical Knowledge Transitions
Clinical Skills Transitions</td></tr>
<tr><td colspan="2">1997</td><td colspan="2">1998</td><td>1999</td></tr>
<tr><td colspan="5">July---Sept------------------------Dec--Jan--------July--Sept---------- ------Dec--Jan------------------------------
July</td></tr>
<tr><td rowspan="2">P
R
E

C
O
U
R
S
E</td><td>Academic Year One

Modules
Clinical Assessment Skills 1
Consultation Skills
Pathology and Pharmacology

Summative Assessments
OSCE 1, Essay, Video Tape Analysis</td><td>S
U
M
M
E
R

B
R
E
A
K</td><td colspan="2">Academic Year Two

Modules
Clinical Assessment Skills 2
Research and Evidence Based Practice
Clinical Supervisory skills
Pathology and Pharmacology

Summative Assessments
OSCE 2, Research Proposal, Written Examination, Essay</td></tr>
<tr><td>The Separation Phase
(Chapter 7)</td><td colspan="2">The Transition Phase
(Chapter 8)</td><td>The Incorporation Phase
(Chapter 9)</td></tr>
</table>

Fig. 8.1. The separation and transition phase in context

Before discussing the data further, it is important to review and spell out the links between the transition phase of the rite of passage and this chapter's sub-sections. This chapter presents data that illustrate the five transition themes (chapter one, section 1.2. p.8. / chapter five, section 5.1. p.105) as they occurred during the transition phase. The main concepts and relationships that are relevant to this phase

are outlined below in sub-section 8.1.1. (p.209-210). These are summarised again at the end of this chapter (chapter eight, Figure 8.2. p.280).

8.1.1. Conceptual links and relationships of the transition phase

Social Transitions - based on the experiences of the teacher team and the students

- In this transition the teacher team data were characterised by peer recognition and developing concepts of advanced clinical nursing. These data are linked to establishing and managing standards through the transition phase.

- In this transition the student data were characterised by the students' movement into limbo, and by their marginality. These data are linked to the students' loss of self in the transition phase.

Professional Transitions - based on experiences of the teacher team and the students

- In this transition the teacher team data were characterised by the wider national developments, particularly the changes in clinical stratification. These data are linked to processes that were used in clarifying the transition phase.

- In this transition the student data were characterised by the students' confusion, their experience of border transgression, and their identity loss. These data are linked to processes of negotiating the students' way through the transition phase.

Clinical Authority Transitions – based on the experiences of a combined group of physician mentors and students

- In this transition the physician mentor and student data were characterised by clinical benchmarks, workload allocation, communitas, and the physician mentors' place in self-perceived difficult interactions. These data are linked to processes that facilitated the management of the transition phase.

Transition and Clinical Knowledge Transitions - based on the experiences of the physician mentors and the experiences of a combined group of the teacher team and students

- In this transition the physician mentor data were characterised by professional benchmarks, and the development of new clinician roles. These data are linked to the processes that relate to the outcome of the transition phase.

- In this transition the teacher team and student data were characterised by the curriculum, by the use of language, and issues of autonomy. These data are linked to the personal consequences of the transition phase.

Clinical Skills Transitions - based on the experiences of the students

- In this transition the student data were characterised by the clinical communitas. These data are linked to the process of confronting and surviving the transition phase.

Having listed these concepts and relationships, the next sub-section provides a broad review of the main events of the transition phase. Following this review, each transition theme is examined in detail.

8.2. A BROAD REVIEW OF THE TRANSITION PHASE

The transition phase occurred between February 1998 and December 1998. The following data extract highlighted important features of the transition phase, features of identity loss, social limbo, and rehearsal for a new role and status:

> *"I definitely need more role clarity. I am treading on too many people's toes at the moment. Clinical assistants are feeling threatened by my post, the ward sisters are as well. It's causing problems. I just get the impression that some of them are feeling threatened and the other half are feeling 'she is just a silly little nurse playing at it.' You know its sort of being in between the two at the moment."*
>
> *Student Nurse Practitioner - F1 Data Segment - 1st Interview Data*

I recorded similar data throughout the transition phase of the rite of passage. For example, at the commencement of the phase in February 1998 I made notes that summarised the students' passage from the separation phase to the transition phase:

"Re-socialisation appears to be occurring, seemingly structured on a re-moulding of their existing professional status. As the students are professionals already, they have to reshape that existing status."

Field Note Entry February 1998

"There is an apparent duality of role evident at this time. They referred in discussions today to 'becoming a nurse practitioner,' and to 'taking aspects of nursing with them.' They find themselves existing in two quite distinct personas."

Field Note Entry February 1998

"Part of their new status, new role, is constructed on new knowledge, but a significant part of that is the new language that is being acquired. It is this that is facilitating most of their new identities and relationships."

Field Note Entry February 1998

"Things are beginning to move fast now, there is a discernible change from the first term of quiet anxious expectation, and there is a real feel of intensity and determination. Teacher expectation I would say is high and quite critical, but the students are now equally critical of over expectation and, or, lack of earlier appropriate teacher support and direction."

Field Note Entry - February 1998

These data extracts described students' experiences as they entered the transition phase. The phase was characterised by uncertainties and this was borne out by further data that arose from the first interviews with the students:

"I wasn't sure what to expect when I first started the (nurse practitioner) *course. The course of study is quite in-depth. Its just starting to hit home what the expectations are, and what the nurse practitioner role will allow me to do after the course of study."*

Student Nurse Practitioner - G3 Data segment - 1st Interview Data

"I don't know. I don't really have a viewpoint yet, but I need one. It's all so new. I have to get my own head round it so it can work for me in my work setting."

Student Nurse Practitioner - D2 Data segment - 1st Interview Data

That sense of uncertainty, self-doubt and conflict would persist through the early part of 1998, and into the summer months of 1998. It appeared that the students were increasingly adrift, in liminality, and seeking structure and direction.

As the end of the first academic year approached in July 1998, the students undertook both theoretical and clinical examinations and this led to stress and anxiety. When those examinations were completed, there followed the summer recess, a short break from the structured learning within the nurse practitioner degree programme. The summer recess was characterised by reflection at an uncertain time, and by consequent forward planning. At this halfway stage of the transition phase, I noted that the students were developing occupational markers, signposts that would give structure to their new developing role in clinical practice as they began selectively to use the new clinical and theoretical skills that they were learning.

At the end of the summer recess and the commencement of the second and final year of study in September 1998, I observed that the students were focused on their role development. New roles began to emerge as a direct result of their increasing use of new skills learnt in role-play, and this development in their identity was evident in the following data extracts:

"We are past the halfway stage and there is a preoccupation, focus, on role development. It is an emerging and pressing need of the students to establish some form of clinical identity at this point."

Field Note Entry - September 1998

"Now, when I give drugs, I find my nurse practitioner side coming out as well."

Student Nurse Practitioner - E1 Data Segment - 2nd Interview Data

Emerging clinical roles and new identities marked a final stage in the students' transition phase. These developing roles would be instrumental in bridging the students' experiences of liminality (marginality) and would pave the way forward out of the transition phase. There was now a need to further the development of their new clinical identities. In the later part of 1998, the students began that process of role refinement and by December 1998 preoccupation with their new occupational roles had diminished. Students were now completing their transition phase and were no longer at a threshold, but were passing into the next phase of the rite of passage and preparing to commence incorporation of their new status and responsibilities. From that time, individual student effort became highly individualised. Self-interest rather than group interest prevailed as they prepared for final examinations. Longer-term occupational role issues were temporarily put aside, communitas diminished and the individual's need to succeed predominated.

In this chapter's introduction, I have outlined the chronology, events and experiences of the transition phase. I now consider each of the transition themes in detail.

8.3. THE TRANSITION PHASE AND SOCIAL TRANSITIONS

The social transition theme of the transition phase is divided into two parts. Firstly, I discuss the social experiences of the teacher team (with a particular focus on myself, the researcher). Standards and the general management of the nurse practitioner degree programme link the transition phase to this discussion (chapter eight, sub-section 8.1.1. p.209-210). Secondly, I discuss the social experiences of the students. Personal identity loss links the transition phase to this discussion (chapter eight, sub-section 8.1.1. p.209-210).

8.3.1. The teacher team: social transitions during the transition phase

The teacher team members inevitably influenced the students' transition experiences. This was due to their direct contact with the students as teachers and as degree programme organisers, and also because of the links they had with the wider national developments and national fora. For example, the teachers were involved in clinical standard setting with the RCN, and this I observed as a positive experience that they directly communicated to the students. However, in contrast, early in 1998 I noted negative aspects of the teacher team's relationship with its immediate academic department. Despite the teacher team's view of the nurse practitioner degree programme contributing positively to the concept and development of advanced clinical nursing on a national basis, it felt that its work in this area lacked departmental acknowledgment. That perception was apparent in the data. An example of this arose when members of the teacher team attended a departmental master class given by external speakers on aspects of nurse practitioner education:

"(following a master class seminar) *There is an apparent lack of awareness by our own senior staff regarding our experience as a team in facilitating advanced clinical skills education. The department invites outside speakers to instruct us on a subject we are versed in, and appears unaware of the experience under their own roof."*

Field Note Entry - February 1998

Other data arose from the interviews with senior academic staff that complemented this view of a lack of departmental recognition of the nurse practitioner teacher team's expertise. These data extracts gave substance to the teacher team view that it lacked the profile within its own department that it had achieved on a wider national basis:

"The course hasn't got the profile that I think it ought to have. Why doesn't it have the profile? Well there must be something about underlying values there."

Senior Academic - G3 Data Segment - 2nd Interview Data

"But somehow I don't believe it has been seen through (the nurse practitioner degree). *In particular I don't believe – I said I don't know too much about it – why don't I know too much about it for heavens sake? That tells me something!"*

Senior Academic - G3 Data Segment - 2nd Interview Data

Why was there this contrast between the teacher team's limited departmental profile and the status it had nationally? One possible answer to this lay in the relatively small scale of the nurse practitioner degree programme in a department that dealt with large student numbers on many other education programmes (chapter six, sub-section 6.2.1. p.131-133). Thus, although on a national basis the teacher team members were

involved in concept and standard development for nurse practitioner education and practice, the number of students they represented was undeniably small in comparison with other degree programmes, both within their own department, and in other universities. For example, equivalent nurse practitioner degree programmes elsewhere in the UK at that time (1997-1999) dealt with student intakes five times greater than the number of students studied in this research. Therefore, it was possible that the small scale of the nurse practitioner degree programme was a factor that contributed to its low profile within its own department. However, to identify the scale of the degree programme as the only factor in this lack of departmental recognition was too simple. Another factor was the underdeveloped concept of nurse practitioner activity (chapter ten, sub-section 10.3.2. p.374-381 / chapter ten sub-section 10.3.3. p.381-391). Acknowledging this as a factor linked the lack of departmental recognition of the nurse practitioner degree programme to the lack of a wider occupational structure for nurse practitioners. Without that occupational structure, the nurse practitioner degree programme lacked identity and relevance in the department. It was apparent that this view had some foundation, and this was evident in the following data extracts:

> "(on advanced clinical practice) *There isn't a central core philosophy in which every course feeds into another course and all the bits fit together."*
>
> *Senior Academic - G3 Data Segment - 2nd Interview Data*

> *"I think that the whole culture of our organisation needs to move more towards having this clear view, demonstrating and making that view clear to others of how we perceive practice within a higher education setting. I think there needs to be work on that. We talk about research, we talk about teaching, and there is some reference to clinical practice. I think we have got, as far as the*

discipline of nursing and midwifery goes, work to do in bringing those three activities very much closer together."

Senior Academic - G3 Data Segment - 2nd Interview Data

These data extracts revealed that, during the transition phase in 1998, the department did not have a framework that described or coordinated its advanced clinical practice educational activity. This contributed to the low profile of the nurse practitioner degree programme, and that low profile led to teacher team disaffection when its immediate academic peers appeared to view the degree programme as lacking in credential or wider scholarship.

Teacher team members' disaffection was conspicuous in the data at that time. The teachers were re-evaluating their personal values and evolving new social constructs that enabled their role as teachers on a clinically orientated nurse practitioner degree programme. Despite their experience of early student cohorts, the teacher team members were in no less a state of social and cultural evolution than that of their students. As nurse practitioner students sought new status and recognition, so did their teachers by virtue of being the educators of nurse practitioners, thus seeing themselves as leaders of this innovation.

In addition, the teacher team was refining the ideas that underpinned some of its curriculum developmental work, such as the clinical skills map (chapter seven, Figure 7.2. p.198). For example, it increasingly began to use advanced clinical nursing as a concept within the curriculum philosophy. Advanced clinical nursing

circumnavigated the problem of the title nurse practitioner by placing an emphasis on clinical and diagnostic management (chapter ten, sub-section 10.3.3. p.381-391). The teacher team saw these ideas as baselines for future clinical standards.

However, these ideas led to concerns on the relative importance, or weighting, of the varied aspects of the curriculum. For example, focusing on aspects of clinical management led to an emphasis on clinical diagnostics, with less emphasis on interpersonal and consultation skills (chapter seven, sub-section 7.7.1. p.194-198 / chapter eight, sub-section 8.6.2. p.260-264 / chapter nine, sub-section 9.6.1. p.328-329). Nevertheless, there was a view within the teacher team that the department should implement and adopt a coordinated educational framework that supported the principles and philosophy of advanced clinical nursing. It was also aware that this could meet with resistance, and specific questions arose: how ready was the senior academic staff for this change and would senior management support it? Although the teaching team debated these points at length, it failed to translate this strategic discussion into a formal proposal.

What can be made of these observations of the teacher team and advanced nursing practice? That the teacher team gave time and effort to developing these ideas, and discussed them freely and openly, would have influence on the students' experience of the transition phase. However, as indicated previously (chapter seven, sub-section 7.3.1. p.157), the students remained unaware of any difficulties within the teacher team which dismissed any suggestion of lack of collaboration or cohesion amongst its

members or with the wider department. The eventual formal implementation of a framework of advanced clinical nursing did not occur in the department until a much later date, after this data collection. In conclusion, I noted that many of the teacher team members' frustrations of that time were based on their perception that they lacked influence or credential within the wider department. This perceived lack of influence and its consequence is most apparent in the following sub-section.

8.3.1.1. A new research project

The teacher team's view of its low status within the department in 1998, and its hesitancy in implementing new concepts and ideas, linked closely to an important parallel event of that time. In the early months of 1998, a new and unexpected variable arose; the inclusion of the teacher and student sample into another research project that was quite separate from the project that has been described in this thesis. This new project was a qualitative analysis, undertaken by a research team, which sought to examine and evaluate different stakeholders' impressions and experiences of the nurse practitioner education provided by the department. It is not my intention here to discuss in any detail the remit, or findings of that new research project. I also do not intend to give details of the team of researchers who managed this new research project. However, I will highlight the implication of the recruitment of the teacher team and the students of the nurse practitioner degree programme as respondents to that new project. An effect of that recruitment was the active involvement of the sample of teachers and students used in my research in another parallel research project. In the following discussion, I distinguish between the two

research projects by referring to them as the new research project and as my own research project.

The new research project presented three main areas of concern to my research project. The first concern arose from possible adverse consequence for individual students that could arise from being involved simultaneously in two research projects. The second concern arose from the affect that this might have on my research project's design and data collection. The third concern arose from the new research project's influence on the teacher team and on the students' perceptions of the status of the nurse practitioner degree programme within the department. Thus, the first two concerns focused on my own research project's design, whilst the third concern focused on perceptions of the nurse practitioner degree programme's status.

The first concern was that I was worried that using the same group of students within the new research project would have an adverse affect on their educational experience. As has been observed, the nurse practitioner degree was a difficult and stressful programme of education for the students. I was concerned that the new research project could heighten the students' stress experience. Secondly, I was also concerned that further research scrutiny could potentially affect or change the data I was collecting in my own research project. Consequently, I requested exclusion of my student sample from the new research project. Despite that request, the new research project proceeded as planned and recruited my student sample, and members of the teacher team, into their study for data collection by interview and observation.

That inclusion resulted initially in some difficult interactions with students and teachers and I discuss these shortly. However, in regard of the first two issues, I observed that the new research project team made considerable effort to minimise its affect on my research sample. A research assistant from the new research project undertook student interviews, ensuring minimum disruption to the students' college or clinical work. This research assistant also collected data by participant observation, and developed a good rapport with both the nurse practitioner students and teacher team. Thus, the students, who were familiar with observers, appeared mostly unconcerned. Additionally, my role as a researcher continued unchanged and the data I was collecting for my research project did not, when analysed, demonstrate any major changes following the commencement of the new research project. Thus, these points and observations overcame the two initial concerns.

My third concern regarding the affect of the introduction of the new research project on the teacher team's perceptions, and students' perceptions, was the status of the nurse practitioner degree programme within the department. From their first contact with the nurse practitioner programme, the researchers from the new research project openly discussed their intention to collect data not only from the nurse practitioner degree programme but also from several other sources that they saw as part of the department's portfolio of nurse practitioner education. For example, they planned to include in their sample students and teachers from other education modules that made use of the term nurse practitioner within their documentation and outcomes. An example of this was a module for endoscopy nurses. However, these other modules

were not a part of the nurse practitioner degree programme; they were not part of the integrated profile of modules that made up the programme described in chapter six (chapter six, sub-section 6.2.4 p.137-138 / chapter six, sub-section 6.2.5. p.138-141) which specifically focused on advanced clinical practice. Additionally, these other modules did not prepare students for the level of clinical activity of nurse practitioners that was described in the introductory chapter (chapter one, section 1.1. p.2.). They were modules that were relatively small-scale and they formed a part of the extensive portfolio of modules of the department's post-registration general nursing degree.

There were strong feelings amongst the teacher team and students in this study regarding these other modules. They reacted angrily to the implication that these other modules should be considered as part of the department's portfolio of nurse practitioner education and that they were to be included as data sources in the new research project. A simple explanation for this hostile reaction was that it arose from the sample member's sensitivities to their developing nurse practitioner identity during this transition phase of the rite of passage.

The inclusion of these other modules as nurse practitioner data sources in the new research project had increased the teacher team's anxieties over the hesitant endorsement by the department of the clinical standards of the nurse practitioner degree programme. For the teacher team members, whose interpersonal relationships I have described as unpredictable (chapter seven, sub-section 7.3.1. p.154-158), the

new research project served only to further their uncertainties and their self-perceived lack of immediate influence and recognition within the department. The cause of this tension amongst the teacher team members arose specifically from the assumption by the new research project team that there was a structured framework within the department for nurse practitioner education from which data could be drawn. In reality, that was not so. There was little coordination within the department and limited departmental consensus on the underlying principles of nurse practitioner education and practice. As mentioned earlier, the teacher team was aware of this problem and had sought to rectify it by considering a proposal for a departmental framework of advanced clinical nursing practice (chapter eight, sub-section 8.3.1. p.214-219). However, the new research project's inclusion of data sources, which it had suggested were representative of a departmental portfolio of nurse practitioner education, was clearly a view contrary to that of the teacher team, and had intensified the teacher team's view of its personal lack of departmental influence.

These problems associated with the new research project emerged when the researchers from the alternative project first approached the student sample of my research project. At that meeting, I noted that the students became extremely defensive. That verbal defense was intense as they rejected the suggestion that their educational experience was comparable to that of students on other modules that they deemed to be less rigorous or clinically appropriate. This verbal hostility was perhaps evidence of their wider concern over the national lack of regulation and legitimisation of nurse practitioner competencies and practice in 1998. However,

more obviously, as the transition phase was marked by clinical identity loss and a negotiation of a new clinical role, comparison with what the students perceived as a lesser alternative to their educational preparation was perhaps understandably antagonistic. In simple terms, the students viewed the alternative modules as undermining the value of their rite of passage to a new clinical status.

Communitas (chapter three, section 3.3. p.67) is a social mechanism that protects and enables passage through the transition phase. The communitas of the student group enabled a negotiable and yet collaborative relationship with the teacher team. It facilitated the students' ability, and the teacher team's ability, to effectively deal with the challenges that arose from within the social confines of the nurse practitioner degree programme's experience. However, when a challenge to the legitimacy of the rite of passage arose from what was perceived as an influential source (the new research project team), this resulted in anxiety and defensive behaviour. The students manifested this anxiety verbally whilst the teacher team more formally wrote to senior academic staff. That letter outlined the teacher team's views regarding the need for recognition and regulation of nurse practitioner preparation within the department. The senior management did not respond to this correspondence.

These events reflected an integral part of the lived experience of the sample, and they revealed facets of my dual role as teacher team member and researcher. Indeed the events were a reflexive part of the data (chapter four, sub-section 4.2.4. p.79-87 / chapter eleven, sub-section 11.3.1. p.405-409). They were a part of the social

dynamic that was influencing the management and delivery of the nurse practitioner degree programme and the experiences of the sample. In conclusion, although there was no specific adverse effect on the students, the new research project influenced their general experience of the transition phase. For the teacher team, it focused attention on existing issues and anxieties, exampled by the invisibility of the nurse practitioner role, the lack of educational and professional coordination, and the lack of departmental regulation and management support.

This completes the presentation of these sub-sections on the teacher team's social transition experiences during the transition phase. In the next sub-section I review the students' experiences of the social transition theme during the transition phase.

8.3.2. The students: social transitions during the transition phase

In this social transition theme, it was the students' experiences of change in their self-perceived identity that was apparent. In February 1998, I observed the students in an interactive taught session. The debate centred on the meaning of consultancy, and on the meanings of medical and nursing diagnosis. The discussion ranged widely on aspects of autonomy, authority, language and vocabulary, and this is illustrated in the following field note extract:

> *"Student Z said, 'its consultants* (doctors) *who make the diagnosis.' Student X replied, 'OK, but we make diagnosis as well, only we don't call it that, so as nurses we don't make real diagnoses.' Student Z retorted, 'Oh come on, its just semantics, like the* (medical) *notes and the* (nursing) *cardex.' They are displaying anxiety and insecurity over identity. They went on to discuss the*

quandary on where nurse practitioners should record their work, in the nursing or medical notes?"

Field Note Entry - February 1998

This data extract revealed crucial aspects of identity loss, as the recording of professional activity partly defines the nature and status of that activity. When individuals become uncertain on where to record their occupational activity, then uncertain occupational identity results. As nurse practitioners used a blend of nursing and medical skills, the nature of the information that they collected from patients in consultation was ambiguous in terms of its use. If the recording of their clinical activity was ambiguous, this then implied that the role undertaken was ambiguous. Further evidence of this identity loss emerged from my observations at an early stage of the transition phase, and this was illustrated in the following data extract:

"The students appear to be experiencing an identity crisis. There are no benchmarks for them out in the clinical world. The observation about patient notes is crucial. In class today, they again talked about how they were unsure where they should enter written records. They also discussed their new medical vocabulary. New language creates new identity and new activities. Language defines identity, and the ability to record your history using appropriate vocabulary also defines your identity. If the language is missing, and there is nowhere to adequately record your activities, then you become invisible."

Field Note Entry - February 1998

This data extract also suggested that language was crucial in the construction of professional identity. Conversely, a lack of appropriate vocabulary would impede the development of professional identity. However, perhaps what is missing from this analysis is the integration of two professional vocabularies. The first was a humanistic nursing vocabulary that made limited use of medical terminology, and the

second was a medical vocabulary that was scientifically constructed from bio-physiology but with limited humanistic content. Thus, it seems that the students' identity problem arose firstly from the loss of a known concept (nursing), and secondly from the inability to place the evolving concept (the nurse practitioner). Either way the resultant role uncertainty led to feelings of social inadequacy and invisibility. These are key features of social transition that were evident in the data extract below:

> *"One of the doctors I spoke to this week summed it up for me really. He said, 'you are going to be learning all of these new skills but what are you going to do with them?' I guess it is to gain clinical skills, to develop my role, whatever that turns out to be. Because I feel that I have taken on this new job without having the clinical skills. I want to do it to its full extent and I am hoping it will develop. It's about getting the confidence, and people respecting that to some degree."*
>
> *Student Nurse Practitioner - F2 Data Segment - 1st Interview Data*

The students continued to express these feelings of uncertainty over the following months. In June 1998 I observed a teaching session that evaluated the students' experiences of their first year of study. At that time, the anxiety amongst the students was heightened due to the forthcoming first year clinical OSCE examination. I described this evaluation session as:

> *"Fragmented, fractious and hesitant."*
>
> *Field Note Entry - June 1998*

The teacher team members used the evaluation session to make clear the students' expected clinical activity during the summer recess. They also reviewed the nurse

practitioner degree programme content for the next year of study. This review of the forthcoming year was a response to the anticipated student hesitancies and anxieties that the teacher team members had experienced with earlier cohorts of students. They had previously used individually planned student learning contracts, with structured aims and objectives, as a way to guide the students through this difficult mid-programme time. However, on this occasion the suggestion of self-direction and increased personal effort was not well received by the students. The students resisted this educational structuring, and instead questioned the teachers in a repetitive and exacting way, seeking responses that would alleviate their anxieties:

> *"I noted the following questions from the students: 'what is our role going to be next year, what preparation can we do for our new role, what other changes do we need to make?'"*
>
> *Field Note Entry - June 1998*

Thus, from the students' perspective, the teacher team was not meeting their demand for pastoral guidance through a time of uncertainty. The students were in liminality, they had lost much of their familiar identity, and they were unsure and anxious. The relationship with the teacher team was being tested as the teachers persistently placed the responsibility for future transition and ongoing effort with the students. It was a moment of unresolved conflict that illuminated the students' experience of identity loss. That conflict for the students would not begin to resolve until the process of identity re-assertion began late in the transition phase.

This completes the presentation of the social transition theme during the transition phase. In the next section, I discuss the professional transition theme during the transition phase.

8.4. THE TRANSITION PHASE AND PROFESSIONAL TRANSITIONS

The professional transition theme in the transition phase is divided into two parts. Firstly, I discuss the professional experiences of the teacher team. Processes of clarification link the transition phase to this discussion (chapter eight, sub-section 8.1.1. p.209-210). Secondly, I discuss the professional experiences of the students. Their forward planning and related negotiations link the transition phase to this discussion (chapter eight, sub-section 8.1.1. p.209-210).

8.4.1. The teacher team: professional transitions during the transition phase

In early 1998, members of the teacher team met with educators from other institutions at a national meeting to discuss the regulation and standardisation of nurse practitioner education in the UK. This meeting was evidence of a developing alliance between the higher education institutions and the RCN on nurse practitioner education. They discussed aspects of the curricula used by the differing institutions, the types of clinical assessment and examination being used, and the development of national clinical competencies. This alliance played an essential role in influencing, conceptualising and implementing aspects of advanced clinical nursing practice in the UK at that time. Nevertheless, the politics of the time were sensitive, and this was evident in the following data extract:

"At a simple level the RCN is trying to keep some control over this rapidly growing group, and one cannot help but wonder how they will manage this in the long run. But it is more than this. A central premise is the lack of national control. There is no strategic planning, no mandate at this time. The UKCC offers little and, as a result, disorder and confusion is potentially just around the corner. But there are powerful individuals and groups with vested interests in seeing that not happen. The developing Nurse Practitioner Association could be an influence, and the universities certainly have influence and are obviously prepared to use it. The RCN is striving to maintain control and co-ordinate a way forward. However it is evident that there is a need for change in the present arrangements if they are to keep pace with the innovations that the universities are seeking."

Field Note Entry - January 1998

This data extract revealed the organisational challenges that were arising from the emergence of the nurse practitioner into the professional and political arena in the UK at that time. As the universities developed their own curricula, and the RCN sought to develop some regulation and control, the health service employed increasingly more nurse practitioners. Thus, there was a need for a national standard of clinical competence for nurse practitioners. Some of this demand would be reflected in the implementation the Higher Level of Practice Project (UKCC 1998) and in the developmental work of the RCN and the alliance of higher education institutes. The RCN and the universities would continue to collaborate in the identification, clarification, education and recognition of nurse practitioner practice and eventually form an accreditation framework by 2002. By 2004 the Nursing and Midwifery Council (NMC) was undertaking a formal restructuring of the regulation and register of nurses. It was expected that the new register would provide regulation of nurse practitioner activity. In the event it did not, and at the time of writing (2005) further proposals are being considered.

It is in the nature of the process of longitudinal observational data collection that unexpected events may influence the research enquiry. I allude here, in this professional transition theme, to an important development in September 1998 that had affect on this study's findings. The then Prime Minister (Tony Blair) announced at the annual RCN national conference the introduction of consultant nurses into the UK NHS. Consultant nurses were to be the clinical leaders and autonomous practitioners of nursing. They would maintain their patient contact, influence strategic decisions, direct research activity, and receive a salary commensurate with their responsibilities. The expectation was that they would provide nursing with a full recognition of its professional status.

The RCN welcomed the proposal, but with a proviso that the role and status of the ordinary nurse would be protected. The BMA gave cautious approval whilst airing concerns about the use of the title of consultant. Regardless of the differing responses and perspectives, the proposal added to the debate on the nursing profession and its clinical career structure. The proposed introduction of the consultant nurse pointed to a new career pathway that would begin with the clinical nurse novice, and extend to the clinical nurse expert. Immediately following the government proposals for consultant nurses, the general professional confusion on the defining characteristics and place of nurse practitioners increased. However, in the longer-term, the consultant nurse concept promoted a professional debate that would lead to a clearer understanding of an extended clinical career structure in the nursing profession

(chapter nine, sub-section 9.4.2. p.309-313 / chapter ten, sub-section 10.3.3. p.381-391).

It may be concluded that this proposed introduction of the consultant nurse was not just a government initiative in response to health service demands, but a wider response to long-term professional demands from nursing. Consequently, it was from the nursing profession that the government claimed it would seek guidance on such matters of role definition. I noted that amongst the wider population of nurse lecturers in the department that there were varied responses to the planned introduction of the consultant nurse:

> *"Today lecturer X was dead against the whole idea* (of consultant nurses), *antagonistic toward any hint of the medical model, this was supported by lecturer Y. However other lecturers I spoke to seemed to think it was a potentially good idea."*
>
> *Field Note Entry - September 1998*

In a broader perspective, the data reflected a longer-term consequence of the consultant nurse for advanced clinical nursing:

> *"I would see this whole area of nurse practitioner, of higher level of practice, consultant nurses, as about completing the circle. Higher level of practice, nurse practitioner, academic award - that cycle, where one feeds the other. So I think they* (consultant nurses) *are very significant."*
>
> *Senior Academic - G3 Data Segment - 2nd Interview Data*

However, nurse educators and academics antagonistic to medicalisation of the nursing profession echoed the BMA's anxiety that professional challenges and

confusion might result from the use of a traditional medical title (consultant). Additionally, there were concerns that existing clinical nurse specialists and nurse practitioners would become consultant nurses without any real change in role. This further emphasised the continuing lack of professional regulation, and the lack of a clinical career structure in nursing.

In September 1998, the proposed introduction of consultant nurses had little daily impact on the teacher team, the students or physician mentors in this study. They were all, in different ways, immersed in their own discovery of the nature, identity and place of nurse practitioners. Nevertheless, the prospective introduction of the nurse consultant was an important development. It was a political mandate that underlined the professionally driven call for wide-ranging clinical stratification and recognition of levels of advanced clinical nursing practice. I return to the consultant nurse implementation later in the incorporation phase (chapter nine, sub-section 9.4.2. p.309-313).

This completes the presentation of this sub-section on the teacher team's professional transition experiences during the transition phase. In the next sub-section I review the students' experiences of the professional transition theme during the transition phase.

8.4.2. The students: professional transitions during the transition phase

The broad and changing professional situation, which I have discussed in the previous sub-section, formed the backdrop to the students' professional transition phase. The debate on advanced clinical nursing roles mirrored the students' experiences of professional identity and professional border negotiations. The following field note entry highlighted aspects of those identity experiences:

> *"I met X* (a nurse practitioner student) *on her ward as I was going to interview her mentor. She showed me around and started to tell me that she has been very unhappy because she feels alone, not a part of a team. She says she is suffering from an identity crisis. She says it was particularly bad up until recently but has improved slightly since. Her physician mentor was relaxed and forthcoming. When asked to define the professions he simply stated, 'well, nursing is nursing and doctoring is doctoring!'"*
>
> *Field Note Entry - February 1998*

This data extract, which arose early in the transition phase in 1998, illustrated a preliminary identity loss and role change that the students were experiencing, and contrasted with the traditional professional role concepts held by other colleagues. That perception of identity loss experienced by the students was not only influenced by nursing issues, but also was affected by transgressions across the boundary between the nursing and medicine. The process of separation had not only removed from the students the clear markers that outlined their nursing identity, but had also, by virtue of the nurse practitioner degree programme's aims, thrown doubt on regulation and control of the professional boundary.

The students were now without the familiar signposts that allowed them to measure themselves as nurses or to gauge their relative status and position with other professional groups. They attempted to assess and test the limits of their enhanced clinical authority, and rationalised their self-perceived clinical authority limitations as arising from arbitrary personality traits and sanctions bestowed by medicine. This was evident in the following data extract:

> *"There are different kinds of physicians. There are three kinds. One of them thinks nurses should just do nursing roles, and care for the patient in the general sense, the essential skills, basic nursing. The second type says that they should do that and give, for example, IV drugs. Why should a doctor go to a ward at ten o'clock at night to do IV's, nurses should do that. Now these people are in the middle but they don't want us to do more than that. The third kind, who is really good, because they can see that nurses have a lot of experience, a lot of skills, a lot of knowledge. They say why not use nurses, they are a good resource therefore let them have some training and take up some of the jobs."*
>
> *Nurse Practitioner Student - B1 Data Segment - 1st Interview Data*

This apparent dependence on the goodwill of medical colleagues to sanction aspects of their new role underlined the students' experience of professional identity loss. The students were entering a professional limbo where their only protection was their shared experience with the other students and the guidance of the teacher team and the physician mentors. It was in this marginal state, during the early part of the transition phase in 1998, that challenges from clinical peers would confront the students with a professional transition decision, and a dilemma over their future identity. For example, if the students accepted that nursing and medicine were occupations that should not overlap in any way, they could concede that the nurse practitioner role was flawed, that it wrongly transgressed professional boundaries,

and they could go back and re-establish their previous nurse identity. But doing this would constitute failure. Their alternative was to accept that the nurse practitioner was a new role that challenged the boundaries of the existing social order. Thus, they could continue to go forward into an uncertain future with no guarantee of success. To do this would lead to further anxiety and stress.

In April 1998, I noted another influence on the students' professional development during the transition phase. This arose from data that pointed to a particular emerging sub-theme of the students' professional transition:

> *"The secondary and primary sector divide is becoming evident. Acute sector students are expressing specific difficulties to us* (the teacher team) *because their existing occupational roles are more definitive and inflexible."*
>
> *Field Note Entry - April 1998*

Thus, the primary and secondary healthcare sector emerged as an important sub-theme of the data that linked the level and nature of professional border negotiations to the students' experiences. Nurse practitioners had originated as a response to workforce shortages in primary healthcare, and thus the primary healthcare sector was, in one sense, most suited to their activity. However, the nurse practitioner degree programme studied in this research had also recruited students from the secondary healthcare sector (chapter six, sub-section 6.2.9. p.145-147). It was evident, in the early part of the transition phase in 1998, that there was a specific issue arising from this emerging sub-theme of primary healthcare and secondary healthcare. Secondary healthcare appeared less able to adapt to new clinical nursing

roles that permitted wide-ranging clinical autonomy. The large-scale hospital organisations of secondary healthcare were traditionally more hierarchical and inflexible than the smaller-scale health centre organisations of primary healthcare. The data revealed that the primary healthcare students had a more certain view of their role development than their secondary healthcare student colleagues:

> *"I can see in primary care practices that nurses will develop partnerships with general practitioners. I don't think that will happen in secondary care, because of the hierarchy in secondary care. I don't think that will come about yet."*
>
> *Student Nurse Practitioner - C1 Data Segment - 1st Interview Data*

> *"At the moment I think it* (the nurse practitioner role) *will work very well in the primary care setting. I think there is the need for it and that the role will fit very nicely there. I think it will really develop and take off quite nicely if the general practitioners agree with that. I don't work in primary care so I am just looking at it. I have a feeling from talking to the others that it's a very good role out there, and that there is need for it. But in the clinical hospital setting, the acute setting (pause) - there is room for it I suppose, yes there is room."*
>
> *Student Nurse Practitioner - C1 Data Segment - 1st Interview Data*

Thus, the students' confidence in implementing a new clinical role was influenced by the healthcare sector that they worked in and their use of new clinical skills within their practice area. In secondary healthcare, the students found that implementing these new skills met with more resistance than that experienced by their primary healthcare student colleagues. Several factors contributed to this. Medical mentorship in secondary healthcare was less certain, as the hospital physicians were often specialists and unsure of the scope of their student's future role. Additionally, there was more resistance from nurse peers in secondary healthcare than in primary healthcare, and secondary healthcare students reported that the skills they were

acquiring were often labeled by their nursing colleagues as medical skills that were inappropriate for nurses to undertake. More generally, the traditionally hierarchical organisation of secondary healthcare made it difficult to situate the nurse practitioner role in the clinical structure of either nursing or medicine. Thus, secondary healthcare students had more to negotiate to establish a place in the occupational framework, or alternatively they had to negotiate a new order in that framework that would enable their new role. This view was evident in the data not only from the students but also from the physician mentors:

> *"I think that one of the worrying things about the nurse practitioner role is where you fit them into the system."*
>
> *Physician Mentor - D1 Data Segment - 2nd Interview Data*

I reflected on this issue of the primary and secondary healthcare sector in my field notes, and this emphasised the prominence that this had during the transition phase of the rite of passage:

> *"Again it is apparent that the acute* (secondary healthcare) *sector issue is a developing theme. Certainly, the development of nurse practitioner roles in hospitals appears several years behind the primary care development. But, I don't think that it is simply that. There is a more fundamental difference in role between the two sectors. Perhaps this brings into focus the contrast between the potential roles of the clinical nurse specialist and the nurse practitioner. X* (an academic in the department) *is very clear that nurse practitioners have developed in the acute sector in the USA. However, Y* (another academic in the department) *is equally sure that nurse roles should not be restricted by titles. So the point is this - there is evidence pointing to different roles in primary care and acute care. These differences in role may in some way be reflected in the distinct titles of nurse practitioner and clinical nurse specialist and their associated definitions. I need to clarify what these definitions are, or establish that such definitions exist! Even if they do, such focused definitions could be redundant if one accepts the multitude of potential clinical roles at an advanced level of clinical practice. Alternatively this diversity may be a call for some*

form of ring fencing, some means of controlling the chaos. What is the pattern here, are the roles parallel, clinically side by side, or is there a hierarchy where one is above the other? I do not know, because we have not long had such roles that reached above the traditional clinical ceiling of the ward sister or charge nurse. There was no formal clinical progression for the nurse above this level previously, and now there is, but we are inventing it as we go. If there are some identifiable commonalties that define the diversity of roles then this may help resolve the problem from a conceptual basis. For example medicine has multiple roles, but they think within a very clear central framework or philosophy."

Field Note Entry - June 1998

This reflection highlighted issues of professional clinical hierarchy and diversity, and suggested that the nursing profession was using an occupational framework where different levels of practice, and areas of practice, were possible. This thinking led to the need to define and measure such levels of practice.

The secondary healthcare and primary healthcare sector issue highlighted the problem of the confusion of clinical titles being used. In the separation phase (chapter seven, sub-section 7.4.1. p.165-170) this problem had been observed as a part of the teacher team experience, following its involvement with the RCN and its general discussions regarding the lack of regulation and arbitrary use of titles. In this transition phase, I recorded a growing awareness over the title confusion amongst the student sample. For the secondary healthcare students and their physician mentors, there was a particular focus and concern with which title (nurse practitioner or clinical nurse specialists) most appropriately described their clinical role:

"The nurse practitioner in the community is a real generalist to a certain extent, dealing with first presentations and having the skills to sort at a pre-

doctor level. Whereas their hospital colleagues will be specialists. The anaesthetic nurse is the classic example isn't it."

Physician Mentor - C1 Data Segment - 1st Interview Data

"Although I am not called a clinical specialist I am in fact very specialised."

Student Nurse Practitioner - C2 Data Segment - 1st Interview Data

"The nurse practitioner in hospital is a specialised nurse practitioner."

Physician Mentor - C1 Data Segment - 1st Interview Data

These data highlighted the confusion that arose from the lack of a formally recognised extended professional clinical career framework in the nursing profession. Concepts (specialists and generalists) and titles (nurse practitioner and clinical nurse specialists) were used interchangeably in a range of arbitrary combinations. This confusion was potentially resolved by introducing and defining levels of practice and clinical competence. Titles could then be consistently assigned that would represent a level and type of clinical skill. It is significant that my data persistently referred to this issue of titles. It was certainly a suggestion that there was an important difference between the sample's perception of the role of the nurse practitioners and clinical nurse specialists. The general view was that nurse practitioners dealt with undifferentiated health problems (generalists) and that clinical nurse specialists dealt with a specific disease or client groups (specialists). This was evident in the following data extract:

> *"The nurse practitioner is a generalist approach. You're looking at all conditions. Whereas the area I work in you are specifically looking at Ontology and Haematology - that is very specialised."*
>
> *Student Nurse Practitioner - C2 Data Segment - 2nd Interview Data*

Data such as this indicated that the clinical skills required and used by both future nurse practitioners and clinical nurse specialists were the same. Both attended the same taught curriculum process and (importantly) both perceived this as meeting their prospective clinical skills needs. Nevertheless, it appeared these clinical roles required some conceptual independence from each other. It also appeared that the concept of advanced clinical nursing practice could encompass both (chapter ten, sub-section 10.3.2. p.374-381 / chapter ten, sub-section 10.3.3. p.381-391).

The students' professional development during the transition phase was characterised by their discovery of the unstructured clinical hierarchy of the nursing profession. That problem confounded their ability to put a name to their new role, and this frustration was an important feature of their professional identity loss. Their identity loss was made worse when clinical mentors also expressed a confusion of ideas regarding the students' future clinical and professional role:

> *"I think the name nurse practitioner is the clinical nurse specialist. Call them a clinical nurse specialist if you like. When I worked in a regional hospital A&E the idea was you had a nurse practitioner doing the triage. That was someone who hadn't been on the course* (the nurse practitioner degree programme), *because it wasn't there then. So they had that - but I don't think they should have the name nurse practitioner - they should have maybe have the name clinical nurse specialist. So then, people can say, 'all right, a clinical nurse specialist in whatever,' as opposed to a nurse practitioner who has been on the course. Because the skills that these two separate people or bodies have are totally different. A nurse practitioner will not have some of the skills, abilities*

and knowledge that clinical nurse specialist in chest has, or wound care. But the flip side of that is that the nurse practitioner will have a lot more diagnostic ability than a clinical nurse specialist."

Physician Mentor - C2 Data Segment - 1st Interview Data

This data extract showed that concepts of advanced clinical nursing roles lacked consistency, and that this was leading to confusion. It was indicative of the problems the students faced when their own mentors had such disordered ideas. The longer-term implication of this was the need for a formal clinical nursing career framework.

An earlier professional transgression observed during clinical skill transitions in the separation phase now re-emerged as a significant professional issue during the transition phase. During the separation phase, the students had identified the use of traditional medical skills by nurses as a professional border transgression, and they had reacted to this cautiously (chapter seven, sub-section 7.7.2. p.198-201). When the teacher team indicated that this was acceptable (if one viewed such skills as no longer the property of medicine) then processes of separation from the conceptual confines of both nursing and medicine began. However, when students experienced that border transgression into the medical domain, it would become a focus of their identity development in the transition phase.

My field notes reflected on this issue of professional border transgressions during the incorporation phase:

"Do they become a mini doctor first? Do they have to adopt this mindset so that it may be eventually modified? This is perhaps a crucial concept, an

important finding that links with previous issues on vocabulary. What would happen for instance if a student did not achieve the mini-doctor mindset? Is there a re-socialisation occurring here, nurse to doctor and then to nurse practitioner, a professional to another type of professional?"

Field Note Entry - June 1998

However, this idea of the student nurse practitioner having to adopt a medical mindset was too simple a model. Further analysis revealed two quite distinct professional identity transitions. Firstly, there was the transition away from traditional nursing, and this I have described in the separation phase (chapter seven, sub-section 7.7.2. p.198-201). Secondly, there was a transition toward medicine, and this was part of the transition phase. Moreover, this professional transition resulted in a professional border transgression, as the students had to cross the occupational boundary to acquire and use traditional medical skills. This appeared to breach the implicit rules of that boundary order. However, an alternative view to this was that, although it was a boundary transgression, it was a mutually negotiated one. If that were the case, then the negotiation had resulted in a realignment of the social hierarchy between the nurse practitioner and medical practitioner. In this model, the move toward an advanced clinical nursing role was matched by a consequent realignment of nursing's relationship with medicine, and this was revealed in the following data extract:

"I feel that my nursing colleagues see me as different. Their perception of me is different, and in a way my medical colleague's perception of me is also different. But they (the physicians) *treat me more as an equal whereas I don't think my nursing colleagues know how to treat me, although they* (the nurses) *know that I am different. So eventually you won't have medicine and nursing, you will have healthcare practitioners. It would be a new dimension. You*

know you wouldn't just go down the medical or nursing route; it would be all the same level. It would be more global. That's what I want."

Student Nurse Practitioner - D1 Data Segment - 2nd Interview Data

This data extract supported a more general observation that the students' professional transitions were prompting them to look at healthcare systems where interprofessional relationships were less structured and more collaborative. The total effect of all these issues on the students' perception at this time was one of a general professional identity confusion rather than specific role conflict. This was apparent in the following data extracts:

"Sometimes it's important to feel that you belong. Before you were safe, you were a nurse, safe belonging to this huge group of people. To have that undermined makes you feel vulnerable."

Student Nurse Practitioner - D2 Data Segment - 2nd Interview Data

"I don't feel like I am one thing or the other. It is the feeling of being neither a fish nor a fowl. You're not a nurse, you're not a doctor. You are a new breed that has been created. That's how I feel. Nurses think that, 'what are you doing this for, it's nothing to do with nursing,' that's their criticism."

Student Nurse Practitioner - D1 Data Segment - 2nd Interview Data

"You leave nursing behind. It's very difficult to try and cross that bridge, away from nursing, and yet you're not in medicine."

Student Nurse Practitioner - D1 Data Segment - 2nd Interview Data

As the transition phase progressed, these identity anxieties decreased. By December 1998, there emerged in the students the beginnings of a new professional identity.

The data from this late stage of the transition phase revealed a change in the students' overall perspective:

> *"There is a sense that the students are now looking forward to the Christmas recess, seeing it as a well earned reward after a hard term. They were cheerful and relaxed today, one of our last days before the holiday. They said it had been a difficult term and the academic workload had been tough. Their view was to 'enjoy the break while you can.' They see this as the last significant respite before the grand finale of the last two terms."*
>
> *Field Note Entry - December 1998*

The students began to display a growing awareness of their new emerging identity. Evidence of this arose when I observed them in a clinical session:

> *"There is a lot of friendly banter. The books are out and they are in small groups, looking up points on pharmacology. Student X said, 'I hear that Y* (a student from an earlier diploma group) *is only working as a practice nurse.' Student Z replied, 'Oh, so she isn't practising then!'"*
>
> *Field Note Entry - December 1998*

Here we can see the students creating a new social construct, where practising implicitly identified the clinical activity of a nurse practitioner. This was a statement of a new identity that distinguished them apart from their previous role. The field notes provided further evidence of the emerging new identity:

> *"A detailed complex discourse on pathology ensues. Whilst detailing particular drug combination therapies and investigations, the physician teacher draws their attention to the varying cost implications. The students are being increasingly placed in a decision-making arena that they have not been in before and are taking this on effectively. Their thinking is more complex and holistic than I have observed before. Student X* (from secondary healthcare) *said, 'but we would do this test routinely.' The physician teacher replied, 'yes, if you were in a hospital, but why, you need to be able to give a rationale for your tests.' As the teaching session progresses it begins to fragment into small*

individual discussions, but they are all topic related. The physician teacher encourages this process; it is a very mature and professional session. The students discuss patient compliance with therapeutic regimes and the physician teacher notes that this is an area that nurses (not her students) would deal with."

Field Note Entry - December 1998

This data extract revealed an interesting moment at the end of the transition phase. The physician teacher, whilst absorbed in a complex interactive session, had ceased to identify the students as members of the nursing profession. She tells the nurse practitioner students to delegate patient non-compliance problems to *"nurses"* as that is not (in her view) a task for a nurse practitioner. Thus, unwittingly, she has described the students' activity as outside of traditional nursing activity. Whilst she did not explicitly place them professionally elsewhere, it was nevertheless a commentary on their acquisition of a new identity and status. What was equally interesting was that the students let this observation from the physician teacher pass without comment. As the transition phase ended there was a general feel that their roles were developing, being negotiated, and emerging.

This completes the presentation of the professional transition theme during the transition phase. In the next section, I discuss the clinical authority transition theme during the transition phase.

8.5. THE TRANSITION PHASE AND CLINICAL AUTHORITY TRANSITIONS

In this clinical authority transition theme during the transition phase, I discuss the authority transitions that were influencing the physician mentors and the students as a group. The management of that process links the transition phase to this discussion (chapter eight, sub-section 8.1.1. p.209-210).

8.5.1 Physician mentors and students: clinical authority transitions during the transition phase

In this theme of clinical authority during the transition phase, the discussion is focused on the data that showed the authority transitions that were influencing both the physician mentors and the students. During the separation phase, the physician mentors' transition experiences had been the primary focus of the clinical authority theme. However, in the transition phase the relationship between the physician mentors and students became more interactive, and was a feature of the experience of the marginality of the clinical authority transition.

The physician mentors were clinicians whose relationship with their students was a voluntary one. Their commitment to their students involved time and effort. However, there were certainly motivations for them to support the students. The possible benefits of reallocation of low order clinical work (low order as perceived by the physicians) to nurse practitioners, was not lost on the mentors, and this was apparent in the following data extract:

> *"But there are things that should contribute towards medicine, I think it* (nurse practitioner practice) *will develop, it will reduce the work that you don't need a very experienced doctor to do."*
>
> *Physician Mentor - E1 Data Segment - 1st Interview Data*

However, it is important to note that the work (tasks) undertaken by junior doctors was underpinned by clinical skills associated with medical practice. It is thus important to distinguish between tasks (the division of labour) and skill (the level of practice). The use of advanced clinical skills, and how workload allocation was controlled, were important issues in this clinical authority transition theme.

The acquisition of health assessment skills, with the knowledge that was required to underpin them, was, from the students' perspective, a high profile activity. The students' weighting of the curricular content demonstrated this (chapter seven, sub-sections 7.6.1 p.184-188 / chapter seven, sub-section 7.7.1. p.194). However, the view that nurse practitioners were undertaking unwanted low status clinical tasks, rigidly controlled by medicine, would not necessarily be an option favoured by nurse practitioners. Indeed nurse practitioners could be expected to want authority to select the tasks (work) that they would be prepared to undertake. They could then use their advanced skills in a way that best met their own personal and professional agenda. The distribution and management of clinical work would thus be a feature of the professional border negotiation and clinical authority negotiation between the two groups.

Clinical authority transitions would inevitably influence traditional aspects of the nurse / doctor relationship as perceived by both the students and their physician mentors. Both the students and physician mentors were experiencing challenges to their traditional value system. Some of their reflections on those changing value systems were evident in the following data extracts:

> *"I think that historically nurses have always been subservient. I mean under the definition of a good nurse, there are nurses' definitions of a good nurse and there are doctors' definitions of a good nurse. Theirs* (the doctors) *is that the notes are always there, the X-rays are always there, and it's nothing to do with the patient. It's sort of trotting around after them."*
>
> *Student Nurse Practitioner- E1Data Segment - 1st Interview Data*

> *"I feel that at the end of this course she* (the nurse practitioner student) *should be able to take a history from a patient, and help me with my specialty. If she is going to be a rehabilitation nurse, well this course will be very helpful in her understanding basic medical problems. Basic problems only however, and how to diagnose, particularly when to alert the doctors."*
>
> *Physician Mentor - E1 Data Segment - 1st Interview Data*

The students and physician mentors were evaluating options, reflecting on traditional values and yet (at this relatively early stage of the transition phase) not offering any alternatives. In the following data extracts, a student nurse practitioner and physician mentor suggested that authority conflicts would resolve in time, but again they have not suggested what structures or roles would enable that resolution:

> *"It depends on individual attitudes, I don't think you can generalise really. I wouldn't like to say that the nurse is the handmaiden to the doctor as it very much depends on that nurse and her attitude. I think that some nurses will be handmaidens to doctors but that is the way they want to be. Others will be on more of a level with a doctor or consultant; especially I think where that nurse*

has a specialist knowledge to offer that perhaps the GP or consultant doesn't have. For the future ideally I see nurse practitioners in partnerships with GPs."

Student Nurse Practitioner - E1 Data Segment - 1st Interview Data

"But obviously it's a matter of trust really, and professional competency. Over time I think the 'boss and the nurse' relationship will break down. But initially I think you would probably think of yourself as still responsible. I suspect that the nurse would keep asking for reassurance, that role I think will take a while to break down. But after a while, probably some years, and with confidence, the relationship will improve."

Physician Mentor - E1 Segment - 1st Interview Data

The relationship between the student and physician mentor represented only a part of the students' experience of authority transition. For example, in daily clinical practice, students were encouraged to implement their new skills and to develop and refine them. This resulted in interactions with other clinical staff who did not have any specific contact with the nurse practitioner degree programme. Because of that, the students encountered situations that served to add to their sense of isolation and loss, but which also reinforced the strength of the student communitas. The following data extract revealed particular aspects of the authority transition and the challenge it posed. The student (from a secondary healthcare setting) saw herself in a low status position in the clinical hierarchy. The medical consultant sought to maintain the current social and clinical hierarchy and actively opposed any challenge by the student to that established order. Mutual negotiation in this instance was not possible:

"One of the doctors actually told me that he sees this as role erosion. He said something like that if people want to do more than what they are trained for shouldn't they go and succeed at medical college and then come back. He said that you don't go and ask the pilot how to fly the plane. I told him that it was different pilots but he said it was the same thing. He went on for ages about how much harm can be done by too much information and uses his pilot story to everybody. I do feel that they see us eroding into their profession. Definitely, they feel threatened by it. I don't know why though, because in my opinion we are nurses, at the end of the day nurse practitioners, but still nurses. That is the way I look at it, nurses with much more knowledge."

Student Nurse Practitioner - E1 Data Segment - 1st Interview Data

This episode focused on professional identity. The student identified the nurse practitioner as a nurse, and defended her acquisition of new knowledge and new skills. The medical consultant however saw the nurse practitioner as a threat to medical authority. Embedded in this authority conflict was the process of clinical decision making. If the nurse practitioner acquired the knowledge and skill to act autonomously on patient management, then this threatened medical authority. The consultant sought to preserve his authority by alluding to clinical safety and professional license. Only qualified pilots were safe pilots and had a license to fly airliners (and that license was not one easily acquired). Nor was that license readily transferable to another who had only limited or intuitive knowledge. There would have to be a mutually negotiated agreement that would allow another (group) to use the license, and that would have implications for training and education, and for the sharing of the authority and status of the airline pilot. The metaphor of the physician who was the 'Captain of the Ship' (King et al 1988) was here transposed to the image of the airline pilot.

King et al (1988) outlined three types of authority that physicians used to maintain their control over other healthcare professions. These were cultural authority (behaviors, expectations and norms), professional authority (concerned with boundary control and hierarchies) and legal authority (a combination and refinement of the first two). From the cultural perspective, medicine's influence over the clinical authority of the nurse practitioner appeared a diminished one as organisational and cultural changes were occurring in the UK health service that advocated alternative and more cost efficient clinical roles (Kaufman 1996). Driving these new roles were the healthcare needs of the population and a social and political agenda that actively sought to remove medical dominance in healthcare delivery. However, from the professional perspective medicine was still able to exert considerable influence in controlling and conferring clinical authority. Finally, from the legal perspective, the uncertain regulation and ill-defined clinical nursing hierarchy left nurse practitioners' authority position unclear.

To conclude the analysis of this particular data episode, I focus on issues that arose from the student's challenge to the consultant's authority. Although she had not yet been able to change this consultant's dominance over the professional hierarchy, the liminal student was testing new ground and new possibilities, indicating that she would not always accept her low position in the clinical hierarchy. This view was also evident in other student's data. It seemed that the students were seeking a negotiated means to redefine the professional hierarchy and find a higher status position for themselves. They rationalised that despite their transitional state they

remained within nursing. This enabled their safe separation from their traditional clinical role and allowed them to defend and manage their developing new skills, despite authority challenges from the medical profession. Nevertheless, they still used medical standards to assess the elevated status that they sought. There was an apparent contradiction in this; the students in their liminal condition were not in one camp or in the other, but used both to their own end. This early selective use of professional features from both professions was evident in the following data extract, and it would become increasingly formalised in the later incorporation phase (chapter nine, sub-section 9.4.1. p.296-299):

> *"As a nurse you have a caring and supportive role, now we can actually diagnose and give treatment. We are allowed to. So, we have gone that much further. Doctors do that, but we have the added advantage that we also have the caring side. Doctors just diagnose and treat but we are caring and supportive. We are holistic, the real whole."*
>
> *Student Nurse Practitioner - B1 Data Segment - 2nd Interview Data*

This data extract also underpinned the importance of the relationship between the students and their physician mentors. Students' acquisitions of medical skills were dependent on that relationship. This was evident in April 1998 when I observed a meeting with the clinical mentors. The teacher team structured the session on the mentors' positive and negative feelings regarding the development of nurse practitioners, and their impression of their student's academic and clinical development to date. I recorded the following in my field notes:

"Positive Feelings:
The mentorship process was found to be stimulating.
The introduction of the nurse practitioner was viewed as highly positive for patients.
There was an overall feeling of a pioneering spirit."

"Negative Feelings:
There was a general agreement on the lack of time to achieve the desired outcomes.
The physician mentors particularly noted that the mentorship process could impose on their medical colleagues.
The depth of knowledge identified and required was extensive a difficult to achieve in the time allowed.
The physician mentors observed that traditional nurse uniforms were a hindrance to the students' role development."

"This was a positive meeting. It demonstrated a perspective of pioneering, something new, not done before. There was a collaborative mood between the nurses and doctors. The issue on uniforms was interesting. Is the new role being hampered by old traditions and images?"

Field Note Entry - April 1998

This data extract suggested a working communitas at this meeting. Both the physician mentors and students were in an environment where they shared the common ground of identity confusion and loss. They freely articulated their anxieties and confusions without threat from any establishment. For example, the physician mentors identified nurses' uniforms as a hindrance to their student's clinical role development, an idea that would have (probably) met with resistance elsewhere. The data indicated that the students also held this view:

"I do my practice nurse bit, and then when I do my practice as a nurse practitioner I do it in the evenings or come in on my days off to practice that as a separate role. When I do it in the evenings after work, I am still in my uniform and I miss out in the training, I get all the bits from the doctors. But, on my day off, if I come in not in my uniform then I manage to get a lot more experience of being a nurse practitioner, diagnosing and doing a lot of

practical things. In (a nurses) *uniform I get asked to do lots of routine things, 'can you do this dressing,' or 'take this blood,' or 'answer this telephone.'"*

Student Nurse Practitioner - E1 Data Segment - 2nd Interview Data

Thus, from both the physician mentors' perspective and the students' perspective, nurses' uniforms marked them out as a subservient in the professional hierarchy, and compromised the clinical authority required to enact the nurse practitioner role. This professional identity issue was evident later in a meeting with the clinical mentors in October 1998. This event marked a later part of the students' authority transition in this transition phase. The meeting aimed to prepare the mentors and students for the forthcoming OSCE examinations. The OSCE requirements were formally outlined by the physician teacher and she also presented the clinical skills map with which the students were already familiar (chapter seven, sub-section 7.7.1. p.194-198). Reiteration of this clinical model, with its emphasis on diagnosis, was important in reaffirming commonly understood clinical standards, although this persistent referral to aspects of diagnosis pointed to medicalisation. However, the nurse practitioner degree programme's curriculum and philosophy suggested an alternative interpretation to medicalisation, and this was apparent in the following data extract:

"(physician teacher's comment) *The whole idea of this course is a generalist one, and the OSCE is a generalist exam which assesses this new being, this nurse practitioner role."*

Field Note Entry - October 1998

Here, the physician teacher's view of the students as a new type of clinical practitioner is evident. In her view she does not see the students as nurses, but neither

does she see them as doctors. Therefore, although common standards of measurement were being used, drawn from both the professional domains of medicine and nursing, it was not necessarily expected that the students would become doctors (or cease to be nurses). I noted a growing awareness of the interprofessional nature of the students' socialisation and collegiality:

> *"It is a strange feeling to see a room full of doctors and nurses (on a nursing course), all being taught by a doctor. The feedback and discussion is evenly distributed between the nurses and doctors (who are incidentally all sitting in their mentorship couples). In fact the nurses' discussion is more medically orientated than the doctors' feedback!"*
>
> *Field Note Entry - October 1998*

This data extract indicated that new authorities were arising and that the relationship between physician mentors and the students had materially changed. At this time, physician mentors had a growing confidence in their students, and equally the students were able to relate to their mentors in an increasingly collegiate way. Thus, I noted a blending and combining of the clinical roles of nursing and medicine and a re-negotiation of their professional boundaries. The students began to participate more fully in a process of change that would enable the establishment of new agreed clinical authority that had a multi-disciplinary endorsement.

This completes the presentation of the clinical authority transition theme during the transition phase. In the next section, I discuss the clinical knowledge transition theme during the transition phase.

8.6. THE TRANSITION PHASE AND CLINICAL KNOWLEDGE TRANSITIONS

This clinical knowledge transition theme in the transition phase is divided into two parts. Firstly, I discuss the physician mentors' experiences of clinical knowledge transitions. Process and outcome link the transition phase to this discussion (chapter eight, sub-section 8.1.1. p.209-210). Secondly, I discuss the teacher team and the students' experience of clinical knowledge transitions. The overall consequence and affect on the sample link the transition phase to this discussion (chapter eight, sub-section 8.1.1. p.209-210).

8.6.1. The physician mentors: clinical knowledge transitions during the transition phase

The physician mentors had played only a small part in the clinical knowledge transition theme during the initial separation phase. However, as the nurse practitioner degree programme progressed into the transition phase, the physician mentors became increasingly involved. For example, at the outset of the degree programme the physician mentors had noted the limited timescale of the programme in comparison to its overall aim. This would become an increasingly important concern for the physician mentors as they worked with the students in clinical practice.

As we have seen previously in the clinical authority transitions in the separation phase (chapter seven, sub-section 7.5.1. p.179-180), the physician mentors would use their own profession to benchmark standards, knowledge and values. Although this

was a useful mechanism, the transposing of these values into an unfamiliar setting would raise concerns amongst the physician mentors. These concerns were evident in the following data extract:

> *"But I have a concern that trying to teach somebody in a relatively short period of time the basis of cardiac murmurs, neurology, chest medicine, is asking an awful lot, the level of expertise must be basic. I have a concern that, if that is the level, does that qualify them to go and do something outside their normal range of expertise."*
>
> *Physician Mentor - E1 Data Segment - 1st Interview Data*

These medical benchmarks naturally reflected a medical value system. However, for a physician mentor to apply them in a nursing context was problematic. A process of negotiation was needed to produce a modified set of benchmarks that would adequately reflect the level of clinical competence of the nurse practitioner (chapter nine, sub-section 9.4.1. p.296-299). The physician's allusion to a normal range of expertise was an (unwitting) explanation of this. As the nurse practitioner students acquired new knowledge, and thus new skills, the problem was that there was no normal range that described their expertise. Discovering that was a fundamental part of the transition phase experience, and it was followed by a need to identify professional structures that would enable the process.

The exposure to the nurse practitioner degree programme (and the subsequent process of reflection) had challenged the physician mentors on some of their most fundamental concepts and beliefs. A cornerstone of a profession is its possession of a systematic body of knowledge, and application of that knowledge to particular

problems (Barber 1963). To become members of the medical profession had required an extensive programme of education. Yet the physician mentors were involved with an education programme which was teaching nurses medical knowledge, and had clinical outcomes that were not (from their perspective) far removed from the role they had when they were newly qualified doctors. Thus, there was potential for conflict, the physician mentors experiencing aspects of marginality and identity loss similar to that of their nurse practitioner students. This conflict resulted in considerable levels of confusion and hesitancy as they tried to identify concepts that made sense of a nurse practitioners' clinical role. The first and perhaps most obvious response would be that the nurse practitioner students would (should) not be expected to achieve the skills (and thus status) that they possessed. Such hesitancies regarding the clinical skill and related status of the nurse practitioner were evident in the following data extract:

> *"To produce a doctor takes five years. Here you are trying to do that in two years, so there are limitations, and quite rightly as she is a nurse, I am not expecting her to be a doctor. As an ordinary nurse on the ward, my way of treating her would be as a nurse, not a doctor, not even a junior doctor. I assume there are certain things that the junior doctor will know. But with a trained nurse practitioner who specialised in a certain field, I would listen to her more than to a senior house officer from a different specialty. So I think how I see a specialised nurse is more towards a junior doctor."*
>
> *Physician Mentor - E1 Data Segment - 1st Interview Data*

This data extract presented a confusion of ideas and several important issues arose from it. Firstly, there was the assumption that a nurse practitioner would want to be a doctor (which they may not), or that the degree programme sought such an end (which it did not). Secondly, there was the utilisation of particular knowledge in

clinical settings that would confer different degrees of social status and facilitate some movement between the two professional groups. Finally, these points contrasted with the following searching reflection:

> *"I think that anyone who is realistic will realise that the limitations of five years of medical school are phenomenal. It's actually not that useful, most of it, for the day-to-day practice of medicine. There is a degree of over training. So the concept of the G.P. may go. There are some countries where such a thing as a general practitioner doesn't exist."*
>
> *Physician Mentor - E1 Data Segment - 1st Interview Data*

This data extract revealed the physician reflecting on the curricular process of medical training and questioning its effectiveness in meeting clinical outcomes that were relevant to daily practice. This led the physician to consider alternative healthcare roles that could replace or augment the general practitioner. In general terms this underlined the challenge to the physician mentors' own identity following their exposure to nurse practitioner students.

This completes the presentation of this sub-section on the physician mentors' clinical knowledge transition experiences during the transition phase. In the next sub-section, I review the teacher team's experiences, and the students' experiences, of the clinical knowledge transition theme during the transition phase.

8.6.2. The teacher team and the students: clinical knowledge transitions during the transition phase

In the previous separation phase, the students' clinical knowledge transition had focused on the acquisition of medical knowledge and medical vocabulary. However,

as the students entered the transition phase they began to further develop both their nursing and medical vocabularies. This was evident in the following data extract:

> *"There is recognition of each others* (doctors and nurses) *skills, respect for those skills, and less of a hierarchical relationship between them. That grows in training, they certainly don't start off like that, it develops. I think it develops as the nurse practitioners begin to understand and be able to communicate in the language of medicine. That doesn't necessarily mean that they leave behind the language of nursing, but that is the bridge. The third language that develops is the collegiate one, where they can both see each have a lot to offer the other."*
>
> *Physician Teacher - E1 Data Segment - 1st Interview Data*

The idea of a third language is important in understanding the students' journey through marginality. Firstly, they had to separate from the language of nursing. Secondly, they had to acquire the language of medicine. Only then could they use the two languages to formulate the third language. I suggest that the third language is a component of advanced clinical nursing (chapter ten, sub-section 10.3.3. p.385).

In September 1998, I observed the students in clinical skills classes. They continued to give particular attention to components of the curriculum that were concerned with diagnostic skills, pathology and pharmacology:

> *"It is interesting that in general conversation they appear to trivialise or to be irritated by the modules they see as peripheral (modules like Clinical Supervision). They see them as filling up time; time that they feel could be devoted to more important subjects like diagnostics."*
>
> *Field Note Entry - September 1998*

This data extract illustrated that the students' focus on clinical knowledge (and related clinical skills) was leading to increasing levels of stress as the transition phase progressed. As their role-playing became more complex, the students became increasingly hesitant and more anxious. Members of the teacher team had a particular relation with these student fears, and this was evident in the following data extract:

> *"Today, as the students hesitantly practiced a difficult physical examination skill the teacher exclaimed in an almost exasperated way, 'it's easy, you can do this!'"*
>
> *Field Note Entry - September 1998*

I had noted that the students looked worried and anxious, apparently unconvinced by the teacher's short-tempered reassurance. This illustrated the level of the students' anxiety over their clinical skills development at that time. Paradoxically, as the students became more knowledgeable, their stress levels started to increase. The students were learning new theory and new clinical skills to ensure that their prospective new role would be competent and professional, and this, coupled with the prospect of the final clinical OSCE examination (an important finale to the rite of passage), was beginning to heighten levels of anxiety (chapter nine, sub-section 9.7.1.1. p.335-336).

During September 1998, I made observations on individual student's academic performance. One student was particularly knowledgeable, articulate and outspoken. In teaching sessions, I observed teaching staff asking her to let other students have an

opportunity to answer questions. This observation revealed a new diversity in the students' development. The communitas, which had been evident in the summer months, faltered as each student now sought success independently from the group identity. Despite that developing individuality amongst the students, the overall academic and clinical standard observed, from a teacher team perspective, was demonstrably high. I noted that the teacher team members frequently reassured the students that their work and effort was of good standard, and they provided the students with knowledge and practice benchmarks that would allow them to judge that standard. This was illustrated in the following data extract:

> "(physician teacher's comment) *You must be clear in your writing as in a few years time you will be writing prescriptions."*
>
> *Field Note Entry - October 1998*

This was an example of clinical benchmarking, using clarity of documentation to illustrate a clinical safety issue, and linking taught knowledge to the skill of prescribing. One interpretation of this was that the teacher had simply highlighted the need for safe clinical practice. Another interpretation was that the teacher had disclaimed any future clinical errors by explicitly highlighting the correctness of the curriculum. Here we see the students facing the uncertain prospect of professional independence without the safety net of communitas. The teacher had made it plain that, from her perspective, the time was coming for the students to move into the incorporation phase and develop clinical autonomy. It was not surprising that such an expectation would serve to heighten the students' anxiety. However, later in that same session I observed the students challenging the teacher and correcting her on

specific points. Thus, in regard of their clinical knowledge development, they displayed contrasting behaviours of anxiety and confidence.

In comparison to this mixed behaviour over their clinical knowledge was the students' generally negative response to more traditional and formal taught aspects of the nurse practitioner degree programme that they had ranked as low order. For example, I observed sessions during their research module and noted the following:

> *"I assumed, as these are such proactive and verbal students, that their research ability would be good. Their critical ability is evident but their knowledge of research and research language is surprisingly underdeveloped. I was surprised when one of them looked up from a research paper and exclaimed, 'this is like Swahili to me!' This I suppose must be a facet of the clinical focus of much of their learning so far."*
>
> *Field Note Entry - November 1998*

Here, another dimension of the students' learning experience arose. There has been considerable attention in this analysis to the students' acquisition of new knowledge and language in relation to clinical skills, but they were additionally acquiring new vocabularies that related to traditional academic components of a degree programme. Thus, a part of their experience of this clinical knowledge transition theme was both clinical and academic, and the rite of passage had several dimensions (chapter ten, sub-section 10.3.4. p.391-397).

This completes the presentation of the clinical knowledge transition theme during the transition phase. In the next section, I discuss the clinical skills transition theme during the transition phase.

8.7. THE TRANSITION PHASE AND CLINICAL SKILLS TRANSITIONS

This clinical skills transition theme in the transition phase discusses the students' experiences of clinical skill acquisition and development. Confronting and surviving the process links the transition phase to this discussion (chapter eight, sub-section 8.1.1. p.209-210).

8.7.1. The students: clinical skills transitions during the transition phase

The students saw the development of new clinical skills as providing them with a demonstrable change in their professional status. But developing those clinical skills was also seen as an outcome of the nurse practitioner degree programme that was most time consuming and difficult to achieve. That was most apparent in the students' experience of the transition phase and was evident in the following data extract:

> *"So when I came in* (started the nurse practitioner degree programme) *I thought when I finished the degree I could go back and develop my role in nurse practitioning and they would accept that. But now I am spending all this time learning, which is sometimes very hard for me. I was talking to one of the doctors last week. He asked me how I would implement this knowledge of examining patients."*
>
> *Student Nurse Practitioner - F2 Data Segment - 1st Interview Data*

That difficult process of disengaging from traditional nursing practice, and developing advanced clinical skills, persisted throughout the transition phase. However, the data also indicated that the students' previous professional nursing experience was assisting them in this clinical transition:

"We are six months in and already the teachers report that they are developing good skills in health assessment and diagnostics. This should not be possible normally in such a short time, and is thus probably due to their years of existing clinical experience. They are not complete novices."

Field Note Entry - March 1998

Thus, the students' development of complex clinical skills was enhanced because of their previous professional experience, that experience a prerequisite of the nurse practitioner degree programme entry criteria of three years of specific clinical experience (chapter six, Figure 6.1. p.140). However, the students in this sample were well motivated, as was shown by their presence on a clinical degree programme that was known to be difficult. It was possible that equally motivated but clinically less experienced qualified nurses could have achieved the same, but there is no data available here to answer that question. However, I have already described that the students were developing their clinical skills by expanding their existing professional knowledge and vocabulary (chapter seven, sub-section 7.6.2. p.188-194). Thus, it appeared that their acquisition of diagnostic skills was influenced by their previous professional experience.

Toward the end of the first academic year (June 1998), the students undertook the first of their clinical examinations. This first-year OSCE examination was a key event in the students' clinical skills transition experience. I noted at this OSCE examination that the students were extremely nervous. Anxiety at any formal examination is a common experience, but the nature of OSCEs, where the student's practice is observed, appeared to heighten that experience of anxiety. In this OSCE

examination, each student had to complete a patient consultation where they undertook a physical examination and then outlined a suggested clinical management plan. A differential diagnosis was not expected from the students at this first OSCE examination, but would be expected at their final OSCE examination (a more prolonged and extensive examination) at the end of the nurse practitioner degree programme in May 1999 (chapter nine, sub-section 9.7.1.3. p.342-348). That future responsibility was not lost on them as during this first year OSCE examination some students had made errors in judgment. Thus, they were aware that they had to improve their ability to undertake examination skills and develop diagnosis if they were to safely direct patients' clinical management. This was evident in the following data extract that arose from a student's personal observation of her own hesitancies in patient management at this first year OSCE examination:

> "(student nurse practitioner's comment) *I am going to kill someone if I am not careful at this rate."*
>
> *Field Note Entry - June 1998*

Along with this growing awareness and concern over potential clinical errors, the post examination review session with the students revealed several other issues. Typically, the students demanded more classroom opportunities to practice clinical skills. This illustrated a difficulty that arose from the development of a clinical nurse practitioner degree programme such as this, where the emphasis on academic study had to balance against that of clinical development. The students had already established clinical roles, and there was a tension between those roles and their developing nurse practitioner role. This tension led the students to develop and

structure their communitas. Clinical communitas was the main mechanism that the students used to support each other as they experienced their clinical role transition and was their means of confronting and coping with the transition phase. The following sub-section considers the data that illuminated aspects of the students' individual clinical skills experiences in the transition phase.

8.7.1.1. Student reflections - September 1998 - mid clinical skills transition

Following the summer recess, the students' second year of study began in September 1998 with a day of orientation and debriefing. On that day, students reflected on their summer experience, and on their expectations for the final academic year ahead. The data I recorded revealed aspects of the students' clinical skills transitions. It showed how the teachers and students developed and used varied coping mechanisms. The remainder of this section reviews and discusses the field notes that were recorded during each student's reflection. The healthcare sector for each student is noted as it gives context to the discussion and was an important issue for the students during the transition phase (chapter eight, sub-section 8.4.2. p.236-239).

Student 1 - (Secondary Healthcare)

> *"She has visited medical wards. She is not happy with medical domination and refers to being, 'carted around on ward rounds.' She doesn't feel she is getting what she needs to develop her role. She is annoyed that a member of the course teaching team failed to turn up for appointment with her at the hospital. She says, 'I am not seeing ill patients and cannot develop assessment skills.'"*
>
> *Field Note Entry - September 1998*

It was evident that Student 1 was frustrated by the perceived limitations of her secondary healthcare environment. From a specialised and focused clinical specialty, she was finding general clinical experience difficult to gain. In her view, many of her patients were in relatively good physical health and she saw this as hampering her development of physical examinations skills. She had tried to overcome this by seeking clinical experience away from her own clinical environment, but the medical team that facilitated this had only provided observational time during its formal consultant rounds. Such frustrations underlined her perception that her clinical environment had delayed her acquisition of clinical health assessment skills.

Here we see an example of how clinical mentorship, a necessary component of all the students' learning experience, varied in its delivery. Students were able to progress despite poor mentorship experiences, but poor mentorship made that process more difficult. The teacher team had only marginal influence on clinical mentorship support, but had developed a range of alternatives when problems arose. Clinical time was offered to the student with the physician teacher in a primary healthcare general practice to help her overcome her difficulties.

Student 2 - (Secondary Healthcare)

> *"She has been working with Orthopaedic doctors. She describes this as a very good experience. The doctors allow her to examine patients and she then has to feedback to whole medical team. She has been doing pre-admission clinics, 'the senior house officers hate doing them,' she says, so she does them."*
>
> *Field Note Entry - September 1998*

This data extract contrasted with the first student's experience. Although also working in a secondary care area, within a specific clinical specialty, Student 2 had found that her clinical mentorship experience during the summer recess had enabled her learning needs. She had quite openly exploited low order routine medical work to her own advantage, taking on unwanted clerking duties that gave her access to patients. The student had made compromises to negotiate her progression. By acting out a traditional professional apprentice role, the student had been able to acquire the skills she needed, and at the same time satisfy the expert professionals (chapter six, sub-section 6.2.6. p.141-142 / chapter ten, sub-section 10.3.1. p.367-374).

Student 3 - (Primary Healthcare)

> *"This student has formalised her role in her surgery. She has developed a patient information leaflet on her role as a nurse practitioner, and has put this as a proposal to the GPs (coming out of the closet is the term she used). She says that following this challenge the GPs claimed to have been unaware of the scope and potential of the nurse practitioner role even though they have mentored her. Nevertheless they were generally supportive. Thus she is asserting her new identity at this halfway stage and is challenging the establishment."*
>
> *Field Note Entry - September 1998*

Student 3 was acutely aware of her invisibility, and of her lack of role identity. Her approach to this problem was proactive and creative. She had acted on her invisibility by informing potential clients of her availability, and thus had actively begun the establishment of her future clinical role. This gate of entry to the new clinical role and new identity was created by the student, but was legitimised by the physician mentors. In this instance, they had allowed the nurse practitioner student to

do this, whilst claiming a certain ignorance of her role. Had they objected to this new clinical role, she would not have been able to develop it as well as she had.

Student 4 - (Primary Healthcare)

> *"She is working alone more. Her mentor is giving her space but is still requiring feedback. 'I am not getting enough meaty stuff,' she says (the students are all expecting to see difficult cases; they don't just want the easy stuff that the doctors don't want). She says, 'I am still having to fulfill my role as a practice nurse,' and thus, her nurse practitioner role is different and she is enacting two distinct roles. Her GP sees the nurse practitioner role as a specialist one she says, he doesn't want her to do just the basics. Listening to this student reveals her own confusion on what she wants."*
>
> *Field Note Entry - September 1998*

Student 4's comments illuminated her own identity crisis in her daily clinical practice as she dealt with two distinct clinical roles. This indicated that the nurse practitioner role was distinct and in need of wider recognition and identity. Further confusion arose from expectations of specialism in a role that had inherent generalist characteristics. The skills taught on the nurse practitioner degree programme were broad, and the student was actively engaged in that educational process. Her experience of marginality appeared quite acute and her feelings of being neither one thing nor the other were focused by her duality in clinical practice. Her student self had separated from her nursing identity, but her daily occupation retained her in a traditional role. The student's experience at that moment was therefore characterised by that process of clinical skill transition.

Student 5 - (Primary Healthcare)

> *"She cites lack of time as a problem and has had to change her mentor. 'You don't realise how important your mentor is going to be,' she says. 'My vocabulary has changed, I am more confident now.' She sees isolation as a problem, 'there are so few of us,' she says. 'People don't know what we are about. Patients have asked me if I am going to be a consultant nurse.'"*
>
> *Field Note Entry - September 1998*

Student 5 had realised how important the physician mentor was to her in clinical skill acquisition. She also identified that her acquisition of medical vocabulary had gone some of the way to enable her construction of her new role, but her sense of isolation was also evident. This student had some sense of her future identity, but also recognised the confusion that the wider professional and lay community had of the nurse practitioner role.

Student 6 - (Secondary Healthcare)

> *"She has been working with a qualified nurse practitioner in her area and has been doing clinics. The question of time comes up (or lack of it). She also has changed her mentor. She said, 'I haven't got a lot of autonomy, that's down to the consultant I think, and I am unsure how can I incorporate my clinical skills into my role?' She continued, 'I need more clarity, there is such a lot of politics, I need to be allowed to practice my clinical skills, and I need the consultant's confidence.'"*
>
> *Field Note Entry - September 1998*

This student saw many restrictions imposed on her by traditional boundaries. She openly acknowledged her lack of autonomous clinical activity and saw this as a direct result of the professional hierarchy within the hospital environment. She perceived that she required the permission of medicine to use new clinical skills in the

development of a new clinical role, but that this was proving a difficult thing to achieve. She had changed her mentor recently and was experiencing feelings of confusion and conflict because of these changes. These feelings were characteristic of the transition phase, but for this student they were exacerbated as the secondary healthcare sector presented particular difficulties. The medical hierarchy in hospitals was more pronounced than it was in primary healthcare and that had implication not only for this nurse practitioner student, but also for all the secondary healthcare students. For example, the regular six monthly clinical rotations of junior doctors had posed difficulties for the continuity of mentorship as it was often they who were active as the clinical mentors. Thus, even if a student had the confidence of the consultant, they still would have to renegotiate a relationship with a junior physician mentor on a regular basis.

Student 7 - (Secondary Healthcare)

> *"Her workload has spiralled and she has no protected study time. She said, 'I have to revisit my role as my senior nurse wants to know what I do that is different from any other nurse, and she says she feels threatened.' The student explained that her senior nurse wanted clear protocols. The student went on to say that her role was snowballing. That, she says, is OK, but she feels she has no higher level support. 'It's the isolation of it all; we have created a service but not resourced or supported it.'"*
>
> *Field Note Entry - September 1998*

In this data extract, issues of professional isolation and identity loss were again evident. Student 7 was experiencing antagonism from her own professional peer group. She was attempting to enact a new clinical role but had no clear understanding of what that role was. That lack of role identity was part of the senior

nurse's concern, and her response to this was to seek clinical protocols that would provide some identity and regulation. But, in the absence of an existing clinical career structure, those protocols would first have to be created. It was the student's passage through the transition phase, and later through the incorporation phase, that would enable protocol development.

Student 8 - (Secondary Healthcare)

> *"This student has worked in emergency surgery for a week. She saw patients (took histories and did clinical exams) and then presented her findings to the doctors afterwards. She says she wants to see, 'gross abnormal physical signs.' She is preoccupied with the assessment skills, this is her whole focus. She wants to 'absorb medical skills' (her words), and sees her role as underdeveloped. 'I am doing this by myself, but I am getting there,' she says."*
>
> *Field Note Entry - September 1998*

In this data I alluded to Student 8's focus on medical skills, and this links to my earlier proposal that a process of transition for the student nurse practitioner was one of relinquishing nursing and passing transiently through medicine (chapter seven, section 7.8. p.203). For this student it appeared that the passage through medicine had become a preoccupation. I noted that that she gave a high status to clinical assessment skills acquisition beyond that of her other student colleagues. She appeared to be distancing herself from her nursing background. However, this student was a singular example, personifying many of the concerns of those antagonistic to nurse practitioner development. For example, in clinical practice she chose to wear a white coat as opposed to a nurse's uniform as she thought this clarified her new role with patients. The student saw herself as developing a role

defined by diagnostic skill proficiency. She based her new role identity on a traditional medical identity that was directed by the medical role model. She was highly status conscious and quite openly rejected her nursing background. This student would later fail the final year clinical OSCE examination (chapter nine, sub-section 9.7.1.4. p.348-349).

Student 9 - (Primary Healthcare)

> *"Her GP is selecting patients for her, and she has to feedback to him on her consultations. She wants 'more juicy' patients (her words). She has also been visiting local hospital to see patients for experience. She is very pro-active in her role development. She is self-funded, has effectively elected to do the* (nurse practitioner) *programme without support of her employer, and she feels that she has no specific mandate for her role development. 'I am carving my own role out but I can't really see where I am going, I have just spent a lot of money on this, and I am in a fog,' she says."*
>
> *Field Note Entry - September 1998*

Student 9 had chosen to undertake the nurse practitioner degree programme and its requirement for clinical development without employer support. This presented her with additional difficulties in clinical skills acquisition as the onus for such a development arose almost entirely from her own ambitions. Nevertheless her sense of identity loss and liminality was no less or different from that of her other student colleagues. Her employer had not originally supported her studies on the nurse practitioner degree programme, but subsequently had allowed her to develop new clinical skills. Her physician mentors were now selectively allowing her to exploit some clinical opportunities. This data extract illustrated that many employers at that time remained uncertain over the nature of advanced clinical nurses and their benefits

to practice. This is an example of how students were undergoing clinical role transitions in environments where support for such roles was uncertain and hesitant.

This concludes the nine individual student reflections recorded in September 1998. They have illustrated the variety of clinical skills transitions that the students were experiencing, and they have highlighted areas of common experience. For example, clinical mentorship was a common theme, and its importance was emphasised in a variety of ways. Equally, time and opportunity to practice new clinical skills was a common theme. Finally, the students' use of new clinical skills led to issues on professional identity and clinical authority.

This completes the presentation of the clinical skills transition theme during the transition phase. In the concluding section of this chapter, I summarise the data presentation and main findings of the transition phase.

8.8. THE SUMMARY OF THE TRANSITION PHASE

The transition phase of the rite of passage began in February 1998, immediately following the end of the separation phase, and ended in December 1998, just before the beginning of the incorporation phase. There was some blurring as one phase gave way to another.

During the transition phase of the rite of passage, each of the five transition themes (chapter one, section 1.2. p.8. / chapter five, section 5.1. p.105) revealed activity that involved, to varying degrees, the teachers, students and physician mentors. The

teacher team developed its conceptual thinking on aspects of advanced clinical nursing practice. For example, the discussion on primary and secondary healthcare, and the discussion on the regulation of nurse practitioners, continued and developed. The teacher team also had a perceived lack of peer recognition, and a transition of educational status emerged. This intensified following introduction of another research programme that recruited the students and affected the teacher team's relationship with academic peers. The physician mentors were experiencing transition phase that mirrored much of the students' experience. For example, the physician mentors had to make conceptual judgments that would enable their understanding of the nurse practitioner role. What were the components of the nurse practitioner role? How did the role components compare with traditional medical standards? How was clinical workload to be divided, and who would be in control of this? All these questions arose from the physician mentors' contact with the students. The realisation that medical benchmarking would not fully underpin the new nurse practitioner role was a slow process, and defensive attitudes were equally slow to change. Nevertheless, during the transition phase there was a communitas that had developed between the physician mentors and their students, and a shared collegiality emerged.

Finally, the students also experienced transitional events, particularly those of liminality and communitas. They moved into a state of limbo and this resulted in loss of identity. There were uncertainties over record keeping, the use of new vocabularies, and the title nurse practitioner. Difficult encounters with peers, both

nurses and doctors, occurred. There also arose differences between the primary healthcare and secondary healthcare experiences, although these were not always consistent. An important feature of the students' identity experiences in the transition phase was their role duality, being both a professional nurse and a student nurse practitioner at the same time.

The mid-transition disengagement from formal study, occasioned by the academic summer recess, was a pivotal point. Following this, the students' reliance on role development within the safe confines of communitas diminished. Self-interest slowly predominated with the emergence of their new role. Thus, the transition phase was characterised in many ways by issues of uncertainty and concluded with the early development of the new nurse practitioner role. The final data extracts in this chapter revealed this:

> *"So it's like you're being squashed in the middle. You're not a nurse; you're not a doctor. You're a new breed that has been created."*
>
> *Student Nurse Practitioner - B1 Data Segment - 2nd Interview Data*

> *"I feel that a lot of the views that I have come across about nurse practitioners are that it takes them away from nursing. But I think it makes you a more holistic nurse, a better nurse. It's about patient care; it's like having the blinkers taken off you. Things were shrouded in mystery before, the doctors' round and blood results. I know so much more about that now. A better understanding of what is going on with patients."*
>
> *Student Nurse Practitioner - D1 Data Segment - 2nd Interview Data*

I conclude this chapter, which has presented a detailed analysis of the five transition themes within the context of the transition phase, with a concept summary (chapter

eight, Figure 8.2. p.280). The summary lists the main issues that arose in the transition themes during the transition phase, and this correlates with the conceptual links and relationships of the transition phase provisionally outlined at the beginning of this chapter (chapter eight, sub-section 8.1.1. p.209-210). It is also linked to the summary of the transition themes data in chapter ten (section 10.2. p.355-366). The following chapter (chapter nine) will consider the detailed analysis of the final phase of the rite of passage, the incorporation phase.

- **The Transition Phase and the Social Transitions Theme**

The Teacher Team

(Conceptual links - standards in the transition phase)

Lack of peer recognition / advanced clinical nursing concepts / the new research project / conflict in the school and the student and teacher team / identifying a clinical educational standard

The Students

(Conceptual links - the loss of self in the transition phase)

Keeping notes / personal identity loss / mixed vocabularies / moving into limbo / mid transition disengagement

- **The Transition Phase and the Professional Transitions Theme**

The Teacher Team

(Conceptual links - clarifying the transition phase)

National developments, consultant nurses, clinical stratification

The Students

(Conceptual links - negotiating transition)

Professional identity loss / professional permissions from others to proceed / primary and secondary healthcare uncertainties / title confusion / professional transgression / professionalisation

- **The Transition Phase and the Clinical Authority Transitions Theme**

The Physician Mentors and Students

(Conceptual links - managing the transition phase)

Limited time scales / medical benchmarks that don't fit / identity threats (and loss), alternative clinicians occur / task reallocation, task status, managing clinical workload / nurse - doctor relationship / future structures are uncertain / communitas / hostile clinicians / badges of status / developing new confidences / collegiality / moving out of transition

- **The Transition Phase and the Clinical Knowledge Transitions Theme**

The Physician Mentors

(Conceptual links - outcomes of the transition phase)

The limited time scale comparison / medical benchmarks that don't fit / identity threats (and loss) / alternative clinicians occur

The Teacher Team and the Students

(Conceptual links - consequence and effect of the transition phase)

The third language, weighting aspects of the curriculum / developing clinical autonomy - individualism rather than communitas / research - another aspect of rite of passage

- **The Transition Phase and the Clinical Skills Transitions Theme**

The Students

(Conceptual links - confronting and surviving the transition phase)

Quick skills acquisition following previous experience / clinical communitas / post mid transition disengagement 'clinical' reflections / varied mentorship - clinical areas not 'tuned in' - the primary secondary healthcare sector experience / exploiting medical dirty work, gate of entry to new roles via clients / the danger of the transition through medicine – consumed by medicine / clinical duality - a confusion of identities, invisibility / acting uncertain roles - developing boundaries

Figure 8.2. Concept summary of the transition themes during the transition phase

CHAPTER NINE

THE INCORPORATION PHASE

9.1. INTRODUCTION TO THE INCORPORATION PHASE

This chapter describes in detail the third and final phase of the rite of passage. Turner (1982) characterised the incorporation phase as:

> "The symbolic phenomena and actions which represent the return of the subjects to their new, relatively stable, well-defined position in the total society."
>
> (Turner 1982 p.24)

The incorporation phase is also called the re-aggregation phase (Partapuoli and Nielsen 2003). As the name implies, the phase distinguishes itself not only by a process of re-introduction into the social world, but also by the possibility of combining experiences into new social orders and structures. It is a construction of an ordered and ordinary way of life from the once extreme and unfamiliar experiences of the transition (marginal) experience. Thus, characteristics of the incorporation phase are the decline of communitas and the introduction of new social orders and structures (Turner 1982). For the nurse practitioner students in this study, the incorporation phase required a re-negotiation of social order at the professional border of nursing and medicine, and a re-negotiation of their social order status within nursing. However, I conclude the analysis of the final phase of the rite of passage, the incorporation phase, by suggesting that these negotiations,

uncharacteristically, were not finalised at the end of students' studies with the nurse practitioner degree programme.

In the previous two chapters (chapter seven and chapter eight), I described the first two phases of the rite of passage: the separation phase and the transition phase. During the separation phase the loss of occupational identity stood as the notable experience for the student sample, and this was marked by the changing relationships between students, teachers and physicians. During the transition phase, experiences of marginality and associated communitas were evident, and were characterised by the students' transient passage through medicine and the affect this had on the teacher team and the physician mentors.

In the final phase (the incorporation phase) the students' clinical skills developed further. The students selectively merged aspects of the two distinct identities of nursing and medicine, and this suggested that status negotiations at the professional boundary were occurring. Consequently, in the incorporation phase, the nurse practitioner students were actively determining their new role and identity. I suggest that the place of this new identity lay situated in the advanced clinical practice domain of nursing.

This chapter reviews the third phase of the rite of passage: the incorporation phase (January 1999 to July 1999). It examines each transition theme individually within the context of this phase. The structure of this chapter is as follows. Firstly, there is

a summary of the general timing of the incorporation phase within the structure and chronology of the nurse practitioner degree programme (Fig 9.1. p.284). and an outline of the key conceptual links between the chapter's sub-sections (the transition themes and the data) and the elements of the incorporation phase. Following this there is a broad review of the main features of the incorporation phase. The main body of the chapter consists of the detailed review of each transition theme. At the end of the chapter, the data, findings and links of this incorporation phase are again summarised.

<table>
<tr><td colspan="5">The Rite of Passage - Transition Time Line – Incorporation

TRANSITION THEMES
Social Transitions,
Professional Transitions
Clinical Authority Transitions
Clinical Knowledge Transitions
Clinical Skills Transitions</td></tr>
<tr><td colspan="2">1997</td><td colspan="2">1998</td><td>1999</td></tr>
<tr><td colspan="5">July---Sept------------------------Dec--Jan--------July--Sept----------------Dec--Jan--------------------------July</td></tr>
<tr><td rowspan="2">P R E C O U R S E</td><td>Academic Year One

Modules
Clinical Assessment Skills 1
Consultation Skills
Pathology and Pharmacology

Summative Assessments
OSCE 1, Essay, Video Tape Analysis</td><td>S U M M E R B R E A K</td><td colspan="2">Academic Year Two

Modules
Clinical Assessment Skills 2
Research and Evidence Based Practice
Clinical Supervisory skills
Pathology and Pharmacology

Summative Assessments
OSCE 2, Research Proposal, Written Examination, Essay</td></tr>
<tr><td>The Separation Phase (Chapter 7)</td><td colspan="2">The Transition Phase (Chapter 8)</td><td>The Incorporation Phase (Chapter 9)</td></tr>
</table>

Fig. 9.1. The separation, transition and incorporation phase in context

Before discussing the data further, it is important to review and spell out the links between the incorporation phase of the rite of passage and this chapter's sub-sections. This chapter presents data that illustrate the five transition themes (chapter one, section 1.2. p.8. / chapter five, section 5.1. p.105) as they occurred during the incorporation phase. The main concepts and relationships that are relevant to this phase are outlined below in sub-section 9.1.1. (p.285-286). These are summarised again at the end of this chapter (chapter nine, Figure 9.2. p.352).

9.1.1. Conceptual links and relationships of the incorporation phase

Social Transitions – based on the experiences of the students

- In this transition the student data were characterised by the decline of communitas, the construction of new identities, the prospect of future responsibility, and forced re-socialisation. These data are linked to the process of social re-emergence during the incorporation phase.

Professional Transitions - based on the experiences of the students and the practitioner ethnographer

- In this transition the student data were characterised by wide-ranging negotiations on the new professional clinical role. Examples were the selection of multi-professional role models, a prolonged incorporation into clinical reality, identity confusion, secondary healthcare and primary healthcare issues, the use of titles in an advanced clinical nurse construct, and emerging as new novices. These data are linked with fundamental processes of professional re-structuring in the incorporation phase.

- In this transition the data were characterised by the practitioner ethnographer's exposure to the national development of higher level of practice, the introduction of consultant nurses, and the related introduction of nursing clinical career strata. These data are linked to the emergence of social structures during the incorporation phase.

Clinical Authority Transitions – based on the experiences of a combined group of students and physician mentors, and based on the experiences of a combined group of physician mentors and the teacher team

- In this transition the student and physician mentor data were characterised by new areas of clinical authority, changing hierarchies, closure, formal clinical structures and a professional apprenticeship model. These data are linked to the changes in professional status occurring in the incorporation phase.

- In this transition the physician mentor and the teacher team data were characterised by the means of defining nurse practitioners, authority influences on the curriculum, lack of controlling structures, power conflicts, and advanced clinical nursing practice. These data are all linked to the emerging clinical and professional authority of nurse practitioners during the incorporation phase.

Transition and Clinical Knowledge Transitions - based on the experiences of the students

- In this transition, the student data were characterised by knowledge acquisition, self-perceived knowledge deficits, knowledge ownership, and selective knowledge utilisation. These data are linked to processes of aggregation of new structures into the new social role of the nurse practitioner during the incorporation phase.

Clinical Skills Transitions - based on the experiences of a combined group that includes the students, physician mentors and teacher team

- In this transition data arose from the experiences of the students, teacher team, physician mentors. These data were characterised by the experiences of OSCE examinations, the nature of clinical specialists and generalists, the decline of clinical communitas, the rise of individual identity, the introduction of graduate nurse practitioner examiners, and the use of regulations and standards. These data are all linked to the evolution and emergence of the students' new clinical role during the incorporation phase.

Having listed these concepts and relationships, the next sub-section provides a broad review of the main events of the incorporation phase. Following this review, each transition theme is examined in detail.

9.2. A BROAD REVIEW OF THE INCORPORATION PHASE

The incorporation phase occurred between January 1999 and July 1999. It followed the previous transition phase and ended at the completion of the nurse practitioner degree programme. The analysis of the incorporation phase revealed an emerging nurse practitioner identity. The following data extract highlighted that a feature of that emerging identity was that it was distinct from a medical identity:

> *"I still think there is a divide, between nurses and physicians; and there will be a divide between physicians and nurse practitioners."*
>
> *Student Nurse Practitioner - E1 Data Segment - 2nd Interview Data*

Consequently, during the incorporation phase, it was the students' experiences that were most evident in the data. The physician mentors' experiences and the teacher team's experiences, whilst important, featured less prominently than in the previous separation and transition phases.

As incorporation phase progressed the students incorporated new clinical skills into their roles, skills that they had rehearsed during the separation phase and the transition phase. However, as the final examinations approached, I observed increasing tensions amongst the students and a decline of the general communitas. They became less concerned with understanding the scope of their new professional role, and attended more to the specific clinical skills that would be tested at the final examinations, specifically at the OSCE examination. Thus, student's personal needs became more important than those of the student group.

Throughout the incorporation phase, the students continued to favour specific areas of the curricular content within the nurse practitioner degree programme, giving more attention to taught clinical skills than to more traditional academic subjects such as research skills. Low attendance at particular teaching sessions was evidence of the students' selective behaviour during the incorporation phase. They were finishing off their learning, refining their skills, and moving into the diagnostic and management part of the clinical skills map (chapter seven, Figure 7.2. p.198). This sense of

emerging with a new identity, and of achieving a final outcome from the nurse practitioner degree programme, was evident in the following data extract:

> *"My role has changed as I have begun to feel more confident, and there are a greater range of patient's problems that I now feel that I can deal with which I didn't used to feel able to cope with. That was part of my aim, if you like, of doing this course* (the nurse practitioner degree)*, which I have achieved to a certain extent. It used to be quite frustrating that patients would come to us as practice nurses, with minor problems, which I should have been able to cope with, which I couldn't, but now increasingly feel that I can. So I have achieved that aim, or if I haven't achieved it, I am getting there."*
>
> *Student Nurse Practitioner - F1 Data Segment - 2nd Interview Data*

The students continued to exhibit the mixture of developing clinical confidence and increasing anxieties that had been observed in the transition phase (chapter eight, sub-section 8.6.2. p.262). They frequently asked for information from the teacher team on their options in the event that they failed an assessment, and persistently checked on resubmission dates for examinations and essays. It was the fear of the final examinations, the fear of potential failure, and a need to negotiate that possibility, which stood out in the data. The final OSCE examination was the focus of the students' fear and it became a preoccupation in their daily experience. The advent of the final OSCE examination led to progressive levels of stress in every student, and some became so anxious they sought advice and support from teacher team members. I noted that the teacher team had discussed the variety of physical and emotional symptoms experienced by some students, such as insomnia, appetite change, loss of concentration, bouts of tearfulness and depression.

Fear of examination was not unique to this degree programme; completion of many education programmes was by end of year examinations and assessment, and these often caused student anxiety. For example in this nurse practitioner degree programme, there was a range of end of year examinations in addition to the final OSCE. The question that arose was why the final OSCE examination featured so centrally for the students over and above their other assessments. The extreme importance that the students placed on the final OSCE examination appeared to be disproportionate. I suggest that the reason for this was that the final OSCE represented a concluding initiation event of the rite of passage to nurse practitioner status and legitimacy. Failure of the final OSCE would not be viewed by the students as failure of a single and retrievable examination, but as failure of the entire purpose and raison d'être of the nurse practitioner degree programme. Conversely, a student's success in the final OSCE was the event that marked his or her passage to advanced clinical nursing practice and its associated status and privilege.

The students' view of the final OSCE examination arose from multiple sources. For example, they had met with diploma students from the previous cohorts and had listened to their experiences. There was the influence and emphasis placed on the examination by the teacher team. There was also the influence of the physician mentors, who had experienced clinical OSCEs during their medical training. Beyond this, in the event of failure, there was a wait of a year before retaking the examination, and that would be with another cohort of students, making failure visible to a wider audience. Thus, the final OSCE was important, and its clinical

nature and use in both medical and nursing education gave it a special profile. The prospect of failure of the final OSCE was viewed by the students as not only a personal failure but also as a public humiliation. This was shown in the following data extract:

> *"And the fear of the OSCE coming up as well - that if you fail you're going to have to wait another year to sit again. I couldn't bear it!"*
>
> *Student Nurse Practitioner - F1 Data Segment - 2nd Interview Data*

The final OSCE examination was a defining ritual of the rite of passage. Despite this, it was evident that the end of the nurse practitioner degree programme would not conclude the students' role development. Their role development would continue after the formal ending of the nurse practitioner degree and they would have to undergo further transitions to develop their identity.

Although the teacher team's experiences, and the physician mentors' experiences, were less prominent in the incorporation phase, issues arose for them. These issues were focused on the control (management) of the degree programme. For example, who decided the acceptable clinical or professional outcome of the nurse practitioner degree programme, and who regulated this? An important issue was that the teacher team and the physician mentors who trained the student nurse practitioners were not themselves nurse practitioners. The traditional professional apprenticeship model, where an older generation of experts handed down their skills to the next generation of novices, did not apply in this context (chapter six, sub-section 6.2.6. p.141-142 / chapter ten, sub-section 10.3.1. p.367-374). Thus, during the incorporation phase, as

the students began to develop a new professional identity, the professional authority relationship between the physician mentors and the teacher team was prominent. Into this relationship a new element emerged that, in the longer term, offered a solution to the tension between the teacher team and the physician mentors. The introduction of graduate nurse practitioner clinical examiners to the OSCE examinations would bring a new perspective to the professional border negotiations between medicine and nursing.

The final OSCE examination marked the end of the nurse practitioner degree programme. During that examination, I observed the students supporting each other through the final event of a prolonged rite of passage. When the examination period was completed, including resubmissions and viva voce examinations, the students left the degree programme as novice nurse practitioners (with one exception).

In this chapter's introduction, I have outlined the chronology, events and experiences of the incorporation phase. I now consider each of the transition themes in detail.

9.3. THE INCORPORATION PHASE AND SOCIAL TRANSITIONS

In this social transition theme during the incorporation phase, I discuss specifically the students' experiences. Social re-emergence from marginality links this section's discussion to the incorporation phase (chapter nine, sub-section 9.1.1. p.285-286).

9.3.1. The students: social transitions during the incorporation phase

Following the Christmas recess of 1998, the nurse practitioner students returned to their studies in January 1999. I observed them discussing their anxieties over a forthcoming written examination. I also noted that the earlier group cohesion was less marked than it had previously been. Individual anxieties were particularly evident in the data at this time:

> *"There is a written pathology and pharmacology examination next week. All the students here today are quiet. There is a low mood and an air of apprehension."*
>
> *Field Note Entry - January 1999*
>
> *"It's the nature of the second year; the pressure is on to get assignments done. Because we have got some knowledge people think we can just get on with it. But in fact because you have a little bit of knowledge, it makes you question everything you're doing. So I think there is a lot of pressure, too much pressure in the second year, it could be spread out a bit."*
>
> *Student Nurse Practitioner - F1 Data Segment - 2nd Interview Data*

It was in the context of this uncertainty and anxiety that I observed an angry outburst amongst the students directly following the pathology and pharmacology examination:

> *"It is the week following the pathology and pharmacology examination, and the students were demanding, anxious and upset. They wanted me to explain marking criteria, to provide re-sit dates. There was a vaguely hostile mood, particularly from one student who was openly angry. She was very upset, believing she had done very badly in the exam. The debriefing session went on for some time and the other teacher and I tried to calm the mood, but with limited success. I recorded the following dialogue: Student A, 'I know what he* (the lecturer) *is trying to say, but I am not as good as you, I need more help.' Student B replied, 'you are much better at some things than me.' Student A, 'well I don't know about that, and why didn't they* (the teachers) *give me more information about the marking and resits when I called, I was really upset!' The lecturer responded to this stating, 'that was because when you called I*

didn't have that information; I have it now and have passed it on to you.' Student A looked upset and replied, 'yes, but I needed it then, I was nearly ready to give up.' Student C said, 'don't do that, we all feel the same!' Student A replied, 'yes, but you work in primary care and get more opportunities then I do.' Student C retorted, 'I don't know that that is fair, you have opportunities that I don't have!' At this point the teacher intervened, 'I think we need to move on!'"

Field Note Entry - January 1999

Thus, the students were now openly discussing their views on personal differences in ability and opportunity amongst themselves. This outburst revealed interpersonal issues not previously observed between the students, and revealed an increasing mood of self-interest. The approaching end of the nurse practitioner degree programme, and the fear of failure, were factors in the decline of group cohesion. I reflected on this tense mood amongst the students:

"The students now face the rapidly approaching reality of final exams, and the possibility of failure. They have moved clearly into another stage, that of the final examinations and of OSCEs. They are looking for safety valves, asking for the dates of re-sits, the nature and process of aggregating marks, and the details of university regulations. They are really quite anxious and self-absorbed."

Field Note Entry - January 1999

This data extract indicated that the protective communitas that the students had during the transition phase, which had enabled safe role-playing to prepare them for their new clinical role, was no longer protecting them from stress and anxiety. The growing demand to re-integrate with practice, the prospect of final examinations, and an increasing preoccupation with the diversity of the clinical role that they would undertake after the nurse practitioner degree programme finished, led to a progressive

decline in the students' communitas. The steady loss of the safety net of clinical role-play, and the increasing expectations of the teacher team and physician mentors, emphasised that their new clinical role was emerging. The students were constructing a new identity from what they had learned, and they were experiencing a process of re-socialisation as a consequence of the approaching end of the nurse practitioner degree programme. This was reflected in their wide-ranging professional and personal uncertainties and anxieties, and this was evident in the data:

> *"There are negative aspects* (of becoming a nurse practitioner) *in that it makes you incredibly vulnerable sometimes because you begin to feel that you can't always pass the buck. You begin to realise that in order to move up you have to accept a greater responsibility. It was always easy to pass the buck in the past and say 'go and ask the doctor.' When you start to try and give advice, or to help people, without involving the doctor it does involve greater responsibility."*
>
> *Student Nurse Practitioner - F2 Data Segment - 2nd Interview Data*
>
> *"I think my practice has changed, in terms of accountability and autonomy. Or has it changed because of what I am doing. I am sure it has changed, even if it's not a conscious change. I don't know. I am very uncertain. I think that I am more personally uncertain rather than professionally uncertain. I don't know where I am going at the moment."*
>
> *Student Nurse Practitioner - F2 Data Segment - 2nd Interview Data*

Much of the anxiety evident in these data extracts arose from the prospect of the final examinations, particularly the clinical OSCE examination, and these anxieties were further intensified by the possibility of failure. Thus, it was the stresses of the nurse practitioner degree programme, coupled with the students' disengagement from group identity, which featured in their re-socialisation with clinical practice. The following data extract highlighted that this re-socialisation process was taking place:

"Patients are already asking to see me, even though I am not qualified, which is quite nice, quite reassuring. They have come to practice sessions where they have seen me, seen the doctor afterwards and then said, 'do I need to see the doctor now or can I see you next time?' They ask the receptionists if they can see me. So at least the patients have confidence in me!"

Student Nurse Practitioner - D1 Data Segment - 2nd Interview Data

However, the decline in group identity, and re-socialisation into clinical practice, reversed on the day of the final OSCE examination in May 1999 when the students experienced extreme levels of stress. That stress resulted in a short-lived group communitas that revealed a final initiation to nurse practitioner legitimacy. After the OSCE examination, they would meet only one more time in June 1999 before parting company as a student group. I noted that the process of social incorporation had not been completed at the time the students formally left the programme. Although the students had sought to change and finalise their clinical activity, by the end of their studies they realised that the context of their new clinical practice, and their status within in it, remained ill-defined. Although they had met the demands of the nurse practitioner degree programme, their role transition in clinical practice was incomplete. This was evident in the following data extract:

"I didn't realise it before but I am not going to be doing what I did before. As practice nurses, although you attend to the psychological aspects of the patient when they come to see you, they are coming for practical things to be done, wounds, dressing or coming for bloods, ear syringing or ECGs. You attend to their psychological needs at the same time but they are coming for practical process. But, when you're a nurse practitioner you're diagnosing and advising and not doing so much of the practical things. So when - if - I qualify, I will have to leave that behind and I will have to get someone to take over the duties so that I can develop my nurse practitioner work."

Student Nurse Practitioner - E1 Data Segment - 2nd Interview Data

This data extract illustrated that there was a need for further role negotiation beyond this student's completion of the nurse practitioner degree programme. This was a common experience for all the students.

This completes the presentation of the social transition theme during the incorporation phase. I now move on to consider the professional transition theme during the incorporation phase.

9.4. THE INCORPORATION PHASE AND PROFESSIONAL TRANSITIONS

The professional transition theme in the incorporation phase is divided into two parts. Firstly, I discuss the professional transitions experienced by the students, and professional re-structuring links this to the incorporation phase (chapter nine, sub-section 9.1.1. p.285-286). Secondly, I discuss the professional transitions that specifically influenced me (the practitioner ethnographer), and the emergence of social structures links this to the incorporation phase (chapter nine, sub-section 9.1.1. p.285-286).

9.4.1. The students: profession transitions during the incorporation phase

Traditional structures and hierarchies from within both nursing and medicine were perceived as major hurdles for the nurse practitioner students when trying to develop new clinical roles. Both the teacher team and the students observed this and it was evident in the following data extract:

"Another thing that shocks me is the defensiveness with which the nursing profession reacts to nurse practitioners. I expected it, and got it, from the medical profession. I go out and visit students in their (clinical) *environments. Again and again, both from their own colleagues* (the student's colleagues), *as well as their superiors, I am told of resistance, defensiveness. So there is a lot of work to be done yet to climb the barriers. I think that can only happen as more nurses qualify as nurse practitioners and as more of them find their feet in whatever niche they find."*

Physician Teacher- D2 Data Segment - 2nd Interview Data

This data extract suggested that students would emerge from the nurse practitioner degree programme to enter an environment that was partly opposed to their existence and provided little structure to identify their clinical practice. To overcome this, students had to collaborate with others to create a structure to accommodate them. Hardy et al (1992) observed five areas that were important to the development of structures that enabled healthcare collaborations. These were: structural (sectors), procedural (planning), financial (resource), professional (ideology, values), and status and legitimacy (power). All of these areas were identified in the data as the students made efforts to negotiate and collaborate on their future clinical and professional role. However, these negotiations were often uncertain, and they required the students to take professional and personal risks. This was an important professional transition issue for the students in the incorporation phase, and it was evident in the following data extract:

"I feel very vulnerable, like I am going out on a limb doing this, a big limb. In terms of personal vulnerability, the impact that the change is having on me is huge. But I am also professionally vulnerable because of my autonomy, my accountability. As a newly qualified RGN (Registered General Nurse), *yes you have an understanding of accountability and autonomy and the code of*

conduct. But when you're living it and practicing it every day as nurse practitioner you are very conscious of accountability issues."

Student Nurse Practitioner - F1 Data Segment - 2nd Interview Data

There is no intention in this thesis to explore in any depth the particular issues of professional accountability. It is enough to note that students' professional anxieties often arose from this type of challenge. As they moved into and through the phase of incorporation, they faced a range of professional identity issues and sought role clarity, structure, and definitions that they could utilise to accommodate their new clinical role. However, as I have already noted, there were few external precedents or existing structures to aid them in that development. Thus, the students based the re-construction of their professional identity on experiences from the two earlier phases of the rite of passage (the separation phase and the transition phases). For example, clinical medical benchmarks had emerged, and had been used, during the separation phase and the transition phase. These had determined standards that enabled clinical role-playing and clinical skills development. Those new skills were assessed by both physician mentors and members of the teacher team. Although these benchmarks had served their purpose as standards and guidelines for the teacher team and the physician mentors, there were nevertheless some fundamental problems. The emerging professional and clinical role of the nurse practitioner did not entirely fit with traditional nursing or medical occupational roles or clinical standards. For example, using traditional nursing skills as sole measures of nurse practitioners activity did not reflect the totality of their clinical role. Equally, whilst the standard of 5th year medical student was useful as a benchmark for assessing nurse practitioner

students' clinical skills, it did not reflect the social or professional context in which those skills were used. It presupposed that the medical paradigm defined the totality of the nurse practitioner, and that such clinical skills were the property of medicine. This was not the case. Beyea (1999) noted that knowledge of pathology and the use of systematic health assessment skills were now part of numerous allied health professions' activity:

> "Insulating and segregating care processes for each discipline is no longer realistic or appropriate in today's healthcare environment."
>
> (Beyea 1999 p.32)

Thus, whilst the use of nursing and medical benchmarks gave the teacher team and the physician mentors familiar structures and standards, they did not reflect the practice context of the role of the nurse practitioner. Nevertheless, the students, and their mentors and teachers, had used professional and clinical benchmarks to facilitate the successful acquisition of new clinical skills, but that had left issues of professional identity uncertain and incomplete.

I observed that the students had developed new clinical abilities, and that they were proficient in these new skills, but that they were still evolving their professional identity. This contrast between skills competence and a developing professional identity was evident in the following data extracts:

> *"When I observe the clinical sessions now they are always fluid, interactive, and their skills are of a good order. Their interaction with Lecturer Z is now*

effortless and flowing and they chat together in a collegiate way on diagnostic case histories."

Field Note Entry - February 1999

"My role? I think it's going to be a case of moulding a path as you go along. Seeing where you fit in and where the need is, and what the patients want. I don't think I have a clear idea of what it should be. Afterwards I will hopefully be having my own sessions where patients can see me if they want, see me rather than a doctor. I can assess them and take more time than the doctors who only have seven minutes allotted for each patient in the morning surgery. I don't want to be tied down to that."

Student Nurse Practitioner - D1 Data Segment - 2nd Interview Data

These data extracts illuminated the contrast between the students' newly developed clinical skills and their underdeveloped clinical identity. This led to negotiations on a structure for a new professional role that would encompass all the necessary aspects of clinical skills, clinical tasks, clinical knowledge and clinical authority, regardless of professional origin. Thus, a professional role began to evolve. It evolved from the experiences of the students' separation from their earlier identity, and from transitional role playing that had allowed them to safely experiment with different possible role options. However, it finally emerged because of a new negotiated social order. Where nursing and medical benchmarking had failed to fit with the nature of the emerging role of the nurse practitioner, selecting role models from nursing and medicine became an acceptable and useful feature of negotiating the future nurse practitioner role. The following data extract was illustrative of the students' reflections on their developing nurse practitioner role during the incorporation phase:

"My ideas on nurse practitioners seem to change from day to day. I think I am trying to make it something I want it to be. I don't know, I don't know what it is meant to be. I feel like I am being (pause) like I am being led down the path of it being more medical than nursing now, unless it is just because the learning that I am doing is more medical. In the end, I want to try to integrate the two I think. I am sure I can do that."

Student Nurse Practitioner - D1 Data Segment - 2nd Interview Data

This reveals that the students had identified the selective integration of skills and knowledge from both nursing and medicine as a means to overcome their uncertain clinical identity. Thus, the data provided evidence of the selection of multi-professional role models. For example, the students commonly identified the diagnostic clinical skills of the medical general practitioner as a clinical standard, a benchmark for nurse practitioner health assessment skills. In a teaching session in February 1999, I noted that the physician lecturer used this standard to emphasise the identification of normal and abnormal clinical signs. She stated that:

"(physician teacher's comment) *Occasionally a GP would not know the normal from abnormal."*

Field Note Entry - February 1999

The physician teacher went on to explain why this caused difficulties in clinical referral decisions. The character of the discussion between the physician teacher and the students was different from earlier discussion groups I had observed during the separation and transition phase. The physician teacher was no longer teaching nurses the skills of medical assessment; she was sharing a mutual clinical experience with peers, and listening to the experiences of other clinicians. In the incorporation phase, when selecting multi-professional role models, the traditional patriarchy of medicine

no longer dominated the students' relationship with physicians. Instead, there was a relaxation of the traditional boundary that allowed a sharing and merging of skills and knowledge. This developing collegial relationship with medical colleagues was a feature of the students' new evolving professional role and their gradual re-integration with mainstream clinical practice. The following data extract illustrated that the physician mentors were active in that negotiation to enable a collegiate interaction between themselves and student nurse practitioners:

> *"But what I have seen with the* (nurse practitioner) *students that we have trained here is that there is a basis to what they say. They can examine a patient and be able to tell you what the clinical findings are. I think you ultimately have to respect that. You can't train someone, see that they have achieved standards by assessing them (because we have done some mock exams here), and then dismiss them. You have to listen to them!"*
>
> *Physician Mentor - E1 Data Segment - 2nd Interview Data*

That developing professional respect was exemplified by the relationship between the physician teacher and the students during the incorporation phase. For example, I had noted the physician teacher's comments in February 1999 regarding the students' developing clinical skills:

> "(physician teacher's comment) *I am pleased, the process is developing well. They are well into the diagnostic stage now.*"
>
> *Field Note Entry - February 1999*

This comment by the physician teacher referred to the diagnostic skills outcome of the clinical skills map (chapter seven, Figure 7.2. p.198). It also revealed this teacher's belief that the students had now acquired sufficient clinical management

skills to enable a change in their professional relationship with her. I observed the physician lecturer questioning the students, probing for a differential diagnosis on a patient case study, and turning to individual students to clarify points. She sought out their individual areas of expertise and I noted her comments on their suggestions:

> "(physician teacher's comment) *If it were me, I would refer to Student X if there were any doubt."*
>
> *Field Note Entry - February 1999*

Thus, the physician teacher openly acknowledged the students' developing clinical expertise. This episode pointed to a changed relationship between the students and physicians, based on the selection of professional role models that drew on knowledge and skills from both medicine and nursing. The new relationship between the students and their medical colleagues was built on a foundation of the new knowledge that they had assimilated and were applying in clinical practice. This was evident in the following data extracts:

> *"I observed a dispersing of knowledge, a process of the students becoming professionals. Well actually new professionals, acting out and being something new by actively acknowledging and utilising their new knowledge."*
>
> *Field Note Entry - February 1999*

> *"When they* (doctors) *talk about the heart to me, they don't talk about how fast it is going anymore. Now they ask me about heart rate, rhythm, and heart sounds etc. They would never have used those words before. They will show you the ECG* (electrocardiogram), *they will ask you what you think, things like that. If you were just a nurse, they wouldn't have bothered. Now they look at blood results and ask you 'what do you think?'"*
>
> *Student Nurse Practitioner - F2 Data Segment - 2nd Interview Data*

These data supported the notion that the students' new knowledge had influenced their professional identity and practice. A new confidence and direction had replaced their earlier hesitancy. Their newly acquired clinical skills were something that they could use with effect in their emerging clinical practice roles. Nevertheless, limits to that new confidence with these clinical skills arose from the still unresolved professional identity. Whilst the students' clinical skills had been developed during the phase of transition, it was their professional role identity that would have to provide the structure for the eventual use of those skills. That professional identity evolved throughout the phase of incorporation and the students were clear that they saw themselves as more than traditional nurses, but also as different from doctors. However, even as their confidence grew, they remained unable to put a name to their new identity. Thus, as they emerged from the rite of passage (defined by the ending of the nurse practitioner degree programme), having re-socialised within the confines of the degree programme and having gained new skills and new status, their new professional identity remained incomplete. This continuing professional identity issue was evident in the following data extracts:

> "(the difference between nurses, nurse practitioners and doctors) *There is a difference, a very great difference, but don't ask me what nurse practitioners are. A definite difference - yes. I think that is because of the way that nurses think and the way that doctors think."*
>
> *Student Nurse Practitioner - B1 Data segment - 2nd Interview Data*

> *"I don't know what a nurse practitioner is, because nurse practitioners are different things in different settings. I think that nurse practitioners have a core set of skills and knowledge that they apply to the area that they are working in. We are talking about taking a history, examining. But there are huge*

differences in what they do, depending on the setting they work in and the culture that they work in."

Student Nurse Practitioner - A3 Data Segment - 2nd Interview Data

These data extracts revealed that, whilst the students were increasingly confident in their new clinical skills, the features of self-perceived professional invisibility that had been evident in the transition phase were persisting through the incorporation phase. Unlike other healthcare rites of passage (medical student to doctor, student nurse to registered nurse), where the student emerged as a recognised socially legitimated professional novice, the student nurse practitioner would emerge as a novice into an uncertain role. Even the university department displayed an uncertainty over nurse practitioners' identity or future role within the world of clinical practice. For example, during the final OSCE examination I noted that the event had attracted interest from other staff and other students:

"One colleague (teacher) *was clearly confused and thought the clinical exam was one for practice nurses. When corrected, the teacher was further confused between what was a practice nurse and a nurse practitioner and said, 'they are the same thing aren't they?'"*

Field Note Entry - May 1999

Thus, when confronted with such confusion, the students had to continue to evolve and assert their future professional role to overcome this professional invisibility. That invisibility was a direct result of a professional role identity that lacked a professional framework. Equally, there was no professional framework or career structure to accommodate nurse practitioners because, until then, there had been no acknowledged role identity for nurse practitioners. Until that cycle was broken, the

problem would remain. To that end, the students' emergence from the nurse practitioner degree programme, and their presence and activity in clinical practice, would contribute to the understanding of their activity and eventually to the development of a more structured clinical career framework for nurses. For example, the development of local groups of nurse practitioners, and on a wider scale the development of national professional fora, resulted in an increase in local and national lobbying to raise awareness and make nurse practitioners more visible in clinical practice. Much of that lobbying was based on a premise that the professional identity of the nurse practitioner lay within the nursing profession. The data supported this perspective of the nurse practitioner undertaking a new clinical role within nursing:

> *"Well I am looking at it* (nurse practitioner practice) *from a primary care point of view but I see it very much as offering the patient another tier of nursing care, where the patient feels happy with the level of care I can offer and are happy to come to me. It gives them another option. Very often in the past people would say, 'I came to see you because I didn't want to trouble the doctor.' They came with problems that were important to them, and now they bring those problems straight to me."*
>
> *Student Nurse Practitioner - G2 data Segment - 2nd Interview Data*

This concept of nurse practitioner activity as a more advanced clinical role within nursing helped the nurse practitioner students to resolve some of their professional identity problems. This is reviewed further in the discussion chapter (chapter ten, sub-section 10.3.2. p.374-381 / chapter ten, sub-section 10.3.3. p.381-391). The relationship with medicine was also important in the development of those new roles, and the negotiation at the professional border has been an important feature of this

discussion. The experience of marginality that instigated such negotiations, and the process of incorporation, had enabled the emergence of a new professional identity. That identity was dependent to an extent on an increasing awareness of nurse practitioner activity amongst other healthcare professionals. That multi-professional perspective was important in facilitating boundary negotiations and was evident in the following data extract:

> *"They will start filtering through to university teaching hospitals; they will start being seen by the new crop of medical students. And not only the medics will see them, but also the physios and pharmacists. People will understand more, when they have a nurse practitioner, what that person has done."*
>
> *Physician Mentor - D1 Data Segment - 2nd Interview Data*

This data extract illustrated the hesitant professional identity transitions of the incorporation phase, and illustrated that the students' role development was dependent on many other professional and lay perspectives of their prospective clinical activity. That uncertainty would persist to the final days of the nurse practitioner degree programme in June 1999. I observed the students and teacher team on the final evaluation morning that followed shortly after the final OSCE examination. This was an event that formally marked the end of the degree programme and the students' return to clinical practice as new graduate nurse practitioners:

> *"There was a sense of exhaustion amongst the students, but they were also pleased that the course had ended. There was a discussion about their new roles. One of the students said, 'and now I have got it* (the nurse practitioner degree), *what will I do with it, I never thought this out carefully enough.'"*
>
> *Field Note Entry - June 1999*

On that final morning, some of the students from secondary healthcare expressed doubts that they could achieve an autonomous nurse practitioner role in their current clinical areas. They discussed primary healthcare employment as an alternative to their current hospital employment, seeing that as a means to fulfilling the clinical responsibilities that they wanted. However, they also discussed clinical nurse specialist roles within their acute hospital areas as alternative career options. The issue of the primary healthcare and secondary healthcare divide has already been discussed in the transition phase of the rite of passage (chapter eight, sub-section 8.4.2. p.236-239). This ongoing issue of the healthcare sector, and the related professional clinical identity problem during the incorporation phase, led the teacher team to re-think the use of titles such nurse practitioner and clinical nurse specialist. For example, it seemed that both titles had a place and use within scope of the nurse practitioner degree programme's clinical outcome. If the teacher team accepted this, and included both titles within its documentation, then students could selectively use the title that suited their clinical role best. The teacher team thought that this could overcome some aspects of the professional identity problem that the students were experiencing. It considered that a more flexible approach to the use of titles within the nurse practitioner degree programme would reflect more accurately the broad advanced clinical nursing outcome of the curriculum. Thus, it was evident during the

incorporation phase that the healthcare sector had influenced the students' developing professional identity, and it was equally evident that the teacher team had responded to this. As the nurse practitioner degree programme ended, the students assessed their professional identity, reflected on their career prospects, and reviewed the influence of their clinical background. This was evident in the following data extract:

> *"One of the students had a job description with her, and passed this around for photocopying. They are planning their own careers (as opposed to others planning it for them). You could feel the course ending for them and that they had a need to now move on to the next step, not a dissimilar experience from when you qualify as a nurse. One student said, 'I was talking to a new applicant the other day and I told her, that if my experience of being a student nurse practitioner was anything to go by, I told her to think ahead about what you see your role as being.' Another student replied to this, 'my senior nurse said she couldn't see a secondary care nurse practitioner working as a primary care nurse practitioner.'"*
>
> *Field Note Entry - June 1999*

This completes the presentation of this sub-section on the students' professional transition experiences during the incorporation phase. In the next sub-section I review the researcher's experiences of the professional transition theme during the incorporation phase.

9.4.2. The researcher: professional transitions during the incorporation phase

In July 1999, when the students had completed their studies, wider national events influenced the analysis of this research project. Those events introduced new clinical career options into nursing, and I allude to them now in terms of their implication for nurse practitioners and this research.

I attended a master class seminar in July 1999 that reviewed research data on the use of diverse titles by healthcare workers. The Exploring New Roles in Practice project (ENRIP) (Reed 1998) had exposed the chaotic and unregulated use of titles amongst nurses and the threats that this posed in terms of patient protection. Additionally the seminar reviewed the UKCC Higher Level of Practice project (HLP) (UKCC 1998):

> *"It is clear that there is at this time a great deal of debate in the profession, and in the wider press. Just as my data collection draws to a close there is now government support and professional determination that is taking advanced roles forward at a pace, and supporting the introduction of a framework to enable it. Although the literature alludes to the multiple clinical roles identified, it also constantly refers to the two terms nurse practitioner and clinical nurse specialist when referring to nurses at a higher level of practice. Is this is an implicit indication that these are the two generic titles (pre-fixes) most commonly understood? During the seminar discussion there is a sense that these are inevitable events, regardless of any misgivings. And it is evident, listening to my colleagues in discussion, that there are certainly misgivings as well as support. The academic staff are openly divided and unsure about the totality of HLP and the newly announced consultant nurses."*
>
> *Field Note Entry - July 1999*

This data extract revealed the level of professional debate and activity during the final part of the incorporation phase in 1999. Complementing this were the parallel political and strategic events evident in data that arose in the final field notes entry in July 1999. That data alluded to my attendance at a national conference that formally launched the government's consultant nurse strategy. The first public announcement of the introduction of the consultant nurse concept had been in September 1998, and I have described this in the transition phase (chapter eight, sub-section 8.4.1. p.229-233). At that original announcement in September 1998, the idea of the consultant nurse had been somewhat ill-defined. However, at the formal launch of the nurse

consultant concept ten months later in July 1999, there was a clearer understanding of the new role. Speaking at the conference, the Assistant Chief Nursing Officer of the NHS Executive (David Moore) reviewed the government's view of the consultant nurse that was outlined in its published strategy (DOH 1999). The government saw the consultant nurse as a clinical leader with high status, authority, clinical expertise, skill and knowledge. The consultant nurse would develop new roles, enable better patient outcomes, be expert in practice, and would be a new clinical leader who would be instrumental in healthcare education, service development and research.

Thus, the consultant nurse was an important and complex role that required clinical, managerial, educational and research expertise. As an innovation, it could not exist in isolation of the context of the nursing workforce. The place of the nurse practitioner in that construction was important as they fulfilled the clinical part of the consultant nurse role, but did not fulfill the research or educational part of the consultant nurse role. Where then was the nurse practitioner, or the clinical nurse specialist, when compared with the consultant nurse? I suggest that they were a clinical rank within the nursing hierarchy immediately below that of the consultant nurse and parallel with nurse educators and nurse managers. This thinking potentially led to a new clinical structure and hierarchy in the nursing profession, and I expand on this in more detail in the next chapter (chapter ten, sub-section 10.3.2. p.374-381).

Thus, despite ongoing confusion on titles and their use, the nurse consultant concept enabled a new nursing career framework. It was now possible to structure a nurse's clinical career from the point of first registration, through developing levels of expertise and specialty, leading ultimately to consultant nurse status. This clinical career progression to an advanced level of nursing practice would require educational preparation and assessment, and professional recognition of advanced practice would influence employment status and salary grading scales.

Implementation of the consultant nurse role reflected many of the issues already encountered by nurse practitioners. For example, effective implementation of consultant nurses' role would require a professional infrastructure to support their educational preparation and clinical practice. That infrastructure would require resources, administrative support, and backing from allied professions such as medicine (Hardy et al 1992). The nurse practitioner students had experienced this resource demand and had found it mostly unavailable. However, the nurse consultant concept, strategically driven by government policy and resource, initiated changes in the structure of the clinical world within which the students would eventually practice. The formal introduction of an advanced nurse consultant role that received both professional and political mandate, underpinned much of the existing development of nurse practitioners. Whilst I have noted several times that the clinical environment was unprepared for nurse practitioners, the foundations for a more complex clinical hierarchy in nursing were being developed.

This completes the presentation of the professional transition theme during the incorporation phase. In the next section, I discuss the clinical authority transitions during the incorporation phase.

9.5. THE INCORPORATION PHASE AND CLINICAL AUTHORITY TRANSITIONS

The clinical authority transition theme in the incorporation phase is divided into two parts. Firstly, I discuss the authority transitions that were influencing the students and their physician mentors as a group. Professional status links the incorporation phase to this discussion (chapter nine, sub-section 9.1.1. p.285-286). Secondly, I discuss the relationship between the physician mentors and the teacher team. Emerging authorities for nurse practitioners links the incorporation phase to this discussion (chapter nine, sub-section 9.1.1. p.285-286).

9.5.1. The students and physician mentors: clinical authority transitions during the incorporation phase

In this final incorporation phase of the rite of passage, the experience of the students' clinical authority transition theme was most apparent when contrasted with the changing relationship that they had with their physician mentors. That is reflected in the changing perceptions the physicians displayed toward the students' education, and this was evident in the following data extract:

> *"What I felt about the course* (nurse practitioner degree programme) *was this - the standards that the students achieved made me think that there was quality in the course and that they had achieved certain standards. That's what I felt. And although I was very impressed with the standards that they had achieved, I*

think there is still a long way to go when they qualify. This is where I query what the role is afterwards and how you can develop that role."

Physician Mentor – G3 Data Segment - 2nd Interview Data

This data extract offered a contrast to the clinical authority transitions observed in the separation phase and in the transition phase. During the separation phase, the students had yet to confront issues of new clinical authorities, and the focus had been on the physician mentors and their traditional view of nurses and doctors. During the transition phase, the physician mentors and students participated in a crucial re-evaluation and negotiation process of their clinical authorities, and they used communitas to enable them to test out new relationships within a safe environment. That role-playing had revealed a lack of nurse practitioner role models for the new emerging role. Because of this, the physician mentors used clinical benchmarks from their own profession, and this had assisted the students in their acquisition of clinical skills. Thus, throughout the first two phases of the rite of passage there was an awareness of the traditional professional authority positions, and this was coupled with awareness that the nurse practitioner degree programme was presenting many professional challenges to that boundary status.

However, during the final (incorporation) phase of the rite of passage, there were significant changes in the physician mentors' perceptions, and the students' perceptions, of clinical authority. The students, although still establishing a new professional identity, also saw themselves as achieving new levels of clinical

authority. That altered their relationship, not only with their physician mentors, but also with other doctors, and this was evident in the following data extracts:

> *"I am more confident in dealing with doctors. I can say, 'I want you to look at this chart.' It has given me a lot of confidence. I think that given time I will be a nurse practitioner."*
>
> *Student Nurse Practitioner - D1 Data Segment - 2nd Interview Data*

> *"You see it is hard to say whether the attitude is coming from them* (the doctors) *or from me. Because I have developed my confidence. Perhaps the attitude has come more from me, the relationship has changed more from my point of view. Because as I have developed confidence maybe the relationship has subtly changed."*
>
> *Student Nurse Practitioner - E1 Data Segment - 2nd Interview Data*

Student data such as these contrasted with the physicians' data. In response to the students' developing confidence, the physician mentors displayed mixed signs of support and hesitation. Whilst mostly pleased to see their own students effectively developing new clinical abilities they became increasingly aware that this could now challenge the traditional clinical world of medicine:

> *"If it were me, I would say to a nurse practitioner, 'go on and organise the tests.' But a lot of doctors would not have that approach. Their immediate feeling would be 'hold on a minute now, what are you talking about, organising tests, let me go and check everything.' And even, 'I don't want you organising tests, you're just a nurse.' That barrier is one that is going to take some time to break down. A lot of doctors will say openly, at least amongst doctors, that they feel very unhappy and very uneasy about the nurse practitioner."*
>
> *Physician Mentor - B1 Data Segment - 2nd Interview Data*

The data extract revealed that physician mentors were reflecting on the traditional role of doctors and on such concepts as the medical domination of healthcare and

professional patient ownership. During the incorporation phase, the physician mentors were re-evaluating their views and, in some cases, seeing the professional medical boundary as threatened by nurse practitioners. Professional closure was the means used to respond to that potential threat (chapter three, sub-section 3.2.4. p.51). Thus, a dilemma arose, where physician mentors had carefully nurtured nurse practitioner students to levels of clinical skill that potentially undermined the dominant position of medicine in healthcare. This was evident in the following data extract:

> *"If somebody is having a therapy they are going to have it through a cannula I put in. They are my patients! Maybe that is me being over protective. But if somebody is going to mess my patients up I would much rather it be me. I also suspect my defense union would much rather it would be me rather than them* (nurse practitioners)*."*
>
> *Physician Mentor - D2 Data Segment - 2nd Interview Data*

This data revealed a new caution on the part of the physician mentors that was based on clinical, professional and legal issues. The physicians reflected on the potential scope of the nurse practitioner role in a climate increasingly sensitive to professional misconduct and patient litigation. This is evident in the following data extract:

> *"What the legal constraints would be, I don't know. Perhaps the thing that concerns me most is that as a practitioner now you are under so much medico-legal pressure. The thing that worries me, going back to my criticisms of the course* (the nurse practitioner degree programme)*, is that if you're going to see patients, if you're going to make judgments and decisions, send them away, discharge them, tell them there is nothing wrong, order investigations, decide whether or not to prioritise on investigations, you have to be able to stand on solid ground. That's where the medico-legal questions really come in. As a doctor, one is protected by, particularly in the context of a hospital job, the consultants who do have the specialist knowledge. You can always run a question past them, and they may say, 'yes, do the test now, tomorrow, discharge this patient.' I think that a difficulty is that the medico-legal pressure*

is such that you're going to have to justify that the nurse practitioner is fully qualified and able to make the decisions that he or she makes responsibly without fear of retribution from the public."

Physician Mentor - G1 Data Segment - 2nd Interview Data

Unpacking this data extract revealed three points. The first point, that medico-legal issues were an increasing concern in healthcare, was clear and indisputable. Secondly, the respondent alluded to the adequacy of the nurse practitioner degree programme curriculum within the time constraints of a two-year programme. The suggestion was that this lack of time could potentially produce an inadequate or incompetent clinical practitioner. Thirdly, in relation to medical practice, the suggestion was that the ability to refer a clinical problem to a consultant for expert advice protected the doctor and patient from negligent clinical decision-making. These three points were valid, and highlighted the lack of an advanced clinical nursing hierarchy. The lack of professional structure certainly made it difficult for the nurse practitioner to assert authority in the process of clinical decision-making. For example, to whom would a nurse practitioner turn for expert advice when faced with a clinical problem? There were no standards agreed for this. Moreover, if advice came from clinically inexperienced individuals, could this lead to negligent decision-making?

However, the above data extract also revealed a fundamental and traditional presumption that only medical practitioners made clinical decisions on patient management. This was clearly untrue, as other healthcare professions took considerable levels of clinical responsibility and accountability for negligence and

litigation, and that they weighed this carefully against the need to refer to medical experts, or to other healthcare experts, for advice. Examples of healthcare professionals who referred between themselves and who also referred to medicine included pharmacists, physiotherapists, dieticians, and speech and occupational therapists. Additionally, the idea that these other professions were different because they did not use biomedical knowledge or traditional health assessment skill was also not true. They commonly did use biomedical knowledge and traditional health assessment skills, drawing from them selectively to meet the needs of their profession (Beyea 1999).

Thus, two possible conclusions arose in the analysis of the data extract. Firstly, it was possible that the nurse practitioner degree programme was inadequately preparing the students for the clinical skills and related decision-making that the nurse practitioner role demanded. Secondly, it was possible that the traditional hierarchical relationship between medicine and nursing was still operating. It is not possible to be definitive as to which of these may be true or not, as this research has not set out to evaluate the clinical outcome of this nurse practitioner degree programme. Nevertheless, in conclusion of this discussion, it seems that the concept of a nurse taking such an explicit autonomous role in clinical authority remained controversial and difficult for some physicians to countenance. An alternative view was that the social and professional organisational structures that would enable that new role to function were not in place. Until they were, this would cause anxiety for those that were involved in mandating new clinical roles such as the nurse

practitioner. This was a demand to continue the transition process that would facilitate the incorporation of advanced clinical nursing into the social and professional structures at the medical / nursing boundary.

The data has shown that there was already a change in the students' level of clinical authority. That new authority was granted by their medical colleagues and was increasingly visible in their clinical practice. This development would be one that would evolve further as the professions of nursing and medicine continued to negotiate at the professional border, and this view was evident in the following data extract:

> *"Knowing where my limits are, so that I can hand them* (the patient) *over to the doctor if necessary. I think it will be a slow process, I don't feel ready for all this now. I feel that when I finish this training it will only be the beginning, it will be a learning process. I will work alongside a doctor and gradually, as I develop more confidence, take on more responsibility."*
>
> *Student Nurse Practitioner - D1 Data Segment - 2nd Interview Data*

Data such as this revealed the students' perception of a change in the relative hierarchical position between themselves and their medical colleagues. Overall, during the incorporation phase, there was a change in the physician mentors' perception, and students' perception, of their mutual authority relationship. There was also a suggestion that the new nurse practitioner role would be one that could provide a new dimension for both groups in healthcare delivery and in the management of a complex clinical workload. So, although negotiation of a new clinical structure gave rise to concerns, there was a potential for positive outcomes.

The students' perspective was one of a developing clinical autonomy that their medical colleagues were permitting and acknowledging. The physician mentors saw that the nurse practitioner role had a positive potential, but they would persist in defining that from a medical perspective. I noted that that the physician mentors' response to nurse practitioner clinical authority, even when accepted, was in medical terms, from the position of becoming a doctor. These perspectives are evident in the final data extracts in this sub-section:

> *"Certainly, with some of the doctors things have changed, yes I think it has. I think that they have seen me doing the course* (the nurse practitioner degree programme)*, and the type of work that we have been involved in, and the way the course has evolved. I feel, I don't know if I am wrong, but I feel that they have treated me with a little more respect than they used to. I don't know if respect is the right word actually, they have treated me differently. It is interesting to see the way it has changed, particularly with some of the GPs. They have been quite impressed with what we have been asked to do."*
>
> *Student Nurse Practitioner - E1 Data Segment - 2nd Interview Data*
>
> *"It may be that the 'nine to five' doctor will, twenty or thirty years down the line, be a role that a doctor or a nurse practitioner can fulfill. Perhaps doctors will become specialists in particular disciplines, maybe nurse practitioners will specialise as well. But within the context of general medicine, I think a nurse practitioner could develop to the level that she is effectively working as a doctor."*
>
> *Physician Mentor - C2 Data Segment - 2nd Interview Data*

This completes the presentation of this sub-section on the students' experiences, and teacher team's experiences, of the clinical authority transition theme during the incorporation phase. In the next sub-section I review the physician mentors' experiences, and the teacher team's experiences, of the clinical authority transition theme during the incorporation phase.

9.5.2. Physician mentors and the teacher team: clinical authority transitions during the incorporation phase

I have observed that the physician mentors defined nurse practitioner authority roles in terms of medical concepts and with medical regulations. I have also observed that the teacher team was concerned about undue emphasis on the acquisition of health assessment and diagnostic skills and the potential of this to medicalise the nurse practitioner degree programme (chapter seven, sub-section 7.6.1. p.184-185). The teacher team's view was that, by maintaining a balanced curriculum, and focusing on new advanced nursing roles, overcoming medicalisation was possible. Thus, for the teacher team, concepts of advanced clinical nursing practice were core to the process of developing and managing new clinical roles within nursing, even when these roles included clinical skills that originated within traditional medical roles.

These contrasting perspectives had implications for the nurse practitioner degree programme management and for the relationship between the physician teacher and the physician mentors. This was evident in a conversation between the physician teacher and a physician mentor that I observed in December 1998:

> *"I observe a discussion between two doctors. Two doctors in a 'School of Nursing' teaching nurses, an old fashioned idea or a new one! I suppose a difference is that they are teaching nurse practitioner students and not pre-registration nursing students. Doctor1said, 'X* (a student) *has come on a lot recently.' Doctor 2 replied, 'yes, she knows some drugs well, but others - she knows their names, but when it comes down to it, not much about them. It's always the same problem with the nurses, not enough background.'"*
>
> *Field Note Entry - December 1998*

This data revealed an authority situation where the doctors were asserting their clinical expertise and dominance in the clinical hierarchy by critically reviewing the development (or lack of development) of nurse practitioner students' knowledge and abilities. The use of physicians in nurse education was by no means new; historically, medical knowledge has always featured in pre-registration nursing curriculum, and physicians commonly taught on these nurse training programmes. In this nurse practitioner degree programme, clinical medicine had a particular influence on the curriculum, despite a multi-professional teaching team who actively strove for a balanced education delivery (chapter seven, sub-section 7.7.1. p.195-196 / chapter eight, sub-section 8.6.2. p.260-262). It appeared that the lack of a qualified nurse practitioner within the teacher team was a significant factor in this imbalance, and I have noted already this was an unusual situation in a clinical degree programme that aimed to develop nurse practitioners (chapter six, sub-section 6.2.6. p.141-142).

In a conventional professional apprenticeship model of education (Kidney 1998), experts would pass down their skills to the next generation of novices. However if no such experts existed, if no actual nurse practitioners were available, then new nurse practitioners would be dependent for their education and evolving role and identity on the expertise of others. This was the situation for the nurse practitioner degree programme during the period 1997 to 1999, and it was a situation open to challenges of authority and control. For example, despite the multi-professional nature of the teacher team, and the professional boundary excursions of the students, it at first appeared that the nurse teachers were the professional group who had the controlling

authority over the nurse practitioner degree programme. However, during the incorporation phase I observed active challenges to the nurse teachers' authority. An example of these challenges arose during an observed session on applied research when the physician teacher made the following comment:

> "(physician teacher's comment) *This type of research* (referring to a research project being discussed) *will be a real entry into medicine for nurse practitioners, it will really help them."*
>
> *Field Note Entry - December 1998*

In this data extract, the physician teacher openly voiced her view that research activity was a route to a wider acceptance into the medical domain for nurse practitioner students. This revealed a personal authority stance still constrained to an extent by traditional boundaries that saw nurses entering medicine in a hierarchical fashion as they developed increasingly advanced clinical skills. However, this contrasted with her lengthy and more considered response within the interview data that revealed a perspective that supported the boundary negotiation as a more intricate process:

> *"Nursing and medicine are two professions that are dogged by century's old traditions that keep them apart. They are well entrenched, other than those people who make the effort to be disentrenched, into their respected roles. But I think what nurse practitioners attempt to do (it's probably why it's so difficult for those early nurse practitioners) is to at least start to speak the lingo and use some of the tools. And because that has been traditionally medical, it allows for better communication. I think if that happens you will have more and more medical practitioners who will also start to walk across the bridge and see and appreciate at a much deeper and more profound level the skills that nursing carries. At the moment what is happening is the nurses have to walk across the bridge to the medics, in terms of skills. They are borrowing their skills and taking them back and integrating them into their nursing profession. What I would like to see happening is the opposite. When that bridge is built enough,*

when we have enough communication, the medics will walk across that bridge to nursing to see what nursing can offer them, and then take it back into their own profession. But I think we have got a way to go for that yet. I think the majority of medics still see themselves as academically superior to nurses. Maybe that is just something that I am still entrenched with. I am using the word academic, I am not saying that medics don't see the skills that nurses carry because they very definitely do. But academically that gap is still there. Nurse practitioners have helped to bridge that gap. Now we have a nurse who knows the same lingo, uses the same diagnostic terminology, and can make the same diagnosis that a group of general doctors can. It's very exciting. So hopefully nurse practitioning is the beginning of the crossing of the bridge."

Physician Teacher - D2 Data Segment - 2nd Interview Data

This data extract illuminated a complex view of the authority position between nursing and medicine that was open to challenge and negotiation. A further example of these authority challenges arose during a viva voce examination in June 1999. These data arose from field note entries I made at the time. The viva voce examination took place with two students, shortly following their final OSCE examination. Both students were borderline failures at the OSCE examination. The viva voce examination was an assessment tool that enabled them to clarify and retrieve that situation.

It was the first time the teacher team had held a viva voce examination following the OSCEs. Present at the viva voce examination was the nurse practitioner degree programme coordinator (a nurse), the physician lecturer, and a physician mentor (a general practitioner) and myself (a nurse). Both students were extremely anxious. What followed revealed a difficult negotiation between the medical profession and the nursing academics over the management of the nurse practitioner degree programme:

"The reason that the two students had been referred to viva from the final OSCE was primarily due to medical diagnostic and medical management issues. The two doctors' enthusiasm for this got out of hand. This was not really their fault as this was something that they were familiar with. This was a thing that doctors were exposed to many times during their training, detailed and probing clinical cross-examination, taking and assuming control. On the other hand, we as nurse lecturers were not as familiar with this as a process. The two doctors commenced the first viva, pushing the student to the limit and asking questions that I certainly would have found it difficult to manage. The student was clearly thrown by this, anxious and very upset, having been previously reassured by both the coordinator and myself that it would not be like this."

Field Note Entry - June 1999

This data extract revealed differences in the two professional cultures. Nurses did not usually use or experience such detailed cross-examination in this type of situation, whilst it was common practice in medicine. Even following the students' two-years of study, they found this intense level of verbal examination difficult. The tension between the medical and nursing examiners during this viva voce examination was unmistakable:

"We (the nurse lecturers) *tried to moderate the depth of the questioning but to little avail. The physicians were still in full control. After the student left there was intense discussion, the doctors debating at length as they tried to impose their medical clinical experience and culture. We then got into difficulties because we weren't playing on the same field or with the same rules."*

Field Note Entry - June 1999

The data extract provided evidence of an authority challenge. The physicians took control of the viva voce examination as the area under discussion pertained to clinical management and thus to their natural clinical authority. To regain some control over the outcome of the viva voce examination the nurse lecturers responded by

establishing their authority base through the formal university regulations. This process of negotiation for control was apparent in the next data extract:

> *"We re-entered the arena by bringing in the issue of the clearly defined criteria and degree regulations. This had the effect of deflating the physicians' confidence, as they were suddenly presented with university regulations, and essentially they had no option but to abide by them. By describing the possible options (pass, fail or resit the module) and considering the student's other academic performance, the two doctors had to make a decision that was mediated by considerations other than clinical criteria alone."*
>
> *Field Note Entry - June 1999*

This data extract revealed an important stage in the developing alliance between these two groups regarding the control of the nurse practitioner degree programme. The two groups, most easily visualised as the nurse teachers and the physicians, had undergone a new and unfamiliar shared experience, and there had been a moment of discord and negotiation. Each side had competed for control, using tools such as clinical outcome or award regulation to gain the upper hand. Finally, the process of negotiation led to both groups making some concessions, and that tense resolution was evident in the final data extract from this viva voce examination:

> *"The next student viva was little better (particularly for the student), although the event was more controlled. But again the debate continued afterwards as previously, the doctors eventually making a decision mediated by the criteria and regulations that bound the degree. One of the physicians in particular had ongoing reservations despite all discussion; this reflected a lack of understanding, not so much of nursing, but of the structure of universities."*
>
> *Field Note Entry - June 1999*

These data have highlighted an important moment of authority negotiation between nursing and medicine. The innovators of the nurse practitioner degree programme

were nurses, and they had developed a curriculum that enabled an advanced clinical nursing role that used clinical skills traditionally associated with medical practice. To that end, they had co-opted and collaborated with physicians to assist in the education and assessment of these new advanced clinical nurses. Medicine however, traditionally controlled and dominated clinical management, and thus traditionally exercised authority and dominance over other healthcare professions. Consequently, in this viva voce examination, close to the end of the nurse practitioner degree programme, that collaboration was tested. The nurses had retained temporary organisational control, by using the procedural regulation of a higher education organisation. In contrast, the physicians had asserted their clinical expertise, and the nurse teachers had in part conceded this to them. An outcome of the event was a new collaborative awareness in the relationship between the two groups at that time.

The viva voce examination highlighted the continuing negotiation at the occupational boundaries on authority and control of an advanced clinical nursing role. Finding a place for the nurse practitioner (social, cultural, organisational) has been a recurrent theme of the incorporation phase. That place had all along been uncertain due to the hybrid aspects of the nurse practitioner role, and which profession would, or could, seek to control them. The establishment of nurse practitioners in clinical practice rested on re-evaluation of some old authorities, and the creation of new authorities that could accommodate a new legitimate clinical identity.

This completes the presentation of the clinical authority transition theme during the incorporation phase. In the next section, I discuss the clinical knowledge transition theme during the incorporation phase.

9.6. THE INCORPORATION PHASE AND CLINICAL KNOWLEDGE TRANSITIONS

In this clinical knowledge transition theme during the incorporation phase I specifically discuss the experiences of the students. Aggregation of new structures into the new social role links the incorporation phase to this discussion (chapter nine, sub-section 9.1.1. p.285-286).

9.6.1. The students: clinical knowledge transitions during the incorporation phase

The students' knowledge base had broadly developed during the course of their studies and this had been assessed by formal and informal examination throughout the nurse practitioner degree programme. These assessments had revealed a positive outcome and pointed to the students' commitment in attaining such knowledge:

> *"I observe a Physiology session. It is very detailed and focused on Epilepsy. As is now becoming usual, the students demonstrate an impressive pathological knowledge base. One of the students observed, 'it's difficult to know where and when to stop learning, and to know how much you want to use?'"*
>
> *Field Note Entry - January 1999*

This data extract illustrated the depth of new clinical knowledge achieved by the students during the incorporation phase. It also highlighted that they were uncertain regarding the limits of their knowledge acquisition. Although the teacher team had

outlined baseline knowledge requirements and objectives, the students' personal commitment to knowledge acquisition was occasionally difficult to contain. This was apparent in the following data extract:

> *"I have found it very difficult, the volume of work. I got so stressed that I couldn't stop learning. That was very difficult. I think that if it had been over three years it would have been less pressure. It's been awful, very bad, especially in the second year."*
>
> *Student Nurse Practitioner - G3 Data Segment - 2nd Interview Data*

I also noted at this later stage of the nurse practitioner degree programme that the students remained focused on the knowledge of pathology and pharmacology rather than on other curricular content. This was complemented by observations that I made during February 1999 of the students during a taught research session. I had noted that the research critiques which they had been required to present in a seminar session had all been from papers in well-known medical journals. When I asked why they chosen medical rather than nursing research papers, one student replied:

> *"These* (the medical papers) *are the types of research that help us to understand and stay up with our physician mentors*."
>
> *Field Note Entry - February 1999*

The data extract revealed the students negotiating their own outcomes in knowledge acquisition. The clinical role that the students were developing required a level of clinical dexterity and knowledge. That knowledge level was comparable with the knowledge level of medical practitioners. In their view, to achieve the clinical

standards set by another profession, it seemed reasonable to review the research evidence that the other profession produced and used.

An issue that arose from this observation was that of knowledge ownership. Nurse practitioners used detailed biomedical knowledge traditionally associated with medical practice, and this suggested a professional border transgression as the ownership of biomedical knowledge had traditionally resided with medicine, doctors being the prime users of this knowledge in their clinical work. However, Strong (1984) observed that it was specialised laboratory based research scientists, rather than clinical doctors, that now developed such biomedical knowledge. This view was supported by my observation that other healthcare professionals, all within the context of their particular practice, were using biomedical knowledge. It became clear that, in a diverse world of many healthcare professionals, the idea of biomedical knowledge ownership was no longer applicable. For example, a wide range of healthcare professionals used the sciences of physiology, pathology and associated clinical pharmacology, and consequently, the focus on biomedical science by the nurse practitioner students no longer constituted a transgression into medical practice in the way it had previously. Nevertheless, the students perceived that it afforded them status with their medical peers in terms of their clinical practice. This transition, beyond knowledge acquisition to knowledge use, was another feature of medical and nursing identities merging to form a new professional identity and a new clinical role within an advanced clinical nursing framework. This new clinical role

drew on advanced knowledge that bridged the gap between nursing and medicine. This was evident in the following data extract:

> *"For example, the other day I picked up a drug chart on the ward. The patient was having Warfarin, but they were also on Vitamin K. It's common sense if you're a nurse practitioner, Vitamin K is the antidote to Warfarin. I am sure that there are lots of anecdotal stories like that. But once it has been pointed out to the ward nurses they realise, 'oh right, we didn't know that!'"*
>
> *Student Nurse Practitioner - F2 Data Segment - 2nd Interview Data*

The data extract revealed that the students were using the new knowledge they had gained from the nurse practitioner degree programme in their daily clinical practice.

By April 1999, the students' attendance at formal teaching sessions had become increasingly erratic. As the final examinations approached, the students focused on the final OSCE examination. They continued to weigh up the relative importance of particular areas of the overall curricular content, and attended taught sessions selectively. This had been a feature of the students' behaviour throughout the phase of transition, and it persisted in the incorporation phase:

> *"It is clear that students are playing the system. Why focus on, or attend, what they see as less taxing modules (clinical supervision and research) when you need to throw all your effort into the OSCE. One student said to me that other module essays can be knocked out several days before hand. They are playing the system, assessing what the teacher team wants, negotiating the best possible path to meet all outcomes, and placing the learning requirements in a clear hierarchy of self (group) perceived importance."*
>
> *Field Note Entry - April 1999*

This data extract revealed that, even at this late stage of the students' study experience, they still placed modules in a clear order of perceived importance (chapter seven, sub-section 7.6.1. p.184-185). Clinical assessment skills were of a high order, practical, useful and important, while research was viewed as low order, non-practical and generally not immediately important. The students' absences were from the low order modules, never from high order modules. Thus, acquiring knowledge for the new clinical identity of the nurse practitioner was a selective process. As the students had selected multi-professional role models (chapter nine, sub-section 9.4.1. p.298), they also selected new knowledge for the new clinical role.

This completes the presentation of the clinical knowledge transition theme during the incorporation phase. In the next section, I discuss the clinical skills transition theme during the incorporation phase.

9.7. THE INCORPORATION PHASE AND CLINICAL SKILLS TRANSITIONS

In this clinical skills transition theme in the incorporation phase I discuss the experiences of the students, the teacher team and the physician mentors. Linked to this discussion is the evolution and emergence of the students' advanced clinical nursing role during the incorporation phase. Whilst the student outcome is a central focus of this section, the discussion draws on data that illuminated the broad clinical skills transitions experience of the students, teacher team and physician mentors (chapter nine, sub-section 9.1.1. p.285-286).

9.7.1. The students, teacher team and physician mentors: clinical skills transitions during the incorporation phase

The clinical skills transition theme of the incorporation phase represented the culmination of the students' rite of passage to a new advanced clinical nursing role. The following data extract revealed their anxiety and apprehension as they reflected on the prospect of their formal entry into clinical practice as nurse practitioners:

> *"You are making decisions based on your judgment. Is your judgment sound, is your judgment right, true. I am sure that newly qualified doctors feel the same. I don't know, do other nurse practitioners feel the same?"*
>
> *Student Nurse Practitioner - E1 Data Segment - 2nd Interview Data*

This anxiety pervaded much of the students' experience during the incorporation phase. However, this was balanced with an equal sense of purpose and determination as the end of the nurse practitioner degree programme drew near. In March 1999, I observed the students refining their clinical skills in clinical sessions. Despite their anxieties, I observed the student group taking control and leading in clinical discussions and using their new clinical knowledge and clinical skill. This was evident in the following data extract:

> "(observation of a pathology session) *Again their interaction is now always articulate and their discussion advanced. They discuss pathology and are digging into issues and exploring them without being led. Student X said, 'now in this presentation a GP would refer to us straight away - but don't forget that these symptoms may also indicate...* (a long complex description).*' Student Z replied, 'so how would you distinguish between these different clinical presentations?' This elicits a long complicated reply."*
>
> *Field Note Entry - March 1999*

This data was extracted from a lengthy field note record. In that record I had noted that the students debated aspects of referral criteria. The discussion had focused on specific areas of clinical management and they compared and contrasted care interventions in primary healthcare and secondary healthcare sectors. It was notable that as the students refined their clinical skills and developed their professional identity, they also identified amongst themselves specialist and generalist traits. Their awareness of these particular traits was evident in other data during the incorporation phase:

> *"Although I have generalist role now as a nurse practitioner, I can see people taking on specialist roles and really developing their area of specialty as well as being a generalist."*
>
> *Student Nurse Practitioner - C2 Data Segment - 2nd Interview Data*

The students actively used this specialist and generalist divide to share and teach each other in areas of particular expertise. This important event in their clinical identity transition occurred as a group response, independently of any specific guidance from the teacher team or clinical mentors. The use of medical benchmarking that had enabled the students' progress through the separation phase and the transition phase now subtly changed. Students began to self-assess their own clinical backgrounds and reflect on their own emerging role. The clinical communitas, observed in the transition phase, gave way to attempts to construct individual clinical identities.

In this sub-section, I have outlined the students' general experiences of the clinical skills transition theme during the incorporation phase. In the following sub-sections

of this clinical skills transition theme, I describe the second year clinical examinations (OSCEs) and review specifically the students' experiences, the teacher team's experiences, and the physician mentors' experiences of these examinations.

9.7.1.1. Objective Structured Clinical Examination (OSCE)

The OSCE examinations were an essential part of the clinical assessment strategy of the nurse practitioner degree programme. At the end of their first year of study the students had undertaken a single station OSCE examination, and I have discussed this in the transition phase (chapter eight, sub-section 8.7.1. p.266-268). In their second year of study the students undertook a three station mock OSCE examination, and a six station final OSCE examination. These second year OSCE examinations reflected important aspects of the educational assessment of the clinical skills transition theme in the incorporation phase. However, the analysis has shown that they were also a fundamental feature of the rite of passage and had a symbolic function in the nurse practitioner degree programme. The students viewed the second year final OSCE examination as a unique and stressful part of their studies. Thus, the final OSCE was a ceremony, and an initiation, that embodied the students' passage to a new clinical status. That initiation would pave the way to a new clinical status, although an anomaly arose when it became evident that this transition was not completed at the formal end of the nurse practitioner degree programme in June 1999.

OSCE examinations are common tools in professional clinical assessment and may be designed in many different ways. They are extensively used to assess medical

practitioners at all levels of clinical expertise, and historically have been used to assess student nurses' clinical skills. However, the use of OSCEs in the assessment of more advanced clinical nursing skills was a relatively recent innovation that was linked to the introduction of clinical programmes that sought to develop nurse practitioners and other advanced clinical nursing roles. In the nurse practitioner degree programme examined in this research, the second year OSCE examinations required students to attend two types of station. The first type of station required the student to undertake a full diagnostic consultation with a patient. The second type of station required the student to discuss a clinically applied theoretical scenario. Both second year OSCE examinations had a mix of both types of station design.

This completes this sub-section, which has described the second year OSCE examinations that form part of the clinical skills transition theme during the incorporation phase. In the next sub-section of this clinical skills transition theme, I discuss the data that arose from the mock OSCE examination in March 1999.

9.7.1.2. The mock OSCE

The advent of the second year mock OSCE examination in March 1999 was an important milestone for the students in preparation for their final OSCE examination. The introduction of the mock OSCE examination had resulted from student evaluations of earlier diploma cohorts that had highlighted the need for a formal rehearsal of the final OSCE examination.

The day of the mock OSCE examination brought together nine students, three actors (patients), two teacher team members and two qualified nurse practitioners who acted as examiners. The mock OSCE examination itself consisted of three stations. Students undertook the examination in groups of three, each student attending each of the three stations. I made the following observations of the examination:

> *"The students were very nervous (as has always been the case in our experience of OSCEs). I was examining at a station, so my social interaction with the students was limited. Several of them failed my station on a point of order, although they generally did well. The day achieved its end in that it illuminated for the students and teachers areas that needed to be tightened up on. It was very interesting to have examiners who were qualified nurse practitioners from our previous cohorts. The students, in the natural order of things, should become the teachers. The nurse practitioner examiners said that they thought the standard was much higher than they remembered it being. The students said they thought the nurse practitioner examiners were very kind and helpful."*
>
> *Field Note Entry - March 1999*

The data extract indicated that the mock OSCE examination had included qualified nurse practitioners as examiners. The inclusion of nurse practitioner clinicians to the degree programme as examiners had long been an objective of the teacher team. This was the first occasion when such clinicians had examined OSCE stations on the nurse practitioner degree programme. This influenced the clinical skills transitions experienced by the students, as the assessment of student nurse practitioners, by qualified nurse practitioners, was a statement of clinical identity. It provided for the first time in this nurse practitioner degree programme a legitimate measure of clinical standard, based on an expertise in the role examined that none of the teacher team, or the physician mentors, could claim to have. The development of measurement tools

of clinical competence (chapter seven, sub-section 7.4.1. p. 165-166 / chapter eight, sub-section 8.3.1. p.214 / chapter eight, sub-section 8.4.1. p. 229-230) would ultimately be validated by the introduction of clinical nurse practitioners into the education and assessment of student nurse practitioners.

The teacher team feedback to the students following the mock OSCE examination occurred one week later. This feedback was lengthy and detailed. Initially, in the general discussion, the artificiality of the OSCE arose as a specific issue. The students had known the patients (actors) that had been used in the examination from previous clinical practice sessions. This had caused difficulties for some students and this resulted in discussion with the teacher team. In an examination situation, when a familiar patient (actor) presented a different medical condition, this caused difficulties for already anxious students. This was evident in the following data extract:

> *"It was clear that the students who failed a particular station did so because they identified the patient with a previous role. We will have to ensure that this doesn't happen again."*
>
> *Field Note Entry - March 1999*

Although a relatively minor organisational point, it underlined that the OSCE examination was an assessment tool that was difficult to design, and not beyond criticism. During the mock OSCE examination feedback, the students had also commented on their personal experiences during the examination:

> *"The students commented on the examination. One student said, 'couldn't we take over the whole building on a Sunday to reduce distraction from other ongoing classes?' Another student said, 'it was certainly nice to have a drink,*

my mouth was so dry.' Another student observed, 'sitting outside the exam room on my own waiting; that was very miserable.'"

Field Note Entry - March 1999

Following these comments from the students, I observed an interaction with the physician teacher. The physician teacher reviewed the students' examination performance. It had been apparent that the students had found the examiner cross-examination during the mock OSCE a difficult experience, and the physician teacher pointed out the students' lack of precise and accurate reporting of their findings. The physician teacher, naturally grounded in the medical tradition, was used to targeted and repeated questioning as a means of skills and knowledge learning, and she expected nurse practitioner students to be able to manage critical questioning from examiners. This expectation resulted in a degree of measured anxiety and calculation on the students' part, and that was evident in the following data extract:

"One student said to the teacher, 'teach us what we need to do to pass the exam?' Another said, 'what is it that you want from us in the OSCE examination?'"

Field Note Entry - March 1999

This data extract also revealed that student stress and anxiety could become a prime motivator for the preparation for the final OSCE, rather than professional or clinical need. It was therefore interesting to note that the students had viewed the inclusion of nurse practitioner clinical examiners positively, and had been reassured and motivated by their involvement. They were pleased to know that their final OSCE would include nurse practitioner examiners. Thus, when those who had successfully

experienced a final OSCE then (in part) directed that ritual, this not only validated it as a core feature of the rite of passage, but also changed the students' perception of that examination experience.

As the teacher feedback session on the mock OSCE examination ended, the students took a calculating position regarding the final months of the nurse practitioner degree programme. They highlighted the numerous ongoing assignments they had to finish and their self-perceived difficulty in managing their clinical skill development and existing clinical workload. They were seeking dispensations from the teacher team. The teacher team responded to this by offering to see each student in an individual tutorial session later that day. I include now my observations of the subsequent tutorials with the teacher team and each student:

> **Student 1:** *"I observed that the student was concerned that she had offended the team, but despite her openly hostile approach in the wider group she took the team's tutorial comments constructively."*
>
> **Student 2**: *"I noted that she identified her loss of interpersonal skills in the mock OSCE due to intense nerves. She had always been a very quiet student. When questioned on the excessive clinical investigations she had ordered she stated, 'I wanted to go for the worst scenario, I wanted to be safe.' She went on, 'I panicked, I had the wrong mind set, it wasn't what I expected, and I am no good at role plays.'"*
>
> **Student 3:** *"The student was objective, had a calm approach and was able to express her anxieties in a focused way. 'The OSCE reminds you how you could so easily miss clinical signs, God it worries me,' she said."*
>
> **Student 4:** *"The student was very nervous during her tutorial. 'I was rushed and the patient's history was very misleading, because I had seen her before; my anxiety levels were so extreme I literally had palpitations. I nearly said I can't do this station.' The student continued, 'it went on for days afterwards, look at me, I am anxious now, and I am not usually like this at work.' This*

student found the mock OSCE a very difficult event that served to make her anxieties worse, to the point of overt physical symptoms."

Student 5: *"The student was particularly miserable having accidentally erased assignment work from her computer. She had been up all night writing to try and retrieve the lost work. She looked tired and pale. In reference to the OSCE examination she said, 'there just wasn't enough time, it's very difficult. I don't think I have worked enough with my mentor.'"*

Student 6: *"The student entered the tutorial room in a confident manner, and discussed her difficulties during the OSCE. She said, 'I lost the plot at one of the stations, honestly I did.' However, on closer observation I noted that she was clearly anxious, wringing her hands and keen to leave the room."*

Student 7: *"The student was stoical. Her background in acute hospital care she perceived as a problem in her role development and she was free in verbalising her anxiety. Her comments were important indicators of this role mismatch. 'It's pretend isn't it,' she said. 'I have to pretend not to do the job I am doing, and fit into another role. I have to become a generalist, but I am not, I am a specialist. I feel unsafe, what if I was wrong, I could kill someone.' She said, 'it's like a great void, a great leap forward.'"*

Student 8: *"The student presented with a belligerent and aggressive manner. She said, 'You tell me where I need to brush up'. Our feedback to the student alluded particularly to communication and interpersonal skills. I noted that the student went quiet during this, clearly not liking it. She then engaged in further discussion, this verging on hostile debate. She was outwardly cheerfully but remained argumentative. She said, 'seeing the same patient again threw me. My problem is the same for all of us that work in secondary healthcare; we work in a very different way.' The teacher team responded to this, 'your approach is very, we hate to say this, medical, and working with a qualified nurse practitioner would help you.' The student retorted, 'I haven't got time; I haven't got time to go home.' Thus, the interaction with this student ended in an unresolved manner."*

Student 9: *"This student was absent despite, or perhaps because of, her poor performance at the mock OSCE."*

Field Note Entry - March 1999

These data extracts revealed the students asserting their individuality as they completed the final months of the nurse practitioner degree programme. This process was characterised by their disengagement from each other as a homogeneous student

group, each individual in different ways trying to negotiate a personal way forward. As can be seen, Student 8 was having particular difficulties, not only with the teacher team but also amongst her own peer group, and she was becoming isolated from them. Finally, in conclusion of the mock OSCE examination and the subsequent teacher team feedback, I noted that the students were planning and evaluating the potential scope of their new roles as they refined the clinical skills they had acquired. This is evident in the final data extracts of this sub-section:

> *"You know I can see a lot I could do in my job given the scope. I could do a lot more of the routine screening, which isn't just a matter of testing urine and recording a blood pressure. I would be examining patients and making a diagnosis."*
>
> *Student Nurse Practitioner - E1 Data Segment - 2nd Interview Data*

> *"The students want to achieve, they are negotiating new roles. They are coming to see us individually at personal tutor times. They are looking to us to give guidance, asking us to see their senior nurses and help pave the way. But there is also a realisation of their own responsibility for their future practice."*
>
> *Field Note Entry - March 1999*

This completes the presentation of this sub-section on the mock OSCE examination in the clinical skills transition theme during the incorporation phase. In the next sub-section of the clinical skills transition theme, I discuss the data that arose from the final OSCE examination.

9.7.1.3. The final OSCE

I noted in May 1999 that the final OSCE examination was an exceptionally busy and full day that was attended by all the students and the teacher team. I also observed

that there were physician mentors and qualified nurse practitioners attending as examiners. This extensive examination required considerable preparation. The physical environment of the examination was important, as it required six examination rooms to be prepared for patient consultations and theory stations, and other rest rooms were set-aside for students, actors and examiners. The preparation of each patient scenario had taken place several months previously and examiners and patients (or actors) had seen these before the examination day. The final OSCE included a range of examiners, a tripartite of three quite distinct examining types, clinical nurse practitioners, physician mentors and teacher team members. A teacher team member acted as overall examination coordinator.

I have noted that the OSCE examinations gave rise to extreme levels of stress and anxiety in the students, this indicative of the importance of the examination as a final initiation ceremony of the rite of passage. In the field notes I described the students that morning as:

> "(students at the final OSCE examination) *They are in a predictable state of complete fear and alarm.*"
>
> *Field Note Entry - May 1999*

All the students experienced considerable stress, manifested in general agitation, and for some in physical signs such as nausea. They had a room set aside where they could wait between stations, and here I observed them giving support and reassurance to each other. I noted that when students completed stations, and rejoined their student colleagues who were waiting to commence other stations, they rallied

together to overcome their fears and anxieties. I saw them providing emotional reassurance and support for those who became upset or overly anxious. From this data I later concluded that they were experiencing a brief reassertion of their communitas, a mutual group support, similar to that observed during the transition phase (chapter eight, sub-section 8.5.1. p.254):

> *"At my station no student failed, although some were limited in their performance, this mainly due to anxiety. The good students did well as we predicted. I know there were some upsets on occasion outside of the examination rooms and the overall examination organiser was busy managing this. On occasion I managed to slip out (my station was a short one) and chat to them in the rest room. They were visibly very anxious, pacing, and shaking."*
>
> *Field Note Entry - May 1999*

Other data arose from this final OSCE examination day that focused on the teacher team and examiners (the physician mentors and qualified nurse practitioners). When all the students had completed the OSCE examination, the examiners and academic staff met and collated information on each student and on each station. The following data extracts revealed the different features of each of the three distinct examiner groups present:

> **Nurse practitioner examiners:**
> *"It is interesting to see them assuming the role of teacher and educator. They gave critical feedback on the current students. This is definitely a way forward, and it is a step forward, where qualified nurse practitioners examine student nurse practitioners. They were critical, but fair, and gave a balance to the proceeding. They indicated how much more difficult they felt the OSCE was compared to their own several years previously."*

> **Physician examiners:**
> *"The medical examiners were generally more severe - delving into medical diagnostics and anecdote, using their knowledge of medicine (understandably*

perhaps) as their point of reference. This is an ongoing situation and is our experience from previous OSCE examinations. It reflects, I think, a cultural meeting point between the physicians' experience of their educational culture and the nurse education culture."

Teacher team examiners:
"The nurse lecturer examiners tended toward the more precise and academic response to students' performance. By that I mean they abided by the set criteria and regulations of the exam and degree."

Field Note Entry - March 1999

These data extracts revealed that the differing examining groups had different approaches. This required the examiners to negotiate their decisions, and consequently the examiners sought to achieve a common ground or a common standard. I commented on this negotiation process:

"Perhaps this is an inevitable process as this multi-professional team attempts to establish new rules that are acceptable at the meeting point of the two clinical professions and at the meeting point of two realities - education and clinical practice. It is the qualified nurse practitioner examiners who are pivotal; they are the groundbreakers who guide this, and it is interesting to note that both the academic lecturers and physicians where actively taking guidance from them. One of the physician mentors asked a nurse practitioner examiner, 'what would you do in this instance X, after all you're doing the job?'"

Field Note Entry - March 1999

This data extract revealed that the examiners had established new perspectives at the end of the OSCE examination review. The physician mentors found themselves in a different culture with a different influence, exposed to a process of re-socialisation in a culture of advanced clinical nursing. The teacher team used the faculty regulations to maintain overall control but was guided, and to some extent controlled, by the expert clinicians. The nurse practitioner examiners were the clinical professionals

who were taking control of their own professional development, regulation and education.

The decision of the examiners revealed a consistency that accorded with my own observations of the students over the two years of data collection. The student cohort had its successes and failures. The student previously referred to as Student 8 performed poorly and was required to re-take the final OSCE examination the following year. All the examiners noted her problems with interpersonal consultation skills. The unanimity of this observation came from all three examining groups, nurse practitioners, physicians and nurse academics. One of the physicians noted:

> "(physician examiner's comment) *If I had been to see her as a patient, I wouldn't go back!"*
>
> *Field Note Entry - March 1999*

That comment revealed a shared agenda amongst the examiners, an agenda essentially beyond that of formal examination criteria. This agenda was a moral code of conduct of patient service and safety that was shared by the cultures of medicine and nursing (chapter one, sub-section 1.3 p. 14-15).

The final OSCE examination also resulted in two borderline results. These arose after long debate amongst the examiners regarding issues of clinical management by the two students at specific stations. The two students were referred to viva voce examination for clarification of their clinical management (chapter nine, sub-section 9.5.2. p.324-328). Finally, in contrast to the students who were referred for re-

examination or viva voce examination, Student 3 achieved an overall mark of 70%. The examiners reported her performance as outstandingly good. The physicians noted that they had tested her diagnostic and management knowledge and considered her extremely clinically able. The teacher team focused more on her competent interpersonal skills whilst the nurse practitioners examiners had a positive perspective that encompassed both. Thus, whilst the teacher team and physician mentors focused on different issues, it appeared that the nurse practitioner examiners had integrated aspects of nursing and medicine into their clinical practice, this enabling their leading role as examiners of student nurse practitioners.

The analysis presented in this sub-section has shown that the final OSCE examination was an initiation event of the rite of passage. It was an important ceremony that marked the emergence and legitimation of new nurse practitioners. The students viewed it as the pinnacle event of their studies, and the academic and clinical staff saw it as the verification of safe practice. It represented a moment at which key respondents met and agreed on the developing level of clinical practice. The students received their OSCE result from the teacher team the following a day.

The final nurse practitioner degree award was agreed several weeks after the final OSCE examination at a formal university examination board. However, the OSCE result was notable as an examination of observed clinical practice. The outcome of the OSCE examination rested with the OSCE examining team, although others could later review the documentation of that day. This OSCE examination was the students' final transition experience of the nurse practitioner degree course.

This completes the presentation of this sub-section on the final OSCE examination in the clinical skills transition theme during the incorporation phase. In the next sub-section of the clinical skills transition theme, I discuss the data that arose regarding student who failed the final OSCE examination.

9.7.1.4. The Failure

In this short sub-section I review the teacher team's encounter with the student who failed the OSCE examination. This meeting occurred one week after the final OSCE examination. The following data extract described the event:

> *"At our first meeting with the student her immediate response was one of disbelief, although she had already had the result by telephone. This was quickly followed by a calculative response. She said that we were picking on her, being unfair to her. She said that the examiners had made mistakes in the exam, and that our decision on her performance was wrong. We produced the detailed written documentation made by all examiners, as this was crucial evidence of the reason for her failure. We met with her again later that morning. By then she was distressed and tearful. She tried again to argue and debate the exam decision, but this again was effectively blocked by our production of the documentation and regulations."*
>
> *Field Note Entry - June 1999*

This data extract revealed how the teacher team used the detailed recording of the examination event and the regulations of the nurse practitioner degree programme to explain and enforce its decision. In the following academic year (1999-2000) the student re-attended clinical revision sessions with the subsequent cohort of students and also undertook intensive supervised mentorship in practice. She re-took and passed the OSCE examination in May 2000.

This completes the presentation of the clinical skills transition theme during the incorporation phase. In the concluding section of this chapter, I summarise the data presentation and main findings of the incorporation phase.

9.8. THE SUMMARY OF THE INCORPORATION PHASE

The incorporation phase began in January 1999 and ended in July 1999. There was some blurring at the beginning of the incorporation phase with the previous transition phase.

During this phase of the rite of passage, each of the five themes of transition (chapter one, section 1.2. p.8. / chapter five, section 5.1. p.105) had revealed activity that involved, to varying degrees the teachers, students and physician mentors. The teacher team had provided pastoral support to the students, facilitating their gradual emergence into new clinical and professional roles, and coping with increasing levels of anxiety and stress. The teacher team members were also evaluating and evolving the management of the nurse practitioner degree programme. For example, their relationship with the physician mentors had resulted in negotiations on management and authority responsibilities.

The introduction of qualified nurse practitioner examiners in the OSCE examinations represented an important event for the future of the nurse practitioner degree programme. It was an opportunity for expert clinical nurse practitioners to become

active and influential in the education of future nurse practitioners. The importance of clinical nurse practitioners in developing and assessing clinical and educational standards arose toward the end of the nurse practitioner degree programme and was linked to my observations on the developing national frameworks of advanced levels of clinical practice in nursing.

The physician mentors' experience of the incorporation phase revealed developing concerns and hesitancies as the potential clinical scope of the emerging nurse practitioner role became apparent to them. The physician mentors perceived and acted on professional border threats. However, in contrast to this, there was also evidence of a change, or realignment, of the hierarchical relation between the nurse practitioner students and physician mentors as the new nurse practitioner role and the associated professional boundaries were negotiated. Nevertheless the physician mentors persisted in defining nurse practitioners in their own medical terms, and this would lead to some authority conflicts between themselves and the teacher team in relation to the control of the nurse practitioner degree programme.

The students' experience of the incorporation phase was difficult. An increased awareness of self, and the emergence of new clinical authority and new professional identity, revealed the declining communitas. My observations of their increasing confidence and competence balanced against their self-perceived knowledge deficits and clinical skill deficits. Consequently, there was a general level of anxiety that increased as the final OSCE examination approached. The concluding feature of the

rite of passage was the initiation ceremony of the final OSCE examination. Following this, they emerged as novice nurse practitioners, as new clinicians with increased social status, but with professional identity issues still unresolved and incomplete.

I conclude this chapter, which has presented a detailed analysis of the five transition themes within the context of the incorporation phase, with a concept summary (chapter nine, Figure 9.2. p.352). The summary lists the main issues that arose in the transition themes during the incorporation phase and correlates with the conceptual links and relationships of the incorporation phase provisionally outlined at the beginning of this chapter (chapter nine, sub-section 9.1.1. p.285-286). It is also linked to the discussion summary of the transition themes data in the discussion chapter (chapter ten, section 10.2. p.355-366). The following chapter (chapter ten) summarises and concludes the analysis of this research.

- **Incorporation and Social Transitions**

The Students
(Conceptual links - social re-emergence in the incorporation phase)
The decline of communitas / constructing new identities - future responsibility / forced re-socialisation

- **Incorporation and Professional Transitions**

The Students
(Conceptual links - professional re-structuring in the incorporation phase)
Clinical reality shock / negotiating the new clinical role, professional role / selecting multi-professional role models / professional role uncertainty, a prolonged incorporation into clinical reality / identity difficulties, secondary, primary healthcare - titles in an advanced clinical nurse construct / the final evaluation, no longer students, novices on a new rite of passage
The Practitioner Ethnographer
(Conceptual links - enabling social structures in the incorporation phase)
The development of HLP and consultant nurses / a formal clinical nursing strata

- **Incorporation and Clinical Authority Transitions**

The Students and Physician Mentors
(Conceptual links - changes in professional status in the incorporation phase)
Developing new clinical authority abilities and roles / relative relationships change and hierarchies are leveling / physicians display hesitance and concerns, traditional closure and litigation are used / medicine defines the nurse practitioner in medical terms, lack of formal clinical structures and stratification in nursing / the professional apprenticeship model
The Physician Mentors and the Teacher Team
(Conceptual links - commanding authorities in the incorporation phase)
Defining nurse practitioners in medical terms / authority influences on the curriculum / lack of control structures, crossing the bridge, power conflicts and temporary resolutions / nursing faculty verses clinical physicians / the place of nurse practitioners, advanced clinical nursing practice

- **Incorporation and Clinical Knowledge Transitions**

The Students
(Conceptual links - aggregation of new structures in the incorporation phase)
Knowledge acquisition to knowledge utilisation / self-perceived knowledge deficits / knowledge ownership, not transgression, selective utilisation / curriculum weighting to the end

- **Incorporation and Clinical Skills Transitions**

The Students, Teacher Team, Physician Mentors and Qualified Nurse Practitioner Examiners
(Conceptual links - The emergence of a new clinician from the incorporation phase)
OSCEs / specialists and generalists / the decline of clinical communitas and rise of individual identity, qualified nurse practitioner examiners / evidence of individualism / three examining groups / controlling groups / enforcing the regulations and standards

Figure 9.2 Concept summary of the transition themes during the incorporation phase

CHAPTER TEN

THE DISCUSSION

10.1. INTRODUCTION TO THE DISCUSSION

This discussion chapter concludes the research findings, and is divided into two main sections. In the first section, I briefly review the social and cultural concepts used in the study, and summarise the main data findings that have been detailed in chapters seven, eight, and nine. In the second section, I discuss the four thematic processes that arose from the final analysis of the data.

The objectives of this study were:

a) To examine the experiences and perceptions of a diverse group of individuals involved in a nurse practitioner degree programme.

b) To examine the evolving nurse practitioner role and identity, and its affect on:

- Professional structures and concepts
- Occupational boundaries

c) To consider how transitional experiences compared and contrasted with the concept of a rite of passage.

To achieve these objectives, I set out to explore the development of the nurse practitioner role by observing a group of individuals participating in a nurse practitioner degree programme. That sample was a multi-professional group comprised of nurse and physician educators, physician mentors and nurse practitioner students. Daley and Carnwell (2003) stated that:

"Nursing practice is becoming more diverse than ever before and the boundaries of inter and intra-professional practices are becoming increasingly blurred."

(Daly and Carnwell 2003 p.159)

Thus, the professional diversity of the sample, and professional boundaries, were an area of particular interest in this research. I sought to explore the nurse practitioner role and its affect on professional boundaries by comparing and contrasting the data with the traditional occupational roles of nursing and medicine. I also aimed to investigate the idea of nurse practitioners as a new evolving professional group. These areas of investigation accorded with the project's multi-professional objectives.

The study examined the lived experience of the students, and others, involved in the educational preparation of nurse practitioners. As the analysis progressed, it revealed a complex professional situation:

"Then you get into boundaries, and I use the analogy of the cake. Nurses use medical knowledge, they use pathology; they use all sorts of thing. But they use those ingredients in different doses according to the context that they are working in."

Senior Academic - B1 Data Segment - 2nd Interview Data

This data extract illustrated how an advanced clinical nursing role, such as the nurse practitioner role, affected knowledge acquisition, skill acquisition, multi-professional boundaries, and clinical practice. In chapters seven, eight and nine I have discussed these issues in detail as they arose in the data. In the following section, I summarise those findings.

10.2. SUMMARISING THE FINDINGS

This section provides a final review of the findings presented in chapters seven, eight and nine of this thesis. Firstly, I briefly review social and cultural transitions and Van Gennep's (1960) rite of passage framework - both theoretical concepts used extensively in this research. Secondly, there is a summary of the transition experiences of the sample that were discussed in detail in chapters seven, eight and nine. There are three individual summaries: a summary of the transition experiences of the student nurse practitioners, a summary of the transition experiences of the teacher team, and a summary of the transition experiences of the physician mentors. Each summary spans the totality of the data collection period from June 1997 to July 1999.

10.2.1. Social and cultural transitions

The key concepts used throughout this study have been the concepts of social and cultural transition and Van Gennep's (1960) rite of passage framework. The study examined individuals involved in a nurse practitioner degree programme, and data led to the induction of five social and cultural transitions that that gave basis to the sample's experience over the two-year period of data collection (June 1997 to July 1999). Those five themes about transitions were structured within Van Gennep's (1960) concept of a rite of passage. This has provided a chronological and a theoretical framework that has provided a logical division of the data that arose from the five transition themes.

The five themes of transition were interconnected and it was important to view them in totality, rather than as a series of independent and discrete transitional experiences. Schumacher and Meleis (1994) suggested that social and cultural transitions had a specific direction in terms of their development from one state to another. Thus, it was also important to establish the overall direction and development of the five themes of transition identified in this project. For example, Woods (1999) investigated aspects of advanced nursing practice, and described social and professional transitions from experienced nurse to advanced nurse practitioner. Woods (1999) noted that these transitions all displayed characteristics of role orientation, either as a professional clinician or as a professional consultant.

In this study, my evidence has also shown that the sample underwent several transitions all structured within an encompassing rite of passage framework. If Woods (1999) concept of role orientation were applied to the findings of this study, a conclusion would be that the sample's identity experiences arose because of different occupational and professional perspectives. The students and physician mentors would see their identity transitions in a professional and clinical context and the teacher team and senior academics would see their identity transitions in terms of an organisational and educational context. However, the sample's transition experiences identified in this research, were not limited to role orientation as described by Woods (1999), but revealed four broad themes (processes) that I discuss shortly (chapter ten, section 10.3. p.366-367).

Before that final analysis, I now summarise the transition experiences of the nurse practitioner students, the teacher team, and the physician mentors, that have been described in the three main data chapters (chapters seven, eight and nine).

10.2.2. Summary of the transition experiences of the student nurse practitioners

Woods (1999) has effectively summarised the students' experience observed in this study as follows:

> "The transitional process of moving from experienced nurse to ANP (advanced nursing practice) appears to require the practitioner to reconstruct their practice and professional frame of reference. Reconstruction in this sense involves personal and practice development in order to demonstrate that practice has not only changed, but is being performed at a different level. The reconstruction of practice and the transitional process in which nurses engage are influenced by a multiplicity of factors."
>
> (Woods 1999 p.122)

In this study, the students' role transitions were marked by identity loss, the process of reconstruction of a new role, and re-socialisation into clinical practice. The phases of the rite of passage structured and correlated with much of the students' observed social and professional transition experience.

The students' first experience of identity transition occurred when they became aware of their role duality. The contrast between being a novice nurse practitioner student and yet remaining an experienced professional nurse, represented a departure from the classic view of the phase of separation. This was a particular aspect of the students' experience of this initial separation phase. The students, although

experiencing aspects of separation from their previous status, were unable to detach themselves fully from their previous social role. They had to fulfil that existing role as part of their ongoing employment, and that duality added to their sense of identity loss as there was a clear dissonance between their role as student nurse practitioners and their role as nurses. Whilst this was occurring, the students were also involved in a learning transition, acquiring new knowledge and skills and absorbing new vocabulary. This learning transition served to advance their perception of identity loss, as their acquisition of new knowledge and skills influenced their clinical practice within their existing occupational role. Increasing awareness of these stresses brought the first evidence of group cohesion in adversity and this pre-communitas quickly evolved into full communitas (chapter three, section 3.3. p.67).

In the transition phase, the students' role duality became increasingly marked, and their uncertainties regarding their identity became more pronounced. The students moved into a professional and clinical limbo. Their perspective in the transition phase was one of being clinically invisible, socially inept, and neither one thing nor the other. In this state, communitas was established. The physician mentors were a part of the students' communitas, and that enabled a mutual understanding which helped the students to manage resistance and hostility from other professionals. Communitas permitted practice of new skills and the utilisation of new knowledge and new clinical authority. These transition experiences were enhanced as the students began to develop a third language, a hybrid of nursing and medical vocabulary, which they included into their developing concepts of advanced practice.

During the transition phase, professional and clinical benchmarking was used as a means of assessing the students' new skills. These benchmarks were useful for skills acquisition but had limitations as they failed to capture the totality of nurse practitioner practice and could not be integrated into the students' new professional role or identity without modification.

At the peak of the transition phase, the temporary disengagement from the formal educational programme, occasioned by the summer break, enabled a moment of role evolution and reflection. Following this, the structure of communitas would slowly decline, due both to the impending end of the nurse practitioner degree programme and to the prospect of final examinations. The decline in communitas contributed to an agenda of re-socialisation, as the students began to evolve their own roles and own identities. In the face of such self-interest, the student group cohesion began to diminish and this marked the end of the phase of transition. The students' liminality (chapter three, section 3.3. p.67) was characterised by a progression that enabled the evolution and construction of a new professional clinical role and status.

As the students entered the incorporation phase, they had to reconcile their new role with their clinical world. The students began to consider practical issues, such as managing and allocating clinical workload, and establishing new positions in existing organisational structures. However, the students' future identity remained uncertain as the social structure needed to accommodate them was mostly absent. In response

to this difficulty they began to select role models from the multi-professional context. Unlike the earlier benchmarking, this was flexible and selective, and allowed the students to begin merging and modifying professional traits into a new role construct. For example, they began to take ownership of their expanded health assessment skills knowledge base, using it in their clinical practice and identifying it as part of their professional activity. They no longer saw it as knowledge that they had borrowed from another profession. Also, during this final phase, the students' perceived relationship with medical colleagues began to change. There was an increasing collegiate understanding, coupled with a change in clinical authority relations, between the students and their physician mentors, and this was apparent in the following data extracts:

> *"We have a lot of junior doctors on the ward that I work in. I have this joke going that I am going to demand half their salary as I am doing half their work. I think that they do look on me as more of an equal than they did two years ago."*
>
> *Student Nurse Practitioner - D2 Data Segment - 2nd Interview Data*

> *"If a patient came and asked me something and I didn't feel capable of answering it I was always able to say, 'I will ask the doctor'. But I find myself, especially in the last few months, thinking well hold on, I am not going to ask the doctor, I have got to work with that one myself and where possible try and solve the patients' problems without necessarily including the doctor. It is difficult sometimes to know where to draw that line."*
>
> *Student Nurse Practitioner - F1 Data Segment - 2nd Interview Data*

This increasing awareness of aspects of advanced clinical nursing practice enhanced the students' professional confidence. The concept of advanced clinical nursing was in the public and professional domain and it was apparent that the students saw

aspects of their role construction within that wider debate - a debate that reflected a process of clinical stratification within nursing.

The final OSCE was a singular event, a final ceremony and initiation of the rite of passage that, despite ongoing uncertainties, would legitimate the students' identity. Having been successful at the OSCE, the students emerged with that legitimation, as new professional novices that were still establishing a professional identity. That final student perspective was evident in the following data extract:

> *"We have a few nurse practitioners in our area, and they are always fully booked with patients requesting to see them again. The patients have confidence in the nurse practitioners. I haven't heard any negative things. I think that's maybe what it's about; we just aren't there yet, not visible yet."*
>
> *Student Nurse Practitioner - G2 Data Segment - 2nd Interview Data*

This sub-section has summarised the students' transitional experiences of the rite of passage. In the next sub-section I summarise the teacher team's transition experiences of the rite of passage.

10.2.3. Summary of the transition experiences of the teacher team

The teacher team studied in this research was managing a new nurse practitioner degree programme (chapter six, sub-section 6.2.3. p.136-137), and had previously managed a clinical nurse practitioner programme at diploma level since 1992. Consequently, the teacher team's transition experiences of the new degree programme were inevitably influenced by its previous management experiences, and this was evident in the following data extract:

"I mean it's certainly a lot easier now to do this course than it was six years ago because a lot of the stuff simply does not have to be discussed anymore, whereas six years ago every little step had to be worked through. So, there is certainly a progression there. I think that there is now a critical mass of people who have heard about it, talked about it. All of that has contributed to it becoming a lot easier."

Nurse Teacher - D1 Data Segment - 2nd Interview Data

The teacher team played an essential part in the delivery of the nurse practitioner programme content. The team members provided pastoral support to the students during their transition experiences, and influenced the thinking and development of new professional and social concepts. Balancing the curriculum was certainly a challenge for the teacher team in the face of the students' persistent and active weighting of curriculum content. The general impression of the teacher team's relationship with the student group was a positive one, and it was notable that it saw the students' development as relatively consistent with that of previous student groups:

"I think a lot of it was predictable from past experience and from what I have observed with students. They went through similar patterns, from feelings of being de-skilled and to learning new skills and hanging onto those like a new uniform, then gradually integrating their old skills with the new skills. I think they have done that possibly quicker than students previously, partly maybe because we have become better at teaching them and because it's more acceptable. But the process still happened, but it happened a bit earlier."

Nurse Teacher - G3 Data Segment - 2nd Interview Data

Despite a positive relationship with the students, the teacher team members experienced episodes of interpersonal conflict amongst themselves, and collectively

had a generally low self esteem. Additionally, toward the end of the nurse practitioner degree programme, the teacher team had experienced some conflict with the physician mentors over the management and control of the programme. It was its professional closure behaviour that had prevented these problems from becoming visible to the students or to others.

Although the teacher team had, to some extent, been preoccupied with these problems, it had also been active both nationally and locally in the development of nurse practitioner education. For example, the teacher team was one of the few education teams who had developed and delivered a degree programme that specifically prepared nurses for a nurse practitioner role at that time (1997-1999). This had been a challenge. The teacher team had sought to evolve a new professional clinical identity without having any personal clinical experience of it. That situation arose as expediency to the clinical and professional and resource driven demand to develop an advanced clinical nursing role as soon as possible. Thus, it was the introduction of qualified nurse practitioner examiners that marked a crucial moment in the degree programme's delivery and development. Finally, the teacher team's experience was one of constant uncertainty. It had to be creative and adaptable as the nurse practitioner degree programme progressed, and that was evident in the following data extract:

> *"But I think it's been a fairly steep learning curve. Because the degree is moving fast, because professionally its a fast moving new evolving profession and we as lecturers have to be fluid, adaptable and proactive rather than reactive. I see it as a bit like an acorn, from which mighty things do grow. It's the thin end of the wedge basically, academically and professionally. Also I*

think it's the beginning of (and I know it's been happening for a long time in some ways) an academic level of inter-professional co-operation and development. I think it's very exciting. But there are lots of political hurdles in the way that need to be jumped."

Physician Teacher - G1 Data Segment - 2nd Interview Data

This sub-section has summarised the teacher team's transition experiences of the rite of passage. In the next sub-section I summarise the physician mentors' transition experiences of the rite of passage.

10.2.4. Summary of the transition experiences of the physician mentors

The transition experiences of the physician mentors correlated largely with the phases of the rite of passage and the students' experiences. For example, the role duality in the phase of separation was a clinical experience for both the students and the physician mentors. The physician mentors saw their students in both their old and new clinical roles - one moment experienced nurses and the next student nurse practitioners. Equally, toward the end of the nurse practitioner degree programme, the physician mentors observed that the lack of an advanced clinical hierarchy in nursing resulted in structural constraints for the new nurse practitioner role in practice.

At the commencement of the nurse practitioner degree programme, the physician mentors displayed a generally positive approach toward the aims of the nurse practitioner degree programme and toward teaching health assessment and diagnostic clinical skills to nurses. However, they were uncertain about the future professional

role identity of the nurse practitioner, and manifested this uncertainty in their use of traditional concepts and images of the nurse and doctor relationship. The physician mentors first concern was to identify some familiar standard that they could apply when teaching their clinical skills to nurse practitioner students. Medical benchmarking proved to be an efficient way of doing this as it provided direction for the physician mentors, although it presented difficulties for the students as it introduced a medically defined clinical measure into the nurse practitioner degree programme. I also observed that the use of medical benchmarking by the physician mentors limited their professional concepts of the scope of medicine and nursing practice, with the result that they tried to define the nurse practitioner role in traditional ways. That ultimately gave rise to anxieties amongst the physician mentors as the potential scope of the nurse practitioner students' clinical role was realised. Much of that anxiety was legitimately concerned with issues of wider regulation, implementation of recognised clinical standards, and issues of litigation. However, they dealt with those perceived professional boundary threats with professional (social) closure (chapter three, sub-section 3.2.4. p.51).

The physician mentors saw nurse practitioners as something more than an ordinary nurse, although they could not put a name to that. The following data extracts illuminated the physician mentors' view of nurse practitioners as a potential positive clinical resource, and yet a threat to the power and autonomy of medicine:

> *"I am for the nurse practitioner, but I am also for a more decisive and more clinically defined role for the nurse practitioner. I see them as more than a nurse, but I wouldn't see them yet as a doctor. I think that years down the line,*

I can't put a time frame on it, there is going to be a lot of resistance from the medical schools and so on, because they will effectively be as good as a doctor."

Physician Mentor - D1 Data Segment - 2nd Interview Data

"I think that there are doctors who are worried that nurse practitioners may replace doctors. They don't want to see this happen. I am sure that there are some doctors who will try and stop this from happening."

Physician Mentor - D2 Data Segment - 2nd Interview Data

This sub-section has summarised the physician mentors' transition experiences of the rite of passage. This concludes this section, which has reviewed the findings of the main data chapters (chapters seven, eight and nine).

10.3. PROCESSES

In this section, the discussion reviews the four thematic processes that finally arose from the analysis of the data. Those processes conclude the findings of this study. At its outset, this project outlined general aims (chapter one, section 1.1. p.1 / chapter ten, section 10.1. p.353). As the analysis of the transition themes in each phase of the rite of passage progressed, I reviewed the findings carefully by comparing and contrasting them with the broad research aims. This led to the induction from the data of four final thematic processes. These processes are closely interrelated, and their connections with the research aims are as follows:

- **Process One - sanctioning a new and atypical professional apprenticeship**
  A professional consequence of the sample members' experience was their sanction of the degree programme. This process legitimised the aim of the nurse practitioner degree programme within the local education and clinical area.

- **Process Two - re-negotiating occupational boundaries - constructing the career lattice**
  The sample's professional experiences arose through occupational boundary negotiations, professional identity evolution, and a developing clinical career structure.

- **Process Three - advanced nursing practice and advanced clinical nursing - defining new professional identities**
  The evolving nurse practitioner role and identity, and its implication for professional structures and occupational boundaries, was revealed in its association and correlation with the emerging structure of advanced nursing practice.

- **A Rite of Passage - becoming a nurse practitioner**
  The analysis revealed the sample's transition experiences as components of a rite of passage.

The following sub-sections of this chapter review each of the four final thematic processes.

10.3.1. Process One - sanctioning a new (atypical) professional apprenticeship

In this sub-section, I consider the first of the final thematic processes, the sanctioning of a new and atypical professional apprenticeship. The nurse practitioner degree programme examined in this research had a structure that deviated from the traditional professional apprenticeship education model (chapter six, sub-section 6.2.6. p.141-142). The result of that atypical educational structure was an education process that initially lacked credibility and validity with all the professionals involved in it: student nurse practitioners, the teacher team, and the physician mentors. However, by 1999, toward the end of the data collection period, the nurse practitioner degree programme had established a confidence in the sample that legitimised its aim

to provide educational preparation for nurse practitioners. That was evident in the following data extracts:

> *"We are moving on, now that our nurse practitioner programme is established as part of our portfolio of what we offer; we have expertise in the area as a result of this."*
>
> *Senior Academic - G1 Data Segment - 2nd Interview Data*

> *"I felt really uncomfortable with it to start off with* (a nurse practitioner role); *I didn't want to be called a nurse practitioner. I thought it was wrong because there was no way I was functioning in that way. I may not be now, but I feel more validated because I have done this course* (the nurse practitioner degree programme) *and I have more knowledge and skills."*
>
> *Student Nurse Practitioner - F2 Data Segment - 2nd Interview Data*

I was able to observe this developing educational confidence in the nurse practitioner degree programme as a result of my utilisation of practitioner ethnography. That process enabled me as a member of the teacher team to use my prolonged exposure to the nurse practitioner degree programme to describe it in context. That context arose from the early developments of nurse practitioner education in the UK, where the use of a professional apprenticeship model of education contrasted with the limited professional and educational resources that were available. However, it was clear that the educators, clinical nurses and clinical physicians, all had influence on the evolution of this nurse practitioner degree programme. In this multi-professional context there was a need to sanction it, to legitimise it, to identify its control, purpose, and future regulation. That demand for recognition of the nurse practitioner degree programme was evident in the following data extract:

"It (nurse practitioner education) *had to move to degree level. I can quite clearly understand why we had to move to degree level so quickly. From the responses I have had, these people* (student nurse practitioners) *are very able, clinically adept and have an expertise of knowledge. Therefore, in respect of their clinical mentors, GPs or Consultants, they need to have that degree level of education. The degree gives them the ability to problem solve effectively, the ability to ensure that their diagnosis is effective, and that their decisions are research-based. It gives them the ability to think coherently and cogently, to put a point of view across and stand up with that point of view. I very much feel that the degree gives people the ability to do that."*

Nurse Teacher - F2 Data Segment - 1st Interview Data

In this data extract, the nurse practitioner degree was advocated as clinically effective and as professionally useful. To understand how the degree programme achieved this status it is necessary to review further the concept of the apprenticeship model of education.

Although I have already discussed the principle of the apprenticeship model of education (chapter six, sub-section 6.2.6. p.141-142), I review this again now in the context of the sample's experiences of the nurse practitioner degree programme that have been described in the main data chapters (chapters seven, eight and nine). Apprenticeship, at its simplest, is the combining the acquisition of skills with training (Kidney 1998). In the traditional apprenticeship model, the aim is to make a skill or task tangible and operational. Apprenticeship teaching is a mechanistic process delivered by an expert to a novice, and there is little expectation of evolution or change. It is thus an effective process for skills training, but it is limited within professional education. Recent educational theory has, however, suggested the development of the cognitive apprenticeship model as one that is more applicable to,

and descriptive of, professional skills education (Stein 1998). Cognitive apprenticeship sees the educational task of developing complex professional roles as a much more difficult process than that of simple rote skills acquisition. As a process, cognitive apprenticeship constructs the professional role from many complex skills and behaviours. Thus, it is an educational process linked to social transitions, and those transitions model the specific skills that the student requires.

Although the cognitive apprenticeship curriculum simplifies tasks and reduces them to components of the syllabus, it also provides maps and guidelines for the student. The educational outcomes become more difficult as the student progresses. Repetition of taught content, a network of peers and use of expert instructors and mentors nurture the student's eventual success. As the student becomes increasingly proficient in the required skills, the new knowledge and behaviour becomes natural, rather than rehearsed. This type of learning is a function of activity within a particular social context and culture, and is described as situated (Stein 1998). Whilst theoretical learning involves knowledge acquisition which may be abstract and lacking in context, in situated learning the student interacts with the reality of a practice that embodies certain beliefs, codes and identities. In establishing that identity, the student moves from the periphery of this identity to its center, they engage with the culture and adopt the new identity and role.

This model of apprenticeship describes a process that closely accords with the educational process I observed in the nurse practitioner degree programme, and these

processes of cognitive apprenticeship and situated learning were mirrored in the sample's experiences of the degree programme. The nurse practitioner degree programme was characterised by its aim to provide particular knowledge and to see that knowledge actively applied to clinical skills. That clinical application was evident in the following data extract:

> *"It's* (the nurse practitioner degree) *been challenging, most of the courses I have done before were not that clinical. I have loved the course from start to finish really. So much of it I can bring back to my practice and use, rather than having theory that doesn't affect my clinical practice."*
>
> *Student Nurse Practitioner - G3 Data Segment - 2nd Interview Data*

Despite that evidence of clinical application, the nurse practitioner degree programme deviated from the cognitive apprenticeship model of education in an important respect. There was normally an expectation that the primary expert teacher would be an expert (an occupational role model), and that his or her expertise would be the focus of the education programme. Thus in an ideal world, physiotherapists would be the primary (but not necessarily the sole) professional teachers of a physiotherapy programme, nurses of a nurse programme, and doctors of a medical programme. The nurse practitioner programme departed from this model, because the primary educational contributors, whilst experts in their own professional fields, were not expert nurse practitioners. When considering the core nursing origins of the programme, this lack of focused primary teacher expertise inferred a perspective that nurse practitioners were no longer nurses. If the nurse practitioner students were still nurses, then the nurse teacher should have been the primary expert, the occupational role model, but that was not the case. This was further contradicted by the students'

perception of themselves as nurses at the end of the nurse practitioner degree programme. The answer to this contradiction lay in the clinical outcomes of the nurse practitioner degree programme. These outcomes represented a level of clinical practice and expertise that the nurse teachers, despite their controlling authority over the programme, were not able to achieve. However, the combined expertise of the teacher team in conjunction with the expertise of the physician mentors, and the use of selective role modeling, had enabled the evolution of a new clinical nursing role.

Although the nurse practitioner degree programme was able to facilitate the required clinical outcomes for the new role, advanced clinical nursing was at the time (1997-1999) not professionally recognised or regulated. Few clinical nurses had achieved that formal level of clinical diagnostic skill that student nurse practitioners aimed to develop in their clinical practice. In short, the student nurse practitioners had no clear role models, and no contributing member of the teaching team or the clinical mentors had claim to the professional identity that the students sought to develop. The only individuals who could claim such an affinity were the few qualified nurse practitioners who did not become involved in the educational process until late in the data collection process.

Thus, the study revealed that the process of preparing nurse practitioners was unusual. The research findings have revealed an educational process where the very identity of the final product was uncertain, and consequently this resulted in the professional identity difficulties that featured so prominently in the data. Although

the teacher team had the experience of previous student groups, which gave it a certain level of experience, there was no significant population of nurse practitioners in the clinical field to provide structure.

Despite these uncertainties, I have shown that the different groups within the sample did their best to engage with the education programme and its curriculum during the two-years of the study (1997-1999), although the wider national professional sanction remained unresolved. Each group (students, teacher team, and physician mentors) wanted the nurse practitioner degree programme to succeed, and each group gave their own implicit support. It was to their benefit to do so, as not doing so would have undermined their involvement in the nurse practitioner degree programme and its aims. The result was that the sample gave the nurse practitioner degree programme its general approval, and this had the effect of a local sanction for a process that had a wider national implication.

The teacher team's interaction at both local and national level gave evidence of its role in developing the curriculum into a conceptually stronger place. The physician mentors' influence was crucial as their cooperative involvement endorsed the use of the traditional medical clinical outcomes of the nurse practitioner degree programme. Also, and despite the physician mentors' wider concerns on professional border threats, their involvement and agreement of standards at clinical examinations was a clear recommendation and endorsement.

The students progressed through the nurse practitioner degree programme, undergoing several transitions, challenging aspects of the curriculum, but finally developed new roles and identities that would impact materially on their clinical practice, and on the healthcare organisations within which they practiced. Their active development of roles in practice was a mechanism of standard setting. For the students, becoming a nurse practitioner required the successful completion of the nurse practitioner degree programme. From their perspective, the degree programme legitimated the nurse practitioner role.

All these points had the effect of sanctioning the degree programme. Consequently the nurse practitioner degree programme became identified as a professionally recognised standard. That was evident in the following data extract:

> *"You cannot criticise a course that develops nurses to the level that they have been developed on this course. You can't do that, get them to that standard, and then play down that role."*
>
> *Physician Mentor - G3 Data Segment - 2nd Interview Data*

This completes this sub-section which has reviewed the first of the four thematic processes that arose from the final analysis of the data.

10.3.2. Process Two - re-negotiating occupational boundaries - constructing the career lattice

In this sub-section I discuss the second thematic process. Darnell (1973) referred to professional mobility in terms of a career lattice. Examination of the professional structure of nursing in the UK in the late 20th century revealed limited career mobility

for qualified nurses, both in terms of horizontal role change, and in terms of the vertical clinical hierarchy. Consequently, the UK nursing profession's career lattice was underdeveloped. In contrast to this was the professional, political and resource agenda that saw nurses acquiring clinical skills that were increasingly diverse and complex. Thus, there were divides between the nursing profession's desire for greater professional status, the political and workforce imperatives, and the structural limitations of limited career mobility in nursing (McCartney et al 1999). In the review of the theoretical framework (chapter three, sub-section 3.2.2. p.43-44) this professional / bureaucratic conflict (Dingwall & Lewis 1985) was considered, and Friedson's (1970, 1979) view that this problem was best overcome by considering context and constraints was noted. The context of this study was a healthcare service driven by demands for a more flexible and responsive workforce where clinical roles and tasks were rapidly being acquired and developed in practice. The constraint for nurses lay in the lack of a comprehensive career lattice.

This development of new clinical roles and responsibilities needs further consideration. At the outset and at its simplest, role extension was a term used to identify those tasks undertaken by nurses that were not included in their training for initial registration as a qualified nurse. These tasks were often medical-technical interventions traditionally undertaken by doctors, such as intravenous cannulation, or the administration of intravenous drugs. This piecemeal acquisition of clinical tasks reflected a lack of professional coherence or regulation. A survey of hospital nurses by the RCN (1990) described the situation regarding extended roles as chaotic, with

training and monitoring inconsistent and varying enormously. There was no mechanism to permit recognition or transfer of skills between different employing authorities. Nevertheless, Wright (1995) cautioned that the introduction of wider regulation, if not carefully thought out, could result in a complex, and possibly inefficient, organisational bureaucracy.

The Scope of Professional Practice (UKCC 1992) had responded to this problem. It challenged the traditional practice of the regulation of nurses' clinical work by employers and locally devised protocols. The proposed alternative to this traditional restriction was a model of self-regulated, independent, and accountable professional practice. This conceptual change affected the breadth and depth of the clinical scope of nurses' practice, a clinical focus that added a new dimension to existing managerial and educational nursing roles. The need for change was accelerated by the European Working Time Directive on junior doctor working hours (DOH 1998b) and strategic health service directives that suggested review of traditional organisational and professional practices (DOH 1989, DOH1998a). These strategic directives suggested that nurses should develop advanced clinical skills and roles to address clinical resource problems. Overall, this sequence of events revealed that the clinical components of the career lattice remained incomplete. The RCN (1997) summarised that lack of career structure in its statement on nurse practitioner identity:

> "Nurse practitioner practice is not bounded by any convenient definition of nursing and what might be perceived as medical practice. Such parameters do not exist and, even if they did, they would be subject to constant change as the nurse practitioner role develops to incorporate a wider scope of activity."
>
> (RCN 1997 p.5)

Thus, as nurse practitioners began to practice in the UK during the 1990s, the traditional relationship between doctors and nurses was already undergoing transformation. For example, Stein et al (1990) observed that, since his original observations in 1967, the doctor nurse relationship had changed. Originally, he had observed a well-defined boundary between the doctor and nurse and that this boundary structured a hierarchical relationship. In that relationship, maintaining role integrity had been dependent on the absence of boundary challenges, and nurses had been passive players even when it was tacitly acknowledged that they were undertaking clinical decision-making.

The professional career model of the late 1960s allowed for only limited career developments. It had enabled a certain restricted growth of the nurse as a healthcare professional, but ultimately it had denied nurses what I have termed as the 'third pathway'. By this, I mean that whilst the Salmon Report (MOH 1967) had enabled nurse's managerial or educational development, the clinical route had been limited. The nursing clinical career lattice was underdeveloped, and the necessary social infrastructure for an advanced clinical nurse was not formalised (Figure 10.1. p.378).

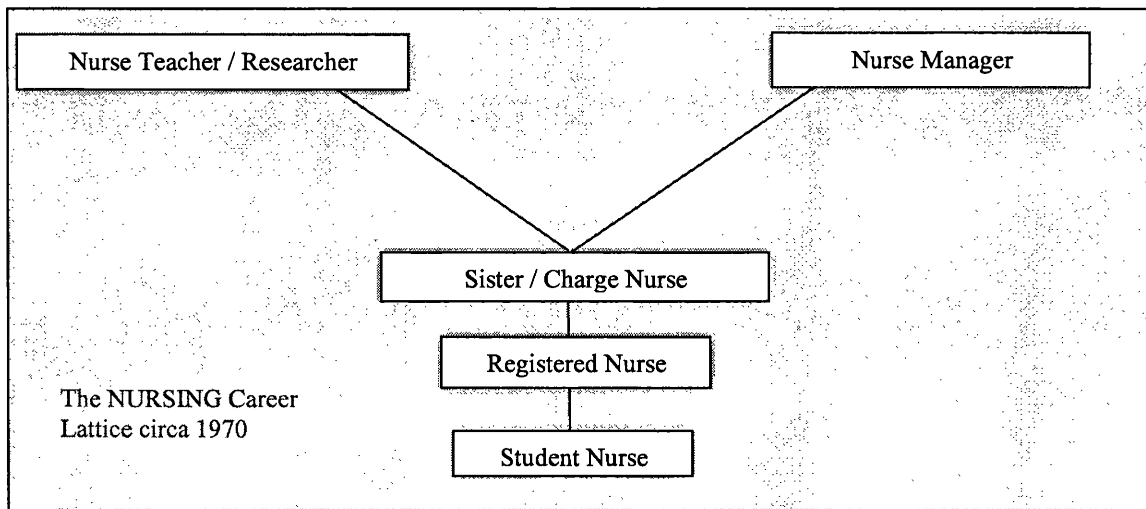


Figure 10.1. The two-way pathway career lattice - an incomplete professional structure

This reveals that, whilst nurses had begun to use unregistered titles that inferred advanced clinical ability, formal assessment or regulation of advanced clinical practice beyond the level of registered nurse was limited. Where alternative registered titles did exist (e.g. in community nursing), or where extended training programmes were undertaken, they were not rationally or coherently formalised within an encompassing professional career structure.

The changes that occurred in the nurse / doctor relationship during the 1990s arose from a wide range of social, cultural and resource events. These events would enable the emergence of a professional structure that introduced the third pathway, a route to an advanced clinical nursing role and identity (Figure 10.2. p.379). My analysis has revealed that the transition experiences of the study's sample resulted in part from the

development of that new professional identify. In this new model, the career lattice becomes more complete.

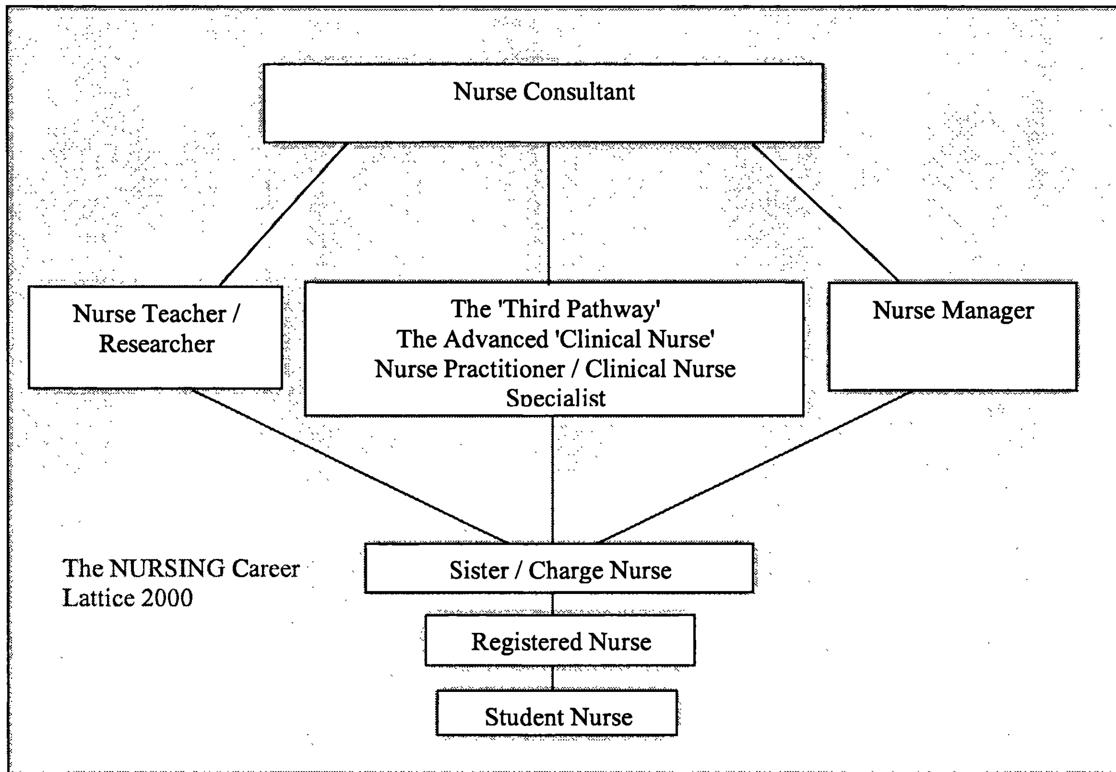


Figure 10.2. The three-way pathway career lattice - a more complete professional structure

The introduction of the third pathway was dependent on a change in the relationship between nursing and medicine. Wright (1995) claimed that this change in relationship occurred when challenges to the boundary status quo arose as nurses began to assert their autonomy. However, I suggest that this was only one part of a more complex equation. The wider socio-economic changes affecting the structure of medicine, the demographic changes in the wider population, and even advances in

medical technology (that made certain medical tasks more widely available and usable), all had their influence. The net effect of these changes was to permit a new level of boundary negotiations between the two professions that would have previously been unthinkable (Svensson 1996). This would result in resistance from the medical profession, and from the nursing profession, but the overall momentum was sufficient to ensure that the changes progressed. Indeed Stein et al (1990) observed that these changes, despite resistance to them, could have benefit. The subservient and dominant tradition of the two professions was psychologically and mutually restrictive, and therefore liberating the subordinate group would liberate the dominant group as well. With that as a potential professional outcome, reflected in the results that arose in this research, Svensson's (1996) observation that new levels of interprofessional negotiation and cooperation as a future demand were particularly emphasised. This desire for a cooperative multi-professional dialogue was evident in the following data extract:

> *"It's about, ideally, having programmes where there is shared learning with other professional groups. I think the nurse practitioner has been able to facilitate that kind of working, because they have had medical mentors, medical staff have therefore realised the extent to which nurses can work given the right opportunities to develop the skills and competencies."*
>
> *Senior Academic - D1 Data Segment - 2nd Interview Data*

A central premise of this study, as its title suggests, is that boundaries between professions are constantly changing. Thus, whilst it is possible to construct role identities that have particular characteristics, and possible to place such identities within the constructs of a profession, professional boundaries are not static. It is the

process of the negotiations between professions that affect boundary changes (Stein 1967, Svensson 1996, Allen 1997). A feature of recent negotiations has been the efforts to professionalise nursing, and a consequence of that was the realisation that its professional infrastructure had to evolve. It is that infrastructure, and the social construct of advanced nursing practice, that I consider next. This completes this sub-section which has reviewed the second of the four thematic processes that arose from the final anises of the data.

10.3.3. Process Three - advanced nursing practice and advanced clinical nursing - defining new professional identities

In this sub-section I discuss the third thematic process. Styles (1982) identified advanced nursing practice development as dependent on a social and occupational structure:

> "(advanced practice) nursing's maximum contribution is dependent on the organisational, legal, economic, social, and political arrangements that enable the full and proper expression of nursing values and expertise."
>
> (Styles 1982 p.213)

The present study describes the experiences of a small group of individuals in the UK who were involved in developing an advanced clinical nursing role. Styles (1982) had indicated that a social and professional infrastructure was required for the development of such a role. A finding of this study has been the lack of that infrastructure in the UK during the time of the data collection (1997-1999). However, in the USA, the professional control of advanced clinical nursing roles had been more firmly established through a system of accreditation:

> "The professional certification process (of advance practice nursing) meets the objective of greater professional autonomy and provides recognition of a nationally uniform measure of competence that can be relied on by the public in making healthcare provider choices with confidence."
>
> (American Association of Colleges of Nursing 1999 p.132)

Thus, there was a professional experience of advanced nursing practice outside of the UK. That international experience had not been professionally acknowledged or implemented in the UK. This study does not claim to have observed the implementation of advanced nursing practice in the UK on any scale, but its findings reflect how its constructs were being effectively used within a particular clinical and educational arena. That small-scale implementation could potentially be generalised to other settings. How did this broad concept of advanced nursing practice compare with the rather more focused clinical concepts that arose in my analysis? For example, what was the difference between advanced nursing practice and advanced clinical nursing?

Firstly, the origin of the concept of advanced nursing must be considered. In the literature review (chapter two, section 2.3. p.28-30), the early development of specialist nurses in the USA in the early 20th Century was considered. These specialist nurses evolved because of physician shortages and a consequent demand for substitute expert nursing. Expert nurses were characterised by their clinical specialisation, by their enhanced clinical autonomy, and by their abilities to manage health needs and to develop responsive new clinical practice roles (Mirr and Snyder 1995, Dunn 1997). Over time, many specialised roles emerged, for example, certified

nurse-midwives, registered nurse anesthetists, clinical nurse specialists and nurse practitioners. Carnwell and Daly (2003) noted that recently the latter two had received the most attention in the literature.

Secondly, it must be accepted that a range of clinical activities arose from the concept of advanced nursing practice. These activities were flexible and had scope that could be scaled vertically and horizontally. Thus, advanced nursing practice was a framework for diversity. That framework had certain generalist features, but it also enabled wide-ranging clinical specialisation. For example, the findings of this research have pointed to differences between specialists and generalists. The UKCC (1994) suggested that advanced nursing practice was a concept concerned with adjusting boundaries for the development of future practice and developing new roles responsive to changing needs. The UKCC (1994) had also suggested that within that concept lay aspects of advanced clinical practice, research and education. However, they did not identify any standards for these roles, and as a result, there were widespread inconsistencies in interpretation of advanced nursing practice. More recently, Thompson and Watson (2003) have described advanced nursing practice as reflecting current social and healthcare needs, demands and technologies. This view accords with that of Benner (1984) who suggested that an advanced level nurse should have critical judgment skills, should be able to recognise and master knowledge utilisation, and relate this theory and practice to social and clinical populations. Benner (1984) broadly saw the expertise of advanced clinical nursing reflected in clinical judgment that enabled the nurse to recognise subtle changes in

patients and at the same time empathise with that experience. In contrast to this, Castledine (1996) was far more specific and identified seven features of advanced nursing practice, namely:

- Being an autonomous practitioner
- Being experienced and knowledgeable
- Being a researcher and evaluator of care
- Being an expert in health and nursing assessment
- Being an expert in case management
- Being a consultant, educator and leader
- Being a role model

(Castledine 1996 p.288)

Thus, the concept of advanced nursing practice lent itself to several interpretations, and it is beneficial to examine how these somewhat diffuse concepts compared and contrasted with the concept of advanced clinical nursing practice as represented by the nurse practitioner role described in this thesis. McLoughlin (1992) saw nurses involved in advanced clinical nursing practice as being graduates who demonstrated high levels of autonomy, and who had expert skills in diagnosis and holistic treatment of complex human health responses. McLoughlin (1992) stated:

> "Nurses in advanced clinical nursing practice have a graduate degree in nursing. They conduct comprehensive health assessments and demonstrate a high level of autonomy and expert skill in diagnosis and treatment of complex responses of individuals, families and communities to actual or potential health problems. They formulate clinical decisions to manage acute and chronic illness and promote wellness. Nurses in advanced clinical practice integrate education, research, management, leadership and consultation into their role. They function in collegial relationships with nursing peers, physicians, professionals, and others who influence the health environment."
>
> (McLoughlin 1992 p.23)

It is important to deconstruct these concepts of advanced clinical nursing practice outlined by McLoughlin (1992), and much of the analysis in this study has been directed to this aim. For example, during the transition phase (chapter eight, sub-section 8.6.2. p.261) the acquisition and use of biomedical language arose as a central concern in the construction of advanced clinical nursing. My analysis revealed the students absorbing and utilising technical medical language, this new vocabulary providing a means of communication between the physician mentors and their students. Thus, one important finding of this study was that advanced clinical nursing required the learning, and selective use, of new language. Daly and Carnwell (2003) observed that consistent language use amongst healthcare professionals was an important focus in the facilitation of clinical decision-making and in the identification of new clinical structures and roles:

> "Some may take the view that it does not matter whether different (professional) titles are used, but there is an argument that consistent language should be used for the benefit of colleagues and healthcare consumers in making decisions about appropriate referral and the expected competence of practitioners. Clear frameworks for roles and associated competencies might facilitate such decision-making."
>
> (Daly and Carnwell 2003 p.161)

Daly and Carnwell's (2003) proposal for role-facilitating frameworks contrasted with the career framework in nursing which had historically been incomplete, had lacked a clinical hierarchy, and had not facilitated the development of advanced clinical roles (chapter ten, Figure 10.1. p.378). Figure 10.3. (p.386) proposes a new nursing career framework that includes advanced nursing practice. As can be seen, this encompasses those roles characterised by, and concerned with, aspects of education,

research, management, and advanced clinical practice. In this model, advanced clinical nursing is a component of that wider framework, and although it touches on aspects of education, management and consultancy, it is focused on the clinical roles of the new third pathway.

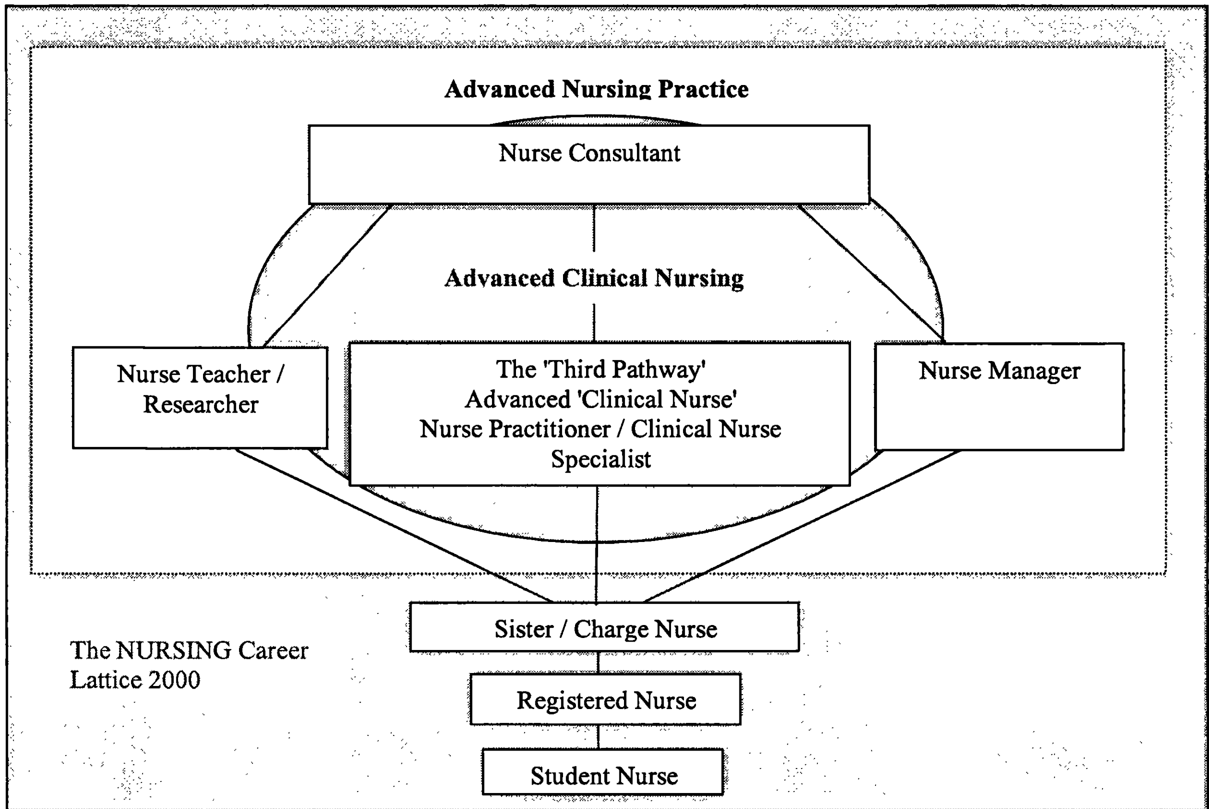


Figure 10.3. The nursing career lattice - advanced nursing practice and advanced clinical nursing

Having proposed this new career framework, I now focus on the clinical roles and the new clinical professional identities that have contributed to the construction of the concept of advanced clinical nursing practice within this framework. Many titles have been used in identifying advanced clinical nursing roles, but the titles clinical nurse specialist and nurse practitioner are the titles most commonly used. During

their historical early development, both the clinical nurse specialist and the nurse practitioner roles were synonymous with advanced levels of nursing practice, and both to varying degrees involved areas of traditional medical tasks. Commonly, nurse practitioners were viewed as generalists based in community settings, whilst clinical nurse specialists practiced in acute hospital settings and dealt with a more focused pathology or client groups (Carwell and Daly 2003). The distinction between primary and secondary healthcare is not as clear as it might be and recently the two different roles have diverged into many areas, nurse practitioners into secondary healthcare and clinical nurse specialists into primary healthcare. The distinction may rest on the concepts of generalism and specialisation, rather than on the healthcare sector, as suggested in the following data extract:

> *"I see the nurse practitioner role as being a general one, like a general practitioner if you like, seeing a multiplicity of situations, patient conditions and whatever. Clinical nurse specialists are very much focused on a particular specialist part of practice. They develop their diagnostic and assessment skills within a confined area of practice. A focused area is a better word I think."*
>
> *Senior Academic - C2 Data Segment - 2nd Interview Data*

However, I have also noted (chapter two, section 2.3. p.29) that the clinical nurse specialist was traditionally perceived as practising within a nursing domain, within a hospital culture that was essentially medically dominated and controlled. In the hospital, the doctor remained in overall control of healthcare delivery, and the challenges to professional boundaries were, at least initially, less marked. However, nurse practitioner practice was characterised by generalist undifferentiated health assessment and autonomous patient management, and that presented a significant

professional boundary challenge. Read et al (2000) also identified similarities and differences between the nurse practitioner and clinical nurse specialist roles, finding some core competencies and some important differences. Commonly, they both practiced at a more advanced clinical level than a newly qualified nurse, and their practice extended beyond that of just using technically complex procedures into a more refined use and synthesis of knowledge and skills. However, their relationship with physicians reflected differences. Clinical nurse specialists usually liaised closely with medical teams, their patient caseload dictated by medical management. In contrast, nurse practitioners managed a patient caseload more independently, and dealt with a wide range of undifferentiated health problems. This contrast was evident in this data extract:

> *"As far as a nurse practitioner is concerned, I see that as a quite clearly defined role with regard to autonomous practice and making differential diagnosis, whereas perhaps other nursing roles don't have as clearly defined remits."*
>
> *Nurse Teacher - B1 Data Segment - 2nd Interview Data*

Thus, these two roles, nurse practitioner and clinical nurse specialist, have some similar features, but have also evolved to encompass slightly different aspects of role expansion and advanced levels of clinical autonomy. Those role developments involved the acquisition of knowledge and skills and the development of expert clinical practice that required an extended period of clinical professional experience, all this resulting in complex professional border transgressions and negotiations (Read et al 2000). Academic preparation for these advanced clinical nursing roles had some recent professional endorsement via the specialist practice framework

introduced by the UKCC (1994). However, this specialist practice framework was limited in scope, did not apply to all clinical academic programmes, and was not founded on any widely agreed clinical standards or competencies. Consequently, the development of higher education programmes that sought to facilitate advanced clinical nursing roles were also not standardised, or based on any agreed clinical competencies or outcome. It was other resource difficulties and political issues, as opposed to professional and educational regulation, that drove the development of advanced clinical nursing roles and overcame the professional hesitancies over advanced clinical role definitions.

The understanding of advanced nursing practice was facilitated by the experience of the nurse practitioner degree programme. The programme provided social, cultural, and professional structures that enabled the sample group to begin to construct a professional identity. Within the structure of advanced nursing practice important professional concepts were identified: education, research, management and clinical practice. The literature has indicated that advanced nursing practice was a relatively mature concept that had been subject to considerable scrutiny (Castledine 1997, Manley 1997, Woods 1999, Carnwell and Daly 2003). Despite this, its implementation into the social world of nursing in the UK was only recently underway. Embodied in this process were the two commonly used professional identities of the clinical nurse specialist and the nurse practitioner. As has been demonstrated above, these identities had certain commonalties, but also they had differences. It was the nature and scope of the practice of the nurse practitioner that

brought them into the border area between nursing and medicine and thus into the area of possible border transgression, conflict and negotiation.

Woods (1999) proposed that the passage from nurse to advanced nurse practitioner was a highly individual and complex transition marked by three discrete stages: idealism, organisational governance, and resolution. Woods (1999) saw these stages as influenced by a complex interaction of social, cultural, and professional variables in a social and occupational situation that lacked structure.

> "As such, the way in which various factors were likely to influence the process was anticipated to be different from those situations where individuals and / or organisations have an established frame of reference against which to judge the progress of role transition."
>
> (Woods 1999 p.123)

Ewens (2003) furthered this view of the limited occupational structure in nursing by suggesting that dated and rigid hierarchies in healthcare organisations hampered the development of new nursing identities. This suggested that a responsibility for the necessary social structures for more advanced nursing roles lay not only with the clinical nurse, but also with healthcare managers and politicians. However, such structures cannot necessarily be put in place quickly. Transition processes must occur first so that the structure can evolve. Whilst that process is underway, it may yet be difficult to conceptualise fully the eventual outcome. I complete the discussion of this process with data extracts that highlighted the difficulties encountered when conceptualising and establishing advanced nursing roles:

"I hope it's accepted (nurse practitioning), *it's a very exciting development. One of the beauties of it is that it enables you to move up in nursing without going into administration. It's really nice to be able to retain that patient contact and yet still be able to consider yourself as going up and achieving. I really hope it takes off, but there are a lot of barriers to get over."*

Student Nurse Practitioner - F1 Data Segment - 2nd Interview Data

"I think that the potential for development of the role of the nurse practitioner is tremendous. You know you have got a lot of very experienced nurses whose practice would be enhanced by undergoing a programme like this. This group of advanced practitioners, who don't need to do the managerial stuff, but do the hands on clinical stuff, I think it's very much the cutting edge of nursing."

Student Nurse Practitioner - F1 Data Segment - 2nd Interview Data

"Well it's the way that practice has changed. The government proposals (pause), where does the consultant nurse come into this? Its all been complicated by the UKCC's definitions of specialist practice, what is the specialist practitioner as opposed to the nurse practitioner as opposed to a clinical nurse specialist? It's a whole melting pot of different things. Perhaps we should get rid of the role titles and whatever. Get rid of the titles and redefine it as a higher level of practice. And what do you call those individuals? It would be nice to have some kind of consensus on that!"

Senior Academic - C2 Data Segment - 2nd Interview Data

This completes this sub-section which has reviewed the third of the four thematic processes that arose from the final anises of the data.

10.3.4. Process Four - a rite of passage

In this sub-section I discuss the fourth and final thematic process. Van Gennep (1960) described a rite of passage as a stabilising event that enabled social cohesion. When groups or individuals undergo transitions or changes of relative status in society, a rite of passage eases this. In the absence of a rite of passage, society faces conflict, as

status transitions would have no pattern and no recognised purpose in social order. Rites of passage are then the institutionalisation of social transitions in social status.

Two main points require finalising following this project's use of the rite of passage concept. Firstly, did Van Gennep's (1960) concept of a rite of passage succeed as an analytical tool and, secondly, did a rite of passage occur? As an analytical tool, it was possible that the phases of a rite of passage would not usefully describe or illuminate the experiences of the identified sample. However, the data presentation has shown that the rite of passage model has effectively illuminated the sample's experiences, even when there were atypical findings. An example of an atypical finding was the unfinished development of the nurse practitioner role at the end of the students' formal studies on the nurse practitioner degree programme. Consequently, the students' transition experiences were also incomplete when their degree studies ended. This implies that, for the students in this study, the perspective of a rite of passage as a clearly defined experience occurring over a prescribed time-period is misleading. In reality, the beginning and end of the rite of passage was unclear and diffuse. Nevertheless, at a simple level, a well-known social transitional model (theory) appears to have effectively illuminated the transition experiences and social status changes of the sample.

The final question remains unanswered. Did the sample's experiences denote a rite of passage? To answer that question it is important to be clear on the overall structure, composition and character of a rite of passage, and to be clear on the stages

of transition experiences and their interaction with other transition experiences. It is important to be clear on how these concepts fit together. The sample's experiences arose from a composite of several simultaneous and inter-linked transitions, as opposed to a singular complex transition. Van Gennep's (1960) rite of passage provided a model that staged and structured that transitional analysis. However, it was also apparent that the sample was experiencing a rite of passage. That rite of passage was a product of the totality of the sample's experience, revealing it as a process that was greater than the sum of the individual transitions.

However, this proposal still requires further analysis. How would this proposed rite of passage compare if I had used other equivalent models of social transition? Could other models of social transition have structured and described the sample's experiences? I will now briefly consider several other models of social transition, and compare and contrast them with the transitional model of a rite of passage used in this study in order to identify similarities between them and Van Gennep's (1960) rite of passage.

It was noted earlier that Woods (1999) observed three stages in the passage from nurse to advanced nurse practitioner (idealism, organisational governance and resolution). However, the transitional stages described by Woods (1999) do resemble Van Gennep's (1960) phases of a rite of passage. For example, idealism was certainly an aspect of the students' experiences during the separation phase, organisational governance reflected role rehearsal for new social roles during the

transition phase, and resolution mirrored much of the students' experiences of the incorporation phase. Thus, Woods (1999) transitional model was comparable with the three phases of a rite of passage (Van Gennep 1960).

Another transitional model that could have been used in this study was perspective transformation. Mezirow (1981) developed this educational theory, and described adult learning as beyond the simple accumulation of knowledge, and more as a process by which an individual's basic social and cultural values and assumptions changed because of reflection on the accumulation of knowledge and experience. Thus, the model is an educational and reflective framework. When using this framework, individuals are critically aware of their social and cultural context, and structured reflection reconstructs and refines their perceptions and experiences. Glaze (2002) saw this type of reflection as a useful tool for a professional group that had existed in a subordinate place and that functioned in an oppressive professional hierarchy. As such, it was suited to the nursing profession and its relationship with the medicine profession. Of particular interest were the perspective transformation stages experienced by advanced practice nursing students. Glaze (2002) identified these as:

- Initial stage - entry shock
- Early difficulties - the struggle
- Acceptance
- Familiarity - making connections
- Learning to reflect more deeply
- Perspective transformation stage
- Internalization
- Dissemination

(Glaze 2002 p.267)

Again, these stages described by Glaze (2002) were, when scrutinised, similar and applicable to the general experiences that Van Gennep (1960) predicted during the phases of a rite of passage and were comparable with the staged findings in this study.

A third possibility was Becker's (1961) complex model of social transition and perspectives that arose from his study of medical students. Becker divided his work into areas of developmental perspective as follows:

- The long-range perspective
- The initial perspective
- The provisional perspective
- The interaction and consensus
- The final perspective

(Becker 1961 p.34-45)

Yet again, the transitional stages outlined by Becker (1961) were comparable with the transitional features of a rite of passage and the staged findings observed in this research. For example, the long-range perspective compared with the pre-course stage in this study. The initial perspective compared with the separation phase of the rite of passage. The provisional perspective compared with the transition phase of the rite of passage. Lastly, the interaction and final perspectives compared with the incorporation phase of the rite of passage.

Finally, Brown and Draye (2003) identified six stages that described the transitional experiences of pioneer nurse practitioners in the USA. Those stages were:

- Breaking free
- Moulding the clay
- Encountering obstacles
- Surviving the proving ground
- Staying committed
- Building the eldership

(Brown and Draye 2003 p.392)

Again, these stages outlined by Brown and Draye (2003) were similar to the Van Gennep (1960) phases of a rite of passage. For example, breaking free and moulding the clay could be compared with the separation phase of a rite of passage. Encountering obstacles and surviving the proving ground was similar to the transition phase of the rite of passage. Staying committed and building the eldership was similar to the incorporation phase of a rite of passage.

It became clear that whichever model was used, all equally valuable and valid, that there was an underlying process of staged social transitions. These varied transitional models all compared with the features and the fundamental basis of a rite of passage outlined by Van Gennep (1960). An alternatively view was that they were social transition models that described particular perspectives of a rite of passage.

Amaladoss (2003) saw all human action and experience as symbolic. Any behaviour or event in human life could become a symbolic action if given a special connotative meaning in a particular context by a group of people. Thus, social transitions, either

group or individual, involve communication that is mediated through symbols. A rite of passage is socially symbolic, it is a process defined by social and cultural perceptions. If society acknowledges an experience of social transitions, if it permits social transitions to occur, and sees social transitions as having a useful function, then those transitions become a rite of passage. In this way, we can mark any process of social initiation, social transition, or change in social status as revealing a rite of passage.

In this research, a rite of passage legitimised the status of the nurse practitioner. The nurse practitioner students evolved to become advanced clinical nurses by a partial transition through the medical domain. A rite of passage enabled the identity of the nurse practitioner students. That identity lay within the nursing paradigm, built on the social construct of advanced nursing practice and advanced clinical nursing.

This completes the analysis of the data and the related discussion on the research findings. In the following and final chapter (chapter eleven) I conclude this research project.

CHAPTER ELEVEN

THE CONCLUSION

11.1. INTRODUCTION TO THE CONCLUSION

This final chapter of the thesis is divided into two sections. Firstly, I draw to a conclusion the findings of this research. Secondly, I offer a final critical review of practitioner ethnography as a research design.

11.2. CONCLUDING THE FINDINGS OF THE STUDY

Svensson (1996) indicated that the professional boundary between nursing and medicine was unclear and difficult to define. The reality of professional status, regulation, and governance, was that it was constantly changing in response to changes in society. Thus, many factors influenced this project. It was a topical subject at a time of change and innovation in the UK health service and in the healthcare professions. It was also an investigative opportunity. I had ready access to the sample members within the nurse practitioner degree programme, and a professional interest in their prospective experiences that I developed as a research proposal. In terms of the initial project design it was first necessary to review the boundaries that separated the professions of nursing and medicine, the regulation of those boundaries, and their influence on role development and occupational definitions. For example, the literature had already suggested that nurse practitioners were actively transgressing previously established professional boundaries between nursing and medicine (Vayda 1965, Bates 1970, Marchione and Garland 1980,

Bennett 1984, Stilwell et al 1987, Brown 1995, Castledine 1995, Cahill 1996, Ashburner et al 1997, Campbell-Heider et al 1997, Walsh 1999, Brown and Draye 2003). There was also a need to review the social organisation, and the traditional divisions of labour within, and between, these occupational groups. These reviews provided a background that enabled assessment of change at the professional boundary. The literature suggested that both the nursing and medical professions were attempting to negotiate new occupational territories and to ascertain new authority and power boundaries. A wide range of political, economic, professional and social factors influenced those negotiations.

As a central aspect of the study lay in professional boundary issues, it was important to understand how a redefinition of the boundary could actually manifest itself. Thus, questions began to arise. What was happening at professional boundary between nursing and medicine? Were professional boundaries being changed? Were new healthcare roles emerging? What were the regulations governing these boundaries, and were new regulations being negotiated? If negotiations were in progress, were they formal, legislative, or perhaps more subtle negotiations?

Since this project started in 1997, the concepts of advanced nursing practice have evolved considerably in the UK. This inevitably influenced the outcome of the project. An early proposition that nurse practitioners were a new emerging professional group was effectively overtaken by significant and wide reaching professional and political developments. Indeed, the study has argued that this early

idea of nurse practitioners as a new healthcare professional group arose as a direct result of the lack of a social professional career structure within nursing. That lack of an occupational structure prevented nurse practitioners from being located in a professional nursing context. During this research analysis (1998-2003), a framework for advanced nursing practice began to emerge in the UK, and this progressively resolved the problem of the nurse practitioners professional identity. Examples of this emerging concept of advanced nursing practice were first found in the UKCC's specialist practice award and later in its Higher Level of Practice framework (UKCC 1992, UKCC 1998). Those frameworks initiated the introduction of a more complex clinical career structure in nursing. Additionally, the political demand for nurses to adopt roles that supported medical resource shortfalls, and the introduction of consultant nurses, also influenced the delivery of the nurse practitioner degree programme and the individuals within the sample. Thus, the data I collected were a reflection of a dynamic situation.

The data were presented within the theoretical construct of a rite of passage. Analysis of the data revealed that the overall sample experience accorded with the general features of a rite of passage (with some anomalies) and that this was central to the evolution of a new professional identity. The rite of passage was a prolonged one marked by an extended period of education. The sample experienced social, cultural and professional transitions. Those transitions led to the development of a social structure, and that enabled the students to find a new identity and new social status. The sample's acknowledgement of the nurse practitioner degree programme as a rite

of passage gave the evolving nurse practitioner role credibility and validity. A part of the transition process involved boundary transgression, but this was negotiated and became an acceptable component of the transition. That transgression was a part of a local event and was not a process yet agreed in the wider professional social context. For that wider acceptance to occur, the sample's experience would ultimately have to be generalised to a wider professional audience. It was thus an example of unfinished business for the sample, and a reflection of the incomplete nature of the rite of passage.

I have made much of the identity of the nurse practitioner, and that the boundaries that define their practice were unclear and changing. Even with the introduction of a third career pathway of advanced nursing practice, and as professions are always changing, I suspect that definitions of professional identities will remain elusive. A fact of nurse practitioner development is that nurse practitioners are substituting into existing work needs and work roles. As that substitution continues, the function and role of the nurse practitioner will change. Learning that there are no fixed points or firm foundations is an unsettling thought. However, this is simply a fact, and it need not necessarily be a negative issue from a professional, clinical or managerial point of view. It is a current reflection of much older sociological observation that the tasks of professions are handed from one to another, and that the boundaries are consequently changeable. This reallocation of healthcare tasks was evident in the following data extract:

"Nurse practitioners have something to do with the distinction between substitution and delegation. Just take the boundary between medicine and nursing, we know that work is passing from doctors to nurses both in the acute sector and in the primary care sector and we know that for some nurses this is delegated work. But, we know that for others their experience is that they are undertaking the work and the associated responsibilities, and that they have a degree of autonomy, at least in the eyes of some people. So it seems to me that the defining point of the nurse practitioner is someone who will, if you can forgive the term, 'substitute', and is actually taking on responsibility with a degree of autonomy in relation to the work they do."

Senior Academic - D1 Data Segment - 2nd Interview Data

The recognition that skills were already passing readily across the boundary was important, as perceptions of that process varied. My data showed that the teachers, students and mentors saw the bridge between the two professions as under construction, whilst the senior academics' view was that the bridge was already in existence and functional. Whichever was the case, the development of nurse practitioners had the effect of raising the level of boundary negotiations, and also brought an existing process of negotiation and skills-sharing into a more explicit focus. New norms, new rules, and new regulations were being negotiated, and older norms, rules and regulations were being re-negotiated. The emerging theme was one of a changed professional hierarchy that was involved in ongoing negotiation and dialogue. The need for that dialogue was clear in the following data extract:

"There is need for more multi-disciplinary working, and working in partnership with other professionals, and agreeing individual professional outcomes for care as well as joint outcomes. We need to be able to work in much closer relationships with medical staff, social workers, anybody who is involved in healthcare. There is no one professional who has the monopoly on it all."

Senior Academic - D1 Segment - 2nd Interview Data

This data extract described a healthcare organisation which would be more professionally collaborative, and where hierarchies between professional groups would be comparable, resulting in a more equal distribution of clinical responsibility. The experiences of the sample members have shown that their negotiations at the professional boundary between nursing and medicine had resulted in a more equivalent hierarchy. That outcome was evident in the following data extract:

> *"It came to mind that at one of the OSCEs that I had attended on the nurse practitioner course, that I had really felt that there was a sense of engagement between the doctors and nurses present. There was no attempt to speak down to either party and that the focus of discussion was on the work and the problem, rather than vying for professional recognition."*
>
> *Senior Academic - D2 Data Segment - 2nd Interview Data*

The relationship between nurse practitioners and their medical colleagues has prompted this review of healthcare professions. The data I collected has revealed many processes and events that presented analytical challenges. Observation revealed nurses, doctors and academics working together in new ways, leading to changes in traditional hierarchies, authorities and boundaries. Thus, there were challenges to traditional prejudices and stereotypes:

> *"I would like to see greater integration academically. It would be good if we had some kind of pre-training, whereby students trained with medical students to get their initial biosciences training. Possibly, ultimately, I would like to see nursing students training with medical students, as a common pathway, so that those professions held equal academic status. Then nurses could specialise as nurses and medics could specialise as medics, or whatever type of ilk happened in the meantime."*
>
> *Physician Teacher - C2 Data Segment - 2nd Interview Data*

This data extract described a reality in which healthcare professions would have few boundaries and hierarchies. As already indicated the title of this thesis, which alludes to redefining occupational boundaries, is significant. In the final analysis, I have found a process of mutual negotiation of a professional border order with a tacitly agreed transgression, this coupled with the introduction of the clinical career pathway in nursing. The process of the transitional experience was eased by a rite of passage that left the students grounded within the nursing profession and evolving a new identity within the construct of advanced nursing practice. This concludes the final discussion of the research project and its findings.

11.3. CONCLUDING THE CRITICAL REVIEW OF THE RESEARCH DESIGN

In this final section of this chapter, I examine the potential limitations of this research project's design. A particular feature of this research project was the use of practitioner ethnography. Hammersley (1992) saw this applied approach as specific to the experiences and needs of the sample, as the practitioner ethnographer was grounded in the sample's reality, and from that arose particular credibility (validity) of the findings. This practical research application was only possible when the researcher was an active participant in the researched event, and this was a feature of the research design in this work. Practitioner ethnography was described in the methodological discussion (chapter four, sub-section 4.2.4. p.79-87), but in this concluding part of the thesis I review two areas of potential weakness in the research approach. Firstly, I review the issue of the place of the researcher in the study and

my particular relationship with the participants. Secondly, I review the issue of the generalisability of the research findings.

11.3.1. The place of the researcher

Practitioner ethnography, and its particular orientation in the reflexive context, has been reviewed in the methodological discussion (chapter four, section 4.2.4. p.79-87). However, it remains open to further critique, and it is necessary here to revisit some of the issues that arose from that earlier discussion. Hammersley (1992) debated the relative values of more traditional specialist ethnography with that of practitioner ethnography, and questioned the assumption that all research must be relevant to all practitioners. For example, the traditional ethnographer was an academic specialist, and consequently research outcomes would be indirect and general, whereas the practitioner ethnographer was a practitioner in the field and research outcomes would tend to be more direct and specific. Thus, specialist ethnography may be viewed as irrelevant to non-academics as theoretical and not addressing practical problems, whilst practitioner ethnography may be seen as a method that was non-theoretical and focused on practical problems. However, Hammersley (1992) rejected these perspectives and viewed both specialist and practitioner ethnography as of equal value, where the outcome was essentially context dependent, and the research approach was tailored accordingly.

Nevertheless, the intimate reflexive involvement of the practitioner ethnographer with the sample will raise questions about subjectivity and objectivity. That reflexive involvement of the researcher is a theme to which I have repeatedly alluded in this

thesis. From the design perspective, the ethnographer's insider experience of the lived world becomes a necessary component of participant observation balanced against a necessary objective observer component of that same process (Genzuk 2003). The challenge is to combine participation and observation, to be an insider capable of understanding the sample's experience, and an outsider who could describe the sample's experience to others. For example, when the specialist ethnographer enters the world of the sample to observe them, a particular feature of that challenge emerges. On entry into the sample's world, the researcher may be suspected by the respondents of being an investigator with hidden intentions, a representative of a distant research team, or of a government, commercial or industrial organisation. Leininger (1985, 1987) explained that this stranger / friend model could evolve to meet the needs of the research aims (chapter four, sub-section 4.2.5. p.88). However, it is also quite possible that the respondents will try to manipulate or exploit the researcher to their advantage. Thus, observations of the lived world are distorted by the very act of investigation. In contrast, I have observed that the role of the practitioner ethnographer is different from this traditional model, presenting a quite different relationship between the researcher and the lived world investigated. For the practitioner ethnographer, the challenge is to achieve objectivity, to be able to take an outsider view of a lived reality.

Thus, much arises from the nature of the researcher's access and participation in the lived world investigated. There are many variables, for example: physical appearance, gender, age, ethnicity, and perceived authority. All variables have

implication for the researcher and his or hers relationship with the sample. The researcher has to establish an identity in the researched world that is neutral, marginal, and yet equally acceptable to the sample. Additionally, a sample constructed from differing groups (such as in this research; students, teachers and clinicians) can result in a need to establish several identities.

In this project, I actively participated with the sample as a practitioner ethnographer. I had an existing role and relationship with the research sample. I had native knowledge of the social milieu, and effectively unrestricted access to the nurse practitioner degree programme and the sample. Whilst I may have been a novice to ethnography, I was not a novice or a stranger to the area being studied. Hammersley's (1992) view of the specialist ethnographer at the outset of the research being a novice and having to find a place as an acceptable incompetent was not applicable in this study. The sample knew me as a member of the teaching staff and an authority figure. In the methodological discussion (chapter four, sub-section 4.2.4 p.82-84), I described my research role as being initially defined by practitioner ethnography, defined as an experienced practitioner (member) of the sample, and equally as a naive observer and naive ethnographer. That position was not static, and my self-perceived status in the research would change over time as my relationship with the sample evolved.

As described in the methodological discussion, I attempted to adopt a reflexive role with all the groups within the sample (chapter four, sub-section 4.2.4. p.82-84). That

personal relationship had the potential for a subjective perspective of events. However, the risk of 'going native' was not applicable. I was already a native, I was a teacher and a nurse, and I had therefore to discover the objective research perspective. Thus, the interaction between the sample and myself was ultimately an important component of data generation. The challenge was to structure my reflection carefully, to examine the subjective experience, and then objectively and analytically review the data. The need to develop a rapport with the subjects, whilst playing an essential authoritative role in their lives, rested on maintaining a marginal insider-outsider role, as a researcher and participant. I had, for example, several selves with the three core sample groups (students, teachers and physician mentors). As I actively participated in the world of those individuals, maintaining my research perspective was sometimes difficult. That position of marginality was not an easy position to maintain, as the data was rich with the subjectivity of actions, interactions, emotions, culture, symbols and rituals (Morgan and Drury 2003). An objective review of the experience was only possible in the light of the prolonged and careful analysis of the data after the data collection had finished. That process of critical analysis took place over several years, and it was that which permitted a distance between the familiarity with the sample and objective analysis and interpretation of data.

Fieldwork research can result in a situation in which respondents push for disclosure of results or personal beliefs. My relationship with the sample I kept as a generally friendly and informal one, and I only occasionally had to adopt the more formal interventions of a course lecturer, this mostly toward the end the data collection. My

relationship with the respondents typified a practitioner ethnographer approach and philosophy, and my involvement in their lived world was a part of the data. Certainly, the student group questioned me on occasion about my research, but ultimately my identity with the sample became predominantly that of a teacher rather than that of a data collector. In the final analysis, my role had facilitated a close intimate contact with the sample that gave a rich contextual interpretation. This concludes the discussion on the place of the researcher. In the next sub-section I discuss the issue of the generalisability of the research findings.

11.3.2. Generalisability

Kincheloe and McLaren (1994) referred to generalisability as a measure of external reliability. Morgan (2003) described the term as one that referred to the extent to which findings of a research study applied to other groups, situations or settings. In respect of these definitions, it was important that any research study be evaluated in terms of its findings and their relevance. Some writers questioned whether generalisability was possible in qualitative research, as data focused on individuals and not on aggregates (Grbich 1999). However, Maxwell (1992) countered this view, seeing findings derived from qualitative data as feasibly generalised to other comparable or similar situations. Hammersley (1992) described two components of generalisability: empirical generalisation and theoretical inference. I discuss each of these in the next sub-sections.

11.3.2.1 Empirical Generalisations

There are four broad categories of empirical generalisation described by Hammersley (1992). The first category is that of typical singular empirical generalisations. These generalisations are suggested when a particular setting may be typical of a larger social construct or aggregate. In this case, the suggestion would be that the experience of the sample observed in this study would be that observed for all others involved in nurse practitioner education. If that were true then the findings could be generalised to a wider audience. The second category of empirical generalisation is the atypical singular empirical generalisation. This is suggested when the relevance of such generalisations need not be based on typicality. By this, it is meant that observed experiences could be viewed as unusual, atypical, to those observed in other similar situations. The third category of empirical generalisation is the multiple empirical generalisation. In some instances, such multiple generalisations may occur, and again this study has shown the experiences of several professional groups. It is possible that findings from each may be generalisable to different settings and situations. The fourth and final empirical generalisation is the chronological empirical generalisation. I have noted that the wider strategic experience of nurse practitioner education in the 1960s and 1970s in the USA was in certain respects mirrored by that in the UK in the 1980s and 1990s. Thus, empirical generalisation may be transferable to other settings in time.

Empirical generalised findings may be similar or different, and inferences made on aggregates of phenomena (Hammersley 1992). This study's generalisations compared with some of the wider phenomena of the time. For example, the implementation of

new clinical roles in the context of advanced nursing practice was occurring on a national scale in the UK during the 1990s. It is also possible that the experiences of transition observed in this study were transferable to other similar education programmes. However, there were also identified atypical contexts of generalisability. The programme examined was a new graduate programme, and the team of teachers involved would change over the following years with the inclusion of qualified nurse practitioner teachers. This would change the profile and experience of future students who would be studying from within a more established educational programme. However, despite this changing situation, it is feasible that the findings that emerged from this study could be generalised to other nurse practitioner education programmes elsewhere.

The experience of a rite of passage is a universal one that has been used in many social contexts where social or cultural status changes. It is probable, in the light of a broad research base that has underpinned that process, that the experiences of a rite of passage observed in this research were transferable to other education programmes and student groups in other settings. However, when generalising research findings about a rite of passage to other social groups, an important feature of that transferability is the identification of the nature and nuances of the target groups. In the case of nurses undertaking programmes of clinical education, it is important to consider the time and place of the events. By this, I mean that when attempting to generalise to a wider population, it is important to understand the wider context. To suggest that the findings of a small-scale study on advanced clinical practice may

have wider application can only be inferred if the history and national and international context of that concept is understood. Thus, generalisation from a single small-scale study as exemplified by this research to larger populations may be legitimate (Morgan 2003). Statistical techniques that make generalisations are not a demand in an ethnographic study (Hammersley 1992), but critical reflection on the specifics and variables of both the original and target groups is necessary. This completes this discussion on empirical generalisation. I now conclude the critical review with a discussion on theoretical inference.

11.3.2.2. Theoretical Inference

Processes that are more complex may also reveal generalisability. Inferences may arise from research findings that validate, refute or extend social theories. The phenomena observed on a small scale may have implication for aggregate phenomena and wide theoretical ideas. That would occur when making logical generalisations to theoretical comprehension of similar types of phenomena. The applicability of such theoretical inference from one setting to another depends on the likelihood that the known theory will accord with the context of the research finding as estimated by those wishing to apply the findings. Fossey (2002) indicated that a responsibility for making this link lies with the researcher, who must provide an adequate description that is sufficiently detailed. Fossey (2002) also indicated that a responsibility for theoretical inference lies also with the reader, who must evaluate research findings and make judgments on their applicability in other settings.

A rite of passage was a theoretical construct that was applicable in a wide arena of human experience. All societies use aspects of rite of passage to identify significant transitions in the social status. Van Gennep (1960) observed that a rite of passage was theoretically composed of three discernable phases and that these phases could be replicated in differing social and cultural contexts. Given those similarities, a rite of passage becomes an analytical concept and an analytical tool. When applying that concept and tool in this research, it correlated closely with aspects of the data. On such a small scale, to suggest that the findings have in anyway validated the broad social concept of a rite of passage was not possible. However, I conclude that my findings revealed an event marked by a rite of passage. Equally, I accept that theoretical generalisations of these findings to other similar events were difficult to infer, and dependent on the adequacy of the descriptions of the experiences in this study.

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Appendix A - Field Note Entry – Example (Extract)

Appendix A

Field Note Entry – Example (Extract)

FILE: C29 (Dated and timed)
THE PLACE: *********
THE PEOPLE: **, **, Eight Students, **** ***** (Qualified NP)
THE ACTIVITY - THE EVENT – GOAL: End of Course Evaluation
THE TIME - SEQUENCE: Afternoon Session
OBJECTS: NA

INDIVIDUAL ACTS:

This follows on from C28 - the afternoon after the OSCE Vivas. There was a sense of exhaustion, perhaps exhilaration at the course end. ***** did not stay. I had been asked to feedback on the research I was doing - which I did - giving some of the preliminary results from the first wave of data collection - but no field note information.

There was a very interesting discussion about their new roles.

Student – 'Now I have got it - what will I do with it - I never though this out carefully enough.'

The secondary care nurses now are clearly articulating their concerns over being able to enact a nurse practitioner role - as they have come to understand it - several are outspokenly discussing a need for them to move toward primary care employment. I guess this is not really a desirable outcome - it presses upon me the need to revalidate the course name to Nurse Practitioner and Clinical Nurse Specialist. Thus hopefully we will have a process that will facilitate the role - rather than a process that dictates the title.

Student – 'I was talking to a new applicant the other day and I told her, that if my experience of being a student nurse practitioner was anything to go by, I told her to think ahead about what you see your role as being.'

Student – 'My senior nurse said she couldn't see a secondary care nurse practitioner working as a primary care nurse practitioner.'

One of the students had a job description with her, and passed this around for photocopying. They are planning their own careers (as opposed to others planning it for them). You could feel the course ending for them and that they had a need to now move on to the next step, not a dissimilar experience from when you qualify as a nurse. But they have a less established framework to work with - there are few real signposts here and therefore there is a tangible anxiety.

**** gives advice - GPs trust qualified NPs LESS than students - as student is still essentially under control and supervision - but the qualified NP has the licence (figuratively). **** urged that the physician mentorship role must continue for some time - several years - and that this will eventually evolve into a partnership.

FEELINGS AND EMOTIONS:

Beginnings and endings they say are very delicate things - indeed very often they come together as one of the same thing. I would like to meet all the students in a year's time - perhaps do a group interview - and see what has happened.

They have changed - very remarkably - they are still nurses and yet more - they are not doctors - they may be the makings of the consultant nurses.

Appendix B - Semi Structured Interview Questions

Appendix B

Semi Structured Interview Questions

Student Questions:

1) Tell me about what you think nursing is?
2) Tell me about what you think medicine is?
3) Tell me about what you think a nurse practitioner is?
4) Tell me about your role as a nurse?
5) What do you see the Nurse Practitioners role as?
6) How do you view the relationship between physicians and nurses?
7) Is this different to the relationship between physicians and nurse practitioners?
8) What are your expectations of the nurse practitioner degree?
9) Where do you see nurse practitioners in the future?

Educator Questions:

1) Tell me about what you think nursing is?
2) Tell me about what you think medicine is?
3) Tell me about what you think a nurse practitioner is?
4) Tell me about your view of a nurse's role?
5) What do you see the nurse practitioner's role as?
6) How do you view the relationship between physicians and nurses?
7) Is this different to the relationship between physicians and nurse practitioners?
8) What are your expectations of the nurse practitioner degree?
9) Where do you see nurse practitioners in the future?

Mentor Questions:

1) Tell me about what you think nursing is?
2) Tell me about what you think medicine is?
3) Tell me about what you think a nurse practitioner is?
4) Tell me about your view of a nurse's role?
5) What do you see the nurse practitioners role as?
6) How do you view the relationship between physicians and nurses?
7) Is this different to the relationship between physicians and nurse practitioners?
8) What are your expectations of the nurse practitioner degree?
9) Where do you see nurse practitioners in the future?

Appendix C – Ethical Approval

Appendix C

Health Authority Ethical Approval Request

T. D. Barton

Lecturer in Nursing

University of ***** *******

1997

Dear Sir / Madam

I am currently working with the above department as a Nurse Lecturer. I have recently registered as a Ph.D. student with the University of ***** and enclosed is a copy of my research proposal that provides theoretical and methodological background to this study.

In brief, the study seeks a qualitative exploration into aspects of student and professional concept of the evolving and emerging role of Nurse Practitioners. Detailed qualitative data is to be collected from key individuals involved in a newly established degree program by a variety of qualitative tools, most specifically by means of short semi-structured interviews. Interview transcripts will then be subject to systematic content analysis to establish inductively research categories and themes. The sample will consist of a small number of students, educationalists and medical mentors. Medical mentors are physicians who elect to support and guide the students in practice settings throughout the two years of the course, and may be either general practitioners or based in acute hospital settings.

Thus, one data collection tool in the project is a brief half-hour interview with these medical mentors at the outset and again on completion of their student's two-year part time studies. These interviews will be semi-structured, audio taped, and thy aim to gain information in regard of these individuals opinions and attitudes on the emerging role of Nurse Practitioners. The interview schedule will consist of some very broad questions prompting the interviewee to discuss their personal view and experience of the Nurse Practitioner concept.

Individual mentors will be invited to be part of the project and will be given broad details of the project aim. They may unconditionally opt-out at any time during the study. All information will be anonymous. The sample of medical mentors is approximately eight.

I would like the ethics committee's approval to undertake such interviews with medical mentors and would be grateful for any comments or advice that would be deemed appropriate to ensure ethical acceptability. I look forward to hearing from you and will of course be happy to provide any further information you require and /or attend the committee at you convenience.

Yours Sincerely

David Barton

Appendix C

Health Authority Ethical Approval Reply

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Mr T D Barton
Lecturer.
Confidential information hidden
Confidential information hidden
Confidential information hidden
Confidential information hidden

30/06/97

Dear Mr T D Barton

97.074 "The Nurse Practitioner:Redefining Occupational Boundaries? A Qualitative Exploration Into Aspects of Student and Professional Concept of the Evolving & Emerging Role of Nurse Practitioners.

The Committee has approved the above submission by Chairman's Action and the Protocol has now been registered. I enclose a signed copy of the approved submission. Please quote the registration number in any future correspondence. Please also note :

1 The enclosed document is confidential and not for publication
2 Any publication resulting from the Protocol must define how subjects were chosen and to what extent they were volunteers.
3 That the form of consent must be read and signed by each subject or, if oral consent has been approved by the Committee, that the consent of each subject must be appropriately recorded. In either case, forms and records must be kept for subsequent examination, if required, by the Committee
4 That changes to the Protocol as approved must be referred to the Committee
5 Ethical approval does not imply acceptance of materials and drug costs by the Authorities or provider units
6 Any untoward incident which occurs in connection with this Protocol must be reported back to the Chairman of the Committee **without delay**.

Yours sincerely

Confidential information hidden
Confidential information hidden

DIRECTOR OF PATIENT CARE
& SECRETARY TO THE LOCAL RESEARCH ETHICS COMMITTEE

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Appendix C

University Ethical Approval Request

T. D. Barton

Lecturer in Nursing,

1997

Dear Sir

I have recently registered as a Ph.D. student with the University of ******* and enclosed is a copy of my research proposal that provides theoretical and methodological background to the study. I will be collecting data from departmental staff and students and therefore need to obtain ethical departmental approval. I am also currently seeking ethical approval from the local health authority committee as I intend to collect data from Physicians. The formal process of data collection commences in September of this year (1997).

In brief the study seeks a qualitative exploration into aspects of student and professional concept of the evolving and emerging role of Nurse Practitioners. Detailed qualitative data is to be collected from key individuals involved in the newly established degree program by a variety of qualitative tools, most specifically by means of short semi-structured interviews and detailed observational field notes. Interview transcripts and field notes will then be subject to systematic content analysis to establish inductively research categories and themes. The sample will consist of a small number of students, educationalists and medical mentors. Medical mentors are physicians who elect to support and guide the students in practice settings throughout the two years of the course, and may be either general practitioners or based in acute hospital settings.

Thus, the broad intention of the project is to collect data by a variety of qualitative methods throughout the two-year part time program. Key individuals will be invited to be part of the project and will be given broad details of the project aim. They may unconditionally opt-out from the study at any time. All information will be anonymous.

I would like the committees (departments) approval to undertake such data collection and would be grateful for any comments or advice that would be deemed appropriate to ensure ethical acceptability. I look forward to hearing from you and will of course be happy to provide any further information you require and/or attend the committee at you convenience.

Yours Sincerely

David Barton

Appendix C

University Ethical Approval Reply

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Our Ref JE/DB
Your Ref.

11 June 1997

Mr D Barton
Confidential information hidden
Confidential information hidden

Dear Mr Barton

DEPARTMENTAL ETHICAL APPROVAL COMMITTEE

Thank you for your research proposal which you wish to undertake as a central feature of your doctorate studies. This was considered by a sub group of the committee on 10 June 1997.

I am pleased to inform you that the proposal was approved. On behalf of the committee I would like to wish you every success in your studies.

Yours sincerely

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Confidential information hidden
ASSISTANT DIRECTOR
Confidential information

cc. Prof. D. Hughes

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Appendix D – Sample Consent

Appendix D

General Letter for Students, Physician Mentors and Teachers

David Barton

Lecturer to the Nurse Practitioner B.Sc.

I am currently undertaking a doctoral research project examining the developing role of Nurse Practitioners in the United Kingdom. The project is set to run over a two-year period, from commencement to conclusion of the first cohort of the new Nurse Practitioner B.Sc.

As you have been selected as a potential part of the population sample I would like to seek your consent to be involved in this project. This will involve two short interviews at the beginning and end of the course (arranged at your convenience) and, if you are a student to the course, I will be observing some taught sessions.

I have enclosed some brief information relating to the project which I hope is useful. I would also be happy to provide any further information in regard of this that you may wish to know. All information will be strictly confidential, data such as names, dates and events will be fully anonymous and you may unconditionally withdraw at any time, and request that data that may have pertained to yourself be removed from the project.

If you agree to participate in this study please sign the enclosed identical forms, return one to me and retain one for your information. The form asks for some basic details such as address and contact numbers.

Thank you for your help

David Barton

Appendix D

Letter for Senior Academics

David Barton

1999

Dear

As you know I am currently undertaking a research study for my Ph.D. entitled "Nurse Practitioners: Redefining occupational boundaries". The study has focused primarily on a longitudinal qualitative review of the experience of a specific cohort of students undertaking the Nurse Practitioner program, their mentors and the educators involved in the program.

It is clear that there is currently much topical and controversial debate regarding nurse practitioners, clinical nurse specialists and higher levels of practice. This is reflected within the School. As this study has progressed it has become evident that there is a demand for information to be collected from key influential members of the School to illuminate some of these wider issues.

I would like, with your permission, to undertake an audio taped interview lasting about 30 minutes with you. The interview would be semi-structured and would aim to elicit your personal views regarding some of these topical issues. All interview material will, of course, be completely anonymous and you may request any information to be removed from the study at any time.

The interview can be undertaken at any time over the next few months and at you convenience. I will call you to confirm whether you would be agreeable to this suggestion.

Yours sincerely,

David Barton

Appendix D

General Information for Sample

<u>**Project Title:**</u> The Nurse Practitioner: Redefining Occupational Boundaries?

<u>**Researcher:**</u> David Barton, M.Phil., B.Ed., Dip.N., R.G.N., R.N.T.

<u>**Research Aims:**</u>

The study seeks to explore the evolving Nurse Practitioner concept and role by means of a qualitative, inductive, comparative and longitudinal approach. The proposed research will employ an ethnographic case study approach reviewing the development and early experience of the new Nurse Practitioner (B.Sc.) degree course and its students. The framing of the emergent role will be examined primarily by studying the students, and this will be further illuminated by also assessing the views of educators and professional staff involved in the course.

<u>**Data Collection:**</u>

It is intended that data be collected by two means.

a) By short individual semi-structured audio taped interviews at the outset and completion of the degree program.

b) By researcher participation in taught educational sessions and the recording of pertinent ethnographic field notes throughout the two-year program.

<u>**Ethical Considerations:**</u>

Ethical approval has been obtained from the ********** committee. The researcher has discussed issues with the project supervisor and relevant individuals within the department to ensure that appropriate consent is obtained and ethical issues are addressed. All participants have been provided with brief details of the studies basic intent, outlined above, prior to the studies commencement with an option for more verbal detailed information. Participants are requested to give written consent, indicating their willingness to participate, by signing the enclosed form.

All individuals, and any data generated, will be anonymous and confidentiality assured. Any participant may unconditionally withdraw from the project at any time and data collected from that individual removed from the data set if they wish.

Interviews will be kept brief and informal and will be undertaken to suit the participant's timetable. All efforts will be taken to ensure there is no inconvenience to normal activity.

Appendix D

Consent for Participation

Project Title: **The Nurse Practitioner: Redefining Occupational Boundaries?**

Researcher: **David Barton**

I agree to participate in the above named research project.

I understand that I may unconditionally withdraw at any time, that all information and data will be treated in complete confidentiality, be fully anonymous and that data that pertains to myself may be removed from the data sets should I request it.

Name (Printed):

Post Held:

Date of Birth:

Address Home:

Address Work:

Telephone No. (Work and Home)

Signature:

Date:

Appendix E – Interview Transcript Extract

Appendix E

Interview Transcript Extract

First Interview Set

T2 = Teacher
I = Interviewer (Researcher)

Shaded areas indicated some examples coded segments as an illustration of the coding process. The coding list is reproduced below:

Sub-theme code and name	Issues	Code
A - Professional Definitions	Nursing Medicine Nurse Practitioner	A1 A2 A3
B - Professional Perceptions and Imagery	Traditional doctor and nurse (traditional stereotypes), new nursing roles, new images	B1
C - Healthcare Settings - Generalists and Specialists	Primary and secondary healthcare Generalists and specialists	C1 C2
D - Professional Identity and Boundary Conflicts	Merging / emerging / submerging / separating Membership	D1 D2
E – Hierarchies and Boundaries	Positioning / levelling / boundaries	E1
F - Attitude, Motivation, Power and knowledge	Ambition / positive and negative power Knowledge / skills / experience	F1 F2
G – Healthcare Professions and Healthcare Services	Regulation / legislation The healthcare market Standards / education	G1 G2 G3

PLEASE NOTE that the transcript in this appendix does not include all coded segments identified.

I - Tell me what you think nursing is?

T2 - I think that is a very difficult question.

I - OK - any general feelings about what nursing is?

T2 – It's a profession which involves interactions with people. Sometimes those people are sick sometimes their not. It involves, for me, the concept of caring - connecting with people in some way. It's a therapeutic activity. It has a body of knowledge. It has skills and competencies that are regulated by the nursing body - and that is important. It involves a specific training. I think that covers it - to some extent **(CODED A1)**.

I - In the light of that tell me what you think medicine is?

T2 - I think medicine is also a profession with knowledge, skills and competencies - possibly for the emphasis in terms of medicine is more to do with the physical - although it doesn't exclude other domains of psychological by any means. It is possibly more to do with diagnosing and curing as opposed to the more broad aspect of caring that I would see as part of the nursing paradigm. Obviously those boundaries are fluid because certainly medicine crosses those boundaries and so does nursing. But that's where both are meeting and that's the grey in between (visual hand demonstration). I do think that medicine, in terms of status is much more powerful than nursing - it has power at all sorts of different levels, legal powers, but also perceptions, peoples perceptions of what it is - what powers doctors are perceived to have. But the main difference is one of emphasis really. Both would be, hopefully therapeutic activities - but in different ways **(CODED A2)**.

I - In the light of that answer can you tell me what you think a nurse practitioner is?

T2 - For me a nurse practitioner operates in that particular grey area between nursing and medicine. I think nurse practitioners are taking on some of the competencies and tools that have been the preserve of medicine and their using them within their practice of nursing. So ideally it becomes a synthesis of the two - up to a point, because they wouldn't be fully doing doctoring work - but there would be areas where there would be a synthesis of medicine and nursing and that would be where aspects of nurse practitioning lie. I would hope that it would stay and remain very much holistic in terms of its nursing and therapeutic aspects and not fall into the slightly narrower viewpoint of medicine. That sounds very critical of medicine but its horses for courses - different people do different things. So there is an opportunity there for nurse to expand their skills, expand their competencies - to give them an possibility of a wider, a more holistic approach to patient care and to underpin that with a nursing and caring ethos - I would hope - but it is difficult to define **(CODED A3)**.

I - The next two questions are very much intertwined. What is your view of a nurse's role and how do you view the role of a nurse practitioner. Can you see a role for each - differentiate between them?

T2 - Well I think it is about level of practice really and also competencies in terms of decision making. I would see that a nurse practitioner is different from a nurse. In as much that she would have different and more advanced skills if you like **(CODED D2)**. She would have not different decision making skills, but her decision making skills would more sophisticated if you like. She would have possibly more autonomy because of that - because she is making more decisions. Because of that, she in a sense would have more power in her realm of practice. That is not necessarily power over patients, but power of determination and self determination. She would be practising skills that are not currently part of the nursing set in terms of history taking and physical examination skills and so on. She will have a holistic view of that as opposed to what some nurses do at the moment - honing in on a particular specialist area **(CODED C2)**. So she will have a broad understanding within those competencies. So yes she is different from the ordinary nurse - although she shares with her a number of characteristics she has also moved on from that - in terms, as I said, of her decision making, autonomy, self-determination and to some extent culture.

I - How do see the relationship between physicians and nurses?

T2 - In what context?

I - In very general terms, the professional relationship?

T2 - I guess there is a long history of what that has been. My hope is, and I have certainly seen that working with the nurse practitioners I have worked with, is that they will develop a much more collegiate relationship, that they will have a much more shared language and that they will learn from each other **(CODED D2).** Each would come with their specific skills, Each would take from the other. Whereas I think that nurses have seen that they could possibly learn a lot from doctors, doctors have never seen perhaps how much they could learn from nurse. Certainly not overtly - I think it has happened - but covertly, its not been recognised. What I do find with the nurse practitioners that I have worked with, that have gone through this training is that does actually happen - there is much more a recognition of each others skills and a respect for those skills - less of a hierarchical relationship between them. That grows in training - they certainly don't start of like that - that develops. I think it develops as the nurse practitioners begin to understand and be able to communicate in the language of medicine. That doesn't necessarily mean that they leave behind the language of nursing - but that is the bridge. The third language that develops is the collegiate one - where they can both see each have a lot to offer the other.

I - You have answered the next question (laughter) - what I wanted to explore next was the difference between the relationship between nurses and doctors and nurse practitioners and doctors?

T2 - Yes I do - I think I have just talked about that relationship. I think if I answer the previous question now - what I notice at the beginning of the nurse practitioner course is the relation between the mentor and the student is still very much two different cultures operating within their own boundaries and they are very reluctant and fearful to cross those boundaries - on both sides, but particularly on the nursing side. You get situations where nurse will not approach their mentor to ask them for what they need because that is not what happens between doctors and nurses. Nurses are told that they don't ask - that sort of thing. So I think that the relation between physicians and nurse, however friendly and pleasant and comfortable, is one of subordination. Where I really do see a change and a shift to a more equal relationship is with nurse practitioners. That culture change is just fascinating to watch. In a funny way I have had to go through that to as I have taught on the course and developed - that has been part of my cultural change to - because it is so ingrained in nursing when I was training – it is quite a shift.

I - Your very involved in the education process of this course - in general what are your expectations of the nurse practitioner degree?

T2 - Loads!! My expectation and hope is that it will produce, at the end of the course, a nurse practitioner who is confident, competent and who has an understanding of the different cultures of medicine and nursing and perhaps can be a bridge between them, be in that grey area in between. I suppose the worst thing that could happen, and in my experience it hasn't, is that nurse practitioners become what many people accuse them of - mini doctors - which for me means that they are powerful and less than sensitive to the needs of the patients. What I would hope is that they are very competent in what they do and that they retain that sensitivity to the patient. Therefore, together with their medical colleagues, offer better patient care. That they retain their holistic approach, if they had it, if they didn't have it, then they gain one. To care, not just in individual terms, but also care in terms of communities and families and the broader perspective of public health. Because I do believe, that given the change of culture they go through, that they can be very much innovators and work in a much broader scope then just identifying disease. Again that is born out by some of the nurse practitioners who have gone through so far. But it is a tall order.

I - Where do you see nurse practitioners in the future?

T2 - Well I suppose I have my official version and my private version - I don't know which one you want.

I – Both (Laughter).

T2 - My private vision is that all nurses in a sense should have the skills and competencies that a nurse practitioner has. That should be a part of basic nursing up to a point. Nurses could develop their interests to greater degrees - to further advance their level of practice. So my vision is that every nurse would have the empowerment, the skills, autonomy and confidence that I see nurse practitioners have - their relation with medical colleagues is a collegiate one - that's my private hope. I supposed on a more realistic level - how do I see nurse practitioners?

I - How do you see them in the future?

T2 - My sense is that with some political will this aspect of nursing will continue to develop. I think there will be many more nurse practitioners as nurses realise that they can do this. I don't see them necessarily as elite or super nurses or in any kind of hierarchical position. What I see is an opportunity for nurses to advance their practice and to stay with the patient. To continue their educational process and so on but to actually stay at the bedside, or wherever their practice happens to be as opposed to the best of us moving on to different things that no longer include patient care.

I – Thank You

Appendix F - Selected examples from a coded segment catalogue

Appendix F

Selected examples from a coded segment catalogue

Note – only selected segments are included as examples – this Appendix is not a complete coded catalogue.

Category Code D2 / Professional Identity – Membership

2nd Interview Set

M = Mentor
S = Student
T = Teacher
ST= Senior Teacher (Senior Academic)

M1 Interview D2 Segment 1

M1 I think that one of the worrying things about the nurse practitioner role is where you fit them into the system subsequently. There is a danger - whilst I don't think the course is perfect by any means - there are a lot of things that could be developed and integrated into it - I think it s perhaps going to over-train people. They are going to be so well qualified at the end of it that they are going to find that the career options open to them are going to be somewhat limited. They may be seen as someone who fulfils a basic role on a ward and they may not be able to develop those skills that they have learnt over two years.

M1 Interview D2 Segment 2

The key thing for me coming out of the course was that you are training people, and ultimately what is their designation. Can they develop what they have learnt or are they going to feel that going into employment on the basis of the degree is a backward step.

M1 Interview D2 Segment 3

I think you have to develop the role further and encourage them to examine patients, to feedback, to write in the notes and bring things forward from that point of view.

M1 Interview D2 Segment 4

DB Did you think that the course facilitated that?
M1 I think that the course facilitates that - but I am not sure what's available at the end of it will enable them to practice in that way. At least from what I have seen, but I have only limited exposure to how nurse practitioners function.

M1 Interview D2 Segment 5

M1 But judging from what we have seen here, the nurses that you have trained are beyond a nurse level.

M2 Interview D2 Segment 1

DB What is a nurse practitioner then?
M2 Having seen it - I would consider someone who has done the degree course as a nurse practitioner.

M5 Interview D2 Segment 1

DB What do you see Student X's role in the practice now she has completed the course?
M5 We see it as a nurse practitioner - someone who will be seeing emergencies, a role with some form of triage as well as some of the role that she would want to do - with certain clinics, supervising certain clinics. We would hope to use her as a morning and evening support for the surgeries.

M6 Interview D2 Segment 1

DB So as an experienced medical practitioner would you describe yourself as a supporter of nurse practitioners?
M6 In the hospital, if I were a consultant, I would probably not. As a GP I would say yes. As a junior doctor in a hospital I would say yes - because they would be very helpful - they support us and we support them. As a consultant no - as a GP yes, I would have them in my practice.

M6 Interview D2 Segment 2

M6 So from my point of view - yes I support nurse practitioners. But I am sure there are doctors who don't want them because they will erode the role of doctors.
DB So do you think it will take off in the UK.?
M6 I don't think it will be that quick because there are a lot of doctors who are very conservative and don't want change.

S2 Interview D2 Segment 1

S2 I think nurses are not as able to assess - I think doctors look at their practice - I don't think nurses do that well enough. The other thing I think is that the medics, rightly or wrongly, stick together through thick and thin - and that's how they are able to take themselves as a body to here they are. I think nurses have certainly got to get their act together more - have a bit more allegiance to each other. And that's because I have worked more with doctors now - trying to learn - and I see that about them.

S3 Interview D2 Segment 1

S3 My role hasn't changed. However I do see that some doctors treat me differently. They know that I have got a different knowledge of things - for example pharmacology. In that way it has changed. When they talk to me I can sense the difference. If there are three doctors together they will also talk to me. They know that I will understand. If I am on duty they will ask me directly if I can do things. It's difficult for me to say as I don't strictly have a nurse practitioner role - it's more a mentor thing.

S4 Interview D2 Segment 1
S4 - Initially when I started I was still a bit dubious - very much aware of this idea of nurse practitioners being seen as these mini doctors. I have gradually evolved during the course to realise that, or hope that I realise, as a nurse practitioner I hope to have the best bits of both to offer the role. But I still hope to retain my nursing philosophy and perhaps to draw out a greater depth of knowledge from the medical side of it.

S6 Interview D2 Segment
S6 I don't think any of us are sure what we are going to do. I have time now when I don't want to be a nurse practitioner. I want to go back to my old job - I knew what I was doing, I knew where the line was drawn. But now I have pushed out all the boundaries of that role - I have new job descriptions, new protocols.

S7 Interview D2 Segment 1
S7 - Because I am doing different things.... nobody actually asks me what I am doing - and I don't elaborate. From my nursing colleagues I get a kind of blank. Even doing a cannulation - it was

described as 'Oh she is doing a cannulation on the ward because its part of her funny course'. Right! Now my doctor colleagues are around like a rash and go 'Oh - let me help you'.

S7 Interview D2 Segment 1
DB Where do you see the nurse practitioner concept going?
S7 It's going to come into fruition - we are going to have medical and nurse practitioners - maybe they will change he role so that you don't have two - you just have one – eventually.
DB How do you mean?
S7 Well you have two similar professions in healthcare. So, you won't have medicine and nursing - you will have health care practitioners. It would be a new dimension.

S8 Interview D2 Segment 1
S8 There are so few of us? The validity of what we are doing? Is it valid to practice your nursing in this way? I don't know.
DB You question that (validity)?
S8 I do - but only because it has been flagged up by my colleagues as well. When somebody sows that seed of doubt you think 'is this the right way - am I doing nursing a favour here' - is nursing doing me a favour?

S9 Interview D2 Segment 1
S9 I have a clearer picture of what a nurse practitioner is. But there are huge differences in what they do depending on the setting they work in and the culture that they work in.
DB Do you see them as different from nurses?
S9 Yes I do see them different from nurses. I think I might have said this before. I feel that a lot of the views that I have come across about nurse practitioners is that it takes them away from nursing. You're not a nurse anymore. But I think it makes you a more holistic nurse, a better nurse.

S10 Interview D2 Segment 1
DB Do you think you're being led down the medical route?
S10 Well - maybe because that is the new learning I have got to do. I already have the nursing basis. So I am really concentrating on the bits I haven't got.
DB Does it worry you?
S10 Yes - it does a bit.
DB Why?
S10 Because I feel it is important - the nursing aspect - I don't want to lose it. It's more rounded having the nursing bit as well?
DB How do you see your relationship with physicians? Have things changed?
S10 Now?
DB Now - or in the future.
S10 Yes they have. I think I can understand more from where they are coming from. Because of that (pause) I don't know (pause) there is more communication that has maybe enabled me to communicate better with the doctors. They can see where I am coming from as well. I think they have more respect for your ideas and are willing to explore ideas with you about how you want to develop - you know you're not just a worker.