UNTIE MY HANDS: THE NURSE PRACTITIONER, THE RESTRICTION-FREEDOM PARADIGM AND LEGAL IMPLICATIONS OF PRACTICE

A Dissertation submitted by

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Abstract

The role of the nurse practitioner has been established in Australia since 1996 (Driscoll et al. 2005). During this time it has also been established that nurse practitioners provide a service that fills a gap in service provision (Gardner 2004). Nurse practitioners in Australia have proved themselves to be clinical experts in their chosen nursing field (Gardner 2004).

In 2006 (RCNA 2006), an article stated that in order to fulfil their role nurse practitioners argued that their hands were tied due to the need for strict adherence to clinical practice guidelines and protocols. They argued that a nurse practitioner's ability to use clinical judgement was inhibited by the need for strict adherence to clinical practice guidelines and protocols.

The above statements going to press provided the roots of this study, beginning with an historical-comparative examination of the emergence of the nurse practitioner role in five countries: USA, Canada, United Kingdom, New Zealand and Australia. These findings were compared using analytical comparison in relation to education, registration, regulation, legal and professional issues and future possibilities.

Field research examined the world of the nurse practitioner as seen through the eyes of four nurse practitioner participants in order to gain insight into this world, assisted by a qualitative interpretative approach and methodological theory. Data was collected from structured in-depth interviews using open ended questions.

Thematic analysis of the data, alongside nurse practitioner research, revealed that to allow less stringent adherence to clinical practice guidelines would seem unlikely at the present time. Important issues that are apparent in preventing this less stringent approach include the need to ensure that nurse practitioners are fully aware of the Ipp Reforms enacted into Civil Liabilities legislation in 2005 and the relevance of other Torts in the daily clinical practice of the nurse practitioner. This would ensure that all nurse practitioners are more knowledgeable about these important areas of law.

CERTIFICATION OF DISSERTATION

I certify that the ideas, experimental work, results analyses and conclusions reported in this dissertation are entirely my own effort, except where otherwise acknowledged. I also certify that the work is original and has not been previously submitted for any other award, except where otherwise acknowledged.

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Signature of Candidate **Date**

ENDORSEMENT

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Signature of Principal Supervisor **Date**

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Signature of Associate Supervisor **Date**

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CHAPTER 1 BEGINNINGS

"Let there be light, and there was light" (Genesis ch.1 verse 3)

1.1 Introduction

The role of the nurse practitioner has become an important role in nursing since it began in Australia in 1996 (Driscoll et al.2005) although globally the first initiatives were begun in the USA in the 1960s (Bigbee 1996 in Hamric, Spross & Hansen 1996 p.20). The role is a developing one within Australia and is identified by Gardner (2004) as one of the most exciting developments in nursing and healthcare over the last decade.

The thesis statement for this study is that the Federal and State governments have limited the legitimate freedom of nurse practitioners in Australia as nurse practitioners in other countries have been limited. This has occurred in tandem as the nursing profession in Australia has hampered the development and full implementation of the nurse practitioner role by restricting legitimate freedoms (e.g. the need to use compulsory clinical practice guidelines and protocols for every aspect of expanded practice). This is a form of intra-professional downward closure (Yuginovich 2009) and arises concurrently with the inter-professional downward closure demonstrated by the medical profession by their lack of support for implementation of the nurse practitioner role.

This study focuses on the nurse practitioner, the legal position surrounding advanced and expanded practice and the potential for increased litigation risks. To date, this legal position has received scant attention either through academic study or through

published articles. There is limited evidence to support opposition to the intra-professional downward closure from the nursing profession, or the inter-professional downward closure by the medical profession. Intra/inter-professional downward closure is a form of deliberate discrimination by treating one discipline within a clinical practice arena in a different way to others (Yuginovich 2009). When compared to nurse practitioners, other advanced practice nurses within Australia, such as physician's assistants, have not been subject to the same degree of intra/inter-professional downward closure as nurse practitioners.

A further issue for stakeholders, regulators and nurse practitioners themselves is ensuring that indemnity insurance, important to every nurse is adequate to cover compensation if patients are injured or harmed as a result of nurse practitioners' direct acts, omissions or actions. Indemnity insurance and the significance of adequate cover have also been poorly addressed in terms of the nurse practitioner and other disciplines of advanced practice nurses (Nursing and Education Taskforce Report 2005). Indemnity insurance is important when compensation in liability is calculated in a case of alleged negligence (Petersen in Freckleton & Petersen 2006, p.487) and as such, has the potential to affect the nurse practitioner because he/she could be a future defendant in an alleged negligence situation.

National Registration in Australia came into force in July 2010. New regulations mean that adequate indemnity insurance is compulsory for every health care professional in order to register. It is up to professional organisations working with their nurse members to ensure this is adequate for the purpose that the indemnity is intended.

National Registration is a Federal initiative in the form of The Australian Health Practitioners Regulation Authority (AHPRA 2010: no author cited). There is a professional register for all professional disciplines and also a specialist register (e.g. nurse practitioners). Eligible registrants can be registered on both of these. This initiative is governed by The Australian Health Practitioner Regulation Agency, which has Health Boards for individual disciplines within every state and territory within Australia (e.g. nurses, doctors and dentists).

This study does not seek to challenge the ideology upon which development of the nurse practitioner is built, but rather aims to shed light on some major problems that have so far not received much attention. Examples include the legal and professional issues facing the nurse practitioner and the lack of a theory of liability for nurse practitioners who may be unfortunate enough to be the subject of alleged negligence. Such a theory of liability could be a nurse practitioner's main defence (Baker 1992). The term theory of liability is somewhat ambiguous. For clarity the term legal responsibilities and accountability will be used, alongside the tenets of authority and autonomy as these are the co-constituents of a theory of liability. In terms of liability every registered nurse, regardless of status, carries liability for their erroneous actions (Forrester & Griffiths 2005).

All healthcare professionals, not just nurse practitioners, should be aware of the pitfalls of expanding their clinical practice due to an increased litigation risk, even though professionals might be prepared and willing to undertake such a challenge.

1.1.2 Aim of Research

The aim of this research is to place legal issues pertinent to the role and functions of nurse practitioners firmly at the forefront of debate, in order to create further awareness of the legal position derived from the increased litigation risks amongst the nurse practitioner workforce within Australia.

1.1.3 The Research Questions

The research questions for this study are:-

1. To what extent did nurse practitioner development, education requirements legal and professional issues differ historically between the five countries?

2. What do nurse practitioners believe are the most important legal and professional aspects of their practice?

3. What is the most appropriate approach to further enhance the professional autonomy of nurse practitioners in Australia?

1.1.4 Problem Statement

The Royal College of Nursing Australia (RCNA 2006) reported that nurse practitioners felt their hands were tied in terms of their development due to the need for them to adhere to strict clinical practice guidelines and protocols, thus reducing their own ability to assert clinical judgement when treating patients. This was suggestive of there being a lack of appreciation on the part of nurse practitioners about their increased liability and the subsequent increased litigation risk involved in any movement outside their scope of practice, prescriptive clinical practice

guidelines, local policies and protocols. In short, the RCNA (2006) suggested that nurse practitioners may have sacrificed an appreciation of the importance of law in nursing practice as a whole as shown by their desire for less prescriptive clinical practice guidelines and protocols.

There are 19 pieces of Commonwealth legislation that directly affect nursing practice in Australia prior to the commencement of national registration which occurred in July 2010. This legislation is proclaimed at Federal Level. There were 28 pieces of legislation specific to the Australian Capital Territory that directly affect nursing practice, 36 within New South Wales, 22 within the Northern Territory, 29 within Queensland, 29 within South Australia, 21 within Tasmania, 37 within Victoria and 26 within Western Australia (see Table of Statutes pp. XV-XXIV). Some legislation could be subject to change as a result of National Registration and its implications for change.

One potential problem is that should nurse practitioners ignore or are unaware of the place of law in their practice many of these pieces of legislation could become less important to them, but these will have a direct impact within nurse practitioner practice if acts, omissions or errors arise. The role of the nurse practitioner is practice driven but legislation that is directly related to clinical nursing practice should not be ignored.

1.2 Defining the Nurse Practitioner Role

For the purpose of this study Gardner's (2004) definition of the nurse practitioner is used:

> "A nurse practitioner is a registered nurse educated to function autonomously and collaboratively in an advanced and extended clinical role. The nursing of clients, using nursing knowledge and skills may vary and include, but is not limited to, the direct referral of patients to other healthcare professionals, prescribing medications and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practice (Gardner 2004 p.1)."

Research (Sherwood et al. 1997; Hughes & Carryer 2002; Gardner 2004; Gardner & Gardner 2005; Ball 2005; Gardner, Dunn & Carryer 2006; Ball 2006; Pearson 2007; Pearson et al. 2007) has shown that Nurse Practitioners offer a beneficial service and fill a gap in healthcare provision, both in primary and acute hospital care. There are several aspects of the nurse practitioner role that need to be borne in mind before any examination of this role is pursued.

1.2.1 Extended practice

The element that differentiates the nurse practitioner from other advanced nursing practice roles (e.g. physicians' assistants; clinical specialists) is that the scope of practice of the nurse practitioner is subject to different practice privileges that are protected within Australia by legislation. This includes the protection of the title 'Nurse Practitioner'. Extended practice is therefore defined by those elements of nursing activity that defer to a legislative structure outside the scope of practice of mainstream registered nurses (Gardner 2004, p.2).

1.2.2 Autonomous Practice

This is a key aspect of practice within the role of the nurse practitioner and sets it apart from other aspects of nursing practice in Australia. The nurse practitioner engages in clinical nursing practice with significant clinical autonomy and accountability, which incorporates responsibility for the complete episode of care. This means that every nurse practitioner accepts the need to act autonomously in decision-making and the follow-through in patient care. This autonomy is situated within a team approach to health services whereby the nurse practitioner works in a multidisciplinary team in a clinical partnership role that is aimed at good patient outcomes (Gardner 2004, p.2).

1.2.3 Nursing Model

The role of the nurse practitioner is located within a nursing model of care in that their clinical practice is about "clinical flexibility in nursing care" (Gardner 2004 p.2) and not about merely curative or treating a patient with a disease. Holistic care is part and parcel of the nurse practitioner remit. Evidence-based nursing practice is a feature of the nurse practitioner role, as is teaching in clinical areas and acting as a role model/ preceptor for junior nursing staff (Gardner 2004, p.2). Clinical flexibility refers to a nurse practitioner being able to autonomously respond to clinical care needs of patients under their care. This includes elements of expanded practice (e.g. prescribing) and extended practice (e.g. assessing, implementing and evaluating complex care needs). This mostly takes place without recourse to another health professional (Gardner 2004 p.2).

While researching the nurse practitioner role the researcher found a limited body of published literature relating to the legal position in the expanded practice of the nurse practitioner. Peterson (2006) provided one of the first direct references regarding the increased litigation risk for nurse practitioners owing to the expanded nature of the nursing role and the wider range of clinical activity undertaken (Petersen in Freckleton & Petersen 2006, pp. 487- 488).

1.3 Regulatory Frameworks

Published guidelines and regulatory frameworks published by the then nursing boards and councils in Australia (e.g. Queensland Nursing Council 2006) make little or no reference to the legal implications of role expansion. Legal references within such texts are limited to the citing of amendments to legislation that were made in order to allow the development of the role of nurse practitioner to become a reality.

This lack of attention to law presents a challenge in that other than Petersen (2006 in Freckleton & Petersen 2006) little attention to the main aspects of law that affect the extended and expanded nursing practice of the nurse practitioner has been identified in any literature. It appears that issues such as tort law, criminal negligence, fraud, theft, assault and battery have either been ignored, or assumed as previously understood by these nurses despite an expanded role that increases the risk of legal sanction where these issues may become relevant. The latter examples might be unlikely to feature in the work of a nurse practitioner but are worthy of mention.

1.4 Historical Comparative Research Methodology

Historical comparative research (sometimes referred to as comparative history or comparative historical research) was the method used to study the history of the emergence of the nurse practitioner role in five countries: The USA, Canada, the UK, Australia and New Zealand. The results of this research are found in Chapter 5. The history of the nurse practitioner and the emergence of the role is well documented (Bigbee 1996 cited in Hamric, Spross & Hansen 1996; Driscoll et al. 2005) but to the best of the researcher's knowledge the legal issues relevant to nurse practitioner development milestones have yet to feature in nursing research outcomes. Evidence of this is provided in the results shown in this study of five countries in the development of the role from their beginnings to the present day and within the literature review presented within this dissertation.

1.5 Analytical Comparison

Historical data obtained during this study was compared using analytic comparison, similar to that developed by John Stuart Mill in the 19th century (Neuman 2006). Analysis facilitated a comparison between those aspects of emergence of nurse practitioners that were 'in agreement' with other countries, and those aspects of emergence that were 'in disagreement'. In this way the common ground became apparent as did the areas where no commonality was apparent. One such area was education. In Canada, USA and UK, there was no compulsory minimum education standard that applies throughout the country. In some of these jurisdictions qualifications other than a nurse practitioner master's degree were acceptable. This

created an entry-gate with more than one portal, and thus a double standard (Canadian Nursing Association 2005; Ball 2005: Ball 2006 Pearson 2007).

1.6 Field Research

Field Research has been used to examine the world of the nurse practitioner, as seen through the eyes of four nurse practitioners. The sample consisted of two endorsed registered nurse practitioners and two second year nurse practitioner interns, who have yet to complete their degree and become endorsed as nurse practitioners. This phase of the study explored the issues identified by four nurses developing within the role of a nurse practitioner. In addition, these four nurse practitioners' views were sought about how their knowledge about legislation and law is in their daily practice and how relevant law is to them including their knowledge about legislation. In-depth interviews were utilised resulting in reports using the Parse Human Becoming Theory (Parse, 1995, pp 151-193) within the Restriction-Freedom paradigm.

Historians who have researched the establishment of the nurse practitioner role (Bigbee 1996 in Hamric, Spross & Hansen 1996; Hanson 1998; Castledine 1998 in Castledine & McGee 1998) have shown examples of the role of the nurse practitioner being grounded within the model of the aetiology of disease, disease management and treatment (i.e. the medical model). Research by later authors' shows through the restriction-freedom paradigm, that this is not the case in Australia (see Dunn 2004; Gardner 2004; Gardner & Gardner 2005). Restrictions occurred where identified medical control infringed on the clinical practice of the nurse practitioner role. The freedom element illustrated examples of clinical practice where medical control was

largely absent. This included examples where the nurse practitioner is giving guidance and direction to the doctor.

1.7 The Legal Position

The main legal issue within this study is focused on whether nurse practitioners within Australia are able to understand and appreciate the true legal implications of expanded and extended practice that encompass the role of a nurse practitioner. Nurse practitioners are carrying out tasks that may have been previously within the domain of medical practitioners (e.g. prescribing and ordering diagnostic tests). They are expected, as clinical experts, to carry out these tasks to the same exacting standards of medical staff and as such to demonstrate the accompanying accountability, responsibility. Competence for these tasks is identified in the Australian Nursing and Midwifery Council (ANMC) National Competency Standards for the Nurse Practitioner (2005).

The medical fraternity within Australia has consistently demonstrated strong opposition to the nurse practitioner role (Dunn 2004) yet historically and currently nurse practitioners are frequently utilised in rural and remote areas within Australia where there is a shortage of medical personnel, often working without the support of medical personnel. As Dunn (2004) pointed out it is time for all healthcare professionals to give a ‘Fair Go’ to the nurse practitioner and accept them as an equal partner within the healthcare workforce. Nurse practitioners are an adjunct to the medical practitioners and not a threat (Dunn 2004).

It appears that perhaps the nursing profession has failed in its support of the nurse practitioner (Gardner 2004). This was not assisted, in part, by the use of a varying nomenclature being attached to the role and causing confusion (Gardner 2004). Likewise, lack of nurse practitioner access to the Pharmaceutical Benefits System (PBS) and the Medicare Benefits Schedule (MBS) did not assist this either.

1.8 Examples of Legal Case Law to Illustrate the Legal Position

It is important to bear in mind that nurse practitioners and indeed many registered nurses, often work as members of multidisciplinary teams. An important, historical legal case illustrates the significant legal implications of this (*Wilshire vs. Essex Area Health Authority* All ER 1986 3; All ER 801 HL 1988; 1 All ER 871). This case established that team liability under law is questionable. In this case, a premature baby was placed in a special care baby unit staffed by a team consisting of two consultants, a senior registrar, several junior doctors and a group of nurses. A junior doctor inadvertently cannulated a vein not an artery meant to measure arterial blood gas levels. A more senior registrar missed this error and later repeated the error on the same baby when the cannula needed re-siting. As the catheter was in a vein and not an artery, blood gas levels were not monitored correctly and it was alleged that the baby later suffered an incurable condition of the eye resulting in near blindness. On the point of the standard of care the court held that there was no concept of team negligence in the sense that each individual team member was required to adhere to standards demanded of the unit as a whole.

The standard of care required was that of the ordinary skilled person exercising and professing to have special skill. The standard was to be determined in the context of

particular posts in the unit and not according to the general rank or status of people filling the posts. Inexperience was no defence in an action for negligence. The more junior doctor was thus found not to have been negligent because he consulted his superior. The senior registrar however had been negligent in failing to notice that the cannula had been inserted into a vein rather than an artery because the senior registrar was more experienced. Accordingly, the health authority was vicariously liable for the negligent actions of the senior registrar. The relevance of this case for the nurse practitioner is that when one exercises an increased level of skill commensurate with knowledge and experience a nurse practitioner could be culpable in negligence for any wrongdoing (Dimond 2004, pp. 43-44).

There are four elements in negligence that must be proven in order for a defendant to be held liable in negligence (Forrester & Griffiths 2005 p.5). These are:

- The defendant owed the plaintiff a duty of care
- The defendant breached the duty of care if it is proven that the standard of care was below that of a reasonable competent professional
- The plaintiff sustained a damage that was foreseeable
- The breach of the duty caused the damage

Although there is no concept of team negligence in law (Dimond 2004), each person who comprises the team is responsible for his/her negligent acts. This does not mean that instances never arise where multiple liabilities does not exist.

In the case of *Dwyer 1984 QBD*, Mrs Dwyer was prescribed medication for migraine. The pharmaceutical company that manufactured the medication stated that not more than four tablets should be taken for any one attack of migraine and that not more than twelve tablets should be taken in the course of one week**.** The doctor treating Mrs Dwyer had prescribed two tablets to be taken every four hours as necessary**.** The doctor prescribed a total of 60 tablets and in a very short space of time Mrs Dwyer had received a dangerous overdose of the medication. The doctor offered no explanation for this error. When the prescription was dispensed, two qualified pharmacists were in the dispensary, neither of whom noticed the error and simply repeated the doctor's instructions from the prescription onto the label of the tablet container (two tablets every four hours as necessary). The pharmacists accepted part liability.

Over the next six days Mrs Dwyer took 36 tablets. As a result of the irreversible ergotamine poisoning from this medication, Mrs Dwyer suffered serious personal injuries consisting of constriction of blood vessels and gangrene of her toes and lower limbs (Dimond 2004). In addition to suing her General Practitioner (GP), Mrs Dwyer also sued the GP's partner who saw Mrs Dwyer three days after she started taking the medication. The partner failed to realise that the prescription error had been made therefore did not stop Mrs Dwyer from taking the medication (Dimond 2004).

This was a prescribing error. Because many nurse practitioners are now licensed as prescribers, it is essential to realise the consequences of prescribing errors and why attention to detail and full knowledge of all the drugs prescribed is so vitally

important. This is essential when considering the prescription history of every patient treated. Additionally, accurate and timely documented records are essential. If a nurse practitioner is sued for alleged negligence, high standards of documentation in the recording of facts surrounding events and actions can be a distinct advantage when recalling incidents at a later date. Documentation that is accurate, objective and timely could be the best defence the nurse practitioner, or any other nurse, can put forward (Dimond 2004). If a nurse practitioner was to be in a similar position, they could be liable for sanction in litigation if there was evidence of erroneous prescribing.

1.9 Significance of the Study

The title of this dissertation is 'Untie My Hands'. Many nurse practitioners may feel that their practice is hindered, their hands tied and their judgement hampered by the restrictions imposed by having to adhere to so many clinical practice guidelines, procedures and protocols (RCNA 2006). The fact remains that their hands will continue to be tied for as long as stakeholders involved in setting standards, protocols and procedures for nurse practitioners are of the opinion that the 'rules' mean that a greater number of sanctions due to error could arise if these were made less stringent. This is a very relevant issue. All nurse practitioners are valued as clinical experts in their particular field (Gardner 2004) so it might seem at first that errors in judgement and actions in alleged negligence are unlikely. Healthcare regulators, employers and decision makers would also be culpable in negligence if such policies and protocols were to become non-existent or less stringent and a case of alleged negligence was then to arise.

The case of *Cassidy v. Minister of Health* 1939 (2 KB 14), illustrates this in relation to alleged negligence (Dimond 2004). A patient lost the use of his left hand and suffered severe pain as a result of alleged negligent treatment, following an operation on his hand. During trial the evidence showed a primae facie case existed in negligence on the part of the persons in whose care the patient was, though it was not clearly established whether the negligence was as a result of the actions of the doctor in charge, an assistant medical officer, the house surgeon or the nursing staff. Any hospital or community healthcare organisation will always be primarily responsible for any negligence to the patients in their care, whether the negligent person was an employee, a volunteer, or an agency employee (Dimond 2004).

1.10. Limitations

1. In terms of the historical roots of this study limitations presented in some instances in relation to access to primary sources of literature. This was due to the fact that a paucity of primary sources exists articulating the historical aspects of the development of the role especially the history of nurse practitioners in the USA.

2. A small sample of nurse practitioners was used in this study because at the time the field research was required there were only a limited number of suitable nurse practitioners who were sufficiently able/ willing to accurately articulate their practice journey. However similarly, the larger scale study by Gardner and Gardner (2005) had just four participants, the same number used in this study demonstrating that a small in-depth study can provide useful data.

At the time of obtaining the sample for the present study, several potential participants withdrew from the study as a result of feared sanctions from their employers if they agreed to participate. Although the sample size was small it did provide sufficient data to explore the importance of law in their practice. The consequences of this study may result in further debate and thus place legal issues at the forefront of debate and not in the background as at present. This is important in enhancing the autonomy of nurse practitioners.

1.11. Chapter Outline

Chapter 1 provides an introduction and sets the scene for the study. Chapter 2 presents an historical-comparative review of literature that encompasses the history of nurse practitioner development in five countries and aligns this development to present day issues. Chapter 3 introduces the Parse Human Becoming Theory, which was used as the methodological theory for this study (Parse 1995 pp. 1-7). Field research examined the world of the nurse practitioner as described by four participants and using the Restriction-Freedom paradigm within the Parse Theory (Parse 1995, pp.153-191). Chapter 3 also contains an overview of the Strong (2004) Model of Advanced Nursing Practice. Synergy between the Strong Model (2004) and the Parse Human Becoming Theory developed as each was explored.

Chapter 4 describes the research methodology used in this study and includes historical comparative research, analytical comparison, in-depth interviews and reports, an examination of why these methods were chosen and definitions of these research methods.

Chapter 5 includes the findings from the two phases of data collection. Phase 1 presents the results of the historical-comparative research and the analytical comparison. Phase 2 presents the results of the field research concerning the work of four nurse practitioner participants, which was completed using in-depth interviews and reports emanating from these in-depth interviews. Short discussions follow and research questions are answered directly.

The final chapter consists of overall conclusions from the study. The chapter also proposes a model for nurse practitioners, developed from the synergy between the Strong Model of Advanced Nursing Practice (2004) with the three main principles of the Parse Human Becoming Theory (1995). The ability of nurse practitioner practice to move away from medical control in patient management is presented. The conclusions from the study will be presented in this chapter with the recommendations emanating from the study.

1.12. Chapter Summary

In this first chapter the role of the nurse practitioner in Australia has been defined, with the chapter outline for this study. The legal position as applied to nurse practitioner work and the research questions that relates to this have been presented. Examples of case law have been used to demonstrate the links between extended and expanded practice and liability for nurse practitioners. This explains the legal position for the nurse practitioner why nurse practitioners could become culpable should a similar adverse situation arise. While none of the cases given as examples involved a nurse practitioner they serve to illustrate instances in which the more senior practitioner is at risk in litigation.

CHAPTER 2

AN HISTORICAL-COMPARATIVE REVIEW OF LITERATURE

"Dall Pob Angyfarwydd": Translated from Welsh: "All ignorance is blind"

2.1 Introduction

Worldwide, there has been much interest in nurse practitioner development, because this is seen as an effective approach in enhancing the quality of life for patients and clients (Sherwood et al. 1997; Dunn 2004; Gardner 2004; Gardner & Gardner 2005).

Literature responding to the key concepts of nurse practitioner, nurse practitioner development, nurse practitioner regulation and registration, legal issues, nurse practitioner history, advanced practice, education, support and opposition for the role of the nurse practitioner and competency standards were sourced. These sources included empirical studies, discussion papers, published reports, conference presentations, unpublished theses, nursing orations and text books. Relevant web pages such as The Australian Nursing and Midwifery Council (ANMC), The Canadian Nursing Association (CNA) The Royal College of Nursing (Australia: RCNA), The Royal College of Nursing (UK: RCN), University of Southern Queensland Library web pages and regulatory indices relating to states, territories, provinces and principalities (e.g. England and Wales) were also resourced. Search engines used included EBSCOHOST Mega File Primer including CINAHL. Year limiters involving the history and development of nurse practitioners were set at 1964 to early 2010. It was quickly identified that a paucity of information is available

about legal and professional issues directly relevant to the role of the nurse practitioner.

Inclusion criteria for the literature review included:-

- Relevance to the history of the development of the nurse practitioner in five countries.
- Relevance to regulation and registration of nurse practitioners in five countries.
- Relevance to educational requirement variables within five countries.
- Relevance to development of the nurse practitioner role in five countries.
- Relevance to support or obstruction to regarding nurse practitioner development.
- Relevance to expanded and extended practice and advanced nursing practice, including previous research in this area.
- Relevance to legal and professional issues in five countries.

Texts were reviewed in relation to the following key issues:-

- Peer reviewed articles and texts relative to the history of nurse practitioners in five countries.
- The research methods used by authors.

- Types of research undertaken that directly explored the role of the nurse practitioner.
- The range of issues explored.
- Supporting the answering of the research questions.
- Differing approaches to professional status within nursing.

Exclusion criteria included those texts that provided general information but did not directly inform about the nurse practitioner role or duplicated the data found in major research reports.

The critical indicators of all texts searched was how the role has developed over time in five countries, the differing approaches to nurse practitioner development regulation and registration, the timeline for nurse practitioner implementation within five countries, educational requirements and variables and legal and professional issues. The literature review examined each country in turn from the first country to implement the role of the nurse practitioner (USA) and onward to the most recent (Australia).

While at first glance some texts within this literature review might be considered outdated, historical-comparative research methodology requires the inclusion of such texts in order to provide the historical framework to enable the analysis. This involves examining texts from the past to establish the role of the nurse practitioner contextually in history to make connections and comparisons to present day contexts. The review ‘travelled’ from historical aspects to present day developments. Many texts examined present work that identified the first published texts on the history of

nurse practitioner development and involve those authors who supported and opposed nurse practitioner development. This chapter explores and critiques texts that are both historical and contemporary and compares findings under the above headings. Using this approach to explore the historical development of nurse practitioners within the literature review means that the historical-comparative research method becomes a main focus of the work.

2.2. USA

2.2.1 History

Bigbee (1996, in Hamric, Spross & Hansen 1996) explored the history of advanced practice nursing in the USA. A number of nursing disciplines were involved including nurse anaesthetists, nurse practitioners, respiratory nurses, clinical nurse specialists, physician's assistants and surgeon's assistants, because according to Bigbee (1996 in Hamric, Spross & Hansen 1996 p.20) all nurses who go on to specialisation in the USA away from mainstream nursing are classified under one umbrella of advanced practice nurses. Bigbee outlined the first formal nurse practitioner degree course in the USA, initiated by Ford and Silver in 1965 at the University of Colorado. Ford later said this about the nurse practitioner:

> "The nurse practitioner movement is one of the finest demonstrations of how nurses exploited trends in the larger health care system to advance their own professional agenda and to realise their great potential to serve society (in Hamric, Spross & Hansen 1996 p.20)."

However, as Bigbee (1996 in Hamric, Spross & Hansen 1996, p.20) stated, the legal and legislative history of nurse practitioners in the USA has been stormy. Ford (1965 cited in Hamric, Spross & Hansen 1996, p.20) was perhaps slightly naive in

understating the struggle that nurse practitioners had in becoming accepted by the nursing profession in the USA, in other countries and by society as a whole. The ability for nurse practitioners to realise their great potential to serve society is still to become reality in some countries, one of these being the USA.

There was considerable inter and intra-professional opposition, at the time of the inception of nurse practitioners in the USA, not only from other health professionals but also from other nurses. Rogers (cited in Hamric, Spross & Hansen1996, p.20) was one of the most outspoken nursing opponents and argued that the development of the nurse practitioner role was a ploy to lure nurses away from nursing and into posts resembling the physician extender model, thereby undermining the unique role of nursing in health care. This view caused division within the ranks of nurse leaders and nurse educators, preventing the further establishment of nurse practitioner courses as an integral part of mainstream nurse education (Bigbee 1996 in Hamric, Spross & Hansen 1996, p.20).

Over time, USA nurse practitioners proved that they provided a high quality of care using a nursing approach (Sherwood et al. 1997). This caused a shift of education for nurse practitioners towards master's level education, which served to reduce tension as this level was also demanded by other advanced nursing practice roles in existence at this time, during the 1960s (Bigbee 1996 in Hamric, Spross & Hansen 1996, p.21).

Other conflicts emerged, mainly with the medical profession and pharmacists. This opposition centred on a perceived loss of control on the part of doctors and pharmacists, due to the degree of independence given to the nurse practitioner and the fact that prescribing medication (albeit limited) had been envisaged as an

addition to nurse practitioner practice (Pearson 2007, p.1). Throughout the 1960s and 1970s conflicts intensified as nurse practitioners moved beyond the 'physician extender' model to a more autonomous nursing role, with their own caseload and holding patient consultations without reference to other healthcare professionals (Sherwood et al. 1997).

An example of this conflict was a landmark legal case, *Sermchief v Gonzales* (660S.W.2nd 683 MO 1983). This case involved two nurse practitioners charged by The Missouri State Medical Board to be practising medicine without a licence. The initial ruling supported the view of the Missouri State Medical Board, but on appeal the Missouri Supreme Court concluded that advanced nursing practice functions may evolve without statutory constraints (Bigbee 1996 in Hamric, Spross & Hansen 1996, p.21). Later this case supported more liberalised legislation. This was crucial in order to allow legislation that supported future nursing practice developments at an advanced practice level, within all advanced practice disciplines in the USA.

Bigbee suggested that in 1986, nurse practitioners faced a liability insurance crisis (in Hamric, Spross & Hansen 1996, p.22). Major malpractice insurance providers threatened to cease coverage for nurse practitioners or to dramatically increase rates for indemnity insurance. This crisis was preceded by a similar crisis amongst Clinical Nurse Midwives in 1985, creating awareness amongst nurse practitioners of the potential for problems in gaining indemnity insurance (Bigbee1996 in Hamric, Spross & Hansen 1996, p.22). Leaders negotiated reasonable cover for nurse practitioners, in various clinical settings. This was a rapid response to quickly meet the challenge of adequate malpractice insurance. At this time, nurse practitioners

became aware of the need for more sophisticated and accurate documentation and claims data relating to their practice (Sherwood et al. 1997). This may have been the beginning of informal professional recognition of a need for acknowledgment by nurse practitioners to formally identify their legal responsibility and accountability.

2.2.2 Development of the Nurse Practitioner Role in the USA

One of the most comprehensive reports within the USA, about nurse practitioner practice development to emerge in recent times was published by Pearson (2007), who is a nurse practitioner. This report was the first national overview of nurse practitioner legislation and healthcare issues in the USA and included an account of the formal opposition to organisational, legislative and regulatory changes affecting nurse practitioners. Not surprisingly, the major opposition to emerge came from the American Medical Association (AMA), both at Federal and State levels. This organisation wanted to limit nurse practitioner's scope of practice, limit the licence to practice and reduce nurse practitioner autonomy (Pearson 2007, p.1). This opposition by the AMA to limit practice licences was not confined to nurse practitioners or other nursing disciplines but also included other health professionals such as chiropractors, optometrists, occupational therapists, physical therapists, nurse-midwives and psychologists, indicating that the AMA was against any expansion of the scope of practice for all these disciplines (Pearson 2007).

Pearson (2007, p.1) asked several important questions and these are quoted below:

a) "Could nurse practitioner programmes be adequately supported and encouraged to provide nurse practitioner leaders in primary health care provision?" (Pearson 2007,

p.1 cites that one quarter of residents-in training in primary care positions are filled by foreign medical school graduates).

Would a change-over from medical residents training programmes to nurse practitioner training programmes encourage an expansion of primary care providers? (Pearson (2007, p.1) suggested replacing primary care physicians with nurse practitioners).

c) "Are nurse practitioners being utilised to their maximum potential both in medical centres and within the healthcare system (Pearson 2007, p.1)?"

d) "Does providing positions to develop foreign graduates as specialist physicians in the USA result in even further turf protection (Pearson 2007, p.1)?"

These questions raise some important issues, such as turf protection and nurse practitioners and a differing role for nurse practitioners to replace primary care physicians. Pearson (2007, p.2) assertively argued her case to replace physicians' training in primary care with nurse practitioner training in primary care.

While nurse practitioners have featured in the USA health system for over 40 years, the debate on doctor-nurse 'turf protection' continued to be contentious (Pearson 2007, p.1; Bigbee 1996 in Hamric, Spross & Hansen 1996, p.20). To suggest that a nurse practitioner programme becomes a substitute for a medical resident programme could become even more contentious, especially in terms of turf protection and the organisation of professional boundaries (Pearson 2007, p.1).

The literature indicated that educational and supervision requirements were inconsistent within states of the USA (Sherwood et al.1997; Pearson 2007). Not all

states in the USA required degree education for nurse practitioners at master's level. Some states accept a bachelors' degree and others a diploma (Pearson 2007) such as Hawaii and Washington. This inconsistency continues to cause problems and Pearson (2007) highlighted these differences through a state by state analysis.

Pearson (2007) as other writers (Hughes & Carryer 2002; CNA 2005) did not clearly identify in detail any current professional issues that directly affect nurse practitioner development. This is despite the fact that she provides long and detailed discussions about what she identifies as requirements for change.

Snook (2006), the then executive director of the Pennsylvania State Nursing Association, explored better utilisation of nurses and nurse practitioners in the USA and to a certain degree supports the findings of Pearson (2007). Snook advocated change for providing better primary care facilities within the state and outlined how Pennsylvania appeared to be out of step with the rest of the USA. The differences that she cited are:-

- A nurse practitioner is allowed to suture a wound at a hospital, but is barred, by State law, from performing this procedure at a health clinic (Snook 2006, p1).

- It is a crime in State law, for a nurse practitioner to treat infected toenails or remove moles, despite the fact that the state education programme trains nurse practitioners in these procedures (Snook 2006, p.1).

Limitations to practice, despite education and demonstrated competence, were alarming because it indicated inconsistency in education relative to what nurse

practitioners are allowed to do in clinical practice. In addition, such conditions implied that double standards existed between primary care and secondary care nurse practitioners. This may have arisen due to more direct supervision by doctors in secondary care than primary care. It raised the question about the motive for training nurse practitioners in such tasks and not allowing them to utilise these skills within every clinical setting and contributed to a further example of intra-professional downward closure (Yuginovich 2009). Snook (2006) raised further concern about the status of nurse practitioners and how they are utilised within the Pennsylvania healthcare workforce.

As an advocate of nurse-led primary health care, where there is a shortage of primary care physicians, Snook (2006, p.2) claimed that greater autonomy of nurse practitioners in nurse-led primary care could save money, providing the state is willing to amend health law that is restrictive to nurse practitioner clinical practice. Snook suggested that nurse practitioners should be recognised as sole primary care providers in nurse-led primary health care centres (Snook 2006, p.2). It is probably too impractical (regardless of a physician shortage) to ask primary health care leaders to adopt Snook's recommendations because until 2006, Pennsylvania had been reliant on physicians as major providers of primary health care and to recognise nurse practitioners as sole providers of primary care would change their current emphasis of physician-led care. An awareness campaign of nurse practitioner work would need to be undertaken beforehand. In terms of informing the public about what a nurse practitioner can do and what he/she cannot do and getting the public to better realise this potential. The public trust (which must include stakeholders) would

be vital (Snook 2006, p.2). The Pennsylvania Nurses Association could be trailblazers in this regard.

Reassurance of the medical fraternity by the nursing profession was required in terms of adequate training, authority, accountability and responsibility of nurse practitioners, so that any sanction through error will not fall to the medical profession to address (Snook 2006, p.2). It must be noted here that the rule of employee/employer vicarious liability varies in the USA on a state by state basis, in terms of who takes responsibility for the actions of whom, especially in health care and therefore indemnity insurance is an important issue.

Whether Snook will succeed in making this perceived change a reality remains to be seen. She nevertheless, provided a detailed example of what nurse practitioners problems were in the USA which provided a useful matrix for comparison for the present study.

According to Sherwood (1997 p.1) fifty eight million Americans had no health insurance coverage in 1997. People with no health insurance were forced to seek the services of primary care nurse practitioners (Sherwood et al. 1997 p.1). This situation reflected the inequity to health care within the USA at this time, in terms of people who have no health insurance (Sherwood et al.1997, p.1). Sherwood et al. (1997) stated that nurse practitioners in the USA have demonstrated the ability to provide care to many underserved groups such as children, women, migrant workers, the homeless and the elderly, in non-traditional settings.

Sherwood et al. (1997) stated that nurse practitioners are graduating in record numbers from USA Schools of Nursing. If this was the case, the validity of the USA replacing primary care training places for doctors with nurse practitioner training, as advocated in the Pearson Report (2007), comes into this debate, because this could become a feasible option especially if the numbers of physicians opting to specialise in primary care continues to fall. This debate continues to this day (Snook 2006; Pearson 2007; Stokowski 2010).

Stokowski (2010) reported that recruitment of primary health physicians continued to fall in the USA and adduced that nurse practitioners could fill the void left by low numbers of primary health care physicians. Stokowski (2010) described an almost identical debate to that of Sherwood et al. (1997) in that this was prevented by issues involving remuneration and the nurse practitioner scope of practice. There was no consensus within the USA in developing the scope of practice for nurse practitioners in primary care so that he/she could be fully autonomous, nor was there consensus regarding remuneration of the nurse practitioner as a primary provider of health care. These two factors were considered to be essential for a nurse practitioner to function within this vision (Stokowski 2010).

Whilst Sherwood et al. (1997) emphasised the many opportunities for nurses with advanced practice skills, they suggested it becomes imperative to resolve scope of practice issues for nurse practitioners. This could potentially gain public support to expand their role to meet much needed primary care services. These authors also mentioned an important issue that influences nurse practitioner work in the USA equally relevant in Australia in that nurse practitioners in Australia (as in the USA)

work in environments that restrict the scope of practice and thus limit their efficient use (Sherwood et al. 1997, p.2; Gardner 2004).

Unlike Pearson (2007) and Snook (2006) the most important aspect Sherwood et al. (1997) highlighted is actually an examination of the scope of nurse practitioner practice including the assessment of patients' health status, diagnosis and case management. The target population being served in the USA were children, women and the elderly. Clinical settings within the USA included health clinics, hospital-based skilled nursing facilities, age-related development centres, day-centre care facilities for the sick, correctional facilities, oncology clinics, paediatric clinics, high schools, colleges and emergency departments (Sherwood et al. 1997, p.2).

Brown and Grimes (1992, in Sherwood et al. 1997 p.2), compared the effects of nurse practitioner care with that of physicians in similar settings and noted that the nurse practitioner clinical outcomes were better than physicians, and there was better compliance with health promotion advice and treatment administered by nurse practitioners.

Historically, barriers to the expansion of the nurse practitioner scope of practice within the USA have been cited as being organisational medicine, lack of third party reimbursement, prescriptive authority and hospital admission privileges (Sherwood et al.1997 p.3). Despite the findings of Snook (2006) and Pearson (2007) little progress has been made within the USA in this regard (Stokowski 2010).

In some USA states, systems are utilised for prescription 'disimbursements' such as doctors pre-signing their prescription pads for nurse practitioners to complete at a

later time (Sherwood et al. 1997, p.4). The only states in the USA with unrestricted prescribing privileges for nurse practitioners were Alaska and Oregon, where the rule is ‘equal pay for equal services’ (Sherwood et al. 1997, p.5). Some medical insurance organisations awarded nurse practitioners 100% payment providing the work that they do would otherwise been performed by a physician (e.g. Medicaid), whereas other companies only reimbursed 85% (Sherwood et al. 1997, p.5). This resulted in some salary imbalances but with no reported difference in practice outcomes.

Limited prescribing in the USA meant that nurse practitioners were only able to prescribe on a prescription pre-signed by a physician (Sherwood et al.1997, p.6). This factor in itself was liable to misuse. This identified a further issue of improper use of prescription pads by doctors who were unwilling to allow delegated prescribing by nurse practitioners.

In the latter part of 2009, significant developments occurred. Stanley (2009) reported the outcome of a series of meetings of the National Council for Advanced Practice Registered Nurses (APRN). In 2009 universal agreement was reached by all delegates for a uniform approach to the regulation, registration and education of APRNs in the USA. All nurse practitioners and advanced practice nurses come under the APRN umbrella within the USA (APRN 2009). The implementation deadline set for these initiatives to be in place was 2015. This is significant progress in the USA for a universal approach to nurse practitioner development.

2.2.4 Legal and Professional Issues in the USA

Holder and Schenthal (2007) discussed an account of the nurse who first identified the importance of maintaining professional boundaries (Holder & Schenthal 2007, p.1). This is especially important when considering nurse practitioners' duty to protect the patient from inappropriate interpersonal relationships suggested from other nurses. Holder and Schenthal (2007) quoted Florence Nightingale who stated:-

> "I will abstain from whatever is deleterious and mischievous;
>
> I will maintain and elevate the standard of my profession;
>
> I will hold in confidence matters committed to my keeping in the practice of my calling;
>
> I will devote myself to the welfare of those committed to my care (Holder and Schenthal 2007, p.1)."

The above short statements refer to standards or boundaries relating to duties as nurses by Florence Nightingale. The American Nurses Association, in their *Code of Ethics* states:-

> "When acting within one's role as a professional, the nurse recognises and maintains boundaries that establish appropriate limits to relationships"

Such statements inform about what nurses needed to do but did not inform about what action to take in the many difficult situations that arose within the nursing profession. Nurses were sometimes at a loss about what action to take in some situations where an ethical or legal dilemma existed (Holder & Schenthal 2007, p.1). Nurses may be aware of a dilemma when witnessing an inappropriate relationship (particularly if a nurse involved is more senior or of the same rank) but do not know

what action to take because they have received insufficient guidance (Holder & Schenthal 2007, p.1).

Hospitals and health care organisations have done a great deal in setting standards to maintain professional boundaries and describing such actions to take through local policy provision that involve all staff disciplines. The conduct expected for all professionals, both in clinical practice and general conduct, is firmly laid down within policy and endures that all professional staff know what is expected of them. Holder and Schenthal (2007) failed to identify the impact that local policy achieves in this regard. The authors place an over-reliance on the Code of Ethics. A Code of Ethics informs about what a health professional should do, whereas a hospital policy informs a health professional what they must do. A health professional could ignore a Code of Ethics even though this is hazardous. However, to ignore a hospital policy could involve disciplinary sanctions and/or loss of livelihood.

2.2.4.1. Supervision, Power and Liability

An issue to be considered, in terms of inherent power differentials between the doctor and the nurse, was particularly important especially when a nurse practitioner is working in a doctor's office, directly employed by and accountable to, that doctor. This was very pertinent to the governance of nursing because the clinical supervision of such nurse practitioners within the USA was often the remit of a physician who was also the employer (Holder & Schenthal 2007, p.3) and the scope of practice may be dictated by that physician. The scope of practice is totally dependent in this context, how the physician viewed a nurse practitioner's scope of practice and

whether to expand or place limits on role extension and expansion (Holder & Schenthal 2007, p.3).

Another important legal issue that Holder and Schenthal (2007) omitted is that in a negligence case, a counsel for the plaintiff will attempt to ascertain if a defendant worked beyond the prescriptive remit of the scope of practice. If, for example, a nurse attempted to perform a task that he/she had watched but had no training in performance of the task, that nurse would be working beyond the prescriptive remits of a scope of practice.

If such a case is proven and a nurse did work beyond prescriptive powers, an insurer is not obligated to support the claim if a defendant deliberately went beyond the prescriptive remit allocated to the role (Freckleton in Freckleton & Petersen 2006, p.467). In a discussion about what nurse practitioners are not allowed to do (within a scope of practice) Snook (2006) suggested that working beyond powers is important if a nurse practitioner decided that it is within the scope of practice to perform certain procedures and legal sanctions arose as a result. Prior to this in 1992, Baker also explored nurse practitioners malpractice actions and the standard of care and legal responsibility and accountability required in advanced practice nursing. Today this remains an important source of reference because little written evidence is available about nurse practitioners acknowledging their legal responsibilities and accountability.

Baker (1992, p.2) included some relevant facts about the economics of nurse practitioner utilisation such as the overall cost of a nurse practitioner compared to a doctor. Nurse practitioners saved money within healthcare organisations due to lower

salaries than doctors and it cost less to train a nurse practitioner than training a primary care resident (Baker 1992, p.2). She stated that the biggest impediment to nurse practitioner growth may be organisational medicine (p.4). State medical boards had to resort to the courts in challenging the scope of practice. She cited some important legal decisions made in USA courts (Baker 1992 p.3).

In Arkansas, an important legal case arose (*Arkansas State Nursing Association v Arkansas State Medical Board*, 677 S.W.2nd 293 [Ark1984]) that involved the Medical Board in Arkansas attempting to revoke a physician's license by positing the notion that the physician had committed malpractice because he had employed more nurse practitioners than the board wanted. The court held that this medical board had no power to revoke the physician's license on these grounds (Baker 1992, p.4). Additionally in Louisiana, the State Board of Medicine challenged the statute that allowed nurse practitioners to practice in an expanded role (*Louisiana State Board of Medicine v. Louisiana State Board of Nursing*, 493 SO. 2nd 581 [Louisiana 1986]). The Medical Board claimed that the statute gave nurse practitioners the right to practice medicine and demanded a judicial review of the statute. The court refused judicial review because the statute had been on the statute books since 1981 without challenge and deemed that the period for challenge had elapsed (Baker 1992, p.3).

The American Nurses Insurance administrator, in the 1980s (Maginnis and Associates) informed the American Nurses Association (ANA) that it would no longer accept new applications from nurse practitioners, because it had decided not to accept the risk of insuring such nurses working in an expanded role. Maginnis also informed the ANA that nurse practitioners already insured with them would face

much higher premiums based on their area of employment and experience rating. This move occurred at the same time as the medical profession was facing a malpractice crisis (Baker 1992 p.4).

Nurse practitioners attempted to guard against malpractice claims, by various means of self-regulation. Regulation and discipline of the nurse practitioner was accomplished through the state boards of nursing. The policy of such state boards was to insist on minimum education levels required for licensure and these regulations were not written to establish practice standards. These regulations varied considerably between the states. In Ohio, the role of the nurse practitioner was not addressed through the legislative process. This meant that the scope of practice and standard of care are not defined within statute (Baker 1992, p.4). This left a nurse practitioner at great risk in litigation within the state of Ohio, as there was less control over scope of practice and thus left any nurse practitioner more vulnerable to a malpractice claim.

Baker (1992 p.4) asserted that clearly defining in statute what a nurse practitioner was able to do, what a nurse practitioner was unable to do and to also define the professional boundaries, in terms of situations where a nurse practitioner must refer to a physician is fundamental to the identification of an appropriate theory of liability and standard of care. However, in practical terms this assertion may be difficult to achieve, especially when so many scopes of practice exist and nurse practitioners may be sole providers of a service where no doctor is accessible, such as in rural and remote areas. The need to access medical practitioner care would rely totally on the clinical judgement of the nurse practitioner. The clinical management scenarios that

would need to be identified in statute could be too numerous in these cases. The current system of using clinical practice guidelines and protocols may be more suitable and probably just as effective.

If implementation into statute did not occur, Baker (1992) stated, it would be difficult for courts to say if a nurse practitioner was indeed acting within a scope of practice or if the standard of care was breached. In this regard, the use of clinical practice guidelines and protocols defined the required action to be taken (e.g. the use of opiates for emergency pain relief). Although Baker (1992, p.4) stated that nurse practitioners needed a theory of liability and a need to recognise legal obligations and accountability as a means of defence in litigation, she made little reference to important content needed within this theory. Baker (1992) failed to address the importance of the scope of practice, the nurse practitioners' drug formulary or the regulatory requirements for registration and underpinning knowledge required to achieve this. These were all key elements to be considered in a theory of liability. There was some reference to what a nurse practitioner ought to do, or should do, but this was not enough information and justifies the need for this study.

2.2.5 Education of Nurse Practitioners in the USA

Pearson (2007) identified the educational qualifications required by registered nurses within the USA in order to obtain licensure as a nurse practitioner in the USA. That not every state required a degree at master's level did not appear overly contentious but criticism did exist on the part of the American Medical Association (AMA) (Pearson 2007). As Pearson (2007) pointed out, the AMA seemed to centre on what nurse practitioners did that affected medical practice and not how a nurse practitioner

obtained a license to practice or whether a nurse practitioner had a postgraduate Diploma, Bachelor's degree or Master's degree. This meant that medical staff were more concerned with what nurse practitioners were permitted by law to do and less concerned with the underpinning preparation and required knowledge and competence that a nurse practitioner possessed in order to obtain a licence (Pearson 2007).

Of the 52 states in the USA, 13 did not require a master's degree to become licensed as a nurse practitioner. Instead they offered alternative courses at bachelor's and diploma level. Ohio had no rules of governance for nurse practitioners within legislation. Examples of other states that do not require a master's degree included Hawaii and Washington (Pearson 2007).

Sawyer et al. (2000) evaluated the National Organisation for Nurse Practitioner Faculties Standards (NONPF) and suggested that the term Faculty Practice (in terms of Nurse Practitioner Faculties Standards) meant formal arrangements that existed between a clinical setting and a university, which allowed nurse academics to consult and deliver client care resulting in research and 'scholarly outcomes'. Attempts had been made to bridge the gap between academe and the clinical setting but these authors advocated further utilisation of the joint appointment role, where a professional spent equal proportions of time in both university and clinical setting. Sawyer et al. (2000) adduced that this could be advantageous in supporting the role of the nurse practitioner within the USA in enhancing the educational profile of nurse practitioners.

Pearson (2007) largely ignored education needs, apart from identifying qualifications for licensure that are required within each USA state. This was unfortunate because Sawyer et al. (2000) had advocated a way of addressing some of the issues mentioned by Pearson (2007). That the findings of Sawyer et al. (2000) have not been further explored in the USA gives rise to the impression of policy makers being uninterested or ignoring the need for bridging the clinical/academic gap, especially involving nurse practitioner practice. When considering the overall focus within the USA, Sawyer et al. (2002) made a valid case for increasing the professional bearing of nurse practitioners in the USA by utilising the joint appointment because nurses tenured in such positions will also be supported by academic institutions.

2.3 CANADA

2.3.1 History

The development of the nurse practitioner role in Canada can be traced back to the late 1960s (Canadian Nurses Association (CNA) 2005). This evolved as a result of nurses in Canada changing nurses' roles and extending their practice. At that time, there was a perceived shortage of physicians with a movement of physicians toward specialisation rather than generalist physician roles in primary care. Whilst there was general recognition of the need for the nurse practitioner role at that time there was very little movement toward legislation making provision for role development, or regulation to protect the public from unsafe practice (CNA 2005).

In the 1970s, several institutions began development of education programmes for the preparation of nurse practitioners, but without the support of either legislation or

regulation (CNA 2005). Most graduates of these programmes worked in-the-role, in posts that resembled an envisaged nurse practitioner role. Working-in-the-role described a nurse who is working in an as yet, untitled role that broadly resembled a role envisaged by an employer, such as a nurse practitioner. An example could include trainee nurse practitioners whose duties resemble that of a qualified nurse practitioner, but with much more direct supervision by medical staff or qualified nurse practitioners. Such nurses maintained licensure as registered nurses only and work under delegated medical or more senior nurses' control. The nurse practitioner role relied heavily on physician collaboration and supervision, particularly in urban areas. By the 1980s, most of the earlier initiatives to develop nurse practitioners had disappeared (CNA 2005).

In the 1990s, further interest in the nurse practitioner role developed as a result of a revision of healthcare provision in Canada, with a shift toward primary health care and a change in how the Canadian health care system was to be funded (CNA 2005). This led to more provinces and territories pursuing legislation in order to support nurse practitioner role development, regulation and education. This included a defined scope of practice (CNA 2005). In rural areas of Canada there were inequalities in access to primary health care and the role of the nurse practitioner was seen as an adjunct role that would assist in improving access to primary care (CNA 2005).

Nurse practitioners were seen as a means to change these inequalities. Again, over time, as in the USA, nurse practitioners proved their value as an important resource

that is able to contribute to improved access to health care for Canadians (CNA 2005).

This is borne out in the findings of the Burlington Randomised Trial (1972 cited in Sherwood et al.1997). This was a trial that examined the role of the nurse practitioner in primary care that existed at this time. Findings showed nurse practitioners in primary care looked after 67% of patient visits without recourse to a primary care physician. Nurse practitioners were also found to have referred 33% of the patient population to a physician. These examples reinforce the nature of nurse practitioner work, which allowed for clinical judgement but also nurse practitioners were cognizant about where their role must cease and physician intervention sought (Sherwood et al. 1997 p.2).

2.3.2 Development of the Nurse Practitioner Role in Canada

The above implementation may seem too simplistic, if CNA (2005) is to be believed. The transcript from a Canadian Television network provides a contrary view (*CanadianTelevisionNews*(www.ctv.ca/ArticleNews/story/*CTVNews*/20051011/nurse_practitioners_ - accessed 9 June 2008). This transcript stated:-

> "The number of nurse practitioners working in Canada may be slowly increasing, but health officials say there are still significant obstacles to the profession receiving full acceptance within the health care system"

The controversy centred on doctors not wanting to employ nurse practitioners within primary care and the Canadian nursing unions claiming that nurse practitioners were 'wannabe doctors'. This was attributed to Duffy, of the Prince Edward Island Nurses Union. This was reported in the CNA findings (2005 p.9).

In parts of Canada the Medical Society opposed the nurse practitioner programme because the Society had doubts about the scope of practice and feared the encroachment of nurse practitioners undertaking tasks that were traditionally within the domain of doctors (Canadian Television 2005, p.2 no author cited). These tasks were the same as in the USA (Baker 1992; Sherwood et al. 1997, p.1). One doctor, cited in this article, whose name was not given, was quoted as saying to the media:-

> "If you want good care, come to me, not them. Well, people trust doctors"
> (Canadian Television 2005, p.2).

There was some success in Ontario and New Brunswick (Canadian Television 2005, p.2), where nurse practitioners were utilised to assist the doctor shortage in rural areas as has occurred in Australia (Driscoll et al 2005). Ontario encouraged the development of family health teams that include GPs, practice nurses, nurse practitioners and other specialists, providing a range of health services in one location (Canadian Television 2005 p. 2). This was the only document that provided any written evidence to opposition to the nurse practitioners role in Canada. Though this paper is not peer reviewed it is relevant as many nurse academics contributed to the discussion within the original broadcast, in 2005.

Knock (2005, p.2), of the Canadian Nurse Practitioner Initiative, stated that the key to successful implementation of the nurse practitioner role was to lay the groundwork for their arrival so that the public and other health professionals clearly understood their role and their abilities. She stated that we (Canada) needed a common curriculum for training nurse practitioners, a national examination and better funding

models for positions. She also emphasised the need for consistency so that the public knew what the credentials are across the whole country (Knock 2008 p.2).

Sangster-Gormley (2007) emphasised the need for the nursing profession in Canada to realise that health policy, at both provincial and national level, was influenced and strengthened by evidence related to outcomes of nurse practitioner practice. She stated that one of the key initiatives of the College of Nurse Practitioners in Nova Scotia was to provide stakeholders (including government, registered nurses, nurse practitioners, employers and other health professionals) with access to written evidence of the contribution made by nurse practitioners to health outcomes (Sangster-Gormley, p.1). Her overview of nurse practitioner outcomes was sensitive to the practice of nurse practitioners daily practice.

The context of the word 'sensitive' related to findings of research directly related to nurse practitioner practice that the author undertook by reviewing research articles and discussion papers relevant to nurse practitioner clinical practice (Sangster-Gormley, p.1). She stated that The Nursing Role Effectiveness Model (NREM) showed that much of the early research on the outcomes of nurse practitioner practice lacked a theoretical framework and failed to demonstrate a relationship between interventions and outcomes of care, as well as the inability to differentiate outcomes directly attributable to the nurse practitioner (Sangster-Gormley p.2).

None of the articles or discussions papers reviewed by Sangster-Gormley (2007) featured literature from Australasia, despite the author's claim that all available articles were reviewed. The research of Gardner et al. (Australia) and Hughes and Carryer (New Zealand) was available at this time but was not examined.

While Sangster-Gormley's (2007) research had a North America bias, both favouring the USA and Canada with one or two outside, from the UK, the review did provide conclusive data about the growing body of evidence in North America supporting nurse practitioner practice and demonstrated that nurse practitioners improve access to healthcare, improve health promotion activities and resulted in good health outcomes for patients.

2.3.3. Legal and Professional Issues in Canada

In 2006, The CNA published a Toolkit for Nurse Practitioners. In section 3 of this toolkit (p.26) is a section entitled 'Understand the Legal, Professional and Regulatory Environment for the Nurse Practitioner Role'. Key questions were asked of nurse practitioners:-

1. Have you ensured that the vision for the nurse practitioner role in your practice setting is consistent with federal and provincial regulations and guidelines?

2. Have you considered any union issues that may influence the implementation of the role?

3. Do all members of the health care team have liability protection?

4. Are members of the health care team aware of the additional authorities (e.g. diagnosing, ordering and interpreting diagnostic tests and prescribing) that the nurse practitioner is authorised to perform?

5. How is clinical competency monitored in your practice setting? (CNA Toolkit p.26).

The key steps to be undertaken to address the five key questions was then given. This empowered the nurse as they researched and provided key written evidence concerned with province/territory regulations, guidelines and standards concerning nurse practitioner practice. The key steps involved ensuring sufficient information was known about educational requirements, licensure regulation and guidelines for collaboration, clinical supervision and independent practice. Indemnity issues were addressed as were the implications of joining a trade union and the implications for that union involving a member holding a new developing position within a health care organisation. Dissemination of this information to colleagues within the clinical setting, including senior colleagues, peers and subordinates was recommended (CNA Toolkit 2007 p.27).

In addition, the document identified potential pitfalls for the implementation team to consider. One such issue was that that the envisioned nurse practitioner role may not meet the federal and provincial/territorial regulatory and professional standards. This encouraged organisations to look at the nurse practitioner role they envisaged and take steps to ensure the role complied with requirements before implementation (CNA Toolkit p.27).

The toolkit was designed as guidance for newly registered nurse practitioners and their employers to assist in the successful implementation of new nurse practitioner positions. The document provided very helpful guidelines about legal and professional requirements. The document informed the reader about how to successfully implement a new nurse practitioner position within a clinical setting in very specific terms. However, the document assumed that the people concerned have

direct access to a company lawyer knowledgeable about the process of implementation of new posts that was available within the workplace (CNA Toolkit 2007 p.27). Such people are very fortunate to have this advantage. Not all the countries, especially New Zealand and Australia, have direct contact within the workplace with a company lawyer.

The document did not identify the legal implications of opposition to the role from other key personnel such as medical staff, which was apparent in the Canadian Television Transcript (2008). There was no reference to assisting with conflict resolution. Nevertheless the Toolkit did provide a resource that other countries could examine, because it is so detailed.

In 2005 the Canadian Nurses Protection Society (CNPS) and the Canadian Medical Protection Association (CMPA) collaborated on a joint statement on liability protection for nurse practitioners and physicians in collaborative practice. This was the first piece of written evidence the researcher discovered that identified nurse practitioners and physicians working together to define their responsibilities when working collaboratively. The society identified liability risks such as medical malpractice and stated that a finding of negligence by a court may have a financial impact on the defendants in three ways:-

1. Direct Liability: each health care professional, both individually and as a member of the collaborative practice team, is accountable for his or her own professional practice. Therefore if a nurse practitioner or physician is found to have been negligent, a court may award damages to a plaintiff that is paid directly to the

plaintiff by the defendant. This form of liability is direct liability (2005 CMPA/CNPS Joint Statement p.1).

2. Vicarious Liability: If an employee is found negligent, the court may order that damages be paid by the employer pursuant to the doctrine of vicarious liability. This legal doctrine provides that an employer, which may be an individual or an organisation, can be held financially responsible for the negligence of its employees. An employment relationship must have existed at the time of the incident and the defendant employee must have been sued for work done within the scope of his or her employment. It will be up to the court to determine in each case if an employee/employment relationship existed. Additional factors for consideration would include the level of control an employer had over an employee and contractual arrangements which demand that a defendant follows the employer's policies and procedures (2005 CMPA/CNPS Joint Statement p.2).

3. Joint and Several Liability: When a court finds more than one defendant negligent following an incident, the court will assess the amount (often expressed as a percentage of the total damage award) to be paid by each defendant. Defendants can be jointly and severally liable for the damages awarded. This means the plaintiff may recover full compensation from any one of the negligent defendants, even though that defendant may then be paying for more than their share of the damages. That defendant may then seek contribution from the other negligent defendant(s) (2005 CMPA/CNPS Joint Statement p.2).

For this reason, it was essential for physicians and nurse practitioners working in collaborative practice to verify that all members of the collaborative practice team

and the facility or provider organisation have adequate professional liability protection in place at the beginning of the work relationship and on an ongoing basis (2005 CMPA/CNPS Joint Statement p.2).

The statement did not cover employees that a nurse practitioner might hire (e.g. phlebotomist) and the fact that the nurse practitioner was vicariously liable for any employees he/she hired under Canadian Law. The statement recommended commercial insurance from the CNPS group insurance plan (2005 CMPA/CNPS joint statement p.3).

The joint statement identified the following steps to help decrease risks amongst nurse practitioners and physicians who work collaboratively:

- Have appropriate and adequate professional liability protection and/or insurance cover.
- Confirm that colleagues also have adequate professional liability protection and insurance.
- Contact CMPA/CNPS directly to discuss issues related to collaborative practice and the extent of assistance available.
- Schedule periodic review of indemnity and professional liability protection (2005 CMPA/CNPS Joint Statement p.3).

The Joint Statement provided adequate advice for collaborative practice. In addition the statement made provision for independent nurse practitioners by using a business entity, such as an incorporated company that independent nurse practitioners were

able to set up themselves. This was covered by the CNPS and covers liability claims and professional discipline defence costs via CNPS Plus. This was a mechanism for additional provisions and provided a CNPS group insurance plan (2005 CMPA/CNPS Joint Statement p.3).

The statement is very didactic and impersonal. There was no reference to conflict resolution nor was there any reference to what constituted malpractice, only about liability and damages. The statement assumed that nurse practitioners and doctors were fully cognizant about what constituted malpractice. The CNA (2005) competency standards contained a standard that dealt with knowledge of legal issues and this assumption was probably fair, but did not take into account personnel who graduated overseas and were licensed with overseas qualifications that might not have reached the same standards of underpinning knowledge.

2.3.4. Education of Nurse Practitioners in Canada

The CNA reported (CNA 2005) that at this time only 23% of nurse practitioners in Canada were educated to master's degree level. As a result of a committee (Nurse Practitioner Initiative (NPI) 2007) master's degrees have been developed for many courses in Canada that were previously at bachelor's level (NPI 2007). Various groups within this initiative, formed from practitioners, managers and academics, researched the various requirements for all provinces and territories in Canada to adopt similar approaches to the regulation, registration and education of nurse practitioners in Canada. This was a similar approach to the ongoing initiative within the USA.

2.4 UNITED KINGDOM

2.4.1 History

The claim that the role of nurse practitioners originated in the 1960s in the USA (Bigbee 1996 in Hamric, Spross & Hansen 1996) is debatable. Abel-Smith (1979, p.53-54) actually identified a nursing role that began in the early 1900s. According to Abel Smith (1979) these were 'Lady Nurses' and they emerged after society recognised the value of skilled nursing. Lady Nurses differed from district nurses in that they did not work under the direct supervision of a doctor and more importantly, were independent practitioners within nursing and were trained 'scientifically' (Abel-Smith 1979, p.53). Such nurses were usually employed directly by householders to nurse family members (Abel-Smith 1979).

It must be remembered that in the early 1900s the UK nursing profession was not regulated and the Nurse Registration Act was not proclaimed until 1919 (Abel-Smith 1979, pp.96-98). Additionally, hospitals in the UK did not enjoy the prestige that they do today and skilled nurses often preferred nursing patients in their own homes, rather than work in sub-standard conditions in hospitals (Abel-Smith 1979, p.53). It is conceivable that Lady Nurses were the first early evidence of a nurse practitioner role in the developed world due to their ability to work autonomously within the sickroom and independently from medical personnel.

Expansion of the role of mainstream nursing in the UK did not attract formal attention until Castledine (1982 in Castledine & McGee 1998, p.33) surveyed nurses who claimed to work in a clinical specialist role with an expanded clinical remit over

and above that of mainstream nurses. This research was the first formal study undertaken to define the range of expanded nursing practice being undertaken within the UK. The nurse practitioner role was being examined at this time, in terms of the feasibility for development within the UK. Castledine was opposed to the development of the nurse practitioner role within the UK (Castledine in Castledine & McGee 1998, pp. 47-48). His research was of no advantage to those nurses and stakeholders who were keen to develop the role of the nurse practitioner.

The grading of advanced practice roles in the UK was an issue (Castledine in Castledine & McGee 1998 pp.47-48). Nurse specialist roles were very developmental at this time and scant attention was paid to remuneration. Such nurses tended to work outside the grading remit of ward managers and charge nurses. Such specialist nurses were subject to the clinical grading exercise in the 1980s where nurses were graded by seniority by letters A to I, with I grades being the most senior. Specialist nurses did not fit easily into any category and many clinical specialist roles failed to meet the criteria matched to senior nurses' clinical grading (at G, H, or I grade). This resulted in senior clinical specialists being paid at the lower salary points within clinical grading, usually deputy ward manager grade, at grade F. This was an extremely contentious issue at the time the clinical grading exercise was undertaken within the UK because of the lower grading of advanced practice roles (Castledine in Castledine & McGee 1998, p.34-35).

2.4.2 The Scope of Professional Practice

Role expansion for nurses developed further as a result of the Scope of Professional Practice published by the then United Kingdom Central Council for Nursing and Midwifery, in 1992 (UKCC 1992). This scope of practice replaced previous guidelines from government about extending roles for nurses. Ground-breaking research, done by Greenalgh (1994) further developed this work. Greenalgh (1994) was the first UK nurse to define the difference between role extension and role expansion. Greenalgh (1994) defined role extension as nurses accepting new tasks, frequently delegated to them from other groups and involving some form of technical skills, training and competence. Greenalgh (1994) defined role expansion as the decision to learn based on each practitioner's situation: the nurse is learning as a direct response to health needs of patients within the clinical setting. As a consequence expanded practice forms the roots upon which the eventual development of nurse practitioner practice grew, by means of clinical practice guidelines and protocols that involve expanded practice branches in response to the needs of patients. In order to fully appreciate the developing role of the nurse practitioner it is vitally important to fully appreciate the difference between extended practice and expanded practice.

2.4.3 The Growth of the Nurse Practitioner in the UK

Castledine (in Castledine & McGee 1998, p.47) explored the growth of the nurse practitioner role in the United Kingdom. Growth in this context concerns how a nurse practitioner is utilised within the healthcare workforce. Castledine (1998 p.47) stated that the term 'nurse practitioner' describes nurses who have taken on new

functions specifically related to medical knowledge and medical tasks and that 'nurse practitioner' is an abuse of the term. He argued that there was no universally accepted definition of a nurse practitioner and that the title had been used to describe any nurse, regardless of discipline or field of nursing. Castledine failed to grasp that nurse practitioners, then and now, work with an ethos of caring and a nursing framework and not within a medically controlled ethos and therefore the clinical practice of a nurse practitioner is not dependent on supervision by a medical practitioner (Gardner 2004; Ball 2005; Ball 2006). Castledine (p.47) explored the various clinical settings where a 'nurse practitioner' is known to function as an advanced nurse practitioner: in GP practices assisting with chronic disease management and as night duty nurse practitioners assisting doctors with cannulation, ECG recording, male catheterisation and confirming expected deaths (Castledine in Castledine & McGee 1998, p 48).

One key argument that Castledine made which is still relevant today, is that nurse practitioners may be putting their careers at risk by ending up in a career 'cul-de-sac' as a result of being cut off from the mainstream of nursing development and career opportunity. Castledine argued that nurses in such roles should be seeking clarification about which aspects of their role require medical judgements and which require nursing judgements (Castledine in Castledine and McGee 1998, pp.47-48). Nevertheless, evidence of the 'cul-de-sac', in terms of professional isolation of nurse practitioners, is very relevant today and should to be addressed by employers of nurse practitioners.

Tye (1997) gave a totally different account of nurse practitioner development in the UK in terms of accident and emergency nursing (A/E) when compared to Castledine and McGee (1998). Tye stated that this role had attracted increased attention, driven by steadily rising attendance figures against a backdrop of medical staffing shortfalls, skill mix issues and the professional boundary debate. This caused the A/E nurse practitioner role to be reviewed in order to explore the potential for expansion. Evidence indicated that the emergency room nurse practitioner role had been established in the UK since the early nineties (Tye 1997, p.1).

What was interesting is Tye's need to give two definitions of a nurse practitioner. One definition was given by the RCN (1992) and the other by Read et al (1992) and are given thus:-

> a)" An ENP (emergency nurse practitioner) is an Accident and Emergency nurse who has a sound nursing practice base in all aspects of A/E nursing, with formal post-basic education in holistic assessment, physical diagnosis, in prescription of treatment and in the promotion of health" (RCN 1992).
>
> b)"A nurse who is authorised to assess and treat patients in an accident and emergency department, either as an alternative to the patient being seen by a doctor, or in the absence of a doctor where a continuous medical presence is not maintained. Some nurses function as nurse practitioner without holding the title" (Read et al 1992).

The latter definition, according to Tye, raised the notion of an 'informal' system of care, which he suggested had been associated with nurse-led community hospitals and specialist units. He suggested that this challenges the traditional demarcation represented by the development of nurse practitioners in A/E (Tye 1997, p.2). He argued that experienced A/E nurses were frequently advising junior doctors regarding the pivotal areas of diagnosis and treatment, without formal recognition. He asserted that to allow such nurse practitioners in A/E to independently manage a

clinical caseload conferred a degree of professional respectability that had been lacking historically (Tye 1997, p2). This issue was perhaps compounded by the fact that the nurse practitioner role was not regulated within the UK and thus the scope to widen the variety within the role had not been addressed, particularly concerning parallels of the nurse practitioner role to that of the doctor.

From a liability and risk management standpoint the nurse practitioner may have become restricted by the use of very conservative protocols in A/E (Tye 1997, p.2). Tye asserted that this varied according to the level of expertise of the nurse and the approach taken by the employer, with medico-legal concerns involving litigation. This was one of the major inhibitors in the development of the nurse practitioner role in A/E (Tye 1997, p.3). He argued that whilst clinical protocols were perhaps an inevitable consequence of an increasingly litigation-conscious society. He claimed that there was a danger that rigid, over-prescriptive protocols may restrict judgement and thus increased the cost of an effective nurse practitioner service in A/E due to the need to constantly refer to a doctor (Tye 1992, p.3).

2.4.4 Working Outside the Clinical Prescriptive Remit

A differing view was put forward by another UK nurse (Walsh 2006). Restrictive protocols are a consequence of healthcare organisations' implementing such protocols that can be used by both doctors and nurse practitioners (Walsh 2006). Protocols provided a working standard for a procedure that ensures a user performs a procedure in a safe, efficient and timely manner. Protocols are written as a result of evidence based research as the standard for best practice (Walsh 2006).

Tye (1997, p.3) stated that by their nature, protocols were restrictive, because they dictated how a procedure was to be done and the rationale behind this and to move outside the protocol and beyond the remit of the role was cause for concern. The notion of a person working outside the clinical remit of a role was one of the important factors in a theory of liability (Baker 1992) because it showed where a health professional moved outside the remit of prescriptive authority and autonomy attached to a specific role.

While Tye (1997) was an example of a highly efficient professional who wanted to provide a good service he appeared less aware of the legal issues of role expansion and freeing up of the restrictions behind professional protocols, which were written to ensure that every professional using them performed a task to the same standard each time the protocol was used. In contrast to Castledine and McGee (1998), Tye (1997) emphasised the positive contribution a nurse practitioner can make in A/E as opposed to the cynical negativity displayed in Castledine and McGee (1998).

2.4.5 Development of the Nurse Practitioner Role in the UK

Development of the nurse practitioner role differs from growth of the nurse practitioner role. Growth is concerned with how a nurse practitioner is utilised within the healthcare workforce. Development differs in that development is chiefly concerned with legislation, registration and regulation of the role of the nurse practitioner and how this has evolved over time. Some of the countries in this study, for example, have no such measures for legislation, regulation or registration in place (UK), yet in other countries this is well established (e.g. USA, New Zealand & Australia).

Like Tye (1997), Castledine and McGee (1998) and Ball (2005) explored the development and work of nurse practitioners in the UK. Ball (2005) provided an important example of a study in the measurement of the work of advanced practice nurses and nurse practitioners within the UK as a whole.

Ball (2005) suggested that in terms of division of time a nurse practitioner spends 75% of the working day in the clinical area and a nurse consultant 50%. Nurse consultants do more research that any other discipline, at 10%, with nurse practitioners spending 2% of their time and clinical nurse specialists 4% (Ball 2005, p.12).

Only 9% of advanced practice nurses in the USA prescribed medication as designated prescribers, with 42% making the decision, but needing countersignature from a doctor. Sherwood et al. (1997) identified examples where USA nurse practitioners prescribed medication on prescriptions pre-signed by a medical practitioner.

The professional bearing of nurse practitioners was perceived positively as evidenced by the number of referrals they received from consultants, GPs, other health professionals and other nurses. This showed some difference in the professional bearing of nurse practitioners in the UK, when compared to Australia and the USA. The UK nurses were respected for their expertise sufficiently so that consultants and GPs willingly refer patients to them (Ball 2005).

Ball's findings (2005, p.33) showed lack of pay parity amongst both nurse practitioners and advanced practice nurses which, potentially will be controversial

when regulation of all grades beyond mainstream registered nurses and registered midwives finally occurs in the UK. Some hospital NHS Trusts paid their staff according to their own pay spine within the Trust. A pay spine is a means of defining the incremental pay levels which, over time, a group of employees will be paid. This would account for the 11% in both disciplines on an unspecified grade (Ball 2005, p.33).

Ball (2005, p.33) found that just 17% of nurse practitioners felt that they could move to a higher grade post in their specialist field, compared to 23 % of advanced practice nurses and 40% of nurse consultants. This factor could lend some credence to Castledine's argument (Castledine & McGee 1998) of a career cul-de-sac amongst nurse practitioners and advanced practice nurses, due to the relatively small number who felt able to progress to a higher grade post, or perhaps nurse practitioners are already at the top of their specialist field.

Ball (2005, p.56) identified problems such as lack of funding and time, problems with role boundaries and variable working relationships with colleagues as important issues for nurse practitioners. Role specific problems included being unable to see care through to the end of an episode due to practice restrictions. This included the national context of legislation governing practice and the lack of specific legislation for the regulation and registration of nurse practitioners in the UK (Ball 2005, p.57). Additional issues identified were under-resourced services, skills not fully utilised and lack of support through poor communication between departments' agencies and other staff. These circumstances were similar to those encountered by nurse

practitioners in Australia, USA, New Zealand and Canada (Sherwood et al. 1997; Hughes & Carryer 2002; Gardner 2004; Dunn 2004; CNA 2005; Pearson 2007).

Nurse practitioner groups identified that in order for them to perform more efficiently, several important factors such as better support from managers, clerical workers and other healthcare teams were needed. Other factors included time, better communication, improved professional development, better clinical supervision and national recognition through proper legislation and regulation (Ball 2005, p.57). There is no legislation in place for the title protection, registration or regulation of nurse practitioners in the UK and thus their status and credibility are affected through poor recognition of the role by other professions within health care and by the NMC (Ball 2005, p.57). Ball (2005) does not mention the need to protect the title within legislation in order that only a qualified and registered nurse practitioner can truly use the title nurse practitioner.

Ball (2005), suggests that there are two important issues holding back further development of advanced practice role development in the UK :-

a) Time and funding constraints (Ball 2005, p.58). These are unique posts, with post holders being originally involved in the setting up of their post from the beginning as well as the service planning integral to this provision.

b) There are the issues around others' understanding of the role (Ball 2005, p.58). Many of these posts are relatively new and, in some cases, the infrastructure and organisational culture has lagged behind in terms of new ways of working and thus

not providing the support needed to make the development of all advanced practice roles as successful as they could be.

Unless special provision is made in the UK formally recognising the need for title protection and legislation for registration and regulation of all disciplines, all development opportunities are likely to be limited due to lack of understanding of the professional and legal aspects of role development on the part of employers. There were some important legal and professional issues missed by Ball (2005). Little reference, for example, was made to the different scope of practice that would have been evident in every new post set up. Ball (2005) emphasised the uniqueness of the posts, but failed to follow through how one scope of practice could differ from another.

Legal issues such as accountability, authority and responsibility were given little or no attention in the Ball (2005) report, although the greater autonomy given to the posts had been highlighted on several occasions. Every aspect of increased autonomy carries with it potential for increased responsibility, accountability and authority. This was a lost opportunity in further developing the legislation issues governing practice that has created a stalemate within the UK.

2.4.6 Legal and Professional Issues in the UK

Legislation provision within the UK governing regulation, registration and title protection for nurse practitioners in the UK has yet to be addressed. This is apparent due to the fact that although the Nursing and Midwifery Council (NMC) issued a position statement in 2005 stating that Privy Council permission needed to be

obtained before any further registration and regulation of nurse practitioners can take place, further initiatives to this end have not been initiated. There has been little or no progress in this regard (NMC Press Release 2005, p.1).

Nurse practitioners as members of the RCN Nurse Practitioner Association (NPA) are working jointly with the RCN having developed an Action Plan to be completed during 2008-2009 (RCN/ NPA 2008). Apart from the written intention to work toward regulation of the nurse practitioner role there has been little or no progress in this regard. The Prime Minister's office however, announced that all advanced nursing practice roles must be regulated (Nursing Times 2 March 2010). This arose as a direct result of a government inquiry about the future of nursing within the UK. Work towards this goal is to commence shortly. The recent change of government within the UK however, may affect this initiative. The approach to nursing development by the new government is yet to be made clear (Nursing Times 10 August 2010-no author cited).

The first action suggested in the RCN plan is to integrate the process for non-medical prescribing training with advanced nurse practitioner education, rather than having to complete this education separately. The provision for better information technology, on a par with doctors in Quality Use of Medicines is also being addressed as part of the RCN (2008) plan. In the UK this involved access to intranet sited that provides information about good prescribing and changes in prescribing policy. This is important, as nurse practitioner prescribing standards need to be the same as those for medical colleagues in order that identical high standards are maintained by all licensed prescribers (RCN 2008, p.4). The Plan (RCN p. 4) presented a process to

support the NMC in developing regulation and registration for all advanced practice disciplines in nursing. Nurse practitioners felt that their ability to refer to other health professionals was limited due to no approved formal licensing or scope of practice (RCN Plan 2008, p.4). The ability to expand practice in referrals to other health professionals was therefore severely curtailed. There are many issues for the RCN and regulators to address. However, this initiative was encouraging from the standpoint of a body of representatives being proactive in addressing the issues as opposed to being inactive and not addressing them.

Within the plans are processes to address issues of remuneration. In addition national guidelines on making clinical imaging requests are also envisaged with joint working by the RCN and the NMC (RCN/ NPA Report 2008). The Nurse Practitioner Association within the UK had been extremely proactive in advocating change, in terms of nurse practitioner and advanced practice role development, led and supported by the RCN.

The NMC investigated nurses, midwives and health visitors working at a higher level of practice (NMC 2007). The report is extensive and gives evidence that proves some nurses who claim to work at a higher level of practice fail to reach the Higher Level of Practice (HLP) standards, reflecting the findings of Castledine. However, until the HLP standards move away from the pilot study arena and onto the regulation and standards rules, this situation is likely to continue (NMC 2007).

Despite the fact that many nurses underwent specialist training in skills such as prescribing, the use of evidence based practice, research and education to master's degree level, the NMC report claimed that these skills were weak within nursing.

This was similarly evidenced in the Castledine (1982) study (in Castledine & Magee 1998, p. 33) The inaccuracy of the NMC study was evidenced by selection of participants being based on assumptions by the NMC that certain disciplines within nursing were likely to work at a higher level of practice. There was no finite selection of a workforce that actually worked at a higher level of practice, identifying only those who claimed to work at this level. This strongly suggested that findings were compromised by poor selection criteria. This resulted in no analysis of nursing within the context of nursing roles that had a remit for higher levels of practice (e.g. a nurse practitioner). There was no focus on what nurses' do who specifically worked at a higher level of practice. The outcome of this research had little value as the participant group was too generalised and the findings were compromised. This was due to poor sample identification and non-specific outcomes that do not give a true reflection about what a higher level of practice actually entailed and more specific descriptions of nursing disciplines who worked at this higher level of practice.

The NMC (2005) introduced a policy for prescribing for nurses, classified as non-medical prescribers. The process involved a training programme and tests for competency. Once the programme was completed the nurse was awarded authorisation to prescribe medication. These were qualifications considered as non-mandatory but still significant in nursing development and consisted of approved courses for additional qualifications above those of mainstream nursing. For registration purposes these were called non-registrable qualifications.

In the UK, nurse prescribing has not been such a bone of contention as it has been in the USA, Canada or Australia (CNA 2005; Pearson 2007; Dunn 2008). Once the NMC developed their programme, prescribing was allowed and the course of this was extremely smooth. There is no published literature to show opposition to this, to the best of the researcher's knowledge.

Ball (2006) provided the first report of its kind in the UK. The report analysed specifically what the scope of nurse practitioners' practice entails in the UK and the problems associated with working as a nurse practitioner within the UK as a whole. Problems such as lack of understanding about the role, associated with nurse practitioner practice in the UK are similar to other areas (Dunn 2004; Pearson 2007; Pearson et al. 2007; Chiarella & McInnes 2008). Two thirds of nurse practitioners in the UK worked in primary care, whilst a quarter worked in hospitals, with one in twenty working in NHS walk-in centres and another one in twenty working in minor injury clinics/units (Ball 2006, p.4).

Nurse practitioners working outside of GP practices reported that they were able to advance their roles (Ball 2006, p.4) 72% of nurse practitioners hold a degree but only 35% of these were studying for or held a degree at master's level (Ball 2006 p.4). This mirrors the situation in the USA and Canada (Pearson 2007; CNA 2005).

The main problems identified in working as a nurse practitioner within the UK were that of autonomy and supervision and included 44% having x-ray requests refused by radiologists, with 57% of these requests from nurse practitioners working in a GP practice. 44 % l had referrals refused with the insistence that a doctor must complete the referral (Ball 2006, p.5). Many regard these instances as being due to lack of

awareness about the role, and presented a similar picture to that in Canada, the USA and Australia (Sherwood et al.1997; Dunn 2004; CNA 2005; Pearson 2007; Canadian Television 2008; Chiarella & McInnes 2008). Regulation by the NMC was seen as a means by which both public and professionals may understand and facilitate the consistency of what is understood by the term 'nurse practitioner' (Ball 2006, p.5). One in three nurse practitioner respondents identified this as an issue that needed to be addressed to improve and promote the status and professional bearing of the nurse practitioner (Ball 2006, p.5). This was consistent with the findings in Australia of Gardner (2004) and Chiarella and McInnes (2008) in gaining understanding about what the role of a nurse practitioner actually entailed and the professional status of a nurse practitioner within the healthcare workforce.

A Nursing Times editorial (unauthored March 2010) published the announcement from the Prime Minister that the need to regulate all advanced practice nursing roles was required as part of the government review on the future of nursing. Advanced practice roles include nurse practitioners. As in the USA and Canada, advanced practice roles in the UK are currently under one advanced practice 'umbrella' and not yet separated.

Ball (2006, p.5) identified that UK nurse practitioners see themselves under threat, in terms of job security, from the creation of more physician's assistant posts within the UK. She posits (p.5) that one in five (25%) of respondents feared redundancy as a real concern with role of physician's assistant gaining momentum. However, by the same token, these respondents also viewed their job to be 92% nursing focused and

only 8% medically focused, suggesting that nurse practitioners were not subject to medical control within the UK (Ball 2006 p.4).

2.4.8. Education of Nurse practitioners in the UK

There is no provision within the UK for registration, regulation or title protection of the nurse practitioner role. There is also no minimum educational qualification (RCN 2008). The RCN have approved nurse practitioner preparation courses at universities within the UK both at bachelor's and master's levels. These initiatives did not involve the NMC (RCN 2008).

2.5 NEW ZEALAND

2.5.1 History

Much of the historical context of nurse practitioner development in New Zealand was provided by Hughes and Carryer (2002**).** In 1998, a report from the Ministerial Taskforce, similar in construction to the NSW Taskforce (Driscoll at al. 2005) that focused on the untapped potential of the nursing workforce and concluded that, to release this potential, nurses needed to:-

a) Use their knowledge and skills more effectively;

b) Pioneer innovative service provision;

c) Enhance the access to, and quality of, primary health care;

d) Contribute positively to health gain (in Hughes and Carryer 2002 p.3).

As in NSW (Australia) there existed great numbers of highly educated and skilled nurses in practice with no identifiable career ladder, with advanced clinical and leadership competencies as in the UK and USA and NSW studies (Ball 2005; Driscoll et al. 2005; Pearson 2007). In the public health system, the most prominent of these nurses worked in multidisciplinary teams and/or in acute care, neonatal units and emergency departments. An example of advanced nursing practice within the private sector was given as an occupational health nurse practitioner, who tailored their practice in response to the specific context of the workplace.

The New Zealand system at the time worked against the best utilisation of well qualified nurses and poor access to postgraduate education (Hughes & Carryer 2002). Legislative and funding barriers and the conditions under which many nurses practised with no identifiable career structure were also identified by Hughes and Carryer (2002). These factors were seen by the taskforce as inhibiting the effective development and utilisation of nurses with advanced competencies and the ongoing development of clinical career options (Hughes & Carryer 2002). The taskforce recommended the development of a 'nurse practitioner' role in New Zealand to provide highly skilled care, co-ordination of particular patient groups across the hospital and community interface and a high level of family health care services (Hughes & Carryer 2002).

Hughes and Carryer (2002) perceived the New Zealand nurse practitioner role to be attractive to consumers, the health care team and service managers because the role offered an approach that not only built on existing personal health services but also

provided a means of working with consumers in many different models to deliver high standards of clinical nursing care.

The Hughes and Carryer (2002) report was a major step in nurse practitioner development. The history of nurse practitioner development was described. Following this Hughes and Carryer (2002) defined what a nurse practitioner is, what a scope of practice actually meant, what it consists of, in terms of what a nurse practitioner was allowed to do and the clinical settings in which nurse practitioners practiced. This process was similar to the work undertaken in NSW specifically and within other studies undertaken in Australia (Driscoll et al. 2005; Australian Taskforce 2005; Gardner, Dunn & Carryer 2005; ACT 2005; Pearson et al. 2007).

2.5.2 Development of the Nurse Practitioner Role in New Zealand

Models of service delivery in New Zealand for nurse practitioners differ from those in Canada, the USA and the UK. The models of service fall into four main categories:-

Integrated Nursing Teams: this refers to a group of nurses that includes nurse practitioners who provide, co-ordinate and manage care as a cohesive team (Hughes & Carryer p.2).

Nurse Consultancy: the nurse practitioner works independently and refers clients to other health professionals, where required. An example here could be nurse practitioners who work as consultants in a specific field such as cardiac care, working between hospital and community (Hughes & Carryer p.2).

Independent Practice: nurse practitioners who are self employed and establish their own independent practice, offering care and services direct to the public. This could include a nurse practitioner, for example, who is under contract to a hospital or community care organisation to provide a specific service, such as rehabilitation (Hughes & Carryer 2002, p.2).

Nurse Practitioner Speciality Practice: the nurse practitioner is the recognised lead health professional within the health care team in a hospital, for establishing and managing speciality clinics and services for a particular health specialty or population group. A speciality, for example, could be acute surgery and a group could be Maori Health Services within a hospital (Hughes & Carryer 2002, p.2).

Hughes and Carryer (2002) defined the difference between a nurse practitioner and a clinical nurse specialist suggesting that sometimes these roles overlap (p.3), with no clear boundaries between the two roles. This is similar to the problem Hansen identified (in Castledine & McGee 1998 p.65) where the role of a nurse practitioner and clinical specialist overlap in the USA.

In New Zealand the clinical nurse specialist provided specialist care within a field, such as diabetes, whereas a nurse practitioner was the person who was the lead patient care manager and had a remit during admission, intervention and discharge of patients and managed the total nursing care of the patient. A clinical nurse specialist may only have input concerning patients within their own specialty, such as breast care, stoma therapy, diabetes or wound management which formed only a part of the total nursing care of the patient (Hughes & Carryer 2002, p.4). This suggested that

the nurse practitioner role was the more comprehensive of these roles as they were often responsible for the whole health care episode.

2.5.3 Regulation of Nurse Practitioners in New Zealand

In New Zealand there is only one Nursing Council for the whole country, under the 1977 Nurses' Act. The initial framework for the regulation of nurse practitioners was introduced within New Zealand in 2001 (Hughes & Carryer 2002, p.4). This framework included standards of competency, minimal education requirements and the process to be undertaken for a candidate seeking nurse practitioner registration. As in Australia, the title nurse practitioner is protected, which means that no nurse may be titled as a nurse practitioner unless the process of licensure has been completed and a registration certificate stating this has been awarded (Hughes & Carryer 2002, p.4). Seven scopes of practice had been developed for nurse practitioners as in other countries (Ball 2005; CNA 2005; Gardner 2005; Pearson 2007). These are Mental Health, Disease Management, Peri operative Care, Palliative Care, Emergency and Trauma, Primary Health Care and High Dependency Care (Hughes & Carryer 2002).

The generic categories within the competencies for practice (Hughes & Carryer 2002) reflected those of Canada, the USA and UK (CNA Report 2005; Pearson 2007; Ball 2005) and included:-

a) Articulation of the scope of nursing practice and its advancement.

b) Showing expert practice working collaboratively across clinical settings and within interdisciplinary environments.

c) Showing effective nursing leadership and consultancy.

d) Developing and influencing health/socio-economic policies and nursing practice at a local and national level.

e) Showing scholarly research inquiry into nursing practice.

f) Prescribing interventions, appliances, treatments and medication within the scope of practice (Hughes & Carryer 2002, p.5).

These categories were not dissimilar to those of the Strong Model of Advanced Nursing Practice (2004) that will be introduced later in this chapter.

2.5.4 Education of Nurse Practitioners in New Zealand

The minimum education requirement for licensure in New Zealand as a nurse practitioner was four to five years experience within the relevant scope of practice and a clinically focused master's degree in nursing, specific to the nurse practitioner (Hughes & Carryer 2002).

The New Zealand Nursing Council had allowed for a 'period of transition', from 2000-2010. Currently, those nurses with extensive nursing experience and a master's degree in nursing (not necessarily specific to the nurse practitioner role) could meet the Nursing Council's requirements. From 2010 the specific postgraduate nurse practitioner degree will be mandatory, before licensure will be allowed (New Zealand Nursing Council 2000). The establishment of nurse practitioner posts in New Zealand is under the auspices of the District Health Boards and primary healthcare organisations (Hughes & Carryer 2002, p.7). A nurse practitioner was

allowed to practice independently from any employment organisation but may contract with employment organisations in provision of a nurse practitioner service. This is similar to initiatives in the USA (Pearson 2007). Hughes and Carryer (2007) gave an important insight into the provision and development of nurse practitioners in New Zealand. The standards were fairly strict but as this is one of the smaller countries studied, probably much easier to implement.

The prescribing of medication by people other than doctors in New Zealand has always been a contentious issue, not least for nurse practitioners. This was an issue in most countries in this study, apart from the UK, where the NMC has extremely strict prescribing regulations, but the process of getting this programme off the ground was relatively smooth (Ball 2005). Commitment to prescribing standards by nurse practitioners within New Zealand meant that all nurse practitioners would become subject to scrutiny, in terms of best practice prescribing and would also follow the same standards of use of medicines and prescribing regulations as other prescribers, both medical and non-medical (e.g. psychologists) (Hughes & Carryer 2002).

2.5.5 Legal and Professional Issues in New Zealand.

Maloney-Mori (2006) was the first Maori to become licensed as a nurse practitioner in New Zealand. She presented an account of what it means to be a Maori woman and a nurse practitioner working amongst her own Iwi (tribe) in New Zealand and the events that led up to this. Her journey toward seeking endorsement as a nurse practitioner was stormy, with major personal stressors.

Prior to seeking endorsement as a nurse practitioner, Maloney-Mori was a registered nurse, working in the field of disease management (see Hughes & Carryer 2002). As this was one of the categories that the New Zealand Nursing Council sought nurse practitioner applicants, so began her journey. This was a similar process to that of Australia, in that senior nurses working within a specific scope of practice (e.g. A/E or Remote Area Nursing) sought endorsement as nurse practitioners (Maloney-Mori 2006).

Cultural awareness and cultural safety are important aspects of nursing practice for any nurse, but one sees a different vitality to this domain of cultural awareness when examining Maloney-Mori's (2006) writing, where she dwelt within her culture and presented new and dynamic ideas to a non-Maori. Within New Zealand, to practice nursing in a culturally unsafe manner is liable to attract sanctions from both the employer and nurse regulators and thus this issue has legal implications (Nursing Council of New Zealand Code of Professional Conduct 2008).

Maloney-Mori (2006) presented valuable information within this text for overseas nurses working in New Zealand, in understanding the context of the Maori culture in the practice of nursing and the importance of cultural safety. This could be equally important to nurses from overseas working in Australia, when beginning to understand what it means to be Indigenous.

As part of her practice she aimed to identify, describe and generate a theoretical explanation of her nursing care, its origins and how this improved health outcomes for her clients. This she called "Kia Mana" as the pathway to wellbeing and stated that this was twofold and combined the old and the new (Maloney-Mori 2006,

p.178). In this context, the caregiver was non-judgemental and strived to achieve a whanau (family) relationship between carer and client, so that a bond developed. Wherever a Maori person is, however temporary, the Maori see this as a whare (home) and hospitalisation of Maori patients in a ward involved a strong family network who acted as assistant care givers and enhanced the value of nursing intervention, by assisting in empowering patients to manage their health, developing co-ordinated and collaborative care (Maloney-Mori 2006, p.178).

This is an important issue in New Zealand nursing. If a nurse is found to practice in a culturally unsafe manner in New Zealand, there may be grounds for removal of that nurse's name from the register (Nursing Council of New Zealand 2008). For the nurse practitioner working in New Zealand it is considered a mandatory part of clinical practice to work in a culturally safe manner. Removal from the register for proven culturally unsafe practice means loss of livelihood and possible poor future employment prospects outside or within the field of health care.

In New Zealand, the Northern District Health Board (2002) undertook a survey about GP attitudes toward nurse practitioners asking GPs if they were likely to employ a nurse practitioner in the future. Many New Zealand GPs doubted that they would in the beginning, but after a series of awareness sessions by the New Zealand Northern Health Board this trend was turned around with 75% of GPs in favour of the role. This showed that willingness to employ nurse practitioners was directly related to how well the role was understood. The Northern District Health Board asserted that awareness of others about the nurse practitioner role showed that this would allow them to stand fast as an accepted member of any healthcare workforce (Northern

Health Board 2002). The pathway toward role development was eased as a result of this survey (Northern Health Board 2002). This is in contrast to initiatives undertaken in Australia, the USA, Canada and the UK.

Jacobs (2007**)** described the criticisms cited by New Zealand nurse practitioners toward Hughes and Carryer (2002). Contrary to these authors she emphasised the need for political support as being central to further development of the nurse practitioner role and asserted that differences in class, gender, personal experiences, values and beliefs have caused gulfs throughout the history of health care in New Zealand. She cited the many instances that occurred in the 1990s, through consistent health reform so that nurses had become 'so disillusioned and demoralised that it had become difficult to build energy and enthusiasm for any political activity' (p.2). This reflected a similar situation in Canada in the 1980s, where poor support politically led to many nurse practitioner initiatives disappearing (CNA 2005, p.3). Jacobs asserted however, that the health reforms had repeatedly signalled opportunities for nursing.

By the mid to late 1990s in New Zealand many nursing leaders understood the opportunities that had been foreshadowed by incessant health reform and in 1998 a ministerial taskforce was commissioned. Jacobs (2007) recommended, as did Hughes and Carryer (2002), optimising of the potential of highly skilled experienced nurses within the healthcare workforce. At the same time Bill English (the then New Zealand Health Minister) announced plans to amend the Medicines Act to enable nurse prescribing.

Jacobs continued to identify that the 'body' of nursing was just beginning to develop astute approaches to politics and that nursing was still struggling to be heard when decisions were being made about nursing or health policy (Jacobs 2007). This state of affairs was not too far removed from comments made by Dunn (2004) who outlined the difficulty Australian nurses had in getting their voices heard, when the medical profession appeared to be the dominant force in health service decision-making (Dunn 2004, p.5).

Jacobs concurred with other authors (Dunn 2004; Gardner 2004; Driscoll et al, 2005) as to the four main areas within politics where a nurse might exert influence: such as within the community, the workplace, as a member of a government statutory body and within professional organisations. Nurse practitioners could become involved through their associations and nursing colleges. These areas also correlated with the determinants of professional power from the nursing profession itself, from the laity, the employer and the State (Jacobs 2007, p.3).

Each nurse had the opportunity to contribute as a citizen, a trade union activist or as an elected member of a governing board/body within New Zealand (Jacobs, 2007, p.3). The elimination of barriers to the effective deployment of nurse practitioners required not only an understanding of policy and politics but also an appreciation of the pull of conservative views. This reflected the conclusions of Gardner (2004), who discussed issues affecting nurse practitioners in Australia.

Jacobs (2007, p.3) claimed that most of the community within New Zealand, including GPs, retained a view of nursing and medicine that is not only traditional, but also archaic. Again, a similar stance exists in Australia. It is vitally important for

Australia and New Zealand to work together in standardising the role of the nurse practitioner in both countries in order to comply with the provisions of the 1973 Trans-Tasman Agreement. This agreement allows for freedom of travel for New Zealand and Australian citizens in both countries and the ability to gain employment for New Zealand citizens and Australian citizens within both countries. This means that competency standards, regulation and registration and educational requirements for nurse practitioners needed to be mutually agreed.

In defence of medical staff opposition to nursing developments, Jacobs cited Diers (in Jacobs 2007 p.3), and suggested that where physician resistance is encountered, it could be due to their inability to respond in a changing world, due to lack of knowledge about the role of the nurse practitioner. When physicians argued that nurse practitioners would be in direct competition with them, it was important to note that behind this claim is the acknowledgement of there being nothing faulty in the nurse practitioner knowledge or skill, but about their perception of the role and competition for government funding (Jacobs 2007). Jacobs (2007) adduced that the problem was not actually about performance, competence or quality or indeed legal rights of nurse practitioners in New Zealand (Jacobs 2007). Nurses when viewed as subordinate beings ran more of a risk of perpetuating the nursing handmaiden image (Chiarella & McInnes 2008) or arousing professional patch protection as in the USA and Canada (CNA 2005; Pearson 2007). Jacobs stated that it is the right of health consumers to have access to professional care and improved population health outcomes. Jacobs asserted that there was a need to consider the use of high profile marketing and media expertise to ensure that the public was fully aware about what

nurse practitioners did (Jacobs 2007, p.4). To not engage politically was to limit the potential for awareness and the development of self esteem, limit one's consciousness, one's ability to use sources of energy and power and to limit one's capacity to nurse (Jacobs 2007, p.4).

Jacobs presented a very powerful message in this paper for all nurse practitioners and academics to become politically aware and politically active, to prevent the continuance of the traditional handmaiden image as described by Chiarella and McInnes in Australia (Chiarella & McInnes 2008, p.1) and enhance the modern day image of the nurse practitioner as a professional capable of providing care for patients and clients, with good patient outcomes that is not in direct competition with medical staff colleagues (Dunn 2004, p.5).

Like Maloney-Mori, Phillips (2008) presented from the perspective of a nurse practitioner intern (trainee) and provided her observations of nurse practitioner work in New Zealand. She began by introducing the task force initiative (Hughes & Carryer 2002) and stated that up to the time of her publication (March 2008) even though nurse practitioners began in 2002, there were only 45 nurse practitioners, with just 25 of these as registered prescribers. Phillips cited two reasons for this lack of growth (Phillips 2008, p.1):

- A requirement to prove prescribing competence to the New Zealand Nursing Council.
- Lack of ability to obtain a nurse practitioner position.

This was a similar situation to Australia (Gardner 2004). Nurse practitioner interns first had to prove competence in the six designated competencies. Additionally they had to provide documentary evidence within their portfolio that supported their competence to support staff, colleagues, managers, patients, patients' families, clinical associates and academic supervisors. Competence was assessed in a variety of ways such as designing new documents, demonstrating initiative by generating ideas about changing some long-standing practice and creating learning contracts.

Phillips (2008) suggested that she is not sure that proving competence was a consistently applied principle and that it seemed to her that unless the area of practice is very narrow, the nurse practitioner would not be able to complete certain tasks. A newly endorsed nurse practitioner would require supervision when prescribing at least at the first attempt. This would dampen the sense of worth for the nurse and indeed, lead one to question what was being asked of potential nurse practitioners and would this process ever become transparent (Phillips 2008, p.3)? Phillips argued this raised the question of how the Ministry of Health vision for nurse practitioners was actually being articulated within the nursing profession and the regulating body (Phillips 2008, p.3). Phillips (2008, p.3) recommended four changes designed to lead to a more consistent approach to the registration process, remove barriers to practice and improve public safety. These were:-

a) The portfolio: this was an excellent tool, when constructed properly, with a focus on criteria that address the practice of an entry-level nurse practitioner. That is, the criteria should reflect an acceptable minimum level of clinical skills required to enter safe nurse practitioner practice (Phillips 2008, p.2).

b) An entry-level nurse practitioner should be encouraged to focus on the precise application of advanced clinical skills in their specific area of practice; the portfolio of the first-time applicant should document the education, experience and rigorous evaluations of the applicant by trusted senior practitioners in nursing and the medical profession. This would ensure that the nurse practitioner has the experience required and the support of a mentor (Phillips 2008, p.2).

c) Registration: A nurse practitioner applicant should automatically include prescribing within their practice specialty. To demonstrate prescribing competence the nurse practitioner should be able to document a course of study including pharmacology and pharmacotherapeutics. The applicant should be able to identify medication they feel competent to prescribe and submit documentation of actual use, while under the mentorship of a prescribing professional, or document the need for specific medications and the circumstances in which these medications would be prescribed in their practice (Phillips 2008, p.2).

d) The interview by a select New Zealand Nursing Council panel should be abolished. The panel is a time consuming, expensive and a stress-inducing exercise in subjectivity. It is an artificial barrier to practice (Phillips 2008). The time and expense of assembling and preparing the panel to question an applicant could be better spent on ensuring the educational and experiential background of the applicant supports their application and that individuals are safe practitioners in their new roles (Phillips 2008, p.2). Action by the Queensland Nursing Council in 2008 concurs with this. Today in Queensland, if a nurse practitioner candidate is able to provide documentary evidence of successfully completing the master's degree for nurse

practitioners they are eligible for endorsement. The formal interview process has been abolished within Queensland.

There are gaps in Phillips (2008) four steps for change. There was no reference whatsoever to legal issues of accountability, autonomy, authority or responsibility of nurse practitioners in clinical practice. She made no reference to the legal implications of advanced clinical practice but argued that the above changes would not create more risk to the patients. In fact changes such as these may lessen risk to patients and the practitioner by ensuring the system is creating competent entry-level nurse practitioners who would have the confidence and knowledge to expand the horizons of practice and nursing knowledge. These were important legal issues associated with development of the nurse practitioner role in New Zealand. Phillips (2008) identified some key elements about clinical risk especially involving novice prescribers. The lack of a mentor was a further issue that could result in a costly error in practice without a suitable person to assist in problem solving, immediately following endorsement (Phillips 2008, p.2).

According to Phillips (2008, p.2) employment issues were a reason for slow growth in nurse practitioners within New Zealand. She cited reports of registered nurse practitioners who are working as volunteers or have returned to their previous mainstream nursing post. This reflected little change to their practice or income. In addition, Phillips (2008) reported on some nurse practitioners being unemployed or under-utilised as a nurse practitioner. This showed that supply exceeded demand and is a reflection of good education marred by poor utilisation of the nurse practitioner or non-acceptance of the role.

Few nurses from primary care were studying to be nurse practitioners and Phillips (2008) questioned why primary health organisations and non-government organisations were not creating nurse practitioner positions. It was curious that there are so few positions for nurse practitioners within individual health boards.

Phillips was at this time registered as a mental health nurse practitioner but was actually employed as a nurse academic at the local polytechnic, highlighting her inability to secure a nurse practitioner position, as none existed within her own health board (Phillips 2008, p.2). This begged the question that if there are no positions within this health board for nurse practitioners then why they were trained in the first instance, in the knowledge that no position was available at the end of the process.

The slow growth of nurse practitioner numbers within New Zealand was further impaired by Health Boards that wavered in establishing new nurse practitioner positions. Attempts to resolve the issue by the implementation of a five year plan that could include the establishment of new nurse practitioner positions may alleviate this position (Phillips 2008)

Phillips' (2008, p.2) recommendations appeared feasible and some regulators in Australia have indeed abolished the panel interview as a means of assessing nurse practitioner candidates. Her prescribing recommendation is well worthy of attention from academics, employers and regulators.

This was an important paper documenting that all is not entirely well with nurse practitioners in New Zealand, despite reports of successful implementation from regulators (Hughes and Carryer 2002). In Australia, Dunn et al. (2008) described an

interactive internet training programme that describes nurse practitioner training in the Quality Use of Medicines (QUM) perhaps in the future New Zealand could take advantage of this training package for their nurse practitioner interns and thus Phillips (2008) recommendation will be fulfilled.

2.6 AUSTRALIA

2.6.1 History

Driscoll et al. (2005) described the history of nurse practitioners in Australia and chronicled nurse practitioner development from the early stages up to 2004. Development data from 2004 onwards will be discussed later in this Australian review.

The nurse practitioner movement began in Australia in New South Wales (NSW) in 1990 when the first discussions were held there at a conference of the NSW Nurses' Association. A taskforce was set up after this conference to examine nurse practitioner development within NSW, by the chief nursing officer to consider the issues of nurse practitioner implementation (Driscoll et al. 2005).

In the late 1980s, (as in the UK and USA), NSW was experiencing a shortage of doctors in under serviced communities, especially in rural and remote areas. Additionally, retention of experienced nurses in NSW was proving difficult. A reason for critics questioning substitution of nurse practitioners for doctors and to promote retention of senior nurses was an inadequate clinical career structure existing within NSW at this time, especially for more senior experienced nurses (Driscoll et al. 2005). It emerged (Driscoll et al. 2005) that the nurse practitioner role

would help solve the retention crisis amongst nurses, through the creation of an additional clinical career pathway. Prescribing and ordering diagnostic tests by nurse practitioners was one of the issues to be addressed- especially because advanced practice nurses were already ordering diagnostic tests outside any legislative boundaries (Driscoll et al. 2005).

Between 1992 and 1995 pilot projects were established to investigate nurse practitioner models such as primary care in rural, remote and metropolitan areas (Driscoll et al. 2005). The evaluation of these pilot projects in 1995 was positive but debate continued about the geographical areas within the state where nurse practitioners would practice. Consequently, the first nurse practitioner models within NSW were to be concentrated within rural and remote areas, as this was viewed as the most cost-effective approach and gave access to healthcare to consumers within remote areas with limited healthcare provision. This move restricted the nurse practitioner to practise only in rural and remote areas in NSW, as this role was seen as a substitute for doctors (Driscoll et al. 2005).

In 1998, the Victorian taskforce considered that the utilisation of nurse practitioners solely within rural and remote areas was too restrictive when the taskforce was formed. This taskforce was of the opinion that a nurse practitioner should not necessarily act as a substitute for a doctor in areas of poor provision, but be based upon the development of an advanced nursing framework that focused on advanced practice nursing and decision making, to ensure that the needs of the patient were met (Driscoll et al. 2005). Within Victoria in March 1998, 11 nurse practitioner categories were developed and funded, with phase 1 of the nurse practitioner project

being launched by the health minister. The pilot categories included primary health care, operating theatre, emergency care, women's health, paediatrics, neonatal care, haematology wound care and the psychiatric and homeless care programme. In 2000, Melbourne University undertook to evaluate the pilot models (Driscoll et al. 2005). The outcome of these evaluations was that nurse practitioner legislation was enacted in 2001 that made provision for nurse practitioner regulation and registration within the state of Victoria (Driscoll et al. 2005).

In 1999 South Australia (SA) took a similar approach, developing nurse practitioner projects. The initiatives in SA acknowledged the relevance of literature produced by other states, endorsing the value of the nurse practitioner role (Driscoll et al. 2005). The legislation for implementation, regulation and registration was formalised in 1999 with candidates commencing the process for endorsement later in 2000.

The Australian Capital Territory funded trials of nurse practitioner models in March 2001. The report on these trials was published in 2002 and nurse practitioner legislation changes began in the same year, as well as the defining of the role of the nurse practitioner within the territory. Table 1, The Comparison of Nurse Practitioner Policy in NSW, demonstrates a state by state/territory comparison of key elements in nurse practitioner development in the five states that had made legislative provision at this time (Driscoll et al. 2005 at page 5). The table overleaf shows some of the key elements of nurse practitioner development at this time within the states that had developed the role of the nurse practitioner (Source: Driscoll et al. 2005).

TABLE 1. Comparison of Key Elements of Nurse Practitioner Policy in New South Wales, Victoria, South Australia, and Australian Capital Territory Nurse Practitioner Taskforce Reports

Key Elements	New South Wales	Victoria	South Australia	Australian Capital Territory
Year of implementation of the nurse practitioner role	1998	2001	2002	2002
Definition of nurse practitioner (as cited in relevant policy)	Advanced practice with the characteristics defined by context of practice	Advanced practice skills and knowledge, educator,counseling, manager, administrator, quality improvement	Advanced practice, educator, mentor, research, autonomous	Extended practice in autonomous assessment and management of clients
Scope of practice and health care sector	Initially only rural and primary care. Currently specialist areas. Private and public health care sector.	Specialist areas. Private and public health care sectors	Specialist areas. Private and public health care sectors	Specialist areas. Private and public health care sectors
Minimal educational qualifications	Dependent upon qualifications and experience and/or master's degree	Master's degree	No minimal qualifications	Master's degree
Prescribing rights	Yes with limited formulary specific to context of practice	Yes with limited formulary specific to context of of practice	Yes with limited formulary specific to context of practice	Yes with limited formulary specific to context of practice
Diagnostic tests	Yes specific to context of practice	Yes specific to context of practice	Yes specific to context of practice	Yes specific to context of practice
Referrals	Allowed to refer only to outpatient clinics, allied health professionals, and community health centers	Referrals to be coordinated by the patient's general practitioner in consultation with the nurse practitioner	Yes	Yes
Admitting privileges	No	Recommends	Must apply to the Nursing & Midwifery Clinical Privileges Advisory Committee (at the Department of Human Services) and if granted, to individual hospital boards	No

2.6.2 Development of the Nurse Practitioner Role from 2004 Onwards

From 2004, the states and territories involved in the Driscoll et al. (2005) study had established the role of the nurse practitioner. The discourse within this review will now transcend to issues concerned with the further development of the nurse practitioner role in other states and territories within Australia.

Dunn (2004, p.4) stated that Australia, in the 21st century did not offer a level playing field to all within its borders and that there was not a 'Fair Go' within our health care

system. This was relevant to the nurse practitioner because Dunn related this directly to how the health system in Australia viewed the nurse practitioner. She suggested that advanced practice did not get a 'Fair Go' in Australia. Dunn (2004, p.9) asserted that the nursing profession's evolution into advanced practice was not simply a few more skills thrown into the pot, or the passage of time within a clinical setting. She stated that there were competency standards defining the role of the advanced practice nurse in Australia. These included the integration of clinical and professional characteristics, combining a high level of specialist skills and knowledge, leadership ability and an advanced level of professional practice above that of mainstream nursing. Dunn (2004) asserted that healthcare within Australia was not friendly to clients or families and did not value the professional status of nursing. She quoted (p.9) Laurence (1997 in Dunn 2004, p.9) who said:-

> "Bureaucracy defends the status quo long past the time when quo has lost its status"

According to Dunn (2004, p11) nurse practitioner extended practice did not exist as an isolated set of tasks, but rather as an additional arena into which the nurse might confidently step in order to provide a comprehensive and coherent health care service to meet clients' needs. She suggested that extended practice demands an extensive knowledge, the skills required to apply that knowledge and the clinical problem solving ability to determine when and how to best utilise knowledge and skills Such a practice arena was the domain of the nurse practitioner (Dunn 2004, p.11).

As stated in the Victorian, South Australian and New South Wales guidelines the extended practice skills associated with the nurse practitioner include:-

> Advanced clinical assessment; ordering and interpretation of diagnostic tests including diagnostic imaging; implementation and monitoring of therapeutic regimes including prescribing, pharmacological interventions; initiating and receiving appropriate referrals (Dunn 2004, p.11).

Although the role of a nurse practitioner incorporated the components of extended practice, Dunn (2004, p.11) suggested that this extended role was provided in the context of nursing care including assessing, diagnosing and managing the client's requirements in activities of daily living, health education, health promotion, counselling, managing the care environment and addressing both biophysical and psychosocial needs (Dunn 2004, p.11).

Dunn presented a strong argument as to the reasons why the nurse practitioner role had not been sufficiently embraced within Australian healthcare, either in primary or hospital care settings. The question arises, in 2010, as to how far this has moved on in the ensuing six years since Dunn presented these comments.

Dunn (2004, p.15), asserted that of just over 60 nurse practitioners endorsed at that time, none was able to practice to the full extent of their educational preparation and experience. This was due to the inability of the nursing profession in Australia to develop a strategy to prevent the medical fraternity in Australia from high-jacking the moral high ground. With the high-jacking of the moral high ground the medical fraternity was allowed political dominance and assumed authority to speak as the legitimate voice of health care (Dunn 2004, p.15). Today, although there have been some small inroads into reducing the dominance of doctors as the only voice, this issue remains contentious within Australia.

According to Dunn (2004, p.15) the Australian Medical Association (AMA) as a trade union, is an industrial body committed to the protection and promotion of its members. It has assumed the prerogative-repeatedly enforced in the media and the policy-making bodies of this country-to impose their opinions as to what is right and good for Australian health care. Despite decades of accumulated evidence to the contrary, the AMA, in 2004 was of the opinion that nurse practitioners were dangerous, poorly trained and ill equipped to deal with the health related problems of the Australian public. In contrast, evidence gathered around the world has demonstrated that the nurse practitioner has the ability to provide safe, effective and accessible health care. Dunn stated (2004, p.17) that every day these brave pioneers were facing intolerable barriers fabricated by those for whom it is more important to ensure their turf is protected than to provide equitable, efficient, effective and acceptable health care.

When Dunn's (2004) comments are compared with Jacobs' (2007) viewpoint on nurses' duty to become politically active one can see the strength of Dunn's argument in promoting the role of the nurse practitioner through the political arena as well as through the academic and journalistic portals.

Gardner, Carryer, Dunn and Gardner (2004) supported such comments outlining the embryonic nature of the nurse practitioner role at that time, both in Australia and New Zealand. They also identified that nurse practitioners were practicing in environments that were not entirely prepared for them and in some sectors that were politically resistant (p.1). Nurse practitioners were pioneers, forging pathways

toward improved services and expanding interpretations of the role and the potential the role offered.

The core role of the nurse practitioner was distinguished by autonomous extended practice (Gardner, Carryer, Dunn & Gardner 2004, p.1). The practice was dynamic, in that it required the application of a high level of clinical knowledge and nursing skills, in stable and unpredictable as well as complex situations. The role was characterised by professional efficacy and had a therapeutic potential enhanced autonomy and legislative privileges (e.g. prescribing).

Practice in this role was sustained by adhering to the primacy of a nursing model of practice, movement away from medical control in advanced practice nursing and a commitment to lifelong learning. The nurse practitioner was seen to be a clinical leader with a readiness and obligation to advocate for their client base and their profession (Gardner, Carryer, Dunn & Gardner 2004, p.1).

While the Gardner, Carryer, Dunn and Gardner (2004) research was very comprehensive both in the research methods and scope of the research itself, it lacked any specific legal focus. Interviews revealed nurse practitioners' awareness of their increased autonomy and authority but the study failed to capture other aspects of professional practice, such as responsible practice and accountability. These may have been addressed by the authors at interview but there was no written evidence to show that with increased accountability, authority and autonomy came more responsibility and also potential liability. Their report was practice driven and this is understandable, given that the role of a nurse practitioner focused on a unique scope of practice. This did not excuse the absence of attention to clinical practice errors,

acts and omissions having a serious effect on safe practice when following the unique scope of practice. Equal emphasis needed to be placed on evidence of initiatives to prevent legal sanctions caused by moving outside the prescriptive remit of a scope of practice, as well as providing evidence for excellence in clinical practice (Petersen in Freckleton & Petersen 2006, p.487).

We live in a litigation-conscious society (Tye 1997) and all nurse education should have a focus on legal issues and legal education (Dimond 2004, p.1). There is a legal focus within competency standards within Australia and also legal and professional issues form part of the curriculum for many nurse practitioner master's degrees at universities within Australia, but not all of them (See Appendix A). Opportunities existed to capture the depth of knowledge uptake by nurse practitioners themselves in relation to legal boundaries and the evidence provided within a portfolio. This is required to establish actual knowledge that a nurse practitioner candidate possesses. The portfolio assessment process is very limited and relies totally on the accuracy of evidence. This is supported by Phillips' (2008) comment. Phillips (2008) asserted that portfolio evidence is a valuable tool in assessing the competence of a nurse practitioner if this evidence is properly assessed by a panel of experts experienced in nurse practitioner practice.

In 2007 (Pearson et al. 2007) published a report that evaluated the service provided in healthcare of aged care nurse practitioner-like roles within the Australian Capital Territory (ACT). This study used the term nurse practitioner-like services in order to accommodate those registered nurses working toward establishing their eligibility for registration as a nurse practitioner. The trial involved the establishment of nurse

practitioner-like roles and broadly evaluating them, to investigate issues within the candidates endorsement journey as Phillips (2008) identified in New Zealand.

These nurses did not have access to PBS or MBS and therefore could not prescribe for their patients. As a result the prescribing was 'hypothetical' within this study but the overall results are interesting and important to future nurse practitioner development (Pearson et al. 2007, p.1).

Two thirds of residents in one of six sites participating in the trial were female and aged 80 and over. Over 20% were born outside Australia and over 10% of these spoke a language other than English as their first language. On average, residents had about six co-morbidities and were taking eight medications, indicating their suitability for the study (Pearson et al. 2007).

Practitioner interventions totalled 3146 and involved 510 residents. Nurse participants in the trial made referrals to a specialist in 13 per 100 visits and ordered diagnostic tests for 7 in every 100 patients. 'Hypothetical' prescribing by nurses was compared directly to the medical officers' actual prescribing. Results showed that nurse prescribing was done at or before the time of medical officer prescribing and on average 11 hours before the medical officer intervention indicated the same prescription. Nurses in the study identified that the most common intervention was implementing treatments/medication for acute conditions (Pearson et al. 2007). The study concluded that full access to PBS and MBS was clearly warranted.

Barriers to successful practice were identified as part of this study and included:-

- The Aged Care nurse practitioner role needs to be identified as a generic role rather than person-specific role.

- The need for national clinical practice guidelines specific to aged care are required, rather than state/territory specific guidelines.

- No access to PBS or MBS.

- Lack of continuity between states and territories in terms of licensure and regulation of nurse practitioners prevents simple movement of practitioners between jurisdictions.

- The need to recognise and promote the clinical leadership potential of aged care nurse practitioners and to also educate the population about the role (Pearson et al. 2007, p.5).

An earlier report published in 2005 within the Australian Capital Territory (ACT) was the Nurse Practitioner Pilot Project (2005). The report was overseen by a multidisciplinary steering committee and was led by the Chief Nurse supported by an investigation team, a project team, a co-ordinating team, a clinical support team and from representatives within the residential sector (ACT Pilot Project 2005, p.62).

It was noted as in Pearson et al. (2007) that the aged care nurse practitioner would make a substantial contribution to aged care settings especially through clinical leadership (ACT Pilot Project 2005, p.62).

The ACT Pilot Project (2005) model identified a need for trans-boundary mechanisms on several levels including:

- Across Disciplines through collaboration.
- Across locations of care, including both public and private sectors and organisations.
- Throughout the client's journey of care (ACT Pilot Project 2005, p.62).

Resistance to the nurse practitioner role was noted by the researchers. These included concerns expressed by registered nurses who occasionally questioned the link between the hierarchical management of nursing care and this new nurse practitioner level and also questioned whether the nurse practitioner would provide any skilled care that was not already carried out by existing registered nurses. Clients and other health professionals expressed acceptance for the concept of an aged care nurse practitioner in the community residential and acute hospital setting (ACT Pilot Project 2005, p.63).

The report identified that there was a need for nurse practitioners and employers within aged care in Australia to develop a generic role involving transboundary responsibility. It represented an important move towards innovation and considerable development within aged care services. Roles and responsibilities were clearly defined and investigated and the clinical model included a prescribing formulary, despite no access to PBS at that time. This suggested that PBS and MBS needed to be considered by parliament much earlier than 2009, as a priority for nurse practitioners.

The National Nursing and Education Taskforce (2005) investigated how the role of a nurse practitioner had been implemented up until 2005, within Australia. The

Taskforce report identified further problems involved as Pearson et al. (2007) identified, such as acceptance of the nurse practitioner role by colleagues. The document does not provide a history of implementation (see Driscoll et al. 2005). More importantly, it focused on the nurse practitioner models in place at the time, with particular reference to nurse/midwife regulatory authority and state/territory government approval processes in place for nurse practitioners.

The Task Force (2005, p.3) acknowledged that in jurisdictions where nurse practitioners have been established, the journey to implementation was often protracted and problematic. Decisions made about how the nurse practitioner role was to be introduced needed to take into account the disparate positions, views and opinions of a range of stakeholders, many of whom were not nurses. In the majority of states, the nurse regulatory authority authorised the nurse practitioner. The process for establishing posts remained within the remit of health service organisations in each state. New South Wales was the only state to authorise midwifery practitioners as well as nurse practitioners who are advanced practitioners in midwifery (National Nursing & Education Taskforce 2005, p.1).

The Task Force report posited that this was based on designated prescribing (as opposed to authorised prescribing) undertaken by nurse practitioners. Authorised prescribing rights were those given only to doctors, veterinary surgeons and dentists (National Nursing & Education Task Force 2005). It means that the prescriber was not to be limited to any particular formulary or protocol. Conversely, designated prescribing meant that the prescriber was limited to prescribe medication from an approved formulary or through the use of a particular drug protocol. Most

prescribing for the nurse practitioner involves formulary and protocol use (National Nursing & Education Task Force 2005).

Nurse practitioners were not independently eligible for an Index of Health Professionals Provider Number (IHP) and are thus ineligible for benefits under the Prescribers Benefits System (PBS) or the Medicare Benefits Schedule (MBS). Currently nurse practitioners' prescribing rights are limited to a hospital pharmacy and its dispensing medication only according to an approved nurse practitioner's formulary. A community-based nurse practitioner cannot prescribe without incurring a cost to the patient as this is classed as a 'private' prescription. This is because it is outside the provisions of PBS (where normally a prescription attracts no additional dispensing fee). Ineligibility under PBS for nurse practitioners has been a major setback in nurse practitioner development.

The decision to allow nurse practitioners access to PBS and MBS was made on 12 May 2009 (Australian Nursing and Midwifery Media Release 13 May 2009) and as a result the autonomy of the nurse practitioner should have become enhanced due to their 'unhindered license to prescribe medication regardless of clinical setting' (Australian nursing and Midwifery Council Media Release 13 May 2009). This notion of 'unhindered' license to prescribe has not been realised.

In its earliest form, the 2009 Health Amendment Bill (Nurse Practitioners and Midwives) attracted opposition from medical practitioners, in that they demanded every nurse and midwife with access to MBS and PBS should enter into a 'collaborative care agreement' with a patient's GP or hospital consultant to ensure continuity of care. This led to a senate inquiry and the findings of this inquiry,

supporting a collaborative care agreement were accepted by the federal government (Report of Senate Inquiry 2009). A further amendment to the original amendment bill was added that demanded a collaborative care agreement. The proposal to add such an amendment received criticism from the Royal College of Nursing Australia (RCNA) who argued that the amendment demanding collaborative care duplicated existing regulatory mechanisms.

The RCNA asserted that the Australian Nursing and Midwifery Council (ANMC) competency standards, code of professional conduct and code of ethics for nurse practitioners form part of a strong regulatory framework supporting collaborative practice within which nurse practitioners currently work (RCNA 2009). This was a strong argument, for it posited that all registered nurses proved their competency in collaborative practice, but the medical fraternity were resisting progress by demanding a collaborative care agreement. This suggested the continuous need for doctors to supervise the work of a nurse practitioner, regardless of their proven competence.

Despite the positive aspects of collaborative care agreements, the overall outcome of this process demonstrated yet another example of inter-professional downward closure (Yuginovich 2009) by the provision of an imposed counterfeit supervisory relationship on the part of medical practitioners who worked alongside nurse practitioners. The nurse practitioner and the midwife, who was also subject under this amendment to the same provisions, were treated differently to other health professionals such as dentists and psychologists, who also have access to PBS and MBS. The answer may be to impose a time limit for this collaborative care

agreement to remain in place. The legislation for nurse practitioners' access to PBS and MBS does not come into force until November 2010. There is still time to re-consider the legislation more closely by nurses, doctors and the government. It could be feasible for Australia to undertake a similar initiative to that in Canada by the CMPA/CNPS Joint Statement (2005). If such a similar initiative were negotiated by doctors and nurse practitioners working together in Australia, further criticism of current legislation could be avoided.

The fact that PBS and MBS have now been approved at Senate for nurse practitioners and midwives is not without criticism from outside the health care sector. Sammut (an independent researcher from the Centre for Independent Research in NSW) criticised the Health Legislation Amendment Bill (Nurse Practitioners and Midwives) in 2010. He stated that it is 'an irrational and immoral rationing in the form of an inverse law' (2010 p.1) because nurse practitioners are undertaking tasks previously the domain of doctors and by nurses gaining further status by being allowed PBS and MBS privileges. He perceived this would take the nurse practitioner away from patient care. He did not mention the midwife at all despite reference to midwives and nurse practitioners as the key personnel affected by the bill. He also stated that problems in nursing stemmed from the shift of hospital nurse training into tertiary education because nursing roles are not as clearly defined as they were prior to this shift. This assertion by Sammut (2010) was uninformed and perpetuates the ancient handmaiden image of nursing.

He mistakenly aligned practice nurses with the role of the nurse practitioner. His perception about what a nurse practitioner role entailed was entirely false. He seemed

to believe that practice nurses and nurse practitioners were the same. He stated that taxpayers' money would be wasted by creating another tier of nurse entrepreneurship (Sammut 2010). This assumption of Sammut (2010) was possibly due to the failure of the nursing profession to enlighten the public about the role of a nurse practitioner from the beginning. Public awareness about the role would have enabled better understanding and an increased awareness about why PBS and MBS are an essential component for the successful development of nurse practitioners in Australia. Such comments openly conflict and attempt to negate those of Gardner (2004, p.1) who claimed that the nurse practitioner level in health care is one of the most important developments in nursing during the last 30 years and marks the opportunity for significant reform within the health care industry in Australia.

In Australia, the introduction of the nurse practitioner role was a state function rather than a federal initiative and in consequence the introduction has been gradual with title protection and practice privileges proclaimed in legislation in every Australian state that has made provisions for nurse practitioner development (Gardner 2004, p.1). This new role has been complicated by existing nomenclature (title given) relating to advanced practice roles in nursing. Titles such as nurse practitioner, advanced specialist, clinical nurse consultant, clinical nurse specialist and advanced practice nurse are frequently used in nursing as interchangeable titles and at times without problems (Gardner 2004, p.1). However, there is no international consensus in the use of these terms. The title of nurse practitioner continues to evolve and develop globally as the most significant of these advanced practice roles (Gardner 2004).

The definition of a nurse practitioner is important, in giving credence for the need to protect the title and the definition adopted within most jurisdictions in Australia, following the publication of the Gardner, Carryer Dunn and Gardner study (2004). For example:-

> "A nurse practitioner is a registered nurse educated to function autonomously and collaboratively in an advanced and extended clinical role. The nursing of clients using nursing knowledge and skills, may include, but is not limited to, taking a patient history the direct referral of patients to other healthcare professionals, prescribing medications and ordering diagnostic investigations and making diagnoses. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise" (Gardner 2004, p.2)

This is the definition that will be used within this study to delineate the Australian nurse practitioner role. There are three points in Gardner's (2004) definition that are central to understanding the nature of the nurse practitioner role:-

i) Extended Practice- the element that differentiates the nurse practitioner from another advanced practice role. The scope of practice of the nurse practitioner is subject to different practice privileges that are protected by legislation. This means that the privileges awarded to nurse practitioners through legislation are specific to the nurse practitioner and remain outside the scope of practice of a mainstream registered nurse (Gardner 2004, p.2). Examples of these privileges include prescribing medication, ordering plain film x-rays, and ordering blood tests.

In order for a nurse practitioner to be allowed these privileges, amendments to Acts of Parliament within the states of Australia were necessary, such as the Queensland Nurses Act 1992, Health (Drugs and Poisons Regulations) 1996 (Queensland). With

a scope of practice that incorporates these extended practice activities, the nurse practitioner functions in such a way that incorporates both nursing activities and some other activities normally within the remit of medical practice (Gardner 2004, p.2).

ii) Autonomous Practice-the nurse practitioner engages in clinical practice with significant clinical autonomy and accountability, which incorporates accepting responsibility for the complete episode of patient care (Gardner 2004, p.2). This means that the nurse practitioner makes all the decisions and carries out the follow-through in patient care without recourse to another healthcare professional. This autonomy is situated, nevertheless, within a team approach to care whereby the nurse practitioner works within a multidisciplinary team in a clinical partnership role to optimise patient outcomes. This would include an accident and emergency department (A/E), where a nurse practitioner will triage, examine and treat patients who do not require physician intervention. This process could entail treating patients suffering from minor injuries such as sprains and strains within joints, wound infections, chest colds, and uncomplicated wounds that require suturing.

Such nurse practitioners carry their own caseload of patients and are able to assess follow-up visits and treatment options without physician involvement. This complements the role of the physician through allowing his/her time to be spent dealing with cases where physician involvement is essential (Gardner 2004, p.2).

iii) Nursing Model**:** This type of practice is firmly located within a nursing model. That is, nurse practitioner practice is rooted in the caring ethos of nursing and is about flexibility in the delivery of nursing care (Gardner 2004, p.2).

Encouragingly within Australia lies the determination for nurse practitioners to remain focused within a nursing model of care. A nurse practitioner may perform tasks normally undertaken by doctors, but remains focused on nursing management and nursing care. Whilst nurse practitioner knowledge will continue to develop as will the medical profession, about the pathophysiology of disease and disease management (the medical model), nurse practitioner practice in Australia has firmly moved outside the medical model of care (Gardner 2004, p.2).

The nurse practitioner role has been shown to offer a beneficial service and fill a gap in health care provision (Sherwood et al. 1997; Hughes & Carryer 2002; Dunn 2004; Gardner 2004; Gardner & Gardner 2005; Pearson et al. 2007). Such services include working with the homeless, women and children, aged care, in rural and remote communities and specialist services in hospitals such as A/E, neonatal care and as midwifery practitioners, as in NSW.

In addition to contributing improvements in health care, Gardner (2004) stated that the nurse practitioner role is an exciting and new clinical career pathway. The nurse practitioner is not a medical substitute, nor should the role replicate existing services. The role is most effective when it fills a gap in existing services such as in rural and remote areas, cardiac rehabilitation, mental health liaison, primary healthcare diabetes, gerontology, or sexual health (Gardner 2004, p.1).

The consequences of increased autonomy, authority, responsibility and indeed the potential liability have not been addressed by Gardner (2004). The legal framework involving nurse practitioner practice has been poorly addressed. Gardner had an opportunity to do this here. She did not take this opportunity. The roots of legislation

for nurse practitioner practice are contained within Gardner's (2004) paper such as title protection, legislation, the scope of practice, autonomy, authority and role development. There are nevertheless, two other tenets that are essential within the context of nurse practitioner clinical practice that are not mentioned. These are responsibility and accountability. Early investigation that could have been undertaken by Gardner (2004) within a legal context would have put the role on a much firmer footing and possibly subject to less criticism from the medical fraternity as identified earlier by Dunn (2004) because the legal context of nurse practitioner practice would have been apparent earlier.

2.6.3 Education of Nurse Practitioners in Australia

Gardner, Dunn, Carryer and Gardner **(**2006) provided parallels to findings presented in the taskforce (2005) research, also by Gardner, Dunn, Carryer and Gardner (2005). The focus in 2006 was indeed different because it was solely on education and preparation for nurse practitioner practice, rather than a whole gamut of nurse practitioner issues (Gardner, Dunn, Carryer & Gardner 2006).

The primary argument stated that findings from this particular research undertaken included support for master's level education as preparation for the nurse practitioner role (Gardner, Carryer, Dunn & Gardner 2006, p.1). Such a program needed to have a strong clinical learning component and in-depth education for the sciences of specialty practice. Additionally, an important aspect of education for the nurse practitioner was the centrality of student directed and flexible learning models. This supported the National Nurse Education Taskforce (2005) findings.

While the mutual interstate recognition of registration had been in effect for several decades in Australia, there had been no standardisation of education, practice competencies and authorisation process relating to the nurse practitioner in the different jurisdictions within Australia. To address this anomaly within Australia and between Australia and New Zealand, The Australian Nursing and Midwifery Council (ANMC) and the Nursing Council of New Zealand formally committed to collaboratively develop the nurse practitioner role and to support recognition of nurse practitioner endorsement qualifications between the two countries (Gardner, Carryer, Dunn, & Gardner, 2006).

Gardner, Carryer, Dunn and Gardner (2006) stated that of 14 programs leading to the award of a nurse practitioner qualification at that time, 13 were at master's degree level. Nurse practitioners' views on qualification related to:-

a) Public perception of the level and stature of a master's degree was viewed as an important aspect of ensuring public confidence in a nurse practitioner service.

b) A belief that the master's degree offered scholarship that was comparable with the nature of the skills, knowledge and attributes required.

c) Personal experience of the value of master's degree education (p. 3).

In some instances nurse practitioners provided support for this view based on their own experiences as pioneers while others offered a perspective influenced by having come to the nurse practitioner role through a different route (Gardner, Dunn, Carryer & Gardner 2006). Nurse practitioners who did not have a master's degree tended to take a more qualified stance and were overwhelmingly committed to the primacy of

clinical experience as preparation for the nurse practitioner role (Gardner, Carryer, Dunn & Gardner 2006). This supported the findings of the National Education Taskforce (2005) and by Dunn (2004) who outlined the importance of education for nurse practitioners.

Entry requirements across the 14 programs were highly consistent apart from the main variation of experience in a specialty in which the applicant desired to work. This varied from no experience at all to five years. Nine programs required postgraduate qualifications in the specialty of choice and most of these concerned entry into master's degree programs. Two required portfolios for entry and two required membership of professional/specialty associations. Ten programs had flexible entry and exit features (Gardner, Carryer, Dunn & Gardner 2006, p.3).

Gardner et al. (2006) related teaching and learning to the importance of adult learning principles with learning as collaborative and use of the clinical field with a mentor/preceptor. This included experiential/situated learning the promotion of self-directed/lifelong learning skills (Gardner, Carryer, Dunn & Gardner 2006, p.3). The apparent diverse curriculum content, particularly between Australia and New Zealand, with content imperatives being determined locally and in response to local regulatory requirements, the attitudes and opinions of each health service and clinical environment had to be recognised. In New Zealand curriculum content was found to be more cohesive due to the centralised nature of nursing regulation. In relation to pharmacology, in many programs the content was spread in several courses, across the curriculum and included pharmacology and pharmacotherapeutics (Gardner, Carryer, Dunn & Gardner 2006, p.5).

Other study areas that were common across many of the programs included:-

Clinical Sciences: Anatomy, physiology and Pathophysiology, Professional and scope of practice studies, Clinical leadership, Society Law and Ethics, Cultural Awareness and Cultural aspects of nurse practitioner practice. Content such as symptoms management and therapeutics tended to be linked to 'specific speciality practice' (Gardner, Carryer, Dunn & Gardner 2006, p.5).

Although most of the above topics in 'other areas of study' are suitably placed as adjunct areas of study within a nurse practitioner program, it could be argued that law and ethics is not given enough emphasis within nurse practitioner programs. Most universities address the need for this within programmes but not as a primary area of study, such as pharmacology. There are specific areas of law relative to autonomous practice that are important such as authority, accountability and responsibility. The more the role extends, expands and diversifies, the greater the potential for liability. This is especially important for nurse practitioners who undertake independent practice, because they are no longer protected by the vicarious liability of an employer (Petersen in Freckleton & Petersen 2006, p.487).

Vicarious liability arises when it is possible that another person or organisation may be held liable as well as someone who is alleged to have committed the tort. The employer is therefore liable for all errors, acts and omissions of the employee (Walsh 2006, p. 362). In such a situation there has to be a clearly recognised relationship between the parties that results in the one party being liable for the torts of another. Examples of such relationships include:-

- Master and servant relationship.
- Principal and independent contractor relationship.
- Principal and agent relationship.
- Parent and child relationship.

Vicarious liability can be aptly described using a legal maxim ‘qui facit per alium facit per se’ (meaning): ‘he who does a thing through another does it himself’ (as quoted by Walsh 2006, p.363). In healthcare an employing organisation fulfils the criteria for vicarious liability and is responsible for the civil wrongs of the employee during the course of employment. The employer will be vicariously liable for the acts and omissions of its employees providing that the employee was not in breach of any policy, procedure, protocol or contract imposed by the employer. A provider of indemnity insurance is not obligated to indemnify a person in breach of any of these provisions (Dimond 2004).

There are standards that healthcare employees (such as competency standards for nurse practitioners) must uphold and legislation in place for nurse practitioners within Australia that governs regulation and registration of nurse practitioners. The civil liabilities legislation within Australia is also important to consider when examining the role of a nurse practitioner when addressing legal issues.

According to Forrester and Griffiths (2005 p.94) The Queensland Civil Liability Act (2003, S.22), for example, stated:-

1. A professional does not breach a duty arising from the provision of a professional service if it is established that the professional acted in a

way that (at the time the service was provided) was widely accepted by peer professional opinion by a respected number of respected practitioners in the field as competent professional practice.

2. However, peer professional opinion can not be relied on for the purpose of this section if the court considers that the opinion is irrational or contrary to a written law.
3. The fact that there are differing peer professional opinions widely accepted by a significant number of respected practitioners in the field concerning a matter does not prevent any one or more (or all) of the opinions being relied on for the purpose of this section.
4. Peer professional opinion does not have to be universally accepted to be considered widely accepted.
5. This section does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information in relation to the risk of harm to a person, that is associated with the provision by the professional of a professional service (Forrester & Griffiths 2005 p.94).

All nurses need to be aware of the implications of errors made in every aspect of clinical practice, in the knowledge that any acts and omissions that result in alleged negligence will be examined by a group of peers appointed by a court. When role expansion and extension is permitted in a role such as that of the nurse practitioner, the implications for risk in litigation become significant. As a result of the expanded role the nurse practitioner carries sole autonomy, accountability, authority, responsibility and most importantly sole liability for everything that they do in the role (Petersen in Freckleton & Petersen 2006, p.487). Safeguards against litigation such as Quality Use of Medicines (QUM) can be implemented but these are only as good as the commitment of the nurse or doctor following any QUM program. This is totally contrary to the findings of Sherwood et al. (1997) and Pearson (2007) who describe some medical practitioners who employ nurse practitioners, being responsible for nurse practitioner practice and therefore the medical practitioner may be vicariously liable if a master and servant relationship is established (Walsh 2006).

Gardner, Carryer, Dunn, and Gardner (2006 p.12) suggested that nurse practitioner narratives spoke strongly about lifelong learning: 'as you go along you learn what you need to know'. There is an additional argument of a nurse not being aware of all that is known, in particular areas of practice: 'they don't know what they don't know' (Dimond 2004, p.1). If a nurse is unaware of the implications of movement outside the clinical remit of a scope of practice that nurse could become liable for sanction as a result of any litigation, if harm to the patient arose as a direct result of his/her actions (Dimond 2004).

In Australia, the need existed for a nurse practitioner nursing model (Gardner, Carryer Dunn, & Gardner 2006, p.13) as the core tenet in preparation for nurse practitioner practice. Gardener, Carryer, Dunn and Gardner (2006, p.12) stated that capable nurse practitioners are those who know how to learn, are creative, have a high degree of self efficacy, would apply competencies in unfamiliar and familiar situations and are able to work well with others. Furthermore they stated that capability emphasised the value of complexity in influencing nurse practitioners' learning by having to work within dynamic systems that provided an environment for learning in non-linear and unpredictable events. This was further evidence that a nurse practitioner was capable of autonomous clinical practice, reflecting leadership potential for clinical practice where high standards of care were required in complex situations. This reflected the findings of Hughes and Carryer (2002) in their study of the nurse practitioner in New Zealand. Findings within the report on which this paper was based also identified a lack of standardisation emerging in Australia in terms of nurse practitioner education. These variations include:-

Standards: a variety of standards, competency frameworks and interpretations of the role itself have informed and influenced the decision makers, in terms of curricula development and regulatory requirements for nurse practitioners;

Education Levels: this also varied, in terms of the lack of clarity between nurse practitioner and advanced practice study requirements consistent with ambiguity in nomenclature and educational requirements for the nurse practitioner (Gardner G, Carryer, Dunn & Gardner A. 2006, p.14).

In 2006, an opportunity existed for New Zealand and Australia to become trailblazers in standardising educational and licensure requirements for nurse practitioners within the Trans-Tasman region. A standardised researched-informed approach to nurse practitioner education and nomenclature could provide obvious advantages within the contexts of interstate or Trans-Tasman agreements for the future. The authors of this study adduced that there was a need for the avoidance of "structured pedagogical approaches" (pedagogical: related to formal, structured education) to nurse practitioner education and more importantly for nurse practitioner candidates as advanced specialist nurses, well placed to define their own specific learning needs (Gardner, Carryer, Dunn & Gardner 2006, p.13).

This statement meant that there should be less emphasis on structured, formal education approaches (such as a fixed syllabus that is generic to all student participants) and more emphasis on education that met the specific needs of nurse practitioner candidates. Gardner, Carryer, Dunn and Gardner (2006) provided a very comprehensive account of problems and examples of benchmarks for nurse practitioner education within Australasia. They offered an emphasis on capability

learning and the advent of flexible learning pathways that allowed for increasing complexity and curriculum scaffolding through a rich variety of learning resources and monitored self- directed learning.

2.6.4 Legal and Professional Issues in Australia

Chiarella and McInnes **(**2008) explored the legal and ethical frameworks that informed nursing practice and health care cultures. They used methodologies informed by critical race and feminist jurisprudence (also called outsider scholarship). Chiarella and McInnes (2008, p.78) identified images of nursing and the positive and negative effects of these images and their legal and moral impact on nursing practice. They explored and assisted in exposing some of the power structures and assumptions that governed contemporary nursing practice and standards of care which impact on factors such as workforce retention. This is reinforced by the work of Dunn (2004) and Driscoll et al. (2005) in Australia and Sherwood et al. (1997) in the USA.

Case law illustrated the relationship between image and power and how these affected legal and moral frameworks and the realities of the workplace for nurses (Chiarella & McInnes 2008, p.78). This was achieved by examining the law as a form of insider stories (whereby the world was described in terms of pre-existing power structures) and outsider story-telling (whereby stories were challenged to reflect experiences). Five dominant and recurrent images of nursing emerged from case law analysis. These had implications for the way in which nurses respond to critical situations, which involve the adoption of a moral stance and include nurses'

legal and ethical status and the environment in which nurses practised (Chiarella & McInnes 2008, p.78).

Moral and ethical frameworks were derived also in normative ways, developed in response to historical and sociological developments. One of those described is 'The Tyranny of Niceness' (Walker 2003, cited in Chiarella & McInnes 2008) which stated:-

> "The pre-eminent value inherent in the technique of sensibility of 'being nice', is one that insists that overt conflict must be avoided wherever and whenever possible. This sensibility is sanctified in our culture in the notion that a good woman does not contradict and a nice woman does what she is told. By extension then, a good nurse takes what she finds (or is given) and does not question. A nice nurse therefore must be a good nurse" (Walker 2003 p.4 in Chiarella & McInnes 2008, p.78).

Chiarella and McInnes (2008) further quoted Walker stating that:-

> "The behaviour this technique initiates is one of backing off, assuming a passive posture, or silencing oneself. It is a technique of sensibility which shapes us in pervasive and powerful ways. The reciprocal behaviour such a technique of sensibility elicits is one that is generally tacit: it does not usually ever come to expression. The combination of value, behaviour and response leads to a form of silent but mutual agreement between the individuals engaged in the conflict situation...it generally insists that no further dialogue is needed to resolve the situation (Walker 2003 p.145 in Chiarella & McInnes 2008, p.78).

Comments such as these suggested that the 'tyranny of niceness' had influenced the legal, moral and ethical frameworks that have developed in nursing and most particularly contributed to feelings of powerlessness in the workplace, affecting the nurses' ability to be heard when patient safety is at stake with even more senior nurses such as nurse practitioners becoming unable to state their views.

A stock story (Chiarella & McInnes 2008, p.78) was defined as:-

> "The one the institution collectively forms and tells about itself. The story picks and chooses from among the available facts to present a picture of what happened: an account that justifies the world as it is (Delgado 1989, p.2421 in Chiarella and McInnes 2008, p.78)".

Medical stock stories provide explorations of power, especially when one considered the challenge (Roxon 2008) to doctors being the 'gatekeepers' of primary care. Roxon argued against this notion of doctors being gatekeepers of primary care, but in terms of primary care, at the present time, the doctors are those in power. Any outside stories that challenge this stance are likely to meet resistance (Australian Broadcasting Corporation 7.30 Report 2008 no author cited). Roxon's outsider challenge was to suggest that this stance is outdated, because doctors need not necessarily be the sole gatekeepers within primary care (p.1). This had a direct impact on the development of the nurse practitioner, especially from the perspective of nurse practitioner/medical fraternity arguments within the five countries studied by this current research.

Chiarella and McInnes (2008) defined five recurrent themes that emerged from the case law analysis. These thus provided the backdrop for the ethical and legal practice frameworks that had developed in nursing. These images were domestic worker, ministering angel, doctor's handmaiden, subordinate professional and autonomous professional. These images provided themes as stock and outsider stories and were classified accordingly:-

a) As stock stories where nurses were under control: associated images were nurses as domestic workers, doctor's handmaiden and subordinate professional. This

reinforced the notion of inter-professional downward closure (Yuginovich 2009) because the nurse was considered to be of lower status.

b) As outsider stories where nurses were in control: associated images being the nurse as ministering angel and as an autonomous professional (Chiarella & McInnes 2008, p.79).

The authors stated that this model had been pursued at the expense of redress to the power imbalances in the way in which health care was structured. It had not addressed, and may even have perpetuated, the cultural problems, such as institutional powerlessness that affected nurse retention. Two reasons given for nurses leaving the profession were that nurses felt unable to deliver the quality of care they believed was required and that nurses were neither valued nor respected (Chiarella & McInnes 2008, p.79). Factors likely to reverse this trend included a multidisciplinary approach to care, the ability to provide care which satisfied both nursing and patient expectations, a formula that ensured reasonable workloads and a work environment which fostered nurse autonomy and control over practice in order to provide safe patient care (Chiarella & McInnes 2008, p.79).

As a leader, the nurse practitioner could become a prime facilitator in ensuring that the above legal factors become reality in all clinical settings in which they practice Chiarella and McInnes (2008). Other issues raised included the need to address power imbalances and the need to have a system based on practice expectations, not personalities (Chiarella & McInnes 2008, p. 79). Nurses can be seen concomitantly as both advanced practitioners and as subordinate to doctors but this factor should be

addressed from both a medical and nursing perspective (Chiarella & McInnes 2008 p.79).

The case of *Bolitho vs. City and Hackney AHA (1998) AC 232* was cited by Chiarella and McInnes (2008) to illustrate the power differences between doctors and nurses. A two year old child was admitted to hospital suffering from croup. Up until the incident the child had improved slightly, appeared lively and had been playing in his cot. However, the child later had three episodes of respiratory difficulty. After the first episode a nurse was assigned to be with the child to monitor his condition, as ordered by the registrar. The child had a second episode. The registrar was in clinic and told nursing staff to page the house officer, who failed to respond. The dilemma here of nursing staff helplessness, with non-attendance of both doctors meant to be looking after the child, was not addressed in this case. Expert evidence showed that if a doctor had attended at the time of the second call, and intubated the child, the child would not have died. The case stood for the proposition that the expert opinion must be logically defensible (i.e. the expert must be able to defend the evidence submitted when questioned by a legal counsel or judge). Though the doctor was in breach of the duty of care it was not established that the breach caused the damage (Chiarella & McInnes p.80).

Power issues within health care do exist. The case of *Bolitho* found that the registrar was in breach of the duty of care. Chiarella and McInnes (2008 p.80) rightly state that the powerlessness/helplessness felt by nurses involved in the care of the child was not addressed in this case.

Chiarella and McInnes (2008) advocated a solution to lack of power issues by personnel self care, as followed in the aviation industry (Flight Safety Foundation 2000 cited in Chiarella & McInnes 2008, p.80). In this situation all employees are encouraged to speak out forcibly if they consider there is a problem, through a process of escalating their concern. The authors argue that such an expectation is an imperative for health care organisations (Chiarella & McInnes 2008 p.80).

Chiarella and McInnes (2008) claimed that there is a correlation between staff retention and patient outcomes. Historically this had a direct impact on recruiting and retaining experienced nurse practitioners, and it outlined the necessary systems that need to be in place to achieve this. Correcting power imbalances had the potential for senior nurses (such as nurse practitioners) to provide the clinical leadership (Chiarella & McInnes 2008, p.81). Chiarella and McInnes (2008) illustrated this by describing a USA study (p.81) where hospitals were investigated to identify the organisational attributes that were successful in recruiting and retaining nurses during national nurse shortages. These characteristics included effective and supportive leadership, nursing staff involvement in hospital decision making, commitment to professional clinical nurses' qualities, participatory management, autonomy and accountability and a supportive environment (Chiarella & McInnes 2008, p.81).

In Australia, efforts have been made to drive the nurse practitioner role as a senior nurse leader capable of functioning within a senior management team as a nurse directing safe nursing practice such as in primary care, operating theatres, acute care, accident and emergency and neonatal care (Gardner & Gardner 2005). However, the

medical fraternity remains steadfast in not always amending their view of always seeing the nurse as a subordinate professional (Chiarella & McInnes 2008, p.82). Chiarella and McInnes (2008, p.82) suggested that the way power relations have evolved and how they have been maintained by employers and stakeholders over the decades confirms that health care delivery is firmly ensconced within a biomedical paradigm and therefore under medical staff control (Chiarella & McInnes 2008, p.82).

Often the only resource a mainstream nurse has when concerned about a patient's condition is to call a doctor. However, whilst some images of nursing such as the nurse practitioner give a nurse some degree of moral and clinical responsibility (Gardner 2004), there continues to be no promise of power for nursing in Australia at a clinical level despite major inroads involving advances in extended and expanded clinical nursing practice of a nurse practitioner. Though all nurses carry out nurse interventions that form a major contribution to client care, medical control sometimes prevents the nurse having total clinical autonomy. Doctors who may be less knowledgeable than senior nurses about wound dressings have to prescribe wound dressings prior to use by nurses-especially the more expensive types. A nurse practitioner who has such wound dressings on her formulary is able to prescribe these without recourse to a doctor. This is suggestive of clinical autonomy but not of control. However, this example provides evidence that a nurse practitioner is able to work as an adjunct to a doctor.

In terms of autonomous nurse practitioner practice, while nursing has welcomed this (Gardner 2004), consideration had not been given to addressing any power

imbalances, neither had nursing addressed the problems which affect retention, such as nursing/medical staff turf wars, prescribing and role expansion (Chiarella & McInnes 2008, p.82). Indeed, Chiarella and McInnes (2008) state that this may have perpetuated some problems.

Petersen (Petersen in Freckleton & Petersen 2006, pp.478-489) discussed nurses as defendants and emerging risks within clinical nursing practice. The authors were specifically discussing the emerging risk of the nurse practitioner (p. 478). A licence to practice in New South Wales will expire after three years and the license will be reviewed to ensure that the nurse practitioner retains the skills required. This ensures that the nurse practitioner maintains the required expertise for continued registration as a nurse practitioner (Petersen in Freckleton & Petersen 2006, p. 478). At the present time in the light of National Registration, this remains unchanged (National Health Practitioners Registration Agency 2009).

The Ipp reforms have major bearing on issues of alleged negligence in relation to nurse practitioners (Freckleton in Freckleton & Petersen 2006, pp. 381-404). Legislative amendments that have occurred in Australia as a result of these reforms since 2003 are explained. The Ipp committee was formed in 2002 to review the laws of negligence in Australia. The terms of reference for the review indicated that:-

> "The award for damages for personal injury has become unaffordable and unsustainable as the principle source of compensation for those injured through the fault of another. It is desirable to examine a method for the reform of the common law with the objective of limiting liability and quantum of damages arising from personal injury and death".

Recommendations from this committee were enacted into civil liability legislation within the States and Territories of the Commonwealth in 2003 (Bennett &

Freckleton in Freckleton & Petersen 2006, p. 382). A major impact of these reforms that affects nurses is in determining the standard of care in negligence through the use of a modified Bolam test. The Bolam test has been a standard test in negligence for many years (*Bolam v. Friern Hospital Management Committee [1997] 1 WLR 582*). Mr Bolam was undergoing a course of electro-convulsive treatment (ECT) for depression. During the convulsive phase in one such treatment Mr Bolam fell from the trolley and sustained a fractured pelvis. No muscle relaxant was given. Mr Bolam sued in negligence on grounds that if he had been give a muscle relaxant he would not have fallen from the trolley. In enunciating the Bolam test McNair stated:-

> "Where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is the standard of the ordinary skilled man exercising and professing to have that special skill……in the case of a medical man, negligence means failure to act in accordance with the standards of reasonable competent medical men at the time…" (Extracted from *Whitehouse vs. Jordan* [1981] All ER 267 cited in Forrester & Griffiths 2005, p.92).

This test was modified to some extent in the case of *Bolitho v. City and Hackney Health Authority* [*1997] UKHL 46[1998] AC 232 [1997]4 All ER 471[1997]* where it was held by the judge that:-

> "In cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence....In my judgement that is because, in some cases it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible" (Bennet & Freckleton in Freckleton & Petersen p.384).

This statement meant that the judge set a precedent to reject expert opinion where the judge thought that this expert opinion was neither reasonable nor responsible in defence of a case (Bennett & Freckleton in Freckleton & Petersen 2006, p.384). As a result the Ipp committee recommended the use of the Bolitho approach and a

modified Bolam test (Bennett & Freckleton in Freckleton & Petersen 2006, p.384) is applied using the precedent of rejecting expert evidence that is neither reasonable nor responsible, in most jurisdictions. The Northern Territory, the Australian Capital Territory and New South Wales use a different modified Bolam test:-

> "A person practising a profession does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice"(Bennett &Freckleton in Freckleton & Petersen 2006, p. 384).

One of the main aims of the Ipp reform was to prevent 'pockets' of expert opinion being accepted without examining the wider body of expert opinion in negligence cases within Australia (Bennet & Freckleton in Freckleton & Petersen 2006, p.384):-

> "Peer professional opinion cannot be relied on for the purposes of this section (*NSW Civil Liabilities Act*) if the court considers that the opinion is irrational".

This meant that a court could reject expert opinion that it considered professionally illogical, but was used in a similar context to the Bolam Test of unreasonable or irresponsible (Bennett & Freckleton in Freckleton & Petersen 2006, p.385). These provisions thus excluded small pockets of opinion being allowed to protect the culpable professional from sanction in negligence, without examining a wider body of opinion in Australia (Bennett & Freckleton in Freckleton & Petersen 2006, pp. 383-385). This placed a nurse practitioner who provides a scope of practice that is unique and provided by that nurse practitioner alone, in a very precarious position. It may only be a small pocket of opinion able to provide expert opinion for a nurse practitioner, should an alleged negligence suit arise. The expanded role of any nurse

practitioner is yet to be tested under Australian civil liability legislation in negligence, but each nurse practitioner needs to be cognizant of the defences in negligence applicable to the scope of practice undertaken and where expert opinion is likely to come from.

Most other jurisdictions in Australia followed the New South Wales lead. Freckleton outlines the scope of the role obviously much broader than mainstream nursing. The changing roles of nursing within the present healthcare environment give rise to two significant issues regarding the nurse practitioner (Petersen in Freckleton & Petersen 2006, p.486):-

> "Where the nursing roles are expanding, both informally (at employer level) and formally (at nurse regulator and professional clinical specialty organisation level) there is the real potential for lack of clarity on behalf of healthcare consumers and the profession itself, as to what is, or is not, a reasonable expectation in terms of the legal standard of 'competent professional practice".

In attempting to reach a decision as to whether a nurse has breached the duty of care, by failing to meet the legal standard of 'competent professional practice' the problem lay in determining this standard. When nursing roles were changing and nurse practitioners' scope of practice was specific only to that nurse, the nurse cannot be totally certain that his/ her actions are 'widely accepted by peer professional opinion by a number of respected practitioners in the field'(Petersen in Freckleton & Petersen 2006, p.487). There was an element of doubt as to obtaining specialist expert opinion to assess whether the standard of competent professional practice actually was, or was not, the standard expected of the nurse practitioner in any given specific role.

The impact here was on potential role expansion and the greater risk for potential liability of nurses (Petersen in Freckleton & Petersen 2006, p.488).

Where the expanding roles of nurses are formalised and sanctioned by regulatory authorities, and clinical specialty organisations, there is a need to ensure that competency standards are validated and consistently applied at the initial stage of registration or certification (Petersen in Freckleton & Petersen 2006, p.488). This has been addressed by other authors (Gardner , Carryer, Dunn & Gardner 2006) in discourses about development of the nurse practitioner role, but not the legal implications of extended and expanded practice where a nurse practitioner provides a unique service as a sole healthcare provider (e.g. sexual health needs in a brothel as in Gardner & Gardner (2005, p.2).

Increasing demands were placed on nurses' roles that are expanding and changing to meet the health care needs of our population (Gardner & Gardner 2005). However, there was an increased risk of being sued for negligence, due to expanding roles, greater autonomy and rising patient acuity resulting in clinical nurse leaders having to cope with this rise in more complex nursing care settings. The potential in these circumstances of being involved in an adverse event and later being sued in negligence was therefore significant (Petersen in Freckleton & Petersen 2006, p.489). In terms of negligence the nurse practitioner, owing to their vulnerability in actually assessing the standard of care is most at risk (Petersen in Freckleton & Petersen 2006, p.489).

Petersen (in Freckleton & Petersen 2006, p.489) did not mention the vital importance of the Scope of Practice or the ANMC Competency Standards within the discourse.

These are the benchmark of nurse practitioner's clinical practice. There are best practice standards for the use of all professionals in health care (e.g. breast cancer) as well as clinical practice guidelines and protocols that are mandatory requirements within the scope of practice.

Freckleton and Petersen (2006) were rather pessimistic in their views. They possibly failed to appreciate clinical competencies that have to be met before endorsement of a registered nurse as a nurse practitioner can take place. These nurse practitioners must maintain these competencies throughout their career as a nurse practitioner. Such competencies, accompanied by a thorough examination of the practice model in which a nurse practitioner works are the benchmarks of practice and can be used as evidence for measuring a standard of care. They did not take into account the fact that each registered nurse practitioner (as does every registered nurse) has to demonstrate competency when they renew their licence to practice annually.

Individual Performance Review which is undertaken in most healthcare organisations (Falcone 2007) is a process where each candidate must identify training needs to meet performance criteria. This is an additional mechanism that assesses performance and identifies where good performance is lacking in some way amongst employees. Problems such as timekeeping or interpersonal relationship conflicts and disputes, for example, would be identified.

Falcone (2007) explored individual performance reviews as a means to turning them into a 'strategic' corporate exercise. In this way the individual organisations intellectual capital defined an organisation's ability to stand out from its peers, measuring that human capital as a true asset may dictate an organisation's ultimate

success or failure. Falcone (2007) asserted that this challenge has gone mainly unresolved because managers see performance appraisal as an exercise that focused only qualitatively on individual performance as the core foundation and building block of the performance review 'process'. Most managers saw performance reviews as an exercise of benevolence and compliance. Falcone suggested that there is a 'Golden Cycle' of performance management which involves:-

- Goal setting and planning.
- Ongoing feedback and coaching.
- Appraisal and reward (Falcone 2007, p.1).

Falcone (2007) suggested that the first two steps rarely get addressed, leaving the culmination in the third step largely theory rather than reality. This implied that it was essential for managers involved in nurse practitioner development to recognise the nurse practitioner as a capital asset in the overall strategic planning within any health care organisation. If such performance reviews were structured in order to tie a nurse practitioner's overall performance (and therefore merit) to the team in which that nurse practitioner worked, the overall merit of that team thus increased and the value contribution of the capital asset (the nurse practitioner) within it (Falcone 2007, p.3).'Strategic' performance review will thus be achieved (Falconer 2007, p.3). When this approach is undertaken, the work of the nurse practitioner would be more readily embraced by organisations as a capital asset within a team. The team cohesion is also maintained in the team's knowledge that the success of that team was achieved in no small way by the nurse practitioner.

From a legal perspective, when considering employment law, the rights and responsibilities of a nurse practitioner can be more clearly defined by goal setting and planning for further development, ongoing feedback and coaching (a mentor/supervisor is an important resource for this to succeed) and the appraisal aspect would dictate the success or failure of any post ensuring value for money.

2.6.5 Development of Clinical Practice of Nurse Practitioners in Australia

Gardner and Gardner (2005) reported the results of a trial of nurse practitioner scope of practice prior to the ACT producing its Framework for Nurse Practitioners in 2006, suggesting that even in jurisdictions where the nurse practitioner role is well established there is often difficulty in interpreting the scope of practice. This was due partly to the broad interpretation of the term ‘advanced practice’ and its associated range of often confusing nomenclature (Gardner & Gardner 2005).

Gardner and Gardner (2005) admitted that in Australia nurse practitioner roles were similarly dogged by a lack of clarity in describing the scope of practice. The collaborative nature of the role and the emphasis placed on maintaining a nursing focus for the role had allowed the Australian nurse practitioner to move away and become separated from medical control (Gardner & Gardner 2005).

The medical control inference of ‘treat the disease’(Gardner 2004) is an outdated and hypothetical assumption that any nurse who practiced outside mainstream nursing into a more advanced practice role would ‘automatically’ follow this model (e.g. the physician assistant role). This had resulted from theorists who posited that nurses who practiced at a more advanced level learned to master skills and procedures

previously performed by doctors, but at the same time spent their working lives concentrating only on the pathophysiology of disease and disease management (Parse 1995). These were processes to be mastered in order to provide optimum services for patients, but they were not the 'whole' nurse. This is where Australia also leads the field, worldwide, in nurse practitioner development because the issue of adherence to medical control has largely been superfluous. The emphasis in Australia is on collaboration and holistic care within a caring ethos of nursing.

Gardner and Gardner (2005) used the trial of practice process based on the premise that researchers did not know prior to conducting research what the potential scope of practice might be within any demonstrated clinical model (Gardner & Gardner 2005 p.1). The four models selected were sexual health with an outreach component, wound care, mental health consultation-liaison and military primary care. Each candidate worked as part of a multidisciplinary care team. Aspects of role extension consisted, at that time, of procedures that lay outside the Australian Capital Territory (ACT) legislative frameworks, such as prescribing, referral, ordering of diagnostic tests and some treatments. These aspects were monitored, supported and reviewed by the specific model's clinical support team, with the legal requirements for these services being met by the medical mentor within the team (Gardner & Gardner 2005). This was necessary to ensure that the participants within the study were supported by the medical staff mentor, in fulfilling all legal requirements with regard to clinical supervision of nurse practitioners in training. Comprehensive negotiations were required to this end (Gardner & Gardner 2005).

Fifty one patients (17% n-302) indicated prior knowledge of the nurse practitioner services. Candidates received referrals for 56% of patients (less than 168) primarily from other health professionals within the base organisation. The mental health candidate received referrals from GPs as did the sexual health candidate who also received referrals from community health and support agencies. Throughout the trial the support teams undertook clinical reviews of candidates' assessments and management plans for patients. Of 396 completed clinical reviews across the models only three caused disagreements. In all cases, the team considered the circumstances were beyond the control of the candidates concerned and thus had no relevance to the outcome of the study (Gardner & Gardner 2005).

Each candidate was able to develop a specific scope of practice for the model within which they worked and, at the same time, identify further training needs required to further develop the model. This process was a totally different approach to any other scope of practice model approach documented elsewhere and was very innovative in developing nurse practitioner practice (Gardner & Gardner 2005).

The findings of Gardner and Gardner (2005) illustrated the diverse nature of the health service that nurse practitioners were able to meet. This included a service for brothel workers; specialist wound care management and liaison for mental health patients admitted to acute hospitals. This further added credence to the Australian approach to nurse practitioner development being firmly rooted within a nursing ethos and not on medical control. Medical control is advocated as the appropriate approach within nurse practitioner practice elsewhere, such as the USA (Pearson 2007).

Gardner et al. (2008) further explored the level and scope of practice of the nurse practitioner in Australia and New Zealand, using a capability framework, seeking to identify competency standards for the extended role of the nurse practitioner in Australia and New Zealand (Gardner et al. 2008). In doing so the authors became aware that while competencies described many of the characteristics of the nurse practitioner they did not tell the whole story (Gardner et al. 2008).

A second analysis was undertaken to ascertain whether or not the components of capability would adequately further explain the characteristics of the nurse practitioner (Gardner et al. 2008). Results showed that capability and its dimensions is a useful model for describing the advanced practice level attributed to nurse practitioners. The nurse practitioners described elements of their practice that involved using their competencies in novel and complex situations they had not previously encountered, as well as with the familiar. The authors concluded that nurse practitioners demonstrated creativity and innovation as well as the ability of knowing how to learn, having a high level of self-efficacy and working well in teams.

Gardner et al. (2008) adduced that distinguishing between different levels of competence was a particular problem when it comes to assessing clinical skills (Girot 2000 cited in Gardner et al. 2008). From this research, the researchers concluded that in addition to competency frameworks, nurse practitioner standards should be informed by an evaluation approach that accommodated additional characteristics and the researchers described the secondary deductive analysis for the study (Gardner et al.2008).

Capable people were viewed as having high levels of self-efficacy; they knew how to learn, they were creative and most importantly they were able to use their competencies in both new and familiar circumstances. They were more likely to manage complex and non-linear challenges (Gardner et al. 2008). The researchers aligned this to the requirements for capability involving the role of the nurse practitioner. Findings of this research noted that nurse practitioner narratives suggested that not only were nurse practitioners ready to utilise the knowledge they had accumulated through education and experience but were also committed to a process of building their practice knowledge. However it could be debated that this was not new in terms of defining capability. All registered nurses, in order to maintain their individual level of competence, have to be prepared to undertake a similar process, albeit at a lower level of practice (Australian Nursing and Midwifery Council Competency Standards for Registered Nurses 2006).

Gardner et al. (2008) based their study on a previous 1995 study, but made no reference to capability amongst nurse practitioners from the standpoints of gaining and applying extended knowledge that included law and the awareness about when it is safe to take risks. According to Gardner et al. (2008), capable people were people willing to experiment and take risks (Phelps, Hase & Ellis 2005 in Gardner et al. 2008). However for the nurse practitioner these risks could include a certain amount of patient risk and one's ability to recognise where taking risks is dangerous or not may come into question. The work that the authors cited for the characteristics of a capable person, originated in a study that revealed the characteristics of a capable computer user (Phelps, Hase & Ellis 2005 in Gardner et al. 2008, p.3). It would have

perhaps been more appropriate if the Gardner et al. study (2008) had drawn from these characteristics and documented the applicability of them to the nurse practitioner.

Dunn et al. (2008) described a web based teaching tool that developed expertise in prescribing, based on the National Prescribing Service (NPS) Quality Use of Medicines (QUM) principles (Dunn et al. 2008). As a result of the newness of the role all nurse practitioners are comparative novices, in terms of prescribing (Dunn et al.2008). Because prescribing is no longer the sole province of medical practitioners, veterinarians and dentists, extensions of this practice to other healthcare professionals, including nurse practitioners, is seen as a way to improve the quality of service offered to patients. This enhances the maintenance of patient safety increasing patient choice and improving access to services (Dunn et al.2008). However, nurse practitioner prescribing remains politically and professionally contentious (Pearson 2007; Dunn et al. 2008).

A consortium, made up of high level Australian multidisciplinary, regulatory and educational partners including members of regulatory bodies and university academics, collaborated to develop flexible innovative professional education to enhance nurse practitioners' judicious selection of management of care options and the Quality Use of Medicines. This was an important factor in maintaining a multidisciplinary approach and helped to ensure that education and practice were addressed together (Dunn et al. 2008). The programme devised by the consortium assisted in supporting nurse practitioner prescribing expertise so that a nurse

practitioner was able to progress from a novice prescriber to a competent prescriber and broaden prescribing boundaries.

These freely available useful interactive web-based modules engaged nurse practitioners in relevant professional education based on research and Quality Use of Medicines principles. The collaboration of key Australian organisations in developing this programme formed an outstanding platform on which to build clinical excellence and professional acceptance within the contentious arena of nurse practitioner prescribing (Dunn et al. 2008).

The programme was a significant advance in addressing prescribing issues and providing the necessary education to address prescribing issues. This project was a developing process but in time to come, a positive outcome may be for training in prescribing to be collaborative, with both doctors and nurses using this interactive training process (Dunn et al, 2008).

Critics of development of the nurse practitioner role in Australia were insistent in 'cutting the nurse practitioner down to size' (Peeters 2003), when they considered the negative value of prescribing and other expanded practice initiatives within nurse practitioner role development. This is sometimes referred to as the Tall Poppy Syndrome (Peeters 2003). This is particularly relevant to medical staff (see Dunn 2004; Gardner 2004; Gardner & Gardner 2005; Pearson et al. 2007; Dunn et al. 2008).

It is possible that nurse practitioners are victims of Tall Poppy Syndrome in Australia as the role is not yet universally accepted within the nursing profession, the medical

profession or the healthcare workforce as a whole because the nurse practitioner is treated differently to other healthcare professional disciplines (Peeters 2003), This occurs sometimes to the detriment of the development of the role of a nurse practitioner. This further supports the Yuginovich (2009) notion of inter-intra professional downward closure.

2.7 Chapter Summary

In this chapter concepts texts and discussion papers relating to the five countries studied that best served to answer the research question have been reviewed. Concepts explored related to the five countries studied. There is a paucity of knowledge about legal issues as part of nurse practitioner role development and this is reflected in the limited articles able to be sourced. Issues have been raised about legal implications of the expanding role of the nurse practitioner. Few researchers have explored this area even fewer have proven through research, the implications for lack of knowledge about law in relation to the daily extended practice of the nurse practitioner.

The concept of a theory of liability has not been addressed in published literature in Australia. This was an important step in reducing any potential sanctions placed upon the nurse practitioner in alleged negligence especially when the scope of practice clearly defined areas of potential liability and clinical risk (Baker 1992). Petersen (in Freckleton & Petersen 2006, p.487) took the first step in discussing the increased litigation risk but the nursing profession need to go a step further in making liability and clinical risk a major feature of any scope of practice.

Current Australian governments might be well advised to take note of Pearson (2007) and its contents, with regard to different ways of working in health care, nurse practitioner role development and the problems associated with this in the USA. Some of the problems, such as turf wars (Pearson 2007) and expanding the scope of practice that were encountered in the USA could be minimised in Australia.

In Australia, as in the USA, UK, New Zealand and Canada, it is necessary to recognise the positive impact that the nurse practitioner role has within the healthcare workforce. Even more progress could be made with the correct legislative change, such as access to the Pharmaceutical Benefits System (PBS) and the Medical Benefits Schedule (MBS) without a quazi-supervisory role by doctors implied within current legislation (Federal Government of Australia Health Amendment Bill (Nurse Practitioners and Midwives) 2009). The ethos of 'Fair Go' in Australia is equally applicable to nurse practitioners as it is in other employment arenas throughout the country (Dunn 2004).

Findings such as these have identified a need for the current study and contributed to two of the three research questions for this study:

1. To what extent did nurse practitioner development, educational requirements and legal and professional issues differ between five countries?

2. What is the most appropriate approach to further enhance the professional autonomy of nurse practitioners in Australia?

It is intended that the answering of the above will enhance the body of knowledge in nursing and positively promote further development of the nurse practitioner role.

CHAPTER 3 METHODOLOGICAL THEORY

> "Humanity will ever seek but never attain perfection. Let us at least survive and keep on trying" (Dora Russell 1975)

3.1 Introduction

The methodological theory for this study was derived from The Parse Human Becoming Theory (Parse 1995), which clearly demonstrated the inter-relationship of human beings, the universe and health (Parse 1995, p.9). The nurse practitioner, a clinical expert, is chiefly concerned with people relevant to their health status (Parse 1995). The theory can be directly applicable to the nurse practitioner journey and its relevance to human patients within the universe and their health. The theory is not based on a problem solving approach. It is a lived experience for all parties that is dynamic and evolving (Parse 1995).

The Parse Human Becoming Theory has its roots in phenomenology (Parse 1995, p.5) and hermeneutics (Parse 1995, p. 271-272). It is the study of lived, human phenomena within everyday social contexts. The phenomena occur within the lives of people who experience them and they are comprised of anything that human beings live or experience (Tichen & Hobson in Somekh & Lewin 2006, p. 121). Phenomena can be directly researched exploring human knowing by accessing conscious thought and indirectly by investigating human beings by accessing their senses and shared background, meanings and practices.

This presented the differing perspectives of phenomenology (Tichen & Hobson in Somekh & Lewin 2006, p.121) if approaches were examined in terms of foreground

and background (as in photography). The researcher focused on the foreground, (the direct approach*)* and then on the background, (the indirect approach) in the same way we take a photograph. The main focus was on the foreground (direct i.e. the subject of the picture), which in phenomenology would be 'knowing', and then on the background (indirect), which would be our perspective on what relation the subject of the picture (the person) has with the background. The shared experience of life within the universe is the being. Taking a photograph is a form of phenomenology because a photograph illustrates a lived experience of life through an expressed image.

3.2 The Origins of Phenomenology

In the 1800s, German philosophers began the quest for a new approach to interpretive science. The work led to the development of two philosophical frameworks that still influence interpretive methodologies today. Husserl (1859-1938) founded phenomenology, premised on epistemological concerns so the starting point was the separation of a conscious actor in a world of objects (Grbich 1998). This was the root of the direct approach used in this study in which the researcher investigated the foreground of the phenomenon and developed research questions that related to a systematic study of the mental content of individuals' inner worlds (Tichen & Hobson in Somekh & Lewin 2006, p.123).This meant that a person's unique place within the universe was explored in the context of the way a person described this (the foreground) and images that created a sense of being with others in the universe (background).

While accepting the epistemological premise of phenomenology (Grbich 1998) Heidegger (1992) disagreed with Husserl, believing that humans were primarily rooted and immersed in the world and not separated from it. They were part of the world, fully integrated and not separate entities (Grbich 1998). The ultimate goal for Heidegerrain phenomenology was to deepen our understanding about what it is to be. His concern is ontological. The indirect approach used to study phenomenon grows from this ontological root. Researchers explore how participants interpret, make sense and seek meaning within their worlds (Grbich1998). The Parse Theory (1995) follows this approach.

Neither Husserl nor Heidegger or any of the philosophers who followed developed methodological frameworks or procedures. They concentrated more on development of theories, because theories were their chief interest and appeared less interested in applied research (Grbich 1998).

In nursing, Benner (1984), Parse (1995) and Crotty (1995) are best known for their work on phenomenology, each drawing on the work of Heidegger (Tichen & Hobson in Somekh & Lewin 2006). Crotty (1995) disagreed with the Benner approach, inferring that Benner 'manipulated' the concept of phenomenology to 'fit' the processes of phenomenology within her research, rather than applying the concepts of phenomenology to her work. Crotty (1995) became extremely critical of this modified approach. According to Crotty (1995) this was inappropriate, as any type of 'manipulation' may lead to inaccuracies and criticism of any research undertaken. He was correct to criticise manipulation of phenomenology within research without applying the concepts within phenomenology to the research.

3.3 Hermeneutics

Hermeneutics is the art and science of interpretation (Neumann 2006). Its origins are both traditional and modern. The traditional focus is finding meanings within a text followed by central processes of interpretation and understanding. Without meaning, there can be no interpretation or understanding (Parse 1995). In order to, for example, understand and interpret the Ten Commandments in a Biblical text, researchers would have had to understand the meaning behind the laying down of these Commandments to Moses on Mount Sinai, why they were given at that particular time and key events surrounding this phenomena.

A hermeneutic study where the human becoming theory is the perspective is rooted in the basic principles of the theory adducing that humans structure personal meaning in co-creating rhythmical patterns while co-transcending (transforming) with the possibles. Co-transcending within the context of Parse means that humans forge their own unique paths with shifting perspectives as light is shed on familiar rhythms in life. The energising force of forging ahead in life or standing still enlivens life's ebb and flow as one is living between conformity and non-conformity, from certainty to uncertainty and from the familiar to the unfamiliar (Parse 1995). Each of us will respond in our own unique way to these forces and thus our own co-transcending. The different ways of becoming (being within) results in an inevitable ambiguity in the creation of different ways of becoming, in transforming within the universe. Parse has identified that people will change as they respond to the ebb and flow of changing forces of life within the universe (Parse 1995).

In summary, research involving hermeneutics is a dialogical process uncovering meaning interpreted through a particular perspective (Parse 1995, p.154). In this study the perspective will be the meaning found in the lived experience within the journey and the work of nurse practitioners and how the human becoming theory is applicable to the world of the nurse practitioner using a restriction-freedom approach (Mitchell 1995 in Parse 1995, p.161-165).

The Heidegerrain (1962) approach as used by Parse involved the study of human experiences studied through human projects (e.g. the development of the nurse practitioner role as seen through the lived experience of nurse practitioners in their care of patients and their journey to endorsement). It was a way of understanding human existence through the interpreter-text dialogue (Parse 1995). Interpretation is the ontological emergence of meaning arising as the researcher views and dwells within the text. In other words the researcher forms meaning within the text, by applying the Human Becoming Theory to the text. This meaning is interpreted through the posits of the Human Becoming Theory in a restriction-freedom context. As the nurse practitioner evolves within the universe of clinical practice, understanding is developed about the elements of the role that are restrictive (e.g. restrictions in prescribing medication such as lack of access to PBS) and also the freedom that the nurse practitioner has in daily practice (e.g. acting as an autonomous practitioner).

There has been much debate about medical control in advanced nurse practice roles (Pearson 2007). Medical control is less apparent in Australia, in terms of nurse practitioner development (Gardner 2004) however, there is much debate about the

control that medical practitioners are able to impose on nurse practitioners and mechanisms to reduce medical control.

While there may be elements of negative aspects relating to medical control within the nurse practitioner role evident in clinical practice, the ethos of nurse practitioner development was a nursing ethos. Medical control where it exists is not necessarily due to the practice model employed (e.g. women's health, accident and emergency, mental health or primary care) by a nurse practitioner, rather it is the degree of medical control that a doctor places on clinical supervision and imposing unnecessary direction of nurse practitioners' clinical practice, particularly in relation to prescribing medicinal products and ordering diagnostic tests (e.g. Federal Government of Australia Health Practitioners Amendment Bill (Nurse Practitioners and Midwives) 2009). The competence of any registered nurse practitioner is already proven and should be acknowledged as such. Freedom in this study was examined in relation to the clinical autonomy within the practice model in which the nurse practitioner is employed and restriction was examined in the context of the negative aspects of the nurse practitioner role where medical control is more obvious.

The additional texts explored in this study were provided by the transcripts of interviews with nurse practitioners. The Parse Theory was applied for discussion of the current research findings in combination with the Strong Model of Advanced Nursing Practice (2004) which also has its roots in phenomenology. This process provided a model of practice for the nurse practitioner that will be capable of measuring the complexity and extent of nurse practitioner work and evaluating

knowledge of and the perceived relevance of law to this work as seen through the eyes of nurse practitioners.

3.4 Explaining the Human Becoming Theory

The Parse Human Becoming Theory was first created in 1981 as the Man-Living-Health Theory and is a human science theory (Parse 1981). The change of name is related to the changes, at that time, in the dictionary definition of man to mankind, to male gender. The Human Becoming Theory is not, therefore, gender-specific. The theory is grounded in the belief that humans co-author their becoming (being or to be) in mutual process with the universe. In this study the nurse practitioner can be seen co-creating clear patterns that reveal the uniqueness of both the human being and the universe, in relation to the role of patient care in nurse practitioner clinical practice (Parse 1995). Parse uses the term human to mean Homo sapiens generically (Parse 1995, p.5). The assumptions of the Human Becoming Theory in the philosophical context are:-

- The human is co-existing while constituting rhythmical patterns within the universe (Parse 1995, pp.5-6).
- The human is an open being, freely choosing meaning in situations, and bearing responsibility for decisions (Parse 1995, pp.5-6).
- The human is a living unity who continuously constitutes patterns of relating with other humans, living creatures and his/her own universe (Parse 1995, pp.5-6).

- The human is transcending (transforming) in many dimensions with the possible within his/her own universe (Parse 1995, pp.5-6).

- Becoming is an open process, experienced by all humans (Parse 1995, pp. 5-6).

- Becoming is the pattern of relating value priorities, what is important in life (Parse 1995, pp.5-6).

- Becoming is an inter-subjective process of transforming (transcending) with the possible within a human's universe (Parse 1995, pp. 5-6).

- Becoming is human evolving (Parse 1995, pp 5-6)".

Three additional assumptions in addition to the philosophy context are:-

- Human becoming is freely choosing personal meaning in people's lives, what is important to them, what is not important. This is inter-subjective and evolves within many areas of our lives such as work, health, leisure, education, what we see, what we do and our experiences in life (Parse 1995, pp.5-6).

- Human becoming is co-creating rhythmical patterns of relating, in open process with the universe, who we are, what we do and where we 'sit' in the overall scheme of life.

- Human becoming is co-transcending (co-transforming) through many dimensions with the emerging possibles of life (Parse 1995, pp 5-6)".

There are three major principles that flow directly from the philosophical assumptions of Parse's Theory. The principles bring to light the notion of paradox apparent opposites but dimensions of one phenomenon (Parse 1995, pp 5-6). It is the only nursing theory that regards paradoxical processes as inherent in being human. These paradoxes are to be viewed not as problems to be solved or eliminated, but as natural rhythms of life (Parse 1995, p.6).

3.4.1 Principle 1

"Structuring meaning and freely choosing meaning in many dimensions is co-creating reality through languaging of valuing and imaging" (Parse 1995 p.6). This principle means that humans construct what is real for them from choices made within many realms of the universe. Humans are continuously languaging values, expressing through speaking, writing, being silent, moving, being still (Parse 1995). Valuing is the confirming or not confirming of what we cherish in the pre-reflective or reflective knowing within imaging: what we understand through learning within the universe and what is precious to us as a result of this learning. Humans co-create meaning which changes as we move through the different experiences of life. As new images arise, these expand the possible. People live their cherished beliefs amid the process of evolving (Parse 1995, p.7).

Within this theory a nurse practitioner will form, or have formed, values that guide the work of a nurse practitioner. These values will create meaning through the lived experience and by using these values they will co-create within the universe the individual meaning and practice derived from unique human values. Each person within the universe has a unique perception about how we apply ourselves to our

work, through experience and value formation about what is important to us. These values arise through their day to day work (the apex) and through the role definition of a nurse practitioner, as interpreted by a nurse practitioner (the origin). These values become apparent as the apex and the origin happen all-at-once through the processes of evolving.

The image of becoming a nurse practitioner may become apparent to someone as a possible next step in their career (the origin) because they see this as a means to make a difference in patients' lives that is more significant than their present contribution (Gardner 2004). They have the image (possibility) of moving upward within their employment organisation, and see personal development in their sights as others before them have successfully done. They energise within this image the notion of belief in oneself that this image can become reality and it is precious to them. After much thought, they apply to their Health District for the position of nurse practitioner candidate. The application is successful (the apex). The next stage in their life becomes reality.

3.4.2 Principle 2

"Co-creating rhythmical patterns of relating is living the paradoxical unity of revealing or concealing, enabling or limiting, whilst connecting or separating" (Parse 1995, p.6). This means that humans live in rhythm with the universe, co-constituting patterns of relating. These patterns are paradoxical in nature. A person conceals or reveals all-at-once the 'who' one is becoming, which also reveals the person one was and the person one is to be. One cannot reveal the all of whom one is and there is always mystery in being human (Parse 1995, p.7). In life, there are many

choices and one can be enabled and limited simultaneously. For every choice, there are opportunities and limitations with each choice. People cannot have one without the other. When people move together and separately all-at-once, we connect and separate within the natural ebb and flow of the universe as we evolve through the rhythmical flow of co-creating. All humans live with mutual processes together and separately all-at-once within the universe (Parse 1995, p.7). There is a shared experience for the nurse practitioner evolving through lived experience caring for the patient alongside the lived experience of the patient in the context of health.

A group of nurse practitioners might be at a seminar about the value of birth control. They would co-create alongside their colleagues the importance of the discussion and its relevance within the universe for patients. This takes place regardless of whether the group is composed of men or women, or a combination of both. They might then think about what values are precious to them in supporting, or not supporting, the notion of birth control. They need to make a choice. Procreation of the species is a natural rhythm of life within the universe. The nurse practitioner may decide that they do not support birth control. They separate from the supporters of the notion of birth control, even though they might be sitting adjacent to them and connect with the people who are not supporters, even if they are sitting across from them on the other side of the room. They thus 'transcend' as a person not in support of birth control, with all its opportunities and limitations. This becomes a value that is precious to them and everyone else in the room that supports their view.

3.4.3 Principle 3

"Co-transcending with the possibles is powering unique ways of originating in the process of transforming" (Parse 1995, p.6). Parse (1995) suggests that this means that people forge paths; unique paths with shifting perspectives as differing meaning is placed with the familiar. The energising force of forging ahead or holding back enliven the ebb and flow of life as one conforms to the norm or moves away from the norm, as one moves from certainty to uncertainty or as one shifts away from the familiar to the unfamiliar. Humans seek to be unique and yet like others, all-at-once. They live with the inevitable ambiguity of creating different ways of becoming, in transforming (Parse 1995, p.5).

In another example, a family makes the decision to migrate to a new country. They will move from the familiar to the unfamiliar, the certainty to the uncertainty. They will need to learn what conformity means in different surroundings in a different culture perhaps, in order to understand the notion of not conforming. The family forge ahead toward a new life. They do not yet know what this life will hold. The family proceed with the ambiguities of fear of the unknown, hope for better things, the different experiences they will have, and they aspire toward an improved quality of life.

Such is the reality for the nurse practitioner, who proceeds from the known as a registered nurse to the unknown as a nurse practitioner, experiences different aspects of nursing practice and patient care and striving to give patients a better quality of life.

The notion of 'becoming' is not new. Nepo (as quoted by Remen in Remen 1996, p. 261. It must be noted that Jung came after the 13th century) a thirteenth century Iraqi philosopher stated:-

> "Each person is born with an unencumbered spot, free of expectation and regret, free of ambition and embarrassment, free of fear and worry: an umbilical spot of grace where we were each touched by God. It is this spot of grace that issues peace. Psychologists call this spot the psyche, theologians call it the soul, Jung calls it the seat of the unconscious, Hindu masters call it the atman, Buddhists call it the dharma, Rilke call it inwardness, Sufis call it qualb and Jesus called it the centre of our love.
>
> To know this spot of inwardness is to know who we are, not by surface markers of identity, not by where we work or what clothes we wear or how we like to be addressed, but by feeling our place in relation to the infinite and inhabiting it. This is a hard lifelong task, for the nature of becoming is a constant filming over where we begun while the nature of being is a constant erosion of what is not essential. We each live in the midst of this ongoing tension, growing tarnished or covered over, only to be worn back to that incorruptible spot of grace at our core"

While this quotation is a differing notion of 'becoming' to that of Parse, there are unmistakeable parallels. It becomes apparent that 'becoming' is also within the realms of a spiritual dimension in which all of us live. At the same time it becomes a co-created process of evolving as we ebb and flow during the process of living our lives, suggesting that life is full of the variants we encounter by meeting different people, by our learning and value formation and the closeness or otherwise of family members. Where there is no family unit we reach out for the support of others outside the family (Parse 1995, pp 4-6).

3.5 Research Paradigms

Research flows from a value laden ontology (in this study ontology is used to mean study of concepts and the nature of being) or paradigm perspective. In nursing this paradigm perspective centres on a certain view of human beings and health (Mitchell

1995 in Parse 1995, p.161). Using the previous analogy of the lens from photography, one can view the paradigm from three different perspectives. The zoom lens focuses on participants and particulars, the wide angle lens focuses on relationships and the motion lens focuses on process (Smith 1998 in Parse 1995, p.161). In this study the focus was on all three perspectives at different times. The 'zoom lens' focussed on the nurse practitioner participants' and their context of practice. The 'wide angle lens' focussed on what relationships are significant to each participant. The 'motion lens' focussed on processes concerning the participants such as qualifications necessary to become a nurse practitioner, assessing competence processes and the processes within the endorsement journey and beyond.

3.5.1 The Nature of the Restriction-Freedom Paradigm and the Parse Theory

The restriction-freedom paradigm extension to the Parse Theory was developed by Mitchell (1995 in Parse 1995, p.161-165) who studied the restriction-freedom paradigm in relation to elderly patients. She defined restriction-freedom patients' daily lives, guided by the Parse Human Becoming Theory (e.g. movement and the freedom and ability to move).

The present study also examined the restriction-freedom paradigm, guided by Parse, using all three 'lenses' of the analogy of the camera. The study examined the restriction-freedom paradigm as 'the lived experience' of nurse practitioners in their day to day work. Factors that were restrictive, factors that constituted freedom to act make judgements and follow up when treating patients, without recourse to a supervisor or other healthcare personnel were all explored.

The restriction-freedom paradigm is a basic tenet of existential thought (Mitchell 1995 in Parse 1995, p.161). This paradigm posits that human beings create the meaning and essence of their lives, as opposed to deities and authorities creating this meaning for them. Heidegger, from whom Parse drew to substantiate her work, was an existentialist and the existential features of the restriction-freedom paradigm relate to three basic truisms:-

- "Human beings are born with certain unchangeable features that provide a defined yet open ground for one's becoming.
- Human beings are born as finite beings, in that non-being can exist as a possibility with being.
- All human beings are born at a particular time and place in the historical evolution of the world (Mitchell 1995 cited in Parse 1995, p. 161)".

All these truisms mean that human beings live with certain unchangeable features of their lives that may both enable and limit their journey through life (Mitchell 1995 in Parse 1995, p.165). Heidegger referred to this as 'throwness' in the world (Parse 1995 p.165). In being 'thrown' a person co-exists with others as a finite being, and yet, one is pure potential for being and becoming according to one's own possibilities (Mitchell 1995 in Parse 1995, p.165). Without memory, for example, a person cannot retain information, without reasoning ability a person cannot analyse information and gain meaning from it. However, fully equipped with these abilities a person shows their uniqueness, by retaining information and gaining meaning from information by reasoning in potential for being in their journey through life.

Parse suggested that human beings experienced restriction-freedom in unique and shared ways. Indeed freedom cannot exist without restriction, for each opposing force breathes vitality into the other. The rhythm of the restriction-freedom pattern

might vary throughout life and in different cultures but all people experienced situations that are restricting yet freeing.

In this study, restriction-freedom was examined through the natural rhythm of the work of the nurse practitioner to discover what restrictions or freedoms exist within nurse practitioner 'being'. In Australia a nurse practitioner has some prescribing privileges according to an approved formulary but no Index of Health Professionals (IHP) provider number that allows access to the Pharmaceutical Benefits System (PBS). The PBS system subsidises a prescription and there is no dispensing fee though there is a charge for the drugs themselves. All prescriptions written by a person without an IHP provider number incur a dispensing charge to the patient for whom the prescription was written. The nurse practitioner in primary care has the freedom to prescribe but this is restrictive, because the prescription will incur a charge to the patient and the nurse practitioner. In order for the prescription to be dispensed free of charge the nurse practitioner has to have a doctor to countersign the prescription (restriction).

If the above situation is a paradigm of being 'thrown' then the nurse practitioner affected is able only to live within the potential for being: to do only what is possible to obtain the drugs without further charges being incurred and this reduces their own potential for being because they lack the autonomy to do so. This means that a legitimate prescriber in Australia without access to PBS is severely disadvantaged, in comparison to peers in other countries, yet the International Council of Nurses (ICN) advocates universal standards (http.www.icn.ch/ accessed June 2007). This is, in itself, a multi-dimensional paradox.

3.5.2 The Nursing Perspective

From the Parse perspective, human beings co-create health in relationship with the universe in the unfolding process of living value priorities. Human beings are unitary, living in mutual process with the universe and are free to construct and structure the meaning of lived experiences to move in unique ways toward possibles that are co-created with others (Parse 1995, p.4).

The first principle of the Parse Theory guided the researcher to realise that each participant's reality was uniquely created involving the participants' chosen meanings, values and experiences. The second principle guided the researcher, in the context of this study to view the nurse practitioner from their co-constituted patterns of being. An example would be the person who they are and what they believe is important in life that may impact on their work such as working within a team, being well supported or being isolated.

Each of these examples was likely to influence how a participant might respond within a work setting. However, the researcher was not judgemental when guided by the Parse Theory. The researcher embraced the values and beliefs the participant had and lived within these values, co-creating with the participant what was important and transcending with the possibles, in terms of care planning and management of the patient's care.

The main concepts were revealing-concealing, enabling-limiting and connecting-separating (Parse 1995). The researcher was only able to work within the realms of what a participant chose to reveal and had no knowledge about that which the

participant chose to conceal. There may have been aspects of a participant's working life that the participant chose to reveal or conceal. There may have been conflicts within working relationships that the participant felt unable to talk about.

The third principle involved the concepts of empowering, originating and transforming. These processes reflected the belief that people continuously reach beyond the now and look to the future, co-constituting and co-creating possibles within the multi-dimensional realities of life. The researcher, guided by this principle, recognised and accepted these principles and 'lived the experience' of the working environment with the nurse practitioner. This is called 'true presence' (Parse 1995, p.5). The researcher did not attempt to influence the participant's views with regard to choices. Rather, the researcher talked to the participant in depth to see the participant's perspective in accordance with the participant's lived experience and value priorities: what values the participant held that made the participant live and act in a certain way, even if this way proves contrary to the supervisor. The researcher could not judge the participant in a negative way and co-constituted with the participant the ways in which the participant overcame problems (Parse 1995).

To be guided by the Parse Theory the researcher for this study utilised communication skills and demonstrated the ability to dialogue and gain rapport with a participant. This was extremely important. The researcher began with a metaphorical blank page and the interview 'evolved' as both researcher and participant co-created the rhythm of the interview and transcended with the possibles in term of actions and processes that co-constituted the journey of the nurse

practitioner in the treatment and management of patient care provided by the nurse practitioner.

This approach presented the nurse practitioner with an opportunity to ‘measure’ their unique work by co-creating this work alongside the rhythms of the researcher. This was demonstrated by development of the care plan and supporting documentation. Often, a nurse practitioner dealt with a whole health care episode for a patient without recourse to another healthcare professional and therefore the care plan and documentation of same were seen as the work of one person, not a multidisciplinary team. In measuring the care plan and management of care, several markers can be investigated such as;

1. Physical examination: the method of inquiry and documentation of findings.

2. Ability to make a diagnosis of a patient’s condition; examined through documentation.

3. History taking and method of inquiry and documentation of findings.

4. Investigations ordered and the rationale for these investigations: examined through documentation;.

5. Prescribing and the rationale for the prescription: examined from formulary and documentation.

6. The tasks a nurse practitioner carries out that a mainstream nurse cannot carry out: examined via nursing documentation, endorsement regulation and job description.

7. The intervention carried out by the nurse practitioner that may demonstrate capability whilst working in complex and straightforward situations, innovation in nursing practice, analysis skills, problem solving, learning taking place whilst intervention occurs, reflection on actions taken and working autonomously (Gardner 2004, p.1).

8. The attributes a nurse practitioner has that may be unique. For example, the ability to work in the absence of a physician, capability in carrying out certain procedures well that would normally be assigned to doctors and capability in making clinical judgements, examined through scope of practice and patient care documentation.

Within the legal and professional perspective the Parse model (1995) also has distinct advantages. The greater the true presence, for example, the lesser the possibility for complaint and subsequent litigation for a bond has developed between the nurse and the client. The research interview dialogues identified that the nurse practitioners had formed a unique bond with the patient through the partnership formed within the lived experience. Both nurse practitioner and patient worked closely together in finding solutions to health problems and the maintenance of good health. To the best of the researcher's knowledge, the Parse Theory offers much but has not been utilised previously in relation to the nurse practitioner journey and the role of a nurse practitioner within Australia in the legal-professional context.

The theoretical proposition that relates to the lived experience has been defined as imaging the originating of enabling-limiting (Parse 1995). This meant that a participant was able to provide images to the researcher about what had enabled their practice and what limited their practice In this study each of these concepts was

considered in the light of extending research guided by the Parse (1995) Theory in order to explore the depth of knowledge development.

Imaging is the process through which people construct reality, seek answers and develop an understanding of the world through the integration of new ideas (Parse 1995). Interview data from this study synthesised and extracted the meaning of reality for four nurse practitioners' experiences of restriction-freedom. This was shown by illustrating revealing as the phenomena nurse practitioners searched for in their imaging about how restriction-freedom affected their clinical nursing practice. These were integrated into freely taking action and making decisions (freedom) or aspects of practice impinge or interfere with participants' judgement in clinical practice, such as being restricted in practice by a physician (restriction). Participants were able to identify certain freedoms and restrictions that directly affected their clinical nursing practice.

Originating represents an unencumbered self-direction within the restriction-freedom experience as enunciated by Mitchell (in Parse 1995, pp. 161-164). This meant a unique unfolding and a particular way of self-emergence: what made the nurse practitioner role unique. This included self-directed action, respect, autonomy, authority, responsibility and accountability. Applying all the ways of originating that were revealed in this study placed the notion of restriction-freedom in nurse practitioner work on more solid ground: a starting point for debate perhaps in looking at the work of the nurse practitioner and its uniqueness in a different light.

Additional concepts linked to restriction-freedom were those of enabling-limiting and concealing-revealing (Parse 1995, pp.161-164). Enabling-limiting related to

opportunities and limitations inherent in making choices. The choice a nurse practitioner made, for example, in becoming a prescriber, even though this means working without an ISP provider number. Concealing-revealing related to a participant's willingness to choose to share enabling-limiting related to restriction-freedom processes in relationship with others (Parse 1995).

3.6 The Strong Model of Advanced Nursing Practice

As an adjunct to Parse (1995), this study applied the Strong Model of Advanced Nursing Practice (2004) to the research in order to demonstrate a synergy between the restriction-freedom paradigm (Mitchell in Parse 1995, pp.161-165) and the Strong Model (2004). Whilst not a theory of practice the model is composed of five domains that comprise the Advanced Nursing Practice role: direct comprehensive care, support systems, education, research, publication and professional leadership (Mick & Ackerman 2006, p.1).

The model is applicable to both advanced practice nurses and nurse practitioners. The fulfilment of each domain will vary, depending on the role and the needs of the population served the practice setting and the practitioners' own interests and strengths. The domains are not mutually exclusive, as some aspects of practice will fall within the bounds of more than one domain (Strong 2004). If for example, a nurse practitioner was researching a new type of dressing for leg ulcers, this would involve:

Research: about the dressing and its uses and benefits in direct patient care.

Education: when using the dressing this would involve education of self and others about the dressing and how to use it.

Support systems: would include involving a possible protocol/policy development and implementation supported by the manufacturer and employing organisation. **Collaboration:** with colleagues would include colleagues in hospital and the community.

Publication: of research findings and practice development through research based studies and publishing this evidence.

Leadership: of nursing practice involving leg ulcers by role modelling best practice in the treatment of leg ulcers and developing appropriate guidelines for all to use.

On completion of these processes, a nurse practitioner, who specialises in wound management and wound care, would enhance both scholarship and expertise within the field of wound management.

The conceptual strands of collaboration, scholarship and empowerment (which describe the attributes of practice) as well as the approach to care and the professional attitudes are included in this model. These strands are circular and are unifying threads which envelop the domains of practice (Strong 2004).

3.6.1 The Domains of Practice within the Strong Model

There are eight strands that form the domains of practice within the Strong Model (2004). These strands are:

a) Direct Comprehensive Care: patient focused activities that include assessments, procedures, interpretation of data and patient counselling (Mick & Ackerman 2006, p.6).

b) Support Systems: professional contributions to standards of performance, quality initiatives and development of policies, procedures, protocols and practice guidelines to optimise nursing practice (Mick & Ackerman 2006, p. 6).

c) Education: contributions toward learning within the healthcare team (Mick & Ackerman 2006, p.6).

d) Research: practice that challenges the status quo and seeks better patient care through rigorous inquiry and incorporating evidence-based practice into direct patient care (Mick & Ackerman 2006, p.6).

e) Publication and Professional Leadership: promotion and dissemination of nursing and health care knowledge beyond the individual practice setting (Mick & Ackerman 2006, p.6).

f) Collaboration: supporting the belief that the unique skills and abilities of various care providers in combination, contribute to the goal of excellence in patient care. A Nurse practitioner is able to influence the multi-disciplinary nature of provision of care within complex clinical situations or settings (Mick & Ackerman 2006, p.6).

g) Leadership: signifies the continuing inquiry that underlies every nursing action and decision, and disseminating this information to juniors, particularly when guiding juniors in complex care situations (Mick & Ackerman 2006, p.6).

h) Empowerment: having the authority to identify and analyse relevant problems and to develop, implement and evaluate/ modify a plan of action (Mick & Ackerman 2006, p.6).

These different skill levels reflect changes in aspects of skill performance as advocated by Benner (1984). These include:-

a) A movement away from reliance on abstract principles to the use of past concrete experiences.

b) A change in the learner's perception about what a situation demands.

c) A passage from the detached observer to one of involved performer, the performer no longer stands outside a situation and becomes engaged in the situation (Benner 1984).

Benner's approach is not without its critics. Crotty (1995), criticised the ways that North American nurses manipulated the field of phenomenology, according to the European tradition. He stated these nurses adapted concepts to suit their own ends and that rather than promote academic excellence what they described was not phenomenology at all but a hybrid concept developed from phenomenology (Barkway 2001). A hybrid concept developed from an original concept could be perceived by others as misleading and thus credibility will be lost.

The debate in nursing continues to take place as to whether Crotty's (1995) work was a scholarly critique or a severe, judgemental, fault-finding criticism of nursing research. To this day, opinion remains divided (Barkway 2001). This is an important factor when considering any form of phenomenological research by nurses, because evaluators of such research might be looking for the same faults as Crotty (1995) described and, if found, could discredit the research, even if the researcher had a valid premise. Despite criticism, the work of Benner continued to be developed through practice models, as seen in the Strong Model (2004), which was one of the practice models in existence created as a framework for advanced nursing practice.

3.7 Chapter Summary

This current research has been embedded within the Parse Framework and Heidegerrain thinking which are very strongly embedded within the realms of phenomenology in the European tradition. Coupled with the Strong model of advanced practice, this makes it a most appropriate framework for this study to explore the lived experience of nurse practitioners as seen through the eyes of four nurse practitioner participants.

CHAPTER 4 RESEARCH METHODOLOGY

"Truth has no particular time of day: the time is now" Confucius.

4.1 Introduction

In 2005 the state nursing boards and councils within Australia produced policies and guidelines that identified the means by which nurse practitioner candidates were to be trained and formally endorsed by nursing councils and boards as nurse practitioners (e.g. Queensland Nursing Council 2005). The most striking feature of these documents was the omission of any reference to legal issues and the professional bearing of nurse practitioners. Advanced practice level in nursing meant that a nurse practitioner was able to undertake some of the duties previously assigned to doctors and they must perform such tasks to the same standard and carry the same accountability for errors or acts and omissions, which meant that nurse practitioners would thus carry similar liability for sanctions that follow (Petersen in Freckleton & Petersen 2006, p.488).

4.2. Problem Statement

The professional bearing of nurse practitioners is not widely accepted by other health professionals, particularly within the nursing profession and amongst medical staff (Gardner 2004; Pearson et al. 2007). They are recognised as clinical experts in their field by some members of the nursing profession, but there is limited written evidence to show how this expertise measures up, especially in relation to legal aspects of clinical practice (Gardner 2004; Petersen in Freckleton & Petersen 2006, p.487).

4.2.1. Aims of this Research

The aims of this study are:

- To bring legal and professional issues to the forefront of debate by exploring nurse practitioners' understanding of and ability to apply legal frameworks at an advanced level of practice.

- To provide clearer identification of the legal boundaries imposed on nurse practitioners in their daily nurse practitioner practice.

It is anticipated that change will be effected at the level of academics and policy-makers as a result of the findings of this study. This would enable more advanced legal training to be available, where applicable, to nurse practitioners in Australia.

4.3 The Research Methodology

In this study, the methodology utilised three distinct elements in order to investigate the different aspects of the study. These were:

a) Historical-Comparative Research

As the emergence of the nurse practitioner has occurred over time, historical-comparative research was used to study this emergence in five countries: Australia, Canada, New Zealand, the United States of America (USA) and the United Kingdom (UK). This was done to compare and contrast how the nurse practitioner role was defined and how it developed within these five countries. In addition the legal and professional issues identified within the study of five countries were compared in order to further bring legal and professional issues to the forefront of debate.

b) Analytical Comparison

A process of analytical comparison (Neuman 2006) was used to compare methods of agreement and methods of difference in the approaches for each country.

c) Field Research

In-depth interviews were followed by the investigation of the lived experience of nurse practitioner work using analysis with the restriction-freedom paradigm of the Parse Human Becoming Theory (as enunciated by Mitchell in Parse 1995 pp. 161-165). This aspect of the study explored the world of the nurse practitioner through the eyes of four nurse practitioner participants. This was for the purpose of gaining insight into the process of seeking endorsement, the extent of legal knowledge of the participants and how they utilise this knowledge. This provided information about how relevant law is to them in their practice.

4.4 The Research Questions

The research questions for this study were:-

1. To what extent did nurse practitioner development, educational requirements and legal and professional issues differ historically between five countries?

2. What do nurse practitioners believe are the most important legal and professional aspects of their practice?

3. What is the most appropriate approach to further enhance the professional autonomy of nurse practitioners in Australia?

4.5 Historical-Comparative Research

Before a researcher can define the present context of the role of the nurse practitioner, the research must explore the emergence of the role in the past (Polit & Hungler 1991, p.204). Historical-comparative research (HC) draws from the Annales school and revitalises local, national regional and global conceptions of history and interpretations of self and other by systematically linking historical paths of development and social processes (Seigrist 2006, p.377). Historical comparitivism uses comparisons of societies and cultures across time in order to explore how social and cultural differences and similarities were constructed and institutionalised as in the development of the nurse practitioner role in five countries in the last 46 years). This process provides the means to determine the power of social structures and revitalise theories (Seigrist 2006, p.379). It depends on the survival data from the past (normally in the form of documents) and the researcher is reliant on what has not been destroyed or lost.

Time is an important factor in HC research. The researcher blends together diverse conditions and collective beliefs into a comprehensive reconstruction of past events. The approach takes a whole view as if situations have multiple layers describing these levels or layers of reality and linking them (Neuman 2006) This means that the researcher must translate, synthesise and analyse that data produced within the social context and practices and take a contingent view of causality to discuss and form conclusions to expand the body of knowledge. As a result the researcher not only analyses structural similarities and differences but also processes and motives, interests, conflicts, decisions and the players associated with them (Seigrist 2006,

p.379) Without expanding the body of knowledge any research endeavour in any profession is futile because professions are constantly seeking answers to questions and it is the objective of research to answer these questions (Polit & Hungler 1991, p.204).

The steps of the HC process include locating evidence, evaluating the quality of the evidence, organising the evidence into themes using theoretical insights (Neuman 2006, p.429). Further steps include synthesising the evidence (refining, revising, identifying) similarities and differences between the concepts to identify plausible explanations and to unite the concepts and evidence into a coherent whole (Neuman 2006, p.430).

Thornton (2005, p.1) defines historical-comparative research as the 'sideways method' and discusses the difficulty scholars had faced with the impossibility of describing historical records due to a dearth of reliable information in the 1700s and 1800s. Many of these scholars turned to the experiences and institutions of contemporary societies that they judged to be less developmentally advanced than their own and used these societies as proxies for their own. For example, Thornton (2005) cited Ferguson (1767) as one such scholar who used information from less developed contemporary societies to proxy for the missing information about societies of the past. Ferguson (cited in Thornton 2005, p.2) suggested that this method was used in ancient Greece and stated that:-

> "Thucydides, notwithstanding the prejudice of his country against the name of Barbarian, understood that it was the customs of barbarous nations that he was to study the manners of ancient Greece" (Ferguson 1797 cited in Thornton 2005, p.2).

Historians researching issues of any contemporary society are able, especially when accurate documents are unavailable, to retreat to an earlier dimension of history. Imagine for example, a researcher who wished to examine the historical development of algebra but there were no reliable documents available. The researcher using the 'sideways method' could study the significant developments within mathematics through all historical dimensions and the study of mathematics thus becomes the 'proxy' for studying algebra.

Similarly, the development of nurse practitioners can also be researched through the dimension of nursing history and not solely through recent or past discussion papers or contemporary texts, hence the 'sideways' notion. Grbich (1998, p.149) asserts that trends in history are not limited by chronological boundaries. In nursing a researcher might undertake a study about gender in the nursing workforce and may find that females predominated within the nursing workforce in eras of nursing history.

Abel-Smith (1979, p. 271) identified the gender distribution of ward managers in 1937 and showed that amongst nurses in general hospitals there were 60 ward managers who were male and 3170 who were female. Today, females outnumber males within the profession as they did when Abel- Smith studied the same pattern for 1937 (AIHW Nursing Workforce Review 2004). The review figures show that in Australia in 2003, 8.6% of nurses were male and 91.4% were female. Though the time span here is 66 years there is very little change in the nursing ratio of men to women within the profession hence the applicability of the sideways method in historical comparative research.

Historical-comparative research can be organised along different dimensions. It is cross-sectional (Neumann 2006, p.425; Grbich 1998, p.148-149) suggesting that a researcher could focus on historical fact derived from one country or group of countries. The dimension focuses on time factors relative to historical fact (when, where, for how long) across a single time period or over a longer period of time. The research can combine both quantitative data (dates, how many etc.) and qualitative data (why, how and consequences) both across time and in the present time (Neuman 2006, p.420; Grbich 1998, p.9). The integration of theory begins with the critical evaluation of the evidence based on theory. For this study evidence was collected, about nurse practitioner development in five countries, covering a time period of 1960 to the present day.

Preliminary analysis in historical comparative research organises the evidence into themes such as how nurse practitioner development began, did this begin in a particular region of a country or was it a nationwide development, where did the development occur, how many people were involved, what input was received from regulators and stakeholders in the early stages, how were nurse practitioners prepared for the role, how are they regulated now? Once the themes were organised it was apparent where agreement existed and where differences were in the approach to nurse practitioner development. To further define this, the researcher might explore how the role of a nurse practitioner differs from an advanced practitioner within the five countries, or if there are instances where these roles are combined. In this study, data were collected relating to the themes of the registration and regulation of nurse

practitioners, education requirements, role development of the nurse practitioner and legal and professional issues facing nurse practitioners in all five countries.

A seminal historical branch within the roots of historical-comparative research can be found in the work of Voltaire (1694-1778). The most significant work of Voltaire was the Comparative History of Nations and he is considered to be the 'father' of historical-comparative research. Voltaire was the first historian to move away from traditional methods of writing history through stories and chronological accounts that stated what happened, where it happened and when it happened. However, stories and chronicles of the time did not state why an event occurred or what led up to the event, or consequences of the event occurring (Jones 2002). Voltaire and Rousseau were famous proponents of comparative history research and its value in researching and writing of history, so much so that this research method remains a popular approach today.

4.5.1 The Role of Historical-Comparative Research in this Study

When comparing the beginnings of the nurse practitioner role in the five countries identified the time frame for emergence of the role became apparent for each of these countries. In the USA the role of nurse practitioners as we know it today began to emerge in the 1960s, in the UK in the 1990s, in Australia from 1996 and in New Zealand from 2000 onwards.

While not formally identified as such, autonomous nurse practitioners existed much earlier than this in the UK (Abel-Smith 1979). A comparison of roles through these dimensions of time needs to be examined in order to understand how these roles

differed and how the roles compare to what we see in the present. In Australia, rural and remote area nurses have worked at the level of nurse practitioners for some considerable time, without the benefit of support and regulation (Gardner 2004).

This current study explored the differences between countries, how they came to be and why. There are rural nurses in Scotland, Wales, Canada the USA and Australia and there are some similarities in their autonomy.

Historical-comparative research is able to cross dimensions in time and in different countries. This makes it an ideal method to explore and compare different developments, in different countries and within differing time dimensions. Themes including early formation of the nurse practitioner role, policy making and guideline development for endorsement, preparation and training requirements for endorsement and role definition emerged from the documents and were examined across a large time period, from the 1900s to the present day.

Primary sources used included documents from nursing councils and boards, academia, nursing organisations and government papers, discussion papers from leading authors and some text books. Internet searches were utilised to gather relevant historical information. The study used a combination of both primary and a small number of secondary sources.

Cross reference and comparison with other documents in a single dimension (e.g. the time dimension) was required (comparing USA, New Zealand, Canadian, Australian and UK papers from the 1960s to the present day). The current research was subject to *Internal Criticism* which involved evaluating the worth of the evidence (Polit &

Hungler 1991, p. 204-208). This involved 'weighing' of evidence in terms of the impact documents had in bringing about change. The weight of a document involves the evaluation as to whether the author is a competent recorder of fact (is it reliable information), whether the author's representation within the text appears biased or unbiased when compared with others and whether the content is in fact accurate for the period about which the author is writing (Polit & Hungler 1991, pp. 204-208).

The outcome of any publication such as books and articles was also relevant since this provided an impression of the credibility of an author. A document that has been largely ignored until examined later by a single researcher might present a totally different perspective and enrich current research. Alternatively the document may remain a piece of irrelevant material. This is important because it is necessary to focus on the seeds of research: where have nurse practitioners been? Where are nurse practitioners now? Where are nurse practitioners going? Analysis of the evidence provided the discovery of the answers.

The major task for historical-comparative researchers is organising and giving new meaning to the evidence presented in the research. Skocpol (1979, cited in Neuman 2006, p. 430) argued that:

> "The comparative historian's task -and potential scholarly contribution- lies not in revealing new data about particular aspects of the large time period and distinctive places surveyed, but rather in establishing the interest and prima facie validity of an overall argument about causal regularities across various historical dimensions".

The above statement means that a researcher using this method does not merely focus on the discovery of new information but is able to use established facts to provide an argument about causal factors across a short or long time period in

differing settings in history by a comprehensive analysis and synthesis of data. In this study this included not only the various strands of opposition to nurse practitioner development in five countries but also the favourable aspects of nurse practitioner development within the five countries.

Another important factor for this research was the formation and illustration of critical indicators in synthesising the research. The use of critical indicators involved presenting unambiguous evidence (e.g. regulation of nurse practitioners specific to a time period), which is usually sufficient for inferring a specific relationship (Neuman 2006 p.430). Researchers need these indicators for key parts of an explanatory model. This included studying the different endorsement regulation systems as part of a 'model of difference' a picture of how the regulators had control over the regulated nurse practitioner emerged.

When studying human relations and actions, care was taken to avoid Galton's Problem (Neuman 2006, p.441). This occurs when a researcher observes the same social relationship in different settings and falsely concludes that this relationship occurred as a result of a differing rationale (Neuman 2006, p.441). For example, the researcher might claim that a similar relationship exists independently from others and in differing settings of the research. The actual reason for this however, is a shared or common origin that has diffused from one setting to another. Regulation of nurse practitioners over time can be researched by looking at nurse practitioner regulation over different time periods and in different countries such as in this study.

The consensus for regulation may provide a similar method of approach (e.g. maintaining registers), the rules for gaining entry to a register may differ from

country to country, may have changed over time or an entirely new set of rules might have been implemented. A researcher needs to look for these false conclusions in order to produce accurate synthesis of research and prevent the research losing credence (Neuman 2006, p.441).

For the above reasons historical-comparative research was used to study the emergence of the nurse practitioner in five countries: the United States of America (USA), Canada, the United Kingdom (UK), New Zealand and Australia.

4.5.2 Validating the use of Historical-Comparative Research

The historical-comparative method is the approach of choice for understanding social processes that operate across time or across different societies. In this study, legal and professional issues involving the nurse practitioner in five countries over a time span from the 1900s to the present day has been investigated. Research into roots of emergence of the nurse practitioner, in different cultural settings and in different time periods is possible. No other qualitative or quantitative research method can do this with the same level of credence, avoidance of bias, translation, accuracy and richness of research content (Maloney 2004; Neuman 2006; Seigrist 2006). Exploring different cultures, different concepts such as legal and professional issues, in different countries in different time periods and in different social societies provided the nursing roots and thereby provided an accurate history of nursing developments in different eras of time and different dimensions in practice developments.

4.6. Analytic Comparison

John Stuart Mill (1806-1873) a philosopher and theorist is said to be the inventor of analytical comparison. He developed the logic of comparison that is still in wide use today. His 'method of difference' and 'method of agreement' form the basis for analytical comparison (Neuman 2006, p.471). When analysing the regulation of nurse practitioners in different places across time models of difference and models of agreement emerged. This can be likened to the application of weight as a level of worth as one would use a weighing scale. The weight parameter is the impact the model of agreement or model of difference had on the outcome of later developments (e.g. standardising mandatory educational requirements for endorsement as a nurse practitioner).

In order to explore the domain of professional regulation of nurse practitioners the researcher explored the 'weighting' allowed by governments to nursing councils in formulating their own systems of regulation, or whether governments did this by legislative procedure. If nursing councils in some countries were allowed to formulate their own systems of regulation it would be possible to 'translate' the level of autonomy nursing councils were given to regulate themselves without State or Federal Parliamentary or Congressional (in USA) intervention.

The degree of difference was important in translating how much influence nursing councils had historically on the developing nurse practitioner role or how much influence governments will potentially have in this regard. A further example is the use of ideal types (e.g. the desirable model of legal awareness on the part of nurse practitioners in terms of awareness of law relevant to their role). This was explored

using field research to ascertain how much nurse practitioners knew about of law relative to their day to day nursing practice.

Analytical comparison is sometimes called nominal comparison because the factors in the qualitative data are at the nominal level. Nominal relates to meaning in its adjective form: purported or supposed (Neuman 2006, p.472). A simplistic example is an ordinary car compared with a four wheel drive vehicle. A car is a type of motor vehicle but is different in shape to a four wheeled drive- also a motor vehicle, yet they both have four wheels. The method of agreement is that each is a motor vehicle and they both have four wheels. The method of difference is shape and wheel control. A four wheel drive vehicle is shaped differently when compared to a car. It also drives differently because it is able to drive on different terrain whereas a car is mostly limited to sealed roads and only certain metal based roads.

4.6.1 Method of Agreement

The concept of method of agreement focused attention on what was common across the domains for analysis. A common factor was established and a common cause, where possible (Neuman 2006, p.473). Causal factors might be different. When comparing the USA with Australia it was noted that the time factor for implementation of the nurse practitioner role was very different in each country. Factors that were not shared between domains were eliminated (e.g. minimum educational qualifications between countries not in agreement). In addition it was possible to eliminate alternative possibilities and identify primary causal factors (e.g. the need to implement minimum educational qualifications in all five countries). The

argument becomes strengthened in that despite the differences, the critical indicators exist.

Examination of the domain of education and preparation for the nurse practitioner role revealed that the 'Grandfather Clause' was used in Australia for a limited time only to facilitate the endorsement of experienced nurses, who were working at the level of nurse practitioners in their workplace without formal recognition or post graduate qualifications. The Grandfather Clause facilitated nurse practitioner endorsement without the need for a master's degree (e.g. Queensland Nursing Council Nurse Practitioner Regulations 2005). This factor was eliminated as a causal factor in education as it is now obsolete. The critical indicator is mandatory education to master's degree level through an approved course of study specific to nurse practitioners. This is one parameter that formed the measurement when one country is compared with another in this study.

4.6.2 Method of Difference

The method of difference is usually stronger than the method of agreement and is a 'double application' due to the fact that the agreement has to be weighed to obtain the difference. Similarities between cases are normally identified first as agreements (positive) and differences second (negative) (Neuman 2006, p.473). When examining the education domain for example, it may be necessary to examine whether or not there is a mandatory time period a nurse needs to be qualified before undertaking nurse practitioner training. The mandatory period would be the similarity (positive) and whether this applies to all countries studied or not (negative). The negative would provide a model of difference.

4.6.3 The Validation for Analytical Comparison in this Study

People often discover differences by comparing two or more objects with each other (Neuman 2006). In the physical assessment of patients for example, nurses use certain rules to diagnose problems when first examining limbs, these being comparison, colour, continuity and capability (Walsh 2006). The limbs are compared in terms of anatomical position: equality of length, joint alignment, protrusions and range of movement. Skin and soft tissue status is examined noting any pallor or redness, rashes, swelling, bruising or broken areas of skin. Ranges of movement are completed, looking at the patient's ability to lift, lower, extend or rotate limbs and the problems encountered in so doing. One arm or one leg is examined alongside its neighbour to compare and identify a problem, if it exists (Walsh 2006).

In this study, analytic comparison was used to compare the emergence, impact and challenges in developing the role of the nurse practitioner in five countries: Australia, Canada, New Zealand, the USA and the United Kingdom. The historical-comparative process explored the history of the emergence of the nurse practitioner role. To analyse the data, the researcher needed to take further steps to identify how the role was implemented, time factors involved and policies and guidelines relative to training and preparation. These were compared to identify models of difference and models of agreement in relation to the critical indicators that identify agreement or difference.

All nurses have a Scope of Professional Practice and this was a key feature that identified professional boundaries and advocated collaborative nursing practice with other health professionals. Nurse practitioners also have a defined Scope of Practice specific to their role, some of which are unique to a specific service a nurse practitioner provides (Gardner & Gardner 2005). Other features included explaining initiatives in nurse practitioner development and comparing them in order to examine the different ways of working within each country that could potentially be an improvement in another country. Analytical comparison was used to analyse the historical-comparative data within the study.

4.7 Field Research Studies

Nurse practitioners work at an advanced level of practice which is different to the normative work undertaken by mainstream nurses (Gardner 2004). Nurse practitioners are regulated within a different supplementary register to general nurses due to this advanced practice status and the preparation that needs to be undertaken to become endorsed with nursing councils (e.g. Policy on the Regulation of Nurse Practitioners in Queensland 2005). How this occurred within the five countries was explored. As an example, in the USA and Canada some Nursing Boards within States and Territories are not allowed to govern regulation of the nurse practitioner alone. In some states joint governance is in place involving Nursing Boards and Medical Boards.

For this phase of the study, the examination took the form of in-depth interviews with four nurse practitioners in their workplace. The purpose of this was to explore their endorsement journey, issues they faced in the workplace, previous

qualifications held in their chosen scope of practice as a nurse practitioner and supervision of the nurse practitioner both prior to, and following, endorsement. In addition, how each participant saw the relevance of law in their day-to-day clinical practice was explored. Interviews were taped and transcribed. These transcriptions were assessed for accuracy by participants to ensure that the researcher had transcribed the content correctly. The data was then compared and analysed using a thematic analysis, to explore the common emergent themes.

4.7.1 The Parse Human Becoming Theory

As previously stated in chapter 3, Parse (1995, p.1) posited that there are two types of research to be undertaken. First, the use of interpretive research that sheds light on meaning of texts from the perspective of the Parse (1995) theory and second, the use of applied research, for evaluating the Human Becoming theory in practice. The first approach of interpretive research was used in this study to guide the research by describing the value of the Parse (1995) theory in terms of nurse practitioner clinical practice. The assumptions underlying this were that the 'person' within this study, was not a consumer of health care it was the nurse practitioner. The research explored the journey and role of the nurse practitioner in-depth and translated this using Hermeneutics into how the journey interconnected with the Human Becoming Theory. As an adjunct to the Parse Theory, the Strong Model of Advanced Practice (2004), which also has roots in phenomenology, was used. This formed the initial foundations for joining the first principles of the Parse (1995) Theory with the Strong Model of Advanced Nursing Practice (2004) and demonstrated the synergy that exists between them.

4.7.2 Hermeneutic Analysis

As part of applying the Parse (1995) Theory to Historical-Comparative research a hermeneutic analysis within critical hermeneutics was used to explore the lived experience of nurse practitioners in their day to day work. There are six dimensions of the process that overlap with Historical-Comparative research and Parse (1995). These concepts are also called the Hermeneutic Spiral and the dimensions of this process include:-

- The researcher engaged in **dialogue** with nurse practitioners, who helped the researcher, through their own language, and discovered life as a nurse practitioner; the highs, the lows, the problems (Cody in Parse 1995, p.280).

- The researcher asked **key questions** about nurse practitioners' work and what it meant to be a nurse practitioner (Cody in Parse 1995, p.280).

- The researcher **configured this inquiry** by using the Parse Human Becoming Theory (1995) as the methodological theory using this as a backdrop to hermeneutic interpretation: what it meant to be a nurse practitioner connecting with human becoming (Cody in Parse 1995, p.280).

- **The meaning was constructed** by movement, item by item, between participants' language and researcher's language: a process of questions derived from actual descriptions of day to day work (the apex) and role definition (the origin) and connecting this to the human becoming theory (Cody in Parse 1995, p.280).

- **The horizons were explored** by assigning meaning to what participants' believed, what they were certain about, what their uncertainties were and the problems they defined as significant. This included explaining restriction-freedom dimensions in what freedoms a nurse practitioner had and what the nurse practitioner defined as restrictions, making connections throughout with human becoming (Cody in Parse 1995, p.280).

- **Possibilities were disseminated** through this study by the researcher defining a nurse practitioner's day to day work, through restriction-freedom dimensions and connecting and applying these to human becoming (Cody in Parse 1995, p.280).

4.8 Ethical Considerations

Approval from the University of Southern Queensland Ethics Committee was granted for this study, as per NHMRC guidelines in Australia and from employing organisations of participants before commencing interviews. Participants were recruited from various geographical areas within Australia. The recruitment was thus opportunistic (Neuman 2006). Inclusion criteria were defined as any registered nurse practitioner or nurse practitioner interns who were able to participate, through their agreement and agreement from the employer.

Participants were those able to give written informed consent to the study and who were able to clearly articulate their practice to the extent required. Exclusion criteria included any nurse practitioner who felt that sanctions from employers as being a likely consequence of participating in the study.

The rights of participants were protected by using plain language statements given in order to ensure that what was required was easily understood. Each participant was accorded the right to know how the research was to be used, the right to formal consent, via an approved consent form before any research commences, the right to know how the research would be stored, how it is stored, and for how long. Data is stored on a computer only accessible to the researcher, within a storage system that is password protected and the password known only by the researcher will be stored for a period of five years.

Participants were informed of their right to feedback. This took the form of a written report and will be sent to relevant parties on request. The written transcripts, following taped interviews, were sent to participants in order for them to check the content and for accuracy and are stored securely in a safe place only accessible to the researcher. Participants were informed of the right to withdraw from the research at any time without sanction, and the right to complain to the University of Southern Queensland Ethics Committee at any time, should the participant deem that the research was carried out in an improper manner.

4.9 Limitations of the Study

The small opportunistic sample size gave the research rich data but this data is not able to be generalised because of the sample size. Nevertheless the sample size provided insight into the nurse practitioner journey as well as some of the unique experiences nurse practitioners bring to the workplace with regard to postgraduate experience prior to seeking endorsement and the all important postgraduate courses.

4.10 Chapter Summary

This chapter has explained the research methodology undertaken for this dissertation. The concepts of Historical-Comparative research and its role within the study were discussed with analytical comparison and evaluation studies of the nurse practitioner universe, as seen through the eyes of four nurse practitioners. Each of these aspects formed a unique but interconnecting basis for undertaking research for the study.

CHAPTER 5 RESEARCH FINDINGS AND DISCUSSION

5.1 PHASE 1 OF RESEARCH FINDINGS

5.1.1 The Emergence of the Nurse Practitioner in Five Countries

> "We will continue our journey for some time; and when we have finished our exploring, we will return to the place where we started and know it for the first time" T.S.Eliot (1942)

In this chapter, findings from the HC analysis of the emergence of the nurse practitioner in five countries: the United States of America (USA), Canada, the United Kingdom (UK), New Zealand and Australia are presented. The analysis began in the literature review starting with the USA, where nurse practitioners emerged earliest and onward to the most recent country (Australia) to fully implement the role.

The specific concepts (characteristics) of locating evidence, evaluating the quality of the evidence, organising the evidence into themes using theoretical insights, synthesising the evidence (refining, revising), identifying similarities and differences between the concepts were applied. This enabled the researcher to explore plausible explanations and to unite the concepts and evidence into a coherent whole (Neuman 2006 p.430). By utilising cross dimensions in time and in different countries, critical indicators (which involved presenting unambiguous evidence such as regulation of nurse practitioners specific to a time period) were applied to the data. Within HC data the latter is usually sufficient for inferring a specific relationship and to identify causal regularities across various historical dimensions (Neuman 2006 p.430). Evidence was weighted in terms of the history of the emergence of the nurse practitioner, development of the nurse practitioner role, education, regulation and

legal and professional issues pertaining to the role within the five countries across 46 years of time.

In some areas of the USA, the role of a nurse practitioner is classified as an advanced nurse practitioner (Hamric 1998 in Castledine & McGee 1998). An advanced nurse practitioner is a registered nurse who has completed an advanced programme of nursing, considered as a clinical expert in a specific field and capable of working without supervision to a pre-determined advanced practice level (Gardner & Gardner 2005).

Advanced practice means that nurses undertake additional clinical practice dimensions (e.g. ordering and interpreting diagnostic tests) that are not part of the remit amongst mainstream registered nurses, involving duties that are normally undertaken by doctors. This 'umbrella' classification also included midwives, clinical specialists and physicians' assistants (Bigbee 1996 in Hamric, Spross & Hansen 1996 p.5). Additionally, in the UK any mainstream nurse who is successful in completing the Nurse Prescriber Programme developed by the UK Nursing and Midwifery Council is allowed to prescribe medicinal products. In the UK, only nurses who are authorised to order diagnostic tests approved by the employer is allowed to order such tests and interpret them. These nurses do not need to be designated nurse practitioners or indeed designated advanced practice nurses. There is no registration or regulation of any designated advanced nursing practice roles within the UK. This is a significant critical indicator of why the UK is so out of step with other countries explored within this study.

The above processes were not uniformly adopted within the five countries studied and no two countries presented exactly the same pathways to endorsement for the nurse practitioner. The research findings will be discussed in response to the research questions. These will be identified at the beginning of each relevant section.

5.2 Nurse Practitioner Development in Five Countries

To what extent did nurse practitioner development, educational requirements and legal and professional issues differ historically between five countries?

5.2.1 USA

In the late 1950s and early 60s, discussions took place in the USA about the expansion of nursing functions (Bigbee 1996, in Hamric, Spross & Hansen 1996, p. 16), related especially to domains of nursing practice expanding and extending into roles traditionally seen as doctors' practice. Growing out of the role of the public health nurse as the closest example of a broad scope of practice and a relatively high degree of autonomy, examples of developments in innovative nurse practitioner practice emerged, in settings such as rural nursing, occupational health and venereal disease clinics (Bigbee 1996, in Hamric, Spross & Hansen 1996, p.17).

In addition, nurse anaesthetists emerged as specialist nurses trained to administer anaesthesia and have since become specialists within their own right with a remuneration in direct competition with doctors who are anaesthesiologists (Bigbee 1996, in Hamric, Spross & Hansen, p.17). These nurses were amongst the first advanced practice specialist nurses to emerge within the USA.

At the same time, medicine became more specialised. Doctors were gradually moving away from primary care and into hospital medicine. This factor became the main impetus for the development of the nurse practitioner role (Bigbee 1996, in Hamric, Spross & Hansen 1996, p.17). The women's movement (1981) increased and at the same time public awareness of nurses being undervalued and under-utilised became noted. Health care costs were increasing at an annual rate of 10-14% (Jonas 1981, cited by Bigbee (1996) in Hamric, Spross & Hansen 1996, p.17).

As a result of combat during the Vietnam War with medics and nurses returning from Vietnam to the USA a further role was developed: that of the physician's assistant (Bigbee 1996 in Hamric, Spross & Hansen 1996, p.17). These were military nurses and combat medics who were trained on demobilisation from the military to assist physicians in hospitals and were supervised by consultants. Physician's assistants could take patient histories, order diagnostic tests, prescribe medication, refer for specialist treatment and act as an assistant during surgery (Bigbee 1996, in Hamric, Spross & Hansen 1996, p18) but the role of physician's assistant is different to that of a nurse practitioner though they are both nursing roles. The physician's assistant training is centred more on delegated doctors' duties. Physicians' and surgeons' assistants today are a common feature of modern day healthcare and come under the 'umbrella' of advanced practice nurses but they are not classified as nurse practitioners.

The landmark event in the emergence of the first formally trained nurse practitioners was the establishment of the first paediatric nurse practitioner course, at the University of Colorado, in 1965 (Bigbee 1996 in Hamric, Spross & Hansen 1996,

p.18). It was funded by the Commonwealth Foundation (Bigbee 1996 in Hamric, Spross & Hansen 1996, p.18) and was designed to prepare experienced registered nurses to provide comprehensive well-child care as well as the management of common childhood ailments such as asthma. Family orientated care and community cultural values were strongly emphasised. This initial programme shifted away from the medical model of care to family orientated health promotion (Bigbee 1996, in Hamric, Spross & Hansen 1996, p.18).

The emergence of the nurse practitioner at this time attracted considerable attention from professional nursing groups and policy makers. The National Advisory Commission on Health Manpower (1996) supported nurse practitioners and established a committee to study extended roles for nurses. The committee was charged with the task of evaluating the feasibility of expanding clinical nurse practice (Bigbee 1996, in Hamric, Spross & Hansen 1996, p.18). It concluded that extending the scope of a nurse's role was essential to provide equal access to health care for all consumers. They advocated a commonality of nursing licensure within the USA and certification, including a model of nursing practice law suitable for national application throughout the USA (Kalisch & Kalisch 1986, in Hamric, Spross & Hansen 1996, p.19).

By 1984, approximately 20,000 graduates of nurse practitioner programmes were employed in mainly primary care settings. By 1992, there were 48,237 nurse practitioners who were licensed, of which 88.4% were active in nursing (American Nurses' Association 1993 in Hamric, Spross & Hansen 1996, p.19). By 2006, there were 139,520 licensed nurse practitioners in the USA (Pearson 2007). Currently,

there is a mechanism for all nurse practitioners to gain national credentialing within their home state through the United States Academy of Nurse Practitioners Credentialing Board (Pearson 2007).

The nursing profession in the USA failed to fully embrace the role of the nurse practitioner (Bigbee 1996 in Hamric, Spross & Hansen 1996, p.19) and While the role of physician's assistant emerged in the same decade but with little or no opposition (Bigbee 1996 in Hamric, Spross & Hansen, 1996), the nursing profession itself brought to bear the brunt of opposition to the nurse practitioner role in the early stages.. Findings from history suggest that despite such opposition the role of the nurse practitioner gained credence as more graduate nursing schools offered nurse practitioner courses. Pearson (2007, p.2) cites that in the primary care arena, the nurse practitioner role is just as effective as is that of the physician.

5.2.2 CANADA

As in the USA, the introduction of the nurse practitioner role in Canada can be traced back to the 1960s resulting from the changing roles of nurses, perceived shortage of physicians and the movement towards specialisation. Whilst there was general recognition of the need for the nurse practitioner role, there was little or no movement to formalise the role in legislation and regulation (CNA 2005, p.3). In the 1970s, several approved education programmes began to emerge, offering graduate programmes without the support of legislation or regulation. This meant that nurses could complete a course at university specific to the nurse practitioner but were not actually regulated by a Nursing Board as nurse practitioners on completion of such courses, as happens in the United Kingdom today (Ball 2005).

Some registered nurses, without formal nurse practitioner qualifications worked in posts that mirrored the nurse practitioner role. These nurses worked through delegated functions assigned by physicians and were primarily dependent upon physician collaboration and supervision, particularly in rural areas (CNA 2005, p.3). The fact that these arrangements existed went largely without comment within healthcare in Canada. In some countries, nurses firmly believe and demand that nursing be run and governed by nurses with all nurses being accountable both professionally and managerially to another nurse (Dimond 2004). However, this may not be possible where resources are scarce such as in rural areas. In some areas one can only work with what is available. In Canada, such initiatives were successful only because professional people were prepared to work together in circumstances where healthcare within a rural area was provided (CNA 2005, p.3).

By the 1980s, unlike in the USA, most nurse practitioner initiatives in Canada that were underway in the 1970s had all but disappeared. Some of the reasons for this decline included a perceived over-supply of physicians, lack of proper remuneration mechanisms, the absence of province and territory legislation, little public awareness of the role, weak support from policy makers, health care organisations and regulators (CNA 2005, pp.3-5).

In the 1990s the Canadian authorities performed a total review of healthcare provision and the roles of healthcare professionals. The renewal of interest in the nurse practitioner role happened particularly as a result of a desired shift towards primary health care in Canada. This resulted in many Canadian provinces and territories pursuing legislation, regulation and provision for education requirements.

These initiatives included a defined scope of practice for all nurse practitioners, particularly those in primary care and secondary care settings. Today, nurse practitioners in both acute and primary care have become an important resource that is able to contribute to improved access to health care (CNA 2005, pp.3-5).

In Canada in 2004, there were a total of 878 licensed nurse practitioners registered in the jurisdictions of Newfoundland, Labrador, Nova Scotia, New Brunswick, Ontario, Saskatchewan, Alberta, the Northwest Territories and Nunavut. Of these 66.9% worked full time implying that not all registered nurse practitioners were actually utilised in full time positions (CNA 2005, p.2).

Early development of the nurse practitioner role in Canada was subject to both acclaim for development of the role, as apparent in the 1960s and to indifference as in the 1970s. This suggests that this role was (as in the USA), not fully embraced by the nursing profession in Canada. The nurse practitioner role during the 1970s was ignored as a developmental opportunity, resulting in most nurse practitioner development initiatives disappearing (CNA 2005). It appears to be a sad fact that in both the USA and Canada the nursing profession failed to support nurse practitioners and stakeholders in their endeavours to establish this role as part of the healthcare workforce.

5.2.3 UNITED KINGDOM (UK)

The advanced practice nurse, including the nurse practitioner is identified as beginning in the USA (Hamric 1998; Bigbee 1996; Castledine and McGee 1998). However, it could be argued that this is not truly accurate. Abel-Smith (1979, p.52) identified an early role of a similar type in the United Kingdom that existed in the late 19th century and early 20th century. He describes the role of 'Lady Nurses', who were trained 'scientifically' and who lived and worked in patients' homes in collaboration with, but not subordinate or accountable to, the general practitioner (GP).

Abel-Smith (1979, p.54) suggested that it could be argued that lady nurses were amongst the first pioneers of advanced clinical practice in nursing. This was at the time prior to World War 1 (1914-1918), and at this time there was no legislation that made provision for the registration and regulation of any nurses within the UK. The registration and regulation of nurses eventually came about as a result of strong associations with the emancipation of women, through the Suffragette Movement (Abel-Smith 1979, p.91). The Nursing Registration Act was finally proclaimed in 1919 (Abel-Smith 1979, p.92) and the first General Nursing Council established in the UK.

Nurse practitioners as we know them today have existed in posts with this designated title in the UK since the early 1990s and work in a variety of clinical settings both in primary and secondary health care (Royal College of Nursing (UK) 2006). However, legislative provisions for regulation and licensure of nurse practitioners do not exist there. The title of 'nurse practitioner' is not protected in the UK (Ball 2005),

meaning that any registered nursing post could be designated as a nurse practitioner and a registered nurse in a designated nurse practitioner post does not require in law any specific additional qualifications in order to accept such a position. In order to protect a title within a profession, a change in legislation is required (Ball 2005). Title protection means that the role (e.g. nurse practitioner) is protected through legislation and no other registered nurse is able to use this title unless registered by nursing regulators as nurse practitioners (Ball 2005). The government has announced (Nursing Times March 2 2010 no author cited) that the prime minister identified the need for all advanced practice nursing roles to be regulated through the legislative process. Work is to begin on this long awaited initiative in the near future and is a critical indicator of the need to regulate all advanced practice roles in the UK, including nurse practitioners. However, the recent change of government in the UK could potentially curtail all such initiatives.

Each of the UK principalities: England, Wales, Scotland and Northern Ireland are regulated by members from each principality serving on a united Council, so that the interests of all of the principalities are managed by one council, the Nursing and Midwifery Council (www.nmc-uk.org viewed 16 November 2007). In terms of nurse practitioners, Council awaits permission from the Privy Council to be able to open a further supplementary register for all grades of advanced practitioner nurses, including nurse practitioners (Nursing and Midwifery Council (NMC) Position Statement 2006). Once Privy Council permission in granted, provision can be made for regulation and registration of nurse practitioners and advanced practitioners. Nevertheless, this might not be as simple as it sounds. Rolfe (in Rolfe & Fulbrook

1998, p.219) argued that in the UK as in other countries, the role of all grades of advanced practitioner was still developing with as yet little agreement about what advanced practice is or what this might become.

Despite some general consensus about the advanced practitioner possessing, using and communicating expert clinical knowledge and skill, little consideration had been given by regulators in all countries explored as to precisely what this means, how it will be achieved or what titles to use. This is, in essence, the epistemology of advanced practice nursing (Rolfe in Rolfe & Fulbrook 1998, p.219).

In 1989 the UK the Department of Health (in Rolfe & Fulbrook 1998, p.219), advocated the use of evidence based practice as a means of role development for nurse practitioners. As Rolfe argued, this is the same evidence on which all registered nurses base their clinical practice and had little significance for the development of advanced practitioner roles (Rolfe in Rolfe & Fulbrook 1998, p.219).

Rolfe argued (Rolfe in Rolfe & Fulbrook 1998, p.219) that people with the most knowledge about nurse practitioner role development issues were not clinical nurses (suggesting that Rolfe believes their knowledge is insufficient) but academics and researchers: those most adept at passing this knowledge on to others. This suggested that if all advanced practitioner nursing was based on higher degree knowledge and university based research, most advanced practitioner nurses would not be hospital or community based but in academia. According to Rolfe (Rolfe in Rolfe & Fulbrook 1998, p.219) academics have the knowledge required but the hospital and community nurses who are likely to be developed as nurse practitioners do not have sufficient knowledge in order to make the transition into nurse practitioners. However, most

hospital and community nurses who have successfully qualified as nurse practitioners could rightfully challenge this statement.

As most nurses who have successfully become nurse practitioners do so without regulation or license within the UK, this claim was arguable because universities were not the institutions responsible for role innovation within the UK health system. Healthcare Trusts (health boards in geographical areas) had this responsibility in conjunction with government. The university may provide educational requirements but they had little or no influence in the establishment of nurse practitioner positions. The argument was that Rolfe was criticising the profession at large in stating superior knowledge in academia compared with hospital or community as being the prime source of educational ability. This could be severely challenged by hospital and community based nurses. Rolfe's (1998) argument devalued the position of experienced and motivated nurses who sought to become nurse practitioners within the UK.

Despite Rolfe's argument, the UK was not without innovation in terms of nurse practitioner development. According Ball (2006), a nurse practitioner working in the Scottish Isles, was the sole health care provider on an island in the Outer Hebrides. Referral to the mainland for more acute care was required, but evidence (Ball 2006) showed that there was less incidence of depressive illness on the island. Chronic illnesses such as diabetes and asthma were better managed as the one practitioner-in-charge had the clinical expertise to work autonomously thereby validating the efficacy of the nurse practitioner role in rural communities.

Despite lack of regulation the Nursing and Midwifery Council (NMC) had recognised nurse prescribers and specialist practice nurse qualifications. These were added to their registration as 'additional recorded qualifications'. These qualifications, as postgraduate certificates and diplomas, included all levels of prescribing and advanced clinical practice in hospital, community, learning disability, paediatrics and mental health (Rolfe 1998). This process, though it was not 'regulation' as such, controlled the development of nurse prescribers in the UK as well as advanced practice nurses. In order for nurse prescribers to gain the additional qualifications required to prescribe, registered nurses followed a strict policy and assessment procedure (NMC 2004). Despite Rolfe's argument, the NMC had obviously moved on to policies and procedures that will make the transition easier when formal legislation processes are completed, following Privy Council approval.

With the establishment of nurse practitioner posts and courses for preparation in progress prior to NMC endorsement, this could work to the distinct advantage of the UK nurse practitioner. Experienced nurse practitioners would have clearer direction because they already work in established posts. Some of the preparation required to become endorsed will already be completed (e.g. prescribing). The scope of practice would be better established because nurse practitioners will have had opportunity to develop their own scope of practice that was tailor made for their caseload, with less bureaucratic, political and regulatory demands placed upon them. The UK could fall victim to the Canadian experience (CNA 2005) whereby many nurses worked in posts that mirrored the nurse practitioner role but were never regulated-either by legislation or a nurse regulator organisation. However, this factor was overcome in

the UK March 2010, when Gordon Brown, the then UK Prime Minister, as part of the UK health review (Nursing Times March 2010) stated that all advanced practice posts within the UK, including nurse practitioners, should be regulated. This work is currently ongoing with an estimated completion date of 2013.

5.2.4 NEW ZEALAND

The 1998 report from the Ministerial Taskforce in New Zealand focused on the untapped potential of the nursing workforce. It concluded that to release this potential nurses needed to use their knowledge and skills more effectively, pioneer innovative service provision, enhance the access to and quality of primary care and contribute positively to health gain (Hughes & Carryer 2002).

This highlighted the existence of increasing numbers of highly educated and skilled nurses in practice with advanced practice and leadership competencies. In the public health system the most visible of these nurses worked in multidisciplinary teams and/or in acute care settings such as neonatal units and emergency departments or as clinical nurse advisors (Hughes & Carryer 2002). The taskforce considered that diverse factors worked against the best utilisation of nurses, including poor access to postgraduate education, legislative and funding barriers and the working conditions under which many of these nurses practised.

These factors were identified as inhibiting the effective development and utilisation of nurses with advanced practice competencies and the development of clinical career options. The taskforce recommended the development of the nurse practitioner role in New Zealand to provide highly skilled care, co-ordination of patient groups

(e.g. diabetic care, asthma care) across the hospital/community interface and a high level of family health care services.

The key principles of nurse practitioner role development in New Zealand were:-

a) Nurse practitioners work towards health gain and reduce inequalities and inequities in health; this includes addressing health needs of all Maori and Pacific peoples;

b) The nurse practitioner is the most advanced level of clinical nursing practice;

c) Nurse practitioners should continue to evolve in response to changing societal and health care needs;

d) Population health status will drive the provision of nurse practitioners;

e) Development of the nurse practitioner challenges traditional boundaries of nursing practice (Hughes & Carryer 2002, p.4).

The nurse practitioner role will mostly complement the role of other health professionals, but overlaps will happen. Such overlap would enable substitution between groups to occur and thus provided efficiency and flexibility in the use of valuable resources. Nurse practitioners, like registered nurses, were autonomous practitioners and did not require supervision of their practice by other disciplines who had a defined scope of practice and substantial clinical expertise in their chosen scope and are certified to practice by the Nursing Council of New Zealand (Hughes & Carryer 2002, p.4). The practice of nurse practitioners was based on collaboration and colleagueship and was based on concern for mutual goals, equality in status,

power, prestige and access to information with diversity in expertise, skills, knowledge and practice (Hughes & Carryer 2002). Nurse practitioners in New Zealand were recognised by the Nursing Council and became registered as nurse practitioners when they had a clinically focused Master's degree, had met the Nursing Council assessment criteria and competencies and completed four to five years experience at an advanced level in a specific scope of practice (Hughes & Carryer 2002 p.4).

5.2.5 AUSTRALIA

The nurse practitioner movement first began in Australia in New South Wales (NSW) in 1990. Similarly to the UK and USA in the 1980s, NSW experienced a shortage of doctors in under-serviced communities especially in rural and remote areas (Driscoll et al. 2005 p.1). At the same time, retention of experienced nurses was becoming difficult and was at a critically low level (Chaboyer & Turner 2002, cited in Driscoll et al. 2005, p.2). Nurses indicated that one of the reasons for their leaving the profession was an inadequate clinical career structure (NSW Department of Health 1995; Turner 2001; Harris & Chaboyer 2002, in Driscoll et al. 2005, p.2). Current thought by policy makers at this time was that the nurse practitioner role would assist the retention crisis through the creation of a further career pathway.

Nurse practitioner development was seen as a way of addressing shortfalls in health service delivery caused by fewer doctors working in rural areas, given that the role of a nurse practitioner was viewed as a substitute doctor role at this time (NSW Department of Health 1995; Turner 2001 in Driscoll et al, 2005 p.2). However, legislation and regulation within NSW prevented registered nurses from prescribing

medications or ordering diagnostic tests. Historically, advanced practice nurses (e.g. physicians' assistants, surgeons' assistants) were already ordering diagnostic tests outside the legislative boundaries for up to two years prior to nurse practitioner development in 1996 even though it required a change in legislation for nurse practitioners to obtain similar privileges (Driscoll et al. 2005).

The nurse practitioner role was first discussed at an annual conference of the NSW Nurses Association (NSW Department of Health 1995). Following this conference, a task force was established by the Chief Nursing Officer to consider the development of the nurse practitioner role. The remit of this taskforce was to produce an action plan for the development of the nurse practitioner role within NSW (Driscoll et al. 2005).

During the period 1992 to 1995 in NSW, pilot projects were implemented to investigate nurse practitioner models within primary care and within the rural and metropolitan health areas. Evaluation of these projects was very positive (NSW Department of Health 2005 cited in Driscoll et al. 2005, p.3*)*. Eventual consensus was reached, following negotiation with medical staff organisations, health departments and nursing organisations, which resulted in the nurse practitioner role being restricted to rural and remote areas (NSW Department of Health 1995 in Driscoll et al. 2005, p.3).

In 1998, The New South Wales Health Registration Act 1991 was amended to incorporate the role of nurse practitioner (NSW Nurses Registration Board 2000 cited in Driscoll et al. 2005, p.3). This was an important step in nurse practitioner role development, both within NSW and Australia.

In Victoria in July 1998, a similar task force to NSW was established. After similar organisational negotiations 11 nurse practitioner models were funded, under an initial phase 1 of a nurse practitioner project. This allowed nurse practitioner development in primary health, theatres, emergency care, women's health, paediatrics, neonatal care, haematology, wound care, psychiatry and a homeless person's programme, but not rural and remote where the need was greatest (Driscoll et al, 2005).

Unlike New South Wales, the implementation of nurse practitioners in Victoria was not based upon substitution of medical care in under-served communities but on the development of an advanced nursing framework that focused on advanced nursing practice and decision making. This was to ensure that the needs of patients, within primary and secondary health care were met (Victorian Department of Human Services 2000 in Driscoll et al.2005, p.3).

After twelve months, each nurse practitioner appointee took part in an evaluation, undertaken by the University of Melbourne. The findings of this evaluation yielded insights rather than conclusions (Driscoll et al. 2005) and were withheld from publication by the Victoria Department of Health. Driscoll et al. (2005) rightly argue that withholding publication of the evaluation report served only to mystify the report rather than clarifying processes and outcomes.

In early 2000, the report of the Victorian Nursing Task Force was released (Victorian Government Department of Human Services 2000 cited in Driscoll et al 2005 p.4). At this time The Australian Medical Association were firmly against any form of nurse prescribing or nurses' ordering of diagnostic tests or having admission privileges. Their reasons included insufficient training of nurses, potential dangers of

unsafe prescribing and fragmentation of health care (Victorian Department of Human Services 2000 cited in Driscoll et al. 2005 p.4). The Australian Medical Association was firmly against the idea that nurse practitioners were able to undertake duties that were previously the sole domain of the medical profession (Driscoll et al. 2005; AMA 2005).

Despite this opposition, in 2000 the Victorian Nurses Act 1993 was amended and provisions were made to allow nurse practitioner registration and regulation; this was enacted in 2001. Similar implementation and developments took place in South Australia the Australian Capital Territory (ACT) Western Australia and Queensland, in 1999, 2001, 2004 and 2005, respectively (Driscoll et al. 2005). The ACT published its full Framework Document, which outlines all policies and procedures for nurse practitioners, from endorsement preparation onward in 2006 (ACT Nurse Practitioner Framework 2006). Western Australia (WA) did not change any legislation to implement the role of nurse practitioners until 2008. The process of registering as a nurse practitioner had been streamlined up until 2008 and is an 'over-the-counter' process for all registered nurses completing courses accredited by the Nurse Registration Authority of Western Australia. All that is required is proof of completion of these approved courses.

Since 2008 Australia is now a nation of a standard process for the regulation, registration and education of nurse practitioners. This occurred as a result of all states and territories within Australia becoming compliant with the Inter Government Agreement (2008) that made provision for a uniform approach to nurse practitioner regulation, registration and education through the legislative process within each

state. Western Australia and South Australia now carries these minimum standards in line with all other jurisdictions.

Table 1 compares the historical nurse practitioner policy in the different Australian states. It must be noted that two jurisdictions in Australia, The Northern Territory and Tasmania have only recently developed legislation processes and policy for the implementation of nurse practitioner role development, so no data is available for comparison and cannot be included within this table. The first nurse practitioner initiatives were begun in these Tasmania and the Northern Territory by 2008.

Using the concept of Analytical Comparison, the table overleaf illustrates the findings, comparing the various nurse practitioner initiatives in Australia.

5.2.5.1Historical Comparison of Nurse Practitioner Development

Table 1 Comparison within Australia of Nurse Practitioner Policy

(Source: Nursing and Education Taskforce 2005)

KEY ELEMENT	NSW	VIC	SA	ACT	WA	QLD
YEAR COMMENCED	1998	2001	2002	2002	2004	2005
SCOPE OF PRACTICE	DEFINED	DEFINED	DEFINED	DEFINED	DEFINED	DEFINED
EDUCATION	MNS#	MNS#	MNP*#	MNS#	MNS#	MNS#
PRESCRIBING	YES	YES	YES	YES	YES	YES
DIAGNOSTIC INVESTIGATIONS	YES	YES	YES	YES	YES	YES
REFERRALS	ALLOWED	ALLOWED WITH GP	ALLOWED	ALLOWED	ALLOWED	ALLOWED
ADMITTING TO HOSPITAL	NO	RECOMMENDS	LIMITED	NO	NO	NO
TITLE PROTECTED	YES	YES	YES	YES	YES	YES

Since 2008* # MNS = Master of Nursing Science (Nurse Practitioner) MNP = Master Nurse Practitioner

5.3.1 Method of Agreement

Analysis using the method of agreement indicated that nurse practitioners in all states and territories of Australia were allowed to prescribe drugs and order diagnostic tests following amendments to legislation. Four of the six states did not grant admission privileges to nurse practitioners. All states allowed nurse practitioners to make referrals to other health care agencies and health professionals. Scopes of practice were defined in all states and territories, to include primary and secondary health care, with no restriction in clinical setting (Driscoll et al. 2005).

The title ‘nurse practitioner’ was protected in all states and territories with legislative provision for nurse practitioner development. This meant that registered nurses cannot call themselves nurse practitioners unless they were endorsed and registered by nursing regulators within a state or territory.

Currently within all states there was a uniform demand for a master's degree as a minimum qualification for registration as a nurse practitioner (Australian Inter Government Agreement 2008).

5.3.2 Method of Difference

There are no methods of difference within Australia since 2008 when all jurisdictions within Australia made legislative provision for a uniform approach to nurse practitioner education, regulation and registration (Inter-Government Agreement 2008), This uniform approach had to take place before the vision of national registration (2010) could become reality.

5.4 Regulation of Nurse Practitioners in Five Countries

5.4.1 USA

Regulation and registration of all registered nurses in the USA was overseen by State Nursing Boards, in every state. This included the registration and regulation of nurse practitioners and was the sole authority for governance in many states but with some exceptions where nurse practitioner regulation was run jointly by medical boards. These exceptions did not necessarily govern all aspects of nurse practitioner practice and were chiefly concerned with prescribing, but some medical boards required supervision of all elements of nurse practitioner clinical practice. Some health departments also have a role in governance of nurse practitioner development (Pearson 2007).

5.4.2 Method of Agreement / Difference between USA States

5.4.2.1 Method of Agreement

Out of the 50 USA states, 16 Boards of Nursing do not have total control of the regulation and registration of nurse practitioners. This equates to 32% of Nursing Boards in the USA that could not totally control the governance of their nurse practitioners. Some medical boards (the governing body for doctors) only had prescribing concerns whereas others had joint regulation for all aspects of nurse practitioner regulation. Some health departments also held interests in nurse practitioner development. All the other nursing boards within jurisdictions of the USA had control of regulation, registration and education of nurse practitioners.

5.4.2.2 Method of Difference

Of these sixteen states, Nursing Boards jointly held governance with 1 State via a Joint Committee between the Health Department, Nursing Board and Medical Board, 13 Nursing Boards held governance jointly with the State Medical Board and 2 states with Nursing Boards holding joint governance with the State Department of Health. This suggested that Nursing Boards conceded to joint management of nurse practitioner development. With Medical Boards playing a part in this management perhaps other states could consider a similar approach especially in states such as Ohio where nurse practitioner prescribing is a major issue (Pearson 2007). These findings showed that the joint governance of nurse practitioners varied between health departments' medical boards working conjointly with nursing boards within states (Pearson 2007).

The philosophy of traditional and contemporary nursing has historically been that nursing should be run and controlled by nurses (Abel-Smith 1979). Whether the USA nursing profession considers this as a retrograde step remains to be seen. The Pearson Report (2007) did not identify any conflict in these arrangements suggesting that this process worked well. While inconsistencies persist, the USA seemed to be well developed in the arena of nurse practitioner registration and regulation.

5.4.3 CANADA

All provinces and territories in Canada had or were enacting legislation and regulation that allowed the development of the nurse practitioner role. Provinces and territories that were leaders in paving the way for nurse practitioner legislation were undertaking reviews and revision of legislation and regulation to reflect and support the evolving and autonomous nature of the nurse practitioner role (CNA 2005).

Canadian provinces and territories that had legislation and regulation in place included British Columbia, Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan, Alberta and the Northern Territories and Nunavut. The Yukon Territory was the only area that was without current legislative provision for nurse practitioners. However, in January 2010 this was proclaimed and the first steps toward making this a reality have now been taken (CNA 2010).

Within those provinces and territories with existing nurse practitioner regulation there was a great deal of congruence between the competency frameworks developed

by each jurisdiction. This allowed for inter-province transfer of skills to occur (CNA 2005).

The title of nurse practitioner was protected in all jurisdictions where legislation was in place. However, it should be noted that this protection existed as in Alberta as an 'extended class' registered nurse umbrella whereby all specialist nursing titles are protected under the 'extended class' regulation of advanced practice nurses (CNA 2005). The term extended class meant those registered nurses who were working beyond the remit of mainstream registered nurses. Similar provision existed in Ontario and Manitoba. In all other jurisdictions title protection existed for the defined role of nurse practitioner (CNA 2005).

5.4.3.1 Method of Agreement / Difference between Provinces / Territories in Canada

5.4.3.1.1 Method of Agreement

a) There was much congruence in these Provinces and Territories in competency frameworks in each jurisdiction making skills transfer possible between all States and Territories.

b) The title 'nurse practitioner' was protected in all Provinces and Territories that have legislative provision for nurse practitioner development.

5.4.3.1.2 Method of Difference

As of February 2010, legislative provision for the development of the nurse practitioner role includes the Yukon Territory (www.yrna.issues/issues accessed 26

February 2010). There was no method of difference in legislative provision in Canada. There was no mandatory demand for education to master's degree level in Canada for nurse practitioners. A master's degree remains 'recommended' only. Only 23% of the nurse practitioner workforce in Canada had educational qualifications at or above master's degree level in 2005 (CNA 2005).

5.4.4 UNITED KINGDOM

In the UK, there was no current legislation that makes provision for nurse practitioner regulation or registration. The 2006 Nursing and Midwifery Council Position Statement stated that application had been made to the Privy Council, for permission to open a supplementary register that would provide for nurse practitioner regulation and registration, however permission has yet to be given. There was no indication within this statement that identified when this permission is likely to be granted. The title 'nurse practitioner' was not protected within the United Kingdom. Title protection would only arise when an Act of Parliament made provision for title protection for a profession, or a discipline within a profession (Abel-Smith 1979).

In order for protection of title, the title of nurse practitioner, regulations must be in place that stated the qualifications, licence provision and regulations for endorsement as a nurse practitioner. This provision allowed for the uniqueness and professional status of the nurse practitioner role being preserved and protected, preventing any other registered nurses or employers or managers from using the title on an 'ad hoc' basis to describe a title for a registered nurse or anyone else not qualified for such a position.

5.4.4.1 Method of Agreement / Difference within the United Kingdom (UK)

5.4.1.2 Method of Agreement within the United Kingdom UK

a) Within the UK the development of the nurse practitioner role has occurred.

b) There is no legislation allowing for the regulation and registration of nurse practitioners in the UK.

c) There is no minimal education qualifications standard demanded within the UK.

d) There are no National Competency Standards approved by regulators in the UK. The only competency standards available are those produced by the UK Royal College of Nursing, which is a trade union body and not a regulatory council.

d) The title 'nurse practitioner' is not protected within the UK.

5.4.1.3. Methods of Difference within the UK

There are no methods of difference within the UK because there is no regulation within which to compare differences, as is the case in other countries.

5.4.5 NEW ZEALAND

In order for an experienced registered nurse to register additionally as a nurse practitioner he/she must first complete an approved master's degree specific to the nurse practitioner role that prepares nurses to undertake this role. At present, if a registered nurse possesses a different clinically focused Master's degree such as the Master of Nursing degree then the application will be considered, providing that the employer supports this and if the post held by the applicant is within the remit of the

nurse practitioner role. This will only be allowed during the 'decade of transition' (2000-2010) (Hughes & Carryer 2002). The sole entry gate for nurse practitioner registration is through a Master's Degree; diploma or certificate courses are not recognised as being appropriate. The title is protected in New Zealand and the sole regulator for nurse practitioners is the Nursing Council of New Zealand.

5.4.5.1 Method of Agreement / Difference within New Zealand

This does not apply within New Zealand as there is just one nursing council which is the sole regulatory authority that has jurisdiction throughout the country. There were mandatory educational qualifications in place and all legislative provisions, including title protection were enacted.

5.4.6 AUSTRALIA

From July 2010, The National Registration Authority commenced endorsement of nurse practitioners in Australia who were previously governed by State Nursing Boards/Councils alongside the Australian Nursing and Midwifery Council (ANMC). This governance includes:-

- Compliance with legislation that made provision for nurse practitioner development, regulation and registration.
- The ANMC National Competency Standards for nurse practitioners. These had been accepted throughout Australia.
- Regulations for the preparation of nurse practitioners.
- Endorsement requirements for registration as a nurse practitioner.

There is now a Nursing and Midwifery Board of Australia with each state having its own nursing board that works in conjunction with national governance organisations in health care (Australian Health Practitioner Registration Authority (AHPRA) 2009).

The processes for endorsement and required competencies to this end must be completed before endorsement is granted as a nurse practitioner. Requirements for endorsement were mirrored in all states and territories within Australia. This excluded the Northern Territory and Tasmania which at the time of writing have developed legislation but no data is available for comparison. States and territories with well developed legislation include:-

Australian Capital Territory: A master's degree specific to nurse practitioners was required. All nurse endorsed nurse practitioners had to meet the requirements for prescribing within this territory. The Health Professional Act 2004 (ACT) consolidated the common provisions for the regulation of all health professions into a single piece of legislation. Nursing was overseen by a Nursing and Midwifery Board, under separate schedules (3 and 4) of the Health Professional Act (2004).

New South Wales: This was the only state in Australia that made legislative provision for midwifery practitioners as well as nurse practitioners as direct care advanced practitioners (Driscoll et al. 2005). The regulation of both these disciplines was similar. The Nurses and Midwives Board regulated both, with a separate register for midwifery practitioners and nurse practitioners. Normally, a master's degree was required, but for very experienced nurses and midwives a system existed for endorsement through provisions for 'equivalence' of education / preparation that

must be demonstrated through a portfolio of written evidence and peer review interview (Nursing Education Taskforce Mapping Report 2005 no author given). This was a temporary arrangement only (Nursing Education Taskforce 2005). For all applicants, from 2008, a master's degree is compulsory (Australian Inter Government Agreement 2008).

Queensland: The Queensland Nursing Council assumed the position that nurse practitioners were expected to be advanced specialist nurses prior to seeking endorsement. As experienced and accountable professionals, they were thus expected to ensure that they have the appropriate education at master's degree level, and the experience and competence for practice at the level for which they were authorised (Nursing Education Taskforce Mapping Report 2005).

South Australia: The Nursing Board of South Australia authorised nurse practitioners to practice. There were two pathways that can be followed fro endorsement:-

- The alternative pathway: this was only available until June 2010. A master's degree in the candidate's own specialism is acceptable (e.g. nursing).
- A master's degree (nurse practitioner) was mandatory for all new candidates and for all candidates without a master's degree specific to the nurse practitioner.

(www.nbsa.sa.gov.au _reg_nurse_practitioner_endorsement.html accessed 27 February 2010).

Prescribing was optional, but if an applicant chose to be endorsed to prescribe, then the prescribing criteria had to show an individual formulary developed by the applicant and approved by the employer. This process had to include evidence about how prescribing by the applicant will benefit patients (Nursing Education Taskforce Mapping Report 2005). Once approved, the formulary was listed on the reverse side of the practising certificate for a nurse practitioner.

Victoria: In Victoria, applicants for endorsement did not have to use any predetermined practice groupings, bands of specified practice or areas of practice to be recognised by the board. To date, the nurse practitioner areas of practice have been defined by current endorsed nurse practitioners. Nurse practitioner candidates proposed and subsequently gained approval from the board, regarding details about their own specific areas of practice and how this area of practice benefited the population served. The process was complex and could take up to a year or more to complete, in total contrast to the South Australia regulations, which are simplistic in comparison. The use of clinical guidelines in the endorsement process (as distinct from a medication list) had become central to the Victoria regulatory model. These guidelines were reviewed by the board. The regulations dictated that a guideline is required for every ‘extension’ to practice that is involved. This included prescribing, ordering of diagnostic tests, making a diagnosis and referral processes (Nursing Education Taskforce Mapping Report 2005). Guidelines must be developed by each registered nurse who sought endorsement as a nurse practitioner and were reviewed by the board as an integral part of the endorsement process and for the purpose of continuing endorsement.

Western Australia: Compared to other states and territories in Australia, the process in Western Australia was streamlined perhaps arguably to the extreme. The process was an over-the-counter process for those who have graduated in courses approved by the National Regulatory Authority (NRA). This authority approved all nurse practitioner courses throughout Australia for preparation of nurse practitioners. Providing proof of graduation from one of these courses was produced, endorsement took place. No written evidence portfolio of current practice was required. Nurse practitioners who moved into the state from another state or territory in Australia must have completed a similar NRA course. These were usually at master's degree level. Within Western Australia, two master's degree courses are available. All new applicants for endorsement had to possess a master's degree course specific to the nurse practitioner and it is this that was be the parameter used for comparison with other areas.

In the **Northern Territory** and **Tasmania**, policies and procedures for nurse practitioner development were in place, as was legislation provision for nurse practitioner development. Endorsement and regulation policies and procedures were now in place and recruitment into degree courses had commenced. At the time of writing, no data was available outlining the number of nurse practitioner candidates. There was no specific master's degree offered in 2010, for nurse practitioner degree preparation, within the University of Tasmania (See Appendix A).

5.4.6.1 Method of Agreement / Difference in Australia

5.4.6.2 Method of Agreement

a) All states and territories within Australia had developed competency standards for nurse practitioners (ANMC 2006).

b) All states and territories had made provision for a master's degree (nurse practitioner) as a mandatory qualification in order to register as a nurse practitioner.

5.4.6.3 Method of Difference

This does not apply within Australia because all states and territories have legislation in place that is required to develop the role of nurse practitioner. A master's degree (nurse practitioner) is now mandatory in all states.

Each state in Australia has its own nursing board within Australia overseeing assessment and qualifications governed by The National Health Practitioners Registration Authority for regulation of all 10 professional disciplines within health care in Australia. Each state and territory within Australia has a professional board for each of the professional disciplines that undertake governance of that discipline. The boards are accountable to the National Health Practitioners Registration Authority (National Health Practitioners Registration Authority 2009).

The table overleaf shows a comparison of the numbers of nurse practitioners in practice, in 2005, within the states and territories that had legislative provision for nurse practitioner development at this time.

Table 2: Comparison of Numbers in Practice in Australia (2005)

STATE	NUMBER ENDORSED	NUMBER OF PRACTICE AREAS
AUSTRALIAN CAPITAL TERRITORY	23	25
NEW SOUTH WALES	62 WITH 2 MIDWIFERY PRACTITIONERS	15 TO DATE
QUEENSLAND	13	NONE SPECIFIC
VICTORIA	4	NONE SPECIFIC
SOUTH AUSTRALIA	11	NONE SPECIFIC
WESTERN AUSTRALIA	23	25

These figures suggested that those states with defined areas of practice and a more complex, but possibly more complete, endorsement process are those that attracted the higher uptake of applicant numbers. Those states with no specific areas of practice were attracting fewer numbers seeking endorsement.

A further comparison table overleaf illustrates education preparation comparisons within the five countries studied. Australia and New Zealand are the only two countries that have developed minimum educational qualifications for nurse practitioner endorsement.

5.5. Table 3. Education Preparation Comparisons in Five Countries

Country	Master's degree Mandatory	Diploma Allowed	Other Qualifications Allowed
USA	Not all States*	Yes	Postgraduate certificate
Canada	Not all Provinces or Territories	Yes	Postgraduate certificate
United Kingdom	Not regulated**	n/a	n/a
New Zealand	Whole Country	No	Nil permitted
Australia	All States and Territories	No	Nil permitted

* ** Until 2015 and 2013 respectively, when uniform approach to be implemented

In the USA, not all states required a mandatory Master of Nursing Science degree. States that did not require such a degree accept post-graduate qualifications, both at certificate and diploma level. The states involved include Delaware, District of Columbia, Hawaii, Idaho, Indiana, Maryland, Massachusetts, Minnesota, Missouri, New York State, North Dakota and Washington. In 2009, Stanley (2009) reported that the APRN Council who has been meeting for the last four years have finally reached agreement that there will be a uniform approach to nurse practitioner regulation, registration and education throughout the USA. This is a landmark decision in the USA with an implementation date of 2015 and a critical indicator in developing a uniform approach within the USA.

In Canada, while a master's degree is recommended, this is by no means compulsory. Indeed, within the Canadian Nurses Association (2005 p. 14 Table 3) only 21.6% of licensed nurse practitioners were educated to master's level or above.

In the United Kingdom, there was no regulation and thus no minima or maxima in terms of education levels, in order to become a nurse practitioner. However, there are courses established at 10 UK universities, which are Royal College of Nursing (UK) approved courses, in order to prepare nurse practitioners. These were at master's and bachelor's level and included universities in Aberdeen in Scotland, Suffolk, Sheffield, London South Bank, London City, Buckingham, Cumbria, Plymouth and Bournemouth in England and Swansea in Wales.

In New Zealand, a Master in the Science of Nursing degree for nurse practitioners is required throughout the country for all new applicants. In some cases however, if an applicant is very experienced and has a clinically focused Master of Nursing degree, this is acceptable, but only during the 'decade of transition' (2002-2012) (Hughes & Carryer 2002).

In Australia, a master's level degree is mandatory for endorsement in all states and territories. Some universities award these degrees under different titles. In the Northern Territory, for example, graduands are awarded a Master of Health Practice (Nurse Practitioner) and in South Australia graduands are awarded a Master of Nurse Practitioner (see Appendix A for a web link to all universities that offer nurse practitioner courses).

5.5.1 Method of Difference / Agreement between Countries

5.5.1.1 Method of difference

The method of difference between the five countries includes:

a) The findings from the inter country comparisons in terms of the method of agreement/ difference reveals that internal consensus within two countries (UK and Canada) has yet to be achieved in terms of the minimal education requirements in order to become endorsed as a nurse practitioner. This fact becomes a serious method of difference between the countries and a critical indicator of differences between five countries. The exceptions where consensus exists are USA, Australia and New Zealand. However, because any non-consensus does not comply with the ICN vision for identical legislation and education standards for all its member countries, the developed world as a whole continues without consensus in nurse practitioner development. This provides a major barrier globally to implementation and acceptance of the role.

b) The findings suggest that nurse practitioners without a Master's degree and qualified only to diploma or certificate level would have difficulty in registering in a different geographical area/ context of practice that demands a master's level degree and would be limited in mobility and career progression. This lends credence to the danger of a career cul-de-sac (Castledine 1998 in Castledine & McGee 1998).

c) The UK has no legislation provision for nurse practitioner development with regard to regulation, registration or title protection.

d) The UK has no competency standards approved by regulators.

5.5.1.2 Method of Agreement

Method of agreement between the five countries includes:

a) All countries support nurse practitioner development, but the differences in education of nurse practitioners still exist in Canada and the UK although progress was made in addressing this. Governance also differs, in that some regulators within some countries are governed jointly with other organisations (e.g. medical and government organisations in Pearson 2007 and in Quebec, Canada in CNA 2005). This means that the overall governance ethos of 'by nurses for nurses' had been lost in some jurisdictions.

b) While there are competency standards within all five countries for nurse practitioner development, in the UK these were informal and produced by the RCN and not by the NMC. Competency standards vary from country to country in terms of format but basic standards are similar

5.6 AN HISTORICAL-COMPARATIVE ANALYSIS ACROSS THE FIVE COUNTRIES.

Some USA states have placed all advanced practice roles including nurse practitioners, clinical specialists, surgeon's assistants, physician's assistants and advanced practice nurses under one 'umbrella' group, for registration purposes (Pearson 2007). This umbrella group such as in Idaho are called 'advanced practice registered nurses'. In effect, the roles might not be merged by nomenclature in clinical areas but are merged in this way for registration purposes. Education qualification requirements within the USA are very diverse (Pearson 2007). Problems of cultural differences and territorial preferences present an immense challenge to any form of uniformity in approach, which becomes a critical indicator for successful nurse practitioner role development in years to come. The key area in

the USA that stands out is the framework of law developed in the USA for all advanced practice nurses from the outset in the early 1960s. This is a framework that outlined the minimum level of legal knowledge required by all advanced practice nurses within the USA, regardless of discipline (Bigbee 1996 in Hamric, Spross & Hanson 1996). This factor was a critical indicator in education as it identified a need for all advanced practice nurses to attain a level of legal knowledge commensurate with their advanced level of clinical practice. Further innovations in education have begun in the USA, such as at the University of Chicago Illinois, where the nurse practitioner degree course is now offered at PhD level (Pearson 2007). This development could be an indicator of future trends in nurse practitioner education, not just within the USA and marks another difference between the countries.

In Canada, many states and territories with nurse practitioner legislation are continually reviewing their provisions (CNA 2005). The Canadian Nursing Association (2005) identifies the desire to increase degree course provisions in Canada for nurse practitioners (Nurse Practitioner Initiative 2007) so that the number of nurse practitioners with a master's degree will improve from current figures to raise this above the 23% of nurse practitioners with a master's or other higher degree. This is a critical indicator of a universal desire in Canada to exercise mandatory minimum educational qualifications for nursed practitioners but still does not match those areas of the USA requiring a master's qualification.

Future developments within the United Kingdom depend on the time frame in gaining Privy Council approval for registration of nurse practitioners, as no legislation exists at present to determine the long term value of the university courses

currently approved by the RCN. It is difficult at this time to provide concrete information. This will depend on the robustness of curricula in role preparation and the timely legislative provision for nurse practitioner regulation and registration. The critical indicator will be movement within the UK in nurse practitioner development and legislation provision on a par with other countries such as the USA, Canada, New Zealand and Australia.

In the UK, the Royal College of Nursing (RCN) is currently developing competencies for nurse practitioners and the university courses approved are providing appropriate educational qualifications, without any input from the NMC. The NMC is not working with the RCN so there is a danger of poor role definition, particularly if the NMC in the long term, takes a different approach or fails to recognise or approve the innovations of the RCN. Title protection is also an issue. It is important to ensure title protection and legislative change in order to provide a robust framework for nurse practitioner regulation and incorporate the high educational standards already emerging.

The role of the nurse practitioner is fairly new in New Zealand and the developmental areas of the role are continuing. Hughes and Carryer (2002) identified the 'decade of transition' (2000-2010) to be the most significant and important time for role development in New Zealand.

Australia, like New Zealand, is in its infancy in terms of nurse practitioner role development. At present there is consensus on education provisions, and all states and territories in Australia requires a mandatory master's degree, in order to become endorsed. Australian academics are working with New Zealand academics in order

to develop a consensus for mutual recognition in the areas of education, competencies and standards for nurse practitioners (Gardner et al. 2006).

In order to enhance the autonomy of nurse practitioners within Australia a move away from generic nurse practitioner competency standards (ANMC 2006) may be required. Pearson et al. (2007) argued that nurse practitioners in aged care might be better utilised if they followed specific competency standards for their specialism. This argument could apply to other nurse practitioner scopes of practice as a means to broaden their legal boundaries. A nurse practitioner in emergency room care will have different clinical practice guidelines to a nurse practitioner in aged care.

The principles established within current competency standards need to reflect the differing specialties, but cannot because they are generic. These competency standards (ANMC 2006) are only applicable up to a point because they are generic and do not cover every aspect of nurse practitioner work. If nurse practitioner competency standards were developed for each scope of practice, for example, by nurse practitioners for nurse practitioners then individual autonomy can be enhanced by making competency standards more meaningful, specific and robust for every scope of practice.

When each country was compared using the process of method of agreement or difference critical indicators were identified as a result of the analysis across time and country aspects of the study and included methods of agreement such as:-

1. Uniformity of approach (applicable within the USA, Canada and UK): work is ongoing (APRN 2009; CNA 2007; Nursing Times 2010). New Zealand and Australia have achieved this goal.

2. Standards in Legal Education (USA): A standard set down from the beginning (Bigbee 1996). This has been achieved in the USA but could be equally applicable for development within Canada, New Zealand, Australia and the UK.

3. Minimum Educational Requirements (applicable within the USA, Canada and the UK): work is ongoing (Pearson 2007; CNA 2007; Stanley 2009; Nursing Times March 2010). New Zealand and Australia have achieved this goal.

4. Further Education Opportunities (USA): Doctoral Education is a reality for further study opportunities within the nurse practitioner discipline within one state in the USA (Pearson 2007) but could be further developed in the USA, Canada, New Zealand and Australia.

5. Legislation provision for regulation and registration of nurse practitioners (Applicable to the UK): work is ongoing (Nursing Times march 2010). The USA, Canada, New Zealand and Australia have achieved this goal.

6. Opposition/Criticism and Inter-Professional Downward Closure (applicable in all five countries). Each of the five countries compared faced opposition and/or criticism leading in some cases to exclusion from practice rights in the development of the nurse practitioner role. Criticism emanated both from within and outside the nursing profession (Bigbee 1996; Gardner 2004; CNA 2005; Ball 2006; Jacobs 2007; Phillips 2008). The inter-professional opposition outside the profession was mainly

from doctors and pharmacists due to their perceived lack of supervision and control of nurse practitioners particularly in the area of prescribing. Employers within New Zealand have opposed nurse practitioner development by failing to provide permanent positions for endorsed nurse practitioners within the health care workforce. This has occurred in certain areas of the country but included areas within both North and South Island (Phillips 2008).

The above critical indicators show that clear leaders in the field of nurse practitioner development are New Zealand and Australia. This is evidenced by the number of critical indicators achieved when compared to the USA, Canada and the UK. The overall outcomes were:

- The poorest performer in nurse practitioner legislation provision was the UK. All other countries have achieved this goal (Hughes & Carryer 2002; Gardner 2004; Ball 2005; CNA 2005; Pearson 2007).

- The USA is the only country to have hitherto developed further studies at doctoral level for nurse practitioners (At the University of Chicago (Pearson 2007).

- Only New Zealand and Australia have a uniformity of approach and have set down minimum educational requirements (Hughes & Carryer 2002; Gardner et al. 2008; Australian Inter Government Agreement 2008).

- All five of the countries studied faced opposition in the development of the nurse practitioner role (Gardner 2004; Ball 2006; Pearson 2007; Jacobs 2007; Phillips 2008; Canadian Television Transcript 2008).

5.7 Legal and Professional Issues: Emphasis on Australia

Law in nursing, especially at advanced practice level centres on a nurse's awareness of the law relative to nursing, being cognizant of law and the ability to apply it to clinical practice (Petersen in Freckleton & Petersen 2006, p.487). The legal obligations of any advanced practice nurse changes in terms of autonomy, accountability, authority and responsibility. Increased authority presents nurses with increased accountability, autonomy and responsibility (Petersen in Freckleton & Petersen 2006, p 487). Unless all nurse practitioners are able to demonstrate competence, by achieving the acceptable criteria within competency standards relating to legal requirements, their boundaries should not be broadened. This would validate claims from other health professionals that nurse practitioners should not have such rights and would cripple development of the role.

All advanced practice nurses, regardless of discipline should possess adequate knowledge of law related to clinical practice. All five countries included in this study (Hughes & Carryer 2002; Education Taskforce Mapping Report 2005; Canadian Nursing Association 2005; Ball 2006; Pearson 2007) identified the need for provision of competencies in legal and professional issues. All countries had these in place. However, this does not seem to be well translated to the individual nurse practitioners everywhere within Australia.

From the outset of nurse practitioner development in 1964, the USA developed a course of study and competency standards that must be successfully completed by all advanced practice nurses including nurse practitioners (Bigbee 1996 in Hamric, Spross & Hansen 1996, p.21).

The main impact of the Ipp Reforms in Australia (Bennett & Freckleton in Freckleton & Petersen 2006, p. 383) concerning nurse practitioners is that a Judge no longer has to accept as valid the expert reports on behalf of plaintiff or defendant as being valid. This would directly affect nurse practitioners if they were to become defendants in an alleged negligence case. Expert opinion was significant in supporting defences in a claim against a nurse, thus establishing the precedent (Bennett & Freckleton in Freckleton & Petersen 2006, p.383).

Were a Judge to reject the expert opinion of either side, or opined that the opposition report had greater credence; the attorney could lose the case for the opposing plaintiff or defendant. This would be because judges could /would rule on information they considered being valid in the case and would ignore opinion seen to be less valid or that they perceived has little validity such as a poorly presented expert opinion. A poorly presented case by an expert would cause the case to lose validity. An expert witness testimony that was weaker than the opposing expert witness would lead to loss of validity in a case (Bennet & Freckleton in Freckleton & Petersen 2006, p.383).

In legal cases, evidence is 'weighed'. The greater the 'weight' evidence has the greater the validity. The Ipp reforms utilised a modified *Bolam* test (*Bolam v. Friern Barnet HMC 1957 2 ALL ER 118).* Though the defendant in this case was a doctor, the Bolam test is equally applicable to nurses especially nurse practitioners as well as doctors. The Bolam controversy was centred on use or otherwise of a muscle relaxant. However, at the trial the judge heard contrary testimony for the defendant and this testimony resulted in the finding of the judge thus:-

> "A doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible of medical opinion, even if other doctors accept a different practice. In short, the law imposes the duty of care: the reasonable man acting with reasonable care and skill; but the standard of care is a matter of medical judgement" (*Bolam v. Friern Barnet HMC* [1957] 2 All ER 118).

The Bolam test (Bolam *v. Friern Barnet HMC 1957 2 All ER 118*) meant that a person providing a service to another person is not negligent providing that he/she carried out his/her duties as a 'reasonable man acting with reasonable care and skill'. The modified Bolam test currently adopted within the Ipp reforms is that expert testimony was no longer regarded as universal and that a judge was able to accept other testimony with a contrary view if the judge so opined that the other testimony carried more weight in the claim in question at the time. In the report this is cited as:

> "As much protection as is desirable in the public interest because the chance that an opinion which was widely held by a significant number of respected practitioners in the relevant field would be held irrational is very small indeed. But if the expert opinion in the defendant's favour were held to be irrational then it seems right that the defendant should not be allowed to rely on it" (Ipp Reforms Report Para 3.18, cited in Freckleton and Petersen p.384).

Australian nurses should be aware of the changed reforms involving a case of negligence especially nurse practitioners with a higher level of autonomy. This example of negligence is only one focus on law relative to nursing practice. Nurse practitioners must be able to defend their actions whatever the situation and a greater awareness of the implications of all of the above is required. Alleged negligence is of major importance to all nurses and in most cases it is preventable (Dimond 2004; Walsh 2006).

This is the crux of research question 3 (**What is the best approach to untie the hands of nurse practitioners in Australia and enhance their autonomy**?). Field research that follows examined the world of the nurse practitioner through the eyes of nurse practitioners and provides more insight into how relevant law is perceived to be to the participants of this study.

The Baker (1992) vision of a theory of liability for the nurse practitioner has not come to fruition in any of the five countries studied. The development of the role of nurse practitioners was practice driven with less emphasis on legal issues (Baker 1992). Within the USA, the role of a nurse practitioner was subject to third party (payment made with the nurse practitioner acting as a sub-contractor to the employer, such as a physician) reimbursement (Stokowski 2010) or the nurse practitioner may be an independent practitioner. Where such conditions exist a theory of liability would not only be an asset but could also be advantageous to all nurse practitioners within the five countries. The term 'theory' in this context could be confusing. This study has addressed this by the applying the terms legal responsibilities and accountability within the need for a nurse practitioner to retain and regularly update evidence gathered as portfolio evidence that could be referenced at any time for the purpose of providing evidence of clinical legal currency. This might occur when renewal of nurse practitioner registration is due or when legal dilemmas or problems arise. Such evidence might include records of training, a job description, job specification and a detailed account of the scope of practice (this could include all clinical practice guidelines in current use). In this way a nurse practitioner is confirming his/her cognizance of legal responsibilities.

The practice of ignoring law at the expense of practice development is very hazardous, particularly within Australia. Walsh (2006, p.359) correctly adduces that nurse practitioners' clinical autonomy is a hypothetical falsehood when the nurse practitioner as a licensed prescriber has to depend on medical staff to sanction their treatment decisions (such as currently exists within Australia for prescribing by nurse practitioners). This is particularly relevant within Canada the USA, UK and Australia.

Issues within the USA and Canada are focused on the hazards of expanding the scope of practice for nurse practitioners (CNA 2005; CNA 2007; Stokowski 2010). In addition, within the USA there is ongoing debate about reforming remuneration policy away from third party remuneration (remuneration paid by an employer) and moving forward to remuneration for nurse practitioners as independent and autonomous nurse practitioners (Stokowski 2010).

The key word in nurse practitioner development in all five countries was fragmentation. No single country was able to develop the role of the nurse practitioner without some serious complication that created an impasse at some stage. In the USA and Canada it was 'turf wars' (in terms of where doctors perceived that nurse practitioners encroached on their work), in the UK it was lack of legislative provision, in Australia it was medical control impinging on identified and realistic potential for nurse practitioner autonomy (e.g. PBS & MBS) and in New Zealand it was lack of employment opportunities for endorsed nurse practitioners.

Each of these issues remains unsolved within the countries concerned and will add further to the fragmentation of nurse practitioner development within these five countries if such issues are not addressed.

5.8. Phase 2 of Research Findings

Research Question 2

What do nurse practitioners believe to be the most important legal and professional aspects of their practice?

5.8.1 Introduction

In this section participants' responses are analysed using the restriction-freedom paradigm of the Human Becoming Theory (Parse 1995) as developed by Mitchell (1995 in Parse 1995, pp. 159-165). The paradigm of restriction-freedom was utilised in this study in a way that is not focused on the nurse-patient relationship but as a lived evolving experience of their own journey of becoming (nurse- profession relationship) and what this means in their own nurse practitioner world. As stated in chapter 3, there are various ways in which the Human Becoming Theory can be used in applied research and the restriction-freedom paradigm is but one example (Parse 1995 pp. 81-85). Cody (1995, in Parse 1995, pp.269-307) looked at lived experiences within the Parse Human Becoming Theory using the poetry of Walt Witmann (Cody 1995 in Parse 1995, p. 269) and described in a different way a lived experience of Human Becoming as seen through the eyes of a poet while in this study a different perspective within the restriction-freedom paradigm is explored as 'the lived experience' of nurse practitioners.

5.8.2 Field Research

Field research completed for this phase of the study consisted of in-depth interviews. Participants were four nurse practitioners (two fully endorsed nurse practitioners and two nurse practitioner candidates working-in-the-role, in their intern year i.e. second year of study). A fully endorsed nurse practitioner is a registered nurse practitioner. An intern is a nurse practitioner candidate in the second (intern) year of training where they work-in-the-role as a nurse practitioner and gain valuable practical experience (Walsh 2006).

Obtaining the sample was opportunistic in nature. The number of registered nurse practitioners within Australia is small but the Gardner and Gardner (2005) study used just four participants for this reason. Initial attempts were made to recruit participants at a nurse practitioner conference. This resulted in only two participants giving signed consent to participate, following a short informal discussion about the study. Both these participants withdrew from the study before the researcher had an opportunity to approach employers (within three days following the end of the conference). Both participants feared sanctions from their employers if they participated in this study.

Further enquiries were then made with healthcare organisations that were known to have nurse practitioners employed within their organisation. Initial interviews with directors of nursing took place to inform them about the nature of the study and what was required of participants. It was important that selection of participants was derived from endorsed nurse practitioners and nurse practitioner interns who were able to articulate their practice accurately and give informed consent in order to

participate in this study. The directors of nursing were able to facilitate both employer and ethical approval for the study and consent from all participants was obtained prior to interviews taking place (see chapter 4).

The research provided insight into the different journeys the four nurse practitioners experienced over time. Each of the four participants in this study had gained expertise in their specialist nursing field prior to seeking endorsement as a nurse practitioner by completing postgraduate courses and gaining experience within their chosen field i.e. yielding to change and transcending with the 'possibles' in becoming a senior clinician, through self development. Programmes undertaken provided postgraduate qualifications in a chosen specific nursing field that involved a nursing ethos. When the opportunity arose, each participant sought to take the important step and take a further degree course to gain the qualification of an endorsed nurse practitioner thus achieving the 'possible' as explained in chapter 3.

Each participant realised the potential of expanding their role and expertise through the role of nurse practitioner. Each participant demonstrated commitment to the ethos of nursing. The fact that very experienced people are seeking to do this in Australia is important for development of the nurse practitioner role. Ambition is one aspect of personal development but this is passive. It takes an extremely proactive and determined person to undertake a nurse practitioner journey 'whilst engaging the now and transcending with the 'possibles' for the future" (Parse 1995, p.4).

Application of the extraction synthesis elements and process to the transcripts of dialogues from the four nurse practitioner participants led to the identification of seven core concepts within the transcripts of in-depth interviews. These were:

- Education preparation for the specialist role prior to seeking endorsement,
- Area of nurse practitioner practice: the type of specialty in which a nurse practitioner functions (e.g. chronic kidney disease).
- The endorsement journey/education as a nurse practitioner candidate.
- Context of practice: the scope of practice for which a nurse practitioner is endorsed and registered (e.g. accident and emergency or rural and remote).
- Relevance of law to their daily practice.
- Professional support for the nurse practitioner.
- Legal and professional issues.

These themes became apparent within the hermeneutic analysis of the transcripts as nurse practitioners articulated the issues that they felt were most important to them in their journey towards becoming nurse practitioners. When examined together, these core concepts formed the structure of the findings and when woven together they have provided insight into helping to answer the research question (see page 232).

5.8.3 Analysis of Findings

Responses have been entered for each emergent theme from each participant in turn. Where individual participant responses are brief, researcher synthesis will be

provided collectively for all participants. Where responses are longer and more detailed, the synthesis is completed individually for each participant's responses. When the process was completed the researcher findings were analysed and compared.

Restriction for the purposes of this analysis examined participant responses in relation to areas where medical control forms the restriction or plays a role in creating the restriction. The concept of Freedom identifies areas within responses where medical control is absent and the aspect of practice centres on a nursing ethos. Other responses demonstrated areas where there is a restriction-freedom issue related to problem areas in clinical practice outside the comparisons of medical officer restriction-freedom. These issues included support in clinical areas, the endorsement journey itself and legal and ethical problems for participants. Participant responses are provided in italics to identify and separate these responses from researcher commentary.

5.8.4 Theme 1: Education for Specialist Role Prior to Seeking Endorsement

5.8.4.1 Extraction Synthesis

Responses suggested that participants demonstrated expertise in a particular field in nursing prior to seeking endorsement as a nurse practitioner. This is a positive enabling response. It might be said that the individual need for career progression spurred their ambition. This was a positive enabling-limiting response that has potential for originating. For example:

Participant 1: *"I was hospital trained, completing in 1989. I did a Bachelor of Nursing in 2000. On top of this I am immunization accredited; I have completed the Trauma Nursing Course and First Line Emergency Care and became accredited and qualified as a remote area nurse with the State Ambulance Service. I am also an asthma educator".*

Similarly **Participant 2**: *"Following RN training I completed postgraduate qualifications in both wound management and stoma therapy. Prior to my intern year I was unit nurse manager of the surgical unit at my hospital".*

Participant 3: "*After RN training I completed a postgraduate course in cardio-thoracic nursing and worked in ICU and CCU for over twenty years. I was an ICU charge nurse in this area prior to becoming a specialist nurse in heart failure".*

Participant 4: "*Prior to my initial nurse training, I completed a science degree, so entered nursing as a postgraduate student in another state. The science degree offered few jobs that I wanted to do, so I decided to do nursing. I worked in nephrology as a registered nurse and did a postgraduate course 3-4 years ago".*

5.8.4.2. Synthesis Analysis

Each participant gained important postgraduate specialist qualifications and had much experience and expertise in their chosen field prior to seeking endorsement as a nurse practitioner. Each participant demonstrated ambition and determination and it was evident from the responses that they valued experience and ongoing education as preparation for the role. These were positive enabling responses.

5.8.5 Theme 2: Area of Nurse Practitioner Practice

5.8.5.1 Extraction Synthesis

All participants chose their area of practice prior to seeking endorsement as a nurse practitioner. Within the lived experience of transcending with the possibles in nursing practice, this demonstrated originating through enabling-limiting the potential in becoming a nurse practitioner in their chosen field.

Each participant demonstrated awareness of their responsibilities within the lived experience of nurse practitioner practice developing awareness about how their specific scope of practice would develop. This suggested that in this regard great awareness was shown how their scope of practice will develop. Participants 2, 3 and 4 were nurse practitioners or interns within their chosen field who worked as both specialist clinicians and nurse practitioners and were considered as clinical experts in their chosen fields. These participants worked in their particular health care organisation in chronic renal disease, wound care and stoma therapy and heart failure respectively. This had potential-for-being for their practice and shows a positive enabling response.

Participant 1: *"I have been an endorsed nurse practitioner since March 2007. I am endorsed in the category of Rural and Remote. The facility that I work in is an innovative model that combines a vast range of community health, health promotion and community development programs with 24-hour accident and emergency. I work across all of these areas".*

Participant 2: "*I begin working-in-the-role as a nurse practitioner in two weeks. Up until then I continue to work as a unit manager of the surgical unit of this busy hospital. My main area of practice is wound care and stoma therapy. I am the sole referring agent for all wound care and stoma therapy patients. I take referrals for these patients and see patients both in wards and as outpatients. In outpatients I also receive referrals from GPs in the area".*

P**articipant 3**: "*I am a nurse specialist in heart failure, which is a State Health initiative to provide heart failure specialist nurses in all areas. I go round the wards and seek out heart failure patients. I liaise with hospital doctors and GPs, follow- up patients at home and also receive referrals from GPs, either by letter or telephone".*

Participant 4: "*I am an endorsed nurse practitioner (December 2007) for chronic kidney disease. Prior to taking up this role, I was the unit nurse manager for this renal unit. My responsibilities are the care of patients, both inpatients and outpatients, with chronic kidney disease and related conditions. I work with a consultant who also acted as my preceptor during internship. I also cover two units and two communities: this one and another one an hour's drive away".*

5.8.5.2 Synthesis Analysis

As well as being nurse practitioners, these nurses were specialist clinicians who showed awareness of their responsibilities and accountability as nurse practitioners by demonstrating expertise within their clinical area prior to seeking endorsement. One participant worked within a unique model of service delivery and the other three were employed as sole specialists in their clinical area.

5.8.6 Theme 3. The Endorsement Journey / Education for the Role

In this section the extraction synthesis is placed after participant responses because it concerns one participant only and is not a collective extraction synthesis as shown in the previous two themed analyses.

Participant 1: *My bachelor's and master's combined have given me a remarkable number of skills that are directly transposable to my role as a nurse practitioner; not only the actual course content but other skills, such as the ability to think clearly and critically, to problem solve, to write succinctly and to work to a deadline.*

The nursing board used a number of methods of establishing my competence, none of which was completely conclusive. They looked at my qualifications, they spoke to my referees, they insisted on a specific level of education, they requested that I justify every clinical decision I would make in the future with a set of Clinical Practice Guidelines. Even having undergone all of this, the first time I actually prescribed medication I felt remarkably under competent (sic).

One of the most difficult things was the nursing board application process. The application pack sent to me was quite nebulous and difficult to understand. There didn't seem to be any hard and fast rules, so it was tough to be sure I was doing the right thing. I really needed something more prescriptive and set in concrete. Time is also a problem, with studying, working and getting a life etc".

5.8.6.1. Extraction Synthesis

Skills acquired from further education were identified by the participant to be directly transportable to the role of a nurse practitioner and examples of such skills

were given such as thinking clearly and critically, problem solving and meeting deadlines.

During the endorsement journey the participant demonstrated considerable ability and determination to meet the challenge of becoming endorsed, particularly as there participant identified that there ‘were no hard and fast rules ‘set by the regulator.

Difficulty with nursing board requirements provided not only restriction in potential for being during the endorsement journey but also the potential for freedom, in allowing the participant to write clinical practice guidelines specific to the clinical practice envisaged within the scope of practice (even though participant might not have been aware of this at the time). This demonstrated ways in which the restriction-freedom paradox had a direct effect on the nurse practitioner endorsement journey.

Being ‘under-competent’ (sic) in prescribing at the early stage of practice was restrictive for this participant but as confidence built there was freedoms as prescribing skills increased and were used effectively. The participant’s cognisance about why prescribing was restricted and how this process could progress to freedom by building confidence, with less reliance on non-nursing colleagues was significant. This became more evident as they developed confidence in the areas of pharmacology, pharmakinetics and the law relevant to prescribing and dispensing medicinal products.

Indecisive regulations at state level presented as restriction, in that there was lack of surety about what expectations of the nursing board were at the time. This was

because initially there was little information provided to the participant. A more prescriptive approach on the part of the Nursing Board could have been helpful but could also have been restrictive in that freedom of self-development was very apparent during the endorsement journey of this participant.

Participant 2: "*Up to now I have only completed my first year. In the first year we did a lot of pharmacology and everything related to it. We have all complained though, because the pharmacology assignments and projects we have been given are not aligned to the state Drug Protocol. The university requirements are different.*

Pharmacology was the most difficult part of the course. There are a lot of psych drugs to learn about, which I rarely see or use. They (the university) seem to ignore the different needs of all of us in terms of learning.

Another problem is time and working as well. I had to do all the clinical assessments and assignments in my own time and this was hard whilst working full time as well.

My competence is assessed firstly by my preceptor, who is a consultant. He signs off all the competency requirements I have to complete in the hospital. These have to be presented and reported to the university as part of the endorsement process. Additionally, the practitioner competencies have to be shown through case studies.

There is insufficient financial support. If the Health Board gets you a scholarship, they should fund the rest as well. The scholarship funding only pays the course fees and the nurse practitioner position is funded for two years only. There is no additional support to release people from work to study and I did the first year of

study in my own time. There is no district funding or learning support. I obtained a small amount of extra funding from the specialist outpatients department".

5.8.6.2 Extraction Synthesis

Lack of clarity or relevance in pharmacology requirements of the university and health district reduced potential for being, enabling and thus became restrictive and limiting for this participant who showed clear awareness of assessment criteria and thus was free to exercise these requirements with a preceptor. The impact of knowledge building in terms of pharmacology, pharmakinetics and law in respect of prescribing and dispensing of medicinal products was yet to be demonstrated on the part of this participant.

Poor support at district level reduced the potential for being and thus became restrictive. Financial insecurity, in terms of personal goals and long term prospects added to the frustration of restricting self development. This process also affected the enabling-limiting process of a vision for the future, because the participant was unable to transcend with the possibles in considering their perception of future development of the role.

The ability of the participant to work full time and complete first year course requirements without assistance from the employer enhanced the potential for being but reduced overall personal satisfaction with the process. This proved restrictive in the lack of opportunity for originating through enabling and limiting due to these factors.

Participant 3: "*I have completed my first year of the nurse practitioner course at university. I think the course is very appropriate, like researching things you would not normally do and improving assessment skills. The course is not easy: I have to study in my own time. I have a scholarship to do the course and my professional development allowance pays for the rest.*

My competence is assessed by doing case studies that cover the competencies. We also do assignments, exams and a portfolio of written evidence. My preceptor is a consultant physician who signs off all the hospital based clinical aspects and I have to develop my own scope of practice for the role, which must be signed off by the CEO.

I do not have access to a specialist consultant in this hospital. I think all nurse practitioners for heart failure should have access to a specialist in this field. My preceptor is a consultant physician with an interest in coronary care, but that's it. If I need the advice of a specialist consultant, I have to contact one in another hospital, whereas other nurses elsewhere who do a similar job all have access to such a specialist.

The process for endorsement as a nurse practitioner will also be easier now. We were told recently that once we satisfy the university requirements and produce our graduation certificate then that's it. No more interviews".

5.8.6.3 Extraction Synthesis

This participant demonstrated appreciation of the overall aims of their university course as preparation for nurse practitioner practice and was transcending with the

possibles of enabling (in developing of knowledge) and limiting (participant is an intern and not an autonomous endorsed nurse practitioner) in development of the self during the process of completing the course.

Responses indicated that the participant was not afraid to tackle new innovation and build on skills thus enhancing his/her own potential for being. The participant was originating through skill building and the challenging quest of discovery through increased knowledge.

Like participant 2 this participant had to combine the first year of study with working full time in the role as a nursing specialist. This reduced his/her potential for being and thus was restrictive. The restriction caused by of lack of access to a specialist consultant at local level was identified by the participant as a problem. The participant identified peers in similar roles who had the advantage of access to a specialist consultant. This factor was a deterrent to freedom of self development due to the lack of adequate support and advice limiting the participant's perception of role development. The participant viewed access to a specialist consultant as an essential component of role development enabling the ability to function in their own right as a stand-alone specialist.

Freedom to develop their own scope of practice for the role provided enhanced potential for being because the participant was in control of this aspect of development. The fact that this participant was developing their own scope of practice showed potential freedom, in that parameters within the scope of practice need to be identified by the participant and not dictated by others. Their potential for

being was also enhanced by a less stringent endorsement process, as is the freedom for enabling-limiting within the education process.

Participant 4: "*The nurse practitioner course was appropriate, especially from the point of view of pharmacology, assessment and diagnosis. The internship also provided speciality specific training.*

During my internship, I worked with a specialist consultant who was both preceptor and supervisor. The biggest problem was being able to spend time with him. He is based elsewhere and feedback from him, as to where I was at and where I was going was difficult. He signed off all my assessments and case studies. He told me once that he would not sign me off if he did not think I was competent, but that's as far as it went.

Another problem was that the wording of competencies is in nurse-speak. Doctors do not always understand this language and it was difficult to work with at times. I think doctors who are nurse practitioner preceptors could be given some lessons about the language of the competencies from the university. A further problem was time off. Until the internship started, I was the unit nurse manager for the renal unit as well as a nurse practitioner and this was difficult. Last year I was just an intern and this was easier.

We also get poor support from the district. They get you a scholarship, but after that they take little interest in what you are doing. Every nurse practitioner has to justify their position. The director of nursing told me that she wanted to meet with me every month for a progress report. I contacted her secretary to make the necessary

arrangements and I am still waiting for a response. The medical director knows I am endorsed but has no idea about what I actually do.

My competency was assessed through patient assessments and case studies. Feedback from my preceptor being difficult, I did a lot of self-directed learning. I did the weekly ward round locally with another consultant as well, and this helped in developing my skills with case studies and problems.

It helped being the nurse manager of the unit before becoming a nurse practitioner. I knew the staff but more important, they knew me. I also, however, have to work with a new unit manager and her ways are different to mine. I have had to learn to step back and let her do it her way. This is difficult sometimes, especially when problems arise".

5.8.6.4 Extraction Synthesis

This participant showed understanding of the relevance of course content in developing and building of expert skills, providing freedom for self development specific to the role undertaken. Limited access to preceptor support was restrictive in self development and caused a reduction in the participant's potential for being as a nurse practitioner, due to lack of opportunity to adequately discuss originating possibilities. This restricted enabling-limiting and transcending with the possibles for the practitioner due to limited access to the preceptor. Discussing cases and improving care plans as a result of doing ward rounds with another consultant improved the participant's originating possibilities. At the same time this allowed the participant the freedom from undue physician influence away from medical control

(caused by the physician being remote) and reduced the ability to over-influence the participant's practice. Support at district level was poor and this was restrictive as identified by the participant. The participant identified the nursing director's desire for monthly meetings and identified that a response is still awaited. A further issue identified by the participant was that the Medical Director was aware of the participant's endorsement but the participant claimed that the medical director 'has no idea what I actually do'.

Lack of interest in what an employee is doing presented a restriction for potential for being for a nurse practitioner because the employer was unaware of what an employee was doing or their developmental needs. Despite these restrictions the participant remained driven to succeed and developed their own potential for being. While this enhanced his/her ability for originating it restricted enabling-limiting possibilities as well as concealing-revealing. The participant had limited ability to gain further interest from superiors perhaps due to this being not the highest priority on the part of the employer in terms of interest in what the participant is doing. This was very restrictive because the employee had little sense of belonging within the health provider organisation and could formulate no solution to rectify the problem.

The Human Becoming Theory (1995) and the Strong Model (2004) would both suggest that this indicates that skill building was driven for much of the time by the participant as they strived to become competent with limited interest being taken by supervisors or the employer. The employer created a situation where the participant could not grow within the role of nurse practitioner as much as their potential demonstrated. Previous knowledge of the clinical area as a manager gave the

participant the freedom to develop the nurse practitioner role without the need to develop new relationships and this was important as it opened up the potential for becoming in the new nurse practitioner role. Working with a new nurse manager became restrictive in that the participant was unable to intervene when problems arose as this was no longer within the participant's remit. This served to restrict the enabling-limiting potential that the participant previously had experienced with the staff of the unit prior to this time.

Working within the competency framework was restrictive due to lack of language perception and understanding, on the part of doctors acting as preceptors in the way the competencies were written. This was overcome by participant showing aptitude in translating these competencies for the medical preceptor, which enhanced originating the enabling-limiting requirements by their ability to overcome the language problem.

The endorsement journey and education for practice was seen as an exciting possibility for all participants but at the same time, demanding. Each participant experienced difficulties such as time constraints and unclear direction during the journey coupled with lack of visible support to help address these difficulties, with all participants expressing feelings of isolation. The two participants who were already endorsed reflected on such feelings immediately following endorsement. The two nurse practitioner interns felt that support from their employers was lacking from the standpoint of time off for study, lack of job security and one had financial problems. This suggested lack of interest or insight on the part of the employer.

In order to work-in-the-role, participants 2 and 3 were only funded for the duration of their university course, which lasted two years. There were no guarantees provided of a permanent contract as a nurse practitioner following the course, or when final endorsement is achieved. Participant 3 indicated that in their particular health district, a case manager from human resources would be utilised to find alternative employment should this be necessary where no nurse practitioner permanent post was offered, suggesting that they may need to find employment elsewhere in the future.

5.8.6.5 Synthesis Analysis

The nurse practitioner role is a developing one. If health districts do not support, or embrace the establishment of permanent posts during the period of candidature this could have a detrimental effect on recruiting future candidates for the role, based on the experiences of the participants' lack of support. This was very apparent and restrictive for any candidate recruited in the future.

One participant (an endorsed nurse practitioner) expressed feelings about senior medical colleagues' lack of knowledge about the purpose of the nurse practitioner role, knowledge about what the job of a nurse practitioner entailed or the nature of the work.

Another participant expressed feelings of frustration about the endorsement process that they had to undertake due to no clear guidance. According to the participant the methods used to establish competence showed that none of these were actually conclusive in demonstrating competence. For example, references from employers,

examining nursing qualifications, education preparation for the nurse practitioner role were all examined by regulators but the participant was unsure about how these were meaningful to the nurse regulator because there was no rationale given about why these were necessary or the relevance to actual current practice at the time the application was made.

Positive feedback was given by all participants about their own professional and personal development, improving critical thinking skills, developing skills in patient assessment and learning about prescribing rules and regulations. Findings indicated that the endorsement journey for all participants lacked the human touch and failed to encourage potential for being. Participants cited lack of mentorship, support mechanisms or positive feedback from preceptors, which made their endorsement journey that much more difficult and therefore transcending with the possibles was made impossible at times.

All participants identified what was restrictive and where freedom existed for them within their endorsement journey. Lack of opportunity for potential for being was shown, for example, by lack of interest from employers in what participants' were doing. The failure of the medical director to inquire what the role of a nurse practitioner involved, even though the nurse practitioner was part of the director's team, was identified by one participant. Provision of more support for the two nurse practitioner candidates was not as proactive as the employer might have been. One participant showed limited opportunity for potential for being due to unclear direction from the nurse regulatory body responsible for endorsement and poor perception of the role from colleagues following endorsement.

A further participant was affected by inability for growth due to lack of interest from the nursing director about what the post involved and/or how this participant was progressing following endorsement. Without this potential for being participants were unable to transcend with the possibles because the enabling-limiting aspects of the role were never addressed by employers and regulators involved. There was limited direction given or interest taken by key bodies or stakeholders. The participants' were thus limited in defining the vision they had for their particular role or the direction this was taking.

Progress is never possible unless the barriers to progress are eliminated (Parse 1995). Some community support however was evident as enunciated by participant 1. Participant 1 stated that deficiency in support in practice occurred because the role of nurse practitioner was difficult to understand as the scope of practice between one nurse practitioner and another may be totally different, even if they worked in the same area of practice. Some nurse practitioners had different titles and other nurse practitioners worked as part of a team whereas some were sole providers of a service. The expectations differed amongst preceptors' employers and patients about what the job entailed. This could be one reason why the role was not fully embraced by the nursing profession, healthcare colleagues and the medical fraternity at the time of implementation within Australia.

Misconceptions amongst patients can also affect how this new role is embraced by the community within Australia. In retrospect, more information should have been given to healthcare organisations and healthcare consumers about the role by stakeholders and regulators before implementation took place. Though it may be

argued that this important step occurred, participant responses in this study indicate an ongoing lack of awareness on the part of managers, employers, colleagues and patients as a problem. This is borne out by the RCNA (May 2010), when they reported that there is a general lack of understanding amongst the public and healthcare organisations about the role of a nurse practitioner and what this entails.

5.8.7 Theme 4: Context of Practice

Participant 1*: "Post endorsement I felt completely alone. I had no idea about contacts or networks. I was endorsed but had no idea about how to actually order a drug (what script format to use etc.). I also had to approach our local pharmacy and pathology service to inform them I was endorsed, show them my formulary, ask them to fill my prescriptions and carry out tests that I order. No one had any idea what I was talking about and this caused a great deal of difficulty. The pathology provider still refuses to carry out my tests for fear of not being paid! In this respect, I was poorly supported. I have suggested to my nursing board that a post endorsement pack be provided in order to assist newly endorsed nurse practitioners through the processes.*

On a more local level my health board, my colleague, the GP I work with and the community as a whole have been remarkably supportive. Deficiency in support in practice occurs because the role of nurse practitioner is difficult to understand and so expectations differ. The community don't understand why I can prescribe some drugs but not others, the GP does not understand why I should only be prescribing drugs out of hours and so expects I can work in the capacity of a nurse practitioner at any old time; completely reasonable really. My role, however, only provides for

me to cover the GP out of hours. I have never encountered any horizontal violence, since commencing as a nurse practitioner. My current case-load of patients comprises A/E patients. However, once application has been approved to extend my scope of practice this will include district nursing patients and palliative care patients.

I do not have an Index of Health Professionals provider number. I therefore have no access to the PBS system for prescribing or the MBS system for ordering diagnostic tests. My prescriptions, therefore, will cost the patient a dispensing fee if they are not countersigned by a GP and the pathology provider will not carry out any tests that I order, as previously mentioned. In order to keep up with changing trends, I have joined the nurse practitioner association, which I found through an internet site and was not aware of its existence beforehand. I also read journal articles. The prohibitive nature of distance often prevents me from attending many conferences or meetings".

5.8.7.1 Extraction Synthesis

For this participant isolation when first endorsed was restrictive because the participant felt 'under-competent' (sic). The participant had no mentor, preceptor or contact person to discuss specific nurse practitioner difficulties. This was further exacerbated by the local pharmacist and pathology provider having no idea what the role of a nurse practitioner can entail or the legal implications of prescribing within the scope of practice, in terms of prescribing or ordering of diagnostic tests. Potential for being as a nurse practitioner was impossible under such circumstances because the participant's ability to gain experience and expertise was lost as a result of

unnecessary gate keeping. While originating was expected of this nurse practitioner, the possibility was lost due to lack of understanding from colleagues. When employers are intending to develop the role of a nurse practitioner, publicising for local awareness of the role amongst other health professionals needs to be undertaken by the employer.

Poor understanding about the scope of practice was apparent on the part of the GP who assumed the participant's freedom to practice without restriction. In reality the nurse practitioner was indeed restricted by the policy for the nurse practitioner to only cover some of the GP functions after hours. Within the enabling-limiting boundary, the participant was cognisant of this restriction but the GP was not. This caused the potential for crossing professional boundaries which, in itself, was a restricted paradox, because it was a statement of contradiction that led to a differing view by the GP from the actual regulations the nurse practitioner had to follow.

The participant was responding to a local need for service provision and had the freedom to apply for extending the scope of practice and include family planning within the scope of practice as well as rural and remote practice. This became restrictive in terms of the time it takes for this application to proceed. The enabling-limiting area of practice thus became restrictive due to bureaucratic processes.

Lack of nurse practitioner access to PBS and MBS was restrictive, in that a GP had to countersign for all laboratory tests and prescriptions. The participant had nurse practitioner registration, to prescribe as a legitimate approved prescriber. This makes potential for being impossible alongside eliminating enabling-limiting possibilities of originating because the nurse practitioner could not realise the actuality of

prescribing as an autonomous nurse practitioner within a defined scope of practice. Independence of a nurse practitioner away from medical control meant that access to PBS and MBS was essential in order to develop the scope of practice within the context of nursing the participant described.

The participant has joined various professional organisations to keep up to date but the restrictive nature of distance is a problem and is further restrictive within their 'becoming' journey.

Participant 2: "*When working-in-the-role as a nurse practitioner my caseload consists of all patients in the hospital who require wound care and stoma therapy. I am the sole referral agent for such patients and I am supported in this role by a surgeon preceptor.*

I have just begun my internship year and during this time I have to be able to justify the role, as a viable role in the future. At present I am funded for the first two years only.

I find it daunting that I need to justify my post over the next year because if they felt the post was justified by getting me a scholarship to complete education then the post should have been fully funded from the beginning. Apart from my preceptor and my colleagues, the support from the district is poor. I have not encountered any horizontal violence in the role of nurse practitioner.

My patient case-load consists of wound management and wound care, as well as stoma therapy. I look after all hospital in patients who need wound management or stoma therapy as well as run an outpatient clinic, to follow up all the hospital

patients and receive referrals from GPs, for both wound management and stoma therapy.

I work in the role as sole provider and work alone. This can increase the isolation within the role. I speak frequently to other wound management and stoma therapy nurses and this lessens the isolation. I also belong to the wound management society and the society of stoma therapists. This keeps me updated on new development in the specialities".

5.8.7.2 Extraction Synthesis

This participant was a sole referral agent for patients, covering two distinct nursing practice fields. Support from a surgeon/preceptor presented this participant with much potential for being by allowing originating in developing their scope of practice independently. The fact that the participant ran their own caseload without undue influence from the medical professional indicated the preceptor support for enabling the role.

Lack of job security, especially in the internship year, was very restrictive in that the participant was unable to develop their full potential in the post and could not set long term goals within the organisation. This reduced their potential for being within the role undertaken restricting the enabling-limiting aspects of role development, such as setting long term goals for personal development within the role.

The fact that this participant worked as a sole agent means that professional isolation was a feature within this role. This was restrictive, even though potential for being was assisted by the support of a surgeon/preceptor, giving the participant some

freedom to develop the role in originating and enabling-limiting in working as an autonomous practitioner.

The participant had begun to develop their own potential for being by having frequent contact with other colleagues in the specialties and by joining specialist organisations relative to the work undertaken. Poor support from the district employer was restrictive in further development and originating due to the participant being unable to form a vision for progress in the future.

Participant 3: "*My position as a clinical nurse specialist is fully funded, but a permanent position as a nurse practitioner is not fully funded yet. Specialist positions are paid at either level 4 or 5, but nurse practitioner posts are paid at level 6. I have a mortgage and two kids, so if things do not work out and I don't get a job as a nurse practitioner, I don't know if I will stay in this job. I am a specialist in heart failure but work-in-the-role as a nurse practitioner. They tell us that if things do not work out, then someone from human resources will act as a case officer in finding us alternative employment.*

I have my own case load. I seek out all hospital inpatients that have been diagnosed with heart failure and follow them up at home, after discharge. I also receive referrals from GPs of heart failure patients discharged from hospital.

Discharge planning at hospital ward level could be improved, by informing me of all patients discharged.

It is my job to assess the patients' current medication regime and make sure it is the right one. It can be a disaster for the patient if the dosages of these is incorrect, thus

worsening the condition. Their diet and fluid intake is also important for good control of heart failure.

*You ring GPs sometimes, because you don't see anything happening with patients. Patients are not always prescribed the proper meds (*Medication*). There is no interest because the patients are mostly elderly and they get treated differently with no access to a consultant.*

Equality of access is poor for these patients. As I don't have access to PBS I cannot prescribe for these patients. Nurse practitioners especially those in the community, need PBS, otherwise it is nonsense. Some GPs aren't interested, but if I prescribe for them the prescription will cost more money which the patient has to pay. I feel isolated in this role because I am a one-man-band in a small area. All the work has to be done by one person. We still wait for district funding for nurse practitioner roles. My colleagues in other nurse practitioner roles are also affected. I think the hospital should do a business case based on admissions and size of case load.

One positive development of my practice in this role is that before this role was established, there was no follow up of heart failure patients. Now the GPs will sometimes follow up patients and also some consultants. I have not encountered any horizontal violence, since coming into post.

It annoys me that I have to develop my own practice protocol for the role, to satisfy the university requirements. There are four similar practice protocols in existence within the district and I cannot see why I cannot adapt one of these for my own use in this regard".

5.8.7.3 Extraction Synthesis

Lack of job security for this participant presented several issues. It became restrictive in developing potential for being, enabling-limiting and also originating. The substantive specialist role was paid on a different pay scale to nurse practitioners who are on a higher pay scale. This factor placed the possibility of remaining as a nurse specialist in doubt, from the participant's point of view, should a continuing nurse practitioner post not be offered at the end of the course. With two children and a mortgage, the prospect of not being promoted to nurse practitioner reduced the potential for being. There was a risk of loss of incentive to develop the role if long term prospects became insecure and therefore this became restrictive.

The prospect of not progressing to a permanent nurse practitioner position had obviously entered the employer's mind by telling the employee that a case officer will be used if the nurse practitioner post did not materialise. This made transcending with the possibles impossible. This role had many possibilities for potential for being with this nurse practitioner utilising their skills to best effect, particularly if the employer took more interest in the progress of this participant to date and acknowledged this excellent work.

The participant had developed a patient case load through their own efforts at seeking out patients. The participant showed a proactive approach, which is evidence of freedom in role development, rather than didactic, as in taking directives from a consultant.

The participant articulated the limitations of progress for the heart failure patient if the GP does not take an interest in such patients. The positivity of the participant actively following up patients has motivated both GPs and hospital consultants to do the same. This showed freedom away from the negative aspects of control by a doctor in nurse practitioner practice, by the participant leading through example. It illustrated the capability of the participant in influencing the benchmark for good practice involving both GPs and medical consultants. This was a major indication of the significance of demonstrated leadership within the nurse practitioner role and showed enabling rather than limiting clinical practice, in terms of following up patients and ensuring high standards of clinical care.

Lack of district support, in not doing business cases to substantiate posts was restricting in both personal support for post holders and interest from employers in role development. Lack of interest by GPs on occasions was restrictive for the participant in developing the support from the GP in managing the care of patients. The inequality of access to medical consultant supervision provided yet another restriction in role development. The participant was not eligible for access to PBS. The restriction existed in the reluctance of the participant to prescribe for fear of costing the patient more money due to a non PBS prescription attracting an additional fee due to lack of appropriate legislative support.

The participant felt annoyed in having to develop an individual practice protocol. However at the same time the opportunity to do so indicated much potential for 'being' in terms of gaining support for substantiating the post by an employer and gaining independence away from medical control of care for patients.

As part of the data collection/ analysis for this study the researcher examined the current protocols available (which are aimed at doctors rather than nurses) and found that if the participant develops an individual protocol, this would serve to justify how the role is enacted, what is involved, including the number of admissions and number of follow-up visits. It could, potentially form the basis of a business case for the post of nurse practitioner serving as an adjunct to both GP and consultant. This would increase the potential for being and further transcending with developmental possibles would become a reality.

The drug formulary to be used by this participant could assist this process in strengthening the case for PBS access by prescribing numbers and by the varied amount of drugs needed to treat the different types of heart failure. Experience should enlighten the participant's cognizance of all the above factors, on completion of the internship year and the completing of the clinical practice protocol. This participant will have developed a unique model of practice specific to the service provided by the role and will be applicable in the context of the Strong Model (2004). This participant showed potential not just as an expert but also as a leader in the field as a nurse practitioner, particularly within the leadership and direct care domains of clinical practice within the Strong Model (2004).

Participant 4: "*During my internship year, I worked with a consultant who was both supervisor and preceptor. This consultant is still my supervisor, and he now lets me see some patients unsupervised. I find feedback difficult and also find little time to spend with the consultant. He is based elsewhere. I can only assume that if he*

doesn't complain, or say anything contradictory about my practice that he is happy about what I am doing.

You need an Index of Health Professionals (IHP) Provider Number, to be able to do certain things. I cannot sign a patient off sick. I cannot do a referral outside hospital, for example, to investigate sleep problems. I can only refer within the hospital. I can only write prescriptions for inpatients within the hospital. I cannot write them for patients outside the hospital setting, without costing the patient more money as I have no access to PBS.

My case load consists of managing patients with chronic kidney disease. Within the state, population studies show that 1:4 older people show signs of chronic kidney disease and 1:7 have some form of chronic kidney disease. There are approximately 300-400 in this area alone.

We treat patients either conservatively, which involves no dialysis, or we offer dialysis. Dialysis or treating by conservative means is a positive choice. Accompanied by management of diet and medication, both approaches rely on patients' mental capacity to cope with whatever treatment is offered. I cover two units. One is in this hospital and one an hour's drive away. As a unit nurse manager I looked after one unit only.

Management of patients involves an increased workload in seeing my own patients, and seeing them in two districts. My increased patient management role in covering two geographical areas means that I help them look after many of the sicker patients

who need more input from a specialist practitioner. We get little or no support in this district and certainly no encouragement as nurse practitioners.

The most supportive people for me in this role are my colleagues within the hospital and elsewhere. There are 10 other renal nurse practitioners doing the same job as I do and I am in regular e-mail contact with them and tend to talk problems through with them more, because they understand the role better.

Advance Health Directives are encouraged within this specialty, but I cannot assist in this process due to no IHP provider number. I have to refer them back to their own GP.

I belong to both the Australian Nurse Practitioner Association and the Renal Society of Australasia. A colleague is a member of The Society of Nephrologists, but I cannot join this society as it is by invitation only. All these organisations help nurse practitioners to develop their role. I have not encountered any horizontal violence as such, since commencing in this post. However, there has been some friction with the new unit nurse manager for this unit.

I feel isolated from my colleagues in the renal unit though, because I do not fit in as a nurse and I am not a doctor. My lack of meetings with the director of nursing means that she does not have much perception about what I do or the professional problems involved".

5.8.7.4 Extraction Synthesis

The participant managed patients without supervision. This indicated a strong degree of autonomy in the role. This participant had developed the originating aspects of

practice by proving competence to the preceptor and developing independence in clinical practice. However, lack of feedback opportunities restricted enabling-limiting aspects of the role as a result of the preceptor not working with the participant in transcending the possibilities for development of the role.

Lack of an IHP provider number and thus no eligibility for PBS or MBS meant that the participant's nurse practitioner role is restricted, similarly for each of the other participants. The formulary for prescribing had been approved and the participant could prescribe for hospital patients but could not do so for outpatients as this would cost the patient more money as it was a 'private' prescription and the patient paid the full price rather than a subsidised price that comes with PBS.

A private prescription was one that is written by a health professional without a PBS number identified on it such as one we would see from a consultant from the private sector. This was extremely restrictive, allowing the participant limited freedom to prescribe for the community without adding an extra burden to patients even though the participant was a legitimate prescriber. The participant could not sign sick certificates or participate in advanced health directives even though the participant was more aware about the condition of a patient than the GP whose role it was to complete such documents when the participant was unable to do so. This required adherence to the medical control of practice restricted the unique role of the nurse practitioner within the service provided.

Support from colleagues and other renal nurse specialists in similar posts was identified as being good and has provided the participant with the freedom to develop the role and more opportunities for originating. This provided peer support for

problem solving. The restriction encountered from poor district support became a problem for the participant in that the district appeared uninterested in what nurse practitioners do nor do they appear to provide much encouragement. This restricted growth and potential for being. In addition, this was not conducive for the enabling-limiting and development aspects of the role (such as providing feedback to management about how the role is developing and the potential for further development opportunities within the district).

The participant identified that they had not encountered horizontal violence since accepting the nurse practitioner post. Nevertheless, the friction between the participant and the unit manager was restrictive as the participant must step back and allow the manager freedom to solve problems even though further clinical problems arose at times as a consequence of this. This was restrictive and isolating in that there was potential for relationship problems in daily practice areas and reduction in potential for being. This was identified as more problematic when the participant perceived some management decisions to be detrimental to the service and staff had no venue for resolution of such issues.

Isolation was identified as a problem. The participant stated that there was difficulty fitting in as a nurse because a nurse practitioner is not a doctor, nor a mainstream nurse. Currently there is not (until further nurse practitioners are endorsed) a peer group that the participant could relate to within the district. This was restrictive because the bonding of peers was an important factor in sustaining motivation and collaboration in keeping with the Strong (2004) model.

Lack of support from the Director of Nursing coupled with the Medical Director's lack of insight about what the nurse practitioner role entailed and associated problems involved, meant that the participant had no forum at local level which could help with ongoing development of the role. There was more opportunity for limiting than enabling and thus the originating of nurse practitioner practice was very restricted for this participant. Mitchell (1995 in Parse 1995, p. 164) related this to being 'thrown' with the participant at a distinct disadvantage.

5.8.7.4 Synthesis Analysis in Relation to Context of Practice (All Participants)

The first feature that emerged from the combined participants' responses was the common degree of isolation felt by each participant for various reasons. This meant that the organisation of nurse practitioner practice (both for interns and newly endorsed nurse practitioners) within their respective districts had failed to address the need for someone credible and like minded to be available to them to discuss problems or provide support. Normally a new job offers to a new employee a period of orientation and transition where a preceptor, mentor or colleague is available to assist with problems and questions about the role to be undertaken (Gardner & Gardner 2005). This does not appear to be evident for endorsed nurse practitioner novices or interns within this current study.

Participant 1 was entirely alone and unsupported with no mentor or preceptor. Participant 2 had a preceptor but felt the health district to be the main cause of problems due to poor support and doubts about a permanent position once endorsed. Participant 3 felt the need for contact with a specialist consultant, rather than a general physician as a preceptor. This participant identified anxiety about a

permanent position once endorsed. Participant 4 felt that the preceptor was distant and failed to give adequate feedback. Although this participant was offered and accepted a permanent post, poor support from the health district caused anxiety.

The employing organisations for participants appeared to be lacking in the human touch which had produced a role conflict for participants that limited their ability 'to become'. Employers appeared not to provide the level of support that participants' required. Every new nurse practitioner may be a clinical expert but they need support in working at a different level of practice, management and legal accountability.

People within the organisations of each of these participants (particularly senior colleagues) appeared to have little or no perception about what the job of a nurse practitioner entailed. This suggests that not only were poor explanations about the nurse practitioner role given to the health care industry as a whole prior to implementation but also that senior employees in the organisations did not appreciate the nature, extent or value of nurse practitioner work. Two of the participants interviewed were interns and have to justify their post for future employment as clearly stated by participant 3.

The expertise of the evaluators and employers to make decisions about nurse practitioner positions must come into question particularly if such evaluators have poor perception of the nurse practitioner role. This was extremely restrictive. In terms of restriction-freedom these restrictions such as poor support in terms of study leave and finance, inhibited development of the role and prevented the freedom and enabling of personal growth for each participant. In this context, looking from the

perspective of the Human Becoming Theory (Parse 1995) participants were restricted in their enabling-limiting, originating and indeed their potential for being as nurse practitioners.

Lack of understanding about the role on the part of an employer can lead to missed opportunities to integrate the role. Nurse practitioners in this study had limited opportunity to become a team player. This was an added restriction that led to a deeper sense of isolation and thus the loss of potential for being a nurse practitioner. From a nurse practitioner as a prescriber perspective, this was evidence of a greater amount of restriction. One participant in this study held a joint community/hospital remit as an intern and will become a legitimate prescriber subject to current legislative restrictions on completion of the university course.

No Australian nurse practitioner to date (PBS and MBS access begins in November 2010) has an Index of Health Professionals Provider Number (IHP) giving access to PBS and MBS. A nurse practitioner working in the community cannot prescribe without incurring a dispensing cost to the patient. In addition, they are unable to sign a sick certificate, assist with an advanced health directive or order diagnostic tests without a GP counter-signature.

This is restriction and downward closure (Yuginovich 2009) evidenced by the constant need for physician input and thus prevents the development potential for any unique scope of practice involved in the service provided by the participants. Not only is lack of an IHP number restrictive it could be viewed as discrimination particularly from the standpoint of PBS by treating some legitimate prescribers in a

different way to others (e.g. the GP). It also imposed an added burden of cost to the patient if nurse practitioners prescribe for outpatients or community based patients.

5.8.8 Theme 5 Relevance of Law to Daily Practice of the Nurse Practitioner

Participant 1: "*This can be confusing, because of the number of different places that the regulating of nursing stems from. In my role as Chief Executive officer (CEO) of my health service, I work probably with 12 Acts of Parliament and associated Regulations. Then there are the internal policies, and also the plans submitted to regulatory departments specific to certain Acts and Regulations. For example, my drugs and poisons plan from government states that all drugs and poisons are kept and stored in a certain way. However, the regulations associated with Private Hospitals (which bizarrely we are governed by) demand different requirements. So, knowing which is which and which law is applicable can be challenging.*

Another difficulty is the Act specific to nurse practitioners. The ability to prescribe is straightforward, what is difficult to understand are all of the requirements of my state nursing board. I am endorsed for 'out-of-hours' A&E, but I am pursuing an increased scope. The Act says as a nurse practitioner, I can prescribe the drugs on my formulary. My endorsement says I am endorsed as a Rural and Remote nurse practitioner. At present, the only document that discusses the scope of the Rural and Remote nurse practitioner role, at this stage, is a letter that I wrote to the nursing board proposing the actual model. The legislation is self explanatory, but the nursing board requirements are really difficult to understand.

Apart from the Nurses Act (1992) and the Drugs and Poisons Act (1996), which enable me to prescribe under the scope of the nurse practitioner role, the legislation that has the most significant impact is the Health Insurance Act. It is this one that prevents my access to MBS and PBS. This means that although I can prescribe medication and order diagnostic tests, the patient is forced to pay the full price. To overcome this, the GP signs my scripts and request slips. Completely illegal, however, given that this area is a declared drought area and our community is significantly economically disadvantaged, the nurse practitioner role would be useless otherwise. It is very frustrating that we are forced to act illegally, despite nurse practitioner endorsement. If the nurse practitioner association and the nursing board sent endorsed nurse practitioners newsletters about changes is law and regulations this would help a lot".

5.8.8.1 Extraction Synthesis

Knowledge of law amongst colleagues appeared to be a problem within the organisation for this participant especially as it was apparent to the participant that law caused confusion amongst junior colleagues. This was restrictive in enabling development in practice. As a senior manager of a health service, the participant recognised that they needed to be better informed about law than junior colleagues in order to role model for others. This provided freedom in enabling-limiting circumstances and the participant was more able to influence the knowledge of other nurses within the service.

Differentiating between what was regulatory, internal policy and legislation was challenging for participants. Colleagues' lack of understanding of the various

policies, procedures, regulations and all relative legislation was restrictive for this participant. As senior manager of the service it should have been easier for the participant to implement a service based on the desired service model envisaged rather than based on legislation because of the more senior position.

This participant has no access to MBS and PBS, but was able to quote the relevant Act from which the legislation stems. This was perceived by the participant as being restrictive and non-enabling and is evidenced by the fact that prescriptions and test requests from the participant for the community had to be countersigned by the GP to benefit the patient. As the participant rightly pointed out countersigning by a GP is illegal (National Health (Pharmaceutical Benefits) Regulations 2002). No nurse practitioner or GP should be required to break the law in order for a system to work. In legal terms this may constitute breach of contract incurring unnecessary sanction.

The Nurse Practitioner Association and the State registration authority could be more proactive (thus enabling) by providing a newsletter to keep members informed of changes in relation to government policy and new legislation relevant to nurse practitioner clinical practice.

Participant 2: "*Apart from pharmacology law, legal aspects of the role are not covered in our course, though we might cover these in the second year, in terms of the role development aspects of the course. To a certain extent I understand the law, for example, the pharmacology. Understanding other aspects is limited at present; Law relates to the role in the competencies in relation to patient care, the documentation, diagnosis, prescribing and ordering diagnostic tests*.

5.8.8.2 Extraction Synthesis

At the time of the interview this participant was unable to cite any legislation relative to the clinical practice of a nurse practitioner. This participant is a nurse practitioner candidate in the second year of the nurse practitioner degree course (the internship year). Legal aspects of pharmacology have been taught at the university, but the participant could not cite relevant legislation (e.g. drugs and therapeutics legislation within the home state in relation to pharmacology). The participant also admitted limited knowledge of law related to the nurse practitioner role and was unable to cite areas of advanced practice where law is important such as in diagnosis and prescribing intervention. This meant that the law in relation to practice potentially will have limited meaning for this participant after one year of study, but could improve on completion of studies. Safe practice relies on knowledge of legal aspects of clinical practice such as negligence, trespass, assault and working beyond the clinical remit of the scope of practice. Enabling in terms of role development is limited because of this lack of knowledge at the time of interview.

Participant 3: This participant is a nurse practitioner candidate currently completing the internship year interestingly at the same university as participant 2.

"We haven't done much legal stuff. This type of knowledge is assumed before you start. I did the basic stuff as a student and I have attended in-service days in legal aspects of general nursing. I think I have acquired the necessary knowledge (the candidate was then asked to specify what legislation was relevant. This is revealed in the next answer).

"Well, there's the code of conduct and that, for general nursing and the scope of practice. I know about those. I know about registration and I have to develop a scope of practice for my role as a nurse practitioner." (The participant was then asked how legislation applied to daily practice in the participant's particular area of practice. This is revealed in the next answer).

"The scope of practice for my role: there are quite a few protocols already in existence. I cannot see why I can't adapt one of these. The scope then has to be signed off by my CEO".

5.8.8.3 Extraction Synthesis

This participant was able to cite aspects of legislation but not the legislation itself. For example, the 2004 amendment of the Nurses Act (1992) made provision for developing the nurse practitioner role but the participant could not cite this directly. This suggested that the candidate is more skills focussed at present.

Having the scope completed and signed off by the CEO was inappropriately identified by the participant as the legislation that directly relates to daily practice. This suggested as another participant pointed out that difficulties arise in the understanding of what is actually law and what is regulation. This in itself posed a risk evidenced by lack of understanding. Policies and what legislation is all about and why it is important, in relation to nurse practitioner practice was misunderstood by this participant and adds further evidence to that suggested by the other participant. This will have a greater impact on restricting enabling-limiting of the development of the scope of practice because the participant lacked full

understanding. This will impact on their accountability, responsibility in clinical practice. It indicated that a theory of liability relating to clinical practice would be an advantage for the legal protection of nurse practitioners.

Participant 4:

"Specifically we covered pharmacology law. We did not cover any other aspects of law on the course, though we did touch on liability. The State covers our liability, through their vicarious liability. We just did not cover law at all.

Legislation in practice is very relevant, in terms of nurse practitioners. The Radiology Act is quite specific in what a nurse practitioner can and cannot do. The Drugs and Therapeutics legislation was covered and mainly involved, for me anyway, translating the regulations within this Act, to produce a formulary as part of the endorsement process and get this approved, so that I can legally prescribe drugs. However, without PBS, I cannot prescribe for patients who are not in-patients at the hospital, without incurring further cost for the prescription by the patient. We also had a visit last year by the Chief Nurse, who told us about all the Acts and specific recent changes made to these Acts. The Radiology Act relates to radiology and all the regulations. I can only order plain films, as a nurse practitioner.

If I had an IHP (Index of Health Professionals) provider number, under the Worker's Compensation Act I could sign sick certificates. As it is at present, I have to refer all my patients back to the GP for this. I can also do only hospital referrals for patients in hospital. I cannot, for example, refer an outpatient for sleep studies without an IHP provider number. This makes some aspects of daily practice a total farce".

5.8.8.4 Extraction Synthesis

This participant was able to cite some law specific to daily practice and showed awareness of the relevance of this law in their daily practice. The participant showed awareness of other relevant aspects of law that were not covered in the university course such as negligence. In terms of originating and enabling-limiting this is likely to be prohibitive in relation to aspects that were not covered. The more senior the grade of the nurse (such as grade 5 or 6), the greater the degree of authority, autonomy, accountability and responsibility for their practice and delegation of duties. The participant seemed cognizant of vicarious liability accepted by a relevant organisation to which the participant belongs. Whether or not this degree of knowledge demonstrated by the practitioner reflected reality or will be sufficient in the longer term in relation to law relevant to clinical practice, only time will tell.

Lack of eligibility for MBS and PBS was extremely prohibitive for the potential for being of the nurse practitioner role, in all respects of originating and enabling-limiting and developing an independent influence in service provision.

5.8.8.5 Overall Synthesis Analysis (All Participants)

The difference between each of these participants responses in understanding law relevant to nurse practitioner practice is obvious within participants' responses. The fact that essential elements of law relating to the autonomous advanced nurse practitioner are poorly understood by two participants in the second year of study was apparent. Participant 2 admits that although they understand the law relating to pharmacology the understanding of other aspects of law in relation to daily practice

is limited. Participant 3 asserted that knowledge of legal aspects is assumed prior to candidates beginning their course. Participants' 2 and 3 were asked to cite legislation relevant to their practice. Neither participant was able to do this.

Participant 3 stated that knowledge of basic law relative to nursing is assumed before a candidate commences a nurse practitioner degree course. The ANMC competencies for all registered nurses indicate that this is a realistic proposition. Although law may be formally taught at undergraduate level, it cannot be assumed that a registered nurse will be cognizant with legal implications of a more advanced clinical practice role and the ramifications of increased liability. This participant claimed to have understanding of law relative to nursing practice but on prompting could not cite any Act or provisions within legislation that were important to their specific practice such as The 1992 Nurses Act .

Neither participant 2 or 3 was able when questioned to cite any particular Acts of Parliament that governed nursing practice. Participant 2 claimed to understand the law related to pharmacology but was unable, despite direct questioning, to cite the Acts that govern nurse practitioner practice in this regard (i.e. Nurses Act 1992; Drugs and Poisons Regulations 1996-1997). Participant 3 was unable to cite any Acts at all despite direct questioning by the researcher suggesting that the participant lacked the requisite knowledge of relevant legislation. However, as neither participant has completed their course this could change by the time they are endorsed.

Participants 1 and 4 demonstrated knowledge at a more advanced level but participant 1 is correct in stating:-

"This can be confusing, because of the number of different places that regulation comes from".

Participant 3 showed poor understanding about the difference between regulations (developing a scope of practice) and law (1992 Nurses Act) that govern the nursing practice of nurse practitioners or indeed regulations for the nurse practitioner. At the time of writing (October 2010) the regulations from the Health Practitioner Regulation Authority are not yet available on their website.

Participants 2 and 3 showed limited perception about the difference between legislation, regulation and policy. Participant 1 identified the confusion that arises in relation to what is legislation, regulation and what is policy.

As advanced nursing practice becomes more autonomous, nurses become more at risk of a complaint from a patient (Petersen in Freckleton & Petersen 2006 p.485). Ignorance about law relative to nursing practice is unacceptable under the law. Incidents of complaint and litigation are likely to become more frequent unless more attention is paid to legal aspects of nursing practice within some nurse practitioner courses. Due to the partnership and 'lived experience' nature of a nurse-patient partnership (Parse 1995) the risk of litigation becomes reduced due directly to the close partnership. The Strong Model (2004) advocated leadership and collaboration in direct patient care with emphasis on patients and clients as partners. Further development in the overlapping areas of the Strong Model (2004) and Parse (1995) would thus reduce the litigation risk considerably by providing a more encompassing and supportive framework.

5.8.9 Theme 6: Legal and Professional Issues and Problems

Participant 1: "*The MBS and PBS ineligibility means there is much I could do, if I had an IHP number, but because I do not my hands are tied.*

I have not encountered any professional dilemmas yet. However, I do anticipate the potential for an issue to arise. This community has had access to a doctor out of hours for the last thirty years. They have become used to it. Now, when they present out of hours they may not have access to the GP and be treated by myself. This will be all well and good whilst I am providing the treatment they think is appropriate. However, I anticipate the potential for patients to become disgruntled and insist on GP input if they do not get what they want such as antibiotics for cold viruses".

5.8.9.1 Extraction Synthesis

To not allow nurse practitioners access to PBS and MBS is extremely restrictive in developing independence from the influence of the medical model from the GP. This participant demonstrates that the approach to be taken when the participant covers the service out of hours will not adhere to the status quo of the GP. The treatment that will be offered will be what the participant thinks is appropriate, avoiding recourse to antibiotics when patients present with cold viruses or other minor ailments that do not warrant antibiotic cover as per current medical approaches reported by the participant.

Participant 2*: "**People here want the glory of publicity in having candidates working in the posts, but funding for the posts has not happened. There can be no funding without planning. The funding of nurse practitioner positions should include*

full funding so that there is a permanent position from the outset. At present, I feel like a vehicle full of fuel with nowhere to go. As the number of endorsed nurse practitioners increases, so will the numbers of nurse prescribers and further support in this area would be useful, such as a network".

5.8.9.2 Extraction Synthesis

Lack of long-term funding for nurse practitioner positions is restrictive for role development because nurse practitioners in this position feel their hands are tied due to lack of a substantive post. They could become less inclined to plan for the future, since they do not know what the future holds and less able to plan for future development of the role.

The Australian College of Nurse Practitioners (ACNP) have set up networks. The Association has chapters in each state within Australia. The ACNP also has a list-serve, which is an e-mail network allowing any member to participate in discussions via e-mail. Interns may not be aware of this if they have not joined the Association, though nurse practitioner students are eligible for membership. The RCNA has a nurse practitioner network, which is only open to RCNA members and the cost of this membership could be restrictive. All nurse practitioners should be encouraged to empower themselves by becoming proactive within associations that promote the developing role of nurse practitioners.

Participant 3: "*Patients are not always prescribed the proper medication to manage their condition. There is less interest in these patients because most are elderly and they get treated differently, with no access to a consultant.*

There is no specialist consultant at this hospital. Patients have to be referred to a larger hospital in a different district, if such a referral is merited. This means that treatment is delayed and more costly. I am a one-man-band. Most other nurses in a similar job have access to a specialist consultant".

5.8.9.3 Extraction Synthesis

The participant identified deficiencies encountered by some patients not being prescribed correct medication when he sees them at home or in hospital. The participant has shown in previous responses that they are able to lead by example in that both GPs and consultants have begun to follow up patients as a result of this influence and use more appropriate medication regimes. In time, this could lead to standard medication regimes as the participant requested of the GPs. The participant had the freedom for interdisciplinary relationship building and collaboration which is a distinct advantage. These initiatives can also be linked to the collaborative care and leadership domains of the Strong Model (2004). This could enhance both the originating and enabling-limiting aspects of the role. This nurse practitioner is in a strong position to further develop a collaborative service model that nurse practitioner, GP and consultant physician could put into practice.

Participant 4: "*All nurse practitioners need to have an IHP provider number otherwise we are restricted in what functions we are able to undertake.*

The advice given to patients can be a problem, especially the ramifications. We sometimes do not offer dialysis as a treatment option and when we educate patients this is based on conservative treatment of medication and diet. When families

become involved this can sometimes become awkward as dialysis is often seen by families as the only option, when this might not be the case.

In my practice, I tend to follow the state guidelines when treating patients. My consultant, however, sometimes has a contrary view and takes a different approach outside these guidelines".

5.8.9.4 Extraction Synthesis.

Family relationship building is required in the enabling-limiting aspects of nurse practitioner practice (Parse 1995). Within concealing-revealing, some aspects of treatment come into question such as a patient concealing non-compliance with a diet regime for a particular medical condition and this appeared to be a problem for the participant. People perhaps perceive that in chronic kidney disease, dialysis is the only option, when clearly this is not the case. This is a concern for the participant.

The participant had a clear ethico-legal dilemma if the consultant takes a contrary view outside recommended guidelines and uses a different approach. If this participant ignored the guidelines they would be working beyond the prescriptive remit of the scope of practice, as indeed the consultant was doing. Providing the participant followed guidelines and clearly documented these, the consultant approach need not be restrictive in influencing the participant's approach. On the contrary, it showed a definite movement away from medical control and gives the participant freedom to develop the required service model. This could become restrictive if the contrary approach is taken with a patient when there is input from both nurse practitioner and consultant. This would then reduce the potential for being

of the nurse practitioner if the consultant approach takes precedence over that of the nurse practitioner. Under the 2009 Health Amendment Bill (Nurse Practitioners and Midwives) a Collaborative Care Agreement is mandatory, particularly in relation to PBS and MBS access. To work collaboratively is vital under such circumstances.

5.8.9.5 Synthesis Analysis (All Participants)

Theme 6 : legal and professional issues and problems that participants have encountered as nurse practitioners or candidates, were identified solely by the participants without any prompting from the researcher. Potential for being was inhibited. This reduced their ability to develop the concealing-revealing aspects of restriction-freedom, in that their ability to consider the possibles was prevented through confusion, lack of interest and role perception difficulties. Evidence of clinical leadership in their field, which is a main focus of the Strong Model, was provided in a variety of ways especially by participants 1, 3 and 4. Participant 1, for example, was determined not to maintain the status quo of prescribing medication for a cold virus based on the patients' perception that antibiotics would be prescribed. Participant 3 gained the co-operation and led the GPs in improved drug regime prescribing for heart failure patients and participant 4 stated that they followed State Health guidelines when managing chronic kidney disease whereas the consultant did not, with participant 4 showing no inclination to follow the consultant's example.

PBS and the lack of an IHP provider number were identified as a problem by three of the four participants, as their prescriptions will attract a dispensing fee to patients when dispensed away from the hospital pharmacy. These participants considered this to be an unacceptable state of affairs, stating that their hands were tied in changing

the situation and those patients were subject to discrimination. Transcending with the possible of being an independent licensed prescriber and prescribing as dictated by their formulary was impossible for all participants. Lack of an IHP provider number totally destroyed their potential for being as a legitimate prescriber and is one of the main restrictions in nurse practitioner practice.

The 2009 Health Amendment Bill (Nurse Practitioners and Midwives), granting PBS and MBS privileges to nurse practitioners, should overcome the problem of patient charges for prescriptions. However, the Collaborative Care Agreement with a doctor or GP-a mandatory provision within this Bill, will not make nurse practitioners independent in prescribing due to the doctor being allowed to exert influence on nurse practitioner prescribing. The enabling aspects of this Bill is restrictive and under medical control.

Full acceptance of the nurse practitioner role within health districts was identified as a problem by all participants. Findings related to this included lack of interest by employers about the role and what it entails, poor perception about the role and its responsibilities when covering for a doctor and funding of positions beyond internship for nurse practitioner candidates. Transcending with the possibles within the universe of the nurse practitioner was inhibited through lack of potential for being and as a result enabling-limiting opportunities were lost.

Role perception was identified as a significant issue by all participants. One participant identified a need to monitor patients and see that patients' medication was appropriate while having to liaise with GPs to ensure correct medication was prescribed. This did not prove easy to start with but through enabling-limiting and

identifying to GPs the advantages of proper prescribing, the GPs began to follow the recommendations the participant made and proper medication was becoming a reality and not a possible.

One participant identified problems in relation to where the role ‘fits’ within the organisation. Feelings expressed were that a nurse practitioner was no longer a mainstream nurse or manager, nor could a nurse practitioner relate to the functions of a doctor due to lack of the requisite qualifications. The implication of this is that stakeholders need to address the risk of a career cul-de-sac (Castledine 1998) to allow a healthcare workforce to integrate the nurse practitioner role more fully and thus enrich the potential for being of the nurse practitioner.

Further participant responses related to the public acceptance of the actions of a nurse practitioner when replacing a doctor in an emergency department after hours with these actions being perceived as different from those of the GP thus open to complaints from patients , possibly due to lack of awareness of the nurse practitioner role and his/her responsibilities.

All participants identified the tyranny of professional isolation as a factor in their being as a nurse practitioner, because often they were sole nurse practitioners in their specialty and worked alone. This had a negative effect on being a member of a team and the role being fully understood by colleagues. Once more potential for being and transcending with the possibles for personal growth were lost.

5.9 Discussion

Research Question 2

What do nurse practitioners believe to be the most important legal and professional aspects of their practice?

5.9.1. Legal Issues

As suggested by findings and analysis in this study, one should never presume that a registered nurse will be able to understand, assimilate and apply law to a level commensurate with their seniority or experience in clinical practice. Two participants were unable to cite any legislation relevant to their clinical practice even though Gardner (2004) adduced that all nurse practitioners were experts in their clinical field. To be an expert one has to have knowledge of law relative to any clinical field of practice and the ability to assimilate and apply this law. Two endorsed nurse practitioners had a better understanding but even some of the knowledge cited was limited with one participant more knowledgeable than the other.

Nurse practitioner development has, over time, been practice driven. This is understandable, taking into account the need to understand and successfully achieve the desired standard concerning the ANMC (2006) Competency Standards for Nurse Practitioners. There has been less emphasis on law.

In terms of legal issues, all participants were able to convey one or more legal issues that they experienced in their day to day practice. Two of these issues related to

doctors following a different approach in the care of patients. One participant admitted a limited knowledge of law, which is worrying, especially because the participant, once endorsed, will be an autonomous practitioner and subject to an increased level of accountability, authority and responsibility. Another participant felt that the Code of Professional Conduct and writing the scope of practice to be the most relevant law in clinical practice. Three of the four participants completed their nurse practitioner degree in a university that does not offer law as a core component within the degree program, but this does not necessarily mean that certain aspects of law were not addressed in other areas of the curriculum. However, legal aspects covered may not be as comprehensive in these institutions as others who have a formal law component within the curriculum (see Appendix A).

5.9.2. Professional Issues

a) Professional isolation was also perceived by all participants as a key issue in their clinical practice. One participant felt completely alone. This was exacerbated by lack of co-operation and understanding from a pharmacist in relation to prescribing and a medical scientist with regard to ordering diagnostic tests. Another participant felt isolated by being outside the realm of mainstream nursing and also unable to relate to medical staff on a professional level. Two other participants felt that as sole referring agents that this isolated them in terms of being a team player within the clinical setting in which they worked.

b) Poor support at district level was apparent for three participants in the study. This is evidence of both inter and intra-professional downward closure (Yuginovich 2009), as it involved both nursing and non nursing personnel.

5.9.3 Discussion

Research Question 3

What is the most appropriate approach to further enhance the professional autonomy of nurse practitioners in Australia?

The nurse practitioner role could be one of the greatest developmental achievements within nursing in Australia. However, responses by participants indicated that nurse practitioners are hindered in this endeavour. Nursing institutions, nursing professional organisations and nursing academia have high regard for nursing research about the development of the nurse practitioner role. It appeared apparent that the medical profession and governments, both state and federal, do not have this high regard, to the point that much of the nurse practitioner research was ignored by them. This is evidenced by the fact that little attention was paid to the research undertaken by Gardner (2004), Gardner and Gardner (2005), Gardner et al. (2006) or Gardner et al. (2008) and Dunn et al. (2008) when considering nurse practitioner access to PBS and MBS.

If this research had been examined before the bill was written, governments would possibly have realised that the legislation provisions for nurse practitioner development, particularly regarding the scope of practice, was a key element in the debate. Yet, this was totally sidelined and the role of the nurse practitioner misunderstood and criticised by researchers outside the nursing profession (Sammut 2010).

Regulators in all states and territories within Australia (as in the USA, Canada and New Zealand), demand that in order for a nurse practitioner candidate to become registered, the scope of practice must be clearly defined and must also be further supported by clinical practice guidelines involving every aspect of expanded practice undertaken (Gardner & Gardner 2005). This included a formulary for designated prescribing. The formulary must include all the medications a nurse practitioner is likely to prescribe and the rationale for including them within the formulary.

Dunn et al. (2008) developed and implemented a computer designed training programme for nurse practitioners involving the principles of Quality Use of Medicines, which is an initiative developed within Australia for doctors. If nurse practitioners are trained in the same way as doctors, prescribe to the same standards as doctors, then the 'Collaborative Care Agreement' within the 2009 Health Amendment Bill (Nurse Practitioners and Midwives) should only involve collaboration and not supervision. However, this is not made clear within the legislation itself. The legislation gives the doctor a licence to interfere and is an example of intra-professional downward closure (Yuginovich 2009).

Pearson et al. (2007) suggest that professional autonomy could be enhanced for nurse practitioners by examining the feasibility of competency standards being related to specialism, rather than the current generic competency standards. While this may be a possibility, it was not suggested by any of the field research participants.

Pearson et al. (2007) reflected the nature of the aged care nurse practitioner in being able to provide care that was transparent and transboundary in nature, involving

collaboration within a multidisciplinary team. This could be equally applicable to other nurse practitioner roles both in Australia and other countries.

If all competency standards were further developed within unique scopes of practice in defined areas of practice such as aged care, emergency room practice or women's health, the competency standards could perhaps better reflect the unique nature of the nurse practitioner role. A nurse practitioner in emergency care will have some clinical practice guidelines that differ from those of a nurse practitioner in aged care, wound management, family planning, heart failure or chronic renal disease. If competency standards incorporated clinical practice guidelines within a specialty framework the process for competency assessment would be more accurate because the evidence would be more robust in identifying competence within a specialist arena rather than a more generic format as exists at present. Whilst possibly cumbersome this may be the most appropriate approach if it was given due consideration by regulators, stakeholders and nurse practitioners themselves.

Application of the tenets of both the Parse (1995) and Strong models support this outcome and identifies the need for a theory of liability coupled with a more synthesised model of practice for the nurse practitioner that better validates and supports their practice roles within this specialty context of their advanced practice.

5.11. Chapter Summary

Phase 1 of this study provided findings and an historical-comparative analysis of the findings of the history of the nurse practitioner role in five countries. The analysis identified the emergence of the modern nurse practitioner in these same five

countries alongside the social movement outcomes that were causes in the fragmentation of implementing the role of nurse practitioners within the five countries. The analytical comparison which preceded the review revealed that globally there is by no means a uniform approach to the education, endorsement process, regulation or registration of the nurse practitioner, even though the International Council of Nurses advocates a uniform approach.

Phase 2 of the study research findings examined the lived experience of the nurse practitioner and what it means for them to be a nurse practitioner within the Australian universe of nursing. The restrictions participants' experienced and how relevant law is perceived by participants' in relation to their daily practice and any legal and professional problems or issues they have encountered to date were explored, using the restriction freedom paradigm as enunciated by Mitchell (1995 in Parse 1995 pp.161-165). Emerging issues included professional isolation, movement away from the nursing workforce, public perceptions of the nurse practitioner role when this was identified by participants. This led to the seven emergent themes of:

- Education preparation for the specialist role prior to seeking endorsement
- Area of nurse practitioner practice
- The endorsement journey/education as a nurse practitioner candidate
- Context of nurse practitioner practice
- Relevance of law to daily practice
- Professional support as a nurse practitioner

- Legal and professional issues

Some participants showed lack of legal insight in relation to law and the role of a nurse practitioner, failing to demonstrate adequate knowledge of relevant legislation with some participants only able to cite aspects of legislation without realising the impact that current legislation has on clinical nursing practice. This meant that participants concerned may lack the essential knowledge of law that enables them to prevent legal sanction likely to result in alleged negligence situation as they showed a limited perception about what negligence actually is.

Restriction-freedom analysis of the participants' responses revealed that for the most part medical control of practice is largely irrelevant in day-to-day nurse practitioner clinical practice. These nurses are forging and pioneering paths in developing service models and in some instances medical practitioners have shown willingness to follow the nurse practitioner's lead. Discussions within the chapter provide some answers to the research questions based on the findings within the study.

CHAPTER 6 CONCLUSIONS

"These things shall be: a loftier race than 'ere the world hath known shall rise"
(D.T Davies, a school headmaster 1947)

6.1. Introduction

The above quotation suggests that with appropriate educational preparation and the adequate facilitation of professional development, a loftier race than 'ere the world has known' could rise- in other words the role of the nurse practitioner could become this 'loftier race' within the nursing workforce. This has become as yet only a partial reality.

The thesis statement of this study was that respective governments in all jurisdictions within all five countries have limited the freedom of nurse practitioners. The study investigated how the nurse practitioner emerged into the healthcare workforce and the historical aspects of this emergence. An historical-comparative review of findings was presented that revealed the emergence of the nurse practitioner role in all five countries was long and fragmented.

This final chapter proposes combining elements of both the Strong Model of Advanced Nursing Practice (2004) and the Parse Human Becoming Theory (1995), each of which is concerned with nurse-patient interaction and direct nursing care.

The literature search revealed that Dunn (2008) provided a strategy to transform novice nurse practitioners prescribers into competent prescribers by developing the Interactive Quality Use of Medicines Programme, which is an excellent interactive online programme that prepares nurse practitioners to become competent prescribers.

There is scope, as a result of Dunn's (2008) work, to enhance the autonomy of nurse practitioners in Australia, which is supported by arguments in Pearson et al. (2007), who argued in favour of specific specialty competency standards for aged care nurse practitioners. Were the same approach to be taken for all scopes of practice and competency standards, it would mean a shift away from the current generic competency standards that are applicable to all nurse practitioners, regardless of their scope of practice. Nurse practitioners stated (RCNA 2006) that their hands were tied and their clinical judgement was impeded by the prolonged use of stringent protocols and practice guidelines. If these protocols were tailored to meet the needs of speciality scopes of practice and written by nurse practitioners for nurse practitioners the nurse practitioners themselves would only have restrictions that they themselves imposed.

A sensitive approach would be required and the College of Nurse Practitioners of Australia would need to work in close partnership with the Health Practitioners Registration Agency Nursing Boards in developing and approving such standards and getting these sanctioned by government. Clinical practice guidelines could be developed within competency standards rather than outside them, for each specialty. This process could be more accurate and the end result would provide a more robust outcome for the actual measurement of nurse practitioner competence and outcomes of care.

The more experienced, endorsed nurse practitioners demonstrated greater knowledge of law relative to clinical practice and its importance in clinical practice, one with much more knowledge than the others. In some instances participants were unable to

theorise and apply law directly to clinical practice leaving them open to litigation should an adverse event occur. Intern participants' awareness varied from scant awareness to almost none at all. This is concerning given that participants were undertaking their master's degree course for nurse practitioners in one of the few universities within Australia that offers limited formal training within the course curriculum in legal aspects of the nurse practitioner role (see appendix A). It means that at the time of interview, these particular nurse practitioners lacked the essential knowledge of law that could enable them to prevent legal sanction by the avoidance of erroneous practice likely to cause alleged negligence. Both participants were working-in-the-role and this is a temporary situation but not without risks of sanction. The fact that respondents showed a limited perception about what negligence actually is and could not cite any legislation relative to their clinical practice suggested that gaps existed in their educational preparation and understanding.

Even though all participants completed postgraduate courses in their specialist field prior to seeking endorsement as nurse practitioners (so in theory have demonstrated their ability as clinical nursing experts prior to seeking endorsement), they did not identify that they have a comparable knowledge of law relevant to this expert practice.

One participant suggested that the university degree did not offer formal training in legal aspects stating that this knowledge is assumed before commencement of the degree course. The folly of this assumption is borne out by the fact that this same participant following adequate prompts could not cite any legislation relevant to

clinical practice as a nurse practitioner. A second participant, endorsed from the same university admitted that law was not covered, apart from a chief nurse visit to review Acts relevant to the clinical practice of a nurse practitioner.

Findings suggested that The Strong (2004) Model of Advanced Nursing Practice (Gardner & Gardner 2005) featured highly but informally within service models. The notion of combining the Parse Human Becoming Theory (1995) with the Strong Model of Clinical Practice (2004) for the nurse practitioner is a dynamic concept. This synergy could provide a basis for best practice, due to the close partnership between nurse and patient (Parse 1995) in synergy with the clinical expertise and high standards of patient care demonstrated in the Strong Model (2004).

The restriction-freedom paradigm (Parse 1995), when linked effectively with concepts within the Strong Model (2004) would provide a theoretical foundation of practice that a nurse practitioner is able to apply as they exercise clinical judgement, applying the knowledge provided within both the scholarship domain and the research domain of the Strong (2004) model. This would facilitate transposing this expert knowledge into direct patient care by applying the close partnership proposed by Parse (1995) as ‘true presence’.

6.1.1 Isolation and Poor Support

Participants expressed concern about the fact that they felt isolated or poorly supported in their practice. To qualify as a nurse practitioner meant movement away from mainstream nursing and feelings of not ‘fitting in’ as a nurse, or having little in common with medical practitioners was identified. This supported Castledine’s

(1998) notion of being in a career cul-de-sac where nurse practitioners could find themselves in a post where limited opportunities exist to develop maximum potential. This can potentially reduce the interest of prospective candidates into the nurse practitioner role and could cause a famine of such expertise within the nursing workforce thereby limiting the potential for further development of the mainstream registered nurse.

In terms of restriction-freedom (Parse 1995), findings indicated that poor support from health care organisations provided a marked degree of restriction, especially for interns and novice nurse practitioners. This could indicate lack of interest in their progress. These candidates had no potential for being as a nurse practitioner because they had little support and no notion of a permanent post after qualification.

A recurrent emerging theme within findings suggested that health professionals with whom participants' worked (such as senior managers and medical directors) appeared to have no notion about what nurse practitioners actually do, what they could do once endorsed, or how the role operated within the healthcare workforce.

Lack of interest from senior colleagues about nurse practitioners' development progress and even lack of interest in gaining further insight in this regard was identified by participants and suggested that employers were exercising restriction for nurse practitioners and offering little sense of potential for being. This indicated that employing authorities may have either failed to introduce the role to the workforce at large, prior to inception or underestimated the degree of inter-professional support that was required by newly endorsed nurse practitioners. This validated the premise of Parse (1995) in relation to failing to facilitate a nurse

practitioner's sense of potential for being (restriction) offering little potential for self development through integration with colleagues. This in turn also meant that participants felt undervalued. This had potential for burnout and high attrition rates amongst these practitioners. These comments were validated by the RCNA (May 2010) who reported that perceptions about what the role of a nurse practitioner actually entails is poorly understood. This same poor perception of the nurse practitioner role was reported in findings from each of the five countries involved in this study. In addition to lack of interest from senior colleagues about nurse practitioners' development, progress and even lack of interest in gaining further insight in this regard was identified not only by participants in the study but also within historical evidence from all countries (Gardner 2004; CNA 2005; Ball 2006; Phillips 2008; Stokowski 2010). This suggested that despite activists' awareness of global needs involved in nurse practitioner support nothing has been done over the last 46 years to address this important key issue.

Working alone or in isolation was not always viewed by participants in this study as a disadvantage. While it meant that their potential for being as a team player was limited, this was recognised as being part and parcel of their clinical expertise that at times removed them from a nursing team within a clinical area to which they felt they belonged. The Parse (1995) Theory provides much insight into the potential being for the nurse practitioner especially in key areas such as enabling-limiting within the restriction-freedom paradigm and aspects of these factors was identified by all participants. While each participant reported that while this increased their isolation from the nursing workforce and was sometimes restrictive in gaining

sufficient acceptance, it also meant that they could automatically receive referred patients within their respective specialties and hence become more autonomous in their role at the same time. This was perceived as a major positive outcome for their 'becoming'.

Lack of job security for respondents and their ongoing need to justify their positions through the course of the intern year was identified as a restriction for their becoming. Two participants felt that because they were already single practitioners and sole referral agents in their specialty, that it was unfair to ask them to justify their position as a nurse practitioner, as the current role already provided a service unique to the organisation.

The above issues are worrying and suggested that within the clinical practice framework that nurse practitioners and interns are 'being left to get on with it' with little or no local support. This conflicts with other researchers' comments (Chiarella & McInnes 2008). Chiarella and McInnes (2008) adduced that every health district needs to support its workforce, regardless of role or grade, in order to facilitate best job performance under optimum conditions, in order to gain the best patient outcomes and maintain staff retention (Chiarella & McInnes 2008). Preceptors, mentors and service managers have a significant role to play in this development but are perceived by participants' to demonstrate lack of awareness of the nurse practitioner role. The fact that participants in this study were striving to succeed in poorly supported clinical practice provides further ongoing examples of both intra and inter-professional downward closure.

6.1.2 The Endorsement Journey

The endorsement journey was not without issues in terms of support of nurse practitioners by regulators, medical staff, pharmacists, pathology laboratories and employers. Problems with the interpretation of endorsement regulatory requirements with no obvious assistance in the form of guidelines from regulators and no mentor or preceptor during the endorsement journey meant that both endorsed nurse practitioners and interns felt disempowered.

The potential for being of some participants was extremely limited because the employer was completely separated from the employee leaving participants' unable to transcend with the possibles without the support of the employer. Some participants had to do the first year of study in their own time with no study leave support from employers. This invaded their family life and at times became restrictive. This concurred with findings of Gardner and Gardner (2005) who stated that during the course of their research they experienced similar problems in that the researchers had to facilitate support for nurse practitioner endeavours from the employers and from doctors acting as preceptors prior to commencing their study. It appears that there was conflicting understanding in terms of some of the aspects of preparations for nurse practitioner endorsement. One participant in this study reported that the university requirements in the pharmacology component of the degree course did not reflect what the requirements were within the nurse practitioner competencies of the ANMC competency standards, pharmacology regulations or state regulations. While recognising that institutions are able to undertake independent curricula, planning for the courses should enable universities

to implement similar benchmarks of good practice, concerning an area of such importance as pharmacology especially when considering comments by Dunn (2008) who asserted that every nurse practitioner was a novice prescriber. While this was restrictive with poor enabling-limiting and originating potential, it now opened up other aspects involving expertise in prescribing registered nurses must gain before freedom can be achieved. This in turn supported the conclusions of Gardner and Gardner (2005) who suggested that less reliance was placed on mentors by nurse practitioner candidates as experience and confidence grew (suggestive of enhanced enactment of freedom).

A theory of liability as a viable option for portfolio purposes needs to be considered in relation to the legal responsibilities and accountability for each candidate. General content of such a statement of liability could include a job description, a person specification (a document that describes the personal attributes for a position), for the post held at the time, the scope of practice and written evidence to assure assessors that the candidate is able to articulate all legal responsibilities and accountability tenets within the scope of their specific context of practice. Evidence could also include where expert support could come from should an adverse event arise during the course of daily nursing practice. This could become a process of self regulation showing understanding and application of legal aspects of practice.

6.1.3. Positive Outcomes of Field Research

Leadership capability as demonstrated by individual endeavours for service improvements in patient care delivery was demonstrated by all participants. None of these participants had access to PBS and MBS and yet they were able to achieve

these positive outcomes which were suggestive of the unrealised movement into the Parse/Strong model as a result of role demands.

6.1.4. Participants' Ability to Articulate Legal Principles of the Practice as Clinical Experts.

Given that nurse practitioner candidates completing their university course are considered clinical experts (Gardner 2004), legal knowledge was limited on the part of interns. Responses to the research question: 'What do nurse practitioners believe to be the most important legal issues relevant to their clinical practice?' that while some participants showed an expected level of understanding and were able to enunciate their responsibilities and accountability, others were mostly unable to enunciate their responsibilities and accountability to the same extent. While they showed some awareness of aspects of legislation, they could not articulate the relevance of these to their own clinical practice. Such participants included two nurse practitioner interns. It is hoped that this situation improved on endorsement.

6.2 The Synergy between the Strong Model and the Parse Human Becoming Theory

Results from this study were mixed. Historical-comparative analysis of five countries across the last forty-six years revealed that framing the nurse practitioner role firmly within the provisions of the Strong Model of Advanced Nursing practice (2004) (while remaining rooted in the Human Becoming Theory (Parse 1995) could become advantageous to nurse practitioners and strengthen their domain of practice within Australia. Using this as a platform for development would provide more solid evidence that nurse practitioners are highly educated individuals capable of autonomous clinical practice as expert clinicians working within a nursing ethos in holistic patient care. It would challenge any claim that nurse practitioners were poorly trained or incapable of undertaking expanded practice initiatives such as prescribing and ordering and interpreting diagnostic tests.

Within the Strong Model (2004), professional advancement is achieved through the combined influence of evidence-based practice, nursing practice development, organisational support and patient and family interaction in clinical settings that promote both individual and group expertise (Mick & Ackerman 2006).Within the Human Becoming Theory (Parse 1995) the interactions are dynamic and interactive between the organisation, the patient, the family and the nurse practitioner.

The work of Benner (1984) as incorporated into the Strong Model of Advanced Nursing Practice has its roots in Heideggerian phenomenology as does the Strong (2004) model and the Human Becoming Theory (Parse 1995). Therefore it provides a useful bridge for enhancing the synergy between the two models of practice.

6.2.1 The Strong Model of Advanced Nursing Practice

As stated in Chapter 2, the theoretical basis for the Strong Model (2004) and the Parse (1995) model is similar being guided by the work of Heidegger (see above). However, the structure of the Strong (2004) model is somewhat different to that of the Strong Nursing Practice Model (2007) in that it contains specific domains of practice using systems thinking (Mick & Ackermann 2006).

While the Strong Model (2004) and the Parse Theory (1995) are dynamic in their own right and while each is capable of standing alone, when they are merged into a combined model which removes some of the restricting elements for the nurse practitioner a synergistic, a dynamic model of practice emerges. Findings from this current study suggested that nurse practitioners within Australia already informally align their practice ethos to the Strong Model (2004).

The Strong Model (2004) and the Parse Theory (1995) intertwine and the new model could be suitable to the achievement of personal goals by advanced practice nurses and nurse practitioners alike. The fulfilment of each domain will be varied based on contexts of practice and individual educational goals as well as in response to the care priorities of the population. The domains are not mutually exclusive but are layered and overlapping and intertwining as some aspects of practice may fall within more than one domain.

The additional conceptual strands of scholarship, collaboration and empowerment describe the attributes of practice, the approach to care and the professional attitude to practice that must be demonstrated by nurse practitioners in their clinical practice.

These strands become circular and unifying threads that develop the domains of nursing practice. These would articulate the results of the restriction-freedom paradoxes as articulated by Mitchell (1995 in Parse 1995, p. 163). The influence of each domain can become apparent to include both direct and indirect care activities. A high standard of holistic nursing care coupled with the monitoring of these standards has a focus within every domain described. This endeavour includes direct patient care, support of systems, education, research, publication through audit research and nursing leadership. These are achieved by identifying problems while providing and evaluating action plans to address problems in daily clinical practice (Mick & Ackerman 2006).

By delivering patient focussed direct care, the novice nurse practitioner utilises scholarship, education and evidence based practice and thus becomes empowered (gains freedom) to contribute towards support systems, collaboration, publication and nursing leadership. As this is patient focused it is firmly grounded within a nursing ethos far removed from adherence to any medical control in care delivery.

6.2.2 Suggested New Model for Nurse Practitioner Practice in Australia

The notion of vertically superimposing the Parse Human Becoming Theory onto the Strong Model of Advanced Nursing Practice is proposed as a means for enrichment of the domain of direct patient care by nurse practitioners. The domains of education, scholarship, support of systems and nursing leadership must be integral to this development by learning about the Parse Theory (education), understanding the Parse Theory (scholarship), helping other team members to do likewise (via support of systems) and nursing leadership and through role modelling for colleagues. To

superimpose the Parse Theory in this way changes the focus used in this study. This study used the participant-professional focus. In the proposed model the nurse-patient relationship is used to extend the focus because it presents not only a theoretical foundation for the practitioner-profession relationship but also a working framework for the nurse practitioner. It enhances the profession-nurse-patient model rather than the historical journey of nurse practitioners as was the principal focus in this study.

At a postgraduate level, a nurse practitioner would need to develop an understanding of both the Strong Model (2004) and the Parse (1995) Theory in order to fully appreciate and develop the intricacies of the nurse practitioner role. When this study first began the researcher concentrated on the Parse (1995) Theory as it applied to nurse practitioners and their place within the universe of nursing, As the study progressed it became clearly evident that synergising the Parse (1995) Theory with the Strong Model of Advanced Nursing Practice (2004) could provide a further example of how a more robust practice model could be developed for the nurse practitioner.

6.2.3. The Model

a) The Strong Model: The Patient-focused activities within this model combine comfortably with all aspects of both models as follows:-

Parse Principle 1: "Structuring meaning multi-dimensionally, creating reality through valuing and imaging" Parse (1995). The nurse is present as the patient and family relates the meaning of their situation through the explicating of what is. In

telling about the meaning persons share thoughts and feelings with each other about illness and wellness, which in itself changes the meaning of a situation by making it more explicit. There is better understanding of the situation and the patient is able to be supported through family involvement, with the family having understanding about the situation. Care planning and intervention is family centred (Parse 1995, p.6). For the nurse practitioner it provides an opportunity for nurse practitioners to work in a partnership between the employing agency, the nurse practitioner, the patient and the family, sharing their thoughts feelings and ideas within a partnership and not set apart from each other.

b) The Strong Model: Includes assessment, procedures and interpretation of nursing and diagnostic data, combines with:-

Parse Principle 2: "Co-creating rhythmical patterns of relating is living paradoxical unity of revealing-concealing and enabling-limiting, while connecting-separating" (Parse 1995). Humans live in rhythm with the universe, co-constituting patterns of relating. The patterns are paradoxical in nature, apparent opposites, but dimensions of one phenomenon. A person (e.g. the patient) reveals and conceals all-at-once the person that one is and is becoming. But one cannot reveal the all of who one is meaning that this co-creating is the mutual process humans live within in their universe. One is limited and enabled by all choices in that with each choice there are an infinite number of opportunities and limitations. No choice is without both. In moving together and apart all-at-once, one connects and separates with the universe in the rhythmical flow of co-creation. This co-creating is the mutual process humans live within in the universe. In practice for the nurse practitioner, the information

gained by a nurse from the patient will be limited to that which the patient chooses to conceal or reveal (Parse 1995, p.7).

When a nurse practitioner first interacts with a patient both the patient and the nurse begin a journey of discovery, the paradox being that by concealing and revealing all-at-once, neither nurse nor patient will be able to discern all that a person is, or is becoming. This is a natural phenomenon when people interact with each other within the universe. However, the dialogue through enabling-limiting will develop into a plan of choices for the patient during the journey toward good health, and the nurse, through enabling-limiting, will be able to devise a suitable care plan. The nurse will also be able to present treatment choices, offering both opportunities (to get well) and limitations of wellness (e.g. chronic disease, such as diabetes, shifting from a process of limitation of being ill to an opportunity for wellness, through monitoring and control of diabetes). The relevance of this from application of concepts of assessment, interpretation and diagnostics is that it ensures best and safest practice from within the Strong Model by an expert practitioner.

c) The Strong Model: Patient Counselling and patient education combines with:-

Parse Principle 3: "Co-transcending with the possibles is powering unique ways of originating in the process of transforming" (Parse 1995). As a result of close communication and understanding, the nurse practitioner and patient, together, forge unique paths with shifting perspectives as a different light is cast on the familiar (the health journey). The energising force of forging ahead / holding back enlivens ebb and flow of life as one lives conformity / non-conformity, certainty and uncertainty in moving the unfamiliar to the familiar. Humans seek to be unique and yet like

others all-at-once, as they live the inevitable ambiguity of creating different ways of becoming in transforming, both in patient care and patient outcomes (Parse 1995, When a nurse interacts with the patient via patient education and counselling they reveal a path of enlightenment for the patient, in terms of transforming from one who is ill to one who is well. The patient is able to move from the unfamiliar to the familiar and an energising force exists in conformity or not with the treatment choice that will enhance wellness (as determined by them). Each plan of care, guided by the Parse Theory is unique, even if this plan does not conform to the recommended treatment course. The nurse is never judgemental but as a result of the received knowledge of best practice guidelines, true respect for and presence with the patient, lives the experience with the patient throughout the health journey and, through patient advocacy, education and counselling as appropriate at various stages. During this journey the nurse is in 'true presence' with the patient, as they journey from beginning to the end of the health care episode and beyond, if follow up by the nurse practitioner is a feature of care.

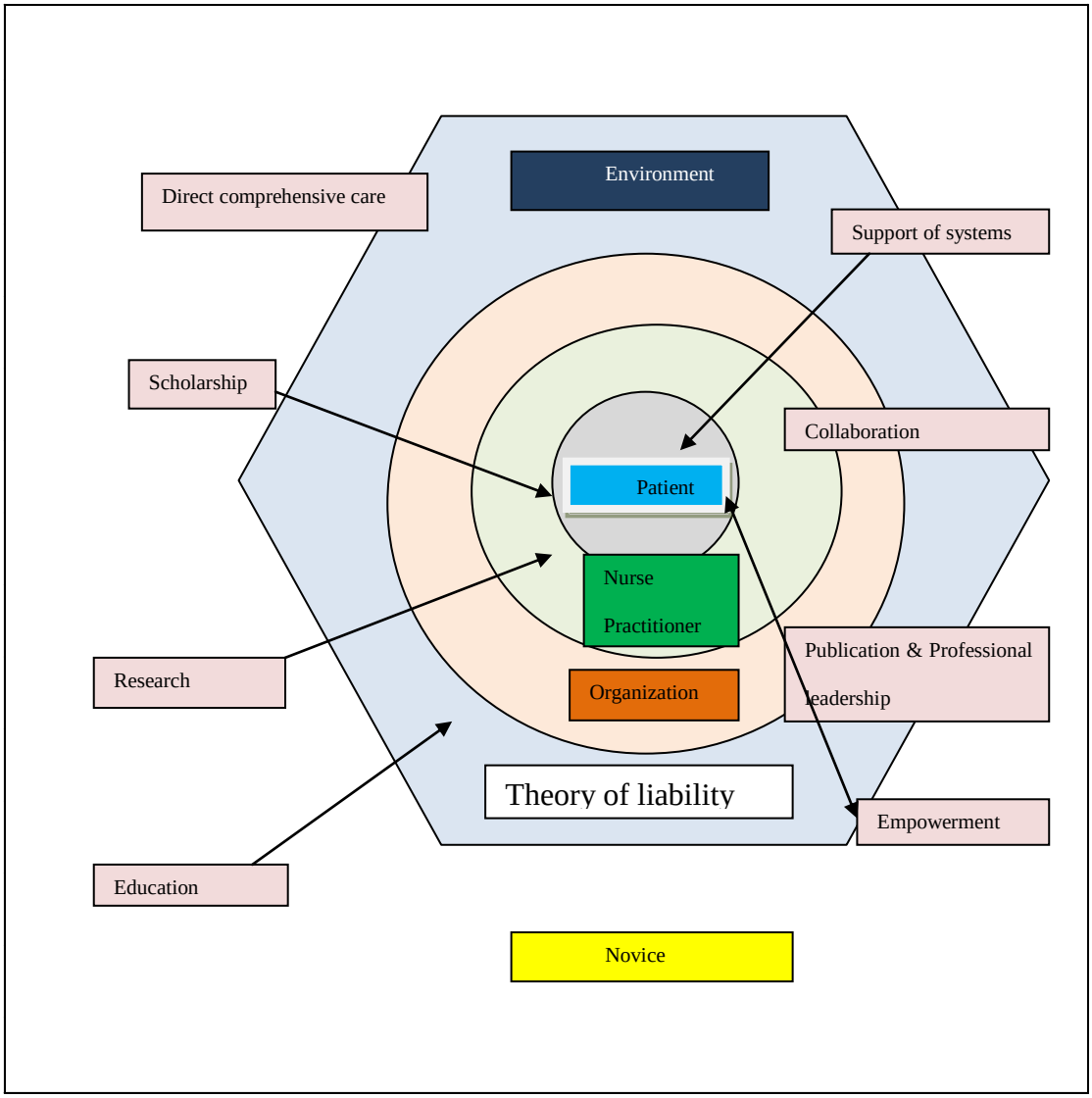
When a nurse practitioner sits in 'true presence' with a patient (Parse 1995, p.81-82) the risks of litigation become lessened because the partnership is close and both patient and nurse work as a team (because nurse practitioners often work as sole referral agents).

Research is a feature of both the Strong (2004) model and the Parse (1995) Theory. There are several ways in which the Parse Theory (1995) might be applied to the new model (e.g. Mitchell 1995; Daly 1995 & Cody1995 in Parse 1995). Research is an integral part of the leadership role of the nurse practitioner and in the new,

synergistic model is placed between the concepts of multidimensionality and becoming. As such it is woven throughout all levels and aspects of the model. It represents the ultimate opportunity for the nurse practitioner, to own their clinical practice and develop the nursing profession. At the same time the nurse practitioner is able to establish best practice within their own speciality while mentoring and developing the practice of others around them.

Table 4 illustrates the juxtapositioning of the Strong Model and the Parse (1995) Human Becoming Theory to create the new Cleeton, synergistic model (2010).

Table 4 The Cleeton synergistic model of nurse practitioner practice



The synergy between the Strong (2004) Model of Advanced Nursing Practice with the Parse (1995) Theory does not address legal issues (a theory of liability) in nurse practitioner practice. While some of the discourse for this study reflected the endorsement journey for the nurse practitioner, the model is designed to build on that journey in preparation and support of the daily practice of the nurse practitioner post endorsement. It provides a structure for the novice and experienced nurse practitioner to

enhance their autonomy using a model that encompasses system thinking in all aspects of nurse practitioner practice within the five domains of the Strong (2004) model. The domain of direct patient care is enriched by adding the three principles of the Parse (1995) Theory. As the theory of liability encircles all aspects of nurse practitioner practice and context, the Cleeton synergistic model of practice would provide a more holistic approach to enhance, enable and support the professional autonomy of the nurse practitioner.

6.3. The Professional bearing of the Nurse Practitioner

Field research in this study has shown that employers provide little or no support when nurse practitioners are newly registered. The use of the Cleeton model would be especially useful to the novice nurse practitioner. Use of this model partly answers the research question from the practice perspective in enhancing autonomy because it provides a systematic means to do this. The model is patient centred yet the scholarly activities of the Strong Model (2004) are interwoven within the circle of direct patient care and the principles of the Parse (1995) Human Becoming Theory. These activities include research, education publication and professional leadership. These functions are intertwined with empowerment and collaboration as a two dimensional circular model that can facilitate movement between domains and develop expert practice systematically.

The government and the medical fraternity within Australia require a Collaborative Care Agreement within the 2009 Health Amendment Bill (Nurse Practitioners and Midwives) in addition to other evidence that proves nurse practitioner competence. This emphatically shows evidence of continuing inter-professional downward closure.

Some of the participants in this study were subject to intra-professional downward closure by their employers showing lack of interest in what they do and demanding that they justify their position within a healthcare organisation. Legal issues included lack of knowledge about law on the part of some participants, the inability to cite relevant legislation by other participants and confusion identified by one participant when attempting to decipher with colleagues what is actually law and what is local policy or rules. Legal training within all nurse practitioner preparation courses within Australia needs to be consistent in application as in the USA, with mandatory levels of required legal knowledge being included within curricula.

6.4. The Research Questions

The research questions explored in this study were:-

1. To what extent did nurse practitioner development, educational requirements and legal and professional issues differ historically between five countries?

2. What do nurse practitioners believe to be the most important legal and professional aspects of the practice?

3. What is the most appropriate approach to further enhance the professional autonomy of nurse practitioners in Australia?

6.5. The Thesis Statement

The thesis statement for this study is that the Federal and State governments have limited the freedom of nurse practitioners in Australia as nurse practitioners in other countries are limited. This has occurred in tandem with the nursing profession in

Australia which has succeeded in hampering the development and full implementation of the nurse practitioner role by restricting legitimate freedoms (e.g. the need to use compulsory clinical practice guidelines and protocols for every aspect of expanded practice). This form of intra-professional downward closure (Yuginovich 2009) arises concurrently with the inter-professional downward closure demonstrated by the medical profession by their lack of support for implementation of the nurse practitioner role.

Adherence to clinical practice guidelines and protocols means there is the ethical problem of deliberately increasing the risk of litigation and consequent liability if a shift away from these strict parameters occurs. An ethical problem today can become a legal problem tomorrow. The risk of further liability could be reduced if the following were addressed in future nurse practitioner development initiatives:

a) As Dunn (2008) asserted, all newly endorsed nurse practitioners are novice prescribers and a less stringent approach is not possible where large pockets of novice nurse prescribers exist until a programme such as Dunn's is completed by registered nurse practitioners to enable them to transcend to the expert role of the nurse practitioner.

b) Documentary evidence is required in portfolio evidence provided by all nurse practitioner interns and endorsed nurse practitioners that they understand the implications of the Ipp reforms that were enacted into civil liability legislation in 2003. They should document within this evidence that they are cognizant with all elements of alleged negligence.

c) All endorsed nurse practitioners and candidates in Australia need to provide documented portfolio evidence demonstrating competence in regards to the law in terms of alleged negligence, both civil and criminal negligence. They should be able to explain the four elements of proof of alleged negligence in relation to a more autonomous and more advanced nurse practitioner role. All registered nurse practitioners and candidates in Australia need to be cognizant with other relevant Torts (e.g. battery, trespass) and be able to show understanding of their liability risks by written portfolio evidence.

d) All registered nurse practitioners and candidates in Australia should provide written portfolio evidence that they can develop and articulate their individual legal obligations and responsibilities alongside the defences if litigation should arise, as applied to their individual context of practice.

This study does not propose the reduction of legal requirements and lessening the emphasis of the use of clinical practice guidelines and protocols, as enunciated by the RCNA (2006). Even if stakeholders were in full agreement to lessen stringent adherence to clinical practice guidelines and protocols in Australia there remains the greater risk of liability in litigation for the nurse practitioner if regulations become less stringent. The nurse practitioner role in Australia may be far too new to undertake any flexibility in lessening the foundations of clinical practice guidelines and protocols at this time.

e) Endorsed nurse practitioners should have the benefit of a model such as the Cleeton synergistic model of Practice to enhance their development within the role

and reduce their restriction within the restriction-freedom paradigm as it currently relates to their practice.

6.6. Further Research

The approach suggested by Pearson et al. (2007) is possibly the only means for enhancing the autonomy of the nurse practitioners by developing competency standards for every context of practice. This means developing speciality competency standards rather than generic competency standards, which means that further work would be required by the Australian College of Nurse Practitioners and the National; Health Practitioners Registration Authority. This would make the framework for nurse practitioner development more robust as it would mean movement away from generic competency standards into speciality competency standards applicable to specific scopes of practice.

The 'collaborative care agreement' as demanded within the Health Amendment Bill (Nurse Practitioners and Midwives) 2009 needs refining to ensure that 'collaboration' means collaboration and not interference. This would prevent any further evidence of intra-professional downward closure (Yuginovich 2009).

Movements within the socio-political issues within the UK surrounding regulation and registration legislative provision will depend on initiatives that will be taken by the new government.

6.7. Recommendations

Analysis of the findings from this study has led to the following recommendations as a way forward to support and enhance the practice of Australian nurse practitioners.

1) The proposed Cleeton synergistic model which incorporates a theory of liability should be adopted as a framework for nurse practitioner master's degree preparation for nurse practitioner registration and endorsement.

2) The curricula for all nurse practitioner master's degree courses should include distinct mandatory studies on Law and Legal Issues within the curriculum at every university within Australia offering master's degree courses for nurse practitioners.

3) All newly endorsed nurse practitioners should have a mentor allocated to assist them with initial workplace assimilation post endorsement. This would assist with problem solving and the avoidance of isolation. This would reduce their vulnerability as they seek to consolidate their position within the health service.

4) In fulfilment of the Ipp reforms (2003) a register of experts able to defend nurse practitioners in negligence claims should be drawn up and held by all indemnity insurers concerned with the nurse practitioner in order to ensure that evidence presented to a judge is logically defensible. All experts should ideally have direct experience of the work of a nurse practitioner, especially where the defendant nurse practitioner works within a unique scope of practice, in order for one nurse practitioner to provide expert opinion on the work of another nurse practitioner in cases of alleged negligence.

5) Developing joint appointments of nurse practitioner/academics in order to narrow the practice-research-education gap and lead to the development of visible expert clinical practice in nursing.

6)A more proactive approach should be undertaken by nursing leaders in clearly articulating the differences between the roles of nurse practitioner, advanced nursing practice and the physician's/surgeon's assistant in order to more appropriately utilise these roles and avoid conflicts when establishing posts for these disciplines.

7) Support should be provided for all endorsed nurse practitioners so that they are able to apply the findings the Pearson et al. (2007) study and develop an approach toward competency standards relevant to their own context and scope of practice within a specialty area.

8) Awareness programs should be provided throughout Australia to inform non-nursing researchers, doctors, academics, employers, politicians, other health care professionals and the public about value and validity of the role of the nurse practitioner, what the role has achieved and what the role could achieve in the future.

6.8. Conclusion

In Australia unlike other countries, a consistent approach to the implementation of the nurse practitioner role and prescribing rights has been adopted providing a safer practice context. The expanded role of any nurse practitioner is yet to be tested under Australian civil liability legislation in negligence or other torts, but each nurse practitioner needs to be cognizant of the defences in negligence applicable to the scope of practice and where expert defence opinion is likely to come from.

Whether or not the nurse practitioner movement in Australia gains further momentum will depend on key stakeholders, academia, governments, employers and regulators fully embracing the role of the nurse practitioner and ensuring the full potential of the role is realised. This is not a reality at the present time as demonstrated by this study. This needs to be undertaken as soon as possible. Though this study has provided some answers to key research questions there is scope for further study in nurse practitioner development, to further establish one of the most important and dynamic roles in nursing that has emerged in recent times within Australia.

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APPENDIX A

A List of Australian Universities offering Nurse Practitioner courses with distinct studies pertaining to legal/ethical issues within the curriculum

Source: http://www.australian-universities.com/list/ Accessed 1 May 2010.

All courses identified are at master's level.

Of 16 universities examined 11 offer ethics and law as distinct units of curriculum. These were clearly identified in course content web pages. Where there were no distinct units identified in course content web pages by the universities concerned, this is stated.

1. Charles Darwin University: No

No distinct elective units offered in ethics or law

2. Curtin University: Yes

Nurse practitioner course offering legal implications of nurse practitioner role as distinct unit

3. Deakin University: Yes

Ethics and law offered as distinct units of curriculum

4. Edith Cowan: No

No distinct or elective units offered in ethics or law

5. Flinders University: Yes

Ethics and law offered as distinct units of curriculum

6. James Cook University: Yes

Ethics and law offered as distinct units of curriculum

7. La Trobe: No

No distinct or elective units offered in ethics or law. Legal text only in reading list

8. Queensland University of Technology: No

No distinct or elective units offered in ethics or law

9. University of Adelaide: Yes

Ethics and law offered as distinct units of curriculum

10. University of Newcastle: Yes

Ethics and law offered as distinct units of curriculum

11. University of Queensland: No

No distinct or elective units offered in ethics or law

12. University of South Australia: No

Nurse practitioner course not offered in 2010

13. University of Sydney: Yes

Ethics and law offered as distinct units of curriculum

14. University of Tasmania: No

Nurse practitioner course not offered in 2010

15. University of Technology Sydney: Yes

Ethics and law offered as distinct units of curriculum

16. University of Western Sydney: Yes

Nurse practitioner course in mental health only. Ethics and law offered as distinct units of curriculum