A HISTORY OF THE EARLY DEVELOPMENT OF THE NURSE PRACTITIONER ROLE IN NEW SOUTH WALES, AUSTRALIA

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Certificate of Authorship and Originality

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information and literature used are indicated in this thesis.

Signature of Candidate

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Glossary

Advanced practice refers to a level of practice that utilises extended and expanded skills, experience and knowledge in assessment, diagnosis, planning, implementation and evaluation of the care required (Royal College of Nursing, Australia, 2006).

Clinical nurse consultants are specialist nurses who fulfil a cross-hospital or cross-area or regional role, and who are principally involved in clinical consultancy, review, assessment and research.

Clinical nurse specialists are nurses who function as resource personnel and sources of expert nursing knowledge within their unit and speciality.

Innovative role is a non-traditional role or one taking responsibility for aspects of care previously provided by another group of health professionals such as doctors.

Local agreed need is seen as an essential step prior to developing a service including nurse practitioners.

Nurse practitioners are registered nurses educated to function autonomously and collaboratively in an advanced and extended clinical role. The NP role includes assessment and management of clients using nursing knowledge and skills, and may include but is not limited to the direct referral of patients to other health professionals, prescribing medications and ordering diagnostic investigations.

Practice nurses are registered nurses or enrolled nurses who are employed by, or whose services are otherwise retained by, a general medical practice (known as general practice).

Primary care refers to a span or an assembly of first-contact health care services directly accessible to the public.

Acronyms

Australian College of Nurse Practitioners (ACNPs)

Area health service (AHS)

Clinical nurse consultant (CNC)

Clinical nurse specialist (CNS)

Director of nursing (DON)

General practitioner (GP)

Key stakeholder (KS)

Medicare benefits scheme (MBS)

Nurse practitioner (NP)

Nurses Registration Board of NSW (NRB)

Pharmaceutical benefits scheme (PBS)

Practice incentives program (PIP)

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Abstract

Changes in the health care environment have required concomitant changes in approaches to health care, and the roles and functions of health care professionals worldwide. The nurse practitioner (NP) role was first introduced in the United States of America (US) in the 1960s to help address critical health care needs that were designed to improve access to health services. The NP role has continued to evolve in the US and other countries including Canada and the United Kingdom (UK) across a range of health care settings.

In Australia, New South Wales (NSW) was the first state to consider the potential for the NP role in 1990 (NSW Department of Health, 1992). The purpose of this research was to trace and document the early development and implementation of the NP role in NSW.

This study adds to the nursing literature by documenting historical events in the inception of the NP role, particularly factors that affected the development and its implementation of the NP role in the NSW health care system. In addition the study preserves the oral histories of figures who were instrumental in the introduction of this new clinical career pathway for nurses, and a new model of care into the Australian health care system. This thesis constitutes original historical research into the development of the NP role in NSW. An historical, descriptive design was used that included recorded interviews with 10 pioneer nurse practitioners and 17 key stakeholders involved in the development of the NP role. Documents were collected that were central to the key historical events, and these documentary accounts were compared and contrasted with the information provided through the interviews. The data was analysed using qualitative thematic analysis.

The development of the NP role began at a nursing conference in 1990 because a nurse asked the NSW Health Minister whether he supported the NP role. This one question triggered a cascade of events. Between 1990 and 1998 the NP role was legislated and the title of the NP protected through the *Nurses Amendment (Nurse Practitioners) Act 1998* (NSW). During this time four committees were formed, four reports had been generated and 10 pilot projects undertaken. In 1997, the NSW Minister for Health established an implementation process for NP authorisation, education and regulation. On May 11, 2001 the NSW Minister for Health announced the first NP to be appointed into a position in remote NSW and in September 2002, NPs were introduced into metropolitan areas of NSW.

Disparate visions and vested interests in relation to the NP role inevitably affected the development of the role and the way it was enacted. Stakeholders who had a 'sense of gain' and supported the NP role saw its benefits for the health care system, and for nursing. Those who fought to maintain the status quo were ultimately driven by a sense of 'loss and fear.' There was considerable fear about the effect of the NP role on the roles of other health care professionals. There was much interplay between those trying to maintain the status quo and those who were trying to counterbalance the sense of loss and fear. The development and implementation of the NP role became an arduous process of negotiation and compromise.

Further complexities arose in understanding tradition's historical legacy on the NP role. The findings illuminated that some doctors were not only resistant to the NP role but had not adapted to the professional status of nursing. Similarly, the findings indicate that there are still many nurses who have not adapted to the advancement of nursing. As a consequence, they also hanker for the supposedly good old days, and strongly opposed new developments such as the introduction of NPs.

The findings attest to significant disruption to professional-working relationships with some health care professionals torn between their personal, professional and organisational commitments. Long-term professional relationships between the NPs, nurses, doctors and managers were challenged.

The study's findings demonstrate the need to assess an organisation's readiness when introducing a new nursing role and an assessment of the environmental conditions to support role implementation.

The findings also revealed the importance and influence of language in introducing a new nursing role such as that of the NP. There was confusion surrounding the use of certain terms (e.g., advanced practice) within and beyond nursing.

The NPs found the authorisation process particularly challenging. The findings show that, with any newly introduced process, there needs to be detailed guidance and an assessment that candidates are able to meet the requirements set by the regulatory body.

Only because of the resilience and perseverance of the nurse leaders, the NPs and others who supported the role, has the NP movement been able to gain momentum. One of the principal

findings of this study has been the political maturation of the nurse leaders during the development of the NP role that, in turn, has benefited nursing.

There was considerable resistance to the NP role by some powerful medical organisations and the findings show that it is important to engage the media and educate the public about the NP role and its value, to help garner support early on in the development of the role. In addition, because of the political nature of the role, NPs require education in using and managing the media and also education about managing themselves in the politics of health care. All of these findings are discussed in detail in this thesis.

Chapter 1 – Introduction

This descriptive historical study examines the early development of the NP role in New South Wales. This chapter begins with an outline of the study including a brief background, the purpose and the study design. I disclose aspects of my journey in undertaking this thesis including my own philosophical underpinnings. The chapter concludes with a discussion on the organisation of this thesis.

1.1 Background to the study

The New South Wales (NSW) health care system is increasingly under pressure with limited resources to deliver high quality services (Williams, Chamboyer, & Patterson, 2000) because of problems associated with population ageing, and more complex and chronic conditions (NSW Department of Health, 2009). In Australia (specifically for this study in NSW), the combination of geography and population presents particular problems for the health care system. The health of Australians in rural and remote areas is generally worse than for those living in major cities (Australian Institute of Health and Welfare, 2006).

There are multiple workforce issues on the political agenda, such as the ageing of the nursing and medical workforce (Garling, 2008). There is a shortage of GPs in rural and remote areas (Department of Ageing, 2008). In contrast, the nursing workforce is more evenly spread (Australian Institute of Health & Ageing, 2008a). The NSW Government's attention has turned to a number of workforce strategies to address these problems, including augmenting and using the existing workforce. Because of nurses' increasing body of knowledge in different specialties and multiple levels of nursing practice (Commonwealth of Australia, 2002b) there has been increased demand for nurses to practise in more advanced roles with greater autonomy (NSW Department of Health, 2008). In addition, nurses have indicated that an inadequate clinical career structure is one of the main reasons why they leave the profession (Appel & Malcolm, 1999, 2002; Driscoll, Worrall-Carter, O'Reilly, & Stewart, 2005; Harris & Chaboyer, 2002; NSW Department of Health, 1996; Turner, 2001).

While nurses, especially those working in rural or remote areas in Australia, had been working in *de facto* NP roles and had begun to describe themselves as NPs, there were no formal structures for their education, registration or regulation when the discussion regarding NP roles in NSW began (Adrian & O'Connell, 2000). New South Wales was the first

Australian state to develop and recognise the NP role through statutory and regulatory provisions (NSW Department of Health, 2008). The visions for the NP role were to provide a clinical nursing career stream for nurses who were uninterested in moving into education or management positions (Australian Nursing Federation, 1998) and to help address some of the challenges facing health care in NSW (NSW Department of Health, 2008).

1.2 Purpose of the study

The paucity of research related to the introduction of the NP role in Australia indicated a pressing need to document the early history of the role's development. This research creates a better understanding of this milestone in Australian nursing by describing, documenting, analysing and exploring the development of the role in NSW, the first state to introduce NPs in Australia. Importantly too, this research preserves the oral histories of the pioneer NPs and stakeholders intimately involved in the development of the role.

1.3 Method summary

Descriptive historical research underpins this project. Data were obtained through document collection and minimally structured interviews. A purposive sample of 10 nurses who were among the first NPs (pioneers) to be authorised in NSW, and a purposive and snowball sample of 17 stakeholders involved in the development of the NP role were recruited for this study. Data were collected for two related reasons: first, to identify and record the chronology of key events in the early development of the NP role in NSW; and second, to gain detailed understanding of the influence of the political, social, economic and cultural context that shaped its development and implementation. Historical research allowed exploration of why certain decisions were made, the conditions under which they were made, and their influence during the early development and implementation of the role. Historical projects create "knowledge that would otherwise not exist: building a library for the future" (Grele, 1991, p. 2). Knowledge of the origins of advanced practice nursing in Australia should guide current and future strategies both for the NP role and other nursing developments.

Data were analysed using thematic coding that is a widely used and accepted approach in qualitative research, and more specifically, historical qualitative research (King, 1998).

This research set out to answer the follow questions:

1.3.1 Research questions

- What were the key historical events that shaped the NP role in NSW?
- What were the experiences of the nurse practitioners during the early years after the inception of the NP role?
- What were the experiences of the key stakeholders during the formative years of the NP role?
- What were the social, political, cultural and economic factors that influenced the introduction of the NP role into the NSW health care system?

The historical research component also:

- Provides direction for the ongoing development of the NP role in Australia by enabling policy makers to learn from past mistakes and successes;
- Provides insight and direction for the development of future nursing roles.

1.4 The researcher

My PhD journey began with motivation, excitement and, I have to admit, naivety. I had decided that, because my previous research experience used the quantitative paradigm, I was keen to gain experience in qualitative research, and thus chose it for my doctoral studies. While it has been a huge learning curve for me, the experience has been immensely rewarding.

Having been a neonatal nurse for the past 20 or so years, and more recently, a neonatal researcher, I thought it would be a good idea to branch out and research another area of practice in nursing.

I had been interested in reflection and reflective practice in nursing, having used the topic for my master's degree. I had become involved in a project in which a group of nurses were undertaking an education program on reflective practice and clinical supervision over a period of a year. The research was supported by the organisation in which the nurses worked. However, for reasons separate to the research, the nurses declined to participate in the interviews and I understood and respected their decision. A colleague suggested that I

should focus on nurses who were not only passionate about their practice but who would also be motivated to be involved in a research project. It was during this conversation that NPs were first discussed. At that time I knew little about the NP role and nothing about the pioneer NPs. What I did assume (correctly) was that they would be passionate about the role, and willing and interested participants in the research. Aside from the policy documents relating to development of the role, there was almost no Australian literature about the role. It was when I started reading the large amount of overseas literature about the role that I wondered what I had gotten myself into.

Nevertheless, my interest and motivation was stimulated while I read about the struggles and triumphs of the NP movement. As a nurse who was hospital-trained in the mid-1970s, I am aware of the shortcomings of hospital training. The hierarchical structure of my training hospital tolerated no dissent, especially the questioning of the doctors' authority. Other nurses and I were often reminded to know our place and stay in it.

I have witnessed the positive changes that have occurred in nursing, such as the move into tertiary education. However, I also know that these advancements in nursing have met opposition within and without nursing. I still hear nurses, the public and the media calling for the return of hospital training because of their belief that the standard of care has since decreased.

During the late 1990s, adjunct nursing professors were introduced into the health care system in NSW to encourage and help clinical nurses be more involved and knowledgeable in research. At that time there was scepticism from some health professionals about this new academic nursing role. I remember hearing negative comments by some doctors about the introduction of nursing professors. However, I made an appointment with the newly appointed nursing professor in the organisation in which I worked. I was frustrated with the lack of clinical career path opportunities in which I could advance my nursing career, while becoming increasingly interested in research. Consequently, I was seconded as a research assistant and enrolled in a research degree, and so began my journey into academia and research. My professional life became and has continued to excite and fulfil. On reflection, had the NP role been available in NSW earlier, I may have considered becoming an NP.

On reading the overseas literature I began to view the NP role as a proverbial "breath of fresh air" for nursing, giving greater autonomy and recognition for nurses' work in addition to its utility for improved patient care. My respect for the overseas nurses who pioneered the

NP role grew as I read of their challenges and triumphs. I realised the importance of documenting the development of the NP role in NSW, and the experiences of the pioneer NPs and nurse leaders who were instrumental in making the role a reality. However, while undertaking the initial analysis of the data, I increasingly realised that I needed a principal supervisor who knew about the NP movement in NSW. This ultimately led to my transferring my doctoral studies to The University of Technology, Sydney, where my principal supervisor was then employed.

As stated above, I entered the research with little knowledge or emotional investment in relation to the NP movement in NSW. Over time I acknowledge becoming emotionally involved in the lives and struggles of the pioneer NPs, which no doubt influenced my questioning and early analysis of the data. Following a review with my supervisors of my original thematic analysis, I returned to the data and the remaining interviews with fresh ears and eyes.

The following section provides an overview of each the chapters within this thesis.

1.5 Organisation of this thesis

Because New South Wales was the first state to introduce the NP role in Australia, a decision was made to allow the data to 'speak for themselves' and as such an overarching theoretical or philosophical framework was not used. Sandelowski (2000), a prominent qualitative nurse researcher, has supported this approach, as she expressed concern that qualitative research has to be informed *a-priori* by a conceptual framework. She suggests that: "researchers conducting descriptive explorative studies are the least encumbered by pre-existing theoretical and philosophical commitments" (Sandelowski, 2000, p. 337) and argues that qualitative description is a method that researchers can "claim unashamedly without resorting to methodological acrobatics" (p. 335). This approach enabled me to analyse the data *de novo* and propose a range of relevant potential theoretical frameworks in the discussion section, according to the issues that arose.

Chapter 2 provides a comprehensive review of the literature relating to the NP role. This chapter begins by providing an historical account of the developments in relation to the NP role in the US, Canada and UK and proceeds towards an overview of the comparable developments in relation to the role in Australia. At the time of writing the literature review there was a dearth of literature relating to the role in Australia, and as such only an overview

of the development of the role is provided. (However, a detailed chronology of events for the first 15 years of the development of the NP role in NSW is provided in Chapter 4, while the discussion in Chapter 8 also examines more recent developments in the NP role in NSW and wider Australia).

Chapter 2 goes on to describe factors affecting the early development of the NP role in these countries followed by factors affecting its implementation in the US, Canada and UK. Next, the supporting research on the effectiveness of the NP role is presented. Understanding the historical developments of the NP role in the US, Canada and UK contexts provides important information and lessons that informed the development of the NP role in NSW.

An overview of the health care system in Australia generally and specifically in NSW is presented. This overview assists in understanding the structure of the health system, factors that influence its functioning, the need for changes to the health care workforce, in particular in nursing, that necessitated the NP role in NSW.

Chapter 3, the Method chapter, begins with an overview of the nature of historical research and, more specifically, its utility in exploring the development of the NP role. The remainder of Chapter 3 is devoted to the research design, ethical considerations, data collection methods, factors relating to the credibility of the data, and concludes by describing my analysis of the data. It is acknowledged that a limitation of this study is the low number of medical stakeholders who were interviewed for this study. Despite invitations being sent to seven medical stakeholders who were involved in the development of the NP role in NSW, only two consented to participate.

The subsequent four chapters cover the findings from this study. Chapter 4 documents the key historical events during the development of the NP role in NSW from 1990 to the end of 2005. This chapter has two purposes: firstly to order chronologically events that were important to the development of the NP role; and secondly, to contextualise the findings from the key stakeholder and NP interviews, and documentation, in the remaining three findings chapters.

Chapter 5 reports findings from the individual NP interviews, highlighting aspects of their pioneering role. Findings obtained from the stakeholder interviews relating to the NPs' pioneering role are presented.

Chapter 6, explores factors that affected people's perceptions, understanding, acceptance and response to the concept of advanced practice in nursing, and thus the NP role. The findings in this chapter are divided into three major themes.

Despite the NP role being underscored by the notion of it being an advanced practice role which is both collaborative and autonomous, the findings from this study reveal confusion and uncertainty about the meaning of advanced practice. In addition, there was considerable disparity between the perceptions of the nursing and medical stakeholders during the development of the role in relation to these the concepts of collaboration and autonomy. There was further dissonance between nursing and medical stakeholders regarding the independence of the NP. Finally, Chapter 6 explores how the historical fact that nursing was a female profession subservient to medicine has negatively affected the introduction of NPs into NSW. The findings show there are still those within and beyond nursing who have not adapted to the increasing professionalism of nursing. They especially resist the introduction of the NP role that recognises nurses' advanced practice and their ability to function more autonomously than before. Conversely, others have adapted to the changes in nursing by embracing the NP role but are nonetheless plagued by historical barriers to its transformation into a profession. These issues are explored and discussed.

Chapter 7 begins with the stakeholders' visions for the NP role. Because of the differing visions and vested interests of those involved in the development and implementation of the NP role, it became a process of negotiation and compromise, as described in the chapters' second section. Reasoning behind important decisions and compromises made during the early development of the role and their influence on the ongoing development and implementation of the NP role is discussed. Effective collaboration between doctors and nurses was seen as critical to the success of the NP role. While doctors espoused their support for collaboration with NPs, in reality many of them used their power to control and restrict the NPs' practice. The findings reveal disruption to existing relationships when the NPs moved into their new role. The introduction of the NP role also created dissonance for some stakeholders between their professional and organisational commitments. These issues are described in the third and final section of Chapter 7.

Chapter 8, the discussion chapter, sets out to position the lessons learnt from the first 15 years of the development of the NP role into the current political and policy debate in relation to NPs. In addition, it seeks to explore political and policy issues in general for the

betterment of nursing careers and the contribution of nurses to health care. I have grouped these lessons into three areas for the purpose of concluding this thesis while acknowledging that all three are related. The three lessons are centred on: the political development of nursing in the politics of health care; preparing for changes in the health workforce (or indeed any other political event in health care); and pragmatism in the politics of health care.

Chapter 9 draws together the key findings from the study including the lessons learnt and their implications for future development of the NP role in Australia and nursing role development in general. Chapter 9 concludes with recommendations for future research, and discussion about my own philosophical stance relating to this study, and to the NP role in general.

1.5.1 Conclusion

This chapter has set out the background to the study, its purpose and the methods used to undertake the research. Information about the researcher including her philosophical stance in relation to nursing and the NP role and the organisation of this thesis has been provided. The following chapter examines the literature in relation to the NP role and also provides an overview of the Australian health care system, all of which provides a background to the development of the NP role in NSW.

Chapter 2 – Literature Review

This chapter begins with an historical account of the developments in relation to the NP role in the US, Canada and UK, and proceeds to an overview of comparable developments in relation to the early development of the role in Australia. The chapter goes on to describe factors affecting the early development of the NP role in these countries followed by discussion of factors affecting its implementation in the US, Canada and UK. Next, the supporting research on the effectiveness of the NP role is presented. Understanding the historical developments of the NP role in the US, Canada and UK contexts provides important information and lessons to inform the development of the NP role in NSW. International similarities and differences in the history of the NP role provide, in part, the context for this thesis.

An overview of the health care system in Australia generally and specifically in NSW is presented which will assist in understanding the structure of the health system, factors that influence its functioning, the need for changes in the health care workforce, in particular in nursing, that necessitated the introduction of the NP role in NSW, Australia.

The following section provides an overview of the origin and development of the NP role in the US.

2.1 Origin of the Nurse Practitioner Role: NPs in the US

This section describes the origin and development of the NP role in the US, including the visions for the role, its legislation, regulation and education and transformation of the NP into a recognised professional nursing role. Issues related to the blurring of traditional practice boundaries are explored. The continued growth of the NP role in terms of their numbers is discussed.

2.1.1 Advanced practice nursing in the US

Advanced practice registered nurse (APRN) is an umbrella term used in the US for nurse anaesthetists, nurse-midwives and clinical nurse specialists (National Council of State Boards of Nursing, 2002) who were introduced many years before the introduction of NPs (Diers, 2004). NPs themselves were later classified as APRNs (National Council of State

Boards of Nursing, 2002). Advanced practice nursing might be considered a precursor of the NP role.

2.1.2 Visions for the NP role in the US

The NP role originated in the US because two visionary leaders, Loretta Ford, a registered nurse (RN) and Henry Silver, a paediatrician had the insight and commitment for nurses to be developed and used more effectively to improve health care in the US.

A range of circumstances presented as opportunities for Ford and Silver to develop the NP role in the US (Ford, 1994). Social programs to assist deprived and depressed populations, especially in relation to access to health care, were on the political agenda (Ford, 1994, 1997) including increased interest by government in primary health care (Bezjak, 1994). A national budget deficit brought the need for cost containment. Rural and inner city areas were underserved owing to geographic clustering of physicians in urban and suburban areas. Demand for generalised primary care was increasing. Physicians were increasingly moving into specialty areas because of associated income, status and lifestyle incentives (Ford, 1994, 1997).

In the mid 1960s, Ford and Silver (1967) grasped the problems in the health care system as an opportunity to create a role such as that of the NP to expand nurses' scope of practice and provide direct services to patients. They sought to bridge the gap between the health care needs of children and families by providing easily accessible and affordable primary or *first contact* health care by nurses in rural underserved areas (Ford & Silver, 1967; Silver, Ford, & Day, 1968; Silver, Ford, & Stearly, 1967).

Over the years, professional clinical nurses had increasingly and competently taken on more medical types of tasks (Ford & Silver, 1967). Clinical nurses were also undertaking less direct patient care because it was delegated to others, leaving them mainly with administrative and technical functions. Ford and Silver (1967) argued that, because of their increased education and knowledge, nurses could be utilised more effectively in a more comprehensive and independent role that was nevertheless consistent with nursing objectives. They argued the need to re-examine professional nurses' practice while accounting for patient needs, and the potential contribution of highly skilled and educated nurses to increase access to health care. They saw the critical role of education to enable this potential to be realised. These visionaries developed a post baccalaureate paediatric nurse

practitioner demonstration program at the University of Colorado to educate and prepare nurses for an expanded role in well child care as practitioners of nursing (Ford, 1997). The program was designed to increase nurses' knowledge and skills in the physical and psychosocial development of well children. Extended skills such as performing developmental tests and evaluative procedures, history taking, physical examinations, some laboratory procedures and referral for medical care that had been the traditional domain of medicine were included in the curricula (Ford & Silver, 1967). This vision for the NP role, and its implementation is now regarded as the catalyst that has changed the face of nursing forever (Diers, 2004; Wilson, 2005).

The following section describes issues related the development of the regulation and legislation of NPs in the US.

2.1.3 Legislation and regulation of NPs in the US

2.1.3.1 Lack of legislation and regulation in the US

Traditionally, nurses' practice in the US was legitimised through education, authorisation and licensure. In contrast, the expanded nursing role of the NP was born by virtue of a qualification gained through education and clinical experience rather than through licensure (Hunter, 1969). During the early development of the NP role, Ford and Silver (1967) knew that NP-physician collaboration would be essential for successful implementation.

2.1.3.2 NP-physician collaboration in the US

Ford and Silver believed that both nursing and medicine could be more effective if they collaborated more. They stressed that the enhanced nursing role should not be seen as a substitute for the physician but instead a collaborative and collegial relationship (Ford & Silver, 1967). Absence of legislation regulating the NPs' scope of practice meant that NPs' expanded practice often depended on the permission and co-operation of their co-workers, in particular, their medical colleagues. It was difficult for the NPs to work collaboratively when physicians and medical organisations such as the American College of Physicians only supported the role when NPs worked in physician-controlled, supervisory environments where physicians maintained responsibility for patient care (Sox, Ginsburg, & Scott, 1994).

The lack of legislation protecting the NPs' expanded practice left the NPs open to legal challenge. It is well documented that in the mid 1970s the NP role was actively resisted by

some State Medical Societies. For example, in New Jersey, the Medical Board of Examiners charged an NP with practising medicine without a license (Diers, 2004; Mauksch, 1978) because she ordered a mammogram for a patient (Diers, 2004). The case was dismissed with support from the New Jersey Nursing Association because the Medical Board was deemed to have no jurisdiction over nursing (Diers, 2004). This case was seen by nurses as a pivotal example of competition between the health care professions rather than concern about NP competence (Diers, 2004).

Resistance to the NP role was not confined to medicine. Rather than viewing the NP role as a collaborative role with physicians, some nurses and nursing organisations argued that the NPs had left nursing to become physician's handmaidens (Rogers, 1972; Edmunds, 2000), an accusation that will seem all the more ironic by the end of this thesis. Hence, Ford and Silver's vision for the NP to be seen and enacted as collaborative and collegial was influenced by the views and vested interests of the people with whom they worked. The following section explores the legislation and regulation of NPs in the US as the role developed.

2.1.4 Move towards NP legislation and regulation in the US

2.1.4.1 Variation between US jurisdictions

By 1997 every US state had independently regulated the APRN scope of practice through legislation (National Council of State Boards of Nursing, 2002). NP educational requirements, certification mechanisms and legal scopes of practice were decided at the state level. Their autonomy, independence, full prescriptive authority, and reimbursement and admitting privileges to health care institutions varied considerably between state jurisdictions (Lugo, O'Grady, Hodnicki, & Hanson, 2007; Ridenour & Grady, 2005). This variation in the NPs' scope of practice across states meant that some NPs were (and still are) prevented from using their skills to their full potential and patient access to health care is compromised (Christian, Dower, & O'Neil, 2007).

2.1.4.2 Under regulation to over regulation of NP practice in the US

The pendulum had swung from a lack of legislation and regulation to what is now considered in many US states to be the over-regulation of NPs. Many impediments to NPs' practice are partly due to legislation that limits their scope of practice. As a consequence, NPs now have a history of seeking legislative changes to reduce these limitations. However,

this process has been arduous because statutory change is difficult to achieve (Christian et al., 2007). The regulation of NP practice exists on a continuum ranging from exceedingly restrictive, one extreme requiring supervision by health care professionals from another discipline such as medicine; to the other extreme which allows practically unimpeded, autonomous practice within the scope of the profession (Lugo et al., 2007). This legislative range is set out in Table 1. When physician involvement is mandated for practice, NPs usually follow agreed protocols or guidelines for the medical management of patient conditions (Cole, Ramirez, & Mickanin, 1999).

Table 1 APN legislation: Legal authority for scope of practice in the US

	1990	**1999**	**2001**	**2003**	**2004**	**2007**	**2008**
	States with nurse **NP title protection**: *The board of nursing has sole authority in scope of practice* with ***no statutory or regulatory requirements*** *for physician collaboration, direction, or supervision*.						
US states	0	22	25	26	27	25	24
	States with **NP title protection**: The board of nursing has sole authority in scope of practice, but *scope of practice requires* ***physician collaboration***.						
US states	0	14	13	14	14	16	20
	States with **NP title protection**; the board of nursing has sole authority in scope of practice, but *scope of practice requires* ***physician supervision***.						
US states	35	8	6	6	5	5	3
	States with **NP title protection**, but the ***scope of practice authorised by the Board of Nursing and the Board of Medicine***.						
US states	8	6	6	5	5	5	4
	States ***without*** **NP title protection** where APNs function under a broad Nurse Practice Act.						
US states	7	1	1	0	0	0	0

Note: Washington DC included as a state from 2000.

Source: Pearson (1991, 2000, 2002, 2004); Phillips (2005, 2008, 2009).

Practice arrangements specify the types of patients (specialty area) and services that NPs can provide, the types of diagnostic or treatment procedures that NPs can perform and the types of patient conditions that NPs may manage within agreed guidelines and without consulting a physician (Cole et al., 1999). Over time, introduced legislation continues to reduce practice

barriers for NPs (Pearson, 1991, 2000, 2002, 2004; Phillips, 2005, 2007, 2009) as also shown in Table 1. Not until 2002 was the title *nurse practitioner* protected through legislation in every US state (Pearson, 2003).

Despite research demonstrating that preventing NPs from practising to the full extent of their competence has impeded patients' access to care, legislative restrictions to NP practice have continued (Lugo et al., 2007). Patients experience delays in accessing care or are forced to use an alternative provider (Burgess, Pruitt, Maybee, Metz, & Leuner, 2003; Grumbach, Hart, Mertz, Coffer, & Palazzo, 2003; Lindeke, Bly, & Wilcox 2001a, 2001b; Mundinger, Kane & Lenz, 2000). These restrictions increase health care costs, and reduce access and quality of health care (Christian et al., 2007).

The following section explores issues such as NP prescribing, reimbursement for NP services and malpractice insurance that pertain to the NP role having the effect of blurring traditional nursing practice boundaries.

2.1.5 Blurring of traditional practice boundaries in the US

2.1.5.1 NP prescribing in the US

Initially in US states where nurses were working as NPs, legislation was introduced allowing them to prescribe medications, subject to the regulatory Boards of Medicine and Nursing. Prescriptive authority for advanced practice nurses was limited to a dependent or collaborative model (Phillips, 2005), described as ghost-provider status (Edmunds, 1991). Similar to the evolution of the legislation and regulation of NPs in general, prescriptive authority has progressed over the years, especially with regard to controlled scheduled drugs (Cole et al., 1999; Phillips 2005). NPs prescribe in all states, but the scope varies across states, as shown in Table 2.

Table 2 APN legislation: Prescribing authority in the US

	1990	1999	2001	2003	2004	2007	2008
	States where *NPs can prescribe* (including controlled substances*) independent of any required physician involvement in prescribing authority*.						
US states	0	13	13	13	14	14	14
	States where *NPs can prescribe* (including controlled substances) with some degree of *physician involvement or delegation of prescription writing*.						
US states	0	29	32	34	33	34	35
	States where *NPs can prescribe* (excluding controlled substances) with some degree of *physician involvement or delegation of prescription writing*.						
US states	35	9	6	4	4	3	2
	States where NPs have *no statutory authority or regulatory prescribing authority*						
US states	15	0	0	0	0	0	0

Note: Washington DC included as a state from 2000.

Source: Pearson (1991, 2000, 2002, 2004); Phillips (2005, 2008, 2009).

Prescribing medications has traditionally been a medical responsibility (Brush & Capezuti, 1996) which may go some way to explain the strong opposition from the medical profession over the years to NPs' independent prescribing. However, as Brush and Capezuti (1996) ironically point out, NPs working in areas with a limited supply of physicians or in areas unattractive to physicians have been deemed more competent to prescribe medications than NPs working in areas without shortages of physicians (Brush & Capezuti, 1996). Nursing's interest in acquiring prescribing authority in the US was seen by nurses as "emblematic" of the effort to create a role that would be more independent of medicine (Brush & Capezuti, 1996, p. 8).

2.1.5.2 Reimbursement for NP Services in the US

As with their prescribing privileges, reimbursement for NP services was seen as a way to increase the visibility and recognition of NPs as independent practitioners because it permitted their services to be reported as NP services rather than services provided by supervising physicians (US Department of Health & Human Services, 2005). In 1997, the Balanced Budget Act was passed after 20 years of lobbying by individuals and nursing organisations to provide Medicare beneficiaries with access to the services of NPs

(American Nurses Association, 2005). See Table 3 for a chronology of the events that led to NP provider status.

Table 3 Chronology of major efforts leading to provider status of nurse practitioners in the US

	Action	**Details**
1974	S.3644 introduced by Senator Inouye, H. Rep. 15867 introduced by Rep. Matsunaga	A bill to amend the Social Security Act to provide for inclusion of the services of licensed (registered) NPs under Medicare and Medicaid.
1977	Rural Health Clinic Act	Mandated that 50% of services in funded rural health clinics be provided by NPs, certified nurse-midwives, and physician assistants.
1979	Nurse Training Act	Mandated a study to assess nursing education, recommend distribution in underserved areas, and suggest actions to encourage nurses to remain active in the profession.
1983	Institute of Medicine report 'Nursing and Nursing Education: Public Policies and Private Actions'	Documented the productivity gains and cost reductions achieved by advanced practice nursing. Recommended federal support for advanced practice nurse education.
1986	Office of technology Assessment report (1986): 'Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis'	'Within their areas of competence NPs provide care whose quality is equivalent to that of care provided by physicians…. [NPs] are more adept at providing services that depend on communication with patients and preventive action'.
1989	Omnibus Budget Reconciliation Act of 1989	Provided limited reimbursement for NPs collaborating with physicians in rural areas and established Medicaid payments for paediatric or family NPs. Created the Resource-based Relative Value Scale (RBRVS), a mechanism for calculating Medicare payments to physicians, and called for a study on the impact of RBRVS on non-physician providers.
1991	Primary Care Health Practitioner Incentive Act of 1991 (stalled in Committee)	Amended title XV111 of the Social Security Act to provide for increased Medicare reimbursement of NPs, CNSs, and certified nurse-midwives and to increase the delivery of health services in underserved areas.
1992	Survey evaluating need for unified national organisation	Representatives of state and national NP organisations acknowledged the need for a national forum to discuss issues common to all NPs regardless of their clinical specialty.
1993	Invitational NP leadership Summit	National Nurse Practitioner Coalition (NNPC) formed to provide nurse practitioners nationwide with information and to support direct involvement in lobbying, advocacy, and health care policy formation.
1996	Reimbursement task force created by American College of Nurse Practitioners (ACNP)	ACNP (formally NNPC) coordinated a national grass-roots effort to spur NP involvement in activism.
1997	Balanced Budget Act of 1997	Granted provider status to NPs and authorised NPs to bill Medicare directly for services furnished in any setting.

Source: O'Brien (2003, p. 2303).

This campaign was led by Margie Koehler, a NP from Maryland who reportedly used email to enlist the help of thousands of NPs, patients and other clinicians to bring the issue to the attention of Congress (Edmunds, 2000). Whilst this achievement was seen as a major for the NP movement, the Medicare reimbursement value for NPs is mainly set at 85% of the physician rate for identical services, suggesting that NP services are viewed as less than that provided by physicians (American College of Nurse Practitioners, 1998; Edmunds, 2000).

Some states have passed legislation reimbursing NPs at 100% of the physician rate and independent of the on-site presence of a physician (Edmunds, 2000; Phillips 2009)**.** Having made this point, it should be noted that it is generally only those NPs employed by a physician who are reimbursed at 100% of the physician reimbursement rate (Centre for Medicare and Medicaid Services, 2004). NPs employed by a physician or physician-directed group or clinic may use the provider number of the supervising physician with a code to denote it as an NP service. In this instance, reimbursement is 100% of the Medicaid schedule fee schedule (Centre for Medicare and Medicaid Services, 2004).

Since 2003, NPs applying for a provider number need to have a master's degree in nursing, must be licensed in the state in which services are provided, and must be certified by a national body (Buppert, 2005). Reimbursement by third-party payers remains a practice barrier for most NPs throughout the US (Phillips, 2009).

2.1.5.3 Malpractice insurance in the US

In the mid 1980s, malpractice insurers refused to cover NPs, and then sought to re-establish and increase their premium rates from $58 to $1500 annually (Brush & Capezuti, 1996). These insurers tried to do this despite lack of supporting evidence. Many NPs were concerned that they could no longer practice. It was speculated by nurses that the actions of the insurance companies were part of a wider conspiracy between insurers and physicians to prevent NPs from practising (Brush & Capezuti, 1996). An editorial in *The New England Journal of Medicine* (Spitzer, 1984) predicting that NPs would not survive in primary care appeared to support this claim (Brush & Capezuti, 1996).

The political growth of nursing during the development of the NP is also evidenced by the success of nursing organisations in their lobbying for affordable insurance for NPs (Brush & Capezuti, 1996). Commentators who predicted the demise of the NP role had to re-think

their position (Ford, 1997). The following section explores developments in the education of NPs in the US.

2.1.6 Education of NPs in the US

During the early development of the NP role, there was resistance to Ford and Silver's (1967) paediatric NP program because some nursing faculty members believed that medicine was trying to control nursing education and practice. Other nurses questioned the legality of NPs performing comprehensive physical appraisals and physical examinations (Ford, 1997). There was opposition and a lack of acceptance by nurse educators to the institutionalisation of the educational programs within mainstream nursing education. However, there was high demand for the expanded skills of the NP, such that NP specialty programs took precedence over a uniform standard for entry-level practice to NP programs (Ford & Silver, 1967; Sultz, Henry, Kinyon, Buck, & Bullough, 1983a, 1983b). This demand resulted in the disorganised development of numerous short-term certificate programs throughout the 1960s and 1970s. These programs were often conducted in continuing education departments and were of variable quality. Many such programs were established even before Ford and Silver's pilot paediatric NP program had been evaluated (Ford, 1979; Ford, 1982; Ford, 1997).

Another important factor facilitating the development of the NP role in the US was the establishment in 1980 of the National Organisation of Nurse Practitioner Faculties (NONPF). This faculty organisation developed strategic alliances with charitable groups outside nursing to help bring resources to NP education (Edmunds, 2000). There was a shifting emphasis on graduate nurse preparation in the universities and colleges together with Federal funding. These two factors contributed to a revival of master's programs preparing NPs. Types of NP education programs expanded to include other specialties such as adult, family and women's health (Sultz et al., 1983a, 1983b).

Not until the 1990s did NPs began to emerge in acute care settings. Nurse practitioners were sometimes described as *non-physician extenders*, *doctor substitutes* and *mid-level practitioners* (Brush & Capezuti, 1996). In 1999, the NONPF announced plans to develop a specific accreditation process for NP programs. The national NP certification program reflected progress towards uniformity in standards that were tied to graduation from NONPF accredited specialty programs, for example, women's and mental health. Most states now require these standards (Edmunds, 2000; National Council of State Boards of Nursing,

2009). Whilst at one level this standardisation is a positive development, it has been pointed out that NPs essentially require two licenses to practice (Klein, 2005). The APRN Nurse Licensure Compact for NPs was developed in 2000 to permit multi-state practice privileges (National Council of State Boards of Nursing, 2009).

Overall, NP curricula have expanded over the past four decades. Programs are more refined, with candidates able to select specialties such as geriatrics and obstetrics. Nationally, the trend is for masters or doctoral level preparation for NPs. Although NP education varies between the states in 2008, as many as 27 states require NPs to have a masters degree to practice (Christian et al., 2007). The following section describes the professionalisation of NPs in the US including the political development of NPs.

2.1.7 Professional and political growth of NPs in the US

During the early development of the NP role, nurses at that time were inexperienced and naïve about political and bureaucratic processes that forced them to resist opposition from organised medicine (Diers, 2005). In 1976, the journal *The Nurse Practitioner: The American Journal of Primary Care* first began publishing clinical and professional issues dedicated to NPs. This journal was often the only source of information for NPs at that time. An article published in this journal describing the barriers that NPs must overcome to avoid "extinction" (Billingsley & Harper, 1982, p. 22) served as a catalyst for NPs to unify and challenge these barriers more systematically. The journal was a vehicle through which NPs could increase their visibility (Edmunds, 2000).

Although specialty organisations had proliferated, a major factor hindering the development of the NP role was the perceived absence of a single organisation representing the NPs' interests. In the 1980s, The American Nurses Association declined to serve as the umbrella organisation for NPs. As a result, the American Academy of NPs was formed. Disunity prevailed and the growing number of special interest groups led to territorial competition. In 1992, a national meeting of NP leaders was called because NPs were concerned that, because of the lack of a unified national political presence, they would be left out of health care reforms proposed by the new Clinton administration. As a result the National NP Coalition was created. This group successfully established a credible, national political presence, with the coalition formalised into a permanent political arm for NPs, known as The American College of Nurse Practitioners (Edmunds, 2000). The legislative success of NPs in the US

was also partly due to coalition-building by the NPs with the other classifications of advanced practice nurses (nurse midwives, nurse anaesthetists and clinical nurse specialists) who also benefited from an expanded scope of practice (Edmunds, 2000).

The following section outlines the growth in numbers of the NPs from the time of the pioneer NPs.

2.1.8 The pioneer NPs and growth of NP numbers in the US

Though the NP movement in the US began with the vision of Ford and Silver, it also required nurses to pioneer the role. The pioneer NPs mainly shouldered the burden (Draye & Brown, 2000). The pioneers are acknowledged as courageous trailblazers who entered educational programs without the assurance of finding positions at the conclusion of their program (Edmunds, 2000). They knew they had to be competent, combining the best of nursing with their new diagnostic and assessment skills, while offsetting and satisfying criticism by their own profession, patients and physicians in an uncertain environment (Edmunds, 1978, 2000). More nurses seized the opportunity and the NP role expanded in the late 1960s and 1970s (Brush & Capezuti, 1996). The number of NPs grew from approximately 250 in 1970 to around 20,000 by 1980 (Sultz et al., 1983a, 1983b). Since then, the number of NPs has increased from approximately 43,000 in 1992 (Stringer, 2003) to nearly 140,000 in 2006 (Pearson, 2007).

2.1.9 Summary of NP role developments: Lessons from the US

The NP role in the US began with a vision to improve primary health care. The role was seen as a way to accomplish this in collaboration with doctors. Opportunities were grasped to transform the vision into reality. Of course, nurses were needed to pioneer the role. These nurses are now acknowledged as courageous trailblazers during a time of uncertainty.

Lack of NP legislation meant that NP practice depended on the permission of doctors, which left NPs open to legal challenge. However, the vested interests of medical and other stakeholders opposing the role influenced legislation, which in turn led to formal collaborative or supervisory arrangements that, in some US states maintained physician control over NPs.

Nurses were politically naïve during the early development of the NP role but they grew in sophistication. NP special interest groups were territorial. Eventually they were replaced by a

unified NP coalition with a single political voice. Over time, the NPs were joined by other nursing organisations in lobbying for political support. Coalition-building with other advanced practice roles further increased their political strength. Resources such as an NP journal increased their visibility and political voice. There was an initial lack of uniformity in NPs' education. The NONPF facilitated funding for NP education programs and development of nationally consistent standards and thus, NP competence. Despite resistance especially from organised medicine, the NP role continues to evolve and grow in numbers.

Having explored the ultimately successful development of the NP role in the US, this chapter will now examine the NP role in Canada.

2.2 The NP role in Canada

2.2.1 Antecedents to the Canadian NP role

The NP role in Canada can also be traced to the late 1960s. As with the US, NP positions and education programs were initially developed in the absence of any legal or policy infrastructure. In 1967 the first education program for NPs commenced at Dalhousie University in Halifax, Nova Scotia (Worster, Sarco, Thrasher, Fernandes, & Chemeris, 2005).

In 1971, the Boudreau Committee was commissioned to produce the *Report of the Committee on Nurse Practitioners* that recommended developing the role to support primary health care (Department of National Health & Welfare: Ottawa, 1972). A joint statement by the Canadian Nurses Association (CNA) and Canadian Medical Association Joint Committee (1973) supported the development of the NP role and university education programs to prepare NPs for roles in rural and urban settings (DiCenso et al., 2007). In the late 1970s and early 1980s approximately 250 NPs graduated from approved education programs in Canada and worked in limited NP roles. As in the US, Canadian NPs initially depended on physician collaboration and supervision in urban areas, and were protocol-driven in rural or remote areas where physicians were in short supply (Canadian Institute for Health Information, 2005).

Coinciding factors such as a perceived surplus of medical physicians and the continued lack of support by professional bodies including nursing, (DiCenso et al., 2007; de Leon-Demare, Chalmers & Askin,1999; International Business Machines 2003) along with the lack of

remuneration mechanisms, public awareness and funding (Worster et al., 2005), resulted in the failure to develop the required policy and legislative changes to implement the NP role fully. In the early 1980s, the NP movement stalled (Canadian Institute for Health Information, 2005) and NP education programs became obsolete (Worster et al., 2005) with the last NP program finishing in 1983 (Nurse Practitioners Association of Ontario, 2005). However, the 250 NPs who were already educated and employed continued to practise through the 1980s, particularly in community health centres (DiCenso et al., 2007).

The early 1990s brought renewed interest in the NP role in Canada, and it re-emerged as an important potential contributor to health care (Canadian Nurses Association 2005). The renewed interest occurred in response to many of the same issues from the 1960s (Canadian Nurses Association 2005), particularly the development of health care reform agendas designed to ensure more efficient use of resources, including an increased emphasis on preventative primary health care (Cummings, Fraser, & Tarlier, 2003; Moulton, 2000; de Leon-Demare et al., 1999; DiCenso et al., 2007). The continued development and effectiveness of the NP role in the US (DiCenso et al., 2007) added to the renewed interest in the NP movement at the federal and provincial levels (Canadian Nurses Association, 2005).

2.2.2 Legislation and regulation of NPs in Canada

This section presents an overview of legislative and regulatory issues and the education and growth of NPs in Canada.

2.2.2.1 Variation between Canadian jurisdictions

As in the US, factors such as the provincially administered health care system and significant regional differences in policy, funding, legislation and education affected the implementation of the NP role in Canada (de Leon-Demare et al., 1999). The various provincial and territory administrations pursued different approaches for title protection, licensure and the education of NPs (Canadian Institute for Health Information, 2004). These approaches produced variability in NPs' scope of practice across provinces and territories, although reportedly less diverse than those in the US (Canadian Institute for Health Information, 2004).

2.2.2.2 Toward a national legislative and regulatory approach in Canada

Canadian NPs were fortunate to have the US historical experience and perspective to validate the importance of a pan-Canadian approach to integrating NPs into the health system. As a consequence, in 2003 the nursing regulatory bodies from each province united

to fully endorse the need for a national approach to the NP role (Canadian Nurses Association, 2005).

In 2004, Health Canada provided funds to the Canadian Nurses Association to create what is commonly known as the *Canadian Nurse Practitioner Initiative* to develop a framework for the integration and sustainability of the NP role into the Canadian health care system. *The Framework for the Sustained Integration of Nurse Practitioners* was released in 2006 (Canadian Institute for Health Information, 2006). There is now substantial congruence in the scope of practice within each jurisdiction, all of the provinces and territories having protected the NP title (Canadian Institute for Health Information, 2006).

In Canada, NPs are legislated, regulated, and permitted to perform comprehensive health assessments, to diagnose and treat health problems, to order and interpret the results of diagnostic and screening tests, and to prescribe drugs and medication (Canadian Institute for Health Information, 2006). NP practice is described as "grounded in the nursing profession's values, knowledge, theories and practice" (Canadian Institute for Health Information, 2006, p. 4). NP practice is autonomous and collaborative: "NPs work both autonomously, from initiating the care process to monitoring health outcomes, and in collaboration with other health care providers including RNs, practical nurses, therapists, nutritionists, social workers, pharmacists and particularly family physicians" (Canadian Institute for Health Information, 2006, p. 4). However, there is no legislated "collaborative arrangement" between NPs and physicians such as those that exist in the US (Canadian Institute for Health Information, 2006, p. 4).

2.2.2.3 Education of NPs in Canada

In 2005, the levels of nursing education for NPs practising in Canada were as follows: 15.2% held a diploma, 62% a baccalaureate degree and 23% of NPs held a master's degree. A masters degree will increasingly be required for NP practice (Canadian Institute for Health Information, 2006).

2.2.2.4 Numbers of NPs in Canada

In 2003 there were 878 licensed NPs working mainly in primary health care (Canadian Institute for Health Information, 2004) increasing to 1,026 in 2005. They still mainly work in primary care (Canadian Institute for Health Information, 2006).

2.2.3 Summary of NP developments in Canada: Lessons from Canada

Whilst the early development of the NP role in Canada experienced a short hiatus, it was able to build on the historical experiences of the US. Before the re-emergence of the role, NPs suffered from many of the problems faced in the US. The role has since re-evolved toward a national approach for legislation, regulation, protection of the NP title and education to integrate NPs into the health system. Canada avoided being overly restricted by legislated collaborative arrangements between NPs and medical practitioners as in the US. Rather, NP practice is not only directed towards doctors but is described as autonomous and collaborative with all health care professionals.

Developments of the NP role in the UK will now be discussed.

2.3 The NP role in the UK

This section begins with a description of the antecedents to the NP role in the UK. Issues pertaining to the legislation, regulation and title protection are also explored.

2.3.1 Antecedents to the NP role in the UK

Factors similar to those in the US and Canada saw the introduction of the NP role in the UK by the British Health Services during the 1980s (Maclaine, 1998). Cost containment and improved access to health care services (Harris & Redshaw 1998; Horrocks, Anderson, & Salisbury, 2002), shortages of physicians (Horrocks et al., 2002; Harris & Redshaw, 1998), and the need to reduce junior doctors' hours of practice (Harris & Redshaw, 1998), stimulated the implementation of the NP in the UK. Changes to health policy and planned modernisation of health services by the UK Department of Health allowed nurses to reconsider and challenge traditional health care roles and professional boundaries (Richardson & Cuncliffe, 2003). The UK Government advocated that nurses should work in new ways, including extended roles to make better use of their skills and knowledge, and developing nurse-led services (Horrocks et al., 2002; Walsh, 2001).

Barbara Stilwell, a nurse at the University of Birmingham Medical School, began exploring an expanded role for nurses in the 1980s. After visiting the US and Canada to examine NP training and practice she concluded that the NP role was appropriate for the UK, and began to enact her vision for the NP role. She authored a series of articles for *Nursing Mirror* describing the NP role in the US. The NP role was subsequently introduced and the title

nurse practitioner has since been used in the British nursing literature (Stilwell, 1981,1985a, 1985b, 1985c, 1985d).

2.3.2 Legislation and regulation of NPs in the UK

The development of the NP role in the UK differs from US and Canadian experiences as it was not originally grounded in educational programs or legislation. Not until 1990 was a formal NP training program implemented by the Royal College of Nursing (Laurent, 1993). Despite years of discussion, debate and reports there is still no regulation, legislation or protection for the NP title (Crumbie, 2001; Le Mon, 2000; Mulholland, 2001; Royal College of Nursing, UK, 2008). Theoretically any nurse may use the *nurse practitioner* title (Royal College of Nursing, UK, 2005).

The Nursing and Midwifery Council (NMC) has recently stated that it intends to work towards regulating the NP role (Royal College of Nursing, UK, 2005, 2008) but to date, most of the professionalising of the NP has occurred through the industrial and professional organisation – the Royal College of Nursing (UK). In 2002 the Royal College of Nursing (RCN) outlined the domains and core competencies for NPs. The domains and competencies were adapted for the UK from those published by the NONPF in the US. It was hoped that a consensus among health care providers of what constituted the professional practice of NPs would guide future regulation of the NP title (Royal College of Nursing, UK, 2005). A survey by the RCN NPA found that a number of titles (NP – generic or primary care or general practice; NP – specialist; advanced NP) were used by NPs to describe their role. In the UK, NPs are employed by GPs and the numbers of NPs are evenly distributed between employment by the NHS Trusts (49%) and by GP practices (47%). NPs working in hospitals and in GP practices receive referrals and may refer to other health professionals (Ball, 2006).

Weaknesses that have arisen from the lack of legislation, regulation and NP title protection include the proliferation of advanced nursing titles, an unclear identity that has affected NPs' ability to communicate their role clearly (Schober & Affara, 2006) leading to difficulty for the public, employers, nurses, other health professionals and patients to understand what NPs do. The lack of NP regulation in the UK continues (Ball, 2006). The issue of NP role ambiguity is further explored later in this chapter.

Following national consultation in 2005 it was agreed that the NMC should seek approval from the Privy Council to open a further subset of the nurses' register and make *nurse*

practitioner a registrable qualification. In the white paper *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century (2007)* the UK Government agreed that the NMC should develop standards, including higher levels of practice such as advanced practice in nursing (Nursing & Midwifery Council, 2007; Royal College of Nursing, UK, 2008).

2.3.2.1 Nurses' prescribing rights in the UK

Unlike the US and Canada, district nurses and health visitors in the UK have prescribing rights (UK Department of Health, 2004). After the introduction of the necessary legislation in 1992 and 1994, nurse prescribing for district nurses and health visitors was first piloted in eight GP practices in 1994. It was expanded to a whole district community National Health Service Trust in 1996 and to a further community trust in each of the seven remaining regions in 1997 (UK Department of Health, 2004). After this successful piloting, Ministers agreed that nurse prescribing for district nurses and health visitors could be expanded throughout England. District nurses and health visitor prescribers are permitted to prescribe from the Nurse Prescribers' Formulary for District Nurses and Health Visitors, which is tailored to the needs of patients in the community. In May 2001 it was announced that nurse prescribing would extend to registered nurses or midwives and to a wider range of medications (UK Department of Health, 2004). Further workforce change in the UK came with the announcement in November 2005 that qualified nurse and pharmacist prescribers would have independent prescribing rights extending to any licensed medicine for any medical condition, with the exception of controlled drugs (UK Department of Health, 2005). The following section outlines developments in the education of NPs in the UK.

2.3.2.2 Education of NPs in the UK

NPs in the UK may have undertaken anything from a single-week, in-house course to an undergraduate degree or master's program. Some NPs have trained on the job by medical practitioners, whilst others have undertaken academic programs in other clinical areas (Walsh, 2001). Scholars have argued that the lack of minimum qualifications for NPs has shifted nursing in the UK toward a biomedical model focusing on technical and medical aspects of patient care (Barton, Thorme, & Hoptroff, 1999; Walsh, 1999a, 1999b).

2.3.2.3 Number of NPs in the UK

Because the NP role is unregulated, reliable information about the numbers of NPs in the UK is unavailable. However, the RCN Nurse Practitioner Association (NPA) reported 2,396 members as at May 2006 (Ball, 2006).

2.3.3 Summary of NP role developments: Lessons from the UK

In contrast to the US and Canadian experience, the NP role in the UK remains unregulated or legislated although negotiations continue. The NP title remains unprotected, allowing any nurse to use the title. There is also no formal recognition of their level of practice. NP education lacks national consistency and, thus the level of NPs' knowledge and skills vary. However, the RCN recognised the importance of developing nationally consistent competencies for NPs but they were not formally introduced as part of NP practice.

Notwithstanding this lack of regulation, registered nurses in the UK have wider prescribing rights than nurses in the US and Canada, which suggests that not having legislation keeps the expansion of advanced practice roles away from doctors' scrutiny.

The following section briefly overviews the early development of the NP role in Australia. An account of preliminaries to the introduction of the role into the NSW health care system is provided later in this chapter. Detailed description of the key events in the early development of role in NSW to the end of 2005 is presented in Chapter 4. Issues relating to the early development and implementation of the NP in NSW are also explored in chapters 5, 6 and 7. The development of the NP role and some of the lessons learnt from the US, Canada and UK will be compared with the findings from the current study in Chapter 8 of this thesis. Lessons learnt from the early development of the NP role in Australia will also be positioned into the current political and policy debate at the time of writing.

2.4 The NP role in Australia

An advanced role for nurses in Australia was discussed as early as 1972 (Coxhead, 1993; Slater, 1973). Only much later, in 1990, was the NP role considered legitimate for the NSW heath care system. As in the US, Canada and UK, a range of health care and nursing-specific factors established the conditions and opportunity for the new clinical career structure of the NP. Visionary nursing leadership, bipartisan government support for the role and senior

clinical nurses willing to take on the challenge to pioneer the role contributed significantly to its inception in NSW, the first Australian state to introduce NPs.

The *Nurses Amendment (Nurse Practitioners) Act 1998* (NSW) was passed in 1998. A chronology of key events in development and implementation of the NP role in NSW is detailed in Chapter 4 (also see Appendix I). A Senate Inquiry into Nursing in 2002 recommended that Commonwealth and State Governments support the development and introduction of NPs across Australia (Commonwealth of Australia, 2002a). The other states and territories continued to develop and implement the role at varying stages. Most of the states took several years to introduce the NP role. The process before the legislation and regulation of NPs has almost always involved pilot projects and steering committees to design frameworks for the development of the role and introduction of NPs. Each state had to work through its own legislative barriers, such as changing their poisons legislation (Driscoll, Worrall-Carter, O'Reilly, & Stewart, 2005; McCallam Pardey, 2004). Legislation for the NP role has been passed in every Australian state: NSW in 1998, Victoria in 2000, South Australia in 2002, Australian Capital Territory in 2002, Western Australia in 2003, Tasmania in 2005 and Northern Territory in 2007. A section added to the existing Nursing Act in 2005 provided for the Queensland Nursing Council to authorise NPs in Queensland under the existing Act.

A Productivity Commission into Australia's Health Workforce identified "a lost opportunity for greater inter-jurisdictional coordination and consistent approach to the development and implementation of the NP role across Australia" (Commonwealth of Australia, 2005, p. 55).

Legislative protection in all Australian states and territories prevented use of the title *nurse practitioner* by anyone unauthorised by a nursing regulatory body (Dunn, 2007). Each state in Australia has developed a different definition for the NP, but a study published in 2004 identified the following common elements:

> A NP is a registered nurse educated to function autonomously and collaboratively in an advanced and extended clinical role. The nurse of [*sic*] clients using nursing knowledge and skills and may include, but is not limited to the direct referral of patients to other health-care professionals, prescribing medications and ordering diagnostic investigations. The NP 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 NP is determined by the context in which the NP is authorised to practice. Gardner (2004, p. 132)

The level of education required for NP authorisation varies across Australia although the trend is towards master's level (Gardner, Dunn, Carryer, & Gardner, 2006).
Each Australian state has benefited and learnt from positive and negative aspects of the development and implementation of the role in other jurisdictions. Inconsistency across state borders is a disadvantage of the piecemeal approach to the NP role across the nation (Driscoll, Worrall-Carter, O'Reilly & Stewart, 2005).

In Australia, as with the development and implementation of the NP role particularly in the US and Canada, decisions made in relation to the development and implementation of the role in each of the states had to account for the "disparate positions, views and opinions of a range of stakeholders, many of whom were not nurses" (National Nursing and Nursing Education Taskforce, 2005, p. 3). These disparate positions rendered implementation of the role in each of the jurisdictions as "protracted and problematic" (National Nursing and Nursing Education Taskforce, 2005, p. 3). See Appendix I for a list of key events in the development of the NP role from 1990 to 2010.

2.5 Summary of NP role development in the US, Canada, UK and Australia

The NP role began with visionaries in the US. The role has since diffused into Canada, UK and more recently, Australia. Exploring the introduction of the role into the US, Canada and UK reveals differences between the US, Canada and UK in NP regulation of practice scope and autonomy, legislation, title protection and education of NPs, as well as differences between provinces, states and territories within these countries. In each of the countries the role has evolved considerably since the first US NP pioneers about 45 years ago. The scope of practice, legislation and regulation in the US, Canada, UK and Australia has increased throughout the time-span addressed in this thesis as legislators responded to the demands of groups and individuals to reform, demonstrating the evolutionary nature of the role. Educational preparation for NPs is trending towards a master's degree in Canada, UK and Australia and towards a Doctorate of Nursing Practice in the US. The numbers of NPs in each of the countries continues to grow.

The next section reviews research exploring influences on the NP role.

2.6 Evidence of positive and negative influences on the NP role

Health care innovations invariably occur within a historical, social, political, cultural and economic context, which influences their progress (Christensen, Bohmer, & Kenagy, 2000; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). Beyond the legislative and regulatory issues identified in the previous section, this section explores the positive and negative influences on the implementation of NPs into health care organisations. These influences relate to: perceived ambiguity of the NP role, the effect of the NP role on working relationships and support and resources.

2.6.1 Perceived ambiguity of the NP role

Role ambiguity is an employee perception resulting from a lack of clarity, and also where employers or other stakeholders are unclear about their conception of the role, or vary in their expectations of it (Handy, 1993; Hardy & Hardy, 1988). Ambiguity about the NP role as perceived by nurses, doctors, other health professionals, administrative and management staff, and the public is cited as a major impediment to its implementation (Anderson, Gilliss & Yoder, 1996; Cummings, Fraser, & Tarlier, 2003; Draye & Brown, 2000; Johnson, 2001; Horrocks, Anderson, & Salisbury. 2002; Irvine et al., 2000; Tye & Ross, 2000). A significant body of literature within and outside nursing identifies that role ambiguity and role conflict are more likely among newly created posts and, when old roles significantly change (Carnwell & Daly, 2003; Jackson & Schuler, 1985; Siegall & Cummings, 1986; Smith, 1957; Van Sell, Brief, & Schuler, 1981). NP role ambiguity began with its early development and continued as it was introduced into new and different clinical settings, especially where other people in the settings had not been previously exposed to NPs (Carnwell & Daly, 2003; Draye & Brown, 2000). The introduction of an NP into a clinical setting is further complicated when the role is new to both the individual NP and the institution (Woods, 1999a, 1999b).

An ad hoc approach to NP implementation and evaluation by managers or administrators occurred (Cameron & Masterson, 2000) as evidenced by a lack of formal planning (Cummings et al., 2003). In some organisations it has been argued the role was almost "set up to fail" (Woods, 1999b, p. 124).

Pioneer NPs in the US found their new role particularly challenging because of a dearth of role models. As a consequence pioneer NPs developed their role through trial and error, and

feedback from colleagues, patients and administrators (Draye & Brown, 2000). The early pioneers reported that they had to continually clarify their NP role, experience, scope of practice and their knowledge and skills to other nurses, patients, health care professionals, administrators and managers (Draye & Brown, 2000). Rather than the NP being seen as an expansion of nursing (as intended), physicians, nurses and management have perceived the role as either complementary, physician extender or a medical substitute but always evolving under the medical model (Tye & Ross, 2000). Others have conceived the role as a joint medical-nursing model (Cummings et al., 2003).

Several US studies have highlighted the public's lack of understanding of the NP role (Johnson, 2001; Lindeke et al., 2001a, 2001b). One study highlighted considerable confusion about RN and NP education, with some participants believing that NPs had less education than RNs (Johnson, 2001). Educating the public about NP education and scope of practice using media campaigns can facilitate public understanding to help generate support, acceptance and utilisation of the NPs (Diers, 2004; Lindeke et al., 2001a, 2001b). In addition, a clear job description and a delineated scope of practice can only assist in reducing NP role ambiguity and consequently conflicting expectations (Carnwell & Daly, 2003; Cummings et al., 2003; Irvine et al., 2000; Kelly & Mathews, 2001; Knaus, Felten, Burton, Fobes, & Davis, 1997; Magdic & Rosenzweig, 1997; Tye & Ross, 2000).

However, it seems that the successful introduction of a role such as the NP into an organisation is complex (Richmond & Becker, 2005). Changes from the stereotypical expectations of nurses can cause disruption, tension and conflict among those resisting change (Stilwell, 1988). Power differences among dominant stakeholders can accentuate problems. It has been hypothesised that NPs move through the three stages of *idealism*, *organisational governance* and *resolution* as they progress from "experienced nurse to advanced nurse practitioner" (Woods, 1999b, p. 121). The second stage of *organisational governance* as a particularly critical adjustment period that is "both personally and professionally difficult and problematical for practitioners" (Woods (1999b, p. 127). During this stage NPs enter a period of *reality shock* as they negotiate the goals and parameters of their role with managerial and medical staff (Woods, 1999b).

2.6.2 The NP role and working relationships

The role behaviour of NPs is determined through the combination of individual and organisational role expectations (Topham, 1987). It has been argued that dominant stakeholders who are more powerful (actual or perceived) than individual NPs control how the advanced practice role is implemented (Bates, 1990; Germov & Freij, 2009; Woods, 1999b; Zelek & Phillips, 2003). As a consequence, NPs' expectations for their role become secondary to dominant stakeholders' intentions, for example, determining the percentage of time NPs spend in the clinical setting. In health care institutions, dominant stakeholders are often the medical practitioners (Bates, 1990; Germov & Freij, 2009; Woods, 1999b; Zelek & Phillips, 2003) followed closely by managers (Fagin & Garelick, 2004; Woods, 1999b). Rather than role expectations being created through a shared vision involving NP incumbents, they are determined by the more powerful organisational stakeholders (Woods, 1999b; Zelek & Phillips, 2003).

NPs have expressed difficulty adhering to their own ideals such as holistic care and health promotion while responding to physician expectations. They struggled to hold on to their identity (who they were), and their role (what they did), which created stress in the physician-NP relationship (Kelly & Mathews, 2001).

Since the 1950s, dissonance in responsibilities or priorities has been a strong catalyst for role conflict between health care professionals (Duffield & Lumby, 1994;Glen & Waddington, 1998; Jackson & Schuler, 1985; Rizzo, House, & Lirtzman, 1970; Smith, 1957; Van Sell, Brief, & Schuler, 1981). The introduction of NPs, in combination with changing work patterns, altered working relationships within health care teams (Draye & Brown, 2000; Irvine et al., 2000; Reay, Golden-Biddle, & Germann, 2003; Tye & Ross, 2000). Whilst studies have revealed medical support for the NP role (e.g., Marsden & Street, 2004; Waters, 1998) they more frequently report a lack of acceptance and resistance to the more autonomous role (Anderson, Gillis, & Yoder, 1996; Ball, 1999; Canada Health Services Research Foundation, 2004; Cummings et al., 2003; Irvine et al., 2000; Kelly & Mathews, 2001; Tye & Ross, 2000; Wilson, Pearson, & Hassey, 2002). Nurse practitioner roles that are medically oriented and supported by physicians are likely to have more medically based expectations (Irvine et al., 2000).

Medical practitioner resistance is complex and related to many factors. The perceived consequences of shifted boundaries between the NP and other professional groups have been identified as a major factor (Mullinix & Bucholtz, 2009; Norris, 2006) because of a fear of losing patients, and hence, a loss of income (Draye & Brown, 2000; Wilson et al., 2002) and challenge to their professional status (Hunter, 1969; Wilson et al., 2002). GPs, especially those who had not worked with an NP before, were especially cautious (Wilson et al., 2002). A UK study found that physicians who had never worked with an NP were concerned that their workload and stress would increase because the easier consultations would be managed by NPs and leave them with the more difficult and complex patients (Wilson et al., 2002).

Reservations about professional deskilling of nurses and doctors have been reported (Long, McCann, McKnight & Bradley, 2004; Reay et al., 2003; Tye & Ross, 2000; Wilson et al., 2002). Discussion about NPs' education as opposed to that of medical practitioners' has attracted considerable attention (Gardner, Gardner & Proctor, 2004; Wilson et al., 2002). Medical practitioner interest in NPs' education has related to the lack of uniformity, and the premise that only medical practitioners have the necessary training, skills and intellect to assess patients and diagnose disease (Elsom, Happell & Manias, 2009; Wilson et al., 2002).

2.6.2.1 NP-doctor collaboration

Collaboration is essential to advanced practice and thus the NP role (Keith & Askin, 2008; Kleinpell & Hravnak, 2005; Patterson & McMurray, 2003; Vazirani, Hays, Shapiro & Cowan, 2005) There is growing evidence that nurse-doctor collaboration improves patient care and outcomes (Ettner, Kotlerman, Afifi, Vazirani, Hays, Shapiro, & Cowan, 2006; Firth-Cozens, 1998; Kramer & Schmalenberg, 2003; Lockwood & Maguire, 2000; Patterson & McMurray, 2003; Stein-Parbury, 2007; Zwarenstein, Goldman, & Reeves, 2009) when health care teams share knowledge and accept joint responsibility for patient care (Bourgeault & Mulvale, 2006; Lindeke & Sieckert, 2005; Lockwood & Maguire, 2000; May, 2009; Scholes & Vaughan, 2002).

Components of the collaborative process include trust, communication, role negotiation, and conflict resolution. Critical elements in collaborative practice between doctors and nurses include communication, cooperation, assertiveness, shared decision-making, planning together, and coordination (Baggs, 1994; Baggs, Ryan, Phelps, Richeson & Johnson, 1992; Baggs & Schmitt, 1988).

Effective collaborative relationships require mutual trust and respect (Lindeke & Sieckert, 2005). While NPs view trusting relationships with doctors as important for the promotion of collaboration and for the development of their role (Draye & Brown, 2000; Irvine et al., 2000), they experience difficulty working with doctors who consider diagnosing and prescribing as specific to medicine (Duffy, 2005). It is difficult for NPs to collaborate with doctors who view them as a second-rate medical service (Anderson et al., 1996) and refuse to relinquish control and allow them autonomy. Unfortunately, factors such as the invisibility of nurse's contribution to health care and difference in income, gender and status have historically favoured medical practitioners (Fagin, 1992; Lindeke & Sieckert, 2005). Examples of obstructive behaviour by medical professionals include specialists rejecting referrals by NPs; physicians excessively scrutinising NP practice through repetitive questioning of their decisions and treatments (Kelly & Mathews, 2001), refusal to sign protocols that the NPs had developed (Carnwell & Daly, 2003) and even refusal to communicate with NPs (Tye & Ross, 2000). There are also accounts of obstruction by other health care professionals, such as pharmacists refusing to fill NP prescriptions (Brown & Draye, 2003; Edmunds, 2003).

2.6.2.2 Implementing the NP role and workplace compatibility

Studies have identified a lack of support, scepticism, resistance and ambivalence to the NP role from nursing colleagues and other health care professionals as particularly disappointing to NPs (Draye & Brown, 2000; Irvine et al., 2000; Tye & Ross, 2000). NPs have described a sense of a loss of identity, of not belonging or fitting in because they are neither traditional nurses nor physicians but members of a unique group. They have tried to cope with these difficulties by distancing themselves from other nurses (Draye & Brown, 2000). NPs reported ostracism by their colleagues, for example, through exclusion such as not being invited to attend medical or nursing meetings (Tye & Ross, 2000). Positive working relationships have developed over time between physicians and NPs, difficulties have continued with the NPs' nurse colleagues, although these relationships may have occurred because NPs focussed excessively on their relationships with the physicians to the detriment of their relationships with nurses and other health care professionals (Reay et al., 2003).

Nurses younger than 45 years old with a bachelor's degree have been found to be more supportive and receptive to an expanded role for nurses compared to older nurses 45 years and over with a diploma (Irvine et al., 2000). Younger nurses may have been less threatened

by the more experienced NPs and more receptive to reduced demarcation between nursing and medicine. The following section provides an overview of support and resources needed to help NPs implement their role.

2.6.3 Support and resources to help implement the NP role

The literature highlights that managers play an important role in the implementation of the NP role. Networking with other NPs may decrease their isolation especially for those that have minimal contact with their peers, and adequate resources are required to facilitate the NP role.

Health unit managers should monitor the NP's transition into the role. They should remain aware that "health professionals will test each other regarding their abilities to perform" and be ready to intervene during conflict and ensure that team members know the goals for the role (Reay et al., 2003, p. 400).

Managers have reported being aware of some experienced nurses' resentment towards the newly introduced NPs but they have admitted uncertainty as to how to intervene. It has been argued that managers have been tempted to frame the difficulties between NPs, nurses and other health care professionals as personal issues. However, the label "personal conflict" can mask system difficulties (Reay et al., 2003, p. 399).

NPs are more likely to feel part of the team if they are assessed as part of the overall team's performance. It is recommended that managers observe a team from a metaphorical balcony perspective and focus on team results rather than on individual NP performance. Because of the evolutionary nature of the NP role, managers will learn progressively as they deal with emerging issues (Cummings et al., 2003; Reay et al., 2003). There appears to have been minimal attention to necessary support for managers to help them integrate NPs into their health care settings. Managers are urged to share information and lessons learned while implementing the role with their management colleagues (Reay et al., 2003).

Local, regional and national NP networking is a beneficial support for NPs (Kleinpell & Hravnak, 2005) especially when they lack access to NP colleagues in their clinical setting or organisation (Draye & Brown, 2000; Lindeke, Jukkala & Tanner, 2005). Local networking enables NPs to learn more about other NPs within their organisation or geographic area. Regional networking is recommended to locate other NPs with similar roles or who can

serve as resources for patient care, to collaborate on quality improvement or research projects; and in forming professional collegial relationships. National networking through organisations, professional associations and conferences enables NPs to maintain their awareness of practice issues and share information. Committee membership provides professional opportunities for NPs and an opportunity for them to promote the role (Kleinpell & Hravnak, 2005).

Limited space or facilities have been cited as significant obstacles to NP practice (Lindeke, Hauck & Tanner, 1998; Sullivan, Dachelet, Sultz, Henry, & Carrol, 1978). Lack of office facilities has reportedly affected the quality of patient teaching, communication privacy and consultations with patients and other health care professionals. NPs report having difficulties from inadequate administrative support and believe that an unprofessional image is conveyed if they have no designated private space (Lindeke et al., 1998). It is unclear whether the lack of resources to implement the role is due to role ambiguity and a lack of understanding of the role, or symptomatic of a lack of management support for the role. Nevertheless, it has been recommended that NPs identify, articulate and negotiate their resources at their pre-employment interview, while emphasising to their prospective employer that well-designed workspace and adequate resources facilitate comprehensive, cost-effective care. These negotiated resources should comprise office space including desk and telephone, computer, reference material area, needed administrative support and budget for the position (Guest et al., 2001; Irvine et al., 2000; Lindeke et al., 1998; Martin & Hutchinson, 1999; Read et al., 2001). NPs had reported the need for more time for illness prevention or health promotion consultations and the need for dedicated time to maintain knowledge currency, especially in the area of pharmaceutical intervention (Kelly & Mathews, 2001).

2.6.4 Summary of influences on the NP role

Environments conducive to the NP must be thoughtfully and deliberately developed (Richmond & Becker, 2005). There needs to be a clear conception of the role and its expectations. NPs' implementation will more likely succeed when stakeholders work together towards a shared vision. A favourable environment will have health professionals collaborating, with individuals valued and their knowledge and skills recognised.

Resistance to the role complicates its implementation. The role of managers in the implementation of NPs has received insufficient attention. NP networking may decrease the isolation of NPs who experience minimal contact with their peers. Organisations should provide resources to support the role.

The following section explores the research literature that has evaluated the NP role. Evaluations are categorised into: clinical effectiveness, access to patient care, acceptability and patient satisfaction of the NP role.

2.7 Evaluations of NP practice

Despite the variability of NPs' scopes of practice and education between and within the countries, evaluation of NPs' practice dates back to its early introduction. NPs are "some of the most researched subjects in the health care delivery field" (Edmunds, 1978, p. 70) with the earliest evaluations about NPs dating from 1963. Early research provided information for other health professionals, and the studies helped shape others' perceptions of NP role development (Edmunds, 1978).

Edmunds (1978) termed the years 1963 to 1969 as the so-called *precursor period* that saw the beginning of a proliferation of studies comparing NP and physician practice, whereas the literature and research from 1970 to 1974 was more focussed towards nurses attempting a new role definition and legitimisation. "The philosophical battles of how nurses should be involved in primary care and their competencies in dealing with new responsibilities were paramount to this period" (Edmunds, 1978, p. 70). Nurse practitioners also "felt compelled to prove that they could provide more service at a lower cost [than physicians] with no decrease in quality…" (Edmunds, 1978, p. 72).

From 1975 the research progressed to the stage of "role consolidation and maturation" and was directed toward a range of issues relating to NP practice including patient compliance, long-term quality of care, the geographical distribution of NPs, and specific issues related to their education, personality and processes involved in their care (Edmunds, 1978, p. 70). When nurses moved into the established, medical domain of practice, it is important to evaluate NPs in terms of their clinical judgment and decision-making abilities, compared to those of physicians (Offredy, 1998; Stroud, Smith, Edlund, & Erkel, 1999). Hence, research into the NP role has been influenced by the debate in nursing and medicine about the role as

substituting for, or complementing the physician, rather than describing NP practice in its own terms (Diers, 2004). More recently, and increasingly there has been a refocus towards the clinical effectiveness (outcomes) research, cost-effectiveness and patient satisfaction with NP practice (Deshefy-Longhi, Swartz, & Grey, 2008) to guide NP practice and influence health policy (Courtney & Rice, 1995; Deshefy-Longhi et al., 2008; Shuler & Huebscher, 1998).

The next section explores the research literature that has evaluated the NP role in terms of its clinical effectiveness, access to patient care, acceptability and patient satisfaction and finally, the cost-effectiveness of NPs.

2.7.1 Clinical effectiveness of NPs

An early landmark 1970s Canadian study commonly known as the *Burlington Trial* was one of the first large randomised controlled trials by nurses and physicians comparing the 1-year health outcomes of patients treated by NPs or physicians in primary care practice. The trial found that NPs can provide first-contact primary clinical care as safely and effectively as the family physician with respect to physical, emotional, social function, mortality and quality of care, with as much patient satisfaction (Spitzer, Sackett, Sibley, Roberts, Gent, Kergin, Hackett, & Olynich, 1974; Sackett, Spitzer, Gent, & Roberts, 1974). Sox (1979) examined 40 evaluation studies of nurse practitioners or physician assistants and found their care to be closely comparable to the physicians.

Since then a number of randomised controlled trials have compared NP and physician practice. Another landmark randomised controlled trial by Mundinger et al., (2000) in the US sought to definitively answer through a large randomised controlled trial whether independent NPs provide primary health care to the same standard as physicians. Patients (N = 1316) were enrolled and randomly assigned to either obtain primary care in a NP practice or in a physician practice and no statistical difference (p = .92) was found in patients' health status at 6 months. It is unclear why health status was not studied at 1 year after the initial appointment, as happened for patient satisfaction and health service utilisation. There was a slight statistically significant difference for patient satisfaction favouring physicians 1 year after the patient's initial appointment. However, the researchers speculatively attributed difference to the NP practice being relocated before the recruitment and data collection were complete. There was no statistical difference in health services

utilisation between the NPs and physicians but there was a higher retention rate for the NP practice group compared to the physician practice group. Sox (2000), while acknowledging the quality of the Mundinger study, highlighted that the study addressed only short-term outcomes of care. Sox cautioned against applying the results to long-term primary care. Subsequently Lenz, Mundinger, Kane, Hopkins, and Lin (2004) undertook a 2 year follow-up (Phase 2) of the patients from the Mundinger et al. (2000) study referred to as Phase 1. The analysis included 406 patients, the results consistent with the 6-month findings of Phase 1 with no differences between the physician and NP groups in any of the outcome measures.

Other randomised control trials have found similar results for NP and medical practitioner practice on measures of patient satisfaction, cost effectiveness, decreased length of hospital stay and/or prevention of re-hospitalisation across a range of settings and specialties. For example, studies have been undertaken in primary care (Dierick-van Daele, Metsemakers, Derckx, Spreeuwenberg, Vrijhoef, 2009; Kinnersley Anderson et al., 2000), neonatal intensive care unit (Mitchell DiCenso et al., 1996); Venning, Durie, Roland, Roberts, & Leese, 2000), the emergency department (Chang et al., 1999; Cooper, Lindsay, Kinn, & Swann, 2002; Sakr et al., 1999); cardiovascular medicine (Stables et al., 2004) and aged care (Leveille et al., 1998).

The meta-analysis by Brown and Grimes (1995) identified that overall, randomised studies showed greater compliance to treatment by NPs, whilst non-randomised trials found greater patient satisfaction and resolution of pathological conditions by NPs.

A Cochrane systematic review (Laurant, Reeves, Hermens, Braspenning, Grol, & Sibbald, 2005) evaluated the effect of doctor-nurse substitution on primary care on patient outcomes and resource utilisation including cost. Patient outcomes included: morbidity, mortality, satisfaction, compliance, and preference. However, the study classified the nurses as nurse clinician, practice nurse, nurse practitioner, or unclear, the concern being that the care of nurses under the different nursing titles (and implying different levels of practice) was analysed as though the levels of care were equivalent. There was also no subgroup analysis separating the outcomes for each of the nurse groups, for example, practice nurse versus nurse practitioner. The findings suggested that appropriately trained nurses can produce as high quality care as primary care doctors and achieve as good health outcomes for patients.

In addition to meta-analysis, several authors have completed comprehensive reports of NP practice through systematic review and concluded that NP practice is effective, safe, well-accepted and cost-effective through a variety of different research measurements (Brown & Grimes, 1995; Horrocks et al., 2002; Prescott & Driscoll, 1979, 1980; Rudy et al., 1998).

2.7.2 Access to patient care

Improved access to care has been identified as a major NP benefit particularly for older patients, those with a disability, the long-standing mentally ill, the terminally ill, the homeless, those living in isolated communities, families with low income, patients newly discharged from hospital, and those experiencing transport difficulties (Luker, Austin, Willcock, Ferguson, & Smith, 1997; Perry, Thurston, Killey, & Miller, 2005; Poulton, 1994; Smith, 1990; Talley & Brooke, 1992). Prescribing privileges for NPs enable patients to receive prescriptions in a timely manner by eliminating separate visits to a GP (Luker et al., 1997) and avoiding delays in discharge caused by patients waiting for the medical practitioner to write a prescription (Mallett, Faithfull, & Rhys-Evans, 1997).

2.7.3 Acceptability and patient satisfaction

Numerous studies report high levels of satisfaction with primary care provided by NPs (Brown & Grimes, 1995; Cooper et al., 2002; Courtney & Rice, 1997; Hamric, Worley, Lindbak, & Jaubert, 1998; Horrocks et al., 2002; Knudtson, 2000; McMullan, Alexander, Bougeois, & Goodman, 2001; Venning, Durie, Roland, Roberts, & Leese, 2000).

Research into the NP role has identified a unique aspect about the caring processes of NP practice leading to high levels of patient satisfaction (Green, 2004), which is important because patient satisfaction is now recognized as a valid health service outcome measure (Donnabedian, 1996; Green & Davis, 2005; Larrabee, Ferri, & Hartig, 1997). Strong evidence supports a high level of satisfaction with the therapeutic relationship between NPs and their patients, which may be especially important to NP success in managing chronic and long term diseases (Deshefy-Longhi, Kinnersley et al., 2000; Swartz & Grey, 2008; Sullivan, 1982; Thrasher & Purc-Stephenson, 2008). Sullivan (1982, p. 8) noted that "NPs…show an uncanny ability not only to provide care equivalent to that of physicians, but also to offer something special that increases adherence [to treatment] or decreases symptoms." The suggestion here is that NPs' behaviour in delivering care apparently improves patients' perceptions and satisfaction. Several elements have been favourably

associated with patient satisfaction of NP services. NPs have been more likely than physicians to engage in counselling of patients (Deshefy-Longhi et al., 2008). Studies have shown high levels of patient satisfaction due to NPs' continuity of care (Johnson, 1993; Ramsay, McKenzie, & Fish, 1982; Thrasher & Purc-Stephenson, 2008), counselling activities (Deshefy-Longhi et al., 2008) and level of attentiveness and comprehensiveness of care (Thrasher & Purc-Stephenson, 2008). Patients have been found to be significantly more satisfied and informed about their illnesses with NP practice compared to physician care (Kinnersley et al., 2000). Patient satisfaction appears dependent on the availability of a NP and time spent with patients. With increasing patient loads and productivity-based reimbursement, the probable expectation for NPs to see more patients in less time may affect the care they provide (Green, 2004).

2.7.4 Cost-effectiveness of NPs

The literature generally supports the cost-effectiveness of NPs. However, different approaches have been used in economic analyses (Horrocks et al., 2002). NPs working in primary care have been shown to cost from 10 to 40% less than comparable services provided by medical officers (Appleby, 1995; Fitzgerald et al., 1995).

NPs use health resources cost effectively (Mundinger et al., 2000; Spisso, O'Callaghan, McKennan, & Holcroft, 1990) with NPs reported to be more likely to use non-pharmacological treatments (Mahoney, 1995; Sutliffe, 1996). While no significant difference was found in one comparison between NPs and GPs in relation to number of prescriptions, investigations ordered, referrals made, and re-attendances (Kinnersley et al., 2000), other studies have reported that NPs tend to order more investigations, write more prescriptions, and requested more return consultations than medical officers (Horrocks et al., 2002; Venning et al., 2000).

2.7.4.1 NP-physician collaborative practice model

Studies report positive effects from NP practice within a collaborative practice model (Hummel & Pirzada, 1994; Jenkins & Torrisi, 1995; Schreiber et al., 2003; van der Sluis, Datema, Saan, Stant, & Dijkstra, 2009). US studies in the acute emergency room (Jenkins & Torrisi, 1995) and a long term care facility (Hummel & Pirzada, 1994) suggest that NPs are most cost-effective when used in a team with medical staff, as opposed to teams comprising only medical staff.

2.7.5 Summary of NP evaluations

The research evaluating NP practice has demonstrated that NPs deliver safe, effective and cost effective care across a range of health care settings. NPs have been shown to improve patient access to health care, with high levels of patient satisfaction.

This and previous sections of this chapter described the development of the NP role in the US, Canada and the UK, the influences on the role's implementation and the research evaluating NP practice. The next sections set the scene for the introduction of NPs into Australia and specifically NSW by describeing the Australian health care system including the funding system and an overview of the NSW health care service. In so doing, it will help situate and contextualise the introduction of NPs into the Australian and NSW health care system.

2.8 The Australian health care system

This section describes the Australian health care system including the funding system and an overview of the NSW health care service. In doing so, it will help situate and contextualise the introduction of NPs into the Australian and NSW health care system.

The Australian healthcare system combines government and private service providers and funding (Australian Institute of Health and Welfare, 2008a). Government responsibilities are divided between the states and the Commonwealth, similar to the healthcare systems of the US and Canada (Australian Institute of Health and Welfare, 2006). Overall coordination of public health care delivery is the responsibility of the Commonwealth (Federal) Government and state and territory health ministers (Australian Institute of Health and Welfare, 2008a).

Australian health services are supported and informed by government and non-government agencies. Consumer and advocacy groups contribute to public discussion and policy development. Professional associations for health practitioners set standards and clinical guidelines, while the media influence health policy (Australian Institute of Health and Welfare, 2008a).

2.8.1 Health care expenditure in Australia

This section gives an overview of health care expenditure in Australia. Issues relating to the Medicare benefits scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) and private health insurance will be described.

Health care represents a major proportion of the Australian economy with annual health expenditure amounting to $86,879 million, or 9% of the gross domestic product (Australian Institute of Health and Welfare, 2008a). Approximately 70% of the total public health expenditure in Australia is funded by governments. The Commonwealth Government contributes two-thirds of the funding, with the state and territory and local governments funding the remaining third (Australian Institute of Health and Welfare, 2008a).

Non-government funding provides the remaining 30% of health expenditure and comes from out-of-pocket funds by individuals, benefits paid by private health insurance, providers of compulsory motor vehicle third-party insurance and workers' compensation insurance (Australian Institute of Health and Welfare, 2008a).

The Commonwealth Government's major contributions include the two national subsidy schemes: the publicly funded universal health insurance scheme called Medicare, and the Pharmaceutical Benefits Scheme (PBS) according to the Australian Institute of Health and Welfare (2008a).

2.8.1.1 The Medicare Benefits Scheme

Medicare is Australia's universal health insurance scheme. The aim of the national health care funding system is universal access to health care while allowing choice for individuals through substantial private sector involvement in delivery and financing (Department of Health and Ageing, 2005). The scheme has a schedule of fees for medical services (*items*) and provides free or subsidised treatment by private practitioners such as doctors and optometrists, and a limited range of dental services (Australian Institute of Health and Welfare, 2008a; Commonwealth of Australia, 2005). The scope of coverage changes as new items are introduced (Australian Institute of Health and Welfare, 2008a). Medicare also subsidises diagnostic services such as pathology tests, X-rays and ultrasound (Australian Association of Pathology Practices, 2008; Commonwealth of Australia, 2005). Some allied health professional services are covered when a patient is referred by a doctor to an approved program of care (Commonwealth of Australia, 2005).

Medicare provides for taxpayer funded public hospital and outpatient care for all Australian residents. Hospital-appointed medical practitioners provide medical care for public patients at no immediate cost to the patient (Australian Institute of Health and Welfare, 2008a). The fee is funded by a levy on taxable incomes.

2.8.1.2 Medicare and the Australian GP

Medicare provides free or subsidised treatment only by medical practitioners including GPs and specialists, selected nonmedical services, and some delegated services from practice nurses (see below for further information about practice nurses) under the direction of the medical practitioners in whose name the claim for reimbursement is made (Commonwealth of Australia, 2005; Medicare Australia, 2009). Thus, there is limited direct access to the national health scheme for non-medical practitioners. Nurses in Australia are currently ineligible for direct reimbursement of their services for ordering of diagnostic or pathology tests.

As in many other countries, the general medical practice has traditionally been central to both the primary healthcare system and the health system overall, mostly because GPs are usually the first point of contact in the healthcare system (Australian Institute of Health and Welfare, 2008a). Approximately 85% of the population visit a GP at least once a year (Medicare Australia, 2005). The 2004-05 National Health Survey reports that over any 2-week period almost one in four Australians visit a medical practitioner (Australian Bureau of Statistics, 2006). Traditionally, the GP has assumed the role of gatekeeper to the health care system in Australia (Britt, Valenti, & Miller, 2005; Lockwood & McGuire, 2000; Williams, Chaboyer, & Patterson, 2000). The NSW Department of Health (2002) identified that one third of GP participants in a review reported chronic disease management representing 75% of their total workload. Half of participants reported chronic disease management as comprising 50% of their total workload.

The operation of Medicare has implications for the deployment of the health workforce. There is limited encouragement for the delegation of Medicare-supported services to health care professionals other than medical practitioners. GPs influence the extent to which nurses, medical specialists, allied health professionals and hospital services are used (Williams et al., 2000). The lack of Medicare-supported services limits other health professionals including nurses (e.g., NPs) from referring patients for specialist treatment or diagnostic tests (Commonwealth of Australia, 2005). It has been argued that current national health funding

arrangements discourage new models of care and undermine equity of access to health care (Commonwealth of Australia, 2005).

Total spending by the Australian Government on medical benefits was $9.9 billion in 2004-2005, of which about a third was for GP services. In the case of GPs, Medicare benefits accounted for about 90% of income derived from consultations (Commonwealth of Australia, 2005). Medicare pays up to 100% of the scheduled fee for GP consultations and up to 85% for services provided by medical specialists. However, medical practitioners are not obliged to adhere to the scheduled fees except when directly-billing Medicare for the full schedule (*bulk-billing*). Approximately 75% of all GP services are bulk-billed (Commonwealth of Australia, 2005). For GPs who do not bulk bill, the patient provides payment up-front to the GP, and later submits a claim to Medicare for partial reimbursement. Patients meet the cost of GPs charges over and above the schedule fee (Australian Institute of Health and Welfare, 2008a).

2.8.1.3 Practice Incentives Program and the Australian GP

Through Medicare, the Commonwealth Government funds initiatives to support GP practice. Under the Practice Incentives Program (PIP), GPs can receive payments above the regular Medicare amount. PIP payments recognise aspects of general practice "that aim to improve the quality of care provided to patients " (Medicare Australia, 2009, p. 1). These payments suggest that GPs in Australia require financial incentives to provide best practice, particularly since these incentives are unavailable to other health care professionals.

The PIP supports GPs' employment of other health professionals. The Mental Health Nurse Incentive Program provides $10,000 to $20,000 annually to encourage psychiatrists or GPs to employ a mental health nurse. The PIP Practice Nurse Incentive encourages GPs in rural and remote areas to employ practice nurses or Aboriginal health workers. The Practice Nurse Incentive is available in urban areas of workforce shortage (Medicare Australia, 2009).

2.8.1.4 Practice nurses and the Australian GP

There has been a nursing presence in Australian general practice for many years (Halcomb, Davidson, & Patterson, 2007). However, it was not until the late 1990s that the practice nurse (PN) role began to gather momentum (Halcomb et al., 2007). This was around the same time that the NP role was being developed and first implemented into the NSW health care system. A lack of GP remuneration for services provided by the practice nurse was seen

as a major obstacle to expanding the role While the role of the practice nurse is seen to have gained momentum because of the increased shift from secondary to primary health care (Halcomb et al., 2007), uptake of practice nurses by GPs increased dramatically following the 2001-2002 Federal Budget when the Government allocated $104.3 million to support the employment of PNs by GPs over the ensuing 4 years. A further 4 year's funding was allocated in the 2005-2006 Budget. This funding substantially increased GPs' support for the role and also demonstrated the Commonwealth Government's strong support for the PN role (Walker, 2006).

In November 2004 the Department of Health and Ageing introduced new Medicare items that allowed GPs to claim for specific tasks undertaken by a practice nurse, "under the direction of the medical practitioner in whose name the Medicare claim is made" (Commonwealth of Australia, 2005, p. 158). The GP is not required to see the patient at the time of the practice nurse service. The tasks for which such claims can currently be made are immunisations, treatment wounds, and taking cervical smears in regional rural or remote area practices (Britt et al., 2007).

As in the UK, there has been strong support for the practice nurse role by Australian GPs and the Australian Medical Association (Australian Medical Association, 2007). Practice nursing is described by the Australian Practice Nurse Association as the fastest growing area within the Australian health care sector and covers many specialist areas including aged care, women's health, men's health, infection control, chronic disease management, cardiovascular care and immunisations (Australian Practice Nurses Association, 2008).

2.8.1.5 The Pharmaceutical Benefits Scheme

The Commonwealth PBS subsidises medications prescribed by doctors and dispensed in the community by independent private sector pharmacies. Currently, only doctors, dentists and optometrists have the authority to write a PBS prescription (Department of Health & Ageing, 2009a). Nurses, including NPs, in Australia have no access to the PBS.

Public hospitals provide medicines to inpatients free of charge and do not attract PBS subsidies. Non-prescription medicines are available from pharmacies and grocery retailers (Department of Health and Ageing, 2005).

2.8.1.6 Private health insurance

In addition to Medicare and PBS, Australians can optionally insure privately for public and private hospital cover (Commonwealth Department of Health and Aged Care, 2000). In 2005-2006, private funds contributed approximately 34% of total spending (Australian Institute of Health and Welfare, 2008a). Approximately 44% of Australians were covered by basic private health insurance as of June 2006 (Australian Institute of Health and Welfare, 2008a). In addition to rising insurance premiums, dissatisfaction with private insurance is attributed to patients' large and often unpredictable out-of-pocket expenses. As with the Medicare rebate system, private insurance rebates cover only scheduled medical fees; actual fees charged by medical practitioners can be much higher. Privately insured and uninsured patients receive identical medical treatment in a public hospital but the private patient can receive a large bill that is not reimbursed by private insurance, while the uninsured patient pays nothing (Hall, 1999). Unlike other countries such as the US and Germany, Australia has almost no employer-based health insurance schemes (Australian Institute of Health and Welfare, 2008a).

Having provided an overview of the Australian health care system, the next section relates to health care in NSW.

2.8.1.7 Health care in New South Wales

New South Wales is the most populous Australian state (Australian Bureau of Statistics, 2008a). The NSW Department of Health (known as NSW Health) supports the executive and statutory roles of the Commonwealth Minister for Health (NSW Department of Health, 2009).

New South Wales public health services include more than 220 public hospitals, 500 community, family and children's health centres, 220 ambulance stations, and a range of other services including mental health, dental, allied health, public health, Aboriginal health and multicultural health services (NSW Department of Health, 2009). Area Health Services in NSW have the main responsibility for health care delivery in their designated regions, which consist of areas within greater metropolitan Sydney, or rural and remote districts covering much larger geographical areas. Responsibility ranges from metropolitan tertiary health centres to primary care posts in the remote outback and rural areas.

In 1993 the management structure of Rural Health Services was reorganised expanding six non-metropolitan regions into 23 District Health Services with the aim of reducing bureaucracy and administrative overhead costs (See Appendix I). These 23 District Health Services were later reduced to eight rural AHSs following a 1995 review of the NSW Department of Health organisational structure (Liang, Short, & Lawrence, 2005).

In July 2004 the NSW Minister for Health announced that the NSW health care system was to undergo another major restructure, including the merging of 17 AHSs to eight (See Appendix I). This restructuring included the amalgamation of three rural and remote AHSs into one, thus substantially increasing its area of responsibility. Across NSW, these reforms were targeted toward unlocking up to $100 million a year for additional front line health care and less on health administration (NSW Department of Health, 2004a).

A typical day for NSW Health across the state of NSW includes:

- An ambulance responding to an emergency call every 30 seconds;
- 6000 patients arriving at emergency departments seeking treatment;
- 4,900 people admitted as in-patient at a hospital;
- 17,000 occupying hospital beds of whom 7,480 are over 65 years old;
- 7,000 procedures performed.

More generally:

- $13 billion or 27% of the budget of the NSW government is spent on health care;
- $34 million spent on providing care in public hospitals, and other health care in NSW, representing almost $1.5 million for each hour of the day (Garling, 2008).

The next section describes the changing health care needs in Australia that are increasingly placing pressure on the effectiveness and efficiency of the health care system.

2.8.2 Changing nature of health care in Australia

The proportion of the population relying on the public system has grown markedly in recent years with the Australian healthcare system under increasing pressure to deliver high quality service to more users with limited resources (Williams, Chaboyer, & Patterson, 2000). Total

health expenditure in Australia is expected to increase by 127% over the three decades between 2002-03 and 2032-33, from $71 billion to $162 billion with total health expenditure projected to increase from 9% of GDP to 10% (Vos, Goss, Begg, & Mann, 2008).

The increased burden on the Australian health care system will happen through factors such as population growth (NSW Department of Health, 2009), the number of patients being treated in hospitals (Garling, 2008), population ageing (Australian Bureau of Statistics, 2008a; Australian Institute of Health and Welfare, 2008a; NSW Department of Health, 2009), less extended family support (NSW Department of Health, 2009), patients presenting with more complex and chronic conditions (NSW Department of Health, 2009), and mental health problems, drug and alcohol dependence (Garling, 2008). Advancements and costs in technology and pharmaceutical products add to the complexity of healthcare (Commonwealth of Australia, 2005; Garling, 2008).

There is strong evidence that health is not uniformly enjoyed across socio-economic indicators. Sickness (measured as days of reduced activity), and reported decreased health (poor or fair) are significantly related to occupation, education and family income. Similar inequalities relate to mortality. Socio-economic status is the strongest indicator for premature death in Australian males (Duckett, 2000).

In Australia, the combination of geography and population presents particular challenges for the health care system. The population of 21,374,000 (Australian Bureau of Statistics, 2008b) is widely distributed across 7,692,024 square kilometres but is highly urbanised, with over 70% living in metropolitan areas and mainly along the 25,7600 kilometres of coastline. The health of Australians in rural and remote areas is generally worse than for those living in major cities (Australian Institute of Health and Welfare, 2006). Recently, there has been increasing attention on improving the health of the 34% of Australians who live in rural and remote areas. They have higher mortality rates and higher risk factors than those living in metropolitan areas. People living in rural and remote areas are more likely to be smokers, drink alcohol in hazardous quantities, to be overweight or obese, (Australian Institute of Health and Welfare, 2005) have lower levels of education and poorer access to work (Garnaut, Connell, Lindsay, & Rodriguez, 2001), and have less access to specialist medical and other health services (Australian Institute of Health and Welfare, 2006). Health workers in rural and remote areas tend to work longer hours than those in metropolitan areas, which partly compensates for their fewer numbers. However, longer working hours impose

additional strain on these workers, resulting in difficulties in staff retention in the longer term (Australian Institute of Health and Welfare, 2006). In addition to changing health care needs, there are a number of health workforce demographic influences on health care in Australia and these are discussed in the next section.

2.8.3 Changing health workforce demographics in Australia

Demographic changes in Australia mean that many people no longer live close to a hospital or even a GP. Medical practitioners are unevenly distributed across the population, especially in rural and remote areas (Garling, 2008). *The Final Report of a Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (known as *The Garling Report*) identified that newly qualified medical practitioners are attracted into work as specialists because the financial rewards (in part driven by the Medicare schedule of fees) are greater than the rewards for work as generalists despite the greater need for GPs (Garling, 2008).

The uneven distribution of medical practitioners across Australia contributes to different levels of health care access. The supply of medical practitioners (specialists and non-specialists) in Australia favours major cities, with 335 full-time equivalents (FTE)[1] per 100,000 population, much higher than for inner regional (181), outer regional (153) and remote or very remote areas (148) where the ratio of the number of medical practitioners to the population is considered low (Australian Institute of Health and Ageing, 2008a). Rural and remote areas in Australia have long experienced medical workforce shortages, particularly in terms of general practice services and some specialist services such as obstetrics and gynaecology (Department of Health and Ageing, 2008a). In recent years, the medical workforce in rural and remote Australia has increased modestly on account of restrictions to Medicare provider numbers for overseas trained doctors to encourage them to work in rural and remote areas. In 2006-2007 one third of doctors working in Australia were trained overseas with 41% of these working in rural and remote areas (Department of Health and Ageing, 2008a).

[1] The FTE rate (the number of FTE health workers per 100,000 population) is a measure of supply. By defining supply in terms of FTE rate, meaningful comparisons of supply can be made across geographical areas and, over time.

Table 4shows that numbers of GPs decrease substantially with remoteness, with the lowest supply to remote and very remote areas, particularly in New South Wales (Department of Health & Ageing, 2008a).

Table 4 Private general practitioners 2006-2007: Total number by state or territory and remoteness

State or territory	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote	Total
New South Wales	6,110	1,612	412	50	3	8,187
Victoria	4,696	1,184	297	6	-	6,183
Queensland	3,120	1,007	750	178	143	5,198
Western Australia	1,776	257	273	139	55	2,501
South Australia	1,504	226	242	58	23	2,053
Tasmania	–	498	158	10	8	674
Australian Capital Territory	412	–	–	–	–	412
Northern Territory	–	–	142	103	109	354
Australian total	17,619	4,785	2,274	545	341	25,564

Source: Department of Health & Ageing (2008a)

Nurses form the largest and most evenly distributed health profession group working in rural and remote communities (Commonwealth of Australia, 2005). Nursing continues to be female-dominated, with males constituting only 7.9% of employed nurses in 2005, down from 8.4% in 2001 (Australian Institute of Health and Welfare, 2008b). Nurses in public hospitals in NSW are frequently junior nurses, with insufficient senior nurses to supervise them. It has been estimated that 22% of the entire nursing profession in NSW qualify for retirement in 2011 (Garling, 2008).

Unlike the distribution of GPs, the supply of nurses is more evenly across urban and remote regions. Between 2001 and 2005 the nursing population increased in all regions of Australia, with the largest number occurring in outer regional areas, from 1,059 to 1,190, and very remote areas, from 957 to 1,078; these rises resulted from increases in nurse numbers being larger than population growth (Australian Institute of Health and Welfare, 2008b). Table 5

shows that, overall the distribution of nurses is relatively even when considered at a national level, but there are considerable variations across state and territories and across remoteness within most jurisdictions. New South Wales has significantly fewer nurses in proportion to its overall population. However, in contrast to medical practitioners, the nursing workforce is evenly distributed across the states (Australian Institute of Health and Ageing, 2008b).

Table 5 Enrolled and registered nurses 2005: Ratio per 100,000 population by state or territory and remoteness

State or territory	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote	Total
New South Wales	1,016	1,157	1,005	951	1,122	1,080
Victoria	1,245	1,493	1,668	1,638	–	1,375
Queensland	1,005	1,013	1,040	866	1,168	1,044
Western Australia	1,164	772	1,152	1,018	1,128	1,139
South Australia	1,508	876	1,342	1,470	1,339	1,534
Tasmania	–	1,577	911	781	1,799	1,369
Australian Capital Territory	1,156	977	–	–	–	1,263
Northern Territory	–	–	2,052	1,439	859	1,710
Australian total	1,136	1,199	1,190	1,090	1,078	1,202

Source: Australian Institute of Health and Welfare (2008b)

Because of the changing nature of health care and the changing health workforce demographic, governments are increasingly examining ways to curb rising health care expenditure. The following section describes factors that have affected the efficiency and effectiveness of health care in Australia including the influence of cost-shifting between the Commonwealth and state governments.

2.8.4 Efficiency and effectiveness of health care

There has been increasing realisation for the need to improve the efficiency and effectiveness of service delivery and quality of healthcare to limit healthcare expenditure (Commonwealth of Australia, 2002b). Inefficiency within the health care sector is said to cost at least $2 billion a year (Leeder, 2003). Traditionally, efficiency budget cuts have led to

cutting staffing levels or deferring costs such as the replacement of worn carpet; economists refer to this form of efficiency achieved within hospitals as *technical efficiency* (Leeder, 2003). However, there is a limit to technical efficiency. More recently, there has been increased interest by economists in efficiency savings from allocation of resources (Leeder, 2003). Inefficiency in the allocation of resources in the health care system is termed *allocative inefficiency* (Leeder, 2003). Lack of coordination between state-funded health services with general medical practice and Commonwealth-funded services is a major contributor to allocative inefficiencies in the Australian health care sector (Leeder, 2003). This allocative inefficiency is aggravated by cost-shifting between the between different levels of government (Commonwealth of Australia, 2008).

The Australian health care system is considered outdated because it was designed for a population composition in a different social, political and economic context (Armstrong, 2008). For example, the increase in the incidence of chronic illness means that up to 75% of the total health budget now goes into managing people with chronic illnesses. Australia has the highest numbers of acute beds per head than any other country but initiatives for health promotion and illness prevention continue to be neglected and poorly supported (Armstrong, 2008; Commonwealth of Australia, 2009). Preventative initiatives have concentrated on the acute care sector, with suboptimal links to general medical practice and community care. As a consequence, prevention initiatives have not effectively reached those most at risk (Armstrong, Gillespie, Leeder, Rubin, & Russell, 2007). Inadequate prevention in the community often leads to patients being re-admitted to hospital, requiring a higher level of resource allocation (Leeder, 2003). Chronic disease itself has further exposed allocative resource inefficiencies. Chronic disease can persist for decades, requiring multiple care modalities such as general practice, hospital and community services. If this care is unavailable because of cost, geography, lack of coordination between services or insufficiency in a particular care modality, the overall service becomes inefficient (Leeder, 2003).

There is almost universal agreement that the health care system must focus on prevention and better management of chronic illness (Department of Health & Ageing, 2006; World Health Organization, 2005; World Health Organisation, 2008). In Australia, it is increasingly recognised that resources should be targeted at populations with the greatest need, especially indigenous communities, establishing better links between acute, primary, and rehabilitative

services while developing innovative ways of delivering health care to rural and remote communities. In the past it has been difficult to achieve these goals in an inflexible system that focuses on fee-for-service and isolated episodes of acute care, growing-out-of-pocket costs for patients, and health workforce shortages (Armstrong et al., 2007). Increasing out-of-pocket costs for patients visiting general practitioners and specialist services and too few subsidies for the services of other health professionals are seen by an increasing number of commentators as contributing to the inefficiencies of the health system (Armstrong, 2008).

Incremental changes in health policy primarily at the state and territory level of Government are favoured over major national health care reforms (Hall, 1999; Roxon, 2008). Indeed, it is argued that the Australian health system is not a system at all but a series of disconnected programs funded by different governments through different mechanisms (Armstrong, 2008). The multiple funding streams and separate instrumentalities lead to service duplication, with billions of dollars wasted each year on administration costs that ensure a flow of funds to keep disparate programs afloat but actually diminish the total available resources to deliver health care (Armstrong, 2008).

2.8.4.1 Cost-shifting between Commonwealth and state governments

The current division of responsibilities between the states and federal governments means that *technical* and *allocative* inefficiencies have plagued health funding, preventing accountability and transparency (Armstrong, 2008). Costs and blame are shifted from one government to another; when people move from one part of the system to another, there is substantial incentive for each level of government to shift costs, and to blame the other administration when services fail community expectations. State or territory funded emergency departments become overcrowded when people are unable to get appointments to see federally funded GPs. Elderly people have been unable to access a federally funded aged care bed, forcing them to stay for an extended time in a more expensive state funded hospital bed (Armstrong, 2008). Other examples of cost-shifting include patients being discharged from state funded public hospitals with only a few days worth of medications, so the cost of medications is shifted to the federally funded PBS when patients fill a prescription at a private pharmacy. This fragmentation and lack of coordination of the health system has led to poor continuity of care throughout the patient's health care journey (Armstrong, 2008).

Changing and increasing health care needs with the changing demographics of health care workers (including the lack of doctors in rural and remote areas) have led to Commonwealth

and state governments becoming increasingly interested in workforce reforms as a way to help control health care costs. Traditional health care roles and responsibilities, including those in nursing, are increasingly being examined and new roles developed. New roles and clinical career paths for nurses in NSW have been developed and there is increasing government interest in role differentiation. These issues are discussed in the next section.

2.8.5 Workforce reforms: Changing roles and responsibilities

Given that contemporary health care roles have been unable to meet patients' needs, there has been increasing interest in health workforce reforms (Australian Institute of Health and Welfare, 2008a). This interest in the health workforce has involved predicting health services and the likely types of health professional roles needed in future years. Models of care, including those in nursing, are being examined in terms of both their cost to the health care system, and added value to consumers (Chapple & Sergison, 1999).

2.8.5.1 New clinical career paths for nurses in NSW

Until 1986 there was no avenue for frontline clinical nurses to progress their career at the clinical level in Australia (NSW Department of Health, 2008). As a consequence, the only career progression for nurses and midwives was to leave clinical nursing to take a position in management or education (Daly, Speedy, & Jackson, 2004; NSW Department of Health, 2008). Ultimately, nurses were financially rewarded for not practising clinical nursing (Chiarella, 2002). Nurses have indicated that an inadequate clinical career structure is one of the main reasons why they leave the profession, as evidenced by the critically low level of retention of experienced nurses (Appel & Malcolm, 1999, 2002; Driscoll, Worrall-Carter, O'Reilly, &Stewart, 2005; Harris & Chaboyer, 2002; NSW Department of Health, 1996; Turner, 2001).

In 1986 the formal recognition of expert clinical nursing was agreed to by the Public Hospital Nurses (State) Conciliation Committee. The new classifications of Clinical Nurse Specialist (CNS) and Clinical Nurse Consultant (CNC) were included in the NSW Public Health System Nurses' (State) award (NSW Department of Health, 2008). The CNS classification was designed "to cater for nurses who function as resource personnel and sources of expert nursing knowledge within their unit and speciality," whereas the CNC classification was intended to "cater for specialist nurses who fulfil a cross-hospital or cross-

area or regional role and who are principally involved in clinical consultancy, review, assessment and research" (Dickenson, 1993, pp. 257-258).

Along with the formal recognition of specialist nurses came the acknowledgement that nurses practice at different levels of expertise and scopes of practice (Commonwealth of Australia, 2002b). There is an overall shortage of nurses in Australia, and also an increased demand for nurses with enhanced skills who can manage a more diverse and complex patient population and changing health care needs (Duffield, Gardner, Chang, & Catling-Paull, 2009). Australian policy makers and nurses, as in the US, Canada and UK, turned their attention to the introduction of new practice roles (National Nursing and Nursing Education Taskforce, 2006a) such as the nurse practitioner and practice nurse.

2.8.5.2 Confusion surrounding role differentiation in nursing

In nursing, terms such as *expanded*, *enhanced*, *advanced*, *expert* and *extended* are often used to distinguish between different nursing roles. However, there is little uniformity and consensus in the use of these terms, leading to confusion about how these terms differ and relate to each other (Betts, 2007; National Nursing and Nursing Education Taskforce, 2006a; Sutton & Smith, 1995).

Role extension implies a unilateral lengthening process (Murphy, 1970; Rolfe & Fulbrook, 2001). Historically, the authority base from which the extended role of the nurse originates has been the medical practitioner who "allows" nurses to undertake additional delegated technical tasks (Lenehan & Watts, 1994; Murphy, 1970, p. 383).

Role expansion is a spreading out or a process of diffusion, and implies multi-directional change (Murphy 1970; Rolfe & Fulbrook, 2001). Expansion is not only about filling perceived gaps in the health care system but it is also the creation of new components or systems of health care. "The authority base from which the expanded role of the nurse emanates is the theoretical (university based) and clinical knowledge that incorporates a broad spectrum of health care needs" (Murphy, 1970, p. 384). Nurses who have been socialised into an expanded role tend to apply broad theoretical principles to patient care. For example, rather than just viewing a physical examination as a technical task, the nurse is responsible for the primary care of patients through the assessment of care needs, planning and evaluation of the care given. Any role overlap between nurses and physicians should be

viewed as a broadening of nurses' contribution to health care rather than impinging on physicians' roles (Murphy, 1970).

The *care-cure* conceptual model emphasises the difference between extended and expanded practice. Historically, the physician is primarily responsible for *curing,* and the nurse for *caring* for patients (Schulman, 1958; Chiarella, 1998a). Whilst the two roles can intersect, the well person does not require a cure and there would be no overlap (Millis, 1970). The complementary nature of the two professions leads to the confusion. What is important is the recognition that it is an overlap of functions or activities, rather than a takeover of roles (Chiarella, 1998a).

As health care has increased in complexity, so has the complexity of the work of the nurse, leading to the evolution of nursing to meet the needs of communities that nurses service. Many of the tasks which nurses now undertake were originally performed by medical practitioners, but that does not detract from the fact that these tasks can now fall within the ambit of the nursing because patients' wellbeing would be diminished if they did not do so (Chiarella, 1998b).

The various types of role skill-mix have been categorised as *delegation, enhancement, substitution* or *innovation*. Delegation refers to moving a particular task up or down the conventional disciplinary ladder, for example, the delegation of the administration of some medications to enrolled nurses. Enhancement increases the depth of a job by extending a particular group of workers' role or skills. Enhancement might include adding new responsibilities within nursing or medicine, for example, development of the NP role as distinct from that of other advanced practice nurses. Substitution refers to the expansion in the breadth of a job, in particular by working across professional divides or exchanging one type of work for another. Substitution occurs when one health profession takes on some of the responsibilities or tasks of another health profession. Thus the difference between enhancement and substitution is subtle. Innovation refers to the creation of new jobs by introducing a new type of worker. New job titles such as the NP are introduced by governing bodies to formally recognise, and are regulated to undertake new roles which require revisions to their training, skills and competencies (Sibbald et al., 2004).

Nurse scholars generally accept that the NP role is a combination of *enhancement* and *innovation* (Dreher, 2008; Humphris & Hean, 2004; Sibbald et al., 2004). The nursing

profession makes a clear distinction between role enhancement (or expansion) and role substitution. Role enhancement is based on the assumption that nursing is distinct from medicine. Enhancement involves expanding and diversifying the scope of nursing practice within its accepted domain. The NP provides an opportunity for enhancement by enabling advanced practice nurses to offer more services to patients, increase access to health care and to deepen their practice (Humphris & Hean, 2004).

A substantial literature reveals considerable confusion about the term *advanced practice* (Betts, 2007; Buchan & Calman, 2004; Callaghan, 2007; Castledine, 1997; Duffield, Gardner, Chang, & Catling-Paull, 2009; Gunn, 1998b; Manley, 1997; Rose, Waterman, & Tullo, 1997; Ruel & Motyka, 2009; Schober, M., 2006; Trim, 1999; Walsh, 1997; Woods, 1999a). Whereas the terms *extended*, and *expanded* practice have been used interchangeably (Commonwealth of Australia, 2005) in Australia they are generally regarded as components of advanced practice. Advanced practice is referred to by the Royal College of Nursing Australia (2006, n.p) as a "level of nursing practice that utilises extended and expanded skills, experience and knowledge in assessment, diagnosis, planning, implementation and evaluation of the care required." In addition, "advanced practice nurses have acquired expert knowledge, complex decision-making skills and clinical competencies for expanded practice… and educationally prepared at post-graduate level" (Royal College of Nursing Australia, 2006, n.p). Thus, NPs in Australia are recognised as "advanced practice nurses who are regulated, educated and prepared to provide comprehensive care in a modern, safe way" (National Nursing and Nursing Education Taskforce, 2006a, p. 16).

2.9 Summary of Chapter 2

In this chapter I have comprehensively reviewed the development of the NP role in the US, Canada, UK and Australia. The influences on the role's development and implementation were examined, and evidence relating to its clinical effectiveness was provided. Understanding the historical developments in the US, Canada and UK provide an international context for this thesis.

Discussion on the Australian health care system, and specifically in NSW, assists understanding of the system's structure, factors that influence its functioning and need for changes in the NSW health care workforce. While the introduction of NPs was largely in response to deficiencies in the provision of health care in NSW, there was also increasing

acknowledgement that nurses practice at different levels of expertise and scopes of practice (Commonwealth of Australia, 2002b). Policy makers and nurses began examining new nursing roles including that of the NP. Further discussion examining the antecedents to the NP role is provided in Chapter 4.The following chapter describes the nature of the historical research design and its utility and implementation in this study.

Chapter 3 – Method

In biography the spotlight is focussed on one actor, in history the whole stage is lit.
(Newton, 1965, p. 21)

Descriptive historical research explores past events, their influences, and conditions under which decisions are made. Future decisions can then be informed and guided by learning from the past. Accurate depiction of events helps prevent accidental or deliberate misinterpretations or inaccuracies that may or may not be influenced by individual or collective agendas. Historical research presents a systematic way of collecting, analysing and presenting the evidence. It exposes chronological elements and key events important to the purpose of the research.

The paucity of research related to the NP role in Australia in general and NSW in particular indicated a pressing need to document the early history of its development. For this reason historical descriptive research was used to document, analyse and explore the development of the NP role in NSW, the first state to introduce NPs in Australia. This chapter describes historical research, argues for its value and relevance, and describes how it was used in this study. The study design is described. This research set out to answer the follow questions:

3.1 Research Questions

- What were the key historical events that shaped the early framework for the development of the NP role in NSW?
- What were the experiences of the NPs during the early development of the role?
- What were the experiences of the key stakeholders during the early development of the role?
- What were the social, political, cultural and economic conditions that influenced the introduction of the NP role into NSW?

The research also sought to:

- Provide direction for the ongoing development of the NP role in Australia by learning from past successes and mistakes;
- Provide insight and direction for the development of future innovative nursing roles.

3.2 The nature of historical research

"The nature of history and its credentials as a discipline have long attracted sophisticated and passionate discussion" (Holmes, 2008, p. 101). As Rafferty (1996) points out, nursing has not been without its historians. She cites the important studies by Lynaugh and Reverby (1986) in the US and Maggs (1983) in the UK who moved nursing research on from the more "hero-centred" view of history to include the wider social and political context in which nurses work (Rafferty, 1996, p. 167).

Historical research presents a systematic way of collecting, analysing and presenting the evidence. It examines individuals, societies, and events in the past (Burns & Grove, 2003; Fitzpatrick, 2001). It exposes chronological elements and key events important to the purpose of the research. Historical research should also contribute to scholarly understanding by illuminating a new perspective (Lusk, 1997).

D'Antonia (2005, p. 241) argues that historical research contributes to nursing's "sense of itself." For D'Antonio (2005, p. 241), it is insufficient for nurse historians merely to provide "more analysis, explore ambiguities, or develop more compelling critique". Rather, historians of nursing must also state not only about "what succeeded and what failed," "what was right and what was wrong," but also "what was good" and "what was bad" (D'Antonio, 2005, pp. 241-242).

Historical research examines an event or social phenomenon by studying its historical context or past (Borbasi, Jackson, & Lanford, 2008), so that events can be explored and themes created through the exploration of opinions, facts and suppositions (Diers, 1979; Rafferty, 1996). However, facts alone are a "bare skeleton and a compilation of them alone a fruitless exercise" (Newton, 1965, p. 20). Historical researchers explore the meaning of facts, the relationships between them and whether they are new or have appeared previously (Newton, 1965). When key concepts and relationships are identified an attempt can then be made to understand their *strength* (Rafferty, 1996) and effect on the present (Borbasi,

Jackson, & Lanford, 2008; Newton, 1965). Similarities and differences between events or phenomena in the past can also be explored (Borbasi et al., 2008).

Historical research also investigates "what should be" (Borbasi et al., 2008, p. 160). That is, historical research helps us learn from past successes, challenges and mistakes to guide us in the future (Newton, 1965). Learning from the past to prevent future mistakes may imply that history can *predict* the future (Holmes, 2008; Newton, 1965) or identify causal factors (Rafferty, 1996). While knowledge of the past can help predict the future, most historians acknowledge that historical research is not an exact science. Historians, at best, can only suggest likely outcomes and possibilities according to similarities of the present with the past (Holmes, 2008).

It has been argued that the relevance of history declines with time. However, if this were true, as Holmes (2008) states, "then there would be no lessons to learn from ancient philosophy, literature or arts, and the great works of the past could be consigned to the flames…" (p. 103).

Historical research can examine traditions. Health professions such as nursing are laden with traditions that can either benefit or hold back the profession (Newton, 1965). Studies of nursing's past can uncover traditions that should be preserved and traditions that have undermined nursing's professional growth and should be discarded (Newton, 1965). Historical research can identify the dangers of inertia which tradition may bring, and the regression that occurs when people lack the courage to challenge tradition in the face of new evidence that questions past practice (Newton, 1965, p. 25).

3.2.1 Using historical descriptive research to explore the NP role

Approximately four decades ago Newton (1965) insightfully proposed that historical research would be particularly important for documenting the development of new nursing roles. During my review of the literature I discovered two studies (Draye & Brown, 2000; Bigbee & Amidi-Nouri, 2000) that reinforced my decision to choose historical descriptive research for this study.

Draye and Brown (2000) identified a near-lost opportunity to capture the experiences of NPs who pioneered the role in the US in the 1960s and 1970s. They claimed that most of the information about the evolution of advanced practice in the US was anecdotal and lacking detailed information on the experiences of pioneer NPs. Knowledge of the origins of

advanced practice nursing would create a better understanding of this milestone in the growth and development of nursing. Consequently, they interviewed the "by then middle-aged NPs" 30 to 40 years after they pioneered the role (Draye & Brown, 2000, p. 1). Had these interviews not been done, the pioneer NPs may not have been around to tell their story.

Bigbee and Amidi-Nouri (2000, p. 29) similarly asserted that the historical trends of "the older siblings" could provide guidance and support in terms of current and future strategies for the NP role in the US. Around the same time, Tropello studied the origins of the NP movement in the US for her doctoral studies. Tropello (2000, p. ii) argued the importance of revisiting the origins of the NP role because of "conflicting accounts in the literature." Whilst it is important to acknowledge those instrumental in the development and success of the NP movement, there are also oral historians who help preserve events and phenomena. Documenting the historical development of the NP arguably helps create a foundation for clearer understanding in the present context (Tropello, 2000).

Historical researchers have since explored the development of NPs in various countries and in a variety of specialties and settings, for example, adult oncology in the US (Murphy-Ende, 2002), paediatric oncology in the US (Wilson, 2005), and in the Netherlands (van den Hoed-Heerschop, 2005). Other health professionals such as pharmacists and dieticians interested in developing advanced practice roles have benefited from the lessons learned from in historical accounts of NP roles (O'Brien, 2003; Skipper, 2004).

Investigations into the successes, failures and challenges of the past can guide future decisions that can save time, effort and money (Newton, 1965). For example, when considering the development of the NP role in the US, the relevant documentation saw NP practice compared to medical practice that was regarded as the gold standard (Diers & Molde, 1979). It would have been more appropriate to regard NP practice as a unique service delivery rather than another form of medical practice (Diers & Molde, 1979). Investigating the intricacies of NP practice rather than doing research comparing NP and physician practice could have saved time, money and resources (Diers & Molde, 1979).

Historical inquiry into the early development of the NP role in NSW may reduce accidental or deliberate misinterpretation, inaccuracies and inconsistencies that may be influenced by individual or collective agendas or ideologies (Holmes, 2008). A lack of understanding and documentation of the conditions that led to decisions during the role's early development makes it easier for individuals or collectives to be critical of current arrangements. For

example, decisions made regarding authorisation of NPs or decisions about implementing NP positions in retrospect may seem poor decisions. However, it is important to locate them within that point in history.

During the early development of the NP role there was considerable uncertainty amongst everybody involved. Over time, with increasing clarity, there may be criticism or false interpretation about why earlier decisions were made. Thus, an important aspect of this research was to accurately describe why, and under what conditions, certain decisions were made.

Gaining knowledge of the origins of advanced practice nursing in Australia will help provide guidance in terms of current and future strategies both for the NP role and for other political nursing developments within health care. It will also help create a better understanding of this milestone of Australian nursing.

At this study's outset, a colleague commented that issues and challenges experienced by pioneer NPs resembled those experienced by pioneer CNCs when that role was introduced into the Australian health care system in the mid to late 1980s. However, I could not find any historical research relating to the development or introduction of CNCs in Australia. "Those who do not remember the past are condemned to repeat it" (Santayana, 1905). Thus, one of the important aims of this thesis is the record the process of the development of the NP role in NSW, so that the information gained can prevent the mistakes of the past.

One possible way of addressing this current study, given the themes of politics and power that are evident in the data, would be to use a 'history of the present.' The term was first coined by Foucault (1970a; 1970b). To Foucault, *all* history is a 'history of the present' insofar as whatever one writes about the past, tells us about the present. The preponderance of power and politics was the focus of Foucault, and has since reflected the concerns of Foucauldian and critical theorists (Holmes, 2011; Skehill, 2007). For Foucauldians, *anything* that has an effect or influence is seen in terms of *power* and *politics* (Holmes, 2011; Skehill, 2007). However, whilst power or politics were significant themes within these data, they were not the only themes. As Newton (1965) asserts "in history the whole stage is lit" (p. 21). The purpose of this study was to do reasonable justice to the facts, and not to fit the available evidence into a predetermined framework. However, given the influence that power and politics had on the development of the NP role in the U.S, Canada and U.K, the

examining of the social, political and cultural influences on the development of the NP role in NSW was seen to be an important aim.

Indeed, there are three key aspects of Foucault's 'history of the present' that had particular significance for the current study. Firstly, a 'history of the present' seeks to examine the influence of tradition and that, which is hidden or taken-for-granted. Thus, when Foucault was studying social work, he used his 'history of the present' approach to problematise social work in the present by recourse to its past, in order to illuminate current understandings of social work. In doing so he was able to expose new possibilities for future developments, by explicating old traditions and hidden and previously taken-for-granted constraints that had historically affected social work (Skehill, 2007). Nursing and medicine are replete with tradition, and as such it was possible that it could have influence on the development of the NP role.

Secondly, a 'history of the present' resists a 'progressivist' approach and calls for caution against the use of chronological historical approaches apart from the mapping of key events to help guide a study. Foucault asserts that it is equally important to examine "reversals of historical pathway" within certain socio-political conditions to uncover complex influences within any chronological or spatial context (Foucault, 1972, p. 147). Thus, I sought to examine factors that not only facilitated the development of the NP role, but also those that impeded it. Another aspect of Foucault's 'history of the present' is not only his examination of major shifts in the "nature, and form of governance, but also their transformative significance" (Skehill, 2007, p. 453). Thus, the effect that any change in governance at the federal or state government level, through to the local level such as management may have had on the development of the NP role were examined.

Finally, and arguably one of the most significant diversions between history, and a 'history of the present' is the insight that researchers always write 'from the inside out' in the sense that historians cannot shake off their context 'in the present'. Thus, the task of the historian is not to write 'objective' history. Rather, as Foucault asserts, the emphasis is on the need for the historian to make explicit their positionality and biases in relation to the area of study, and the need to be rigorous, and use comprehensive empirical data (Black & MacRaild, 2000). Both these important issues are discussed in detail in the following section.

The following section describes the research design that was employed for this historical descriptive study.

3.3 Research design

There were two methods of data collection – interviews and document collection. Data were collected through in-depth yet minimally structured interviews with a purposive sample of NPs and a purposive-snowball sample of stakeholders with a strong interest or involvement in the introduction of NPs in NSW. Some participants were affiliated with organisations that had an interest in the development of the NP role. The purpose of the interviews was to record key historical events, and to help develop a more detailed understanding of the influences on the NP role. The next section details the study's ethical considerations, how the participants were selected and how the data were collected. In addition, issues related to the credibility of the data and researcher credibility including triangulation of the data are discussed. The process for transcription of the interview data and the analysis of the data is detailed.

3.4 Ethical considerations

Ethics approval was granted by the university human research ethics committee, and the area health service human research ethics committees before data collection. All participants were provided with a Participant Information Sheet (see Appendix A), explaining the aims of the study, its procedures, ethical safeguards and their rights as participants. Informed consent was obtained from all participants (see Appendix A). All participants were given pseudonyms. Only the researcher and her supervisors had access to the transcripts. One of the area health service human research ethics committees requested that audiotapes be destroyed following transcription, and this was honoured. Transcripts and journals continue to be kept in a locked cupboard for 5 years after publication as per National Health and Medical Research Council's (2007) recommendations.

All of the participants knew that interviews were recorded but were advised that they could, if they wished, terminate the interview or switch off the audiotape without giving a reason, and that their decision to withdraw would be respected. Two of the NPs and one stakeholder asked for the audiotape to be turned off for short periods during the interview when particularly sensitive information was being provided. No financial or other remuneration or rewards were offered.

Denzin (1997, p. 283) states that while a reader has the right to read what the researcher has learned, the information should be balanced against the principle of nonmaleficence.

Accounts should exhibit "interpretive sufficiency" whereby sufficient depth, detail, emotionality, nuance and coherence of the report permits a reader to form a "critical consciousness." When the study began there were only a small number of authorised NPs, all of whom were well known, with a degree of local celebrity that carried the risk of individual NPs being identified through their self-reports in this thesis. Therefore, writing this thesis involved balancing the need for sufficient detail while preserving participant anonymity.

3.4.1 Selection of the participants

Sampling and data collection were guided by the principle in descriptive studies of *richness*. Richness is attained by sampling for variety of experience, and also by probing into the participants' experiences to develop a deeper understanding of their meaning (Ayers, Kavanaugh, & Knafl, 2003; Braun & Clark, 2006; Diers, 1979; Sandelowski, 2000). Each of the participants was selected because they were identified as being able to provide valuable information relevant to the aims of the research, as recommended by Lincoln and Guba (1985), Morse (1994), Polit and Hungler (2003), Sandelowski (1995, 2000), and Speziale and Carpenter (2003).

3.4.1.1 NP participants

A purposive sample of 10 nurses was chosen for this research were among the first *wave* of NPs (pioneers) to be authorised in NSW. All invited NPs consented to participate in the research. Only general demographic information about the NPs is given rather than detailed bio-data in order to preserve anonymity among this small population. All 10 NPs were white, middle-aged, hospital-trained nurses with at least 10 years clinical experience before their authorisation as an NP. Prior to becoming NPs, 3 of the NPs were working as RNs, 1 as a CNS, 5 were working as CNCs with 2 having been working as a CNC only a few months. One NP was working in a management position. At the time of the interviews, most had worked in the same clinical setting for at least 5 years.

Eight out of 10 NPs were either working full-time in an NP position or, as described by the NPs themselves, working part-time as a registered nurse and part-time as an NP. One NP had previously worked in a NP position but was not working in that position at the time of the interview. Those working in an NP position had been doing so for a period of approximately 12 to 18 months. One of the authorised NPs had never worked in a NP position. Nine out of the 10 NP participant interviews were undertaken before I commenced key stakeholder interviews. Eight of the interviews were undertaken with NPs working in rural and remote

NSW, one of the NPs was working in a regional (semi-rural) centre in NSW, and another was working in metropolitan Sydney.

Four of the NP participants had undertaken education at master's level (a NP-specific masters was unavailable for pioneer NPs), and 2 had undertaken graduate diplomas. Two NPs had undertaken either a graduate certificate or a hospital-based certificate. For 2 of the NPs, their undergraduate degree was their highest level of education. Seven of the NPs were working in rural or remote areas with the remaining 3 working in regional (semi-rural) or metropolitan areas.

3.4.1.2 Key stakeholder participants

A combination of purposive and snowball sampling was used to identify and select the key stakeholders. Each of the participants was selected because they could provide information pertinent to the aims of the research (Lincoln & Guba, 1985; Morse, 1994; Polit & Hungler, 2003; Sandelowski, 1995, 2000; Speziale & Carpenter, 2003). The key stakeholders (see Table 6 for a description) were identified in one of three ways: through their membership of a committee related to the NP role in NSW, through the review of key documents such as reports, journals or newspaper articles, or through recommendation by NP or key stakeholder participants.

Invitations were sent to seven medical key stakeholders. One GP working in a rural area originally consented to participate but later declined. The reason for this withdrawal was not asked, nor was it provided. One medical key stakeholder representing a medical organisation returned my invitation to participate by stating on the form "I do not have the time for this research." An invitation was sent to another five medical key stakeholders but I did not receive a reply. There was also no reply to a follow-up invitation. On advice from one of my supervisors, another medical key stakeholder was invited, and agreed to participate. This stakeholder recommended another medical stakeholder who also consented to participate. Therefore, from the 24 invited key stakeholder participants, 17 consented to participate (see Table 6).

Table 6 Description of key stakeholder participants

Key Stakeholder	**Representation**
KS1	Non-nursing department, NSW State Government
KS2	Nursing academic involved in NP development
KS3	Representative, nursing organisation
KS4	Representative, nursing organisation
KS5	Nursing hospital executive-management
KS6	Nursing department, NSW State Government
KS7	Representative, nursing organisation/nurse academic/ hospital management
KS8	Nursing department, NSW State Government
KS9	Nursing department, NSW State Government
KS10	Non-nursing department, NSW State Government
KS11	Nursing, Area Health Service
KS12	Nursing department, NSW State Government
KS13	Nursing department, NSW State Government
KS14	Nursing department, NSW State Government
KS15	Medical organisation, general medical practitioner
KS16	Medical organisation, general medical practitioner
KS17	Independent (non-nursing, non-medical)

The key stakeholders and NPs were invited to participate by written invitation (see Appendix A). The information sheet outlined the purpose of, and procedure for the research, together with a consent form (see Appendix A) and a reply paid envelope. Once consent was obtained, participants were contacted by telephone and mutually convenient dates, times and places were arranged for the interviews.

3.5 Data Collection

There were a total of 27 interviews, 10 from NPs and 17 from key stakeholders. Twenty-three of the 27 interviews were completed by 2005. Nine of the NP interviews were undertaken in 2003 to 2004, and before the interviews with the key stakeholders. One of the pioneer NPs was not available for interview until mid 2005 and following commencement of

the key stakeholder interviews. One key stakeholder interview was delayed and a further three were conducted as the need for their data became apparent, and at the recommendation of my supervisors. These remaining 4 key stakeholder interviews were undertaken in 2008, and the final one in early 2009.

Chapter 4 entitled *Key events in the development of NPs in NSW,* documents events only to 2005, because the aim of the interviews was to reflect on the early introduction of NPs in NSW and not to explore later developments. However, lessons learnt in the early development of the role will be explored into the current political and policy debate in relation to NPs to the time of writing the discussion chapter.

Data were collected through individual recorded interviews and document review. I conducted all the interviews. These processes are described below beginning with discussion on maintaining credibility of the data.

3.6 Credibility of the data

The credibility of qualitative research is gained through the validity and reliability of the data. Data credibility in historical research relates to the sources (Burns & Grove, 2005; Grbich, 1999; Roberts & Taylor, 1998). The types of data to be collected require careful consideration as it provides "insights into whatever one wants to study" (Stubbs, 1983, p.231). A combination of methods of perspectives has the potential to provide a richness of detail and a more complete understanding of the phenomenon, especially when there are multiple and divergent perspectives to consider (Halcomb & Andrews, 2005; Shih, 1998). Thus, triangulation was seen to be particularly useful for the purpose of this study.

3.6.1 Triangulation of the data

Researchers that rely on one, single piece of data are at greater risk of incorrect analysis than researchers who use multiple, diverse kinds of data that leads to a more convincing basis for conclusions (Hammersley & Atkinson, 1983). However, whilst the use of triangulation is becoming increasingly accepted in nursing research, several important theoretical issues remain regarding its application (Tashakkori & Teddlie, 2003). These issues belong to two categories: substantive and practical issues. The substantive issues are described as relating to the descriptions and complexity of the design and the inherent benefits of utilising mixed methods (Tashakkori & Teddlie, 2003). These researchers argue that the terminology used to describe 'mixed method' research is poorly understood and that researchers have tended to

use terms relating to triangulation incorrectly and interchangeably (Tashakkori & Teddlie, 2003). Some researchers assert that, to avoid confusion over the method of triangulation, the term 'mixed methods' (Tashakkori & Teddlie, 2003) or 'across methods' (Farmer, Robinson, Elliott, & Eyles, 2006) should only be used to describe research that utilises both qualitative and quantitative data collection and analysis techniques. Conversely, the terms 'multi method' (Tashakkori & Teddlie, 2003) or 'within method' research (Casey & Murphy, 2009; Duffy, 1985) should be used to describe two or more data collection methods from the same research tradition (Casey & Murphy, 2009; Tashakkori & Teddlie, 2003). Notwithstanding these semantic concerns, it is important for researchers to explicate which method of triangulation was used. 'Multi method' triangulation using three sources of data (NP and stakeholder interviews and document analysis) within the qualitative paradigm was used for the purpose of the current study.

The second category of important theoretical issues is related to practical issues; methodological rigour and the complexity of the research design. Central to the issues of methodological rigour and the complexity of the research design are the concepts of convergence and completeness (Casey & Murphy, 2009). By using multiple approaches to gain an understanding of the phenomenon, triangulation provides a sense of 'confirmation' or 'completeness' of the data through the enhancement of validity and confidence in the findings (Farmer, Robinson, Elliott, & Eyles, 2006). Triangulation of multiple sources of evidence permits convergence and corroboration of findings and is recognised as supportive to data credibility (Farmer, Robinson, Elliott, & Eyles, 2006; Flick, 2002; Patton, 1990; Tashakkori & Teddlie, 2003). Morgan (1998) proposed the additional concept of 'complementarity' and asserts that this alternative to convergence has been derived from the difficulties inherent when findings do not converge. Instead, Morgan (1998) argues that complementary data seek to elaborate and enhance findings and provides illustrations and clarification of the results of one method, with the findings of the other complementary method (Morgan, 1998). Thus, advantages of multiple sources lie in their potential for verification of the authenticity of the evidence and its interpretation (Rafferty, 1996). In the current study, the use of the data obtained through documentary analysis served to both validate data obtained through the NP and stakeholders interviews as well as complement and enhance the findings. In addition, the stakeholder interviews were complementary to the NP interviews. For example, several of the NPs illuminated that, while they had been initially well supported by their manager, this support changed when their managers' were replaced. It was only during the stakeholder interviews that it became evident that a change

in management had occurred because of a major restructuring of the NSW health care system. This then allowed for further exploration and explication of the profound effect the restructure had on the early development and implementation of the NP role. The data provided through the interviews were supported through documentary analysis of media releases, NSW Health Department reports and journal articles. Thus, the use of triangulation was not only used to support the credibility of the findings, but also had particular utility in the generation and importance of new knowledge. These issues might have otherwise been overlooked using only one method or source of data collection in the current study.

A strong criticism of researchers using triangulation is that they provide minimal account of how, what procedures had been used to triangulate the data or how they undertook to confirm their findings (Farmer, Robinson, Elliott, Eyles, 2006). However, there is a dearth of detailed procedural information with few researchers describing the process that they undertook to heighten credibility of their data (Casey and Murphy, 2009; Farmer, Robinson, Elliott, & Eyles, 2006; Halcomb & Andrews, 2005). Nevertheless, what is important is that researchers explicate the practical process of triangulation so that it is reproducible (Casey and Murphy, 2009), and as such the process for maintaining data credibility and data collection, data management and data analysis are described in detail below.

Data credibility is determined through external and internal criticism. External criticism determines the validity of source material. For example, the researcher needs to know where, when, why, and by whom the document was produced (Burns & Grove, 2005; Cristy, 1975; Kovacs, 1987; Skodol Wilson, 1987). Internal criticism, on the other hand, involves the examination of the reliability of information and researchers need to expose possible biases and verify the accuracy of provided information (Burns & Grove, 2005; Cristy, 1975; Kovacs, 1987; Skodol Wilson, 1987). The most valued sources of data are the primary sources, those are material written or spoken by eyewitnesses to an event. Primary sources are most likely to provide an authentic account. The presumption is that eyewitnesses provide a more accurate account of an event than those not present (Burns & Grove, 2005). The more removed a source from an eyewitness account, the less reliable are their statements (Burns & Grove, 2005; Cristy, 1975; Roberts & Taylor, 1998) so historiographers use primary sources whenever possible (Burns & Grove, 2005). Because it is possible for people to experience the same event differently, researchers should obtain at least two independent accounts for each event.

While reviewing the data, I used the following questions adapted from Grbich (1999) to help establish authenticity of the data collected:

- Where does the documentation come from? Who wrote or produced it, and when?
- If life events are reported, was the reporter actually present (an eyewitness) at these events (i.e., was the author a primary source), or was the information reported by someone who relied on the reports of others (secondary source)?
- Who was the writer in this process? Where was he or she located? What was his or her purpose?
- Why were the documents produced? Do other documents exist that verify the documentation forming the focus of the study? Has the author produced other documentation? Does it match?
- How original are the ideas presented? In what context was the document produced? Was it freely produced for self, for others, or was it produced under coercion? If so, what effect may this duress have had?

The aim of these questions is to demonstrate that the information is genuine, that it can be corroborated by several sources, and that these sources, whether primary or secondary, have been assessed and verified (Grbich, 1999; Kovacs, 1987). Only primary sources were used to document the historical events in the development of the NP role. Other sources of information were used only if the source was known to be closely involved, and knowledgeable in the events or issues being reported.

It is possible to read unintended meaning into an author's words (Burns & Grove, 2005; Cristy, 1975). I tried to ensure that I understood statements that were made by asking probing questions in response to the participant's answers if the meaning they were attributing to words or sentences was not clear to me, because words and their meanings can change over time and across cultures. The credibility of the findings resided to a large extent on my own credibility in the way I conducted the research (Kvale, 1996) as discussed in the next section.

3.6.1.1 Researcher credibility

Oral history is reliant on an 'active relationship' between the researcher and the participants with both parties bringing their own agendas to the interview, and becoming part of the

environment under investigation. During oral history, researchers can develop a certain level of bias; the level to which a researcher becomes biased may also be influenced by "the extent the interviewer belongs to the reality under investigation" (Fairman & Mahon, 2001, p. 323). Historical researchers need to acknowledge their own point of view because it can influence how they gather, read and interpret information (Borbasi et al., 2008). As a consequence, it is possible for researchers with different points of view to interpret the same historical events differently (Borbasi et al., 2008; Burns & Grove, 2005; D'Antonio, 2006). My experience during the early stages of this research supports these researchers. I interviewed 9 of the 10 pioneer NPs before interviewing the key stakeholders, so information gained from the NPs could be compared and contrasted with that obtained from the key stakeholders. Despite my being a RN and a proponent of the NP role, I entered the research with little knowledge or emotional investment in relation to the NP movement. However, it became evident that over time I did become deeply emotionally involved in the lives and struggles of these pioneer NPs and my newfound standpoint began influencing my questioning and early analysis of the data. For example, I began to ask questions that were more closely aligned to the negative rather than the positive aspects of the NP role. This was also evident in the way I began analysing the data. For example, early in the analysis I began to generate sub-themes such as *lack of support*, *lack of resources* and *lack of understanding* despite instances of support, resources and understanding. Some of my initial questioning of the key stakeholders reflected this negative approach.

Following a review with my supervisors of my original thematic analysis and interview transcripts, I returned to the data and the other interviews with fresh ears and eyes. Any changes relating to the conduct of the research (including the analysis) and the reasoning behind the decisions were recorded through a decision trail as per Koch (1994). I also used my reflective journal as per Burns and Grove (2003) that I maintained throughout the study to record my introspections, idiosyncrasies, thoughts, perceptions and reactions.

3.6.2 Individual Interviews

Historical researchers interview individuals who observe or participate in historical events (Burns & Grove, 2003). This type of interview is generally known as *oral history* in historical research. Oral history is an intellectual process (Fairman & Mahon, 2001) to elicit recollections of past events or phenomena (Borbasi et al., 2008; Maggs, 1983; Roberts & Taylor, 1998). Oral history either helps validate existing facts or beliefs or uncover new information (Burns & Grove, 2003). Oral history is particularly useful when the goal is to

connect individual experiences within the context of social change (Fairman & Mahon, 2001; Portelli, 1997). Thus, interviewing the pioneer NPs and stakeholder participants to obtain an insight into their experiences was seen to be a critical aspect of this study.

The questions in the interviews were framed to elicit discussion, rather than forcing responses (Fontana & Frey, 2000; Morse & Field, 1995; Polit & Hungler, 2003; Seidman, 1998; Taylor & Bogdan, 1984). Also, flexibility was used to follow-up on points requiring further exploration (Lincoln & Guba, 1985; Seidman, 1998). The questions addressed in the interviews tended to change as I gained insight during each of the interviews and also through data gained from previous interviews.

More specifically, the interviewing technique that I used was flexible moving from general, to more focused questions as the interviews progressed. The participants were also encouraged to raise issues that were important to them. Hence, the overall goal of the interviews was to obtain an authentic insight into the participant's experiences.

3.6.2.1 Nurse practitioner interviews

NP interviews were undertaken between October 2003 and May 2005. To commence the interview, the NP participants were asked demographic questions such as what were their years of experience of nursing and their age and qualifications. The following questions were used help guide the interviews:

- "describe the processes by which you became an NP"
- "why did you want to want to become and NP"
- "what were your experiences of becoming an NP"
- "what were your experiences during the authorisation process"
- "what were your experiences implementing your role into your clinical setting"

The questioning was guided by their answers.

NP interviews ranged from 1.5 to 4 hours in duration. Short breaks were taken during the longer interviews, which were undertaken outside the NPs' work hours. Seven of the NPs requested the interview at their place of employment; these interviews were held in a quiet and private room. The remaining three interviews were conducted at the NPs' homes. Two

of the NPs working in rural and remote NSW invited me to stay at their home for several days, which enabled me to observe and experience life in rural and remote NSW. I was also invited by these NPs to observe them working in their NP role.

3.6.2.2 Key stakeholder interviews

Key stakeholder (KS) interviews were undertaken between November 2004 and January 2009; 11 being held in 2004-2005, two in 2006-2007, and four in 2008-2009. Most (15 out of 17) of the key stakeholders were interviewed at their place of employment and again, were held in a quiet and private room. One of the key stakeholders was interviewed by a series of emails, and another was interviewed by an audio-recorded telephone conversation as these participants had relocated such that face-to-face interviews were not possible. The key stakeholder participants were initially asked to describe:

- Their view in relation to the NP role, and that of their organisation;
- Their involvement or interest in the development or implementation of the role.
- Further questions were guided by the participants' responses.

3.6.3 Collection of documents

Documentation provides a valuable source for historical researchers (Grbich, 1999). For the current study, documents were collected for two inter-related reasons: to identify and record the chronology of key events (as per Rafferty, 1996) in the development of the NP role in NSW; and for detailed understanding of the influence of the political, social, economic and cultural context that shaped the development and implementation of the role. This information complemented that gained through the NP and key stakeholder interviews, and enabled further exploration of contrasting and similar perspectives between individuals and groups from a range of data sources.

3.6.3.1 Types of documents

Documents were collected from a range of sources dating from 1990 through to the end of 2005. The sources included government agencies (federal, state and area health service), professional associations and organisations (nursing, medical and other health professions), consumer groups and individuals. Data were in the form of reports (research and non-research), legislation, policies, policy directives, clinical practice guidelines, letters (personal and professional letters and letters published in newspapers or magazines), memoranda, media releases (medical, nursing and other), position statements (medical, nursing and

other), newspaper articles (professional and consumer), conference presentations, journal articles, advertisements, minutes of meetings, videotapes, photographs, cartoons, poems, and transcripts from television and radio such as current affairs and news programs**.** I gained access to reports and other information related to the NP role in NSW primarily through contact with nursing organisations and key stakeholders.

Resources now available via the World Wide Web added a new and exciting dimension to this research (Holmes, 2008). Information was collected through personal communication via email, and also through websites such as *crikey.com.au*, an independent Australian electronic magazine that allows general discussion on topical issues. This site was particularly useful as it provided access to dialogue and opinion in the public domain pertinent to health care, in addition to information that specifically related to the NP role.

The Google and Google Scholar search engines were useful in locating media releases and newspaper articles. Email automatic alerts using the search terms Nurse Practitioner.mp. (mp = title, abstract, full text), advanced practice nursing (mp = title, abstract, full text) and advanced nursing practice (mp = title, abstract, full text] identified newspaper articles, (Fairfax Media Corporation NewsAlert), and OvidAutoAlerts for journal articles from the electronic databases CINAHL and Medline.

Government automatic alerts identified Australian Government Department of Health and Ageing Ministerial (enquiries@health.gov.au) media releases. The Australian Medical Association (lists.ama.com.au/mailman/listinfo/media_lists.ama.com.au) was the only relevant professional organisation that provided automatic alerts for media releases, speeches and interviews. Government (federal and state), professional and organisational websites were regularly visited to maintain up-to-date data related to the NP role. Information regarding relevant issues was also gained through membership and access to the Australian Nurse Practitioner Association email list (listnurseprac@lists.health.nsw.gov.au). Finally, colleagues, friends and family alerted me to professional events and journal and newspaper articles that were relevant to this research project.

3.6.4 Interview transcription

To minimise transcription errors I personally transcribed the majority of the audiotapes. For the interviews that I did not initially transcribe, I later listened to the audiotapes to check whether the transcription was accurate. Listening to and transcribing the interviews verbatim provided immersed me in the data while I identified patterns, inconsistencies or

contradictions. Moving between data collection and transcription enabled deeper reflection, new thoughts and insights assisting the analysis. To ensure the faithfulness of the transcripts to the interview, the following editing strategies were used:

- Ellipsis conveyed words left out of sentence;
- Emotional display recorded in brackets (e.g., laughing);
- Empty parenthesis ( ) indicated missing words or the inability to hear a word;
- Bold letters to record loudness or emphasis relative to other words.

As recommended by Poland (1995), these editing strategies maximised transcription quality, reading and trustworthiness while maintaining the intention of the words. The transcripts were transferred to the computer program QSR NVivo Version 7.0 (QSR Nvivo 7^{TM}). Both of my supervisors read the interview transcripts. The following section describes how the data were analysed.

3.7 Data Analysis

3.7.1 Managing the data

The use of an established theory to explain the details of historic documentation is contentious within the discipline of history (Grbich, 1999; Tosh, 1991). Researchers can in advance identify labelled patterns of social action that have historically persisted such as *doctor-patient relationships* that they can apply to new data, or they can allow the data to 'speak for themselves' rather than use established concepts (Grbich, 1999). However, researchers can be left with hundreds of pages of data with everything appearing important. Indeed, Fairman (2008), investigated the history of NPs in the U.S and realised early on in her project that it would be a difficult endeavour "not because of the absence of primary sources," but "because of the sheer volume of them and the number of people who were available to provide perspectives on the time period." As a consequence, Fairman (2008) made the decision early on in her historiography to limit which "historical episodes" to include, and the focus of study was limited to examining what she describes as a "small part of the story" (p. 10). However, it has to be remembered that the inception of the NP role in the U.S was over 50 years ago and thus, the history of the role covers a much longer period when compared to the development of the role in NSW. In addition, Fairman (2008)

acknowledged that limiting her collection of oral history to the NP participants meant that the "individual patient is thinly represented."

As previously highlighted, a decision was made to not be guided by pre-existing theoretical or conceptual concepts and allow the data to 'speak for themselves' because there were no previous studies in relation to the NP role in Australia. However, to assist my managing the volume of data, a decision was also made to limit the study (and collection of data) to a 15-year period from the inception of the NP role (1990-2005). The exceptions were a number of documents that I used to identify ongoing key events to position the first 15 years of the development of the NP role into the current political and policy debate in relation to NPs. In addition, the number of pioneer NPs at the time of the interviews was relatively small (less than 15), and the number of stakeholders involved in the early development of the NP role in NSW was also relatively small. In a similar manner to Fairman (2008), data relating to the perceptions, and understanding of patients, and more generally, the public about the NP role were only drawn from research conducted during the NP pilot projects (as detailed in the *Final Report*) and through the NP and stakeholder interviews.

My collection of primary documents was no doubt facilitated by several of the stakeholders who shared their own collection of documents, or helped directed me towards how I could access them. From 2000 onward, the documents were being collected in 'real time' in the sense that I was collecting them as they were being published. Thus, the difficult task of trying to access important primary source documents that were published many years earlier was largely avoided. However, it was crucial that I approached the data in a rigorous and systematic manner. Using the Nvivo computer program was particularly useful in managing and analysing the interview data but it has to be remembered that computer software for qualitative analysis can only be used as an aid for the management of the data. Ultimately the process of interpretive analysis rests with the researcher (Grbich, 1999). Firstly I created six 'source folders' in the NVivo 7 computer program for my decision trail, my reflective journal, the NP interview transcripts, the stakeholder interview transcripts, the written documents, (e.g. media releases) and a folder for photos and other graphics e.g. cartoons. The following sections describe the process for thematic coding of the interview data and documents.

3.7.2 Thematic coding of the interview data

Thematic coding is widely used and accepted in qualitative research, and more specifically, in historical qualitative research (King, 1998) and was used for the purpose of this study.

I began the data analysis with the aim of coding the interview text. A code (or node as described by QSR NVivo 7) is a label assigned to describe a sequence of words, most often a sentence or paragraph (King, 1998; Miles & Huberman, 1994). Each of the texts were read and re-read and nodes were developed along the way. It was important that clear operational definitions (names that matched the concept being described) were used. Text was coded into either a new or a previously created node. During this process in the early stage of interview analysis a list of 505 'free nodes' as described by QSR NVivo 7, was produced. King (1998, p. 118) refers to a list of nodes as a *template*. These free nodes allowed me to quickly identify, pull out and cluster the nodes. These free nodes in the early stages in the analysis are termed *descriptive*, because they entail no interpretation or judgment by the researcher of what the interviewee means, and are merely attributed to a class of phenomena (King, 1998; Miles & Huberman, 1994). By comparing and contrasting the data obtained from the NP and stakeholder interviews using the Nvivo computer program, the 'free nodes' were merged to form 'tree nodes' (as described by QSR NVivo 7) as common sub-themes, and themes emerged from the data. An example of the thematic analysis for the theme 'Getting to know advanced practice' is provided in Table 7 below[2].

I also used created 'memos' or notes of my ideas, concepts or themes that I wanted to explore later on. Sometimes these early ideas developed into codes and thus became part of my data.

[2] Partial list for the free nodes is provided in this example.

Table 7 Example of thematic analysis

Nodes	Sub-themes	Themes
Drs guardians health Dr nurse power discord Nursing oppressed group Niceness of nursing Traditional nurs & nursing Traditional nurse & medicine Postgrad degree help articulate Status of medicine Adv Prac medical understand Adv Prac stakeholder understand Adv Prac multiple meanings Adv Prac need to articulate Adv Prac roles evolving Language important Collab diff meanings Collab medical understand Collab nursing understand Independent diff meanings AMA language ownership Nursespeak limit commun	Getting to know advanced practice	Recognising advanced practice in nursing
Adv Prac & collaboration Adv Prac & education Adv Prac need definition Adv Prac need understand Adv Prac strategies to understand Adv Prac & portfolios Independent practice Autonomous diff meanings Adv Prac manager understand Adv Prac public understand Adv Prac media understand Adv Prac NP understand Adv Prac health prof. Understand	The NP role: Collaborative, autonomous or independent?	
Don't stand up for ourselves Enculturation nurses submissive Divisions nursing low self esteem GP uses term 'sister' for RN Lack of trust in nursing Lack respect between nurses Lack support take on drs New nurs roles historical view Nurses grieving old days Drs grieving old days Medicine understand nursing Legacy of tradition Nurses as handmaidens Dr pedestal country towns Status important to drs Medicine ownership nursing Status divide nurs med Nurses put drs pedestal Nurses work defacto NP role Nursing struggle identity Nurses comfort trad nursing	Traditions in health care: Good old days or plagued by the past	

For this project, most of the interview data was classified into one or more of the themes. Once all of the preliminary themes had been developed in this way, I was able to proceed to a deeper analysis and interpretation. If applicable, segments of text were classified within two or more different codes (parallel coding) as described by King (1998). This also helped me identify codes that were more inferential and explanatory and allowed for the uncovering of meaning, relationships and patterns within the data. For example, the resulting sub-theme 'collaboration' was coded under the themes 'getting to know advanced practice' *and* 'visions, voices, vested interests.' Relationship 'nodes' represent the connection between two nodes (QSR International, 2006)

As often happens, the lower level and more descriptive themes were uncovered early in the analysis, and the inferential ones were uncovered later on as the relationships between themes appeared. My thoughts flowed back and forth between information provided by an individual participant and other participants. I compared and contrasted information revealed from analysing NP and key stakeholder interview data, and set their information against that obtained from documents.

3.7.3 Ordering and thematic coding of the documents

Initially, information that directly or indirectly related to the NP role outside Australia was separated into categories to help make them manageable. For example, *clearly valuable*, *mildly valuable* and *not valuable* as suggested by Borbasi et al. (2008). Periodically I would re-evaluate documents I had initially felt would not be useful, as often information that was initially identified as not valuable became more important as the analysis progressed. For example, articles about collaboration developed greater significance as I became aware of how the concept of collaboration was perceived differently by various stakeholders.

Documents such as newspaper articles, media releases and position statements were collected and ordered chronologically using a spreadsheet (see Appendix G) under the following headings:

- Author;
- Date;
- Title;
- Source;
- Type of information;

- Location (state or national), and
- Comments.

The ordering of documents chronologically assisted in identifying patterns. For example, I was able to identify media releases and articles written at specific points in time in response to key events related the NP role in NSW. A separate spreadsheet listed published articles that related to the NP role in Australia.

As themes emerged from the interview data, I began to order the documents that I had collected into separate folders in the NVivo database. Hardcopy documents were also scanned and ordered into each corresponding folder. For example, any documents relating to 'key events in the early development of the NP role' were filed under the heading 'key events'. Documents were then further divided into sub-folders. For example, documents, or sections of documents relating to either Stage 1, 2 or 3 (or all Stages) in the development of the NP role, were filed into the corresponding sub-folder. This process was also used for each of the emerging themes and sub-themes. For example, for the theme 'Navigating uncharted waters: Recognising advanced practice in nursing', any documents relating to advanced practice were filed into the corresponding folder. Sub-folders allowed for documents relating to any of the sub-themes as they emerged, and ordered under the corresponding identified sub-theme. For example, documents relating to each of the sub-themes: "Getting to know advanced practice", "The NP role: Collaborative, autonomous or independent?" or "Traditions in health care: Good old days or plagued by the past?" were ordered into a corresponding sub-folder using the same headings. This process allowed for documents to be readily accessed, and also ensured that all collected documents were analysed for their relevance to the study.

This process involved going back and forth between all the forms of data. I revisited the transcripts, re-listened to the original audiotapes, and revised relevant documents. The interview and document data was analysed for relationships and for similarities and differences in perspectives. Information pertaining to particular points in time or key events in the development of the NP role was also compared and contrasted.

3.8 Summary of Chapter 3

This chapter has detailed the methodological and practical considerations that were adhered to throughout the preparation and execution of this study. Historical research presents a systematic way of collecting and analysing historical data. Through the documentation of

key historical events and analysis of the interview data and documentation, I was able to construct a cogent account of the development of the NP role in NSW. The next chapter, the first of the findings chapters, chronologically orders the history of key events in the early development of the NP role in NSW.

Chapter 4 – Findings: Key Events in the Early Development of the NP in NSW (1990-2005)

The next four chapters present the findings. An outline of these chapters is shown below in Table 8, summarising the topics to be presented. The current chapter is emphasised.

Table 8 Outline of findings topics in Chapters 4, 5, 6, and 7

Chapter 4 Key events in the early development of the NP in NSW (1990-2005).	• Antecedents to the NP role in NSW. • Stages 1 to 3 in the development of the NP role. • Process for establishing NP services. • Framework for the implementation of NPs into the NSW health care system. • Other landmark events for the NP role in NSW.
Chapter 5 Entering uncharted waters: Pioneering the NP role in NSW.	• Taking up the challenge. • The challenge of uncertainty. • Recognition, rewards and opportunities. • The legacy of the pioneers to the NP movement in Australia.
Chapter 6 Navigating uncharted waters: Recognising advanced practice in nursing.	• Getting to know advanced practice. • The NP role: Collaborative, autonomous or independent? • Traditions in health care: Good old days or plagued by the past?
Chapter 7 Riding the waves to change: Visions, voices and vested interests.	• Visions for the NP role. • Developing and implementing the NP role: Negotiation and compromise. • Collaboration: Co-operation or control?

This chapter documents important events that occurred during the early development of the NP role in NSW to the end of 2005. Data for this study were collected from documents relating to the development of the NP role in NSW for two related reasons: firstly, to identify and record the chronology of key historical events in the development of the NP role in NSW; and secondly, to gain more detailed understanding of contextual issues that shaped the development of the role positively or negatively. The implications of these events will be

referred to and discussed in the subsequent chapters. This chapter begins by briefly identifying the main antecedents to the development of the role in NSW.

4.1 Antecedents to the NP role in NSW

Many nurses, especially those working in rural or remote areas in Australia, were working in *de facto* NP roles and had begun to describe themselves as NPs by the early 1990s. NSW was the first Australian state to consider formalising these structures in order to recognise the NP role through statutory provisions (NSW Department of Health, 1992). The path to becoming an NP was part of the evolving clinical nursing career stream (Australian Nursing Federation, 1998).

Formal debate regarding the NP role began at the Professional Day at the NSW Nurses' Association Annual conference in 1990 (Chiarella, 1996a, 1996b; Linden-Laufer 1995; NSW Department of Health, 1993) is now seen as a major landmark in the history of the nursing profession in Australia (Adrian & O'Connell, 2000). The then NSW Minister for Health was issued with a challenge to explore the issue of NPs as a *bona fide*, rather than as a *de facto* means of health care (Adrian, 1995; Adrian & O'Connell, 2000). This challenge was accepted and a subsequent letter from the NSW Health Minister invited submissions (Adrian & O'Connell, 2000; Chiarella, 1996a, 1996b).

So began a formal 8-year process "that has tested the professional tolerance and political nerve of the nursing profession, the health bureaucracy and the state and federal governments of the time" (Adrian & O'Connell, 2000, p. 54). From 1990-1998, there were three stages in the development of the NP role (Adrian & O'Connell, 2000)and are described in the following section. See Table 9 for an outline, with Stage 1 to be discussed next.

Table 9 Overview of Stages 1 to 3

ACTION	**OUTCOME**
Stage 1 *Part 1* NSW Department of Health Taskforce – The Independent NP Taskforce	Report to NSW Health Minister
Part 2 Establishment of Stage 1 Nurse Practitioner Working Party – Representatives from nursing organisations	*Nurse Practitioners in NSW: The role and function of Nurse Practitioners in NSW (The Discussion Paper)* Released June 1992
Stage 2 Establishment of Stage 2 Nurse Practitioner Working Party – Multidisciplinary representation	*Nurse Practitioner Stage 2, Vol.1 & 11 The Review* Released September 1993
Stage 3 Establishment of Stage 3 NP Steering Committee – Multidisciplinary representation NP pilot research projects	*The Nurse Practitioner Project Stage3: Final report of the Steering Committee (The Final Report)* Released April 1996

4.2 Stages 1 to 3 in the development of the NP role

4.2.1 Stage 1

Stage 1 of the development of the NP role was a 2-year, two part process (see Table 9). Part 1 began with the establishment of a NSW Department of Health Taskforce (known as the Independent Nurse Practitioner Taskforce) in September 1991 (Adrian & O'Connell, 2000; NSW Department of Health, 1992) that was chaired under the direction of the then NSW Chief Nursing Officer, Judith Meppem. Part 2 was the establishment of a working party in 1992 that comprised representatives from key NSW nursing organisations and whose role it was to service the Taskforce (Adrian & O'Connell, 2000; Chiarella, 1996a, 1996b; NSW Department of Health, 1992).

A working party reviewed a joint submission that was prepared by the NSW Nurses' Association and the NSW College of Nursing, two of the peak nursing professional organisations in NSW that represented both professional and industrial interests (Adrian & O'Connell, 2000; Adrian, 1995; Iliffe, 1996a). It was also the remit of this working party to

develop recommendations and prepare a discussion paper for consideration by the NSW Department of Health Taskforce (Adrian & O'Connell, 2000; Adrian, 1995).

The term *independent nurse practitioner* was debated by the Independent NP Taskforce and it was decided that *independent* be removed in reference to the title (Adrian, 1995; NSW Department of Health, 1996; Meppem, 2000). Thus, the issue of NP independence was dropped from the discussions "very early in the NP Project and before the debate was broadened to include the medical profession, consumers, policy and legal advisors" (Adrian & O'Connell, 2000, p. 46).

4.2.1.1 The Discussion paper

The Stage 1 working party produced a report titled *The Role and Function of Nurse Practitioners in New South Wales*: *Discussion Paper* (NSW Department of Health, 1992: hereafter *The Discussion Paper*) and released by the NSW Minister for Health in June 1992 (Adrian & O'Connell, 2000; NSW Department of Health, 1992). This was 2 years since the issue of NP practice was first raised at the NSW Nurses' Association Conference in 1990, and approximately 1 year after the Stage 1 Independent NP Working Party was established (NSW Department of Health, 1996).

The remit of *The Discussion Paper* was to explore nine key issues in the development of an NP role in NSW.[3] These were: accreditation, professional accountability, professional indemnity insurance, reimbursement, initiation of diagnostic procedures, prescribing rights, referral procedures, hospital admissions and legal implications (NSW Department of Health, 1992). Overall, the NP Working Party identified the "potential for more appropriate utilisation of nursing resources in Australia" (NSW Department of Health, 1992, p. 17). *The Discussion Paper* was given wide circulation to stimulate debate amongst health professionals, health care providers, consumers and government organisations (Adrian & O'Connell, 2000; NSW Department of Health, 1996). There was significant media interest and coverage with approximately 300 written responses received by the NSW Department of Health (Adrian & O'Connell, 2000; Adrian, 1995; NSW Department of Health, 1993; NSW Department of Health, 1996). Respondents included a range of stakeholders such as medical

[3] Stage 1 was focused on the role and function of the NP. Stages 2 and 3 focused more widely on the NP role and function within the NSW health care context.

and nursing organisations, area and regional health services, hospitals, other health care groups, tertiary education institutions, government departments and individual health professions. It was noted in *The Discussion Paper* that there was only "limited response" from consumer groups (NSW Department of Health, 1993, p. 1/1). The issues identified in *The Discussion Paper* were examined as part of Stage 2 in the development of the role.

4.2.2 Stage 2

Stage 2 saw the establishment of a second Nurse Practitioner Working Party by the NSW Health Department in late 1992 (Adrian & O'Connell, 2000; NSW Department of Health, 1993), as per Table 9 from which Stages 1 and 2 appear below with Stage 2 emphasised.

ACTION	**OUTCOME**
Stage 1 *Part 1* NSW Department of Health Taskforce – The independent NP Taskforce *Part 2* Establishment of Stage 1 Nurse Practitioner Working Party – Representatives from nursing organisations	Report to NSW Health Minister *Nurse Practitioners in NSW: The role and function of Nurse Practitioners in NSW (The Discussion Paper)* Released June 1992
Stage 2 Establishment of Stage 2 Nurse Practitioner Working Party – Multidisciplinary representation	*Nurse Practitioner Stage 2, Vol.1 & 11 The Review* Released September 1993

This NP Working Party first convened in March 1993, and consisted of an independent chairperson and 16 members from a much broader representation than the nursing stakeholder Stage 1 NP Working Party. These were:

- Independent chairperson
- NSW Health Department – Nursing Branch
- NSW Health Department (Deputy Chief Health Officer)
- NSW Health Department – Government Relations Branch
- NSW Health Department – Legal Branch
- Council of Remote Area Nurses of Australia

- NSW Midwives Association
- NSW College of Nursing
- NSW Nurses Registration Board
- NSW Nurses Association
- Area/Regional Health Service representative
- Consumers' Health Forum
- Independent representative
- Royal Australian College of General Practitioners
- Australian Medical Association – NSW Branch (2 representatives)

(NSW Department of Health, 1993)

The three Terms of Reference for the Stage 2 NP Working Party were: to analyse the responses to *The Discussion Paper*, discuss issues arising from it, and to develop a Final Report, including recommendations for consideration by the NSW Minister for Health (NSW Department of Health, 1993). The Stage 2 NP Working Party met over a 5-month period (NSW Department of Health, 1993). The Final Report was in the form of the *Nurse Practitioner Review Report Stage 2, Vol 1 & 11* and was commonly referred to as *The Review* (Adrian, 1995; NSW Department of Health, 1995). It was released in September 1993 (NSW Department of Health, 1993).

4.2.2.1 Key Issues identified in The Review

Overall, the submissions from the Stage 1 consultation highlighted a "high level of polarisation of viewpoints" (NSW Department of Health, 1993, p.1). Opposition to *The Discussion Paper* as described in *The Review* was mainly, although not exclusively, from the medical profession. In general, the medical organisations were identified as opposed to, and the nursing organisations in favour of the NP role, but there were exceptions within both organisations to this generalisation (NSW Department of Health, 1993). Overall, the Stage 2 NP Working Party reported that the main reason for opposition to the role at that early stage in the development of the NP role, was attributed to the confusion about what the role entailed (NSW Department of Health, 1993). The key issues raised by the respondents primarily related to the following issues:

- Definition and function of the NP role;
- Community need for the role and substitution of doctors;
- Cost-effectiveness of the role;
- Legitimisation of the role;
- Education of NPs.

  (NSW Department of Health, 1993, pp. 2/3-2/4)

Overall, the issues surrounding the role and function of the NP were described as complex and involved professional, political, economic and consumer arenas (Adrian, 1995; NSW Department of Health, 1993). The Working Party reportedly had considerable difficulty in agreeing upon a specific definition for the NP (Adrian & O'Connell, 2000). The Review noted that, because of the evolving, changing and "ambiguous notion of the role and function of the nurse practitioner that no single definition was appropriate" (NSW Department of Health, 1993, pp. 3/5). However, the NP Working Party agreed "Nurse practitioners are registered nurses educated for advanced practice, the characteristics of which would be determined by the context in which they practice" (NSW Department of Health, 1993, pp. 3/5).

The Review identified that improved interprofessional collaboration would be needed in the evaluation of existing models of health care service delivery, and in the assessment of alternative models. In addition, it identified the need to assess objectively both community

and professional reactions to such alternative models, and their associated benefits and disadvantages (NSW Department of Health, 1993). The Working Party made a number of recommendations.

4.2.2.2 Recommendations from The Review

The NP Working Party reviewed literature from international sources, particularly from the US and UK on the role of the NP (NSW Department of Health, 1993). Because of the dearth of Australian literature, it was deemed essential by the NP Working Party to generate Australian specific data to demonstrate if there would be a viable role for NPs in the Australian health care context (NSW Department of Health, 1993). Fifteen recommendations were made in *The Review* but central to these was the second, which called for pilot projects to be completed within 18-months. These studies were to be designed and coordinated by multidisciplinary committees at the local level. Responsibility for the pilot projects was to be split between a State NP Steering Committee and the local project teams (NSW Department of Health, 1993; Adrian, 1995). The aims of the pilot projects were to achieve a number of broad objectives: to examine the clinical judgements and services of the NP, identify the potential contribution of the NP role and also to ascertain any problems or constraints in the delivery of health care, and opportunities for improvement in these processes (NSW Department of Health, 1993, pp. 3/7).

Overall, the NP projects were to examine seven specific dimensions. These were: competencies, accountability, professional indemnity insurance, diagnostic radiology, diagnostic pathology, prescription of medications and referral procedures. (NSW Department of Health, 1993; Adrian, 1995). The NP Working Party stipulated that the pilot projects were not to compare directly services provided by NPs and medical practitioners (NSW Department of Health, 1996).

A minimum of three projects was recommended in the remote, general practice and area-district health service context. However, the range of projects acceptable to all members of the NP Working Party was extremely limited (Chiarella, 1996a). For example, for the area-district health service context, the NP Working Party was very specific about the areas of practice that could be included in that context. These areas were: sexual health, mental health, outreach services to homeless persons, hospital based emergency departments or units and hospital based maternity services. However, there was no limitation placed on the contexts of remote and general practice (Adrian, 1995; NSW Department of Health, 1993).

In addition, midwives working in private practice and nurses working in diabetes, asthma care, palliative care and women's health were not to be included in the NP projects. "While these were areas where it can be argued that nurses have been working autonomously, bringing advanced knowledge, experience and skills to their practice, they appear to have been "no go" areas" (Adrian & O'Connell, 2000, p. 56)

The NSW Minister for Health accepted all of the NP Working Party's recommendations, including publication of *The Review* which was subsequently released to the public in September 1993 (NSW Department of Health, 1993) and hence, Stage 3 was established (Adrian, 1995; NSW Department of Health, 1996).

4.2.3 Stage 3

The Stage 2 NP Working Party recommended that pilot projects be undertaken. In November 1993, a Project Manager was appointed to coordinate Stage 3 of the Nurse Practitioner Project (Adrian, 1995). At the same time, the Independent Chair of the Stage 2 Working Party was again appointed as the Independent Chair for the Stage 3 NP Steering Committee (Adrian, 1995). Below, Table 9 is shown with Stage 3 emphasised.

ACTION	**OUTCOME**
Stage 1 *Part 1* NSW Department of Health Taskforce – The independent NP Taskforce *Part 2* Establishment of Stage 1 Nurse Practitioner Working Party – Representatives from nursing organisations	Report to NSW Health Minister *Nurse Practitioners in NSW: The role and function of Nurse Practitioners in NSW (The Discussion Paper)* Released June 1992
Stage 2 Establishment of Stage 2 Nurse Practitioner Working Party – Multidisciplinary representation	*Nurse Practitioner Stage 2, Vol.1 & 11 The Review* Released September 1993
Stage 3 Establishment of Stage 3 NP Steering Committee – Multidisciplinary representation NP pilot research projects	*The Nurse Practitioner Project Stage3: Final report of the Steering Committee (The Final Report)* Released April 1996

4.2.3.1 Stage 3 Nurse Practitioner Steering Committee

The establishment of the NP Steering Committee marked the beginning of Stage 3. The Stage 3 NP Steering Committee made up of a number of diverse key stakeholders, all of whom were identified as having significant interest in the legitimisation of NPs as *bona fide* providers of health services in New South Wales (Adrian & O'Connell, 2000). The Stage 3 NP Steering Committee met to oversee the conduct of the research, data analysis and the submission of a final report to the Minister (Chiarella, 1996a, 1996b; NSW Department of Health, 1996). This Steering Committee comprised representatives[4] from the following organisations:

- Project Manager, Nursing Branch, NSW Department of Health;
- Research Officer - Nurse Practitioner Project, NSW Department of Health;
- Epidemiology Branch, NSW Department of Health;
- Policy & Planning Division, NSW Department of Health;
- Legal Branch, NSW Department of Health;
- Nursing Branch, NSW Department of Health;
- Office of the Chief Health Officer (medicine), NSW Department of Health;
- Commonwealth Department of Human Services & Health;[5]
- Area Health Service Representative;
- NSW College of Nursing;
- NSW Health Department;
- NSW Nurses Association;
- NSW Midwives Association;

[4] Sixteen of the members from the Stage 2 Working Group were also members of the Stage 3 Nurse Practitioner Steering Committee. New members on the Stage 3 Steering Committee came from the same organisations that were represented in the Stage 2 Working group while others represented organisations that had been added to the Steering Committee for Stage 3 of the Project.

[5] Two members were from the Commonwealth Department of Human Services and Health highlights the increased interest that the NP project was generating at the national level of Government (Adrian, 1995).

- Council of Remote Area Nurses of Australia;
- Nominee, Consumers Health Forum;
- Royal Australian College of General Practitioners;
- Australian Medical Association, NSW Branch.

(NSW Department of Health, 1996)

4.2.3.2 The Nurse Practitioner Pilot Research Projects

The Stage 2 NP Working Party called for a series of pilot projects to be undertaken. In mid-January 1994, an expression of interest (EOI) was published widely across Australia in national, state and local press, and also in key nursing and medical publications. The EOI was designed for two distinct purposes; firstly, to elicit proposals from interested parties to become pilot sites, and secondly to begin the process of informing health professions and the general Australian community about the projects. Consequently, over 400 resource kits were sent to those who requested them from the NSW Department of Health (NSW Department of Health, 1996). By the deadline of March 1994, 58 applications were received. From these applications, the NP Steering Committee selected ten pilot sites to be recommended to the NSW Health Minister for inclusion. In June 1994, the NSW Health Minister announced that all 10 of the pilot sites would be funded, and the Commonwealth Government also made a financial contribution to the project (NSW Department of Health, 1996). The NSW College of Nursing was made trustee for the Stage 3 Nurse Practitioner Database to encourage and facilitate further appropriate research using the NP pilot project database (NSW Department of Health, 1996).

The pilot projects were developed so that each of the research projects could "stand alone", as well as form part of the broader NP Project. Many of the pilot sites were identified as having made the most of the opportunity to explore not only the NP role, but also its benefits of the role for individual communities (Adrian, 1995).

Of the 10 projects, three of the pilot projects were established in remote[6] areas:

[6] The definition of *remote* as adopted *in The Review* covered those populations that may be attached to an urban or rural centre, but be isolated due to geography, culture or lack of services.

- Wilcannia Hospital – a no doctor, primary and emergency service in the far west of NSW serving a predominantly Aboriginal population;

Figure 1

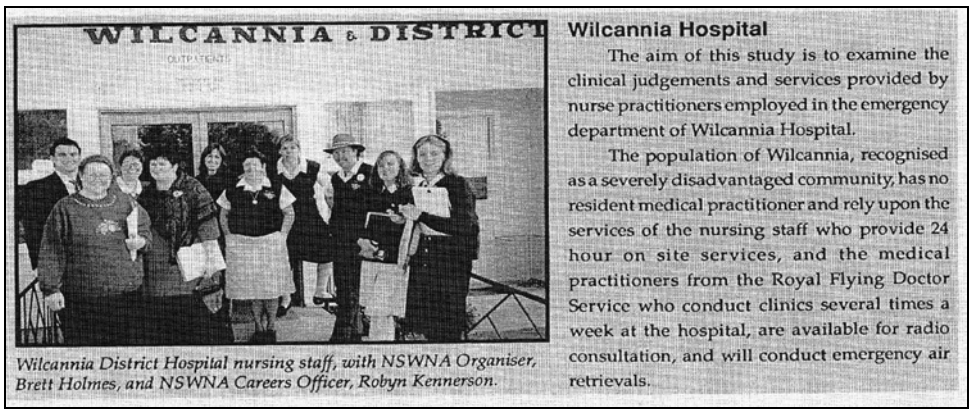

Photo source: Wilcannia Hospital, *The Lamp,* July 1994, p.42.

- Wagga Wagga Base Hospital – a primary and emergency care service in a large, rural community;
- Urana Multi-Purpose Centre – a primary and emergency care service in a small, rural, one doctor community.

Three pilot projects were attached to general medical practice:

- Kable Street General Medical Practice – providing primary health care to older people residing in the Windsor/Richmond districts of NSW;

Figure 2

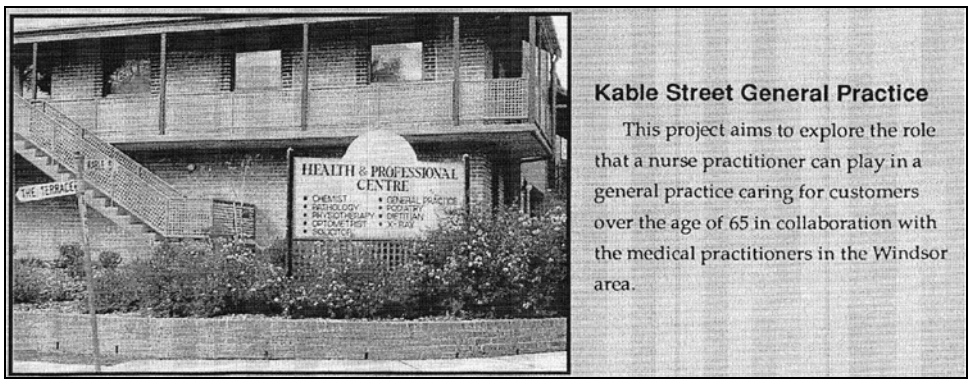

Photo source: Kable Street General Practice, *The Lamp*, July 1994, p.43.

- West Wallsend General Medical Practice – a women's health service in an isolated mining community in the Newcastle district;
- Wallsend Primary Care Service – providing primary care in an extended hours medical centre.

In addition, four pilot projects were established under the umbrella of an area or district health service[7] within the clinical areas of midwifery, accident and emergency, mental health and sexual health:

- Shoalhaven Memorial Hospital – a maternity service on the NSW south coast;
- Concord Hospital and Royal Prince Alfred Hospital – primary and emergency care in two busy Sydney metropolitan tertiary teaching hospitals;
- Mathew Talbot Hostel – a hostel for homeless men in the middle of metropolitan Sydney.

Figure 3

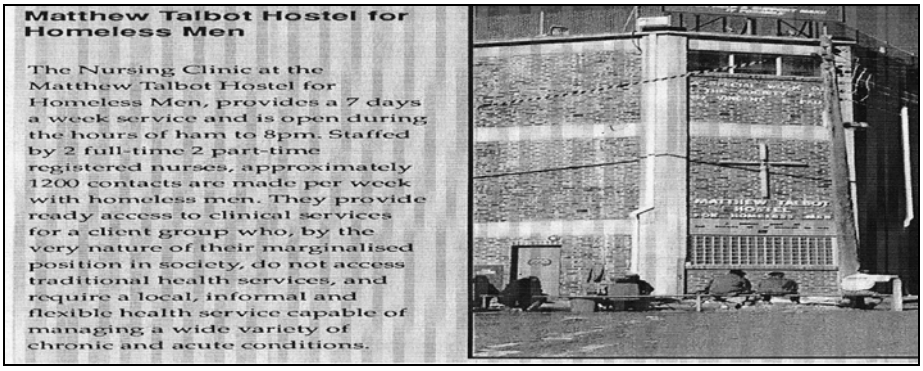

Photo source: Mathew Talbot Hostel, *The Lamp*, July 1994, p. 43.

- Kirketon Road Clinic – a primary and sexual health outreach clinic for prostitutes, street children and the local community in Kings Cross (Sydney's red-light area).

(NSW Department of Health, 1996)

[7] At the time of the publication of the EOI the District Health Services were in the early stages of establishment after a major restructuring of the rural and remote health services. Unfortunately this prevented some of the District Health Services submitting a proposal for this initiative that some regarded at this time as a viable solution to some of their health service delivery problems (Adrian, 1995).

An information pamphlet was released by the NSW Department of Health in November 1994 to provide further information to health professionals and the public about the NP Projects (NSW Department of Health, 1994). While the pilot sites represented a diverse range of services, populations and locations, nine of the chosen sites were described as providing a primary care service (Adrian, 1995).

The key elements for evaluation related to:

- Access – Opportunity for consumers to access services appropriate to their needs, including availability, acceptability, convenience, choice and equity.
- Best practice – How service should be provided and the most efficient and effective. As a prerequisite for the implementation and evaluation of each pilot project, clinical guidelines and protocols were to be developed based on reviews of literature, expert opinion and professional standards and values.
- Appropriateness –The appropriateness of clinical judgements and decision-making evaluated by comparing actual practices recommended in the clinical guidelines and protocols[8] and according to measures of customer satisfaction.
- Costs –Assessment of costs such as a professional's time, supplies, capital (e.g., land, buildings, equipment); overheads (eg. administration, power); costs of other services (e.g., community and voluntary services); costs to patients and their families (e.g., inputs to treatment, out-of-pocket expenses); the indirect costs (e.g., time lost from work).
- Outcomes –Indicators included symptom relief, complications, risk factor modification, physical, psychological and social function, customer satisfaction with the results and impact on other services.

(NSW Department of Health, 1994; NSW Department of Health, 1996)

A recommended common data set was developed and distributed to the pilot projects co-ordinators so that some cross project comparisons could be made. Out of the 10 pilot projects, two were randomised controlled trials and the remaining eight were descriptive

[8] The terms clinical guidelines and protocols were used interchangeably

follow-up studies. The Stage 3 NP project *Final Report* noted that a descriptive methodology was chosen "because of constraints set by the Stage 2 Working Party" (NSW Department of Health, 1996, p. iii).

For five of the 10 pilot sites, the NP model was a new service but three of the sites were already using a *de facto* NP model of care. For these three sites where the *de facto* NP model of care was already being used, one was a hospital in remote NSW with no medical support on site and a predominantly Aboriginal service, one was a primary and sexual health outreach clinic mainly serving prostitutes and street children in metropolitan Sydney, and one was a hostel for homeless men in metropolitan Sydney. Two of the other project sites were also trialling the NP model at the time of the NP Projects so it was not a new concept to those sites (NSW Department of Health, 1996).

4.2.3.3 The "Final Report"

In addition to the research component of the NP projects, the recommendations in the *Final Report* reflected an extensive range of issues that were identified over the three stages of the NP Project (Adrian & O'Connell, 2000). The *Final Report* is a large and complex document that uncovered many issues influential in the development and implementation of a NP role. Specific issues in *The Final Report* that affected, or had the potential to affect the introduction of NPs into the health care system are identified in the following section. In addition, the findings of the pilot projects, and the recommendations of the NP Steering Committee for the development and implementation of NPs will be discussed.

4.2.3.4 Overall findings from the NP Pilot Projects

Overall, the NP Pilot Projects as identified in *The Final Report* provided strong evidence to support the introduction of the NP role into the NSW health care system. The role of the NP was found to be a feasible one that variously added value to already existing health services, either by providing a valuable additional service, or by providing the only available service. The safety of the NP role was established in as much as the NPs satisfactorily followed protocols and clinical guidelines in 96% of cases, their clinical decisions and management skills were judged to be reasonable, as supported by the evidence from clinical review. Approximately half of the remaining 4% of the NPs' clinical decisions and management skills were also deemed reasonable by a multidisciplinary clinical review team. Consequently, the Stage 3 *Final Report* concluded that the empirical evidence as provided by examining 2,706 interludes of care, together with the outcomes of discussions on issues

brought forward from Stage 2, "assured the majority of the members of the NP Steering Committee of the potential positive contribution to be made by establishing the nurse practitioner role within the NSW health care system" (NSW Department of Health, 1996, p. iii).

Two years following the establishment of the Stage 3 NP Steering Committee, the release of the NP Project Stage 3 *Final Report* was approved by the then NSW Health Minister in December 1995 and later published in April 1996 (NSW Department of Health, 1996).

The Stage 3 NP Steering Committee acknowledged that the limitations placed on the conduct of the pilot projects by the Stage 2 Working Party had limited the outcomes that could be examined. In addition, issues relating to confusion surrounding the NP role, inter-professional collaboration and clinical practice guidelines were given particular attention, and these are identified in the following section (NSW Department of Health, 1996).

4.2.3.5 Limitations of the Pilot Projects

It was noted in *The Final Report* that the NP Pilot Projects would have carried more weight if a randomised control design had been used. However, the AMA and Royal Australian College of General Practitioners (RACGPs) representatives requested descriptive studies comparing nursing practice against best practice guidelines as opposed to a large randomised controlled trial that compared nurses' and doctors' practice. The medical stakeholders were concerned that NPs would become doctor substitutes (Chiarella, 1996a). However, one of the pilots compared registered medical officer practice with NP practice in an emergency department, and another compared medical officer and NP practice in a primary care service. *The Final Report* identified that these two projects had achieved similar results between the two groups in outcome measures and patient satisfaction. Furthermore, it was noted that to undertake a thorough randomised control trial of NPs would have been extremely difficult because of the short timeframe of two years within which the pilot projects were to be completed. In addition, it was argued that the available funding would have only supported three or four projects if a randomised controlled trial design had been used.

As a consequence, the major outcome measure for the pilot project focused on the safety of NPs through their adherence to protocols and practice guidelines. The NP Steering Committee concluded that the results of the ten pilot projects were consistent with those of overseas studies which found that NP services were safe and provided acceptable consumer

satisfaction. The *Final Report* noted that examination of the cost-effectiveness of NPs to the heath care system was not possible because the NPs did not provide a fee-for-service and as such did not create additional costs (NSW Department of Health, 1996).

4.2.3.6 Understanding NP role: Role confusion

The Final Report identified that there had been considerable confusion amongst health professions, health managers and the general public surrounding the NP role. Much of the confusion was attributed to uncertainty about role boundaries between nursing and medicine (NSW Department of Health, 1996).

The complementary nature of the two professions was reported as the cause of the confusion because the NP role was seen by many as a 'takeover' of the medical role. *The Final Report* concluded that the intent was not to prepare "nuDRses" (Chiarella, 1994) that, is practitioners who are practising as nurses on the outside, but who in the middle would actually prefer to be doctors, but to equip nurses to have the skills to serve their communities to their best advantage (NSW Department of Health, 1996, p. 9).

Concerned about the confusion over the NP role, the Stage 3 NP Working Party recommended that the NSW Department of Health investigate options for an interdisciplinary forum of health professional organisations to further enhance "collaborative practice and professional development" (NSW Department of Health, 1996, p. 9). It was also identified in the *Final Report* that sensitivities over role boundaries had affected the inter-professional collaboration between the stakeholders during the pilot projects (NSW Department of Health, 1996).

4.2.3.7 Interprofessional collaboration

Throughout the three stages in the development of the NP role, particular attention was afforded to the importance of inter-professional collaboration for the successful introduction of NPs into the health care system. The NP Steering Committee noted that the recommendations of the *Final Report* were only possible because of the inter-professional planning, practice and evaluation that was experienced across the pilot project sites. However, it was also acknowledged that sensitivities over role boundaries had negatively affected inter-professional collaboration between the stakeholders in some sites.

4.2.3.8 Development of clinical practice guidelines

Each multidisciplinary pilot project team was required to oversee the development of clinical practice guidelines, protocols and competencies that were then endorsed by each member of the project team (Adrian & O'Connell, 2000; NSW Department of Health, 1996). Negotiations to develop appropriate competencies, and clinical guidelines and protocols in each of the pilot sites were particularly difficult. A lack of resources (human and financial) and sensitivities related to professional boundaries were reported as the two main barriers to the development of the clinical practice guidelines.

The protection of professional boundaries was played out to a certain extent during the development of the NPs' clinical practice guidelines. The process of guideline development during the NP pilot projects was reportedly extremely difficult because of the diversity of vested interests reflected by the stakeholder members (Adrian & O'Connell, 2000).

In addition to the key issues identified in terms of drivers and obstacles to the implementation of the NP role, there were a number of recommendations proposed by the Stage 3 NP Steering Committee.

4.2.3.9 Overview of Stage 3 NP Steering Committee Recommendations

Overall, the recommendations of the NP Steering Committee were described as being based upon two guiding principles:

- A local agreed need [for a nurse practitioner] to be determined prior to establishing a service that includes nurse practitioners; and
- Collaborative planning, practice and evaluation are the foundation of relationships across professional boundaries.

(NSW Department of Health, 1996).

The recommendations primarily ranged across matters relating to the education and accreditation of NPs, and the process for establishing NP services. Issues relating to NPs' scope of practice such as initiation of diagnostic imaging and pathology, initiation of medications, initiation of referrals to medical practitioners and other service providers are also covered in *The Final Report*. Options for funding NP services and professional indemnity insurance were also identified. (Adrian 1996; NSW Department of Health, 1996). An overview of each of these issues will now be provided.

4.2.3.10 Education of nurse practitioners

The Stage 3 NP Steering Committee recommended that common core education programs which meet the criteria for NP accreditation should be developed by education providers for registered nurses seeking accreditation. It was recommended that education providers include specialist modules to provide the necessary context-based clinical knowledge, skills and attitudes relevant to particular areas of practice. Emphasis was to be placed on equity and access when developing NP education programs with provision to be made for credit transfer and recognition of prior learning for RNs undertaking NP education programs. Nurses already practising in roles similar to those of NPs were to be given priority of access to these programs[9] (NSW Department of Health, 1996).

4.2.3.11 Accreditation of nurse practitioners

The Steering Committee recommended that the responsibility for the accreditation of NPs be vested in the Nurses Registration Board of NSW (NRB), and that an NP Accreditation Steering Committee should be established.[10] It was determined that an NP Accreditation Steering Committee would be responsible for making recommendations to the NRB regarding the criteria and process for NP accreditation. The activities of the Committee would then be subject to ongoing evaluation and review by the nursing profession and the NRB (NSW Department of Health, 1996). In particular, it was recommended that the Nurses Act 1991 (NSW) be amended to provide that the title 'nurse practitioner' only be used by registered nurses who have been accredited by the NRB as NPs, and that the names of these NPs be entered onto a professional register. In addition, it was recommended that a "grandparent provision" was to be incorporated (with a 5 year sunset clause) to allow for the immediate accreditation as NPs for nurses operating in roles similar to those of NPs. The criteria for NP accreditation under such "grandparent provisions" were to be developed by

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[9] The level of NP education, for example, Masters, Graduate Diploma was not stipulated at this stage in the role's development.

[10] The Stage 2 Final Report recommended the Nurses Registration Board of NSW; NSW Nurses' Association; Institute of Nurse Administrators of NSW and ACT; the NSW College of Nursing; Nursing Branch, NSW Dept. of Health; Australian Council of Deans of Nursing; Consumer Representative and at least 2 other representatives from the specialist professional nursing associations.

an NP Accreditation Steering Committee and were to be approved by the NRB[11] (NSW Department of Health, 1996).

The following section presents the process for establishing NP services in NSW including "local agreed need", initiation of diagnostic imaging and diagnostic pathology, initiation of medications, initiation of referrals to medical practitioners and other services providers and issues related to professional indemnity insurance.

4.3 Process for Establishing Nurse Practitioner Services

4.3.1 Establishing a local agreed need

The Stage 3 Report recommended that "Before establishing a service that includes NPs, there must first be an assessment as to whether a need exists within their community which is not being addressed by current services and which could be addressed by the establishment of a service provided by NPs" (NSW Department of Health, 1996, p. 74). Following this assessment, the "key stakeholders with an interest in the area would have to be identified and consulted". These stakeholders were to include:

- Hospital or practice management or employing authority or contracting agency;
- Professional groups, representatives of all professional groups likely to be affected or involved, and including medical practitioners through local divisions of general practice;
- Relevant industrial representatives;
- Consumers.

(NSW Department of Health, 1996, p. 74)

The NP Steering Committee went on to recommend that "a representative consultative committee of all stakeholders should be formed and consultation should take place with the interests of the community to be served as the primary concern" (NSW Department of Health, 1996, p. 74). The following criteria were proposed:

- Is the local population served by existing services? If not, why not?

[11] However, a "grandparent provision was not developed by the NRB. Rather, 2 pathways were developed for NPs with and without an NP specific postgraduate degree (as described in section entitled "NP authorisation).

- Does the local population access existing services? If not, why not?
- Will the service enhance (and not detract from) existing services?
- Is the proposal cost effective, economically viable and an efficient use of resources?

(NSW Department of Health, 1996, p. 74)

The *Final Report* also states "during this process, the stakeholders should also consider any alternatives available to meet the identified local agreed need and consider whether the need (having regard to the criteria outlined above) could be better served by one of these alternatives" (NSW Department of Health, 1996, p. 74).

4.3.1.1 Obtaining consensus

The *Final Report* reiterated that a central factor to the success of the pilot projects was that they operated as "collaborative models", with support from all health professionals. It was acknowledged that co-operation and consensus on a "local agreed need" at times would be difficult to achieve. Rather than consensus stipulated as a "mandatory" requirement, it recommended "all efforts must therefore be made through the Committee to establish consensus" (NSW Department of Health, 1996, p. 75). It was advised that should conflict occur, that stakeholders be provided the opportunity to nominate additional persons to the Committee to assist with the resolution of conflict, to utilise the services of a person(s) with mediation skills, and also to use a formal mediation process (NSW Department of Health, 1996).

4.3.2 Initiation of diagnostic imaging and diagnostic pathology

The Final Report states that investigations (imaging and pathology) undertaken, or not, by the NPs during the pilot projects was appropriate in 2019 (99%) of the cases reviewed. It was recommended that the NSW Department of Health in conjunction with an NP Working party made up of government, nursing and medical representation (including general medical practice) develop a list of specific diagnostic imaging and pathology that may be initiated by an NP working in either the public or private sector. It was also recommended that the NSW Department of Health develop a policy for the initiation of diagnostic imaging and pathology by NPs in the public health system. In addition, it was recommended that local public health services using NP services develop parameters for implementation consistent with the Departmental policy. It was further recommended that written policies and protocols/clinical

guidelines be developed covering the practice of NPs working in the private sector by "appropriately qualified health professionals related to that service" (NSW Department of Health, 1996, p. 79).

It was determined that the protocols/clinical guidelines[12] be developed as appropriate to the context of care and according to written protocols/clinical guidelines, and also include mechanisms for the management of results in conjunction with a medical practitioner nominated to support the NP's practice (NSW Department of Health, 1996).

4.3.2.1 Funding for processing investigations

The *Final Report* stated that if no claim is made against a Medicare item for the processing of the diagnostic imaging or diagnostic pathology, there is no illegality in a nurse initiating diagnostic imaging. It was proposed that for nurses working in the public health care system, the cost for processing public health service diagnostic imaging and diagnostic pathology should be met by the State Government. For NPs working in the private sector, under the Health Insurance Act (1991) Medicare benefits would only be payable for a diagnostic service if rendered following a written request by a medical practitioner (NSW Department of Health, 1995).

The *Final Report* highlighted that under current arrangements, the role of a NP working in the private sector would be restricted because "the processing of any diagnostic imaging and pathology ordered through a private laboratory would not be eligible for reimbursement under Medicare" (NSW Department of Health, 1996, p. 94). Rather, these services would have to be paid for by the employer, the NP, or the consumer/patient and, thus, would be an "obstacle to efficient and best practice". The Area Health Services would have to meet these costs in the public health sector with funding provided through Medicare Hospital Funding Grants. It was identified that the Commonwealth Government would have to agree to recognise NPs as a legitimate provider under Medicare (see p. 62 for discussion on Medicare funding). Thus, it was recommended that the NSW Department of Health negotiate with the Commonwealth Government for the reimbursement for diagnostic imaging and diagnostic pathology initiated by NPs (NSW Department of Health, 1996, p. 95).

[12] The terms *protocol* and *guideline* were used interchangeably.

4.3.3 Initiation of medications

The pilot projects demonstrated that 1,680 (84%) of the cases in which the NPs' recommended medications, or other therapies, were appropriate. In addition, 295 (15%) of the cases where no medications or therapies were recommended were deemed reasonable. In sixteen (1%) of the cases, a medication or therapy was not appropriately recommended (NSW Department of Health, 1996, p. 33). Based on these results, the NP Steering Committee recommended that the Poisons Act and the Regulation be amended to authorise nurse practitioners to "write medication orders" for S3 and S4[13] substances from a nurses' formulary under a set of conditions. The formularies were to be appropriate to the context of care and the specialty of practice and as part of the NPs' to written policies and protocols or clinical guidelines (NSW Department of Health, 1996, p. 87). It was determined that the NSW Department of Health should "establish a working party with representatives from the nursing and medical profession (including general medical practice) and the Pharmaceutical Services Branch of the NSW Department of Health to develop a formulary of specific S3 and S4 substances" (NSW Department of Health, 1996, p. 87). In addition, it was proposed that a working party explore the "issue of nurse practitioners ordering a limited number of S8[14] medications according to written protocols or clinical guidelines, with particular consideration being given to monitoring and evaluation measures" (NSW Department of Health, 1996, p. 94).

4.3.3.1 Funding for medications

In relation to the cost of NP activities associated with the ordering of medications, the NP Steering Committee determined that costs associated with NPs' ordering medications be met by the State Government. To help prevent cost shifting between the State and Federal Governments, the NP Steering Committee recommended that the cost of prescriptions written against a public hospital pharmacy department or those supplied from "ward stock", under nurse initiated or standing order protocol/clinical guidelines, should be met with

[13] Schedule 2 medicines are 'Pharmacy Only Medicines' that are substantially safe but advice or counselling is available if necessary. Schedule 3 (S3) are 'Pharmacist Only Medicines' that require some product information by a pharmacist. Examples are pseudoephedrine and salbutamol. Schedule 4 (S4) is a prescription-only medicine' such as antibiotics and strong sedatives.

[14] Schedule 8 (S8) medicines are controlled drugs that are dependence-producing and which are likely to be abused or misused. Examples are most barbiturates and narcotics such as morphine.

funding provided through Medicare Hospital Funding Grants.[15] However, it was acknowledged that difficulties could arise when prescriptions were required for items not routinely stocked by public facility pharmacies (e.g., hormone replacement therapy, oral contraceptive pill), or in areas such as rural and remote communities where there may not be a public facility pharmacy. In addition, for those NPs working in rural and remote areas that do not have a public facility pharmacy (such as one connected to a hospital) and NPs working in the private sector, under current arrangements, the role of a NP would again be restricted because the cost for any ordered medications would not be eligible for reimbursement under the Pharmaceutical Benefits Scheme (PBS), but would be paid for by the employer, the NP, or the patient. It was acknowledged that these restrictions would affect the viability of the NP role in the private sector and that the Commonwealth Government would need to agree to recognise NPs as legitimate providers under the PBS (NSW Department of Health, 1996).

4.3.4 Initiation of referrals to medical practitioners and other service providers

The pilot projects found that overall the decisions made by the NPs in relation to referral, were appropriate in 2,112 (99%) of the cases (NSW Department of Health, 1996). However, the NP Steering Committee recommended that all referrals to a medical specialist from a NP be made through the patient's nominated GP. Therefore, referrals by an NP would have to be made in consultation with a general medical practitioner (NSW Department of Health, 1996).). It was recommended that patients who do not have a general medical practitioner involved in their care be referred by the medical practitioner nominated to support the NP's practice. However, the Steering Committee deemed it "acceptable" for NPs to refer directly to outpatients clinics, community health centres and allied health practitioners but recommended that full communication be maintained with the "consumer/patient's medical practitioner" (NSW Department of Health, 1996, p. 90). In addition, the issue of NP referral was to be addressed in the NPs' protocols/clinical guidelines (NSW Department of Health, 1996).

[15] Medicare Hospital Funding Grants are a Commonwealth, rather than State Government responsibility.

4.3.5 Professional indemnity insurance

The NP Steering Committee advised that for NPs working in the public health system, the NSW Department of Health must confirm professional indemnity coverage by advising the NSW Treasury Managed Fund of the role of the NP. This provision recognises that NPs who work within a contract of employment (as an employee) are not required to carry professional indemnity insurance. It was recommended that NPs working in the private sector, or those who work within contract for service arrangements should carry professional indemnity. It was also recommended that NPs be recognised as a "separate category of nurse provider (separate to other nurse providers) in quality improvement initiatives including the review of adverse patient outcomes" (NSW Department of Health, 1996, p. 99).

Having described the key three stages in the early development of the NP role and the process for establishing NP services, the next section will identify the framework that was developed for the implementation of NPs into the NSW health care system.

4.4 Framework for the implementation of NPs into the NSW health care system

In the months following the release of the *Final Report* in April 1996, there was considerable concern among nurses that the NP Project had stalled. However, behind the scenes negotiations to implement the recommendations in *The Final Report* were continuing between a number of key nursing organisations and individuals, and the NSW Health Minister (Adrian & O'Connell, 2000). Consequently in February 1997, the NSW Minister for Health established an implementation process for NPs in NSW. The primary focus of this process was to prioritise required actions in the key areas of criteria for accreditation, clinical guidelines, and policy for NP services (Adrian & O'Connell, 2000; NSW Department of Health, 1998). Table 10 below provides an overview of Stages 1, 2 and 3, and the Framework for NP implementation.

Table 10 Overview of Stages 1, 2 and 3, and the Framework for NP Implementation

ACTION	**OUTCOME**
Stage 1 *Part 1* NSW Department of Health Taskforce – The independent NP Taskforce *Part 2* Establishment of Stage 1 Nurse Practitioner Working Party – representatives from nursing organisations	Report to NSW Health Minister *Nurse Practitioners in NSW: The role and function of Nurse Practitioners in NSW (The Discussion Paper)* Released June 1992
Stage 2 Establishment of Stage 2 Nurse Practitioner Working Party – Multidisciplinary representation	*Nurse Practitioner Stage 2, Vol.1 & 11 The Review* Released September 1993
Stage 3 Establishment of Stage 3 NP Steering Committee – Multidisciplinary representation NP pilot research projects	*The Nurse Practitioner Project Stage3: Final report of the Steering Committee (The Final Report)* Released April 1996
Framework for NP Implementation Establishment of NP Steering committee to oversee the implementation of NPs	*The Framework for Nurse Practitioner Services in NSW (The Framework)* Released August 1998

On August 25, 1998 *The Framework for Nurse Practitioner Services in NSW* (known as *The Framework*) was released by the Director-General for Health (NSW Department of Health, 1998). *The Framework* was described as being built on the "primary strengths of Stages 1, 2 and 3 of the NP Project, and covered the following three main areas:

- Accreditation of NPs;
- Development of clinical practice guidelines;
- Legislative changes for NPs to be able to practice in NSW.

(NSW Department of Health, 1998).

The Framework outlined *Guidelines for the Process for Accreditation of Nurse Practitioners in NSW* (see Appendix B). These guidelines covered the criteria for accreditation as an NP in NSW, proposed role of the NP accreditation committee, and professional indemnity cover

for NPs. *The Principles for the Development of Clinical Guidelines for NP Practice by Health Services* were also outlined (see Appendix C), and a flow chart was developed to assist the NPs and Area Health Services in the process for the development of clinical guidelines (see Appendix D). *The Framework* also outlined *The Required Legislative Amendments and Recommendations to Enable NP Practice in NSW* including amendments to three Acts (NSW Department of Health, 1998) – see Appendix E.

4.4.1 NP legislation

Not long after the release of *The Framework* (approximately three months) the *Nurses Amendment (Nurse Practitioners) Act 1998* (NSW) was introduced into the NSW Parliament. The *Nurses Amendment (Nurse Practitioners) Act 1998* (NSW) amends part of the *Nurses Act 1991* (NSW) and the *Poisons and Therapeutic Goods Act 1966* (NSW). The *Nurses Amendment (Nurse Practitioners) Act 1998* (NSW) was assented to (proclaimed into law) on November 2, 1998 providing for the authorisation of nurses to practice as NPs (NSW Government, 1998). October 29, 1999 was later appointed as the day on which that Act was enacted (NSW Government, 1999). The main changes to the *Nurses Act 1991* (NSW) were under: Section 5A that prevents unauthorised persons from using the title *nurse practitioner*: It requires that unauthorised persons do not refer to themselves as nurse practitioners. Section 19A recognises the NSW Nurses Registration board as the authority to authorise registered nurses as nurse practitioners.

4.4.1.1 Clinical practice guidelines

The Nurses Amendment (Nurse Practitioners) Act 1998 (NSW) covers the use of clinical practice guidelines by NPs. However, rather than stipulating that NPs must use clinical guidelines, Section 78A of The Act states that the guidelines "may make provision for the possession, use, supply or prescription by the nurse practitioner of any poison or restricted substance;" "may include such other matters relating to the functions of nurse practitioners as the Director-General considers appropriate", and "may apply differently to different nurse practitioners according to the factors specified in the guidelines". In addition, the Act states that "the Director-General may from time to time approve guidelines relating to the functions of nurse practitioners", and "may authorise a nurse practitioner or class of nurse practitioners to possess, use, supply or prescribe any such substance in accordance with the approved guidelines" The Act also states that a contravention of the approved guidelines by

an NP constitutes professional misconduct or unsatisfactory professional conduct rather than giving rise to a criminal offence.

4.4.2 NP authorisation

It was estimated at the time of the release of *The Framework* on 25th August, 1998 that at least a 12 to 18-month delay could be anticipated before the process for the implementation of NPs as outlined in *The Framework* would be operational within the health care system, including the establishment of NP roles. This was due in part to the need for the NSW Nurses Registration Board to set up the accreditation process (NSW Department of Health, 1998). The NP Accreditation Committee met for the first time on May 24, 1999 (Moait, 1999). The accreditation process involved the development of rigorous criteria that nurses had to meet to be accredited by the Board. Despite the recommendation of the Stage 3 NP Committee there were to be no grandparent provisions for existing nurses and all prospective NPs had to be assessed by the Board (NSW Department of Health, 1998). The traditional process for nurse registration in NSW that involves only the undertaking of a formal tertiary education course endorsed by the NRB. The process for NP authorisation process was the first of its kind in New South Wales. Nurses could apply for NP authorisation through one of two pathways:

4.4.2.1 Pathway 1

This pathway was designed for registered nurses who had completed a master's degree approved by the Nurses Registration Board of NSW, as a course to prepare applicants for practice as NPs. Pathway 1 applications are assessed by a Committee of the Board that considers the documentary evidence of completion of an approved Masters program for the preparation of NP practice, and the evidence of advanced practice experience (Nurses Registration Board of NSW, 2000).

4.4.2.2 Pathway 2

This pathway option, on the other hand, was designed for registered nurses working at an advanced level but who had not completed an approved master's degree for NPs. Applicants applying for NP authorisation under this pathway were to be required to attend a clinical viva (Nurses Registration Board of NSW, 2000).

4.4.2.3 The Portfolio

The Nurses Registration Board of NSW stipulated that nurses applying for NP authorisation[16] (through either Pathway 1 or 2) must submit a portfolio including documentary evidence of their education, knowledge, skills, clinical experience and relevant professional development in their specific area of practice. The areas of practice recognised by the NRB were identified as: maternal and child health nursing, high dependency nursing, mental health nursing, rehabilitation nursing, medical-surgical nursing and community health nursing (Nurses Registration Board of NSW, 2000). Each applicant was required to address criteria listed in the *Assessment Criteria Chart for NP Authorisation* (see Appendix F). Assessment (screening) of the portfolios was deemed the responsibility of the Nurse Practitioner Authorisation Committee, as nominated by the NRB (Nurses Registration Board of NSW, 1999). A portfolio template provided in the NP Information Booklet outlined the required documentation as set out below:

1. Documentary evidence of education awards including transcripts showing completed outlines of subjects studied relevant to the criteria
2. Current authority to practice as a registered nurse in NSW.
3. Documentary evidence about positions held and relevant to the requirement of 5000 hours of practice, within the last five years, in advanced practice roles appropriate for the area (context) in which knowledge and skills can be demonstrated. The documentary evidence may be in the form of statements, references, or reports from the executive of employment or contracting institutions/agencies. It should provide information in regard to: position descriptions, the responsibilities of the position and the competencies demonstrated by the applicant whilst in the position.
4. Declaration of participation in relevant professional activities, including workshops, seminars together with certificates of attendance and achievement where available.
5. Any other information/experience considered by the applicant to be relevant for the application.

(Nurses Registration Board of NSW, 1999)

[16] The Nurses Registration Board of NSW replaced the term “accreditation” with “authorisation”.

Applicants whose portfolios were deemed to not include the essential documentary evidence were not able to progress to the clinical viva stage of the application process. However, unsuccessful applicants were advised of identified deficits in their portfolio and were then able to re-apply. Applicants who satisfied the portfolio requirements were then invited to attend a clinical viva by the NRB (Nurses Registration Board, NSW, 1999).

4.4.2.4 The clinical viva

Prior to the development and approval of an NP specific Masters degree by the Nurses Registration Board, the only option for NP authorisation was through Pathway 2. Clinical practice scenarios were used to assess each of the applicant's knowledge and skills. During the clinical viva, applicants were required to demonstrate their knowledge and skills as outlined in the *Assessment Criteria Chart for NP accreditation* (see Appendix F), (Nurses Registration Board of NSW, 1999). Nurses who were successful in their application for authorisation were issued a Certificate of Authorisation (Nurses Registration Board, NSW, 1999).

4.4.2.5 First NPs Authorised

On the December 12, 2000, and approximately 1 year after the release of the NP Information Booklet by the NRB, the then Health Minister announced in a media release that Mrs Jane O'Connell and Ms Sue Denison had become the first nurses to be authorised as NPs in NSW (and Australia), describing their appointment as "a new era for nursing in our state" and "an historic day for Australian nursing" (NSW Department of Health, 2000).

4.4.2.6 Review of the process for NP authorisation

In late 2002, a review of the process for authorisation was undertaken in accordance with the Nurses Registration Board's NP Committee. A number of changes were made such as the provision of more detailed information to assist nurses with their applications for NP authorisation (Nurses and Midwives Board of NSW, 2009a).

4.4.3 NP positions

In October 1999, following the Nurses Registration Board's approval of the recommendations of the NP Accreditation Committee, the NSW Minister for Health announced that a total of 40 NP positions would be considered for rural and remote areas that lacked direct access to medical services (NSW College of Nursing, 1999; NSW Department of Health, 1999). The first meeting of the NSW NP Steering Committee was

held In February 2000. The purpose of this Committee was to monitor and evaluate the implementation of NP positions into the NSW health care system (Meppem, 2000).

On May 11 2001 the then NSW Minister for Health announced that Olwyn Johnson was the first NP to be appointed to a position in NSW. He declared,

> On the day before International Nurses' Day this news couldn't be more timely. The authorisation of nurse practitioners has been a long process over ten years. It is extremely rewarding for everyone who has worked so hard to see nurse practitioners to become a reality. (NSW Department of Health, 2001)

However, the introduction of NPs continued to be slow and painstaking. As at August 2002, 4 years after the release of *The Framework*, there were 10 authorised NPs with only two of these working in NP positions (NSW Department of Health, 2003).

4.4.3.1 NP positions into metropolitan NSW

On September 5, 2002, approximately fourteen months following the first NP to gain a position in rural or remote NSW, the then NSW Minister for Health announced in a media release entitled *Roll Out of Specialist Nurse Practitioners* that NP positions would be rolled out into metropolitan areas in NSW (NSW Department of Health, 2002). These specialist NP positions were to be created in emergency departments, intensive care units and mental health services in Sydney, the Hunter and the Illawarra areas. In September, 2002, Ms Helen Gosby, was the first authorised NP to be appointed to a position in metropolitan Sydney. The NSW Health Minister also announced in the same media release the appointment of another into an NP position in rural or remote NSW extending the number of positions to four (NSW Department of Health, 2002). As at November 2002, there were also six approved NP positions in rural and remote NSW that were vacant (Dunn, 2002a).

4.4.4 Education of NPs

In May 2000, *Guidelines for institutions wishing to submit courses for approval in regard to authorisation of Nurse Practitioners* were published by the NRB to assist educational institutions in the preparation of courses at the Masters degree level. These courses were then to be submitted to the NRB for consideration and approval for the authorisation of NPs (Nurses Registration Board of NSW, 2000). The first nurse in NSW to be authorised to practice as a NP by completing an NRB approved specific NP Masters degree (Master of

Nursing-Nurse Practitioner) was Chris Murphy from the University of Newcastle in October 2003 (Nurses Registration Board of NSW, 2003)

4.5 Other landmark events for the NP role in NSW

4.5.1 Nurse Practitioners included in public sector salary award

On 23rd May, 2000 the new classification of "Nurse Practitioner" was inserted into the award, and provided for a two year salary structure (ie 1st year and thereafter). The NSW Nurses' Association reported that agreement had been reached with the NSW Health Department for NPs to be paid at the same rate as Nurse Managers Grade 3 (and Clinical Nurse Consultants Grade 3). This was the maximum rate under the award that gave entitlement for NPs to be paid overtime and shift penalties (Moait, 2000a). On December 16 2004, the NSW Industrial Relations Commission varied the Public Hospital Nurses' (State) Award to provide a new definition of "Nurse Practitioner Year 3 and Thereafter" for an expanded salary structure that took effect on or after January 1, 2005. The salary rates for Year 1 and 2 remained the same (NSW Department of Health, 2004). In addition, specific criteria primarily relating to stipulations in the use of clinical practice guidelines that are expected for Year 1, 2 and 3 NPs are detailed in the Award (NSW Department of Health, 2004b).

4.5.2 Australian Nurse Practitioner Association (ANPA) established

The Tambar Springs Community Technology Centre in conjunction with The College of Nursing and the New England Area Health Service facilitated the inaugural Seminar for Rural and Isolated Nurses. The original idea was to hold a luncheon for nurses in the immediate area who had left the nursing workforce so they could network and share stories. However, the idea of a luncheon expanded into a two-day seminar. All the NPs in the State expressed an interest in attending, and the seminar grew into the Inaugural meeting of the NPs across Australia (Pritchard, 2003). On April 1, 2003 the Australian Nurses Practitioners' Association (ANPA) was formally established at the Tambar Springs Community Hall in the rural town of Tambar Springs (College of Nursing, 2003).

Figure 4

The Tambar Springs Community Hall (Source: Foster, J, April 1, 2003)

Figure 5

Luncheon at the Seminar was provided by the Country Women's Association (Source: Foster, J, 1st April, 2003).

Judith Meppem, the NSW Chief Nursing Officer from 1990 to 2002, who established the first NP Committee (Independent NP Taskforce) and worked effectively behind the scenes in the NSW Health Department to maintain the momentum of the process, was named as the Association's Patron. Jane O'Connell became the Association's first President. Administrative and website support was provided to the Australian Nurse Practitioners Association by the NSW College of Nursing during the Association's early inception (Australian Nurse Practitioners Association, 2009).

It had become apparent that, with the increasing number of NPs there was the need for a portal for effective communication between the NPs. To this end, in 2002 The Royal College

of Nursing Australia developed an NP Special Interest Group so that nurses could communicate about issues pertinent to the NP. In 2004, The NSW Department of Health later sponsored an "open email" Listserver for the NPs to discuss and share information (H. Gosby, personal communication, March 11, 2010). The inaugural national conference of ANPA was held on October 28-29, 2005 in Canberra (Australian Nurse Practitioners Association, 2009).

4.5.3 Midwife practitioner legislation

The use of the title 'midwife practitioner' has a very different political history to that of 'nurse practitioner' and has not been embraced by the midwifery profession in Australia. Following the amendment to the Nurses and Midwives Act 1991 in August 2004, the title 'midwife practitioner' has also been protected by law and expert practising midwives were able to apply for authorisation as midwife practitioners (Nurses and Midwives Board of NSW, 2009b). In 2005, The Australian College of Midwives issued a Position Statement entitled *Midwifery and the nurse practitioner* that stated "it is acknowledged that some midwives may wish to apply for NP or MP status, especially where such authorisation is accompanied by financial and/or industrial reward and incentive". However, the College also stated that selection of a few practitioners to have this authorisation through NP status is "ambiguous and fails to achieve the broader, evidence based, public health objective of developing midwifery continuity of care models where *all* midwives have these privileges". The College advocated for "a more robust approach" for the implementation and recognition of adequate educational and legislative frameworks for *all* midwives (The Australian College of Midwives, 2005, n.p).

4.5.4 National competency standards for NPs in Australia

The Australian Nursing and Midwifery Council (ANMC) has, until the establishment of the Nursing and Midwifery Board of Australia in 2009, been the peak national nursing and midwifery regulatory organization. It was established in 1992 to develop a national approach to nursing and midwifery regulation, in conjunction with the state and territory nursing and midwifery regulatory authorities. Prior to 2009, there was no national regulatory authority in Australia so the voluntary development of the ANMC provided the sole national regulatory focus for nursing. In 2004 the ANMC, with a contribution, from the Nursing Council of New Zealand, commissioned a project to investigate the scope and role of nurse practitioners and to develop national standards for practice. Three generic standards define the parameters of

NP practice. These standards are underpinned by nine competencies each with specific performance indicators (Australian Nursing and Midwifery Council, 2006).

4.5.5 First NP working in private practice

In February 2004, the first private practice conducted, owned by and advertised as an authorised NP practice was established. Nurse Practitioner Andrew Cashin was the first to apply for, and be provided with professional indemnity insurance to practise as an NP. The insurers provided the insurance at the rate that would be given "to any registered nurse in private practice" as the insurers were of the opinion that the rate would not change even if the NP used his extended privileges (Cashin, 2006, p. 21).

4.6 Summary of Chapter 4

This chapter has provided a detailed account of the key events in the early development of the NP role in NSW. It has highlighted that the role was developed over a ten-year period from when the role was first proposed in 1990 until the first two NPs were authorised in December 2000. However, it was during this ten-year period that the title of "Nurse Practitioner" was protected through legislation and the processes for NP accreditation, regulation, and education were established. More specifically, the development of the role from Stage 1 through to Stage 3 involved the establishment of four Committees and a number of key reports. The Stage 1 Independent NP Taskforce produced the initial report for the then NSW Health Minister, the Stage 1 NP Working Party produced *The Discussion Paper*, the Stage 2 NP Working Party produced *The Review* and the Stage 3 Steering Committee oversaw the NP research projects and produced *The Final Report. The Framework* was consequently released by the NSW Health Department and the NP Steering Committee was established to oversee the implementation of NPs into the NSW health care system.

A major constraint imposed on the NP role was the need for the identification of local agreed need prior to the establishment of an NP position. In addition, while the NPs' scope of practice and responsibilities were extended to include, for example, the ordering of diagnostic imaging, pathology and medications, such activities conducted by NPs working outside the hospital setting could cost patients hundreds of dollars extra. At the time of

writing, unlike doctors, NPs were not subsidised by the Federal Government through MBS and PBS.

The lack of PBS poses a particular problem where there is a lack of a public facility pharmacy such as one connected to a hospital in rural and remote areas. This lack of access to MBS and PBS also meant that the costs of any tests or medications ordered by the NPs within the hospital setting would have to be met by the State Government. These costs include medications supplied by a public hospital pharmacy department or those supplied from "ward stock". The lack of access to PBS and MBS also threatened the viability of the NP role in the private sector.

The Final Report highlighted the presumption that an NP would have access to a medical practitioner to support their practice. It was also mandated through NSW Health Department policy that NPs would work collaboratively with medical practitioners in the development of clinical practice guidelines that would determine their expanded and extended scope of practice. Furthermore, while it was deemed acceptable for NPs to refer patients directly to out-patient clinics, community health centres and allied health professionals, all referrals to a medical specialist from a NP had to be made through the patient's GP or the GP who had been nominated to support the NP's practice. All NPs working as employees were to be covered by their employer through vicarious liability. NPs working within or outside the public sector not covered by vicarious liability were to carry personal indemnity insurance. Thus, it was made clear that medical practitioners would not be legally liable for the NP's practice.

Following the implementation of NPs into the NSW Health care system the role has continued to evolve, with the introduction of a public sector salary award, the establishment of the Australian Nurse Practitioner Association, the introduction of legislation to include Midwife Practitioners, national competency standards for NPs in Australia and the NP role moving into the private sector. Finally, it was determined that, in addition to the required 5000 hours of clinical experience at an advanced level of practice, the process for NP authorisation would entail the development of a professional portfolio. An extra pathway (pathway 2) to authorisation through examination at a clinical viva was to be available for nurses wishing to become authorised until NP specific postgraduate degree courses could be developed.

Chapter 5 presents research findings relating to the NP's experiences pioneering the role in NSW.

Chapter 5 – Findings - Entering uncharted waters: Pioneering the NP role in NSW

Chapter 4 Key events in the early development of the NP in NSW (1990-2005).	• Antecedents to the NP role in NSW. • Stages 1 to 3 in the development of the NP role. • Process for establishing NP services. • Framework for the implementation of NPs into the NSW health care system. • Other landmark events for the NP role in NSW.
Chapter 5 Entering uncharted waters: Pioneering the NP role in NSW.	• Taking up the challenge. • The challenge of uncertainty. • Recognition, rewards and opportunities. • The legacy of the pioneers to the NP movement in Australia.
Chapter 6 Navigating uncharted waters: Recognising advanced practice in nursing.	• Getting to know advanced practice. • The NP role: Collaborative, autonomous or independent? • Traditions in health care: Good old days or plagued by the past?
Chapter 7 Riding the waves to change: Visions, voices and vested interests.	• Visions for the NP role. • Developing and implementing the NP role: Negotiation and compromise. • Collaboration: Co-operation or control?

This chapter reports findings from the individual NP interviews highlighting aspects of their pioneering role. Findings obtained from the stakeholder interviews relating to the NPs' pioneering role are also presented. As with the experiences of pioneers in the US (Brown & Draye, 2003; Draye & Brown, 2000) the NPs are regarded as the trailblazers in the introduction of NPs in NSW, and also across the wider nursing population of Australia.

> *These are the trailblazers, the pioneers.* [KS4]

The chapter is divided into four sections that have been titled as follows: entering uncharted waters: taking up the challenge; the challenge of uncertainty; recognition, rewards and

opportunities; and the legacy of the pioneers to the NP movement in Australia. These section titles reflect the issues identified from the data and will be briefly described below before being explored in depth within this chapter. Suggestions to prepare others to take on these pioneering roles as a result of these experiences are developed in Chapter 8, the discussion.

The first section entitled *Entering uncharted waters: Taking up the challenge* explores the three main reasons why these nurses were driven to take on the challenge to be pioneers for a role that challenged many traditions inherent within the existing health care system. Firstly, these pioneer NPs were driven by their belief that the NP role would provide a better health care service for their patients by improving the quality of, and access to, patient care. Secondly, they had a strong commitment and passion for nursing, but they also wanted more from it. The pioneers were more than ready to leave behind the constraints of traditional practice. In addition, they expressed a sense of responsibility to pioneer the role for other nurses. Thirdly, the NPs also spoke about their personal reasons for pioneering the role, and also their personal journeys.

A major source of stress for them was the uncertainty that came with pioneering a new role. The sources of uncertainty for the NPs are explored in the section entitled *The challenge of uncertainty*. The major sources of uncertainty were related to the authorisation process, their gaining an NP position and developing their clinical practice guidelines, rather than changes relating to their practice. However, contained within their stories of uncertainty were also stories of perseverance, resilience and courage.

Despite the challenges and uncertainty that came with pioneering the role, the NPs spoke about the recognition they received from those within and outside nursing, and the rewards and opportunities that opened up to them. These are described in the section entitled *Recognition, rewards and opportunities*.

The pioneers were not only pioneering the authorisation and implementation of the role in NSW but also the future of the NP movement in Australia. The contribution of the NPs to the overall NP movement is acknowledged in the section entitled *The legacy of the pioneers to the NP movement in Australia*.

This chapter begins with the NPs' journeys that led to their *taking up the challenge* to pioneer the new NP role in NSW.

5.1 Entering uncharted waters: Taking up the challenge

Early in the interviews each of the NPs were asked to "describe the process by which you became a Nurse Practitioner." All began by describing the reasons that stimulated their interest to pioneer the role. It was these reasons, as described by the NPs, that had driven them to take up the challenge not only to pioneer the NP role but to also succeed in it.

The next section describes their vision for the NP role to contribute to providing a better health care service.

5.1.1 Vision for better health care

The NPs were keen to progress their traditional nursing roles so they could improve the health care they provided for their patients. In particular, NPs working in rural and remote areas described the problems they had faced because of the lack of easily accessible health care in their communities. GP visits to rural and remote communities were often limited to one or two days per week or less and only during traditional working hours. If patients required medical care or medications outside the GP visits, they could have to drive hundreds of kilometres to a larger town.

> *People here in remote areas do not get sick nine to five nor once a week when the doctor visits. Obviously if I could give penicillin for a sore ear or chest or urinary tract infection. I thought yes, the nurse practitioner could answer some of those questions.* [NP7]

The NPs wanted to provide continuity of care. Many of the problems they faced were from a lack of care continuity through infrequent or irregular GPs visits to rural or remote communities. One NP described her surprise when she realised that too many young people in a small rural town had been inappropriately prescribed anti-hypertensive medications. The NP believed that the GP's heavy workload on the days he visited resulted in his using quick fixes such as prescribing medications for problems that required further investigation.

> *Everybody was very blood pressure focussed...there was an enormous amount of young people… who were on hypertensive medications. So I began to have a sense there was something wrong.* [NP1]

This NP went on to describe the difficulty that some people in her community had in accessing a GP, even when GPs visited the town.

> *There were other young families who couldn't access health services, because of transport. They were working on properties and they were very dependent on the person they worked for, whether it was a lack of money to be able to put fuel in the car, whether they could leave their job during a time they could get an appointment with the GP.* [NP1]

Another NP was visibly upset as she spoke about her helplessness because of the limitations on her practice as an RN. She recalled the story of a young girl attending her clinic. The girl could not afford to visit a GP to obtain the morning-after pill because none in the town provided Medicare bulk-billing. She later attended the nurse's antenatal classes because she could not afford a termination. Had the RN been an NP with the legal right to prescribe the morning-after pill events may have turned out otherwise. The NP pointed out that the young girl was not an isolated case.

> *It was frustrating because you keep thinking if I was authorised I'd do this. They didn't have the cash to see the GP so they hoped they would not be pregnant, and if they were pregnant they didn't have the money for a termination.* [NP7]

Another NP described how elderly patients in a small rural town had resorted to using home remedies to treat their illnesses because of a lack of health care.

> *They were treating urinary tract infections with yoghurt douches, and hot baths and vinegar washouts. There were people using WD40 (a metal lubricant) for arthritis on their knees… and there were people also using kerosene to treat their arthritis.* [NP1]

NPs working in metropolitan hospital settings spoke of their frustration with delays as patients waited hours to see a junior doctor for minor ailments.

> *People would come in with complaints that you knew that you could deal with but they'd end up waiting four or five hours and get angry.* [NP5]

These three NPs identified deficits in health care. Significantly, they knew that they had the knowledge and skills to be able to meet these health care gaps but were constrained by traditional limitations of their scope of practice. They believed that the extra responsibilities that were part of the NP role such as prescribing and ordering of investigations would help address these problems and so were keen to take on the challenge of pioneering the new the

role of the NP. This readiness to establish new nursing territory has been described as *breaking free* with pioneer NPs in the US (Brown & Draye, 2003).

A NP working in a rural and remote town spoke about her commitment to becoming an authorised NP because she saw it as an assurance to her community that they would be receiving a high level of nursing patient care:

> *...you could have a first year graduate nurse come along who may have the confidence but not the knowledge to provide an excellent service. Now what we have…is an assurance to the community that the nurse that you have here is at an advanced level.* [NP2]

The NPs stressed the importance for them to have legislative protection for their scope of practice. They described their frustration over how nursing and nurses' practice in the past, had in their view been ruled by the whim and vested interests of powerful individuals or organisations outside nursing. Whilst they regarded the legislative protection for the title of the nurse practitioner and scope of practice as important for the NP role, several commented that protecting their scope through legislation was important for their patients.

To illustrate this position, one of the NPs related her experiences as a bush nurse in the 1970s. At which time nurses were the primary source of health care for the Aboriginal population. She described how bush nurses provided services that included diagnosing and dispensing antibiotics for ear infections. With her voice quivering she recalled that the medical industrial organisation complained to the NSW Department of Health. As a consequence the nurses were directed to cease providing antibiotics despite having diagnosed an ear infection.

> *One group of doctors said that we can't do that anymore and it was all taken away.* [NP1]

This NP was clearly upset describing how she witnessed Aboriginal children dying or losing their hearing. The distress of these incidents impelled her to become an NP.

> *The nurse practitioner will allow that never to happen again…At the end of the day the law is there…so it [practice] is not dependent on the strongest voice of the day.* [NP1]

In addition to their commitment to improving health care, the NPs spoke about professional issues that had driven them to pioneer the role. They saw the NP role as benefiting their own professional growth but also clearly saw the NP role as part of nursing's professional growth. These issues will now be discussed.

5.1.2 Professional drivers to pioneer the NP role

Becoming an NP was perceived as a significant professional goal. Most of the NPs had worked in their previous roles and settings for many years. They believed pioneering the NP role would provide a new and exciting dimension to their nursing careers that would otherwise have been unavailable. Thus, they accepted the challenge to climb the mountain:

> *So I thought why not have a go, it's a challenge, so why not take up the challenge… the mountain was there, so I climbed it.* [NP8]

And:

> *At the time I entered my journey I was fairly well determined this is what I was going to do, I like a bit of adrenalin pumped (laughs)...it's gets a bit boring out here (laughs), I like a bit of a challenge. [NP1]*

Several nursing stakeholders also pointed out that it would be nurses who liked a challenge that would most likely take on the challenge to become NPs.

> *Probably some of the people that are the NPs are the more stronger willed and driven, because to do it you'd have to be prepared to take on a bit of a challenge, professionally and personally.* [KS1]

A number of more specific professional stimuli prompted these NPs to pioneer the NP role. They were not particularly interested in management or education roles and the NP role presented a new clinical career pathway.

> *I wanted to stay by the bedside and look after patients, I didn't want to go to management or education but I needed to go somewhere else in the clinical path, in the ladder, in the nursing ladder.* [NP4]

Several of the NPs who worked closely with other nurses in hospital settings spoke of how they approached their nursing and functioned, compared to some of their nursing colleagues.

They expressed frustration with nurses who (they believed) lacked passion and commitment not only to their nursing practice, but also to professional nursing. One of the NPs described this type of nurse as:

> *The whitegoods nurses, the ones that come to work to just payoff the goods.* [NP5]

They spoke about these nurses as practising in a more automated, task-orientated way and having no interest in nursing, or in progressing their professional development.

> *They practice in a basic sort of way doing temperatures, pulses, the procedures that they **have** to do for that patient…They come to work, they don't want to go off and do any further education.* [NP4]

The above depictions of some nurses' practice reflected their annoyance felt by the NPs because they believed that some nurse's lack of interest in professional development was detrimental to the patients and to the profession. They were frustrated with the absence of formal recognition for nurses who do practice in a more professional way. They saw the NP role as acknowledging clinical nurses who prefer to function in a more sophisticated way to improve patient care. To these pioneers the NP role would distinguish them from clinical nurses who simply went to work to pay their bills.

> *I see it as being, in a lot of ways, it's recognition, it is acknowledging that it is the level at which we work at.* [NP7]

The NPs spoke about the value of the NP role in increasing the visibility of nurses and nursing. As already identified in the literature (e.g., Chiarella, 2002), traditional nursing practice hides nurses' contribution to health care. The NPs expressed their frustration that their care was hidden behind the visibility of medicine because doctors often received the kudos for their care. The NPs wanted to be recognised for their ability to make autonomous clinical judgments and decisions, but they also wanted to take responsibility for them. The NPs expressed concern about the erroneous perception of the public that nurses are merely the administrators of medicines with little recognition of medication knowledge.

In reality the NPs pointed out that they often made recommendations about the medications required for a patient to a doctor and the doctor simply agreed with it and signed off. As pointed out by a nursing stakeholder:

> *The nurses would say just sign this, or the nurses would basically tell them [the doctors] this is what I think needs to be done, the doctors go fine, you do that, I'll sign whatever.* [KS10]

The NPs argued that this was no longer acceptable as it not only has the flow on effect of reinforcing nursing's invisibility and handmaiden image.

> *That really is the way nursing needs to go because for many years you know the old handmaiden and battleaxe approach, which really made it look like you couldn't make a decision without checking with somebody.* [NP6]

One of the most important aspects of the NP role, especially for those working in rural or remote areas, was the legalisation of their existing practice. Essentially the way that many of the NPs practiced would not change substantially because they had been working in as what they described as de facto NP roles for years but their practice boundaries were often blurred.

> *I don't feel that becoming a nurse practitioner has changed [my work] a lot but it's given me the legal background and the legal paperwork and framework of which to do something I really enjoy and that's clinically to get out there...It was a grey area anyway but the line has actually become clearer.* [NP8]

> *In a way we have always done that under standing orders….Getting authorised will mean it will legalise a lot of the practice that we've always done for a long time.* [NP7]

For these pioneers the NP role was seen as a professional challenge, extending their clinical career path. They believed that the NP role would give them recognition for their practice, and help increase the visibility of nurses' practice and nursing in general. The role was seen to legalise the practice of the NPs working in *de facto* NP roles in rural or remote areas. Many of the NPs described their professional and personal lives as inseparable.

> *You can't separate the two in many instances.* [NP5]

However, for the purpose of structuring this thesis, the NPs' personal reasons for pioneering the NP role, and also their personal journeys as they pioneered the role are described in the following section.

5.1.3 The NPs' personal journeys

To begin the interviews with the NPs I asked them to describe their experiences in becoming an NP. It became clear that the journeys for many began years earlier, some dating back to their childhood. Their earlier experiences had driven their passion and commitment to pioneer and succeed in the NP role as revealed below. For these NPs, to pioneer the role was to leave behind old demons.

> *I'm somebody who left school at 15… and was told I wouldn't do anything, never achieve…never amount to anything. Let's sum it up okay that, that had a big bearing on it.* [NP2]

For one of the NPs it was especially important for her to reach what she called the *pinnacle of nursing* because:

> *When I was at school I went to occupational guidance and I said I want to do nursing. They told me I should be a day nursery attendant.* [NP9]

Another recalled a negative childhood experience to illustrate when, at an early age, she became aware of her own powerlessness as a female in an unequal, hierarchical and authoritarian society. She spoke about being prevented from joining a soccer team being she was female. She also recalled her mother's response that life would be easier for her if she simply accepted it.

> *I was a kid about nine… and I remember having this huge temper tantrum and [being] berated by my mother because I said the world was unfair just because I'm a girl… and her attitude was, "Well just be a good girl and keep quiet," which is pretty much the way society is.* [NP identity withheld for anonymity]

She went on to relate her childhood experiences to her experiences as an adult female and nurse. She argued that women are still reminded to *know your place and stay in it*, but also argued that nurses continue to be told by doctors to *be a good girls* and *you are just a nurse.* She commented that it was her childhood experience together with the traditional constraints placed on nurses' practice that had also motivated her to become an NP.

> *But if you look at society these days, it is still a bit like that, you should know your place and stay in it. If you translate that to where I am in nursing or where I have been in nursing, it is the same kind of frustration that I guess keeps us not able to do*

> *what we can do…. Everyone somebody says to me, particularly professionally, "You can't do that." It is like a red rag to a bull*. [NP identity withheld for anonymity]

This NP went on to point out that comments made by the AMA about the NP role also spurred her interest to pioneer the role.

> *…and the AMA made some scathing remarks about nurse practitioners… so I guess that was where it first started pushing my buttons.* [NP identity withheld for anonymity]

For one NP, to pioneer the role was partly her entering a *new period in her life* because *one door shuts and another door opens.* She was shutting the door on harmful past events e to take on the challenge and achieve something significant.

> *He always used to say to me how worthless and how useless I was, you know, and I thought, well you know, "up yours too". So I think it was a culmination of the small incidents that happened in my life*. [NP identity withheld for anonymity]

The NPs had a strong sense of responsibility to pioneer the role not only for nursing but also for the nurses whom they hoped would follow them. Several of the NPs reported that, while they were aware it was possible for them to fail, their concern or fear of failure was overcome by their strong desire to succeed, and encourage others to become NPs.

> *I had this one percent that at the end of the day, all the support would go and I'd fall and the whole lot would collapse, and was I prepared for that because that would be pretty devastating. I thought, well why not give it a go, and then I thought well at fifty or whatever I was at the time, who else was going to do this. You can't expect the young ones to do this; there is no way you can expect the young ones, so I might as well go out with a bang really (laughs) as I have nothing to lose.* [NP1]

An NP also spoke about the responsibility she felt to the NSW government and others that had supported the introduction of NPs in the face of the strong political opposition by some doctors and powerful medical organisations.

> *NSW has put their neck on the line, you know, by virtue that if we get it wrong we're in big trouble, so you know we're very conscious that we've got to get it through for other people.* [NP6]

While many felt a sense of responsibility to pioneer the NP role, they also spoke about weighing the pros and cons. They were cognisant that challenging traditional nursing conventions would most likely be politically controversial.

> *I thought, I've got to be very clear in my own mind that I want to do this, for the right reasons… that I'm prepared to cop the downside as well as the upside of it. I had to make that decision myself that I wanted to do that.* [NP1]

As the NPs began to pioneer the role they became increasingly aware that they were "being watched" that if they did anything wrong it could be seized upon by those, in particular the AMA, who did not support the role.

> *I mean, certainly you are always thinking that some people can't wait for you to trip up and to stuff things up.* [NP7]

Another of the NPs pointed out that if they did something wrong, it could end up being a very public affair if parties such as the AMA found out and used the media to further their political advantage.

> *[number] endorsed nurse practitioner in Australia… It would've really looked good in the papers you know… botched.* [NP8]

Another reported her awareness of being watched because of comments made to her early in her NP role by a doctor who worked in her clinical setting.

> *One of the comments from one of the doctors early on in the process was that he had the form signed for the solicitors. He just had to fill in the incident.* [NP10]

In addition to the doctor's scrutiny, the NPs spoke about their increasing awareness of being monitored by their nursing colleagues.

> *They're watching you to see what's going on and how my role is turning out.* [NP7]

One NP described feeling like an *imposter* [NP1]. She explained that this was not because of her practice but rather the recognition that came with her authorisation. Overall, the NPs reported being pleasantly surprised how quickly they became comfortable in their new role.

> *It took me about four to five months to become really comfortable in my role.* [NP8]

> *After a couple of months I gained enough confidence in my skills that I'd say, "Okay I need this, this and this," and basically write out the scripts for the drugs that were needed and for any of the diagnostic tests whether it be pathology or radiology, and that worked really well.* [NP7]

They described the increased responsibility and accountability that increased their enjoyment and job satisfaction.

> *The first patient was a young girl with tonsillitis and that was easy but I was still very much in the mindset I've got to ring the GP. Why do I have to ring the GP? I can dispense this. I'm allowed to, okay, so I did it but it took me a couple of days to really settle down and to think I don't need permission from the GP.* [NP8]

One aspect of the pioneering role that some were not prepared for was their *standing out*. While some of the NPs enjoyed having a more public profile, this was not the case for all. One revealed that she had not anticipated standing out as much as she did.

> *I had an expectation that we would have, you know, not only myself, but quite a number of [specialty] staff from the unit authorised, and then I was just one more, that they were, you know, going to be coming closely behind me and get authorised.* [NP3]

This NP commented that she did not want her work colleagues to view her becoming an NP as only personal gain and *as feathering my own nest, I didn't want to see it as setting it up for myself* [NP3]. While this NP declined to comment further it is possible that she was concerned that her colleagues may react negatively if the role was seen to be benefiting her personally.

A few NPs described their disappointment and frustration in some of their nursing colleagues' apathy and lack of commitment to help the NP movement during its early development. One pointed out that some nurses were waiting until the role was more established.

> *People come up to me at meetings or conferences that I'm at and say I want to be a nurse practitioner but I'm going to wait until you have sorted it all out and then I'll*

> *think about it, and you think how rude we actually need you guys involved now to help us.* [NP5]

The pioneers were geographically spread out across NSW with most of the NPs during the early development of the role only having sporadic contact with the other NPs. Their sense of isolation increased during times of stress and difficulty. However, their commitment and vision for the role appears to have helped them through their sense of isolation. One NP pointed out that while she would sometimes feel isolated and lost, it was because of her strong vision for the role and the big picture that kept her going. She believed that nurses' strong vision, commitment and passion for the role determined whether nurses would succeed in not only becoming an NP but also implementing the role in practice.

> *I have got such clear vision that even though I feel isolated at times I never feel lost in terms of what I want to achieve, because I have had this vision for years, so I am really comfortable with that. A lot of them aren't… It is so embedded in me and I've such a clear vision of it, I know where we are heading. I guess that is part of the passion.* [NP5]

This NP's view was supported by another pioneer who succeeded in becoming an NP but later *gave up the fight*. In describing her sense of isolation as a pioneer NP, she believed that it would have been easier for her to maintain her motivation to continue had there been NPs in closer proximity with whom she could communicate, and from whom she could receive support. She also pointed out that while she was passionate about the NP role, she probably would have persisted had she had been more committed to working as an NP.

> *The questions that I needed to ask myself was do I want it 100%' because if I want it 100% well okay, I will fight for it; or do I want to walk away from it, and I mean that's the choice, that's the choice I had to make.* [NP not identified to maintain anonymity]

Other NPs spoke about the support and encouragement they received in their personal lives that helped them through the difficult times as they pioneered the role.

> *It's also as much [name's] pride because he has helped me get there…and he supports me in the role.* [NP9]

> *You've got to be fair and say that there was a tremendous amount of support in my own home life. There was my husband there was a tremendous amount of support.* [NP1]

The formation of the Australian Nurse Practitioners Association (ANPA) in 2003 was identified by many as significant in reducing their isolation. It provided them with a sense of belonging by *having a supportive network around them.* [KS6]

The NSW College of Nursing (the College) played a key role in the establishment of ANPA, through financial support and the provision of resources during the role's infancy.

> *The other thing we did of course was establish the Australian Nurse Practitioners Association here, and we've done it under the auspices of the College.* [KS3]

A stakeholder pointed out that it was because the College recognised the difficulty in setting up a new association that it decided to help ANPA until it could support itself financially through increased membership.

> *I don't want necessarily them to feel we are looking after them- it is not for that reason- but it is very hard to establish a new group financially you have to be incorporated and you have to pay quite a bit of money… so we'll continue to have them under our auspices until they've grown up enough to and have a big enough group to be financially viable.* [KS3]

Thus, it was the College's aim to help provide information and support to set up the Association, link ANPA with other international Nurse Practitioner organisations, provide financial support for teleconferences, physical space for face-to-face meetings and a web page for ANPA through its own website.

> *We've supported them financially to set themselves up until they are financially okay to get on with it. We've got them incorporated and put some money behind them because they were a new association… I've linked them into international nurse practitioner associations… We pay for a teleconference for them to have twice a year, and they lease here for nothing.* [KS3]

The NPs acknowledged ANPA in providing support and communication. This communication was important for the NPs working in rural and remote areas because of their geographical isolation. Importantly too, the collegiality and contact with other NPs were also

for NPs working in metropolitan areas because it helped maintain their motivation and decrease their sense of isolation.

> *Our association is flourishing and I have this **great** cohort of people to work on the executive of the Association with me who are as committed and fervent about it as I am, and it's fantastic. For a while there I felt like I was really on my own. I mean it's good, we have got a bit of a groundswell.* [NP5]

Several working in rural or remote areas revealed that they again began to feel isolated with the increasing numbers of metropolitan NPs or *metro NPs* [NP10]. For example, they spoke about being *left out of the loop* [NP9] because organisers of meetings or activities sometimes forgot the wide geographical distribution of the NPs. They felt that information was sometimes directed more toward NPs working in metropolitan NSW or they were given short notice about upcoming events such as workshops.

> *They'll let you know the day before or two days before that there's a nurse practitioner workshop on in Sydney on Monday and we didn't find out about it until Thursday [had] just gone and I can't get days off to go.* [NP10]

In summary for this section on taking up the challenge of pioneering the NP role, many NPs highlighted through their stories that their journey to pioneer the role and become an NP began years ago. Many felt a strong responsibility to pioneer the NP role for their nursing care, nursing and also for other nurses despite being aware of the political risks. Some of the pioneers, especially those in rural or remote areas, felt a sense of isolation. Maintaining their focus on the bigger picture, support from those in their personal lives and the establishment of the ANPA helped to decrease their isolation.

In addition to their reasons for taking up the NP challenge, the NPs spoke about issues that were particularly problematic when pioneering the role. The following section explores the uncertainties associated with pioneering the role.

5.2 Pioneering the NP role: The challenge of uncertainty

It was clear from the interviews that all of the NPs experienced uncertainty as they pioneered the new role, although the degree of uncertainty varied with its underlying reason and between each of the NPs. Uncertainty is described as a "dynamic state in which there is a

perception of being unable to assign probabilities for outcomes" (Penrod, 2001, p. 241). It can prompt a discomforting or uneasy sensation that may be reduced or increased through cognitive, emotive, or behavioural reactions. Uncertainty can change over time and can be mediated by confidence and control that may relate to specific events or more general social circumstances (Penrod, 2001). The NPs spoke about the reasons for their uncertainty as they pioneered the role, how it affected them and sometimes, how they sought to alleviate it. Being a pioneer means that the path ahead is unknown (Draye & Brown, 2000). The NPs and stakeholders agreed that pioneers are never completely prepared for the road ahead.

> *A pioneer is a pioneer, and that is why they are pioneers, because they are going into virgin land, untouched territory and you don't know what is going to happen.* [KS6]

As such, a number of the NPs revealed that they felt in some ways as through they were being used as part of an experiment because they knew that the NP role's future would depend on their experiences.

> *We had basically been the guinea pigs sent out there.* [NP7]

For the majority of NP pioneers the uncertainty was not really associated with the added responsibility and accountability of their clinical practice. As already stated, most had been already working in de facto NP roles [KS10]. Rather, their uncertainty was primarily related to the authorisation process, gaining an NP position and developing their clinical practice guidelines. These issues received considerable attention from both the NPs and stakeholders in their interviews.

5.2.1 The authorisation process

There was clear evidence from the interviews that most of the NPs found the authorisation process testing. Notwithstanding obstacles such as resistance by doctors, managers and other nurses as they were implementing the NP role (see Chapters 6 and 7), gaining authorisation was the most challenging aspect of their pioneering the role.

> *I think if you survive the authorisation process you can survive anything once you get through it [laughs], but it is not easy.* [NP7]

Stakeholders acknowledged the NPs' difficulties. Several reported the pass rate as being approximately 50% at the time of the early pioneers [KS13].

Several stakeholders believed the authorisation process was excessive. One saw it as reflecting a *lack of faith* within nursing that perpetuates nurses having to *jump through hoops* to prove themselves [KS12]. Another stakeholder believed that the authorisation process for NPs should have been through mentoring and observation of the NPs' practice similar to the process for other health professions.

> *I even put forward that to assess a nurse practitioner you should have ready a series of observations to go and work with them. You know that is how registrars are developed up in medicine and how GPs develop, how they mentor their colleagues and that's how physios work and for some reason we are not able to do that which is hugely problematic.* [KS3]

The process for NP authorisation was the first of its kind in NSW, indeed in Australia. Undergraduate nursing registration and postgraduate qualifications are traditionally awarded following the successful completion of a university program. At the time of these pioneers an NP-specific masters program had not been developed (Pathway 1). The pathway to authorisation during the period of these pioneer NPs was through the submission of a professional portfolio, and then sitting for a clinical viva (Pathway 2). The following section explores the NPs' experiences particularly to the development and submission of their portfolio.

5.2.1.1 Authorisation process: the portfolio

The majority of the pioneers NPs were middle-aged and educated in a hospital setting. Whereas some of the NPs had undertaken postgraduate education, they had not yet been exposed to the concept of a portfolio because it was only a recently introduced educational and professional tool within NSW education curricula. Only a few of the NPs had undertaken a non-NP specific masters program in which the final part of the course was the development of a portfolio. As part of their application for NP authorisation, they submitted their portfolio developed during their course. For these NPs the submission of their portfolio was straightforward.

> *So I… sent it to the Registration Board and it was passed and then I had my viva and I was authorised in a very short space of time.* [NP10]

In contrast, those NPs (the majority) without exposure to portfolio development found it challenging and provoking considerable uncertainty and stress.

> *I mean we had no idea what a portfolio was.* [NP8]

> *There was quite a bit of confusion and uncertainty about it.* [NP2]

Nursing stakeholders acknowledged that the lack of exposure to the development of a portfolio that was particularly problematic for the pioneers despite their clinical experience.

> *They had incredible clinical experience but it did not help them in terms of putting a portfolio together that they may never have done before in their lives. I could see that getting that portfolio early on in the piece, it is so onerous, all the hoops they had to jump through.* [KS3]

The NPs confusion was accentuated by what they described as a lack of detailed information, formalised process or direction to help them. Developing their portfolios amounted to trial and error.

> *They [NRB] didn't have any formalised process or anything like that. They just gave you a booklet and you sort of worked through it saying, oh well, I think this is what they were asking there… It felt like you were constantly hitting your head against a brick wall because there was no one to give you any answers or directions.* [NP4]

Some NPs pointed out that the NRB would change the type of information it wanted in the portfolios.

> *I got the portfolio which recorded all the things I'd done and put them into a portfolio, sent it off to the NRB and the NRB wrote back and said they wanted some case studies.* [NP2]

Despite these hurdles, the NPs were undeterred. Each of the NPs employed different strategies to help them develop their portfolios. One described how she utilised a professional service that specialised in portfolio development to help her.

> *I sat down with them and said, "I need a portfolio. I don't know how to do it. No-one's telling us how to do it. I've got a guide, you do it." So they worked with me in*

> *building a portfolio so that was good I kept just on feeding them pieces of paper as I found them, and they collated it, and that was over like a six or seven month period.* [NP3]

Some sought assistance from their pioneer peers who had already submitted their portfolio while others sought help from nurse academics whom they knew could help.

> *People like [name of academic] and other people would ring me up to help me put my portfolio together.* [NP1]

> *A lot of them would send their portfolios to me and we managed that from afar, so we did a lot of that for… the first few years.* [KS3]

NPs reported a process of submission and resubmission up to three or four times over 6 to 18 months before the NRB accepted their portfolio. Several described the need to resubmit their portfolio as having been *failed* [NP1] or *rejected*.

> *I had the dubious honour of being the [number] person to be rejected because the application wasn't good enough… The NRB rejected it.* [NP6]

Some admitted that delays in submitting or resubmitting their portfolios happened because they had not kept documents such as hospital and university transcripts and records of course attendance. Several found it very stressful when requested to provide additional information such as hospital or university transcripts that were difficult for them to access in a short time frame. Sometimes they were only given 2 or 3 weeks by the NRB to collect the additional documents before their clinical viva (see below). The NPs commented that, with time it would become easier for other nurses because they would know more about portfolios and the need for them to keep documents relating to their professional careers.

> *You would build up the portfolio over the years and then, Bang! Ten years down the track when you're ready, it's all documented and ten boxes high.* [NP8]

Despite the uncertainty they experienced during the authorisation process, many of the NPs reported that they expected and accepted that there would be significant challenges and difficulties developing their portfolios and that it was just part of their journey in pioneering the role. One acknowledged the pioneering role of the NRB in the authorisation process.

> *The NRB really didn't know what they were doing and in fairness that's not a criticism of them. It was a whole new process for everybody.* [NP6]

In addition to the NPs' lack of knowledge about portfolios and their difficulty obtaining documentation, the NPs also spoke of their difficulty in demonstrating they had attained the required 5,000 hours of advanced practice. Some NPs expressed their uncertainty over the meaning of advanced practice, and as such did not know how to prove it. The confusion surrounding the concept of advanced practice is explored in detail in the next chapter.

Several stakeholders commented that some of the NPs had not developed a theoretical framework to help them describe their practice, or more specifically, their advanced practice, as compared to the NPs who had completed a masters degree.

> *I think that's where the lack of sophistication, that being said I think their knowledge was broad and rich but not framed in a scholarly way to give them a theoretical framework for what they were doing. I think many of them were brilliant clinicians but there were gaps, I don't think they actually understood their own modus operandi, if they were going through a good clinical masters program that gives you the foundation for that.* [KS14]

In response to the difficulty of the early pioneers, others benefited from portfolio workshops later made available to help them. One of the nursing stakeholders commented that, because the majority of the pioneer NPs were from rural or remote areas and therefore lacked easy access to education or facilities, these pioneers required the most support.

> *You almost needed to hold their hand for six months.* [KS3]

Thus, the development of portfolios was arduous and time-consuming, with many struggling for up to 18 months before their portfolio was finally accepted. A stakeholder reflected that the NPs to develop their portfolios, the NPs might well have undertaken a master's degree or waited until the NP-specific master's degree became available which would have given them a theoretical foundation for their practice.

> *It would have saved at least some of the pain if they'd just put their head down and finished the master's, gone and done it, it might have saved an awful lot of pain.* [KS14]

Once the pioneers' portfolio was accepted, the next challenge was their clinical viva.

5.2.1.2 Authorisation process: The clinical viva

None of the NPs had previously undertaken a clinical viva, so the anticipation of the viva created anxiety. The clinical viva involved a case study, which was unknown to the applicant.[17] Candidates were required to read the case study and answer questions put to them by a panel of experts such as a pharmacist, a senior clinical nurse, an academic and a doctor, whose backgrounds would align to the specialty of the NP. Whilst they found the clinical viva stressful, the NPs' highlighted that the complexity and level of the questioning was for them unprecedented, which they found confronting.

> *It is an incredibly stressful process, mainly because it is like an interrogation of what you do and your knowledge, and I think nurses aren't constantly questioned about what you do in your practice, and to suddenly get that at a higher advanced level of question about everything you do in practice is very intimidating.* [NP7]

The NPs used adjectives such as *nerve wracking* [NP10], *terrifying* [NP8], *interrogation*, *challenging* [NP2], *gruelling* [NP4], *horrendous* [NP1], and *stressful* [NP7] to describe the clinical viva. Several commented that they felt that the examining panel were cognisant of, and sensitive to, their anxiety.

> *I remember the pressure getting so, so tough that I remember just putting my hands in my face and blocking them all out and they didn't rush me, they were very good.* [NP9]

One of the NPs spoke about her surprise when she was given a case study about a diabetic male with a leg ulcer despite her practising in the area of women's health. This occurred because at that time women's health came under the criterion of health and family. [NP7]

Despite having no experience of a clinical viva, the nurses had vast clinical experience. Some NPs commented that the easiest way for them to answer questions was to draw on

[17] This process was later changed so that the NPs provided their own case studies but initially the case study was developed by experts in a similar field to the NP candidates who were selected by the NRB

their clinical experience. They visualised the care they had provided to patients in the past, which helped them describe their advanced practice that they provided to their patients.

> *I was actually picturing the scene in my head, I pictured the patient on the bed… with the equipment I had around me and just talking everything through in my head as I saw it… the first time I've been able to achieve that at such a high level but I found that the easiest way to do it.* [NP8]

Many of the NPs described how they used their experiences to help others applying for authorisation. One commented that she had helped set up mock vivas to assist other NP applicants.

> *We are also now going to do it at this at the hospital do a mock, we have got our first three coming up soon… so at least they are getting their thought processes in the way they should be answering the questions and making them feel more comfortable too.* [NP4]

Many of the pioneers acknowledged that authorisation was a learning process for them and, those who developed it. They also pointed out that because the process lacked structure and direction, it had not been adequately designed.

> *I think the whole process has been a learning process along the way. I think a lot of things hadn't been thought through.* [NP9]

The NPs acknowledged that the authorisation process was later refined following their feedback.

> *I think it's taken the first couple of people that were going through, well probably twelve or fourteen of us that went through the process before they actually stepped back and said look, you know we've got some big errors.* [NP4]

NPs spoke about their pioneering role in making the process easier for others.

> *But that was us that changed the application process, I mean we did it for those that were coming up we got to a meeting in Sydney… and said this is not good enough we need to change this, and that's why it changed.* [NP8]

Even after obtaining their authorisation, not all NPs were successful in gaining a NP position. Indeed this process was complex and politically fraught for several NPs. The next section explores the experiences of gaining an NP position.

5.2.2 Gaining an NP position

Gaining an appointment as a NP is separate to authorisation. NP authorisation did not automatically guarantee a NP position. For an NP position to be created, the AHS had to argue for local agreed need. Many of the NPs working in small rural or remote towns reported that local agreed need had already been determined by their AHS. Consequently positions were set up prior to their authorisation.

> *The [AHS] was initiating the community consultation process and actually setting up positions to become Nurse Practitioner positions before any of their nurses had gone through the authorisation process, they're a bit more insightful than a lot of the other Area Health Services in setting up these positions.* [NP8]

Because a few of the AHSs had already set up NP positions, the pioneers were appointed into a position fairly soon after their authorisation.

> *I applied for it and I was appointed; and it all happened very quickly.* [NP10]

Rapid appointments were not the case for all of the NPs working in other AHSs. Some recalled how they grew increasingly concerned and disillusioned as they waited and waited for an NP position. For these pioneer NPs to gain a position in another AHS would require themselves, and their families, to leave the small rural or remote towns in which they had worked and lived for years. Many reported that it took from 6 months to 2 years following their authorisation before they finally gained an NP position.

> *I think certainly getting a position was certainly quite frustrating, to get authorised but not get anything [a position]…. I got authorised in 2001 and got the position in 2003. So it certainly was a big, big surprise when it happened.* [NP7]

NPs described their increasing frustration as they watched others who were authorised after them gain a NP position in other AHSs.

> *I get a little jealous of them because they've got theirs through, and I'm still waiting, but it's not their fault.* [NP6]

Delays in gaining an NP position were unexpected. Despite being cognisant that a NP position would not be guaranteed following their authorisation, several of the NPs acknowledged that they were nevertheless surprised over the length of the delays. This surprise they attributed to "political naivety". Whilst they were aware of the political nature of the NP role the opposition to its introduction, particularly by some individual doctors and medical organisations, the NPs reported not realising that it would ultimately effect its implementation.

> *I mean, some of it is political naivety…. You get this idea… this will take a week to do [laughs]… that's the politics… it's been in a lot of ways a huge personal cost emotionally.* [NP6]

For the NPs who were appointed in an NP position, the next hurdle was their clinical practice guidelines.

5.2.3 Developing clinical practice guidelines

The NPs were intended to work according to clinical practice guidelines. Development of the guidelines was particularly challenging for some because of their lack of experience in writing or collating them.

Support for the NPs to develop their clinical guidelines varied between the AHSs. Several AHSs employed an NP project officer to either assist or totally develop the clinical guidelines. A manager in one of the AHSs had allocated the development of the guidelines to the clinical area's clinical nurse consultant. Others were expected to develop their own guidelines totally independently and it was these NPs that emphasised the difficulty they experienced through receiving no support from their organisation.

> *I don't think you can have five clinical guidelines and nothing else to support the guidelines, no processes within the organisation to support it.* [NP10]

These NPs argued the need for administrative support within the organisation because of the difficulty developing their guidelines while simultaneously establishing the NP position in their clinical area.

> *There is no money there for clerical support so who gets to do the guidelines? We all do, and the difficulty with that is that if you are trying to set up a new position, how do you find time to write guidelines and do all the research about that?* [NP5]

These NPs pointed out that developing guidelines was particularly time-consuming, not only because of their lack of knowledge and experience in developing clinical guidelines, but also because it limited the time they could spend on other professional activities.

> *If you have never done that kind of work before there is nobody around to help you. I have learnt how to write a guideline because I have had to, but it had been a long slow road because I am also expected to be on the floor, and do education and in-service and present at conferences.* [NP5]

The NPs revealed that there was considerable disparity between doctors' practices that was often based on personal opinion rather than research evidence. This added to the complexity in the development of their guidelines. Several NPs pointed out that it was during guideline development itself that raised awareness of the disparity between the doctors' practices.

> *So I go and work on a clinical practice guideline for that so I was talking to the registrar who works over there and I would say "Well what do you guys do?" and he told me what he did, so I went to one of the other senior doctors… and asked him what he did … so then I started speaking to the junior doctors…. They all do something [different]…. The medicos do something different, every different medico.* [NP4]

> *The doctors wouldn't have realised the discrepancy in their practice without me going around and saying "Well hang on Joe Bloggs doesn't do that, why do you do that…? So you know it has raised their awareness that there is a different way of doing things from the way they normally do or used to do, so it's been a really interesting exercise.* [NP5]

Because of the disparity of practice, the NPs reported that it was extremely difficult and time-consuming for the NPs to try to gain consensus from the doctors for the NPs' guidelines despite the fact that they were presenting best practice based on research evidence.

> *I mean the guideline development is so hard because everyone has a different view on what needs to be put into them, you know, could be totally different to someone else… and that's why they've been so hard for people to write.* [NP4]

Following approval of their clinical guidelines at the local and AHS level, the NPs then submitted them to the Nursing and Midwifery Office of the NSW Department of Health for review by an external review panel appointed by the NSW Department of Health Director General. Were the guidelines to require any amendments, they would be returned to the AHS through the Nursing and Midwifery Office. This process of review and amendment was repeated, sometimes for over a year, until their approval by the Director General, forcing delays in the NPs' right to use their extended skills such as ordering medications or diagnostic tests.

> *We had written guidelines that were then sent into the Health Department. They then got a panel of people who then looked at the guidelines and then came back to us with their suggestions. It went back and forwards.* [NP4]

Considerable frustration was expressed by some stakeholders regarding the NPs developing overly concise and specific guidelines. Thus, they were encouraged to use nationally or internationally available generic guidelines and adapt them to their clinical settings. To help the NPs do this, the NSW Health and the Nursing Midwifery Office provided a list of the websites to access the guidelines [KS12]. Some NPs believed that they were unable to use more generic guidelines as their units were somehow "different" and as such were unable to adapt generic guidelines.

> *They were looking at maybe creating just generic guidelines at that stage, and that we would be able to tap into, but that wasn't the direction I went… I suppose because there's a lot of different local variations on things.* [NP4]

On the other hand, NPs expressed their frustration as they argued that they were forced by doctors to develop overly concise guidelines. The significant influence of doctors on guideline development is further discussed in Chapter 7.

In March 2005 the guideline approval process was simplified.

> *The policy has changed about how we write guidelines, who signs off on them.* [NP5]

The Policy Directive for *Nurse Practitioner Services Implementation in New South Wales* was amended for the approval of NPs' guidelines to be delegated by the Director General to Chief Executives of each Area Health Service. The AHS or hospital Drug Committee also approves the drugs identified on the NP's formulary. Approved clinical guidelines are then sent to the Chief Nursing and Midwifery Officer (NSW Department of Health, 2005).

One of the NPs identified the importance of the influence of timing when instituting change. While the changes for guideline approval meant that the overall process was simplified, for one NP the changes in the approval process led to further problems. As discussed in Chapter 2, in July 2004 the NSW Health Minister announced that 17 Area Health Services would be amalgamated into 8 larger AHSs to reduce administration and direct more resources to frontline care. However, this created a significant amount of stress for those, especially managers.

> *We've had all the chaos with the re-organisation going on within the Area Health Services. The restructure is the biggest that we've had in say over 25 years.* [KS12]

The AHS amalgamation resulted in significant changes in management and clinical staff. For some NPs this meant changes in the personnel involved in establishing local agreed need and implementation of NP positions. An NP commented that the Director-General approved some of her clinical guidelines but the new management that had not been involved demanded they be re-approved under the new policy.

> *I flipped them an email when the new policy [delegation of approval of guidelines by AHS CEOs] came out. You guys have already signed off on this guideline because you were happy for me to work from them, and they went "No." But hang on a minute, we have a few new key players in the Area who weren't involved in the first sign off. I've got to go back to Area and get them to sign off on them.* [NP5]

It could also be postulated that the redirection of funds from management to frontline NP positions may have negatively influenced manager's support for the NP role (see chapters 6 and 7 for further discussion in relation to the influences on manager's support for the NP role). Some NPs noted managerial support for the role generally diminished rather than increase after the amalgamation of AHSs.

Because of the difficulty some the NPs were experiencing in developing clinical guidelines, the NSW Department of Health introduced clinical guideline writing workshops, and also employed personnel to also help NPs who were not receiving support to write their guidelines at the AHS level.

> *I went to a guideline-writing course which they held with the Health Department.* [NP4]

Several stakeholders working at the NSW Department of Health level expressed their frustration with some of the NPs who did not access resources that were increasingly being made available to them.

> *I even put on extra staff… so that if they wanted to use people here to work with them to write their guidelines then they could use that expertise but people really weren't partaking of that either.* [KS12]

> *I think that also people haven't necessarily taken the opportunity to seek assistance when it has been available. I have bent over* ***backwards*** *to provide resources and support… and so when resources are put before them, and put before them and put before them, it became apparent that some of them had been out in the practice for 5 years and they didn't have guidelines.* [KS13]

This stakeholder commented that because some of the NPs found the authorisation process so arduous they had requested to have a cooling off period before they commenced their guidelines.

> *It was like finishing exams and things, once you get over a hurdle, it is a while before you can go onto something else.* [KS13]

Having explored firstly, the reasons why they chose to take up the challenge of pioneering the role and secondly, the attendant uncertainties as they pioneered the role, the third issue that they also described were the aspects of their pioneering role that they found particularly rewarding.

5.3 Recognition, rewards and opportunities

Despite the challenges and uncertainty that the pioneers experienced in becoming NPs, they revealed the considerable recognition they received for their achievement, and its

opportunities and rewards. They spoke about feeling "proud" [NP2], "triumphant" [NP8] and "great satisfaction" in reaching the "pinnacle of their nursing career" [NP9] and success in becoming one of Australia's first NPs.

> *It has also opened up is a whole world of opportunities that weren't there before.* [NP6]

An important aspect was the recognition of their knowledge and skills that came with pioneering the role and becoming an NP.

> *I mean I'm no different to what I was before, but all of a sudden some people think you seem to know what you're talking about.* [NP9]

The NPs described how they had gone from relative obscurity to being familiar and visible. They commented that their personal satisfaction had been cemented by the recognition of the achievement they had received from their communities. NPs, particularly those working in small rural communities, described how it had "become scary" [NP9]. People they knew or did not know would congratulate them in the street and through congratulatory letters. For many, the recognition that meant most to them was that received from their patients.

> *The actual acknowledgment from people of how well I've done has just been absolutely amazing. That's been the mind blower.* [NP8]

> *I had a lot of personal satisfaction in all those areas and that satisfaction was confirmed by the response of the people I cared for, and by the communities that were involved.* [NP9]

They believed pioneering the NP role had enhanced their personal and professional lives. For many of these pioneers, their nursing had been about their clinical practice. Suddenly it also meant much more.

> *I mean it's fun, it's opened up other areas for me so it's just not clinical, I'm doing some other work as well.* [NP6]

These pioneers were suddenly being asked to present as keynote speakers at conferences. They described how they had gained valuable experience in designing PowerPoint presentations, and speaking at local, national and international conferences. NPs working in

rural and remote areas were grateful for the support and funding they received from their AHS so they could travel to Sydney to "advocate for the nurse practitioner*"* [NP2]. Some NPs received recognition of their achievement through national, state and local level awards, and from within and outside nursing. One NP from a rural town proudly recalled how she had been entered into the town's historical notes, recognising her role as a nursing pioneer and as an important part of the town's history:

> *You know there was a lot of publicity. I was recorded in the historical notes of [name of town] as one of the major events in the historical events for [name of town] and I was asked to speak at conferences and I was interviewed by a journalist from The Land and the Herald.* [NP9]

NPs from one AHS revealed how they had grasped the opportunity to undertake a master's degree through scholarships that were jointly offered by the AHS and the university sector. These scholarships were offered to encourage and prepare nurses to apply for NP authorisation. For these NPs it was an opportunity that they would not otherwise have been able to afford or access.

The NPs spoke about their excitement at receiving recognition of their achievement by people such as the NSW Chief Nursing Officer, their local Member of Parliament, colleagues, family and friends:

> *It was the most amazing feeling. It really was, I mean it was just* ***so*** *exciting.* [NP9]

In addition, the pioneer NPs spoke of the considerable media attention they had received following their authorisation, or when they gained an NP position. For some of the NPs, the media attention often followed a media release by their AHS. Many spoke of their enjoyment of media attention. Several described how their AHS had organised opportunities for them to speak to the television, radio or newspaper media at the national, state and local level.

> *[Name of AHS] have been very active to provide opportunities for me to speak to the media.* [NP2]

Media interest was heightened after media releases by nursing organisations or the NSW Department of Health.

> *That was the day Judith Meppem [the NSW Chief Nursing Officer] announced it to the world…. It was a huge day of interviews and radio and television…and they'd prepared me what to say to the media.* [NP8]

However, while the NPs reported enjoying the media attention, many had not been exposed to the media before their authorisation. They found this a particularly daunting aspect of being a pioneer.

> *It was the full frontal TV and the newspapers that was a bit scary.* [NP8]

Several of the NPs highlighted that, while they enjoyed being interviewed, they did acknowledge their inexperience in managing the media. Several commented that the media would sometimes try to manipulate and sensationalise their interview.

> *The interviewer was trying to get onto some of the political stuff and I wouldn't do it… and he said, you've got no comment about this, that you don't want to talk about this, because they'll keep pushing you, they'll keep pushing you and pushing you, so I had a little bit of that stuff.* [NP1]

A NP recalled how she learnt to be very careful with what she said to the media through an experience.

> *They can twist things around…well I mean I was walking down the street and said something like, um, it's like we're living in a bloody goldfish bowl sometimes… it wasn't meant to be a derogatory comment. Well that went into the paper…. You have to be very careful with what you say.* [NP8]

It was generally agreed by the NPs they would have benefited by some training to help them manage the media. They felt this was especially important considering the political nature of the role and, for many, their lack of experience and previous exposure to it.

> *I mean in bureaucracies we are certainly behind the corporate business world, but certainly in the corporate business world, media training is part of their development and it probably should be in ours too.* [NP2]

One of the NPs spoke of the immense personal satisfaction she felt with her achievement in becoming authorised and how had it recharged her motivation to persevere with gaining an NP position.

> *I was happy, yeah, you beauty, that's good. I was proud of myself…. It's like a game. It's like winning a race and then you look forward to the next one…plus 18 months is a long time and then you get the job and, "Go you beauty!"* [NP2]

Having catalogued the rewards, recognition and opportunities offered by the role, the following section highlights the legacy of the pioneers, in particular to the overall NP movement in Australia.

5.4 The legacy of the pioneers to the NP movement in Australia

It is important to recognise that these NPs were pioneering the authorisation and implementation of the role for the future of the whole NP movement in Australia.

Some stakeholders referred to the legacy of the NPs, not only in NSW but also for the wider NP movement in Australia. Stakeholders reported that other Australian states had benefited from NSW pioneering the NP role because the other states could monitor and incorporate aspects of the NP implementation that worked, while avoiding others that did not. There was a snowball effect of change because as each state developed the role, the model changed as lessons continued to be learnt.

> *There are also disadvantages that NSW was the first and so we got saddled with some things that we didn't really need, like local agreed need, for example, that other jurisdictions haven't had to be saddled with because they could see that it hasn't really worked in New South Wales.* [KS4]

In addition to other states learning from the mistakes or challenges from NSW, several stakeholders reported that the other Australian states benefited from the NSW success. Despite the dire predictions of "disasters waiting to happen" by the AMA (AMA, media release, September 5, 2002; Robinson, 2002) the sky did not fall and the introduction of the NP role in NSW was uneventful in terms of adverse outcomes because of the NPs' expert clinical practice. As a consequence, there was increased confidence and acceptance by other state governments so that fewer restrictions were placed on the NPs in other states. For example, there were no geographical restrictions on the placement of NPs in the other Australian states such as in the early introduction of NPs in NSW**.** In addition, the general community had minimal exposure to the title "nurse practitioner" during the time the role was being introduced in NSW.

> *You could see over that period of time the whole world had moved and that the nurse practitioner role was one that was accepted by governments, still not readily accepted by doctors but certainly accepted by governments and well accepted by the community.* [KS4]

Several stakeholders described the NP role in NSW as an evolutionary process and that changes such as continuing to push professional boundaries would continue as part of the role's evolution, as had been the case in other countries. A few of the stakeholders believed it was time for NSW to examine closely the ongoing development and implementation of NPs in the other states to assess what further changes could be made in NSW. Part of this evolutionary process would be to challenge the continuing existing negative influences on NPs' practice.

> *Nurses need to get together and look to see what is happening in other states and territories… and start to flex their muscles a little bit. It really is time. You won't make change unless you start flexing your muscles and demonstrating how ridiculous it [the opposition] all is.* [KS4]

Some of the NPs' experiences in pioneering the NP role were particularly challenging. In addition to the challenges that they experienced as already identified in this chapter, the NPs were faced with a number of other challenges. Additional challenges included their own and others' confusion about advanced practice, and thus their NP role. The confusion surrounding the notion of advanced practice is discussed further in the next chapter. Significant challenges emerged via the visions, voices and vested interests of those who opposed the NP role. These challenges are explored in Chapter 6 and 7. Some of these challenges were particularly distressing for these pioneers as they tried to incorporate the role into their clinical settings.

A sense of helplessness was expressed by some stakeholders as they acknowledged the immense struggle that the majority of the NPs faced early during the introduction of the role into the NSW health care system. Indeed, several stakeholders used the analogy that the pioneer NPs had been sent out to a battle, with the battle having taken casualties. These stakeholders acknowledged that, because of their experiences, some of the NPs were left disillusioned and angry. One stakeholder stated it was somewhat expected that their anger would be directed towards the nurses (generals) who had sent them into the frontline of health care. A stakeholder provided the following colourful account,

> *It requires enormous tenacity, and grit, you know, and the only thing that people like me can do in a leadership position is actually give them support. We can't be on the frontline, but we have got to be good generals and that is what I've been trying to do is be a good general, but to a certain extent when you are on the frontline and you are getting the bullets everyday, you hate your general who is putting you out there, and there is very little you can do about that except to say, "Hey look, we actually know how bloody awful it is, and we are sorry, and we are doing the best we can, but somebody has got to be on the frontline." You know it is bloody tough, and you know they are the pioneers, and that has to be understood.* [KS9]

Another stakeholder highlighted that casualties will continue because any role that transcends across traditional professional boundaries would face resistance from others that seek to maintain the status quo. This stakeholder warned that:

> *We will have to be prepared for sacrificial lambs to put themselves up, and the barricades, to keep the fight going.* [KS2]

Summary-Chapter 5

This chapter explored findings particular to the pioneering nature of the role of the NPs. The NPs revealed three principal reasons for their commitment to enter uncharted waters and take up the challenge to pioneer the NP role. Firstly, they held a desire to improve the existing health care system and care of their patients. Secondly, the NP role provided them with a clinical pathway enabling them to remain at the bedside, and continue to use their knowledge and skills their fullest potential, to function more autonomously, and be recognised for their practice, decision-making and judgment capabilities. For some, NP authorisation legalised their existing practice. NPs also saw the role as a way to increase the visibility of nursing. Thirdly, the pioneers had their personal reasons for pioneering the role, for many their journeys began many years previously. They were ready to leave traditional nursing behind. They also possessed a strong sense of responsibility to pioneer the role for their less experienced and younger colleagues.

However, they faced the challenge of uncertainty particularly when applying for authorisation. The NRB introduced a process for NP authorisation that required knowledge that few of the pioneers possessed. Most of the NPs lacked previous exposure to clinical portfolios. They received minimal guidance, which compounded their stress and uncertainty.

As a consequence each of the NPs developed their personal interpretations of what was required. Ultimately the process became one of trial and error. While many of these pioneers were highly experienced nurses they were unaccustomed to articulating their practice. Although these pioneer NPs did persevere because they clung to their vision to become an NP, it is possible many others simply gave up.

Having to wait many months or even years before they were appointed to a NP position following their authorisation was stressful, particularly for those working in rural and remote areas. Most of the NPs had no exposure to the development of clinical practice guidelines that imposed more uncertainty and stress. While some reported support from their AHS, others had to develop their own guidelines while trying to operate in their new role.

Overall, the NSW NPs' stories also emphasise their perseverance in becoming some of Australia's first NPs and the consequent recognition, rewards and opportunities. Some NPs went on to support and mentor those coming after them, while others became spokespersons for the role around Australia and overseas. Several of the NPs were given awards for their contribution to nursing and or their communities at local, state and national levels. The development of the role in the other Australian states has benefited from the legacy of the role's early development in NSW and, thus, its continued evolution of the role in Australia.

The following chapter explores issues that influenced the recognition of the NP role as an advanced practice role. These issues primarily relate to a lack of understanding of advanced practice, confusion over the collaborative and autonomous nature of advanced practice, and the inhibitory influence of traditions in health care on the acceptance of advanced practice as a valid nursing role.

Chapter 6 – Findings: Navigating uncharted waters: Recognising advanced practice in nursing

Chapter 4 Key events in the early development of the NP in NSW (1990-2005).	• Antecedents to the NP role in NSW. • Stages 1 to 3 in the development of the NP role. • Process for establishing NP services. • Framework for the implementation of NPs into the NSW health care system. • Other landmark events for the NP role in NSW.
Chapter 5 Entering uncharted waters: Pioneering the NP role in NSW.	• Taking up the challenge. • The challenge of uncertainty. • Recognition, rewards and opportunities. • The legacy of the pioneers to the NP movement in Australia.
Chapter 6 Navigating uncharted waters: Recognising advanced practice in nursing.	• Getting to know advanced practice. • The NP role: Collaborative, autonomous or independent? • Traditions in health care: Good old days or plagued by the past?
Chapter 7 Riding the waves to change: Visions, voices and vested interests.	• Visions for the NP role. • Developing and implementing the NP role: Negotiation and compromise. • Collaboration: Co-operation or control?

This chapter entitled *Riding the waves to change*: *Recognising advanced nursing practice- more than meets the eye* explores factors that affected people's perceptions, understanding, acceptance and response to the concept of advanced practice in nursing, and thus the NP role. The findings in this chapter are divided into three major themes: Getting to know advanced practice; The NP role: collaborative, autonomous or independent; and Traditions in health care: Good old days or plagued by the past? Each of these themes and any sub-themes will be discussed in detail below.

Despite the NP role being underpinned by the notion of it being an advanced practice role, which is both collaborative and autonomous, the findings from this study reveal considerable

confusion and uncertainty about the meaning of advanced practice. As such, the development and implementation of the NP role into the NSW health care system involved a process of *getting to know advanced practice*.

Findings in this chapter also reveal considerable disparity between the perceptions of the nursing and medical stakeholders during the development of the role in relation to these the concepts collaboration and autonomy. There was further dissonance between nursing and medical stakeholders regarding the independence of the NP. These disparate views, and the reasons for them are explored in the section entitled *The NP role: Collaborative, autonomous or independent?*

Finally, this chapter shows how nursing being historically a female profession subservient to medicine has negatively affected the introduction of NPs to NSW. There are still those within and beyond nursing who have not adapted to the professional status of nursing and grieve for the "good old days". Thus, they are especially resistant to the introduction of the NP role that recognises nurses' advanced practice and their ability to function more autonomously than before. Conversely, others have adapted to the changes in nursing by embracing the NP role but are nonetheless plagued by historical barriers to its further professional development. These issues are explored in *Traditions in health care: good old days or plagued by the past*?

This chapter begins with the section *Getting to know advanced practice*. The findings indicate confusion surrounding the notion of advanced practice. The influence of this confusion, as expressed by the stakeholders and NPs, on the development and implementation of the NP role into NSW is explored.

6.1 Getting to know advanced practice

Before the NP role, terms such as "expert" and "specialist were formally used to describe the practice of CNCs and CNSs (NSW Department of Health, 2007). Not until the development of the NP was the term "advanced practice" was formally introduced and more widely used to recognise the level of NP practice (NSW Department of Health, 1993). However, as revealed by the stakeholders and NPs there was considerable confusion surrounding the meaning of the term by the NPs themselves, nurses, doctors, managers, the public and the media. Because of this confusion the development and implementation of the NP role

involved a process of *getting to know advanced practice*. This chapter begins with discussion about the use of language in nursing and its influence on communication.

6.1.1 The language of nursing

The findings stress the importance of language and its influence on communication. Several of the nursing and non-nursing stakeholders acknowledged the importance for nursing to develop its own language to distinguish nursing practice from medical practice, they also believed that the language which nurses use is not always understood by those outside nursing and can hinder communication with others.

> *If I'm not communicating with you, well, you're not going to be interested in listening to what I'm saying because you switch off don't you. It is so important.* [KS12]

A nursing stakeholder who was a member of a NP Steering Committee commented:

> *I spoke to somebody who is not nursing and I said what do you think this means and they don't have a clue... that comes from people outside nursing.* [KS11]

A nursing stakeholder who was a member of a NP clinical viva panel similarly recalled a doctor commenting that he did not understanding the language that was used by the nurses, referring to it as *nurse-speak*.

> *All of sudden this doctor said, "I don't understand what you nurses say, it's nurse-speak." And so in terms of our language it wasn't a language that was understood by our colleagues.* [KS12]

There was considerable debate over the use of terms that were or were not acceptable to the doctors on the NP Steering Committee. Stakeholders reported that these debates over the use of terms by the NPs would last several days but in the end they were forced to choose their battles and compromise over issues that were deemed to be less important to the progress discussions.

> *We had to use "write medication orders" as opposed to "prescribing". But this is actually* ***how*** *we got over those* ***hurdles.*** *Doctors diagnose, well okay, well nurses make clinical assessments. At the end of the day what is the difference, non, it is about who owns the language.* [KS14]

A non-nursing non-medical stakeholder believed that the arduous debates over the use of language between the doctors and nurses on the Steering Committees was because they have very different philosophical viewpoints.

> *We almost had to deconstruct a whole range of terms before we could begin to understand one another. I don't think we were all that successful in deconstructing all the language because there were the barriers of professional socialisation. Each professional group had been socialised because of their training to see things in various ways. Professional socialisation sees you see the world through your own paradigm and it is almost impossible to step outside of that paradigm because you have been socialised to see the world in a particular way.* [KS17]

Indeed, stakeholders also commented that there had been strong resistance by the doctors on the NP Steering Committee to nurses using language that they saw as belonging to medicine.

> *Early on there were certain words would just generate fire such as "diagnosis" with the people on the steering committee. This is where I've got to say there was a real bloodying of nurses that had happened when they worked out that there were no-go zones.* [KS14]

The process of negotiation and compromise between medicine and nursing is further explored in Chapter 7. The next section explores issues particular to the concept of advanced practice.

6.1.2 The concept of advanced practice

Stakeholders involved in the early development of the NP role believed that some of the confusion about advanced practice was due to its lack of formal definition. As a result disparate perceptions of the NP role proliferated among the stakeholders and NPs. In addition to stakeholders' and NPs' confusion, they highlighted a lack of understanding of advanced practice by other nurses, doctors, managers, the public and the media.

Whilst *The Framework for NP services in NSW* defined an NP as working at an advanced practice level, the term advanced practice or what was regarded as an advanced level of practice was left open: "A nurse practitioner is a registered nurse working at an advanced practice level leading into practice as an expert nurse, the characteristics of which would be determined by the context in which they have been accredited to practice" (NSW Department of Health, 1998, p. ii).

However, the term was later provided a definition by the Royal College of Nursing Australia in 2006. For the purpose of the current study, wherever I use the term, it is in the context of the following definition:

> Advanced practice nursing defines a level of nursing practice that utilises extended and expanded skills, experience and knowledge in assessment, planning, implementation, diagnosis and evaluation of the care required. Nurses practising at this level are educationally prepared at postgraduate level and may work in a specialist or generalist capacity. However, the basis of advanced practice is the high degree of knowledge, skill and experience that is applied within the nurse-patient/client relationship to achieve optimal outcomes through critical analysis, problem solving and accurate decision-making. (Royal College of Nursing Australia, 2006, n.p)

Several nursing stakeholders involved in the early development of the NP commented that the contextual nature of advanced practice rendered its precise definition impossible during the early development of the NP role. As such, the term was not formally defined.

> *There was a lot of language misunderstanding and it is actually very hard, because it [advanced practice] is such a contextual thing, you know the… ah… practice type thing, there is no kind of blanket description that you can give to people for them to understand, so it was quite a tricky concept to get over.* [KS14]

Nursing stakeholders involved in implementing the NP role pointed out that during the early implementation "advanced practice" was not a commonly used term.

> *I think people don't use that term. I think many people don't define it. They need to define it.* [KS13]

Because those within and outside of nursing were struggling to understand the notion of advanced practice, some people developed their individual interpretations that accentuated the confusion.

> *It is a terrible word [advanced practice] because it means so many different things to so many people. I think advanced practice creates more problems.* [KS13]

Reflecting on the confusion over advanced practice, a nursing stakeholder believed it would have been much less confusing to use more commonly known terms.

> *Terms such as "advanced practice" created even more difficulty for nurse practitioners in many ways…. I mean there are doctors that call themselves specialists so that's fine, but there is no person called an advanced practice doctor. I think the sequelae of that has affected nurse practitioners.* [KS14]

The following section explores the NPs' perceptions of advanced practice when they first began their NP journey.

6.1.2.1 NP perceptions of advanced practice

Most of the NPs had experienced varying degrees of difficulty not only in understanding the meaning of advanced practice, but also in knowing how to articulate it. They described their interpretation of the meaning of advanced practice at the beginning of their NP journey. Their descriptions reveal considerable disparity in the interpretation of advanced practice by the NPs themselves.

One NP recalled that before her authorisation she was unaware of whether her practice was at an advanced practice level. Although she knew that she practised "differently" to some of her colleagues, she did not understand whether her practice was "advanced". Her realisation came during a visit by a nurse academic who was championing the NP role while identifying potential candidates to be pioneers.

> *I guess it's been like people like [names] that have shown me that no, not every nurse could do what I am doing*. [NP1]

A few of the NPs, especially those working in rural and remote areas, described how they believed their everyday practice was too "ordinary" to be advanced.

> *We work at an advanced level of practice as ordinary everyday practice and some of us forget… that's everyday practice for us. We forget about that.* [NP8]

Several commented that they thought advanced practice was working in high-technological settings such as intensive care units.

> *We see advanced practice as an ICU with all the beefy machines and that's how I perceived advanced level practice.* [NP8]

Others working in rural or remote areas believed their practice was less advanced than their NP colleagues working in metropolitan areas.

> *I suppose if I compare it to [name of NP], I sometimes think, My God, mine must be pretty plebby in comparison.* [NP9]

There was also discussion by some NPs as to whether there were levels of advanced practice.

> *So you have to show advanced pharmacology, or advanced anatomy and physiology, or pathophysiology, but what does that mean, and who decides whether it **is** advanced or not, and **how** advanced…like its all a bit grey.* [NP5]

For some, whether practice was expert or advanced depended on the area of practice. NPs working in more generalist role saw their role as being more advanced than expert. On the other hand, other NPs working in a specialty area tended to use the term *expert* rather than *advanced*.

> *You know when they say the nurse practitioners are expert nurses…we're advanced level a lot more but we're expected to be experts in absolutely everything because our title is 'generalist'… whereas a women's health nurse practitioner is an expert in women's health because that's what she deals with day in and day out.* [NP8]

NPs described their difficulty in articulating their advanced practice. These issues are explored further in the next section.

6.1.2.2 Articulating advanced practice

The reported difficulty in describing advanced practice was partly due to the nurses' inexperience and also because they felt uncomfortable arguing why their practice was superior to that of other nurses. The focus on the NPs' extended rather than their advanced practice was thought to be due to the confusion about advanced practice but also because extended practice was an easier concept to explain. Many of the pioneer NPs spoke about suddenly entering a new world that required them to be able to articulate their practice - describing what they did, why their practice was at an advanced level and why they were different to other nurses, health professionals, managers, the media and the public. The NPs recalled their difficulty in finding the words to articulate their advanced practice, as opposed to extended practice. The focus for many of the pioneers had been on their everyday practice. As previously identified, for many of these NPs becoming a NP entailed minimal

change to how they practised because they already worked in de facto NP roles. They had been working under standing orders from medical practitioners, for example, to make decisions about administering medications.

> *In a way we have always done that under standing orders…. We've always done that for a long time.* [NP7]

Not all of these operational nurses had developed the sophisticated language needed to articulate their practice. As described in the Chapter 5, confusion about advanced practice together with their lack of experience articulating their practice contributed to the early NPs' difficulties developing their portfolios.

A few believed that the best way to articulate their advanced practice was to state that their experience, knowledge and skills enabled them to make autonomous decisions for which they were accountable.

> *It's having to think on a different plane, the way I see it is where you're making the clinical decisions and you can prove why you are making those clinical decisions and back them up with evidence, and about being comfortable with those clinical decisions…but ultimately if something goes wrong I am accountable and I think that's a good thing I think that's very professional.* [NP6]

In a similar statement, a stakeholder believed that focus should have been on the increased responsibility and accountability of NP practice. This stakeholder also commented that recognising NPs' advanced practice was also acknowledging that it existed in different context to other nurses.

> *Many of them see, they are just going to carry on. They will have a different title on their door and on their business cards, and that's not what it is about. They might already somehow get tests done and give different medications, but they are not doing it on their own professional reputation. They are not taking legal responsibility for it, and they are not accountable for the practice in the end. So there has got to be recognition that it is different and that they are operating in a different political and professional context of practice.* [KS7]

This stakeholder believed that it was some of the NPs' (and nurses in general) lack of exposure to working with committees and with people at the higher management levels negatively affected their confidence when dealings with others.

> *The political consciousness is not there and it is inhibiting their moving it forward particularly in dealing with steering committees and getting guidelines up, and um, articulating how their practice will benefit the patient cohort.* [KS7]

Some of the NPs provided very detailed and lengthy descriptions of their advanced practice. An example is provided in Appendix H. However, they commented that they had difficulty articulating their advanced practice concisely. One NP [NP1] noted that her focus had always been directed towards what she did differently for each of her patients, rather than what she did differently compared to other nurses or doctors. She believed that the focus on the term *advanced practice* had taken the focus away from the patient. NPs found the easiest way to explain advanced practice was to draw on past experiences of their patient care during their clinical vivas.

Even though the NPs wanted recognition for their practice, some NPs felt uncomfortable having to articulate why they were different or better than other nurses. As a consequence, for these NPs it appears that their modesty, or fear of what is commonly described in Australia as the "no tall poppies culture" served as a barrier.

> *You'd like to think that other nurses can do it and you feel a bit up yourself if you don't think other nurses can do it. You want to hide the fact that you are doing it better than most other nurses because every time you put your hand and head up it gets chopped down. So the best way cope is just trying to be like everyone else.* [NP1]

Considerable concern was expressed by a number of the pioneer NPs that some of their more recently authorised NP colleagues were overly focused on their extended (e.g., prescribing) skills rather than their advanced practice. The pioneer NPs acknowledged that, similar to their own experiences, more recently authorised NPs may have been doing this because it is easier to explain their extended practice as opposed to advanced practice.

> *There are those who are very hung up on the drugs, the diagnosing, they're hung up on that as defining nurse practitioner; if you're not doing that you're not practising at a nurse practitioner level, which I have a problem with. That is going to bring down the whole thing. We're already struggling and it will finish us off, if that concept is fostered with the young ones.* [NP10]

This NP was concerned not only that the focus on NPs' extended skills perpetuated the perception of NPs as doctor substitutes but also the essence of nursing itself would be lost.

> *The cowboys are going to come out, they're going to be shoving drugs down everybody. Nobody is going to be doing the holistic care, looking at your community stuff. That bothers me.* [NP10]

A nursing stakeholder who was an experienced manager believed that the difficulty of NPs articulating their advanced practice reflected a more widespread problem in nursing. She argued that nurses had focused on the extended part of the NP role.

> *I say, "Well what makes you think that you are an advanced practice nurse? and she says, "I do pap smears, I tell the doctor to sign the script for the pill, um, I take swabs all that sort of thing," but I say "Yes, but they're technical aspects in your role, they're tasks, I could teach a monkey to do most of those things. Tell me about your advanced practice. Tell me why you should be made a nurse practitioner."* [KS7]

One NP noted that she was aware of a number of nurses who had not passed their clinical viva because of their difficulty in articulating how their practice was advanced. As a consequence, these nurses decided to undertake a master's degree rather than sit for another clinical viva.

> *I also know of at least half a dozen who were unsuccessful in their vivas and who have gone to do their masters rather than go back for another viva.* [NP5]

Several nursing stakeholders held the view that some of the NPs' difficulty in articulating their advanced practice contributed to the public's confusion about the NP especially in differentiating the NP, especially when differentiating the NP role from other nurses and from doctors.

> *Whilst people like [names of NP] have probably done a reasonable amount of media coverage, I still don't think that they really articulate what sets the nurse practitioner apart from a medical officer, or what sets the nurse practitioner apart from a registered nurse.* [KS5]

A stakeholder closely involved in the implementation of the NP role believed that there had been a lack of communication between some nurses and the NPs about the NP role, which compounded the confusion surrounding the role.

> *A nurse at the bedside should also be saying well what does the nurse Practitioner do, but the nurse practitioner also should be saying, "now I am the Nurse Practitioner and my role differs from "x" and "y" and yours and everybody else's so it is a two way street, it is communication. And if people don't take a balanced approach to it then the nurse practitioner, the new kid on the block, which is the nurse practitioner, will be the one talking to the others.* [KS13]

The findings also highlight a number of factors that influenced managers' recognition of the NPs' advanced practice and are discussed in the next section.

6.1.2.3 Influences on managers recognising advanced practice

The majority of the NPs believed that their managers did not understand the concept of advanced practice. One of the NPs, however, emphasised repeatedly throughout her interview the importance of her manager in the successful implementation of her role. This NP was very articulate, which doubtless contributed to the manager's understanding of her advanced practice. Her manager had a clear understanding of the utility of the NP role for the organisation and for the small rural community. She pointed out that this facilitated her gaining an NP position and her smooth transition into the role.

> *The Area Director in the Area Health was determined to be able to service the community at an advanced level. We had identified that this position requires an advanced level of nursing knowledge.* [NP2]

This NP stressed the importance of having a manager with good leadership skills for the smooth transition and successful implementation of the NP role.

> *It gets back to the Director of Nursing's leadership …. We had the motivated person and she put in a lot of effort. We had the leadership. It is important to have leadership, otherwise nothing is going to get done…. Leadership is the absolute key. If you don't have the leadership, it is just an uphill slog for the person on the ground trying to do whatever. It's the leadership that must drive this and then it's us workers who then make it happen.* [NP2]

The NP also spoke about the manager's specific leadership attributes that she believed contributed to the smooth implementation of her role.

> *It's the direction the leadership provides… keeping communication channels open so that you can feed back… allowing your positive contribution of ideas… its giving ownership to the workers, allowing us to develop, stating what resources we need. We may not get them, but giving the opportunity to say we need a new computer, or we need continual staff development, if you want us to achieve this…. She provided the leadership and encouragement.* [NP2]

This NP believed that the incorporation of the NP role into the organisation's business plan including how the NP role would help the organisation achieve its projected outcomes, rather than as a separate entity, had facilitated acceptance and support for the role by others in the health care team.

> *She insisted on developing core business plans of our service provision and developing core business statements that say what you do, by when we want to do it, and what are our outcomes, what outcomes are we trying to achieve.* [NP2]

This NP went on to illustrate how the role was also linked to the health care priorities of the NSW Health Department.

> *So the bosses come in and say, "What have you got planned for this year?" and you say, "Well I have this plan. I am hoping to reduce the incidence of smoking or whatever it is."*
> *[Managers ask] "So how did you go?"*
> *"Oh we had six smoking cessation courses, and so far 10 people have stopped smoking for six months." So fantastic, that connects with all your cardiovascular and chronic lung disease and all those things that NSW Health is trying to reduce.* [NP2]

She pointed out the incorporation of her NP role into the AHSs' agenda and her contribution to the organisation's business plan helped her feel accepted and a valued member of the health care team, which improved her job satisfaction.

> *So within the business plan it has been identified as requiring an advanced nurse…. It's been a rewarding experience.* [NP2]

A number of stakeholders and NPs spoke about the multiple levels of management within each of the AHSs. These levels include CEOs, Area Directors of Nursing, Directors of Nursing, Health Managers and Clinical Directors. While the managers who worked closely with the NPs may have recognised the added value of the NPs' practice to the organisation, it was difficult for these managers because they often had little control over the AHS budget. Also, while local agreed need for an NP position was determined at the middle management level, the decision could be overturned at a higher management level.

> *It was just a very complex matrix because you not only had to deal with the health service manager. They were in clusters because the Areas were so large. We had a manager for a cluster basically and if the manager for the cluster didn't see the need to budget for a nurse practitioner, they would put a stop to it even if we had the agreed need and even if we had it endorsed. They just wouldn't budget for it, there were all these things to get through and it was difficult. The whole thing was difficult.* [KS11]

Most commonly, the NPs and stakeholders reported managers' differing perceptions of advanced practice. For example, some managers believed that NPs were working at an advanced practice level only if they were using their NP extended skills such as prescribing, or working from their clinical practice guidelines. To illustrate this point, NP1 described how she had been asked by her manager to document the percentage of time she worked as an NP and the percentage of time she worked as an RN.

Some NPs expressed their frustration at what they believed was their managers' lack of interest and understanding about their role.

> *They are incompetent. They haven't taken the time to find out. Certainly, I'm thinking, "Do I look at them from the point of view that they don't know, and I'll hold and guide them through?", and I think that perhaps that's what I'll do.* [NP1]

However, one NP believed that for some managers, the NP role simply wasn't a priority for them at that time because they had other concerns such as adapting to the changes that came with the restructuring of the AHSs. Some NPs pointed out that, while they initially had support for their role, it markedly decreased when a new manager/s were appointed to the AHS.

> *Previously [when] there was a perceived need for a position, the management at the time formed the committee and started to work that out… That was a different manager. Then things fell apart…. I don't see that the priority was there.* [NP3]

Several NPs reported that their managers did not understand the concept of advanced practice because the person had been employed part-time as an RN and part-time as an NP. This account suggests that some managers believed that, while delivering clinical care, such as assessing a patient or providing counselling or therapeutic advice, the NPs could switch their advanced practice on and off. Clearly, employing the NPs in a part-time capacity must have been used by some managers as a cost-cutting measure, but the reality of the situation seems farcical in retrospect, as the clinical care that the NPs would have been delivering could not have been provided at a lower level just because they were paid at a lower rate.

A nursing stakeholder closely involved in the pioneering implementation of the NP role believed that some may have found it difficult to understand advanced practice because it was seen to be an abstract concept. She argued that there are those (such as managers) who prefer quantifiable measures such as competencies to help them determine practice outcomes. Quantifiable measures make it easier for managers to argue the need for a position such the NP.

> *They use these liberalist terms like "advanced practice." I like to quantify things and I think that competencies, specific competencies makes more sense to me.* [KS13]

The propensity to quantify advanced practice was unintentionally identified by several NPs working in the same AHS. They recalled their shock and anger when their manager insisted on assessing their advanced practice level through competencies developed by the AHS despite their being already authorised as NPs. The NPs were extremely upset that they had been asked to do another assessment despite already being authorised as NPs.

> *But for the Area to pull out a form to do an assessment whether or not we are advanced practice nurses or not…. I was just stunned.* [NP1]

A nursing stakeholder at the NSW Health believed that it was reasonable for the AHSs to perform their own competency assessments because they had a duty of care to the public.

> *Well they've gone through the authorisation and they've been authorised but if the Area Health Service wants to do further assessment in terms of somebody's competencies it's then their decision… and the Area Health Service has got a responsibility again to the public.* [KS12]

Several NPs believed that some AHS managers were concerned about the legal implications of their increased responsibility, and the accountability. One NP believed that this proved a significant barrier to her implementing her role.

> *It's like they were afraid of what would happen, partly. Well it was a new thing, you know, very new and I guess they had to trust, they had to trust your ability. It's not that they didn't trust my ability but they couldn't even, I can't even think of an analogy…. They couldn't cut the cord, That's how I felt.* [NP10]

There was much discussion from the stakeholders and NPs about the lack of funding for the employment of the NPs, and its effect on managers' support for formally recognising the NPs' practice. The State Government did not provide funding to create new positions; rather top-up funding covered the gap between, for instance, a RN or CNS and an NP salary. This top-up funding did not cover costs for NP shift penalties for working evenings or night shifts. The AHS received no additional funding to cover costs associated with the NPs' extended practice privileges. However, stakeholders argued that, for managers to support the role they needed to recognise the complexity of the NPs' practice. Otherwise, they argued, managers would be more likely to perceive nurses' practice as a set of tasks that do not require a more expensive health care professional such as the NP to perform [KS9]. Managers who did not recognise the higher sophistication of the NPs' practice would be less likely to recognise the value of employing an NP and less likely to accept the extra cost. At worst, (for the future of the NP) employing an NP would be seen as a waste of resources.

> *They have to demonstrate accountability for the extra money used in terms of drugs and tests and referrals, and they might think, "Well it doesn't cost me anything," but every time they get a prescription filled, every time they order a test done, there is a cost to that. Every time they refer there is a specialist item number. So again with my management hat on I talk to them about the extra cost of that role.* [KS7]

NPs and stakeholders argued that a major problem in implementing the NP role related to the lack of funding for NP positions. Recognising, legitimising and regulating NPs meant that NPs would be financially rewarded at a higher rate of pay than when they were employed as

RNs. On the other hand, many of the managers had de facto NPs working in their organisation for many years, and as such they knew the NPs' value to their organisation. However, nurses working in de facto NP roles were cheaper to employ than authorised NPs. Thus, employing NPs under their new award increased the strain on the AHSs already tight budgets. These managers also have had to justify why they should create an NP position while they were already benefiting from the cheaper de facto NP.

> *They have got to come out of the budget. It's not as if you get money for a nurse practitioner. You know units don't want nurse practitioners positions because they cost as much as CNCs… and then they've got to survive; and then you know you certainly don't want a nurse practitioner doing shifts so you're going to restrict the hours of practice so that you attract the least amount of penalty rates. So there's those kinds of things that haven't been thought through. We're not funded individuals you know externally, so they've got to come from within an already struggling budget.* [NP3]

Indeed, another NP recalled how she had been working as a de facto NP in a small rural hospital using her knowledge and skills on night duty, the shift when she was most needed and when doctors were contacted only if necessary. Following her NP appointment, the AHS would not permit her to work after business hours to avoid her incurring shift penalties. Because of her restricted hours she believed that she was seen as a waste of money by her nursing and medical colleagues. This negatively affected the doctor's support for her NP role.

> *When I worked permanent nights which I did for 6 months or so, the doctors were never called in at night, and I probably worked more as a nurse practitioner then than I did than when I actually go the [NP] job because twelve midnight you know someone comes in and they needed admitting, cannulating and intravenous fluids whatever else I used to do on nights. I suppose I must have just looked like a bit of a waste of money or time*. [NP10]

This NP revealed that the AHS would not fund the medications that were listed on her clinical practice guideline formulary.

> *They wouldn't even stock enough drugs for me to use…. That was an expense that the Health Service wasn't prepared to wear. Where was I going to get a box full of antibiotics? So nowhere.* [NP10]

She also revealed that the Aboriginal Medical Service tried to maintain her supply of antibiotics but were unable to afford to do so long-term.

The NPs did not have PBS prescriber numbers. While NPs working in hospitals could prescribe medications through the hospital pharmacies this was often not the case for those working in isolation in rural or remote areas. If the NPs in rural or remote areas prescribed medications their patients would have to pay the retail price because they were not subsidised by the Federal Government. Some had their own supply of medications that they could prescribe. Generally, however, they were provided with "starter packs" to cover a few days medications by the AHS. Patients were then forced into the ridiculous situation of then having to then visit a GP for the full course of medications. NPs reported that this was also dangerous for patients who would quite often only take the starter pack of antibiotics [NP1]

> *The patients were discriminated against really because if they saw a nurse practitioner…. If she gave them a prescription and they took that to a retail pharmacy, they would have to pay $80.00 for a prescription for antibiotics so there was this ridiculous situation… of them giving the nurses a starter pack and sending the patient to the GP with a referral to say, "Could you please supply the rest of the course of antibiotics?"* [KS8]

Overall, stakeholders and NPs believed that it was the lack of funding for NP positions that served as a significant barrier to managers' identifying local agreed need for such position. Stakeholders also spoke about the lack of understanding by the public and media in relation to the NPs' practice and thus, the NP role.

6.1.2.4 Public and media perceptions of advanced practice

Several stakeholders were aware of public confusion about the NP role. This confusion appeared in the NP pilot projects.

> *But what any sort of community feedback [from the pilot projects] tended to show that there was confusion in the community about what it [advanced practice] was we were talking about.* [KS14]

I asked several stakeholders whether an aggressive marketing campaign might have increased the public's understanding. They firmly believed that the public would not be interested in the NP role unless they needed to be treated by one.

> *You can't educate the public. They are not interested. You can only educate the public when it affects them right at that time. The only time to educate the public about the nurse practitioner is when they come to see a nurse practitioner. You can't if they're not interested. They are not interested in hearing about nurse practitioners when they are not sick.* [KS4]

One stakeholder [KS13] believed that the public is more concerned with knowing they would be cared for by a competent and caring nurse rather than learning about the different levels of nursing practice.

An NP commented that the public's awareness was slowly increasing as they were coming into contact with NPs. She believed that the public's understanding would improve as the numbers increased.

> *I think the general public now are starting to ask about the role because they're coming in more contact with it, and they are reading about it. They will ask questions about it.* [NP4]

Several stakeholders believed that organised medicine, particularly the AMA, had taken advantage of the confusion over the NPs' advanced practice. They argued that because of the confusion the AMA was able to keep the focus in the media on the NPs' extended skills, and to also represent NPs as substitutes for doctors, as discussed further in the next chapter.

> *Of course that was exploited by a number of medical political groups who were trying to run the argument that it [advanced practice] was second-class doctors and that doctors were being replaced.* [KS14]

The majority of NPs spoke of their concern over the way the media portrayed the role. Several believed that the media's lack of understanding of advanced practice led to creating their own interpretations of the role.

> *I mean, I do object to the fact that a lot of NPs have been referred to as* ***super nurses****…. I think certainly that some of the media has also tried to pick up that this is an anti-doctor thing, which it is not.* [NP7]

NPs described their frustration with the media who were focused on the perception of them working as doctors. Several NPs commented that they had been caught off-guard by the media's lack of understanding of advanced practice.

> *I think the one that was an issue with the media… a couple of questions were… so you'll be able to work as a doctor, and I am in the middle of an interview and I have to start all over again and say no this is nothing to do with being a doctor, so that was quite frustrating.* [NP3]

This NP and several others pointed out that they became increasingly aware of how during their interviews they must educate the media about their role because of its confusion.

> *Perhaps I didn't come across that well, because it was like they should have been a little more educated in what the NP positions were about, what the authorisation was about.* [NP3]

Perceptions differed between the medical and nursing stakeholders regarding other concepts inherent to the NP. These concepts of collaboration, autonomy and independence are discussed in the next section.

6.2 The NP role: Collaborative, autonomous or independent?

Embedded within all the discussion about advanced practice is the concept of collaborative practice. The success and acceptance of the NP in NSW was seen largely to hinge on collaboration between nurses and doctors (NSW Department of Health, 1993). However, collaboration was not defined in any of the NP documents during the development of the role. The findings from this study reveal that the lack of definition resulted in disparate perceptions and thus, confusion, about the meaning of collaborative practice, especially between nurses and medical practitioners. Compounding the confusion were differing interpretations relating to the terms autonomy and independence and their relationship to collaboration, or collaborative practice. These issues will now be discussed in the next section.

6.2.1 Collaborative practice

The notion of collaborative practice received considerable attention during the development of the NP role in NSW as evidenced in the *Discussion Paper* (NSW Department of Health, 1992), *The NP Final Review* (NSW Department of Health, 1993) and the *Stage 3 NP Final Report* (NSW Department of Health, 1996).

In these reports, collaborative practice between NPs and doctors was seen as important for NPs' ability to practise at an advanced level. Despite the considerable interest in collaborative practice it was not defined in the *Discussion Paper, the NP Review* or the *NP Final Report*. The *NP Final Review* simply states that medicine and nursing are *interdependent* professions so "decisions as to who does what need to be mutually agreed" (NSW Department of Health, 1993, pp. 3-4).

The lack of formal definition means that collaboration was subject to individual interpretation, which led to misunderstanding and confusion. When nursing stakeholders were discussing collaborative practice during the development of the NP role, medical stakeholders seemed to have a different understanding of the term.

A medical stakeholder who worked in a rural town spoke of the disparate view of collaboration between himself and the NP who worked in a nearby town. He believed that the NP had become less collaborative than when the person was working as an RN. He maintained that traditionally an RN would have to contact him for permission to administer medication, and because of this requirement the RN's communications with him were relatively frequent [KS16]. Presumably this type of basic communication was regarded by the doctor as synonymous with collaboration.

This medical stakeholder explained that NPs are less dependent on doctors compared with other nurses and need not contact a doctor before they independently dispense medications. To this medical stakeholder, independent dispensing of medications effectively reduces collaboration. The nurse's former dependence on the doctor to order medication could be interpreted as a way for doctors to maintain (or control) their relationship with nurses.

> *It wasn't the same collaborative relationship I had [with the RN] put it that way.* [KS16]

According to one medical stakeholder, maintaining the dependence on doctors enables doctors to monitor what's happening, especially when the doctors and nurses are working physically apart [KS16].

The medical stakeholders argued that the NPs' independence fragments health care. They commented that this was one of the important reasons for doctors' resistance to the

independent prescribing of medications by NPs. The AMA advanced this argument as explored in the next chapter.

Both medical stakeholders pointed out that it was insufficient for NPs only to collaborate with them when the NPs needed advice. To these doctors that was not collaboration. One medical stakeholder who had worked with a pioneer NP, described how their working relationship changed following the nurse becoming an NP.

> *The person [NP] there may have said," Yes, I collaborated fully," but at this end it wasn't collaboration. It was, "I'll only call you if I absolutely need you," sort of thing.* [KS16]

A medical stakeholder provided an example of his perception of collaboration. It is evident that the doctor is very much in control over the so-called collaboration.

> *I'm totally supportive of my practice nurse here…. I send her off to every course that comes through the door. I like to see them get all the information they can get. I've thought of up-skilling everybody that can be up-skilled and I'm collaborating with everybody that can collaborate. That's the only way you are going to get good service delivery.* [KS16]

Another medical stakeholder commented:

> *I think we could do incredible teamwork. I work with a nurse who does immunisations, who does a whole lot of things for us.* [KS15]

In contrast, the *NP Working Party* that consisted of nursing stakeholders argued in the *Discussion Paper* that all nurses practice collaboratively within a scope of practice, and seek advice from a medical practitioner when it is required. "It must be emphasised… all practice is necessarily collaborative and nurses recognise both the scope of their own practice, and the need to seek medical advice" (NSW Department of Health, 1992, p. 5).

Several nursing stakeholders revealed that, for them collaboration was about NPs working as autonomous practitioners who nevertheless seek assistance from doctors if required, for example, KS5.

The following comments by a medical stakeholder highlight the potential dangers for the NPs because of conflicting views about collaboration.

> *If they want to act independently when the wheels fall off please don't turn around and ask us to put them back on…. What I see is somebody getting out there and getting a bit gung- ho…. You dig the hole, you fill it.* [KS16]

One medical stakeholder commented that NPs do not have the so-called medical education to be able to determine when they need to seek advice.

> *I do not believe that the training is there that allows an independent role in diagnosis and management of medical problems.* [KS15]

Because of the perceived (by some stakeholders) lack of medical education of the NPs, the medical stakeholders believed that NPs do not know when to seek advice or refer a patient to a GP or specialist.

> *It is not what you know; it is not knowing what you know.* [KS15]

This stakeholder believed that the problem for NPs is when *something happens outside the square that doesn't fit* [KS15]. I asked "You don't think they would know when to refer?" KS15 replied,

> *They may or they may not. You'd only hear about the ones that did know and you don't hear about the ones that they don't know.*

Alarmingly, this medical stakeholder alleged unreported problems with the NP' practice.

> *I know that there is some of the nurse practitioners that are practising at the moment in [specialty] departments in Sydney. There are problems, but they never see the light of day because it is not politically correct (long pause).* [KS15]

I asked KS15 stakeholder whether she was suggesting that problems were swept under the carpet. To which she replied *I think so*. [KS15]

The notion of collaboration is clouded further by the NPs' practice context. For example, NPs working in isolation in rural or remote areas of NSW do not work in team situations. As such their collaboration with doctors is more likely to occur only when they need to seek advice. However, collaboration for NPs working closely with other health care professionals,

such as in hospitals, would differ from collaboration in more isolated situations. As pointed out by a nursing stakeholder who described collaboration with the hospital setting.

> *When I am talking to people about advanced practice…it is also about nursing in a multidisciplinary team and works in a collaborative model, so you know, is happy to have debates and discussions with their team, with the patient and family.* [KS13]

There were disparate views within and outside nursing regarding autonomy and its relationship to the NPs' practice.

Several nursing stakeholders argued that autonomy and collaboration are not two exclusive entities. These stakeholders related NP practice to that of doctors who work autonomously, but also within a team [KS5].

A stakeholder believed that the focus on autonomy should be replaced with *working with others* because of the increasing focus on multidisciplinary teams [KS11]. A non-nursing, non-medical stakeholder also spoke of his confusion about the difference between the terms multidisciplinary and interdisciplinary. He also questioned whether disguised under these terms were the traditional hierarchical structures.

> *It is critically important, even if you use the term like 'multidisciplinary team' or 'interdisciplinary team' what does the term really mean, or are you really talking about a hierarchical series of relationships disguised as the concept of the team, or is it around 'team' that people feel as if they make equal contribution to, very often it is the former rather than the latter.* [KS17]

There was disparity between medical and nursing stakeholders' views regarding the terms autonomous and independent. For some of the stakeholders, autonomy and independence had different meanings, while others tended to use the terms interchangeably. The medical stakeholders believed that it was impossible for NPs to be autonomous or independent, and also collaborative. These issues will now be discussed.

While the term *independent* remained in the title of the Stage 1 *Independent NP Taskforce,* it was removed from the text of its Report to the then Health Minister. Independence was replaced with the descriptor *autonomous*. Any reference to the NP role being independent was removed from the NP title prior to the publication of *The Discussion Paper* (NSW Department of Health, 1992, p. 1). Autonomy became the preferred term by the *NP Working*

Party and it described the NP's practice as having "autonomy in the work setting and has freedom to make decisions consistent with his/her scope of practice, and the freedom to make those decisions" (NSW Department of Health, 1992, p. 5). Therefore, NPs were seen as able to make autonomous decisions within a predetermined scope of practice but would collaborate with doctors when they required support and advice.

However, as revealed in *The Final Review* (NSW Department of Health, 1993) *the* key concern from all of the responses to the *Discussion Paper* was the issue of NP "*autonomy/independence*" versus "*collaboration/teamwork*" (pp. A2-A3). The responses from these reports further highlight that there was substantial confusion surrounding the terms autonomy and independence. Some stakeholders viewed autonomy as synonymous with independence, with these terms often used interchangeably. However, the change to the term autonomous rather than independent had little effect in reassuring some stakeholders, particularly medical practitioners, that NP practice would be collaborative. This was further complicated because some stakeholders believed that autonomous or independent practice were incompatible with collaborative practice. "The emphasis placed on *autonomy* for NPs and the apparent inconsistency between autonomy and teamwork…was seen as contradictory to espouse collaboration but emphasise *independence***"** (NSW Department of Health, 1993, pp. 2-3).

One nursing stakeholder pointed out that historically there have been occasions when doctors and nurses have reversed their positions in relation to the notion of autonomy in nursing. For example, doctors have argued they are not responsible for registered nurses' practice because RN are autonomous practitioners. Conversely, she pointed out that, at times, nurses have argued that doctors are responsible for their practice:

> *But put him [doctor] in a court of law and he is pushing her[nurse] away with a pointy stick to be autonomous…. In fact it is interesting what nurses do at law is they revert to the doctor's handmaiden defence and argue that they were only following orders and that it is exactly the doctor who is responsible.* [KS9]

A nursing stakeholder at the level of state government pointed out that as late as 2005 there were discussions within nursing about whether the term autonomous should describe NPs' practice because of concern that it upset doctors, indicating that nurses continue to be influenced by doctors and remain defensive regarding the language that nurses can, or cannot use.

> *The NP role is a whole new ball game, it's a different role and we talk about it in autonomous terms, it has been raised recently maybe we shouldn't talk about the position in autonomous terms because it might be perceived in a very negative light… so that some of our medical colleagues are not put off by it.* [KS12]

Regarding *independence*, one of the non-medical, non-nursing stakeholders at the state government level believed that the term *independent* during the early Stage 1 NP discussions had *sent all the wrong messages of what we were trying to do* [KS10]. This stakeholder understood that the term had initially been used to represent nurses taking on *things that were not previously available to them by legislation…. They wanted to be more independent in their role.* [KS10]

However, as argued by a nursing stakeholder closely involved in the early development of the NP role, the term *independent* was employed to mean *self-employed*. The term was eventually dropped because a survey had found that most nurses who worked in roles similar to an NP were not self-employed.

> *By independent we meant self-employed…. If you go back to the Discussion Paper it is not even there…[Name] ran a survey in The Lamp to actually find out how many nurses would consider themselves to be working in roles akin to those of NPs, and the majority of them who did were employees…. The first discussion document… doesn't use the term 'independent.'* [KS9]

Nevertheless, many of the stakeholders spoke of their frustration and irritation with the persistent reference to NPs as independent by some doctors and medical organisations such as the AMA.

> *It has been the AMA's term and I think it is psychologically fascinating that that is their obsession*. [KS9]

The continued reference to NPs as *independent* by the AMA is also evidenced through their press releases, articles and position statements. For example, "General practice nurses make perfect sense - but independent nurse practitioners don't" (AMA, 2005a) and an *AMA position statement on independent nurse practitioners 2005* (AMA, 2005b; see Appendix G for list of media documents).

A nursing stakeholder at the level of state government believed that the NPs' knowledge, skills and experience enable them to be able to make independent decisions.

> *I would say that it is actually somebody who has got the knowledge, skills and experience to be able to make informed independent decisions for whatever reason.* [KS14]

I asked the two medical stakeholders who were representing different organisations why they referred to NPs as "independent" given that the term had ceased to be used early in the development of the role. For these medical stakeholders, any practice in which there was no reliance on a medical practitioner was seen as independent. NPs' practice was considered independent because they could prescribe and refer patients to other health professionals such as specialists, and order diagnostic tests *independently* of doctors. For these medical stakeholders the focus was not on the practice of nursing by nurses, but on the control of nurses by doctors.

Furthermore, there remains a sense that independence of practice is the sole domain of doctors and thus, when nurses practice independently of doctors, they must be practising medicine. The following statement highlights this medical stakeholder's belief that NPs "practise medicine."

> *I know it was removed because it wasn't a politically viable thing to have, however, it **is** independent practice, you don't need anyone else to practice if you are a nurse practitioner, if you want to practice medicine as a nurse practitioner, you can independently, you don't need to have somebody there saying yes, you know penicillin for a strep throat or whatever. So it **is** independent practice (long silence).* [KS15]

The findings from the present study provide evidence that there are still those who have not adapted to the increasing professionalism of nursing. These persons resisted nurses being recognised for their practice, accepting that they make their own autonomous decisions, be responsible and accountable for them, and take on an extended role. Additional findings from the current study also revealed that there are also those who not only resisted the NP role, but also grieved for nursing to return to the proverbial good old days before nursing became formally recognised as a health care profession. These issues will be explored in the next section.

6.3 Traditions in health care: Good old days or plagued by the past?

Further complexities arise in understanding the historical legacy and cultural influences on the NP role. Before the development of the NP role many nurses had not contemplated that there could be another way for nurses to function. Historically, some doctors, medical organisations representing doctors and some nurses have attempted to maintain the traditional functioning and hierarchy of the health care system. Many stakeholders and NPs spoke about the legacy of tradition in medicine and nursing. These traditions continue to influence the developing professionalism of nursing and, more specifically, the recognition of NPs as advanced practice nurses who function autonomously. In relation to nursing's relationship to medicine, a stakeholder pointed out that the attitudes and ideologies of the two professions have a long history and are deeply ingrained.

> *Let's accept the fact that these attitudes are rooted in many, many decades, a century of relationship between these two professions.* [KS17]

However, as also stressed by a nursing stakeholder:

> *The historical hierarchy continues to frame the NP debate.* [KS3]

The following section explores how some members of the medical profession yearn for a return to the more traditional doctor-nurse relationships.

6.3.1 Traditional medicine grieving for the return of traditional nursing

During the interviews with the medical stakeholders I felt as though I were caught in a health care time-warp. Before these interviews I had not fully grasped the magnitude of the effect of tradition, its enculturation into medicine and its influence on the perceptions of some doctors towards nursing and its development. I quickly developed a sense that these medical stakeholders were grieving for their ministering angels and handmaidens of health care, their nursing "sisters", the term used by both medical stakeholders, for example, *She is an early childhood sister* [KS16].

Both medical stakeholders stressed that they believed that the NP movement had been led by nurses whose main purpose was to help shed nursing's handmaiden image. They went to great lengths to point out that they did not regard nurses as their handmaidens even though their discussions clear showed to the contrary.

> *I know they are not handmaidens.* [KS16]

The view by the medical stakeholders that the NP role was primarily concerned with nurses' interest in discarding the handmaiden image was reported in the media. The following is an excerpt of a letter by a GP to a medical newspaper, the *NSW Doctor* following the release of the *Discussion Paper* early development of the NP role, Arnold (1992, p. 5) wrote, "Many nurses are determined to overthrow the 'handmaiden' image where doctors make the decisions and nurses carry them out."

A stakeholder argued that nurses had come to view themselves as handmaidens to doctors because within nursing they are continually told they are.

> *You know you all get told that doctors regard nurses as the handmaidens, that's absolute codswallop.* [KS15]

I developed a sense that the medical stakeholders were pining for the nurse from the mythical good old days. There were frequent comparisons by the medical stakeholders between the hospital-trained "good nurses" from the old days and the more contemporary "bad nurse" (my reference), for example, the nursing stakeholders who the doctors believed bullied them during the NP Steering Committee meetings.

> *I mean my [relative] is a registered nurse or was a registered nurse, but you know, she had a great deal of pride and she was the night super at a major teaching hospital when I was growing up. She had a **great** deal of pride in what she did and I sort of grew up with that ethic, and I certainly didn't grow up with the bullying tactics that **I** actually went through during this process, and that my colleagues went through during this process.* [KS15]

I asked a non-nursing stakeholder who was closely involved in the NP negotiations whether he had witnessed any bullying behaviour from the nursing stakeholders towards the doctors on the NP Steering committee. He believed that the medical stakeholders had been surprised by the nursing stakeholders' assertiveness and unity during the NP deliberations that led to the doctors having to compromise, and as such was interpreted as bullying by the doctors. The protracted negotiation and eventual compromise during the development and implementation of the NP are explored in the next chapter.

> *That is certainly nonsense, absolute nonsense. Look, clearly if you compromise, if you feel afterwards that you shouldn't have compromised.* [KS17]

It seemed to a medical stakeholder that the doctor-nurse relationship had deteriorated following the transfer of nurses' education from hospital training to the university sector.

> *You know I got [high pitched voice] on **so** well with the nursing staff, you know, you'd be on nights and it was just like going from one group of friends to another group of friends to another group of friends. Well it was, and it just doesn't happen anymore, what's happened to create that… I think the staff are grieving it. I don't think there is any of that warmth anymore, that we all got on well together and it was, actually it was to the benefit of the patient.* [KS15]

A nursing stakeholder spoke about her meeting with a group of doctors to discuss the NP role. She recalled how she felt like a fabled lamb to the slaughter. However, to her surprise the doctors were more interested in discussing the good old days when nurses were more polite and more respectful to doctors than is the presumed case with the current NP role.

> *The doctors talked about the way they used to teach them [nurses] and how the nurses were always polite to them and respected them, and came to them for help and they [doctors] were grieving, I was looking at some grieving people, they were **grieving** for those days. They were lost… they were grieving, they were grieving, some of them were actually **grieving** for the good old days. You can't do anything with people like that, you have to hope that they would die soon (laughs).* [KS8]

Another stakeholder believed that there would be three types of doctors: those who lament the passing of the good old days, doctors that change only if they were forced to, and doctors who embraced the introduction of NPs.

> *In this room, in this room there was a third that were grieving, a third that could see that they were going to have to change but they were only going to do it when you made them, and then there was a third that were embracing it, give it a go, let's move on, let's make sure that what's important to us protected and you know, move on.* [KS4]

A nursing stakeholder believed that it was GPs' lack of contact with nurses that had contributed to some doctors holding on to their more traditional view of nursing.

> *Doctors working in general practice were completely isolated from expert clinical nurses. They had no idea how nurses worked, they had no idea how they were educated, they had no idea what their expertise was.* [KS4]

She argued that GPs' exposure to practice nurses would eventually lead to GPs supporting NPs in general practice.

> *Once doctors get use to working with nurses at a particular level and they see that they add value to their practice and they see that they are not a threat to them they will want them to be able to do more…. We will have nurse practitioners working in general practice.* [KS4]

The findings reveal that there was the strong perception by those outside medicine that doctors (especially GPs) were resistant to NPs being recognised for their advanced practice because it was seen as a significant challenge to their own status within the community and health care system. These issues will be discussed in the following section.

6.3.2 Status and the doctor

Nursing and non-nursing stakeholders and NPs believed that doctors value their status in the community. They argued that doctors have traditionally resisted the development of increased status and power of other health care professionals because they viewed it as a threat to their own status. Because doctors have been regarded as the leaders of health care they have enjoyed considerable influence and power within the health care system. A NP described how it had been difficult for her to generate community support because the GP who did not support the role had high status and influence over the small rural community.

> *It has been a big political thing and you couldn't push real hard…. I mean the reality is still in a lot of country towns they see the doctor as being the be- all and end-all.* [NP6]

Stakeholders (e.g., KS11) also believed that the NP role was negatively affected because doctors who were not supportive were able to use their high status and influence within the traditional hospital hierarchy.

A NP pointed out that, although GPs have enjoyed high status within the community, generalist doctors do not have the same status within medicine that is accorded to specialists.

A NP recalled her conversation with a GP who had been resistant to the introduction of NPs. It was at this time that she realised the importance of status to some GPs. She was concerned that their need for status exceeded their desire to provide the best care.

> *I said, "Why do you think the GPs have been so against the nurse practitioner program?" and he said, "You know, the specialists look down on us and they make it very hard, and now we've got you all coming on." And I said, "Yes but maybe if the specialists are looking down on you, the NPs and the GPs could band together and we could look down on the patient." He didn't see the funny side of it… We should all be making the patient the key person…. The patient has been the lowest common denominator in my books.* [NP9]

Several of the NPs pointed out that there was greater support for the role from medical specialists than GPs, allegedly because the specialists did not see the NP role as a threat to their status, and also because the specialists had more exposure to expert nurses and so were more informed about the professional development of nursing. NPs believed that the specialists' greater insight into nursing contributed to their support for nurses to be recognised for their advanced practice and ability to work in more autonomous roles.

> *I'll tell you the group that are the easiest to work with and they are the specialty VMOs who are use to working with expert nurses; they rely on them.* [NP5]

Stakeholders commented that the specialists' overt support for NPs dampened the AMA's opposition when the implementation of NPs into metropolitan NSW was announced. Specialists' support was evident in a NSW Health Department media release entitled NSW AMA Out of Step with Leading Doctors (NSW Department of Health, 2002b).

Stakeholders and NPs attributed some medical organisations' resistance to medicine's traditional sense of ownership over nursing. As minor evidence for that attitude, the medical stakeholders frequently referred to "our nurses" during the interviews.

> *We need a lot more [nurses]…. The career structure has not been an added bonus to keeping our nurses in the system.* [KS15]

A non-nursing stakeholder argued that doctors and medical organisations have historically seen themselves as holding the line to stop the collapse of health care. He believed this perception to be a reason for some medical organisations' opposition to the NP role.

> *The AMA sees itself as the guardian of public safety and public values. So this concept of this concept of the thin blue line is an important one. My experience is that the AMA and the RACGP saw themselves as holding the line, [as if] what we need to do is to stop the collapse of the quality of the health care system which (laughs), this [the NP role] in their fantasy represented.* [KS17]

This section has shown that some doctors felt threatened by the NP role because it challenged their status. The following section discusses the historical difference in status between doctors and nurses and how it continues to influence the way some doctors relate and communicate with nurses as happened during the development of the NP role.

6.3.2.1 Status and the doctor-nurse power disparity

Many stakeholders described and discussed the traditional doctor-nurse power relationship and its influence on the development and implementation of NPs.

A nursing stakeholder argued that status and power differential between medicine and nursing had contributed to nurses' lack of confidence and weak sense of self-entitlement, both of which, she argued, are symptomatic of the socio-pathology of an oppressed group [KS9]. Another nursing stakeholder commented that, many nurses seeing themselves as unequal to doctors has negatively affected the way nurses relate to doctors. The stakeholders argued that consequentially, nursing remains dominated by medicine, and nurses continue to be easily intimidated and dominated by doctors.

> *We are not clear about who we are. We are still struggling under the medical model. The doctors are still the dominant person in the nursing sub-profession.We think we are professional and we are saying we are professional, but when we get into a health care situation, in a multi-disciplinary situation. We don't stand up for our own, we can't argue on our own, we can't stand up and be assertive like the medicos.* [KS11]

This point was also stressed by another stakeholder:

> *Because I think nurses when they put on the uniform for some reason they behave differently. They would be more likely to confront motor mechanics and tell them what ought to happen with their vehicle. You have them talking to a medical officer and they become much, much less assertive and much, much less sure of where they are coming from and yet they probably understand their clinical demands better than they understand the motor vehicle.* [KS12]

Nursing and non-nursing stakeholders stressed that nursing's historical hesitancy to challenge medicine perpetuates the power imbalance between doctors and nurses. The inequality diminishes trust between doctors and nurses, and nurses' confidence to take on roles such as the NPs that challenge medicine's authority because of their belief that they would not be fully supported by nursing.

> *I mean talking before when we said about nurses not really being that into it [the NP role], this becomes a bit of a self-fulfilling prophecy in a sense because nurses never believe that anyone is ever going to take on doctors to support them, and then we don't. Well we do, but we don't do it completely.* [KS1]

Some stakeholders and NPs argued that another barrier to nursing's development has been partly "niceness" of nursing [KS9] and nurses desire to be "good girls," which accentuates doctors' power over nursing and nurses' practice.

> *I'm discovering along this bloody tortuous road that I am riding is that in nursing far too often is that we sit back and wait for permission.* [NP5]

This NP argued that the perceived power of doctors often causes nurses to follow doctor's orders without question.

> *I was told by the medical director of the emergency department that patients weren't allowed to leave the emergency department without being seen by a doctor and if they did I had to be responsible for that at triage why they had left. Well, that was* ***him*** *making the law, it is* ***not*** *in the legislation.* [NP5]

Both NPs and stakeholders spoke about the historical influence of gender in nursing and its effect on the development and implementation of the NP role. One non-nursing stakeholder believed that medicine's preoccupation with controlling the mostly female profession of nursing was due in part to it being a predominately male profession. He likened the suffragette movement to the NP movement. He pointed out that, similar to the opposition to women voting, the opposition to NPs being recognised for their advanced practice and increased autonomy will seem ridiculous in years to come.

> *You know, women can't do this, women can't do that, if women are to do this they'll lose their whatever it is. Some of the quotations which in the light of history would seem ridiculous. I mean in fifty year's time it may also seem ridiculous.* [KS17]

Some of the NPs and nursing stakeholders pointed out that doctors try to maintain their dominance by speaking to them in paternalistic tones.

> *There are one or two who are still a bit offensive, who calls me "girlie" on the phone,* ***"girlie!"*** *I think you are getting above yourself. It is quite interesting because I said to him "Are you in the clinic at the moment?" and he said, "Yes, I am," and I said, "Oh, I'll come over and introduce myself." I put down the phone and walked over to the clinic and introduced myself and I said, "I have to thank you. I haven't been called "girlie" for about twenty years. It is really an honour to meet you."* [NP5]

> *But sometimes they [the GPs] talk to me in the level that you know when you've got a problem or a health issue I need it spelt out like c- a- t and d- o- g.* [NP9]

One nursing stakeholder, a prominent and well-respected nurse leader, spoke about her anger and disgust at the paternalistic language that doctors used towards her, and others during the NP Steering Committee meetings.

> *Being called "****girlie"*** *by the RDA representative on the Steering Committee was something I will never forget. I said to him, "I am not your girlie." He knew straight away that he had done the wrong thing, but I will not forget the meeting when he sat there.* [KS6]

The findings indicate that there are still those within nursing who long for the good old days. It is these nurses who were particularly resistant to the introduction of NPs. There was also the perception by some stakeholders that nursing's continuing lack of confidence hinders its progress.

6.3.3 The legacy of tradition in nursing

Stakeholders and NPs argued that, similar to some doctors, there are still many nurses who had not adapted to the advancement of nursing. As a consequence, they hanker for the supposedly good old days, and new developments such as the introduction of NPs.

> *You've still got nurses. They haven't all died yet, (laughs loudly), but getting there. There is still nurses in my age group that want to go back to the good old days, which were terrible old days, I can tell you.* [KS4]

Several stakeholders and NPs pointed out that there were nurses in management positions who retained a traditional view of nursing, its practice, and its place within the health care hierarchy. Participants argued that these nurse managers tended to be subservient to doctors and did not support professional autonomy for nurses, as exemplified by the NP role. They highlighted that despite these nurses having more modern, executive-style positions, some nurse managers function similarly to a hospital matron. One stakeholder involved in the implementation of NPs spoke about her experience with a manager.

> *I liked her as a person, but she was the very old style matron type, yes doctor, no doctor, three bags full doctor and that didn't help, she was too busy trying to keep the doctors happy than worrying about how she could really help the health service make it a better place.* [KS11]

A NP working in a small rural hospital described her difficulty trying to implement the NP role under the manager as described above. The manager's reputedly controlling and obstructive behaviour served to maintain her authority and status within the hierarchy. The NP provided the following example:

> *She's trapped in the fifties matron of the hospital thing and as you know in that sort of hierarchy nothing was dealt with by anybody that's important but the matron…. She was meeting patients in the corridor who were coming to see me and saying over my dead body when people were coming to see me didn't do me any good either…. That's how she operates, so she didn't like people coming in to see another nurse who wasn't in a position of what she considered to be power, being me.* [NP10]

The NP also spoke about the difficulty in tackling the manager's obstruction because it was mostly covert.

> *It's sounding like I didn't stand up to this control freak …, but there was nothing to stand up to. Everything was undercurrent. It wasn't always in your face obstruction. It was done somewhere else at another level. If you were to ring her today and say, "Oh the nurse practitioner thing…" she would probably say it was a good thing.* [NP10]

This NP also believed that the manager controlled her NP practice by withholding resources.

> *I didn't have a phone, and the computer access just was a real problem for me, it was a huge problem. So it's nursing management, when I first started in the role… I needed an office, I needed a place to see patients… there was one phone between three people that made it really difficult without having your own extension and I was making so many calls at the start so that was making life difficult. I needed the support and I needed the infrastructure in the organisation to make it work, and that's what wasn't there.* [NP10]

Overall, and as pointed out by this NP10, the implementation of the NP role is less difficult when introduced into environments receptive to the NP role.

> *They hadn't actually considered the culture of the health service itself and the nursing culture at that time, and I've got to say I didn't either. I was not in a position to effect change…. I felt like a failure.* [NP10]

A nursing stakeholder expressed her concern that some of the younger university educated nurses continue to be socialised into the more traditional hierarchical culture of the health system not only by doctors but also nurses. They argued that this tendency continues to present significant challenges to the ongoing professional development of nursing.

> *It is the way they have been enculturated… Since they came into the hospital they were very rapidly socialised for their own survival into the lowest common denominator and so this behaviour of, you know, nurses being less than doctors.* [KS13]

Some nursing stakeholders maintained that nursing has been a victim of its own doing in its quest to prove itself as a legitimate health care profession. One stakeholder believed that this was evidenced by what she described as the excessive NP authorisation process.

> *We raise the bar within our profession so high, that everyone is trying so hard to climb over it…. We certainly did it for nurse practitioners but again we thought that we had to do that as a profession.* [KS12]

This stakeholder argued that historically there has been too much introspection in nursing. The energy would have been better directed to actual professional development. She also commented that the introspection is due to nursing having to continually justify itself.

> *So whenever you are in a hospital setting for example, at a department level when they're saying, "You don't need clinical nurse educators. They just need to stop doing their educating and getting back to caring for the patients…." They are continually put under the microscope we do a lot of navel-gazing endeavouring to justify why it's this, this and this.* [KS12]

6.4 Summary of Chapter 6

The findings in this chapter document perceived factors that influenced people's perceptions, understanding and acceptance of advanced practice in nursing and thus, the NP role. The use of terms that are not easily or universally understood, within and outside nursing, hinders communication, understanding and a proliferation of individual interpretations. This problem is exemplified by the confusion and disparate interpretations about the meaning of the terms advanced practice, collaboration, autonomy and independence.

The NPs highlighted their own confusion about advanced practice especially when starting their NP journey. These mainly hospital-trained nurses and patient-focussed nurses were unprepared to articulate how practice was advanced, and to explain to a possibly sceptical audience how they were different to other nurses and doctors. Confusion about the NP abounded within the public domain and media and as such, the focus was on the NPs' extended skills. Medical organisations opposed to the role capitalised on the confusion by representing the NP as a doctor-substitute role providing second-class medicine. Rather than marketing and educating the public about the NP role, it was believed at that time that increased understanding of the role by the public would occur with their increased contact with the NPs' practice.

The majority of the NPs were already working in their area of practice prior to their authorisation. As such, the managers were already benefiting from the de facto NPs' practice without having to financially reward them at the increased level of an NP. In addition, there was no funding for the AHSs to cover costs associated with the NPs' extended skills such as prescribing, and their working after hour shifts. The implementation of the NP is facilitated by managerial support for the NP role.

Some within and outside nursing have not adapted to the increasing professionalism of nursing. There are doctors and nurses who continue to grieve for traditional nursing when nurses were subordinate, even servile, to doctors. Some doctors maintain traditional attitudes

towards nursing that may have been accentuated by some GPs' lack misunderstanding of developments in nursing and their lack of contact with the contemporary nurse. Historical barriers to garnering doctors' support for the NP role were identified. Doctors, especially GPs, value their status within the community. Nursing's increasing status was seen as a challenge to the doctors' own status. Medicine's traditional ownership and paternal dominance over nursing and its self-appointment as the "health care guardian" were significant influences on the doctors' support for nurses working in autonomous advanced practice roles such as that of the NP.

However, there are also some nurses who have not adapted to changes in nursing and hold on to a more traditional view of nursing practice. Nurses in positions of power such as managers are able to influence the implementation of the NPs negatively or positively. Managers who have a more traditional view of nurses' practice are less likely to support nurses taking on more advanced practice roles. Some nurses are not comfortable challenging doctors and there was the perception that some nurses believed that they would not be supported if they did so. The findings indicate that some believe that nursing creates its own obstacles to professional growth by imposing unrealistic standards, as happened during the NP authorisation process.

Having detailed the influences on recognising the NPs' advanced practice, the following chapter further explores the visions of the various stakeholders in the development of the NP role. It also explores how these visions for those supportive and those who opposed the NP role was played out during the development of the role.

Chapter 7 – Findings – Riding the waves to change: Visions, voices and vested interests

Chapter 4 Key events in the early development of the NP in NSW (1990-2005).	• Antecedents to the NP role in NSW. • Stages 1 to 3 in the development of the NP role. • Process for establishing NP services. • Framework for the implementation of NPs into the NSW health care system. • Other landmark events for the NP role in NSW.
Chapter 5 Entering uncharted waters: Pioneering the NP role in NSW.	• Taking up the challenge. • The challenge of uncertainty. • Recognition, rewards and opportunities. • The legacy of the pioneers to the NP movement in Australia.
Chapter 6 Navigating uncharted waters: Recognising advanced practice in nursing.	• Getting to know advanced practice. • The NP role: Collaborative, autonomous or independent? • Traditions in health care: Good old days or plagued by the past?
Chapter 7 Riding the waves to change: Visions, voices and vested interests.	• Visions for the NP role. • Developing and implementing the NP role: Negotiation and compromise. • Collaboration: Co-operation or control?

This chapter entitled *Riding the waves to change: Visions, voices and vested interests* begins with the stakeholders' visions for the NP role that the different stakeholders held. At one end of the spectrum there were stakeholders who were supportive of the role because they saw the value for health care in NSW, and also the benefit for the nursing profession. As such, they had a "sense of gain" about the introduction of NPs. On the other hand, there were stakeholders who did not support the role because of their "sense of loss and fear". A particularly strong stimulus to this sense of loss and fear was concern about the effect on other health care professionals both within and without nursing. Thus, the vision of those

who feared loss was for the maintenance of the status quo. These issue are explored in the first section of this chapter *Visions for the NP role.*

The findings demonstrate that because of the differing visions and vested interests of those involved in the development and implementation of the NP role it became a process of negotiation and compromise. Disparate visions and vested interests influenced and impacted the way the NP role was developed and enacted. There was much interplay between NPs and stakeholders according to the vision and power they held. How the different stakeholders tried to enact their visions from the role's early conception through to its ongoing development and early implementation into the NSW health care system is explored in this chapter.

An objective of the present research was the disclosure of the reasoning behind important decisions and compromises that were made during the role's early development. These decisions have ultimately influenced the ongoing development and implementation of the NP role. The NP role was credited as having a significant impact on nursing's political growth. These issues will be discussed in the second section of this chapter, *Developing and implementing the NP role: Negotiation and compromise*.

Effective collaboration between doctors and nurses was seen to be critical to the success of the NP role. However, doctors are historically dominant and powerful within the NSW health care system and in how they manage nurses' practice. While doctors espoused their support for collaboration with NPs, in reality many of them used their power to control and restrict the NPs' practice. The findings reveal considerable disruption to existing relationships when the NPs moved into their new role. The findings also provide evidence that the introduction of the NP role caused dissonance between the professional commitment of some stakeholders and their organisational commitment. These issues are explored in the third section, *Collaboration: Co-operation or control*?

The first section begins by exploring the visions of stakeholders who had a sense of gain with the introduction of NPs into the NSW health care system. This is followed by discussion on the visions of other stakeholders who had a sense of loss and fear and as such their goal was to maintain the status quo. There was much political interplay between those stakeholders trying to maintain the status quo and those who were trying to counter balance the sense of loss and fear.

7.1 Visions for the NP role

The vision for the NP role in NSW began in 1990 with a nurse asking the then state Health Minister whether he supported NPs. None of the participants were able to identify the nurse who asked this question. It was not a 'staged' question by nurse stakeholders.

> *They had the Nurses' Association conference… where the then Minister for Health was asked whether he supported nurse practitioners, and he said, "Absolutely," and I suspect he didn't actually know what they were. Pat Staunton [General Secretary of the NSW Nurses' Association] and Judith Cornell [Director of New South Wales College of Nursing] very wisely wrote immediately to the Minister to ask how the Minister was going to progress his support to nurse practitioners and, of course Judith Meppem as Chief Nurse had to respond, so a taskforce was established.* [KS9]

As in the US, Canada and the UK, the development of the NP in NSW began with a visionary in the form of the NSW Chief Nursing Officer, Judith Meppem to champion the role. Many of the nursing and non-nursing stakeholders acknowledged her vision, commitment and passion.

> *Judith Meppem was absolutely visionary in her push for nurse practitioners.* [KS9]

Henceforth, and especially after the release of the *Discussion Paper* documenting the visions of key nurses and nursing organisations for the introduction of the NP role in NSW, the concept earned the attention of more stakeholders, ranging from nurses who wanted to become NPs, nurses who were already working informally as NPs, and key stakeholders who were nurse leaders in administrative positions and who wanted the role come to happen. Stakeholders held strong and often polarised views on the concept. These others included consumers, politicians and their affiliate parties, nursing and medical organisations, individual doctors and nurses, and also other health care professionals and organisations. All had their visions for the development of the role, and how it should be enacted.

7.1.1 Visions for the NP role: A "sense of gain"

A State Government stakeholder argued that,

> *While all role differentiation has some arbitrary historical context, the challenging of it is always appropriate, especially within the context of changing health care needs.* [KS10]

Because of changing health care needs in NSW there was an increasing realisation that traditional roles must change.

> *So our traditional ways of seeing our health care system and the delivery of services will obviously need to change, so the question really is what roles do we need as opposed to assuming there is always the need for the same roles.* [KS17]

For many of the stakeholders, the NP was a concept *whose time had come in Australia* [KS17].

Nursing and non-nursing stakeholders revealed their visions and how the role would benefit the NSW health care system and the nursing profession. Whilst most stakeholders supported the role in a general sense, behind their support were their own particular interests and visions for NPs into the NSW health system. Other stakeholders, including politicians, saw the role as improving access, consistency and continuity of care, and increasing cost-effectiveness and safety of health care. Stakeholders spoke of the benefits of the NP role for the ongoing professional development of nursing and for nursing career paths.

7.1.1.1 The vision to improve health care in NSW

The vision of the key stakeholders in the "gain" camp was to improve health care in NSW.

> *My driving agenda was patient care and I firmly believe that patient care is enhanced by the nurse practitioner role. I firmly believe that.* [KS5]

There was strong support for the NP role by politicians from the two major political parties (Labor and Liberal) in the NSW Stage Government. This support was demonstrated by the *Nurses Amendment (Nurse Practitioner) Bill* (NSW) progressing unopposed from the Legislative Assembly (Lower House) and passed by the Legislative Council (Upper House) and consequently into law. This development was seen as particularly significant because bipartisan support is unusual in Australian politics.

> *It's probably one of the very few Acts of parliament over recent years that had bipartisan support. The Liberals started it but the Labor party followed it through.* [KS6]

The Honourable Ficarra stated that this "landmark" legislation transcended party politics because it was seen to "benefit the provision of health care in NSW" (Nurses Amendment - Nurse Practitioner Bill, 1998a). The strong support for the NP role, as pointed out by many of the politicians, was sealed by the positive outcomes that were demonstrated by the NP Pilot Projects.

> The pilots demonstrated that NPs are well accepted by the community… and… added value to existing health services, provided a new and valuable additional service and, at times, provided the only service. Nursing practitioner services led to improved access by patients. The services satisfied patient expectations…and provided a service that city dwellers take for granted. The standard of quality service was due to the high level of professional behaviour and management capability. That level of service was reflected in the consistent and positive consumer reports. (Nurses Amendment - Nurse Practitioner Bill, 1998a, p. 8347)

There was also recognition by politicians such as the Honourable Skinner during the second reading of the *Nurses Amendment (Nurse Practitioner) Bill* (NSW) that nurses had already been working in extended roles for many years, with minimal or nonexistent medical support, with communities relying on them as the sole providers of health care advice, management and support (Nurses Amendment - Nurse Practitioner Bill, 1998a)

Politicians representing their constituents in rural or remote NSW spoke of their particular interest in the benefits of the NP role through increasing access to health care in rural or remote area in NSW. As stated by the Honourable Slack-Smith:

> In Bondi there is one general practitioner for 400 patients, while in Narrabri-which is 50 miles east of where I live – there is one doctor for 4,000 patients. In Wee Waa – which is 25 miles west of Narrabri – there is one doctor for 5,000 patients. (Nurses Amendment - Nurse Practitioner Bill, 1998a).

A non-nursing, non-medical stakeholder commented that his passion for the NP role was about improving indigenous health.

> *There was the need to have people working more autonomously because the functioning of certain groups means that there is insufficient health care … the change in the demographics in population… the realisation that indigenous health is not sufficient.* [KS17]

Stakeholders argued that the role would provide more convenient health care in metropolitan areas.

> *It was responding to the need for advanced clinical nurses to be able to practice more sensibly and be able to refer straight to specialists, to be able to prescribe, to be able to initiate diagnostic investigations and pathology. It is convenient for the client …it was to make it much more convenient for clients.* [KS4]

A nursing stakeholder revealed that his support for the NP role was accentuated by the World Health Organisation's 1980s research which found people who do not require medical intervention should be able to directly access nurses and nursing care without having to go through medical services [KS2].

Politicians recognised that the introduction of NPs was a response to the shift from hospital health care to community care. As argued by the Honourable Moppett during the second reading of the *Nurses Amendment (Nurse Practitioner) Bill* (NSW):

> We are now saying for all sorts of good reasons we want to undertake as many health care procedures as we can in situ in our homes…the notion of doctors making house calls are restricted to television soapies…. The truth of the matter is that the days of the doctors making home visits are long gone (Nurses Amendment - Nurse Practitioner Bill, 1998b, p. 8686).

With regard to greater consistency and continuity of care than GPs provide. They pointed out that GPs' MBS-funded salaries are based on the number of GP consults that encourage throughput rather than quality of care.

> *I mean, things like asthma management, it is about that consistency, that follow-up, the things that nurses do, and yes it might not be in an eight hour shift care but it might be over eight days care, you know the fact that they go back and they teach and re-teach them on how to use the puffer and the things like that…. It is about bringing the things that we rank and rate as important in nursing which is that consistency and continuity of care that GPs will argue they should do too but they*

> *can't do it under the current funding scheme of Medicare really, because they can't afford it. It [standard medical] is very episodic care.* [KS14]

With reference to cost effectiveness, a stakeholder who had worked in advanced practice described the added cost to the government of her traditional (non-NP) nursing practice. GPs would repeat and charge patients for examinations such as breast checks that had already been performed by the nurses in the clinics.

> *All the nurses that worked in the community were the ones that were the most frustrated because they then had to send their clients to their GP and the GP wouldn't always comply, they didn't like the nurse recommending a management protocol, they would often repeat the tests,* ***very*** *often repeat the tests.* [KS4]

For many, the NP role provided an increased element of safety in the provision of health care. Stakeholders pointed out that it was much safer for patients to have experienced and knowledgeable NPs prescribing medications, rather than inexperienced and less knowledgeable doctors.

> *You know it is much safer for the nurse practitioner to be prescribing an antibiotic. They have got the clinical experience and educational preparation and the knowledge rather than them wandering around to some first year [doctor] that is still wet behind the ears and say," Please write me a script for blah-de-blah-de, blah. All we are doing is giving them [NPs] the legislation to support what they have been doing for ages, and it is much safer for them to be prescribing than telling somebody else to prescribe it.* [KS8]

Stakeholders also commented that it was safer for patients to have NPs prescribing rather than inexperienced and less knowledgeable nurses administering medications under standing orders.

> *So, in my view, actually having an authorisation process for nurse practitioners could only improve safety, because in the past anyone could do this stuff under standing orders, you know, so what we were doing was improving safety and quality and recognise the expert skills of a group of nurses.* [KS9]

Some stakeholders argued that technological advancements in health care had also contributed to health professionals such as NPs extending their roles and responsibility (e.g., KS17).

There was considerable support for the NP role by health care organisations outside nursing. For example, the Honourable Ficarra acknowledged the support of the NSW Branch of the Pharmacy Guild of Australia of the NP role. She read, "NPs will ensure the expansion of quality health care services in NSW. Consumer equity and access to basic health care will be boosted" (Nurses Amendment – Nurse Practitioner Bill, 1998a, p. 8349).

Despite resistance of the NP role by individual doctors and medical organisations (see below), others such as the Doctors' Reform Society of Australia (DRS) were explicit in their support. This contemporary (and fairly radical by medical standards) medical organisation that "supports health care reforms to ensure justice, equity and quality care for all regardless of social or economic status" (Doctors' Reform Society of Australia, n.d). The Society saw the potential for NPs to improve doctors' working conditions by taking on work that need not be done by a doctor. The DRS advocated that NPs be used more effectively, especially in areas the medical profession was inadequately servicing. In the *Australian Doctor,* Andrew Gunn, DRS national treasurer wrote:

> A range of studies suggest that suitably trained nurse practitioners can perform as well as, if not better than, doctors in diverse areas. Nurse practitioners offer opportunities for us [the medical profession] to concentrate our attention on the tasks which most require medical training…. Many rural GPs have recognised this. (Gunn, 1998a, p. 4)

Stakeholders also spoke about the benefits of the NP role to professional nursing. They argued that because the role provided recognition of nurses' advanced level of practice, and their ability to be autonomous and accountable for their practice, nursing's status would increase; and it offered clinical nurses an improved career path.

7.1.1.2 Benefits to the nursing profession

A nursing stakeholder heavily involved in the early development of the NP role pointed out that initially the main stimulus for the role, was to formally recognise nurses' advanced level of practice.

> *We had these people working at an advanced practice level who weren't being acknowledged for that. That's what it was all about.* [KS6]

She explained that the debate about NPs' was taken up by politicians as a way to improve access to health care because of the shortage of doctors, particularly in rural and remote areas of NSW. NPs were seen to be an effective and less expensive alternative to doctors.

> *And then it got clouded with the shortage of doctors and you had the bean counters saying, "Oh we'll put a position in there because it will be cheaper and we haven't got doctors."* [KS6]

This stakeholder pointed out that rather than deprecating the argument for NPs based on economics and the shortage of doctors, NP advocates used it as an opportunity for introducing NPs into NSW.

> *But you have to seize the opportunities, even though it might have been philosophically a pain.* [KS6]

Nevertheless, there was strong support for the formal recognition of nurses' advanced practice and their capacity for a more autonomous role**.** This vision was acknowledged by stakeholders working in state government.

> *This is really the first major role change for nurses I think, it is about recognising skills of nurses and additional things that they can do in the current environment. I see it as an early significant milestone in that regard.* [KS1]

> *My interest was out of a firm commitment that nurses are firstly capable of fulfilling a broader role than what they had been doing.* [KS10]

For many stakeholders the role meant that the NP legislation would legally protect the practice of the NPs, especially those already working in *de facto* NP positions [KS1]. Politicians such as the Honourable Chesterfield-Evans acknowledged the formal recognition of nurses' knowledge and skills that would, in turn, increase nursing's status within the community. "The creation of the category of nurse practitioner will confer a higher status on the entire nursing profession, and provide nurses with more interesting jobs and recognition of their work" (Nurses Amendment – Nurse Practitioner Bill, 1998b, p. 8659).

Raising nursing's status through recognition of nurses' advanced practice could help alleviate consumers' concerns especially in rural and remote areas that they were being relegated to a cheaper and lower standard of care.

Another nursing stakeholder spoke about her vision for the NP role as a new career path for nurses wanting to progress their career as clinicians and not being forced out of clinical practice into management or education.

> *One of the reasons I chose to be involved in it is…that we can only imagine what it has done for the psyche of our profession to be financially rewarded for not practising clinical nursing. Fundamentally we get rewarded for managing nursing or teaching nursing but we don't get financially rewarded for what it is that goes to the heart of our being as nurses which is the practice of nursing.* [KS9]

Others did not support the NP role and they viewed it with a sense of loss and fear. Their vision was to maintain the status quo. This sense of loss and fear was related to the blurring of traditional role boundaries, such as between nursing and medicine. There was concern about the effect of the NP role on other health care roles within and outside nursing.

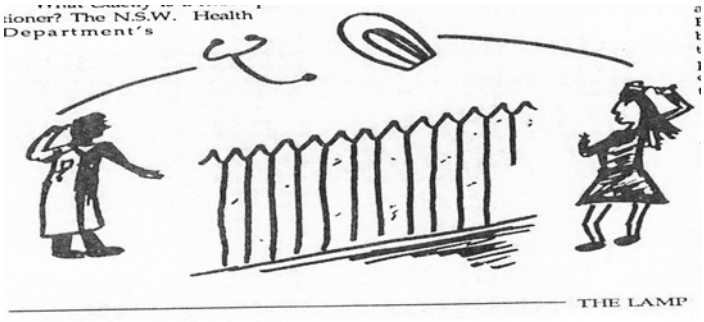
7.1.2 Visions for the NP role: A "sense of loss and fear"

The vision to maintain the status quo in the delivery of health care in NSW was held by organisations and individuals within and outside nursing. These stakeholders sense of loss and fear particularly related to the blurring of traditional role boundaries such as with medicine, and because of its potential affect on other health professions. The accounts in this research leave no doubt that some voices, particularly those within medicine, were more powerful than others in their quest to maintain the status quo.

7.1.2.1 NP role and blurring of traditional role boundaries

Stakeholders interviewed for the present research agreed that most of the opposition to the NP role pertained to the blurring of traditional role boundaries. NPs were seen to be crossing into the medical model rather than extending traditional nursing. This perception was depicted in a cartoon published in the NSW Nurses' Association's *The Lamp* (Coxhead, 1992, p. 27).

Figure 6



Whilst the non-medical stakeholders acknowledged support from individual doctors and some medical organisations, they stressed the vocal opposition from some medical organisations.

> *There are that fringe of GPs who say that nurse practitioners under any circumstances are the worst people that were ever invented because they are neither a nurse nor a medical practitioner um, there are the other ones who recognise that there are people with specific skills in that area that can be utilised in a very sensible and collaborative way, and herein the difference between the groups exists.* [KS16]

The AMA, is a medical union which also sees itself as the voice of the medical profession. However, the AMA is more representative of the GP medical population than specialist medical practitioners, who are generally represented by their specialist organisations. The AMA was vocal in its opposition to the NP role. Its preference for the status quo in health care was communicated to its members, politicians, nurses, other health professionals, and the public via the media. All of the non-medical stakeholders and NPs believed that the vision of the AMA was always to try to maintain the status quo in the delivery of health care.

> *If you looked at the vision of the AMA it would have been that the nurse practitioner role would not exist.* [KS17]

Other medical organisations such as the Royal Australian College of General Practitioners (RACGP) and the Rural Doctors Association (RDA) also voiced their opposition. Following the release of the *Discussion Paper* in 1992, a flurry of letters and editorials with sensational headlines in medical newspapers warned doctors of *Nurse practitioners pushing for power* (Editorial, Australian Doctor Weekly, 31 July 1992. See Appendix G for a list of media documents from 1992 to 2005). One of the first articles to appear in a medical newspaper by

the then President of the RACGP warned that, "strong threats to our profession are being mounted by a handful of nurses with a grossly inflated opinion of their abilities… A united front can achieve wonders" (Buhagiar, 1992a, p. 6).

The RACGP urged doctors that "general practice must repel invaders" (Buhagiar, 1992a, p. 6) and "eyeing off the patients is not on" (Buhagiar, 1992b, p. 10). The AMA similarly reported that "determined nurses worry AMA" (Demou, 1992, p. 2).

Reasons behind the opposition to the NP role by some doctors and medical organisations, particularly the AMA, are multiple and complex. Major reasons for some doctors' and medical organisations' resistance to NPs into NSW, as seen by the stakeholders and as described in the media were fear of losing professional territory; fear of commercial competition and loss of market share, with associated loss of income; fear of losing their nursing handmaidens; and fear of losing professional status, power and control over the health care system.

Several stakeholders acknowledged that the NP role was indeed impinging on medicine's traditional role, but saw that as a natural progression for nursing, and also that nurses were responding to changing health care needs.

> *We were turfing some of the role that has previously been in the historical sense undertaken by doctors.* [KS10]

A stakeholder commented that any health profession that has threatened doctors' professional territory has met resistance.

> *Of course, chemists have really fallen foul of the AMA, and that is a really useful one, the pharmacists, to draw an analogy with, and that proves it's turf, because you know you only have to listen to their conversations around pharmacists. You know, I'm sure they must cut and paste from the nurse practitioner stuff, you know, because it is just the same scare-mongering tactic. I think it is unconscionable the way they try and scare the public.* [KS9]

According to some stakeholders, doctors' resistance to the NP role equated to a demarcation dispute between nursing and medicine. A medical newspaper article entitled *Nurses encroach on GPs' domain* (Tattam, 1997) illustrates GPs' fear of losing their professional territory. As pointed out by an NP,

> *The GPs certainly there was the most antagonism… I think a lot think you are going to pinch their clients.* [NP7]

Stakeholders believed that there was substantial fear, particularly among GPs, that NPs threaten their income.

> *I think it is income. There was a guy who delivered a beautiful paper at the first nurse practitioner conference held in Australia in Melbourne in about '98. A GP from Victoria gave a lovely paper and he basically argued that the problem isn't about spheres of practice or patches, it is actually about economics. It is about income, about doctors being threatened. It was a lovely paper. It was one of the keynote addresses. A number of lights came on for me.* [KS14]

As argued in the previous chapter, doctors value their professional status. It has also been suggested that GPs have been particularly resistant to the NP role. As discussed in previous chapters and later in this chapter, NPs and stakeholders believed that doctors feared that nurses' increased autonomy and status would diminish not only their own status but also the public perception that nurses are doctors' handmaidens and that doctors' supervise their practice. In a media release entitled *Nurse practitioner plan a disaster,* the AMA asked, "Who will supervise the NPs and take responsibility for their decisions?" (Australian Medical Association, 2002a). In a follow-up media release, *Ad-hoc experiment will not solve nursing crisis,* the AMA answers its question, "Ultimately a doctor will have the responsibility," (Australian Medical Association, 2002b).

The following statement by the then President of the RACGP during the early development of the NP role illustrates not only GPs' sense of marginalisation within medicine, but also their fear that nurses would threaten their status.

> Since the explosion of specialist numbers and the consequent freezing out of GPs from all the smaller hospitals we have exited outside the decision-making groups in our professional community…. The only argument we can use to enhance our status and our income is to pull up our socks…. The RACGP and AMA are jointly looking to further develop GP services that will in the end justify general practice's status professionally and publicly. (Buhagiar, 1992, p. 6)

Stakeholders alleged considerable fear among some doctors that NP numbers would quickly grow, as reported by a nursing stakeholder who recalled a rural doctor stating,

> *We'll have to watch them…. They'll breed like rabbits.* [KS3]

Nursing stakeholders and NPs described their disappointment in some of their nursing colleagues who did not support the NP role. A letter by a nurse to the editor of the NSW Nursing Association's *The Lamp* illustrates the rejection of the NP by some nurses: "I am totally opposed to the idea of the nurse practitioner. Am I alone on this view?" (Denning, 1994, p. 9).

Several NPs pointed out that some of their nurse colleagues believed that NPs would end up with tasks that the doctors did not want to do [NP8]. The NPs highlighted that nurses, especially those who had maintained a more traditional view of nursing, did not welcome nurses taking on more responsibility. Some expressed their disappointment with nursing colleagues who suggested that they (aspiring NPs) should study medicine if they wanted more responsibility. One commented that this comment had "absolutely floored" her [NP3].

> *Their comments were around why would you want to be a nurse practitioner, no one wants that kind of responsibility…why don't you go off and be a doctor if you want to work like that.* [NP3]

The following excerpt of a letter from a nurse published in *The Lamp* supports stakeholders' and NPs' view that some nurses feared taking on more complex workloads and responsibility. This letter also illustrates this nurse's view that some nurses' fear maintains their subordinate relationships with doctors.

> Many nurses resist the effort to further education, fearing increased responsibility and a more complicated workload. They continue to fall back upon the relative security of their subordinate position whilst at the same time complaining that their contributions are treated with a certain amount of disdain. I believe nurses cannot have it both ways. (White, 1994, pp. 4-5)

There was also considerable fear about the effect of the NP role on other roles from both within and without nursing. Thus, some nurses' attitudes resembled those of some doctors in that they hoped for the continuation of past arrangements.

While many clinical nurse consultants (CNCs) supported the NP role because they saw the benefits that it could bring to the health care system, to nursing and their own career progression, some CNCs were not so positive (The CNC role is described in Chapter 2, p.

74). There was considerable uncertainty about the effect of NPs on the CNC role. Several of the nursing stakeholders reported how some CNCs envisaged eventual replacement by the NPs, or at the very least, their numbers markedly decreasing [K513]. Several NPs believed that some of the animosity from CNCs was also due to a power and status struggle. The CNC role was historically seen as the elite semi-clinical nursing position antecedent to the NP role.

> *I do believe that there are some people within our own profession that want to see it [the NP role] barred. I think there is, um, I think there are some CNCs that feel that they are top of the tree…. I suppose there is the perception that the nurse practitioner is on top of the tree because they are more independent…. The political struggling goes on.* [NP4]

Several nursing stakeholders spoke of the possibility for the NP role to deskill other nurses and health professionals.

> *There is also room for people to consider whether they are actually pushing people out of the way that were doing a clinically OK job… and whether that's deskilling.* [KS13]

A stakeholder spoke about the belief of a specialist medical college that the introduction of NPs may have affected the training of specialist doctors in clinical settings because NPs would be undertaking practice that would normally be performed by the doctors during their training.

> *The doctors were concerned about the impact on their medical training, so it was going to affect their medical graduates and potential emergency physicians. They believed they were going to be affected by nurses actually taking up some of their role and function is the way they had seen it.* [KS 12]

Stakeholders also reported that health professionals such as physiotherapists and radiographers believed that NPs would encroach on their professional territory.

> *It was such a big deal to the radiographers, it was interesting because I couldn't work out why they cared, why it was such a big deal for them, but unless they, again thought, oh well they might start to move into our territory I think that was what a lot were worried about, that nurses would become sort of able to do everything, that's what the physios were concerned about.* [KS1]

During the early development of the NP role, individual pharmacists were concerned that NPs would significantly threaten their income. At that time they believed that NPs would prescribe a large range of medications supplied through the AHS at no cost to the patient. Hence, patients would not have to purchase medications through pharmacies.

> *If you have a pharmacist in a country town who is barely surviving and yet there is somebody else can order and maybe dispense, that is a threat.* [KS7]

A stakeholder at state government recalled how members of a variety of professional groups who were concerned about the impact of the NP on their role had united and jumped on the medical bandwagon to condemn NPs arguing that they would lower the delivery of health care.

> *I remember one meeting, one meeting with them and they all came in, there was about twenty of them, and radiologists, pharmacists, podiatrists, physios, OTs, you know, all telling me that all they cared about was quality of care.* [KS1]

7.1.3 Maintaining the status quo: Competing voices and vested interests

"Bureaucracy defends the status quo long past the time when the quo has lost its status" (Peter, 1977, n.p).

Whilst the hardline position of some medical organisations and individual doctors against the NP role softened over the years, the AMA's opposition remains unchanged as graphically described by one NP.

> *I mean, the AMA kept up a constant stream of crap.* [NP6]

The AMA continued to reject the NP role, as evidenced by its *Position Statement on Nurse Practitioners*, first released in 1994, and re-released in 2005 (Australian Medical Association, 2005b). In addition to publishing letters and articles in medical journals and medical newspapers, the AMA also addressed the wider public and media in 1996. After the release of the *Final Report,* the AMA warned the public via media releases entitled *Nurse practitioner project flawed* (Australian Medical Association, 1996a) and *Branch rejects flawed nurse practitioner report* (Australian Medical Association, 1996b).

In May 2000, with the pending authorisation of the first NP in NSW, the AMA, RDA and RACGP released a joint position statement on NPs declaring that the NP role was based on "biased and unscientific research" and would "marginalise and jeopardise existing medical services". The Position Statement reported that doctors could be liable for NPs' practice. Interestingly too, despite doctors' demand for collaboration with NPs, the document raised concerns for the medico-legal implications because a "medical practitioner who refuses to be involved with the practice of a nurse practitioner could be joined as breach of duty of care." (Australian Medical Association, 2000)

However, the Chairman of the College's National Rural Faculty later declared that the RACGP's position since 1998 had been one of support for the role within a collaborative model but the College has not supported the concept of independent NP with access to their own Medicare provider number (Thompson, 2003, p. 1).

The AMA has appeared to maintain its portrayal of NPs as doctor substitutes as evidenced by numerous AMA media releases and articles (Australian Medical Association, 1994, 2001, 2002b). The media releases entitled *AMA rejects role substitution and task substitution proposals to address medical workforce shortages* (Australian Medical Association, 2005) and *Consumers fearful of nurses replacing GPs* (Saunders, 2003) are examples. These notions were picked up by the media. For example, a newspaper article was entitled *Doctor substitutes for a leaner health system* (Pollard & O'Malley, 2005).

The AMA's continued opposition to the introduction of NPs is amply evidenced in their media releases, over 20 of which were released between 1994 to the end of 2005 when the collection of media documents for this research ceased (see Appendix G). The AMA and the RDA described the arguments supporting NPs as "unscientific", "flawed" and "biased". They warned that NPs would "dumb down" health care because NPs are not as highly trained as doctors (Australian Medical Association, 2005a, 2005b); that they "lack medical education" (Australian Medical Association, 1994); "fragment health care" (Australian Medical Association, 2002a, 2002b) and should not perform "doctors' duties" (Bidinost, 2005). NPs have been described as a "dangerous alternative to doctors" (Australian Medical Association, 2005a); as a "cheap solution" to health care (Australian Medical Association, 2005e); as lacking training for a diagnostic role (Humphries, 1998) and not able to "cope at this intellectual level" (Overs, 1992).

Many of the stakeholders and NPs were concerned about the considerable political power held by the AMA. Several stakeholders commented that the AMA, despite having a membership approximating only 30% of the Australian medical population, has a powerful voice through its *well-oiled media machine* that several stakeholders described as *second to none.* [KS14]

Thus, overall, the fear and loss held by medical organisations, in particular, the AMA and individual doctors' was primarily concerned with fearing loss of clinical territory and income.

7.1.3.1 The counter balance to the sense of loss and fear

Despite media activity associated with the sense of loss and fear, nursing organisations implemented information and media strategies to counter the opposing campaign. The media activities of the nursing organisations began in response to the media and information generated by those with a sense of loss and fear.

The NSW Nurses' Association (the Association) has tended to be the main political voice for nursing and was actively involved in the development of the NP role. A stakeholder pointed out, however, that the media were not sure which organisation to approach regarding the NP role. Also, several stakeholders commented that the Association had not developed the media presence of the AMA at that point in time. She stated that unlike the Association, the media would automatically go to the AMA for comment because it was seen as the main voice for medicine.

> *Nursing hasn't developed that same skill. It hasn't invested in that same area and it is because there is no other voice in medicine that has got the same standing. What's happened in nursing is that, "Oh should we go the Association today or should we go to the College or should we go to the Department?"* [KS14]

Nevertheless, the Association played a vital role in the introduction of NPs in NSW. The Association's 1992 Annual Conference (specifically their Professional Day, which attracted approximately 800 members) was dedicated to the NP role, and entitled *Nurse Practitioners-Breaking New Ground* (NSW Nurses' Association, 1992). In 2000, the Association organised another one-day conference to provide an opportunity to fully inform nurses about the role. The Association noted that the "range of facts, figures, agendas and other influences" had added to the complexity of the role's introduction into the health care system

(Robeiro, 2000). While the Association had played a key role through participation in the NP negotiations, its magazine *The Lamp* informed nurses and others in NSW by providing updates. *The Lamp* was used for the dissemination of a substantial amount of information by the Association, other organisations and nurse leaders (e.g., Adams, 1999; Buckis, 2003a, 2003b; Holmes, 1994; Collins, 1996; Coxhead, 1992; Howard, 1996; Iliffe, 1996a, 1996b, 1997, 1998; McDonald, 1999, 2000; McKenzie, 2001, 2002; Meppem, 1995; Moait, 1996a, 1996b, 1997a, 1997b, 1998, 2000a, 2000b, 2000c; NSW Nurses Association, 1993, 1994a, 1994b, 1998, 1999; 2000a, 2000b, 2000c, 2001, 2002a, 2002b, 2003, 2004; Rebeiro, 2000; Reid, 2001; Spilsted, 1993; Staunton, 1992a, 1992b, 1992c, 1993, 1994). It also provided an avenue for nurses and other health professionals to debate and voice concerns related to the role (e.g., Denning, 1994; Russell, 1994) and receive clarification and explanation of the issues from stakeholders directly involved in its development (e.g., Meppem, 1994; NSW Nurses' Association, 1994).

I asked nursing stakeholders why there appeared to be little public response by nursing organisations to the AMA's negative portrayal of the NP. Several commented that any response would have been met with yet another response by the AMA and, therefore, would have been pointless. One stakeholder replied with exasperation:

> *Look, I think that what we have got to recognise is, without being afraid of them, the AMA is the most beautifully well-oiled political machine. They have invested in making sure they do their media scanning…. The AMA and RDA have got their media machine ready to roll the minute there is a hint of something going to happen, whereas everybody else has got to go into reactive mode…. They would have people in their office waiting for the first bit of news to come out they'd put out a media release.* [KS6]

The stakeholders view was substantiated by the media. The AMA responded rapidly to any announcements regarding positive developments in the NP role. For example, on 11th May 2001, the NSW Department of Health announced in a media release that the first NP position has been activated: *Nurse practitioner - An Australian first* (NSW Department of Health, 2001). On 15th May, the AMA responded: *Nurse practitioner is recognition of the state of health in the bush* (Australian Medical Association, NSW, 2001). On 5th September, 2002, the NSW Health Department announced the *Roll out of specialist nurse practitioners into metropolitan NSW*. On the same day the College of Nursing announced: *Nurse practitioners – A timely initiative* (College of Nursing, 2002a). However, the AMA's response was: *Nurse*

practitioner plan a disaster (Australian Medical Association, 2002). On September 5, 2002, the same day as its original announcement, the NSW Health Department was also drawn into the media battle with the AMA by responding with yet another media release: *AMA out of step with leading doctors* (NSW Department of Health, 2002b).

With time, and despite nursing stakeholders reluctance to enter a public media battle, it became apparent that nurses could no longer remain silent. For example, the College of Nursing (CON, and formerly the NSW College of Nursing]), a NSW based organisation and key stakeholder in the development of the NP, became a strong political voice for the NP. The CON disseminated information about the NP to its membership through its newsletter *Nursing.Aust*, and increasingly through media releases and articles in general newspapers. The CON began to respond to any inaccuracies that were made, particularly those of the AMA through media releases, general newspaper articles, letters to editors, and also letters in medical newspapers (e.g., College of Nursing, 1999, 2000, 2001a, 2001b, 2002a, 2002b; Lumby, 2001, 2002, 2003a, 2003b, 2005a, 2005b, 2005c, 2005d, 2005e, 2005f, 2005g).

Several stakeholders maintained that, while there had been some media interest, it was difficult to capture attention, especially during the early years. They commented that the media tended to pursue news from medical organisations such as the AMA or RDA rather than from nursing organisations, allegedly because doctors have been traditionally seen as the health care leaders (see Chapter 6). The media would seek information first from doctors and medical organisations because they were considered to be authoritative. Some stakeholders commented that the media believed that the AMA, for example, would provide information that generated public interest.

> *That's who the media went to. They went to the AMA and they went to the RDA, and they didn't go to the nurses to ask. They didn't go to the Nurses' Association or the Department to say, "Well give us some information on this." They went to the doctors because that is what gets the headlines.* [KS6]

The disparate visions for the NP role meant its introduction into the NSW health care system had to play out through negotiation and compromise. This process is described in the next section which also explores the compromises that were made, and their consequences.

7.2 Developing and implementing the NP role: Negotiation and compromise

The disparity in the visions and vested interests of the various stakeholders meant that the development and implementation of the NP role required negotiation and compromise from government level to clinical and community settings.

All stakeholders involved in the NP Steering Committee confirmed their awareness that the introduction of NPs would be a lengthy process owing to the controversial nature of the project and the disparate views about the role as mooted in the *Discussion Paper.*

> *The polarity of the responses to the Discussion Paper was such that clearly nothing was going to happen in a hurry.* [KS9]

One non-nursing stakeholder spoke of the complex nature of the NP Steering Committees. He commented that committees are most functional and efficient when they consist of members who share clear vision and direction. Certainly this was not the case with the NP Steering Committees. The following quotation attests to the tension that surrounded the first Stage 2 Committee meeting:

> *I learnt through rumours that there was a betting book being run… about how long the first meeting would last before people would walk out, and I was told afterwards… most of the money was on twenty minutes…. The first couple of sessions were very heated and were very difficult…. I recall on several occasions they almost came to physical blows because there was a real tension in the room around issues.* [KS17]

Because of the disparate visions and vested interests of those involved in the development of the NP role, it became a process of negotiation and compromise as the various stakeholders fought to maintain their vision.

7.2.1 Negotiation and compromise: Maintaining the vision

An important objective of this research is the disclosure of reasoning behind important decisions during the early development of the role. These decisions influenced the development and implementation. A letter by a nurse published in *The Lamp* highlights the writer's dismay over some of the concessions that were made, particularly those perceived to maintain nursing's dependence on medicine.

> I must confess to a great deal of disappointment on reading the contextual parameters [for the NP]. Despite concerted efforts to elevate nursing to the ranks of a true profession…. The arbitrary, hierarchical structure of the medical model will continue to hamstring nurses as viable, separate treating alternatives. (White, 1994, p. 4)

Both of the interviewed medical stakeholders perceived that the NSW Health Department had already decided to introduce NPs before the NP Steering Committee meetings. A medical stakeholder commented that he had only been asked to take part in the NP Steering Committee negotiations *so that they could then say that the rural's [GPs] been consulted* [KS16]. Because of their perceptions that the NP role would be implemented, the medical stakeholders' aim during the Stage 2 and Stage 3 negotiations was to try to limit the number of NPs and the scope of their role.

> *Look, there was a preconceived idea of what was going to go ahead, we just had to try, if you like, ruralise it, and put some breaks on it in the appropriate areas… so that you didn't have them galloping off into the sunset in their own little way.* [KS16]

The medical stakeholders' views that the NP role was a done deal [KS16] was disputed by a non-nursing stakeholder at state government level and closely involved in the development of the NP role.

> *I certainly wasn't under any direction to implement nurse practitioners in the State. I mean there was a degree of, um, obviously of assessing the risks by Government as to whether that was an area where they wished to go because of what's the gain for the pain, was the question to be had.* [KS10]

Another non-nursing stakeholder believed that the medical stakeholders' fear was due to their awareness of the success of the NP role in other countries.

> *So their fear, you can imagine going into this, their fear was that this was a political move because it has been legitimised in other countries, this really was an exercise to legitimise it in **this** country, so they could see the writing on the wall, that there was no way that it was **not** going to be legitimised.* [KS17]

Thus, it had become clear to them early on in the negotiations that compromises would be necessary, as for the political expediency for the inception of the NP role. Negotiations

would not otherwise have progressed or been successfully developed during the 1990s. Thus, the process of negotiation and compromise or *playing the political game* [KS7], was seen as essential.

Stakeholders credited the appointment of an independent Chair for the Stages 2 and 3 NP Steering Committee for progressing the NP role, given the disparate visions of the Committee members [KS9].

Stakeholders pointed out that negotiations surrounding the NP role were arduous and complex, with disputes over minute details and over language that could or could not be used in the State Government NP legislation and State Government policy. Nursing and non-nursing stakeholders noted that, while a few of the doctors were genuinely concerned with public safety, they believed that the doctors' main agenda was concerned with their supervision of NPs, constraining the NPs' practice, and restricting their geographical placement. Hence, the medical stakeholders focussed on policy relating to "collaboration" between NPs and doctors, the development of the NPs' clinical practice guidelines and local agreed need for NP positions.

> *I think some of that was around doctor's supervision and some other restraints or, local need. There were a whole bunch of new things put into it, guidelines, to control the breadth of the role and where it could actually occur.* [KS1]

For political expediency it was agreed to introduce NPs into rural and remote areas. It was believed that it would have been easier to introduce NPs into rural or remote areas because of the known existing need for their services. It was also accepted that, because of these localities' problems with health care, there would be less resistance to NPs in rural and remote areas [KS14].

State government stakeholder participants commented that they wanted no legislated restrictions on NPs because of the experience of the US, which highlighted the difficulty of changing legislation as opposed to policy regulation. Thus, local agreed need was *very deliberately* written into *The Framework for the Implementation of NPs* state policy rather than into state legislation [KS14]. Therefore, local agreed need has nothing to do with legislation [K514].

Many of stakeholders saw the requirement for the establishment of multidisciplinary groups to determine local agreed need for NP positions as a major concession. The AMA argued for a consensus by these committees before NP positions could be established. However, stakeholders believed that the need for consensus would have given doctors considerable power to obstruct the establishment of NP positions. This was one concession they were not prepared to make.

> *If you look at the Stage 3 report, we held out steadfastly for **not** to be unanimous that there was local agreed need, because we knew absolutely well that if it had to be unanimous, the AMA would have said 'no' every bloody time. You know, there is absolutely no way we would have moved that forward.* [KS9]

While disappointed with the stipulation for local agreed need, a nursing stakeholder pointed out that the policy may have helped ensure that NPs were placed into receptive environments. Organisations with a local agreed need had to ensure that there was a medical practitioner to support the NPs' practice.

> *But what we felt about local agreed need was that it really would have been unconscionable to put the nurse practitioner into an area where they have no support whatsoever. So even if local agreed need was not unanimous… she had to have someone to refer to. She had to have a medical colleague to say "Hey listen, these are the limits of my competency."* [KS 9]

This stakeholder highlighted how they unsuccessfully tried to avoid having the clinical practice guidelines written into legislation; although they successfully blocked a legislative requirement for NPs to use clinical practice guidelines. Again, the need for clinical practice guidelines was determined at the level of state policy. This stakeholder read from the NP legislation to illustrate her point.

> *The Director General may from time to time, **may**, - it's not mandatory - approve guidelines relating to the functions of nurse practitioners', so that's **not** mandatory language…. The guidelines **may**, include other matters including the functions of nurse practitioners, so this is all just giving you power to do what you want to…. It doesn't say that nurse practitioners **must** develop a set of clinical practice guidelines and follow them.* [KS14]

The State policy stipulated the involvement of doctors for the development of the NPs' guidelines and also in identifying the need for NP services through local agreed need. This policy placed doctors in the powerful position of being able to limit the number and deployment of NPs, and the scope of their practice. The doctors' power was unforeseen at that point in time, as discussed later in this chapter. A stakeholder commented that *it [the policy] has created a monster.* [KS14]

Several stakeholders also spoke of their frustration in having to undertake the Stage 3 Pilot Projects. A stakeholder believed that the AMA insisted on the pilot projects because the doctors believed the projects would not be successful

> *There is an article in here that actually argues that we[the AMA] have stopped nurse practitioners in New South Wales by saying we'll do the pilot projects, because we know the pilot projects will fail, there was interesting stuff like that.* [KS14]

Ironically it was the success of the pilot projects that ultimately made it more difficult for medical stakeholders to argue against the role.

> *Rather than end up in a battle we kept trying to find a way forward and their way forward was okay let's do some pilot studies, let's see if it works in New South Wales and it was annoying for them [the nurse KSs]. Because… we knew the research out of North America… demonstrated that nurse practitioners could do as good as safe and efficient job as anyone else.* [KS14]

At the time of the NP pilot projects, the health services in rural and remote NSW were undergoing a major restructure making the success of the pilot projects even more significant.

> *The Regional Health Services were just about to be split up into District Health Services in the rural and remote areas when we were trying to get projects up and running. We are talking about major organisational change happening. The health services were in total disarray. There would be first line managements teams changing over, the second line, the third line, they were all going for their own jobs. It was just crazy, so that was a really challenging time.* [KS14]

One area of particular disappointment expressed by the non-medical stakeholders was the lack of MBS and PBS reimbursement. A stakeholder recalled that it was realised fairly on in

the negotiations that they would be unsuccessful in achieving MBS and PBS reimbursement for NPs.

> *The Commonwealth Department of Health had 2 people [Stage 3 Steering Committee], both interesting. They were there because clearly the Commonwealth was looking at different models of care, but they were running the argument that nurse practitioners would be funded under Medicare over our dead bodies.* [KS14]

A stakeholder argued that the lack of MBS reimbursement for the NPs also meant that the historical dependence of nurses on managers and doctors for resources was maintained.

> *History has shown us that the development of nursing has been dependent on the resources held by managers and doctors…. This stems from the role of the nurse practitioner as an employee of the organisation rather than an independent practitioner.* [KS2]

Stakeholders also acknowledged that it would be difficult for NPs to move into the private sector without Medicare reimbursement privileges.

> *There is no access to reimbursement through Medicare or a similar scheme for the nurses. Now that is a real barrier to moving the role out of the public sector and that was always recognised as going to be a trap.* [KS4]

> *Medicare funding and there is no capacity for nurses to work independently out there unless people pay for their own services. Then it means they have all got to be employed by the doctors or health services, so the model potentially can't work very well.* [KS14]

They also commented that it would be difficult not only because of the associated costs, but also because the Commonwealth Government's close relationship with GPs (and the AMA).

> *I mean the next big thing that would really strengthen the nurse practitioner role is with their connectivity to Medicare, and their access to Medicare numbers but the Commonwealth are unlikely to call on that because it costs money but probably even more importantly in terms of politics of the Commonwealth, their major group they are trying to keep onside is the general practitioners.* [KS10]

During the early development of the NP role the then Federal Health Minister (Liberal Party) was known to be a traditionalist on the conservative side of politics. The Minister held a

traditional view of health care and was not supportive of the NP role. Thus, it was believed that MBS or PBS reimbursement for NPs would not be forthcoming under the Liberal Party.

> Australia does not need radical experiments in health care delivery. We need refinements and improvements that build on our existing strengths…. The Government supports the use of nurses in general practice as part of a team rather than as independent nurse practitioners. (Abbott, 2007a, p. 490)

Abbott continued: "Practice nurses have arguably been more effective than nurse practitioners in reducing 'doctor-centric' primary care because they have worked with doctors rather than independently of them in ways that respect the traditional leadership role of the medical profession" (Abbott, 2007b, n.p).

Several stakeholders at state government pointed out the significance of the political climate during the development of the NP. One such stakeholder pointed out that in March 1995, during Stage 3 of the role's development a state election led to a change in government from the Liberal to the Labor Party (See Appendix 1). Whilst there was continued state government support for the NP role, this stakeholder believed that the government was more intimidated by the AMA's influence (perceived or actual) on public opinion and opposition to the NP role.

> *I think there was a level of trepidation. Perhaps if it was like the second or third term of the Government when we had to deal with nurse practitioners we may not have been so worried about what the public would say. My own regret would be that we probably treaded a bit softly, worried about what they thought too much, and probably should have crushed it through. But…we were just trying to keep our fingers in as many dykes as possible to keep the ship steady.* [KS1]

Another stakeholder at state government level stressed that because nursing was appropriating to itself some of the role that was historically recognised as medical, there was concern that the introduction of NPs would lead to major industrial dispute led by the AMA, something the Government were keen to avoid.

> *That's where you've got to understand this, I mean the politics. Getting the legislation required a whole lot of hoops to be jumped through so that we didn't have doctors on the streets.* [KS10]

Nursing and non-nursing stakeholders described their disappointment and frustration as their original vision was diluted.

> *Over a long period of time the actual role of the nurse practitioner got watered down because of the political pressure and media pressure that they put to bear on it…. Some of the initial roles and responsibilities of the nurse practitioner weren't there by the time we finished.* [KS1]

A non-nursing, non-medical stakeholder also acknowledged disappointment that nursing stakeholders' vision had been watered down, but argued that it was unavoidable because of the competing visions and vested interests.

> *I think we met for about three and a half years I think from memory…. It would have been deemed to have failed if there was no consensus so in order to get the consensus we had to negotiate and sometimes negotiation meant that it watered down the original vision coming from the nursing profession.* [KS17]

However, despite all the negotiations and compromise the AMA decided not to sign the Stage 3 *Final Report*.

> *Ultimately it was the AMA that stood out and they were the only one that dissented in the final. It was almost a rehearsed performance. "No, we cannot support this under any circumstances. Yes, there may be evidence there but we don't support it." I think they tried to challenge the research processes,* ***but*** *it was pretty tough because they'd actually been supervising the research (laughs) processes and they were attacking their own credibility by doing that. I mean at the end of the day it was "Let's protect doctors."* [KS14]

Nursing stakeholders continued to apply pressure. As with the NPs, the stakeholders revealed that, overall they tried desperately to not lose sight of their long-term vision.

> *It is always keeping your eye on the long-term vision and what we are trying to achieve.* [KS17]

The findings highlight political growth of the stakeholders during the development of the NP role. Over time, individual nurses and nursing organisations increasingly banded together to increase their political strength through speaking with unified voice. The development of the NP role was credited with the political and professional growth of nursing.

7.2.2 The NP role and nursing's political growth

Whilst some of the nursing stakeholders and NPs were experienced with the politics of health care, others found the political battles associated with the NP role to be novel and demanding rapid adjustment. Some of the nursing stakeholders, and also the NPs, described how increasingly they grew in political astuteness.

> *You learn, you learn how to kind of be a bit more politically savvy.* [NP5]

> *I mean, we were learning politics, really, at that stage, it was a huge learning curve for us.* [KS9]

A nursing stakeholder at the state government level argued that the lack of united representation of nursing in Australia had long hindered the profession's development. Because of the strong political voice of the AMA, nursing stakeholders knew that they would have to resist disunity.

> *Let's keep our dirty washing out of the public sight which has always been one of the problems with nursing, that has been done spectacularly and that's where medicine really has done so* well. [KS14]

As such, nursing stakeholders recalled how they began meeting at one of the stakeholders' homes the night before each of the NP Steering Committee meetings. There they would confer in what became affectionately known as the *bitchin' kitchen*. These meetings ensured no disagreements between them during the Steering Committee meetings, and particularly in front of the medical stakeholders.

> *We used to caucus all of the nurses on the working groups, used to caucus [in the bitchin' kitchen]… the night before any meeting everyone came to my house, all the nurses, not everyone else…. Everything that was on the agenda for the next day we would talk through, and sometimes it was very, very heated because there was lots of opposing views… so what we would do, everything we agreed on we would put on the table the next day. Anything we disagreed on we refused to discuss the next day and so we'd simply say, sorry we can't discuss this now because we don't have a position on it.* [KS9]

At the beginning of the negotiations the key nursing organisations were individual silos with their own visions for the NP role. Stakeholders described how nursing became increasingly politically sophisticated during the development of the NP.

> *I think right at the beginning there were some people that were quite naive, I think that there were a number of silos within nursing that, um, clearly had to; I think there was a growth in sophistication over the time.* [KS14]

The various nursing organisations overcame their differences. *It is the pig that squeals the loudest* [KS9]. They described the coalition that developed among the key nursing organisations. This unity was significant in light of the history of political difference between some of the organisations.

> *The other thing that was going on that you probably need to appreciate, is that Pat Staunton [NSW Nurses' Association], Judith Cornell at the College [NSW College of Nursing] and Judith Meppem [NSW Chief Nursing Officer] were brokering a political alliance as well. So Pat, Head of the Association [NSW Nurses' Association], Judith Cornell at the College [NSW College of Nursing] and Judith Meppem at the Department [NSW Department of Health] were working much more co-operatively and strategically as a group…. It was, "Okay let's not have our stoushes outside," so there were multiple levels.* [KS14]

The growth in the nurse leaders' political understanding during the early development of the NP role was acknowledged by several of the state government nursing and non-nursing stakeholders.

> *I mean, one of the inspirational things about this whole thing was just how clever and united the nurses became.* [KS14]

A nursing stakeholder described how they had learnt some of the political strategies and manoeuvres from medical stakeholders during the NP Steering Committee negotiations.

> *Because that was exactly the stuff they were doing. I mean, that was exactly how they would come in. No, you know it hasn't gone through, can't, because it hasn't gone to Board. Hasn't done this, hasn't done that.* [KS9]

A nursing stakeholder pointed out that they initially argued for the NP role on its merits for nursing. They eventually realised that arguing for the role for the benefits of the role to the

health service was more effective and counteracted some of the medical stakeholders' objections.

> *If you say quality of care and cost, then you've got the two arms of the health system really covered.* [KS1]

In relation to the negotiations during the Stage 2 and Stage 3 development of the role, a non-nursing stakeholder at state government stressed avoiding a "battle" was central to the successful development of the NP.

> *If you stick to your guns just for principle's sake, it is not going to get through.* [KS7]

The NPs also spoke of their increased political knowledge.

> *I had been getting as much community support as I could, as well as get support from other factors, and just basically building up a lot of statistics to say this is why I think there should be a nurse practitioner.* [NP7]

Another NP described how she became increasingly active politically by lobbying GPs, managers and the community to apply pressure on the AHS to create an NP position. This NP highlighted how community support led to the position being created.

> *Well I went and talked to the GP and got his support and I went and talked to another manager and got her support, I mapped out a strategy with all of them about how we're going to do it and how we're going to get it through…. This particular town gets very feral, like they deserve something. They will work towards something and if the Area tries taking it away they get extremely feral. I then emailed the area CEO and a few other people saying, "What the hell's going on because I've got to make some career decisions?" and, ah, they actually got off their bums and did something about it.* [NP6]

It was evident from Hansard during the second readings of the *Nurses Amendment (Nurse Practitioner) Bill* (NSW) in the Legislative Assembly and in the Legislative Council that there had been substantial political lobbying of politicians by the nursing stakeholders, nursing organisations and the AMA. Throughout the readings, politicians referred to information about nursing and the NP role that had been provided to them by the NSW Nurses' Association, the NSW College of Nursing and other individual nurses and nursing

organisations (Legislative Assembly, 1998; Legislative Council, 1998). Stakeholders and NPs also described how they began asking politically connected colleagues to help in lobbying for the NP.

> *I was fortunate that we also had a member on the [hospital] Board who was a close colleague of Craig Knowles [State Parliamentary Lower House Member] and he really lobbied Craig Knowles as well.* [KS4]

A number of stakeholders stressed the important role that a particular nurse, who happened to be a Member of Parliament, played because of her political knowledge and help rallying political support.

> *Pat Staunton played a very key role as a Member of Parliament who had a lot of knowledge about the process…. She was very credible and whilst there were people who possibly didn't agree with her politics, her credibility, her background, her law degree… she was able to make to make a lot of ground for us.* [KS6]

Stakeholders described how they increasingly believed that they should not take the battles personally because it was part of the political grandstanding.

> *I learnt, obviously over time, people would grandstand and make a noise in meetings but they don't really mean it, it's not about you. They walk out and they pat each other on the back and have a giggle and say, "I got them that time didn't I?", I mean it is like a big charade.* [KS1]

A nursing stakeholder illustrated with a story how during negotiations the nurses had become much more politically shrewd. Some nursing stakeholders visited representatives of the AMA after they refused to endorse the Stage 3 *Final Report*. She described how during that meeting they told AMA members that it would be easy to inform the directors of nursing that it would be unacceptable for nurses to do doctoring tasks that were not part of their job description, and as such the hospitals would cease to function. She commented that the doctors were clearly unnerved and replied that they were going to protect their income and *if you get in the way we will squash you*. A colleague of hers, a doctor and politician, later argued that the doctor's response indicated that because the nurses "took on" the AMA, they were finally being treated as the doctors' equals.

> *He said "Well, [name], congratulations. They are finally starting to treat you as equals. He said, "This is the first time they have put their cards on the table and told you what the real issue is." He said, "You have really got them rattled."* [KS9]

Stakeholders described how they became increasingly skilled at choosing their battles. One stakeholder described how they made sure that the *surfboard is ready to go, and, Yes Minister, this surfboard will carry you to shore* [KS9]. She expanded on what she meant by this metaphor by recalling how the State Government faced an election under increasing public and media criticism about health care in NSW, particularly in relation to long waiting times in hospital emergency departments [KS9]. The then Health Minister was reportedly frustrated with the low numbers of NPs in positions in rural and remote areas at that time despite local agreed need having been identified in the Area Health Services [KS1].

These issues were seized upon by the nursing stakeholders to argue for the rollout of NPs into metropolitan NSW. However, a hospital management stakeholder who was involved in lobbying for NPs in metropolitan NSW was disappointed that it was mandated for each of the metropolitan AHSs to identify NP positions, describing it as *a very sad day for nursing*:

> *There was a lot of damage control that I had to do to get the medical staff in those teams to support the initiative…. What I really wanted to be an initiative became a directive. So I think that was very damaging for the* ***cause*** *of the nurse practitioner role.* [KS5]

A stakeholder acknowledged that while the decision to mandate the creation of NP positions in metropolitan NSW had caused local disruption, it facilitated a rapid increase in NP numbers. It also provided stakeholders with the opportunity to negotiate for more positions in the future. The introduction of NPs into metropolitan NSW disarmed the AMA's objections to NP positions in rural or remote areas.

> *The AMA could no longer say, "We will not have forty rural places," because suddenly we've got one hundred and bloody fifty in there in the middle of the metropolitan area…so whilst it may not have been how I would have done it personally, the flip-side of it was that what it gave us was wonderful middle ground to negotiate some more positions in the metropolitan area that we would not have had, had it not been for the Minister's decision to just do that.* [KS9]

Some of the stakeholders spoke about unexpected opportunities. One nursing stakeholder recalled a pleasant surprise during negotiations with a state government representative over the number of first NP positions into rural or remote NSW.

> *I said to [name] "Don't you dare, don't you dare accept any number less than ten. If we get ten up that would be really good"…. So we went in there [NSW Health Department] and I said, "What is the number in your head just tell us and I'll tell you if you've reached our bottom line." He said, "I can't come at anymore than forty." (Stakeholder laughs.) We both kept a straight face. We were silent for about thirty seconds. [Name of person] turned to me and said, "What do you think" and I said, "I think that's about it." (Laughs.) We told [name] later we would have settled for ten. It was very funny. We had a lot of those incidents. (Laughs.)* [KS4]

A number of the nursing and non-nursing stakeholders and NPs believed that overall, the numerous and valuable lessons learnt, and the political knowledge gained, during the development of the NP role played an important part in the political growth and evolution of professional nursing in Australia.

> *I think nursing is much more politically savvy. Is it the result of the Nurse Practitioner evolution? I think that's been part of it.* [KS12]

> *So I think what you are seeing is a political evolution.* [KS7]

The following section examines collaboration between doctors and NPs, although the NPs reported these relationships often to be more controlling or supervisory than collaborative. There was considerable disruption in professional relationships. The findings revealed considerable dissonance in the professional, personal and organisational commitments of some of the doctors and managers during the implementation of the NP role. These issues will now be discussed.

7.3 Collaboration: Co-operation or control?

Collaboration is a concept important to advanced practice and, so to the NP role. A stakeholder pointed out that it was difficult for nurses to collaborate with doctors because nurses' contribution is not always valued, nor are they always treated as equal partners.

> *Collaboration is around taking time to listen, to value, but to also ensure that you are an equal partner in decision-making, and it is often not the case.* [KS17]

An AMA media release demonstrates that doctors clearly see themselves as the leaders of primary health, and that other health care professionals function complementary to their medical practice: "The AMA supports GPs continuing to lead primary care and using practice nurses and allied health professionals to support the care of patients in a team approach" (AMA media release, 27 July, 2007).

Stakeholders and NPs pointed out that during the development and implementation of the NP role, medical organisations such as the AMA applied substantial effort to maintain the public's perception that doctors supervise nurses, as demonstrated in an AMA media release entitled *New MBS item needed to cover general practice nurses working under GP supervision* (Australian Medical Association, 2005).

The stakeholders spoke about the influence of the introduction of practice nurses on the NP role. Many commented that, while they held no ill feeling towards the practice nurses, they believed that the strong support of the practice nurse by the AMA complicated the introduction of NPs. Practice nurses were being introduced into NSW at the same time as the NP role. The AMA had strongly advocated for the practice nurse role as opposed to NP role as per its media release entitled *General practice nurses make perfect sense – but independent nurse practitioners don't* (Australian Medical Association, 2005a).

Stakeholders believed that doctors supported the practice nurse role because it maintained their control over nurses' practice. In addition, the doctors are funded and are paid for tasks undertaken by the practice nurse.

> *GPs embraced the practice nurse model because they are in control and they are employed by them… like the receptionists are, and they do what the doctor tells them. Some of them might work quite independently on the basis that they might do all the pap smears or they might do all the dressings and all that sort of stuff but, you know, at the end of the day, they work for the doctor, the doctor puts in the Medicare thing, and he gets the money and he pays the nurse. They are not working as a practitioner in their own right.* [KS6]

Stakeholders also believed that the practice nurse role accentuates the image of nurses as doctor's handmaidens.

> *Yes, the little doctor will be happy if he gets himself a fully funded handmaiden but what some of the GPs have done with those nurses is entrench them as a handmaiden, not given them any ability to practice autonomously.* [KS7]

Particular concern was expressed about how the AMA compounded the confusion surrounding the NP role by using the NP and practice nurse titles interchangeably.

> *I've written several articles in "Australian Doctor", the "Australian Doctor" was… purposely confusing practice nurses, nurse practitioner in one sentence they'd use them interchangeably.* [KS3]

In reference to doctors' efforts in maintaining the widespread perception that doctors supervise nurses, a NP commented that whenever she had a photograph taken by the media there was also a doctor in the photo, giving the impression that she (NP) was being supervised. This tendency was acknowledged by a nursing stakeholder.

> *I can't think of a photo that has been in the media where she [the NP] hasn't had a doctor standing next to her with a stethoscope around their neck so that to me just further perpetuates the whole dependence on medical support for a NP…. The media still portray the sentimental view of nursing.* [KS5]

This common media portrayal of nurses as doctor's assistants is evidenced by newspaper photographs, such as Figure 7.

Figure 7

Source: Sydney Morning Herald, September 6, 2002, p. 4.

Generally, the NPs' described their so-called collaboration with doctors, especially with those against the NP role as more controlling than collaborative.

In two key areas the State Government mandated the involvement of doctors. These were "local agreed need" for the implementation of NP positions, and the development of the NPs' clinical practice guidelines. It is important again to note that State Government policy limited NPs to rural and remote areas until the placement of NPs in metropolitan areas in September 2002. Thus, the majority of the pioneers' experiences of collaboration with doctors and others occurred in small population rural, remote or regional areas of NSW. Because of the need to maintain the pioneer NPs' anonymity I am not permitted to identify specifically the number of NPs who were working within each of the AHSs. A few of the NPs' experiences were similar because they were working within the same AHS.

Overall, the NPs' experiences suggest considerable exploitation by doctors, especially those against the NP role. The requirement for collaboration with NPs gave the doctors power and influence over NP numbers and their scope of practice and thus, their clinical effectiveness and efficiency. A few of the NPs reported that they felt they had less control and autonomy over their practice since becoming an NP because their scope of practice was often being determined by doctors, or others, outside of nursing. Some NPs believed there were more restrictions placed on their practice after they became authorised NPs, than when they were working as de facto NPs.

> *I actually did a lot more before clinically as well in the community before I had the nurse practitioner name tag on.* [NP10]

NPs reported a lack of control over the development of their guidelines. Several provided exemplar after exemplar to explain how some doctors with whom they were meant to collaborate to develop their clinical practice guidelines would assume the role of leader and takeover the guideline development. Some NPs were allowed little involvement in the development of their guidelines while others struggled to satisfy the onerous requirements demanded by the NP clinical practice guideline committee. Several NPs reported they had only seen the guidelines once before they were submitted by the clinical guideline committee for approval to the Director General at the NSW Department of Health.

The NPs revealed a range of strategies used by some doctors to limit the scope of the guidelines, and thus their scope of practice, or alternatively, delay their development. Several

NPs described their immense frustration as they were forced to spend hours developing overly concise and detailed guidelines that often became more like a step-by-step cookbook than a clinical practice guideline. The following statement highlights the difficulty an NP faced in developing her guidelines.

> *That is where the medical profession has it, because the nurses are trying to write* ***exact*** *guidelines and it is an impossibility…. They know you can't get a prescriptive guideline because the clinical decision is so grey. You know that they've set the trap. I think they've set the trap.* [NP1]

One of the NPs described her lack of control over her guidelines because she was directed by the doctor-led clinical practice guideline committee to develop a guideline for every clinical presentation, rather than a broad or generic guideline.

> *When we look at NSW… you have to work from approved guidelines that direct what we can do…. We have been looking at individual guidelines for every single presentation that comes in and that is just crazy, so that's been a bit of a problem… just another frustration.* [NP5]

Some NPs reported that the doctors who had substantial influence over the NP guideline committees were also dictating the number of clinical guidelines they were "allowed" to develop. Because the extension to the NPs' practice, for example, their ordering medications, referrals and tests, were determined by their guidelines, the NPs' practice was again being controlled and limited. The following account exemplifies a number of the NPs' experiences.

> *The guidelines are a very big issue…. At the last meeting… they say we haven't got the resources to produce guidelines…. We will only allow you girls to have one guideline…. If you want that you can have that, if you don't want that, have another one, but you can only have one…. Then we've got to review it, every three months…. It was just awful.* [NP1]

One of the NPs spoke about her frustration with the ridiculous situation of having to choose between the inclusion of the contraceptive pill or the morning after pill, but not both. In addition, medications supplied by NPs were not covered by the PBS. Area Health Services had to cover the cost of medications that were supplied by the NPs. Several NPs believed that some doctors used the cost of NPs' dispensing medications to garner support from some

AHS chief executive officers (CEOs) to limit the number of medications that the NPs could include in their formularies.

> *So they are going to review this guideline and all of a sudden doctors come around on this committee including this arse hole [CEO]…. He's sitting there alright, so well, this costs and all. No we don't need Maxalon…and costs it all. "Oh you don't need this, we'll have to rewrite this guideline."* [NP1]

One of the NPs described how a doctor on the clinical guideline committee kept changing the criteria. She believed that her struggle in getting her clinical guideline approved by the committee deterred other nurses who had considered applying for NP authorisation.

> *Yes, the guidelines are a huge barrier. See that's another arena where the goal post kept moving. You've put in the hard yards and you get there and…no the goal posts are over there and you go, "Oh no." and it makes a huge frustration…. It is also another reason why a lot of people say, "I don't want to go through authorisation… I don't have the energy for all of this."* [NP5]

Other factors contributed to the NPs' perceived lack of control over their guidelines. Lack of confidence through inexperience in developing guidelines may have diminished their confidence to challenge the clinical practice guideline committee. Several of the NPs who developed their own guidelines identified a lack of time and resources (as previously highlighted in Chapter 5, p. 164).

Several of the NPs reported that some of their medical associates who supported the NP role were embarrassed about their medical colleagues' behaviour. Several NPs described instances where the doctors helped them bypass their less cooperative colleagues. One NP working in a hospital acknowledged that a doctor had helped her choose other doctors for the guideline committee because they were identified as supportive of the NP role and thus would more likely be able to work more collaboratively.

> *I said to him [the medical director], " So who are we going to get on this guideline committee?" and he said, "I'll tell you," and he knew who the obstructors were, so we didn't put them on… and in many ways we chose who was on that group because we didn't want the obstructors on it.* [NP5]

In response to the obstruction experienced by the NPs in developing guidelines, a stakeholder pointed out that the NSW Department of Health abolished the need for clinical practice guideline committees in 2004. The NPs would develop their guidelines with individual stakeholders.

> *The politics of those committees was that they were utterly and completely unworkable …. In 2004 we put out a statement … they didn't need to form those committees, and what they had to do was… take it to each person, not to put them in a room together because there was no doubt you could pick them off individually.* [KS 9]

This nursing stakeholder went on to point out that the NPs found it easier negotiating with individual doctors.

> *They were actually much more reasonable, the nurse practitioners said, than when they got the doctors in the room and they started forming their own cliques.* [KS9]

The following section explores the disruption that ensued to existing professional working relationships during the early implementation of the NP role.

7.3.1 Changing relationships: Rocking the boat

The findings attest to significant disruption to professional-working relationships with the introduction of NPs. During the implementation of the pioneer NP positions some health care professionals were torn between their personal, professional and organisational commitments.

Several nursing and non-nursing stakeholders perceived that some of the AMA representatives on the NP steering Committees had experienced dissonance because their perception of the NP role changed.

> *I must say [name] who was the AMA representative really changed his view but it was only his personal view that changed not the AMA's view. They brought in a second representative for the AMA because they thought [name] wasn't being aggressive enough in his representation of doctors' interests and interestingly at the end of that process [name] left the AMA.* [KS4]

One stakeholder speculated that NPs who were members of an existing team may have had less difficulty in implementing the role than those who were new to that health care setting.

> *If, for instance, a member of that team seeks authorisation of the nurse practitioner, are they more successful where one of their own seeks authorisation? I would say to you that the relationship stuff would mean that person could be potentially more successful.* [KS14]

Most of the NPs had been working in other nursing roles in the same AHS and clinical setting before their authorisation or gaining an NP position. Once they were authorised and working as an NP, their identity among colleagues changed, along with some of their working relationships.

> *I mean, one of the things that we know about clinical teams is it is about relationships, so suddenly a clinical team has a foreign body dumped into the middle of it and it's a nurse practitioner. The immediate response is they don't trust them.* [KS14]

One NP commented that as soon as she put on her NP tag, her previous working relationships changed with the managers, doctors and to a lesser extent, with her nursing colleagues.

> *From a very early time it was very obvious that when I stuck my head up with my nurse practitioner tag on.* [NP10]

Earlier mentioned findings substantiate the AMA's and RDA's substantial influence on the doctors and managers working in the rural and remote settings. As a consequence, there was considerable disruption in the professional relationships between the NPs and the doctors with whom they had worked, often for many years. One stakeholder argued that disruption experienced among the more traditional working relationships was inevitable and that the *gain had to cause that strain* and that this strain would contribute to the natural evolution of the NP movement and also the delivery of health care services in NSW [KS10].

Some doctors' commitment to their profession took precedence over their commitment to their organisation and their community. An NP described how a GP admitted that, although seeing the benefit of the role to the delivery of health care in the rural and remote town, he

nevertheless could not support her because of the pressure and scrutiny he would have been placed under by the AMA.

> *He [GP] said it wouldn't be worth his while if the AMA knew that he supported me, and so it was very hard…. I mean people that really meant a lot to me that had backed away from me.* [NP9]

Several NPs reported that some visiting medical officers with whom they had worked for many years had threatened to boycott rural and remote town hospitals if NPs began working in their new role.

> *There are some interesting personalities. There are a few issues around ah, VMO's saying we will not come.* [NP3]

One of the NPs working in a small rural town had a particularly distressing response from some of the doctors with whom she had worked with for many years as soon as the doctors were informed that she would apply for NP authorisation. One of the GPs who worked in the small rural town held a prominent position on a medical organisation that vigorously opposed the NP role. She described the 6-month campaign that the GP waged, beginning with a petition. The NP read the petition to me (researcher). It asked community members, "If you had to make a choice between having a doctor's clinic in [name of town] weekly, or a nurse practitioner, which would you prefer?, sign here." She went on to describe the disruptive effect of this on the community. Some people felt considerable guilt and upset at having signed the petition. The patients asked why they couldn't have the GP and an NP. The GP's wife had told them that her husband would be sued if the NP made a mistake. Because of this ill-informed advice, some members of the community signed the petition. The NP spoke about the lasting effect the petition had on the small community because of threats by the GP that he would leave the community if the NP gained a position. However, the community was equally concerned that the NP would leave.

> *The community was being divided…. The next few days were spent reassuring individuals that I would not leave.* [NP1]

I asked this NP to confirm that the GP had been part of the consultation for local agreed need, because I had read a newspaper article in which he had complained about not being party to discussions about the NP position. The NP confirmed that the GP was part of the

discussions but the commitment to the role at management level was maintained despite this GP's objections. The NP also stated that this GP had told to her in private that the role sounded *like a good idea in practice* but had also told her: *If I agree with it publicly I'm on a diving board full of sharks…, the sharks being the other GPs*. She also highlighted that the GP told her that if she wanted to practice informally as an NP he would support her.

> *He said you do what you like and I'll cover you…. He told me to do whatever I wanted to do and he'd cover me. They were quite happy for me to do all this stuff illegally, it was okay then. But I wasn't happy.* [NP1]

A stakeholder commented that the AMA had strongly influenced GPs' lack of support for the NP role.

> *The AMA is still very, very powerful and there are lots of doctors who hear their scare mongering tactics. They are afraid* [KS9]

Several stakeholders claimed that some doctors had tried to intimidate nurses who may have been considering for NP authorisation. One stakeholder recalled how she had letters passed onto her by remote area nurses who had received letters from rural doctors informing them that if they applied for NP authorisation they would not be supported by the rural doctors. This stakeholder corroborated the adverse experience of the NP above.

> *I continued to get letters sent to me from remote area nurses who had letters sent to them from the rural doctors who said, "I will run you out of town," and one of them tried to do that to [NP name] and that tale has to be told at sone stage. I've got the letter that he wrote to her and then he got a petition up against her in the community. It was disgusting, really disgusting behaviour of a professional. Whatever he believed, it wasn't a way to go about it. It was quite immoral and unprofessional and it almost destroyed her.* [KS3]

Some of the NPs and stakeholders believed that nurses had been deterred from NP authorisation because they had seen or heard about the problems and unpleasant experiences of the NPs. They also believed that some nurses were unwilling to disrupt their existing working relationships, especially with the doctors.

> *I think it made a lot of nurses who were thinking about that being their career goal. Some were uncomfortable about, really was this the way forward if the medical staff were not going to be so supportive?* [KS5]

Some stakeholders argued that managers were also *loathe to push the case for NPs* [KS6] because it would *upset the apple cart* [KS10] in their local areas, in their relationship with the doctors, and their boards over which they believed the doctors had substantial influence.

A nursing stakeholder at state government recalled how she would visit the AHSs to speak to the CEO and senior nurses to help generate support the NP role. However, she recognised the need for more sustained support.

> *And that's what I used to spend a lot of my time doing, was talking to CEOs and senior nursing people about how important it was for them to support it, but of course I was one person in a place at a particular point in time. I would sit and talk to them and fly out of the town and things would revert back to normal.* [KS6]

One of the manager stakeholders believed that some AHSs had identified NP positions through local agreed need, not because the organisation supported the role, or because there was a need for the role, but through perceived pressure from the NSW Department of Health. This stakeholder stressed the importance of confirming organisational support before introducing an NP position. She described how she had sought confirmation of her organisation's support from the CEO.

> *So I guess that's where I began with the nurse practitioner role, um, I certainly clarified right at the beginning that I had the support of the CEO to pursue it.* [KS5]

One NP also highlighted the importance of organisational support. She described how she was experiencing obstruction by the GPs and, despite the espoused support by the organisation for the NP role, the organisation had been unwilling to support her materially. She claimed that, because she was the only NP at that time in her organisation, there was a considerable power difference between herself and the doctors. Thus, practical organisational support was critical.

> *I didn't want to tackle them [the doctors] one-on-one over it. It was more an organisational thing. I felt that the remedy was organisational.* [NP10]

One of the NPs provided an interesting insight into relationships in small rural towns. Some of the GPs who had been opposed to the NP role also had long-standing friendships because they had attended the same private school together. She stated that there *was a bit of a club*

between these [name of school] boys but a member of that community (not a doctor) who was very supportive of the NP role, had been the school captain. His influence as former school captain remained, as he was able quell some of the doctors' opposition. She stated: *I thought that was an interesting dynamic, really (laughs) that the school captain still had this sort of dynamic with them* [NP not identified for protection of anonymity].

A special source of disappointment for the nurse stakeholders and the NPs was the lack of support from many of the nurses in management. As with medical practitioners, there was a strong sense that nurses in management positions experienced dissonance between their professional and organisational commitment. The following statement indicates that nurses who were managers could have experienced dissonance if they supported the NP role when executives at Area Health level were not.

> *So their [managers'] loyalty and allegiances were less to nurses working in community-based settings and more to the loyalty and allegiance to the Executive, and if that became an issue of getting fellow members of the executive offside… then they're not going to be supportive of it.* [KS10]

As previously highlighted (see p. 67), during the implementation of pioneer NP positions, the NSW health system was undergoing a significant restructuring. The 17 AHSs were being reduced to eight, causing substantial disruption with flow-on effects for NPs. Some of the NPs had earlier formed close professional relationships with their managers, including CEOs, health service managers, directors of nursing and assistant directors of nursing. The restructuring led to some managers being redeployed, including to other AHSs, while other management positions became redundant. Several of the NPs mentioned that they had management support early during the implementation of their role, but this support was not forthcoming after the changes.

It was the stakeholders who pointed out the significance of the restructuring on the implementation of the NPs. Aside from the lack of continued support after a change in management, the stakeholders highlighted that, because some of the managers were new to their position, they may not have been acquainted with the early negotiations and were less knowledgeable than their predecessors about NP advocacy. Stakeholders believed that the NPs at that immediate time were not a priority because they were concerned with their new position and other priorities such as budget constraints.

One stakeholder believed that one of the biggest issues in the introduction of NPs in NSW was the *influence of being a nurse in a country town* [KS6]. Indeed, there was considerable discussion by the stakeholders and NPs about the disruption of working relationships in small country towns. Many NPs and stakeholders acknowledged the difficulty of introducing NPs into rural and remote areas where there was strong opposition from doctors. To take on the doctors entailed disrupting working relationships and, the wider community.

> *I know there were three or four of those rural nurse practitioners who didn't want to rock the boat…. It would have been a very difficult situation to be in.* [KS5]

Several stakeholders believed that, while the managers may have supported the NP role, it would have been particularly difficult for nurses and managers working in small country towns to have GPs threatening to leave the town if an NP was employed. KS6 stated that managers were in a predicament with doctors threatening to leave if an NP was employed.

> *If you were a CEO and you had a GP threatening to leave town, the only GP you have got threatening to give up his practice, that is a real hurdle.* [KS6]

GPs in small country towns enjoy status and power within their communities. An NP described how she had contacted the CEO to complain formally about the behaviour of a GP in relation to the NP role.

> *So he [CEO] rings me back and says, he says [name of doctor] can do what he likes out there. He is the doctor, and I got off the phone.* [NP1]

The NPs also experienced dissonance between their professional and organisational commitment. They wanted to shake off the constraints of their traditional nursing practice and improve the delivery of health care but were hesitant to disrupt the organisations in which they worked. There appeared to be several reasons for this ambivalence. As discussed in Chapter 5, the NPs felt a great responsibility for pioneering the role and its successful implementation. For this reason they hesitated to cause disruption and conflict within their small communities. One NP who was authorised but did not have a NP position spoke about limited employment opportunities in her small town. Conflict between health care professionals in small country towns is particularly difficult *so you don't want a situation where you burn your bridges.* [NP3]

Some of the NPs described how they gained acceptance from the doctors. Some negotiated with them to undertake some tasks that the doctors did not want to do.

> *I went to him and said, "What can I do, what would you like me to do?" He said, "I don't want to do any health screening or any immunisations. You can do all of those." So that's where we started.* [NP8]

For a few of the NPs, not rocking the boat required their relinquishing extended privileges they would have expected with the NP role. The following statement shows how one doctor maintained considerable control and influence over an NP's practice, maintaining the traditional, doctor's handmaiden relationship.

> *So he's been very good, um, because I really haven't been dispensing medication. That was the thing that was worrying him…. He's seen the guidelines. He's fine with the guidelines… I've politically stayed on the fence and I haven't rocked any boats… I haven't refused to do anything he's asked me to do.* [NP8]

Some of the NPs reported that trust with the doctors developed and increased with time. However, it appears from some NPs' comments that the doctors' trust was for them personally rather than signifying acceptance of the NP role. It is also possible that the GPs' expression of trust derived from their capacity to restrict NP's scope of practice.

> *I said to one of the GPs that I work with. This is this doctor that was so opposed to it, I said, "Have you found the nurse practitioner program as daunting as you thought it would be?" He said, "It's only because it's you and because we know you are so cautious and we trust you." I said, "I'm sure there are other nurses around." He said, "I don't know. I don't know about that." He said, "But we know you're cautious. I know we trust you." He told me that it was me, because he trusted me.* [NP10]

7.4 Summary of Chapter 7

This chapter has shown the disparate visions and vested interests that affected the development of the NP role. Those who supported the role saw its benefits for the health care system and for nursing. Medical organisations, particularly the AMA, RDA and, to a lesser extent, the RACGP were powerful voices. The vested interests of those arguing for the status quo, the development and enactment of the role was an arduous and often frustrating process of negotiation and compromise. For political expediency to keep the negotiation

moving it was agreed upon to only rollout the NPs into rural or remote areas. It was also believed at that point in time that it would have been easier to introduce NPs into rural or remote areas because of the already identified need for improved health care but left open the option to later expand NP services into metropolitan areas. Stakeholders saw compromises as insidious and disappointing. They saw compromises as diluting their vision because they restricted the NPs' practice. Particular compromises were: the lack of MBS/PBS reimbursement for NP services and doctors involvement in identifying local agreed need and the NPs' clinical practice guidelines. These compromises were necessary to keep negotiations moving and achieving the wider aim of introducing NPs into NSW. Despite the negotiations and compromise, the AMA would not sign the *Final Report*. However, the introduction of NPs into NSW still went ahead.

Although some of the nursing stakeholders and NPs had previous experience in the political processes of health care, the NP role was a novel challenge because of the vigorous opposition it faced. As the NP role was being developed and implemented, the nursing stakeholders' political knowledge and confidence increased. They became more politically aware in their negotiations, especially with the medical organisations. Individual nursing stakeholders united and the nursing organisations formed a coalition who spoke with one voice and vision.

Nursing organisations initially concentrated on sharing information about the NP role only within the nursing profession. Stakeholders involved in the early development of the role believed that there was no value in marketing the NP role because the public would not be interested until, they themselves, were treated by a NP.

The media processes of the AMA were much more sophisticated than those of the Association or the College of Nursing. Nursing organisations hesitated initially to get involved in public political conflict with medical organisations. However, they increasingly realised that they must respond to the inaccuracies.

As the nursing stakeholders' political nous increased they capitalised on broad health care issues and how they could be addressed by the NP role. For example, health care concerns assisted the stakeholders arguing for the rollout of NPs into metropolitan areas.

Two significant restructurings of the AHSs occurred during the early development of the NP role, one during the pilot projects, and the other when the NP role was first implemented into

the clinical settings. The restructuring threw the AHSs into dissaray. A new State Government hesitated to take on the AMA and was also dealing with other health care issues during Stage 3 of the development of the role.

Doctors' involvement in identifying local agreed need was used to limit NP positions. NPs' clinical practice guidelines also appeared to be used to constrain the NPs' scope or practice.

The findings record the dissonance in the professional and organisational commitments of managers and doctors during the development and implementation of the role. The AMA's and RDA's collective and substantial influence in rural and remote areas was not fully appreciated during the early implementation of the NP role.

The findings revealed the complexity of relationships in small rural or remote communities. The NPs reported that as soon as they used their NP title their existing relationships changed. Managers were caught between supporting the NPs and the GPs threatening to leave town. Long-term professional relationships between the NPs, nurses, doctors and managers were disrupted. Some health service managers were caught between supporting the NPs and the GPs threatening to leave town. NPs had to decide whether to take on the doctors, or avoid provocation.

NPs who revolted against the doctors were met with hostility but NPs valued their existing professional relationships. Some NPs in rural or remote areas were hesitant to confront doctors because of the expected disruption to their communities and preferred stability above all else. Some NPs reported that GPs accepted their practice on the basis of their personal qualities rather than the NP role itself.

Chapter 8 – Discussion

This chapter brings together the key learnings and ideas generated from this thesis. It sets out to position the lessons learnt from the first 15 years of the development of the NP role into the current political and policy debate in relation to NPs. In addition, it seeks to explore political and policy issues in general for the betterment both of nursing careers and the contribution of nurses to health care.

During the writing of this chapter a new Australian national regulatory scheme for nurses and midwives was about to be introduced and thus a number of my contemporary references may be subject to change because of the political nature of the negotiations that are currently in play at national level in relation to nursing roles and nursing work. Notwithstanding this caveat, there are still lessons that can be learned from the introduction of NPs into NSW, a significant historical development for nursing. I have grouped these lessons into three key areas for the purpose of concluding this thesis while acknowledging that all three are inter-related and that the organisation of the material is also therefore to some extent interchangeable. These three lessons are centred on: the political development of nursing in the politics of health care; preparing for changes in the health workforce (or indeed any other key political event in health care); and pragmatism in the politics of health care.

8.1 The political development of nursing in the politics of health care

Politics is defined as the "social relations involving authority or power" (Webster Dictionary, 2001). Politics and the practice of NPs have long been intimately connected (Wysocki, 1990). The political sensitivity of the NP role was certainly evident in this study's findings and it is fair to say that the development and implementation of NPs into the NSW health care system has been tortuous. Only because of the resilience and perseverance of the nurse leaders, NPs and others who supported the role, has the NP movement been able to continue to gain momentum in NSW, and elsewhere in Australia.

One of the principal findings of this study has been the political maturation of the nursing stakeholders during the development of the NP role which, in turn, has benefited nursing. A useful model for understanding this growth is through the model of Cohen, Mason, Kovner, Leavitt, Pulcini and Sochalski (1996) See Table 10. Cohen et al. proposed their framework

as a way to analyse previous accomplishments and plan future actions to enhance the political development of nursing as it seeks to improve the delivery of health care. As shown in Table 11, Cohen et al. conceptualised the political development of the nursing profession into four categories. These are: Nature of action, Language, Coalition building and Nurses as policy shapers. These categories are further divided into four political development stages: Stage 1 (buy-in), Stage 2 (self-interest), Stage 3 (political sophistication) and Stage 4 (leading the way). It will be shown how actual events in the development of the NP role in Australia can be interpreted via the Cohen et al. model. The Cohen et al. model is prescient in relation to the development of the NP. Hughes (2003) building on the work of Cohen et al. (1996) added another category, namely, "building relationships" which is also divided into four political developmental stages. This additional category will also help to shape the ensuring discussion, which will use the five categories as headings to discuss the political development of nurses in NSW during the introduction of the NP role.

Table 11 The progress of nursing through four stages of political development

	Stage 1 Buy-in	**Stage 2 Self-interest**	**Stage 3 Political sophistication**	**Stage 4 Leading the way**
1. Nature of action	Reactive, with a focus on nursing issues.	Reactive to nursing issues (e.g. funding for nursing education) and broader issues (e.g., long-term care and immunisations).	Proactive on nursing and other health issues (e.g., nursing's agenda for health reform).	Proactive on leadership and agenda-setting for a broad range of health and social policy issues.
2. Language	Learning political language.	Using nurse jargon (e.g., caring, nursing diagnosis).	Using parlance and rhetoric common to health policy deliberations.	Introducing terms to reorder the debate.
3. Coalition building	Political awareness; occasional participation in coalitions.	Coalition forming among nursing organisations.	Coalition forming among nursing groups; active and significant participation in broader health care groups (e.g., task force on health care reform).	Initiating coalitions beyond nursing for broad health policy concerns.

	Stage 1 Buy-in	**Stage 2 Self-interest**	**Stage 3 Political sophistication**	**Stage 4 Leading the way**
4. Nurses as policy shapers	Isolated cases of nurses being appointed to policy positions, primarily because of individual accomplishments.	Professional associations get nurses into nursing-related positions.	Professional organisations get nurses appointed to health-related policy positions.	Many nurses sought to fill nursing and health policy positions because of the value of nursing expertise and knowledge.
5. Building relation-ships (Hughes, 2003)	Identification that there is a problem in one's relationship with others. Recognition that relationships are integral to development.	Learning occurs in regard to oneself and one's organisation that relationships need to be built, networks are established.	Groups or individuals are categorised for their ability to problem-solve and manage relationships. Coupling or joining other groups (bandwagoning) occurs.	Relationship styles and process are modelled by other groups. A new strategic approach is developed, which other's follow. Strategic alliances are common.

Sources: Cohen et al. (1996) p.260; modified by Hughes (2003), p. 46.

8.1.1 Nature of action

As highlighted in the literature review, there were a number of significant political agendas affecting health care delivery in NSW, for example, projected staffing shortages and changing demographics, before and during the development of the NP role. These are discussed in detail in chapter 2, p. 68). These issues persist. The NSW health care system is under pressure with limited resources to deliver high quality services to more users with increasingly complex conditions (Williams, Chamboyer, & Patterson, 2000). There are multiple workforce issues on the political agenda such as the ageing of the nursing and medical workforce (Garling, 2008), and doctors moving into specialist practice from general practice (Garling, 2008). Geographic distribution of doctors is uneven, particularly with a shortage of GPs in rural and remote areas (Department of Ageing, 2008). In contrast to the distribution of doctors, the nursing workforce is more evenly spread (Australian Institute of Health & Ageing, 2008). At the time under consideration in this study, the NSW Government's attention turned to using the existing workforce more efficiently and effectively to help address these problems, and here the NP role was seen to contribute, as highlighted by the pioneer NPs and stakeholders in the current study.

During the early years, nursing stakeholders acknowledged that, although they were concerned about health care and understood the benefits of the NP role for health care, they initially argued the benefits of the NP role for nursing (See Chapter 7, p. 221). In terms of Cohen et al.'s (1996) framework the nursing stakeholders entered the NP debate at Stage 1 of political development because the nursing leaders' main concern was the benefits for nursing, a benefit internal to the profession. Over time, as the nursing stakeholders became more politically astute, their arguments for the role broadened to make overt and explicit their concern for the wider health agenda. The vision for the NP role integrated with the vision of the NSW health care system through arguing the general value of NPs to improve health care delivery, rather than just to improve the lot of nurses. Arguably at this point nursing rhetoric moved into Stage 3 of Cohen et al. al.'s framework because the NP role was seen as a way to help address some of the problems facing the health care system, as described above.

8.1.2 Language

The findings revealed the importance and influence of language in introducing a new nursing role such as that of the NP. There was confusion surrounding the use of certain terms within and without nursing and this was seen by the nurse leaders and NPs as a significant barrier to the development of the role. These language difficulties will be explored in relation to: explaining the nature of nursing work; shared and contested concepts such as diagnosis; the debate around the importance of nursing having its own language; the concept of advanced practice and the misuse and manipulation of the requirement for collaboration.

Perhaps for the first time in many years, nursing stakeholders advocating the NP role were required to explain the nature of nursing work to a broader audience than the nursing profession itself. Evidence from the current research attests to the confusion occurring among those outside nursing in reference to the language that nurses used (see p. 178). Stakeholders outside nursing described the language that the nurses used as jargon or *nurse speak*. Nursing jargon was said to impede communications between those within and others outside nursing. Cohen et al. (1996) places the use of nursing jargon in Stage 2 of political development because, as in the current study, nursing jargon can stall the nursing agenda.

Cohen et al. (1996, p. 261) tell of the dangers of nursing jargon in policy discussions. In the US, nurses were lobbying for changes to practice acts. In doing so they used the term

"nursing diagnosis." Because the term was not commonly understood by those outside nursing, the nursing lobbyists were required to define the term as it was used by nurses and also to differentiate medical from nursing diagnosis. Use of terms that have common meaning might have prevented the confusion in the first place (Cohen et al., 1996).

It has been argued that language that is seen to belong to a particular group identifies membership, promotes power and authority and excludes others from using it (Allen, Chapman, O'Connor, & Francis, 2007). Ironically, (and contrary to the experience of Cohen et al. above), in NSW the debate between the doctors and nurses became heated when the nursing stakeholders attempted to adopt any language that was considered by medical practitioners to be exclusive medical terminology. A classic case in point was the use of the term *diagnosis*, (See Chapter 6, p. 178), with the AMA defining diagnosis in its policy statement as the "sine qua non of the medical profession" (Australian Medical Association, 1992). Such a claim of linguistic ownership shows how terminology can be embedded in traditional viewpoints.

These countervailing views over the use and/or ownership of language go to the heart of discussions about effective communications. It is a widely held belief that for effective communication to occur, words have to have shared meaning (Duffield & Lumby, 1994; Hardy, 1988;Thompson, Watson, Quinn, Worrall-Carter, & O'Connell, 2008). However, there are two opposing views within nursing in relation to the language it uses or does not use. On the one side are those arguing that nursing should maintain its own identity with its own language (e.g., Walker, 1997). On the other side are those who believe that nurses should use more universally understood language (e.g., Thompson et al., 2008). These opposing views are briefly explored below.

On the one hand, those who argue for nursing's own identity in language point out that nurses have uncritically taken on board the powerful "biomedical scientific jargon" (Walker, 1997, p.10**)**. Walker rejects the notion of nurses using only language that is easily understood (common usage), viewing such a stance as "anti-intellectualism". It has also been argued that those who insist on others using clear language so that it is universally understood shifts the focus of the language (and consequently the power) from those who speak it, to those who listen (Giroux, 1992). There is also a question about who determines what language passes for clarity and who decides what language is easily understood (Walker, 1997).

It has been argued that nursing's body of knowledge has not been communicated in a way that promotes understanding of the complexity of nurses' work. The danger with this lack of communication is that nurses' work will continue to be invisible and devalued (Duffield & Lumby, 1994). Nurses will be seen to function more as task-oriented technicians than professionals providing complex care. It is increasingly important for nurses to convey the complexity of their work they do and also describe and demonstrate the overall contribution of that work to health care. Nursing's political growth has moved it into a world in which nurses must communicate their contribution, not only to nursing but also to health care, from the hospital board to the government level (Cohen et al., 1995). Consistent with Cohen's (1996) assertion, stakeholders in the current study (See Chapter 6, p. 178) increasingly realised the importance of using "shared language" when speaking with those outside nursing, not only to facilitate communication within health care teams, but also to help explicate nursing's contribution to health care and positive health outcomes.

As a compromise to these two stances, it has been suggested that nurses and doctors should use *interdisciplinary terms* and language that is mutually understood to enhance communication between the two professions (Milligan, Gilroy, Katz, Rodan, & Subramanian, 1999). However, as highlighted by the findings in the current study there was considerable confusion over the language that was used in the introduction of the NP role not only outside nursing but also within. This was particularly evident in the debates about advanced practice

8.1.3 Advanced practice

While the NP role is underpinned by the notion of advanced practice (Anderson, 2004; Chiarella, 2006; Carnwell & Daly, 2003; Cleary, 2002; Davies & Hughes, 1995; Gardner, Chang, & Catling-Paull, 2009; Gardner Lorentzon, & Hooker, 1996; Schober, 2006; Sutton & Smith, 1995) the international literature reveals uncertainty about its meaning (Betts, 2007; Buchan & Calman, 2004; Castledine, 1997; Daly & Carnwell, 2003; Kilpatrick, 2008; Mantzoukas & Watkinson, 2007; Mathieson, 1996; Trim, 1999; Woods, 1999a, 199b). The findings from this study reflect this confusion. Communication has increased in speed and scope and as such nurses around the world can rapidly share information and ideas (Jamieson & Williams, 2002; Rosenau, 2004). Australia adopted the term *advanced practice* from the US (Duffield, Gardner, Chang, & Catling-Paull, 2009; Gardner, Hase, Gardner, Dunn, & Carryer, 2008; Sutton & Smith, 1995) but, as found in the current study and as

reported by others (e.g., Jamieson & Williams, 2002; Sutton & Smith, 1995), the term was not widely known or used (especially by clinical nurses) in Australia during the early development of the NP role. The findings in this study also show that the lack of a clear and consistent definition of terms such as *advanced practice* led to considerable lack of clarity in advanced role articulation, as also argued by Dunn (2002b).

The deleterious effect on the development of the NP role through the lack of definition of terms such as advanced practice was not fully appreciated at that time. However, defining the term was later seen as an important next step to provide a foundational understanding of the general concept of advanced practice for future NP role development (Jamieson & Williams, 2002). Unfortunately, because of the lack of national nursing regulation at that time, each of the Australian state and territory professional nursing bodies independently sought to develop their own definitions, that then led to multiple and inconsistent definitions of advanced practice (Jamieson & Williams, 2002). Thus, a nationally accepted definition of advanced practice was increasingly seen as essential, at least to provide a common genesis but also to be contextualised to the specific practice environment in which the NP role is developed (Jamieson & Williams, 2002).

Finally, in 2006, the Australian Nursing and Midwifery Council included a definition of advanced practice within their national competency standards for nurse practitioners (see p. 180). Given the confusion about the definition of terms in the development of a new nursing role such as the NP, it appears that providing nationally consistent definitions to terms such as advanced practice early in the NP role's development could only have helped alleviate the uncertainty. However, as shown above, in the example given by Cohen et al. (1996), attempting to define contentious terms with those outside nursing may cause further problems. Thus, it seems important for terms to be defined by those within nursing before entering into discussions to avoid long and arduous debates over the meaning with those outside nursing. It is acknowledged, and as pointed out by Diers (2004, p. 133) that, "any definition of something as dynamic as nursing" will always be incomplete. Further discussion relating to the NPs' advanced practice is provided in the section later in this chapter on "Preparing the NPs."

Another aspect of development in relation to language is its tactical use, as the skilful use of language can be an artful strategy of argument (Seal, 1999). Because of the confusion surrounding the meaning of advanced practice, some NPs and stakeholders felt that the

AMA was able to gain momentum in representing NPs as substitute doctors. A further point of contention in relation to language was (and continues to be) the misuse of the concept of collaboration as described below.

8.1.4 Collaboration

Study findings also showed that, while some doctors and medical organisations espoused their support for collaborating with NPs, the reality was very different to that envisaged by the nurse leaders and NPs when they agreed to the doctors' requirement for collaboration (See discussion on collaboration: co-operation or control, p. 247). The findings provide evidence that mandated collaboration between doctors and nurses is problematic when doctors distort the concept for their professional advantage rather than to improve health care, as earlier identified by Price (1998). Collaboration between NPs and doctors, as discussed by the study participants, was not so much about partnerships or teamwork but rather about doctors continuing to control and supervise the NPs' practice, albeit under the guise of collaboration. Thus the expectation for the NPs to collaborate with doctors in the development of their clinical practice guidelines was fraught with problems. Under the pretext of collaboration doctors attempted, and in many cases succeeded, to constrain the NPs' scope of practice significantly, at times to the extent that they were rendered useless.

Multiple factors acted against the doctors and the NPs working in productive collaboration. Barriers to collaboration related to values, norms, culture, traditions, power and hierarchy (see p. 225) and the perceived or real threat of NPs to doctors' income (see p. 226). Scholars argue that effective collaboration must be non-hierarchical and allow the autonomous functioning of those involved (Boswell & Cannon, 2005; Lindeke & Sieckert, 2005; Sweet & Norman, 1995; Willis, 1989). However, as shown in this study, (see p. 195) proper collaboration proved difficult owing to the inconsistent conceptualisations and theoretical underpinnings between nursing and medicine, as also highlighted by Milligan, Gilroy, Katz, Rodan, and Subramanian (1999). As evidenced in the findings, and as illustrated in the following statement by a doctor in a Sydney newspaper, collaboration between medicine and nursing in Australia still has some way to go.

> Nurses of today are well-educated young women and men who expect to be treated as colleagues of the doctor. This is an unrealistic expectation. They cannot be treated as colleagues-they are not colleagues…. The modern nurse has difficulty relating to the basic yet most important needs of the patient…with a partial

> knowledge of medical procedures and virtually no knowledge of practical nursing procedures, I think "medical mechanic" would be fitting for today's nurse" (Pembroke, 2005, p. 6)

The finding from this study that doctors and nurses perceive collaboration differently is not unique. It has been reported in several studies and in various settings (Baggs, Ryan, Phelps, Richeson, & Johnson, 1992; Baggs & Schmidt, 1997; Copnell et al., 2004; Grindel, Peterson, Kinneman, & Turner, 1996; Henneman, Lee, & Cohen, 1995; Price, 1998). As also revealed in this study (see p. 195), a number of authors suggest that nurses and doctors differ in what they consider to be collaborative behaviour (Baggs & Schmidt, 1997; Copnell et al., 2004; Jones, 1994; Keenan, Cooke, & Hillis, 1998; Wells, Johnson, & Salyer, 1998). An Australian study found that doctors consistently reported a higher degree of collaboration (between doctors and nurses) than did the nurses (Copnell et al., 2004).

In concluding the discussion on the use of language within Cohen's model for political development, the findings highlight the importance of nurses using language that is understood not only within, but also beyond the profession. While the nursing leaders realised that they would have to use parlance and language common to health policy deliberations during the NP Steering Committee discussions forward (Stage 3, political sophistication) confusion about the meaning of terms applied to the NPs' practice remain. If nurses could not or did not agree or understand the meaning of terms they applied to their own practice, they have little hope in educating others about what they do, and convincing others of the importance of their work. To move the language that nurses use to Stage 4 of political development, Cohen et al. argue that nurses and nursing need to introduce terms that reorder the debate. Nursing must deliberately and aggressively articulate clearly the NPs' contribution to health care. To do this, nursing needs to reach audiences that extend beyond its own membership in language that is easily understood. This issue is further discussed in the section below entitled *Relationships*. Finally, it is recommended that with any new role, nursing needs to define the terms that it uses to avoid misinterpretation about their meaning. This will help to avoid the confusion, misinterpretation and abuse of terms by those outside nursing as experienced in the development of the NP role, particularly in relation to the term "collaboration."

Cohen et al. (1996) propose coalition building as a critical component in the political development of nursing and this is discussed in the following section.

8.1.5 Coalition building

The findings highlight political growth of the nurse leaders during the development of the NP role. While many of the nurse leaders and, to a lesser extent the NPs, were politically aware, they found the political battles associated with the NP role to be different from any they had previously experienced and demanded rapid adjustment and political growth.

In relation to coalition building, Cohen et al. (1996) argue that the proliferation of nursing groups has led to growing recognition of the importance for nursing groups to work together, or at least show a united front for the advancement of nursing's political base (Stage 1 - political awareness). During the very early stages in the development of the NP the nurse leaders representing the various nursing organisations realised that to progress the negotiations, and because of the powerful opposition from medical organisations, particularly the AMA, they would have to unite (see p. 242).

A significant event in nursing's political growth was the coalition-forming of the key nursing organisations during the development of the NP role, moving into Stage 2 of political development. Historically, nursing organisations in Australia functioned independently, each with their separate political agendas. For the sake of the NP movement, the NSW Nurses' Association, the NSW College of Nursing, the Nurses Registration Board of NSW and the Office of the Chief Nursing Officer (OCNO) of the NSW Department of Health joined in coalition (See Chapter 7, p. 243) strengthening the NP movement's voice during the early development of the role. Having formed a coalition, the nursing stakeholders were more effectively able to argue the case for the NP role that reflected the nursing profession to the legislators and others during the deliberations, moving the development of the NP role to Stage 3 (political sophistication). It is also important to note here that, while each of the nursing organisations had their visions for how the NP role would be enacted, they all strongly supported the role and this doubtless facilitated the success of its development.

The NSW College of Nursing played an integral role in the formation of the ACNP (see p. 135). Rather than forming a state chapter the College successfully argued for a national organisation to give the NPs a united voice and greater political strength [KS3].

For the future political development of the NP role, coalition-building could also extend to organisations other than those immediately involved in the NP role. For example, coalitions might include specialist nursing organisations and nurse academics within the university

sector who could help counter statements from the AMA, such as its claim that nurses lower the standard of health care. It is anticipated that nursing coalitions will continue to form as the NP role continues to be implemented Australia wide.

Stage 3 of political development also involves nursing groups forming coalitions with other groups outside nursing. It was when the nurse leaders called on the support of the specialist doctors during the appointment of NPs into metropolitan NSW when specialist doctors explicitly acknowledged their support for the role (See chapter 7, p. 206).

The ACNP has recently begun forming coalitions with groups beyond nursing. For example, the organisation along with other nursing groups such as the Australian Nursing Federation and College of Midwives has recently joined the Australian Health Care Reform Alliance to become more proactive in a broad range of health policy concerns. This coalition consists of 46 organisations representing consumers and health care providers advocating for a fairer and more effective health care system (Australian Health Care Reform Alliance, 2010).

8.1.6 Nurses as policy shapers

In relation to nurses as policy shapers, Cohen et al., in their article (although not explicitly in their model) make the link between the different stages of political development and state and federal government engagement. Stage 2 of political development is described as encompassing nurses who work at the state level to organise and lobby for changes in laws and regulations that promote the advancement of nursing. Stage 3 relates to the appointment of nurses to panels at the federal level of government.

At the time of the development of the NP role, nursing in Australia contributed to health care policy at the State Government level through the NSW Chief Nursing Officer (CNO) and individual nurse leaders. It was the political voice, vision and leadership of the then NSW CNO and other nurse leaders that led to the legislation and regulation of NPs in NSW.

However, there was no CNO in the Federal Government's Department of Health and Ageing, or any other Federal Government department. The Federal Liberal-National party coalition had been in office since 1996. Under the coalition the Government's consistent position was for the Chief Medical Officer (CMO) to advise on matters relating to nursing (Iliffe, 2004). Thus, in the early stages of the NSW negotiations with the Federal government on matters relating to the NP role, such as the important issues of access to MBS and PBS,

the Federal government could have been primarily advised by a doctor. In addition, it was the Federal government's position that nursing was a state matter, not a Federal matter. The Federal government's policy represented an antiquated view of nursing that Australian nurses found particularly insulting (Haines, 2005). It was therefore unsurprising that the then Federal Health Minister was of the opinion that nurses should respect the traditional leadership role of medical practitioners in health care (see p. 240). Had there been a national CNO during the early development of the NP role, the nurse leaders may have had more success in arguing for PBS and MBS reimbursement for NPs, amongst other policy matters.

The Australian Nursing Federation, along with other peak national nursing organisations had long lobbied for a national CNO position (Iliffe, 2004). In 2007 the new Federal Labor Government appointed Ms. Rosemary Bryant as Australia's first Chief Nursing and Midwifery Officer (CNMO) on 22 June 2008 (Department of Health & Ageing, 2008b). This was a significant victory for nursing and midwifery and was widely celebrated in Australia. At last there would be a voice for nursing and midwifery both nationally and internationally rather than only at state and territory jurisdictional level. However, there is still some work to be done to bring the CNMO position on par with that of the CMO. On comparing the press releases of the CMO and CNMO positions, the CMO is described as "playing a key, strategic role in developing and administering major health reforms for all Australians" (Department of Health & Ageing, 2009e, n.p), whilst the CNMO is described as a " strong voice within government on all issues relating to Australia's 200,000-strong nursing workforce" (Department of Health & Ageing, 2008b, n.p). It is disappointing to see that this suggests the expectation is that, the CNO in Australia continues to be seen as speaking only for nursing and nurses, rather than being seen to contribute to more general health care matters.

Cohen et al. stress the importance of the media in influencing policy debates. The NSW Nurses' Association and the College of Nursing played a vital role in disseminating a substantial amount of information about the development of the NP role to nurses. However, notwithstanding the coalition building as described above, it would be fair to say that nursing's voice was no match for the AMA's media campaign to the wider public (See Chapter 7, p. 231). The nursing organisations were initially reluctant to enter into a public fracas with the AMA. This gave the AMA considerable traction and free rein to represent the NP role as it pleased with minimal response from nursing, especially in the public arena. The

College of Nursing increasingly became a strong political voice for the NP. However, it would be fair to say that nursing had not developed the media presence such as that of the AMA (see p. 232). Each positive press release or article written about the NP role was generally met with a rapid response from the AMA. But the nursing stakeholders' confidence grew over time, taking on, and even learning from some of the political strategies of the AMA. In addition, the College of Nursing began to respond to any inaccuracies that were made, particularly those of the AMA through media releases, general newspaper articles, letters to editors, and also letters in medical newspapers.

It would be fair to say that the media tends to approach the AMA automatically because of its established media presence and because it seems to be regarded as the main political voice for medicine. Conversely, because there were a number of nursing organisations who engaged the media depending on the issue at hand, the media was unsure which nursing organisation to approach for information (see p. 231). Nominating an organisation to speak on issues relating to the NP role, and engaging the media earlier to help counteract the AMA's and some other medical organisations' negative depiction of the NP role may have contributed to a more coordinated media management strategy from the nursing stakeholder groups. See under the section entitled "building relationships" for further discussion on engaging the media.

It is important for nursing to cultivate and educate the next generation of nurse leaders about the workings of policy development, legislature and government (Diers, 2004). Cohen et al. (1996, p. 254) recommend political mentorship and education on health policy that acknowledges the connections between health, nursing practice and policy and political activism. These recommendations are particularly salient for NPs and especially the NP leaders of the ACNP. The Australian Nursing Federation has taken on a mentoring role for the nurse leaders of the ACNP so that the organisation can become increasingly active in the policy and political arena, including lobbying for MBS and PBS reimbursements for NPs (see below for recent developments). The ACNP released its first media release in 2008 entitled *ACCC called on to investigate why Nurse Practitioners' patients refused Medicare rebates* (Australian College of Nurse Practitioners, 2008).

Cohen et al. (1996) argue that policy development is not an end in itself, nor is it static. As already evidenced from the current study, the legislation and policy that currently governs the NPs' practice has already changed, and will continue to change and evolve over time (see

further discussion on policy developments relating to the NP role in the section "Pragmatics for new role in the health workforce.")

Hughes (2003) stresses the importance of relationships for political development and is discussed in the following section.

8.1.7 Building relationships

Political success depends on "one's ability to establish and sustain strong interpersonal relationships" (Leavitt, Cohen and Mason, 2002, p.71). Recognising problems with relationships (Stage 1) can be stimulated because of a significant event, or when reflecting on issues of individual or organisational development (Hughes, 2003).

The nursing stakeholders were individuals with their own visions for the NP role (Stage 1) but realised they must put aside their differences so they could engage more actively with each other and to work more constructively (See Chapter 7, p. 242). They described how they developed close working relationships during the development of the NP role, even meeting at one of the nursing stakeholder's home before every meeting of the NP Steering Committee to discuss and caucus on matters critical to the NP Steering Committee meetings.

The nursing stakeholders also formed strong relationships with those outside nursing. Stakeholders at government level spoke of their respect and confidence in the nurse leaders. In addition, the nurse leaders highlighted the importance of relationships with nurses who are also politicians. They acknowledged the vital role of a nurse, who was also a Member of Parliament in helping them rally political support (see p. 245) thus highlighting the importance of forming relationships with, and having more, nurses in the political arena.

The findings also revealed complexity in the relationships between NPs and their colleagues (see p. 253). The majority of pioneer NPs had for many years been working in the same settings in their former role as RNs, CNSs or CNCs (see Chapter 2, p. 74 for information about the CNS and CNS roles). Most of the pioneers working in rural or remote communities had already formed working relationships with other nurses, doctors, managers and others. After the pioneer NPs received their authorisation and began working as NPs, they reported major disruption to these previously formed relationships. The NPs found this disruption disappointing to say the least. Chapter 7 (p. 259) describes the lack of support from local GPs, other nurses and other health professionals in the disruption that occurred to

professional relationships and the wider community when implementing the NP role into small country towns. There was no alternative employment unless the NPs moved to another town. Similarly, managers were faced with untenable situations whereby GPs threatened to leave or discontinue their visits, making it difficult for managers to support the NPs.

In regard to relationships, once problems are acknowledged, ideally individuals or organisations would move into Stage 2 of political development when attempts are made to address problems through active engagement with others. Because some NPs were reluctant to disrupt their working relationships, they simply resorted to working in a traditional way by accepting the restrictions that the GPs placed on their practice, for example, limiting the medications they could prescribe. However, for some NPs to gain acceptance of their new role, they negotiated with the GPs to take on tasks that the GP preferred not to perform (see p. 260).

It was the NPs who actively challenged the GPs' authority over their practice that led the most disruption (p. 255). Other NPs used their more cohesive relationships with supportive doctors to bypass some of the obstructive doctors (see p. 252). A few of the NPs eventually gave up the battle.

Whilst the NPs acknowledged the support they received from the nurse leaders, common to these scenarios was the lack of sustained support for NPs at the organisational level. A nursing stakeholder also pointed out the inadequacy of intermittent support for the NPs (p. 257). The section *Preparing health care organisations* (see below) maintains that innovation brings disruption, particularly when some operatives oppose the innovation. Thus, it is crucial that NPs receive support earlier rather than later. One AHS had initially employed a project officer to help the pioneer NPs with their guidelines and provide support but this assistance was only short term (see p. 257). Issues pertaining to preparing organisations in the implementation of the NP role are further discussed below.

The establishment of The Australian Nurse Practitioner Association (now known as The Australian College of Nurse Practitioners) in 2003 was identified by the NPs as a significant event. It enabled NPs, especially those working in rural or remote communities, to communicate and form relationships with their pioneer NP peers, thereby helping them maintain their motivation and decrease their sense of isolation.

Although coalitions within and outside nursing assist in garnering support for the NP cause, it has been suggested that, in the long run, Roberts (2004) proposes that it does not empower nursing and that empowerment in nursing is possible only when the profession is valued and supported. For nursing (and the NP role) to be valued and supported it needs to form a strong relationship with the public (Buresh & Gordon, 2000).

Feedback from the pilot projects showed that there was confusion in the community about the NP role (see p. 192). However, the nursing stakeholders believed there was little utility in marketing the NP role to the public during the early development of the role. Their view was informed at that time by the Stage 2 *Review* that identified ambivalence and even disinterest in the community about NPs (Adrian, 1996).

It has been argued that the public will happily accept health care providers other than doctors if given the choice (Christensen, Bohmer, & Kenagy, 2000) but historically Australians have been unaware of their health care options. At the time of the development of the NP role, there were few alternative health services available, other than the GP (Keegan, 1998). Thus, the public needed the information so that they could understand the difference between NPs and doctors, and importantly too, could understand that the role is based in nursing (Dunbar, 2004; Wilson, 2005). Apart from the involvement of some community members in identifying a local agreed need for an NP position, there was minimal attempt by NP advocates to establish a relationship with the wider public. The findings from this study highlight the importance of communicating with the public to gain support for the NP role. As described by one NP, it was when she commandeered community support she gained herself a position as NP in that town, pointing out that "this particular town gets very feral, like they deserve something" (see p. 244).

The growth and success of the NP role hinges on informing the public about the NP role, including its regulatory and educational requirements (Dunbar, 2004; Stanley, 2005; Wilson, 2005). Therefore, it is important for nursing to make known the contribution of NPs to health care (Keegan, 1998). Informing the public through media campaigns about NP education and scope of practice could have facilitated public understanding of the role and generate support, acceptance and utilisation of the NPs (Lindeke, Bly, & Wilcox, 2001a, 2001b).

The lack of PBS and MBS reimbursement has not only limited fair and equitable access to NP services (Adrian, 1996) but also the public's exposure to the NP role (Truscott, 2007).

With the inclusion of PBS and MBS reimbursements, it is likely that the public visibility of NPs will increase (see below "Pragmatism in the politics of health care" for further discussion about MBS and PBS reimbursements).

The rapid development of nursing in Australia has also affected the public perception of nursing (Lumby, 2004). As a consequence, there are those who hold on to the traditional view of nursing and nurses (Lane & McLoughlin, 2004; Lumby, 2004). The knowledge required to function effectively as a nurse had expanded exponentially prior to the development of the NP role and, in 1984, the Federal government announced its support for the full transfer of nursing education into the university sector over the subsequent decade (Crisp & Taylor, 2001). In 1986, expert nursing was formally recognised with the introduction of the CNS and CNC roles in NSW (NSW Department of Health, 2008). This provided at long last some formal recognition of expert clinical nursing, as pointed out in Chapter 2, p. 74, when nurses began to move into specialist roles in 1986. The professional growth of nursing within the traditional scope of nursing practice has been rapid, especially over the past two decades. In 1990 came the NP movement further expanding the scope of practice and, with the release of the *Discussion Paper*, publicly challenging existing practice boundaries. Suddenly the public were told by groups opposing the movement that nurses wanted to become substitute doctors (see p. 212). Thus, it is the responsibility of nursing and nurses to engage and educate the public to help people discard the old stereotypes of nurses as handmaidens to doctors (Chiarella, 2002) and replace them with an image that is more reflective of the contemporary nurse. Nurses and NPs can no longer be reticent in talking about their education, knowledge and expertise if they wish to be respected by the public as professionals (Dwyer, 2005; Lane & McLoughlin, 2004; Lumby, 2004; Roberts, 2004). Vocal advocacy may also inspire others to join the profession (Dwyer, 2005) and for some nurses to become NPs.

To relate to the public, nurses need to also form relationships with the media (Lane & McLoughlin, (2004; Lumby, 2004). A small Australian survey of articles in two daily newspapers in NSW and South Australia from December 2002 to January 2003 found that the most common items published about nursing were focused on industrial matters. Reports of nurses as primary clinicians and policy-makers were absent. The researchers concluded that the print media continues to perpetuate a distorted portrayal of contemporary nursing in Australia." (Lane & McLoughlin, 2004). Nurses have been criticised for their reluctance to

engage the media. For example, Hudson (2003) argued nursing will not reach its full potential unless the public is provided the opportunity to experience nursing through mainstream media sources. Lumby (2004, p. 14), an Australian journalist, acknowledged that the media stereotyping of nurses is grounded in a "long history of portraying nurses as the underlings of doctors" and argued that this image will not disappear without a sustained and targeted campaign to change the way nurses are represented. Nurses are generally viewed by the media as an extension of the organisation in which they work, rather than a group of individuals with expertise (Lumby, 2004). To establish a positive relationship with the media, nurses must understand what journalists need, and how they work. Journalists want to interview practitioners who are articulate and can express their opinion cogently and consistently (Chiarella, 2005; Lumby, 2004). Lumby (2004) also points out that people are generally willing to speak in support of a service from which they have benefited. However, as experienced by the NPs and some stakeholders (see p. 171) engaging the media involves risks; risk of being misrepresented and misquoted (Lumby, 2004). The NPs found that speaking with the media was particularly daunting. It is therefore recommended that NPs and NP candidates receive education on media management to help them form relationships with the media and learn how to market the NP role, whether it is through mentorship, via nursing organisations or ideally, as part of their master's education.

The next section discusses particular issues that the NPs found especially challenging in the preparation for their new role. In addition, issues relating to the implementation of the NP role into the health care organisations are also discussed.

8.2 Preparing for new roles in the health workforce

The second lesson from the introduction of the NP into NSW relates to how we might better prepare for the introduction of future new roles, and also the continuing implementation of NPs into the Australian health workforce. This section describes issues pertinent to the preparation, or lack thereof, of the NPs and the implementation of the NP role in NSW. Difficulties that the NPs experienced in developing their portfolios during authorisation and the development of the NPs' clinical practice guidelines are also explored. As previously discussed, there was disruption to existing relationships during the implementation of the NP role. Issues relating to a lack of formal organisational planning and preparation for the

implementation of the NPs in their clinical settings are examined. Resources and funding for the successful implementation of the NP role are discussed.

8.2.1 Preparing the NPs

There was considerable uncertainty for the pioneer NPs as they entered uncharted waters to begin their NP journey, although Brown & Draye (2003) point out that being a pioneer means that the journey ahead is always unknown

The NPs found authorisation a challenging and arduous process. A NP-specific masters program had not been developed at the beginning of the introduction of NPs into the NSW workforce so the decision was made to develop an alternate pathway to NP authorisation to expedite the implementation of NPs into the health care system. It was anticipated that the alternative pathway, namely the submission of a portfolio and clinical viva, would expedite the authorisation and thus the implementation of NPs (see p. 131). However, this was not the case. At the time the NPs were preparing their portfolios for their authorisation, assessment through portfolio development was a relatively new concept in Australian nursing (Emden, Hutt, & Bruce, 2003). Portfolios began to be used in undergraduate education in the mid 1990s (Stockhausen, 1996) but in Australia, even before 2004, portfolios had received little attention in the nursing and midwifery journals (Emden et al., 2003/2004). Since that time there has been increasing interest (Anderson, Gardner, Ramsbotham, & Tones, 2009; Andre & Heartfield, 2007). Undergraduate students in Australia now structure their portfolios using the Australian Nursing and Midwifery Council national nursing competency standards for the registered nurse (Australian Nursing and Midwifery Council, 2009; Stockhausen, 1996). At the time of the pioneer NPs there were no advanced practice competencies and thus no appropriate template against which the NPs could structure their portfolios. National competency standards for the nurse practitioner were later developed in 2006 (Australian Nursing and Midwifery Council, 2006) and are now used to help NP candidates structure their portfolios (Nurses and Midwives Board of NSW, 2010).

Portfolio development requires knowledge, time and skill (Gardland & Reed, 2009; Stuart, 2004) and importantly, reflection, which also requires time and skill (Foster & Greenwood, 1998; Schutz, 2007). Thus, developing a portfolio in haste can be difficult and even counterproductive. Most of the hospital trained pioneer NPs working in rural and remote communities had not so much as heard of a portfolio, let alone ever produced one.

Consequently, it took many of the NPs up to 2 years before their portfolios were acceptable to the (then) NSW Nurses Registration Board. Additionally, and compounding their inexperience in developing a portfolio, they were provided with only a small amount of information to help them. This information is shown in Appendix F. One of the biggest barriers to the success of portfolio assessment is the lack of constructive guidance in their development (Emden et al., 2003; Harris & Curran, 1998). Developing portfolios became an exercise in trial and error for the NPs, causing them undue stress, delaying their submission and thus delaying the implementation of the NP role (see p. 157).

Findings in this study suggest that the NSW Nurses Registration Board had not anticipated the difficulty that these pioneer NPs would ultimately experience in relation to applications through the portfolio pathway. However, the findings show that, with any newly introduced authorisation process there needs to be some form of assessment to ensure that candidates would be able to meet the requirements. Regulatory bodies need to provide detailed and structured information to guide candidates so that the process does not become one of trial and error as reported by the pioneer NPs. In addition, with any newly introduced authorisation process there needs to be ongoing monitoring and assistance. It is possible that there were nurses who were also willing to pioneer the NP role but were discouraged from doing so because they did not have the determination to persevere, as in the case of the pioneer NPs in this study.

Another challenge for the NPs was having to define and defend their 5,000 hours of advanced practice. To do so, the NPs had to obtain letters and testimonials from health care professionals within and outside nursing plus a letter of support from their employer. This process enforced reliance on the hierarchy of the existing health care and on legitimisation by other health care professionals. Thus, the traditional power base remained outside the realm of nursing despite the increased responsibility that the nurses in these positions actually shouldered in practice (Chiarella, 2002; Gordon, 2005; Turner, Keyzer, & Rudge, 2007).

Formalising the NP role meant that the NPs not only had to conceptualise their advanced practice, but also had to articulate it. The findings demonstrate that many of the NPs, despite their clinical competence, were not prepared for the NP role. The NPs' confusion relating to advanced practice, together with their difficulty in articulating it, made it challenging for them when applying for authorisation, and also when explaining their practice to others (see

p. 181). Thus, in order to avoid some of the problems experienced by the pioneer NPs, it is imperative that there is a clear understanding of the concepts that underpin a new role.

In hindsight, because it took many of the NPs several years before they were finally authorised, it may have been worthwhile waiting until a postgraduate education course became available. Postgraduate education would have provided the pioneers NPs with support, helped them to develop their theoretical understanding of the role, and also helped them to argue persuasively their advanced practice at the level the role required. The risk with this would have been that the nursing profession and the politicians would have had to have waited an even longer time for the development of programs before they were able to be seen to have acted, and politically this may not have been acceptable.

However, the NPs' difficulty with the notion of advanced practice appears to have disadvantaged them more than was the case with their lack of educational preparation.

Pioneer NPs were excited about legitimately breaking out from the traditional constraints of their RN role (see p. 145). They wanted to improve the care they delivered for their communities or patients but also to be recognised for it. As we have seen, the language used to describe nursing practice can profoundly influence how nurses think about themselves, their work relationships, and the very essence of their practice (Mitchell, Ferguson-Pare, & Richards, 2003). The NPs were concerned (and somewhat irritated) that the focus on why they were different to other nurses and doctors, and the defining, articulating and measuring their practice was in a sense dehumanising the care they provided their patients (see p. 184). While acknowledging the difficulty they experienced in articulating their practice, they also believed that the focus on the concept of advanced practice had taken the focus away from the patient. It has been previously recognised that advanced practice nurses' concern and focus is on their patients, and their clinical practice is *for* (my emphasis) their patients (Hardy, 1988; Sutton & Smith, 1995).

Sutton and Smith (1995) studied the attributes of advanced practice nurses through informal (non-research) observations of RN and client interactions; and discussions with students enrolled in a Master of Nursing (Advanced Practice) in Australia. Sutton and Smith also critiqued the overseas literature before concluding that "for advanced practice nurses, the client is the world." Advanced practice nurses locate themselves according to each client

situation. They are willing to "bend" the rules and stretch the boundaries of their practice (Sutton & Smith, 1995, p. 1040).

In the current study, NPs felt constrained by the need for tight definitions of their practice, and the extent of the rules and boundaries (see p. 251). Rather, the pioneer NPs preferred the freedom to articulate their practice with a focus at the individual level rather than as part of some grand schema, theory or concept, a finding also identified by Sutton and Smith (1995). It has been similarly asserted that advanced practice nurses "ought not have to describe [their] practice with some kind of artificial semantic nonsense which does not match the reality of their work" (Diers, 2004, p. 134). Benner (1984, p. 32) in her seminal work, argued that the expert nurse finds it difficult to capture the descriptions of expert practice because experts operate from a "deeper understanding of the total situation" and because "it feels right". Sutton and Smith (1995, p. 1041) similarly argue that advanced practice nurses (as with expert nurses) examine the totality of situations but *as they affect the client*. Thus, the primary focus moves from the *situation* to the *individual*. The NPs in this current study were being asked to perceive their practice as a concept in order to describe and define it to an outside audience, but their worldview was focussed on the care they delivered to their individual patients.

8.2.1.1 *Clinical practice guidelines: Flexibility versus certainty*

Although the legislative changes determined by the *Nurses Amendment (Nurse Practitioners) Act 1998* (NSW) were permissive, the restrictive (and safety) element was at the State Government level. These restrictions related to the NPs' formularies and clinical practice guidelines. If the NPs practised outside of the agreed scope of practice it may have constituted professional misconduct or unsatisfactory professional conduct. While these NPs were pioneers, they were also advanced practice (and expert) nurses. The NPs felt restricted and constrained by having to work according to what they saw as cook book style, step-by-step instructional clinical practice guidelines. Benner (1984, p. 12) proposed that when experts are forced to follow rules, their performance becomes "halting, rigid and mediocre." Rather, as argued by Sutton and Smith (1995), NPs actually value uncertainty and accept it as part of their everyday practice because they see it as an opportunity for growth and development. In addition, NPs engage in continual critical reflection and such respond to various cues in any given situation.

Sutton and Smith (1995, p. 1037) believe that the "scientification of nursing" has resulted in minimal value being placed on anything that cannot be measured. However, Kitson (1987) argues that the raising of standards has nothing to do with establishing static and rigid protocols. Rather, standards of nursing practice are more likely to be assured when nurses respond to their intuitions and gut reactions (Kitson, 1987). Thus, while there is the expectation that NPs in NSW will work within clinical practice guidelines, it is important that the very essence of their nursing practice is not denied. Clinical practice guidelines need to be broad enough to provide the NPs enough latitude to allow them to maintain the focus on the patient and not deny them the emotional component of nursing practice (Kitson, 1987). Any form of clinical guideline should be used to support flexible practice so that NPs have the opportunity to adjust their clinical responses to each presenting situation (Carryer, Gardner, Dunn, & Gardner, 2007).

Four influences retarded the development of clinical practice guidelines. Firstly, the support that the NPs received in developing their guidelines varied across the AHSs with many having no experience of developing them. Secondly, the process for approval of the guidelines was convoluted and lengthy. While the process for guideline approval has since been amended according to feedback, at the time of the pioneer NPs the development and approval of a single guideline could take up to 2 years . Thirdly, other health care professionals who neither understood nor supported the NP role had to approve the guidelines. Finally, because of the need for consensus on the medications that the NPs could prescribe, and the investigations that they could order, the guidelines became overly restrictive. These factors limited the ability of many of the pioneer NPs to function fully (if at all) in their roles. These findings are similarly reported elsewhere (e.g., NSW Department of Health, 2008). In addition, the NPs working in the hospital setting were exposed to the disparate practices between the different doctors working within one clinical setting, which were often based on individual opinions and preferences rather than relating to the evidence base. Consistent with the findings from the current study (see p. 165) and the literature (e.g., Carryer, Gardner, Dunn, & Gardner, 2007; Grol, Eccles, Maisonneuve, & Woolf, 1998; Landsman, 2006; Wilson, Nasrin, Banwell, Broom, & Douglas, 2000) it was consequently extremely difficult to gain agreement on the content of clinical practice guidelines by those involved in their development.

It has since been proposed for NPs to work within guidelines that "provide a consistent stratified approach to the range of interventions and practices provided by the entire team" as opposed to the NPs working with guidelines separate from the rest of the team (National Nursing & Nursing Education Taskforce, 2006b). It is possible that to have NPs practising according to a guideline that is used by the whole health care team would enhance inclusiveness of the role. There has been considerable energy expended on the regulation of and legislation for NPs. NPs working according to restrictive guidelines that prevent them from working to their full potential is not only wasteful and counterproductive, it reduces the NPs' capability and efficacy, and thus, their contribution to health care. It is anticipated that once the NP role becomes more established in NSW and safety concerns regarding NP practice abate, future NPs will not have to work under such specific clinical practice guidelines.

8.2.1.2 Resources and funding

Successful implementation of the NP role requires resources in the form of office space and equipment, non-clinical time, and educational opportunities (McCallum Pardey, 2004). The findings revealed that some NPs had insufficient office space and would have to share a telephone (see p. 210). Whilst some of the NPs believed that withholding of resources related to their manager's maintaining control over their practice, it is possible that there were no formal negotiation between the managers and NPs about the resources needed for the NPs' new role. NPs experienced conflict trying to fulfil their commitments to promote the NP role, speak at conferences, work in their clinical settings and also develop their clinical practice guidelines (see p. 165). Most of the NPs had no administrative support to help them with their paperwork. The lack of resources could result from the lack of integration of the NP role into existing management structures (NSW Department of Health, 2008).

It has been suggested that the reallocation of resources is an intensely political process (Hamel & Valikangas, 2003). In most organisations, a manager's power relates directly to the resources they control. Managers are concerned with their organisation's performance (Hamel & Valikangas, 2003), thus it will always be more difficult to gain resources from managers for new projects that depart from usual practice, and especially those that are considered risky (Hamel & Valikangas, 2003). Findings from this study highlighted that the hierarchical management structure of the AHSs had most likely influenced resource

allocation for the NP role. While managers closest to the clinical setting may have supported the NP role, the NPs reported that resource decisions were often made at a higher management level (See Chapter 6, p. 286).

The study and other Australian studies (e.g., NSW Department of Health, 2008; Gardner, 2004) reported the inconsistency between state and federal legislation (see p. 192) as a factor limiting the NPs' practice. State legislation allows for NPs to write prescriptions while informal, in-hospital mechanisms allow for NPs to refer patients to other health care professionals, excluding doctors. However, at the Commonwealth level NPs have had no access to PBS or MBS provider numbers, which means they were unable to prescribe medications that patients can collect outside of the hospital pharmacy, or to refer patients to medical practitioners. This ridiculous situation has limited the NPs' practice because most patients would have to pay substantially more to fill a prescription without PBS coverage unless it was from a hospital pharmacy. The NPs were similarly limited in referring patients to other health care providers or requesting diagnostic investigations. The lack of PBS or MBS privileges has discouraged NPs from branching out into the private sector and as such they have relied on managers within the public sector for resources (see p. 238).

From a staffing perspective, once NP positions are established and NPs are receiving a higher rate of pay, the AHSs require extra funding to cover the costs for the NPs to work after business hours and weekends (see p. 190). It has been postulated by other Australian scholars that a veto by management preventing NPs from working busy evening shifts could also have been a matter of control, rather than purely a funding issue (Turner et al., 2007). As highlighted above there was considerable disruption with the introduction of the NP role into the health organisations. The following section explores issues pertaining to the preparation and implementation of the NPs into the health care organisations.

8.2.2 Preparing health care organisations

Altering professional boundaries creates a culture of considerable uncertainty around professional identities because aspects of a role can be seen to be either enhanced or lost (Williams & Sibbald, 1999). This was certainly the case in the current study. For the NPs and those who supported them, the change to their traditional practice boundaries enhanced their work (see p. 216). Conversely, for the doctors and some nurses and other health care

professionals, the boundary changes associated with the NPs' work were perceived as a loss (see p. 223).

During the early development of the NP role it was anticipated that only 3% of the nursing workforce would seek NP authorisation. Thus, it had not been anticipated that the NP role would affect the other 97% of nurses nor other health care professionals (Iliffe, 1993).

Notwithstanding the small number of NPs expected, the findings demonstrate considerable concern about the NP role and also about its overlap and effect on other roles within and beyond nursing (see p. 223). This finding has been reported elsewhere within Australia (e.g., NSW Department of Health, 2008) and beyond (e.g., Diers, 2004; Irvine et al., 2000).

Changes in health care have been described as "disruptive innovations." (Christensen, Bohmer, & Kenagy, 2000). Harvard scholars Christensen et al. (2000) provide the NP role as a classic example of a consumer-focussed disruptive innovation. They argue that disruptive innovation, despite its negative connotation, provides the opportunity for individuals to accomplish complex tasks without a reduction in quality of performance. Christensen et al. propose that the increased knowledge and skills of NPs, together with the advances in diagnostic and therapeutic technologies, allow NPs to diagnose and treat diseases competently that would have previously required the training and a judgment of a doctor. Christensen et al. provide a parallel example of the US automotive industry's resistance to Honda and Toyota, such as the import quotas to these two Japanese brands, and argue that the automotive industry in the US protected its own established automakers. They propose that analogous circumstances prevail with regard to health professionals whose professional territory is threatened by NPs. It comes as no surprise that Christensen et al. believe that doctors' rejected the NP role to preserve their traditional market hegemony (Christensen et al., 2000). The existence of hostile industry players or the absence of helpful ones can hinder consumer-focussed innovation, which could include marketable goods or, in the case of NPs, the labour market. Organisations and individuals who perceive changes as threatening to their interests could mobilise substantial resources and exert their power to influence policy and opinion by attacking the innovator (Christensen et al., 2000; Herzlinger, 2006).

Christensen et al. (2000) believe that changing health care needs and the focus towards illness prevention have resulted in GPs undertaking work where their skills are not properly utilised. These scholars argue that conventional health care provision has overshot the level

of care actually needed, or used by the vast majority of patients. They propose that the answer to these problems in health care is to remove the restrictions on NPs. Health care regulators need to stop preserving the existing system and determine how they can enable disruptive innovations, like NPs, to emerge (Edmunds, 2002). Whilst disruptive innovations have the power to benefit patients, they are much easier to introduce if the entrenched powers are supportive of the innovation (Christensen et al., 2000; Edmunds, 2002; Lewis & Lewis, 2002).

Importantly, Christensen et al. (2000, p. 110) and others (Herzlinger, 2006) point out that historically, when any disruptive innovation enters an entrenched, change-averse organisation (such as the health care sector) there is usually a difficult period that precedes the arrival and incorporation of "truly convenient, lower cost, higher quality products and services" such as that experienced by the nursing stakeholders and NPs in the current study.

8.2.2.1 Change management

An early and long-standing seminal influence on the literature about planned change was the work of Lewin (1947), who proposed a three-stage approach to organisational change (see also Cummings & Worley, 2001).

Lewin (1947, p. 34) suggests that one should not view creating change in an organisation in terms of goal setting but instead as change from the "present level to the desired one." His model involved unfreezing the present situation, moving to a new situation and refreezing in the new situation. In the unfreezing stage a problem or desired change is identified and an analysis conducted to determine the driving and restraining forces. The leader, together with the target group, examines and develops strategies and actions to minimise the forces limiting change and maximise the forces driving the change. In the moving phase, actions move the system towards the desired state. Finally, in the refreezing phase, the change is stabilised in individuals and the system.

Roger and Shoemaker's (1971) model also proposes a different three-phase concept of change: invention of the change; diffusion or communication of information about the change; and consequence, which can be acceptance or rejection of the change. This model is premised on the assumption that people are rational and as such, their knowledge will lead to acceptance of a proposed change. Thus, the dissemination of information and

communication about all aspects of the change is central and critical to the acceptance of a proposed change (Rogers & Shoemaker, 1971).

Rogers and Shoemaker (1971) and Rogers (1995) categorise people according to their willingness to change. These categories are: innovators, who seek change; early adoptors who facilitate change; early majority members, who provide support for change; late majority members, who exert peer pressure to support the change; laggards who strive to maintain the status quo; and rejectors, who actively oppose the change.

It is clear from the findings from the current study, and also from the identified literature above, innovations such as the NP role require planning and monitoring with reference to the change management literature as they are implemented into health care organisations.

While the establishment of a local agreed need involved consultation with stakeholders such as hospital management, professional groups (including nursing and medical practitioners) who were likely to be affected or involved, relevant industrial representatives and consumers (see p. 226), there was no planned process for integrating and monitoring the progress of the pioneer NPs into the health system. As one stakeholder commented, "I think somewhere along the line there is this idea that everything will fall in place but you have got to put in processes" [KS13]. For the most part, the implementation of the pioneer NPs into the clinical settings was largely undertaken on an *ad hoc* basis relying on the initiative of managers within organisations. While several NPs identified that there was a process for assessing the outcomes from their practice, only one of the NPs identified that there had been any *organisational* planning for implementing the NP role. It was this NP who reported a relatively smooth transition into her new role (See Chapter 6, p. 186). The manager, as described by the NP, played a strong leadership role in the implementation of the NP role but was also inclusive by encouraging and valuing the contribution of NPs and other health care professionals. The NP's role was incorporated not only into the organisation's business plan and projected outcomes, but the role was also aligned with the some of the goals of the NSW health care system. This NP highlighted that projected outcomes for the role were evaluated and updated as required. The NP believed that these strategies had raised the visibility and benefits of the NP role leading to greater acceptance of the role by other health care workers within the organisation.

During the early development of the role there was substantial concern about the effect of NPs on other roles within and without nursing (see p. 223). The findings indicate that most of the concern related to the NPs' extended practice. It is difficult to envisage the NP role receiving the same attention and scrutiny had the role not involved legitimising the NPs' extended practice. There was uncertainty over the potential effect of the NP role on other nursing roles such as the CNC. There was also concern expressed by other health professionals such as physiotherapists and radiographers. Rogers and Shoemaker (1971) argue that the dissemination of information and communication about a new innovation is critical for the acceptance of the new innovation. Given the concern of health professionals within and outside nursing in relation to the potential of the NP role to affect their positions negatively, it is proposed that more attention could have been directed to alleviating their fears. Indeed, the Australian literature increasingly recommends extensive consultation (Searle, 2008; Wilson, 2005), education (Searle, 2008), and marketing (Searle, 2008) of the NP role to nurses and other health professionals to help improve understanding and acceptance of the role (Searle, 2008; Wilson, 2005).

According to Christensen et al. (2000), doctors that feel threatened are more likely to reject a change such as the NP role. This was certainly the case for the NP in NSW. Most of the pioneer NPs were working in small rural or remote communities. The findings show how the local GPs were particularly resistant to the NP role. Reasons for this resistance included concern that the NPs would negatively affect their income. The findings also highlighted the degree to which GPs, especially those working in rural or remote areas, feel isolated and marginalised from mainstream or specialist medicine (See Chapter 7, p. 226). As such, the NPs were perceived as threatening the country doctors' already low status within medicine. Paradoxically, GPs have enjoyed high status within their local communities (if not within medicine), so the elevated status of NPs within the local community was also seen to be a threat (see p. 205). In addition, some GPs revealed that some of their GP colleagues and medical organisations such as the RDA and the AMA pressured them to obstruct the NP role (see p. 256). Rogers (1995) proposes that an individual's decision to adopt an innovation can be influenced by others in an organisation, such as when an individual has to acquiesce to the decision of a group, or because an authority directs an individual whether or not to adopt an innovation (Rogers, 1995).

In contrast to their original stance on the NP role, many GPs and particularly the RACGP have embraced the practice nurse role over the NP role for several reasons (see p.). Firstly, practice nurses are not viewed as a potential threat to GP income particularly because GPs are financially rewarded to employ practice nurses. In contrast, GPs receive no financial incentives to collaborate with NPs. It might seem naïve to imagine that GPs would be similarly motivated to collaborate with NPs who are non-income generating and could be perceived as competition. With the introduction of MBS and PBS for NPs, the NPs could increasingly be seen as threatening the GPs' income, unless some form of enforced collaboration were introduced. Secondly, practice nurses work under GP supervision, as opposed to working autonomously. The practice nurse role does not disrupt the traditional hierarchy between doctors and nurses so the GP's status is preserved and perhaps even enhanced by their presence. Media reference to pioneer NPs working in rural and remote areas as 'bush doctors' rather than nurses (e.g., Shine, 2001) doubtless fuelled the professional boundary discomfort of the GPs working in the same locale, contributing to a desire to undermine the NPs as autonomous nurse professionals (Turner et al., 2007). It seems plausible to expect that, for some GPs to accept an innovation such as the NP, there would have to be an additional incentive to improving the delivery of health care.

Because most of the NPs were already working in their clinical settings at an advanced practice level prior to becoming an NP, the disruption that resulted following the NPs authorisation was not anticipated by the pioneer NPs themselves (see chapter 7, changing relationships: rocking the boat, p. 253). However, this (clearly delusional) perspective focussed on the inter-*personal* relationships that had been established, rather than the inter-*professional* roles. There was no automatic acceptance of their new role even though the pioneers had been working in their clinical settings for many years and even though several of them imagined that the doctors were their friends as well as their colleagues. The implementation of the NP role was initially geographically restricted to rural or remote NSW and as such it is conceivable that, wherever the NPs were implemented, there would have ultimately been some degree of disruption given the above discussion. However, undertaking a risk assessment may have exposed the risks when implementing the role and the appropriate support mechanisms could have been instituted. The findings highlight that some managers were put in untenable positions of having to choose between the NP and the GP. Arguably, there is also the need for managers to be provided support when implementing innovative roles into their organisations.

Some medical organisations, in particular the AMA, resisted the NP role, which is consistent with experiences in the US with organised medicine (see p. 38). The findings document the substantial time and effort expended by nursing stakeholders appeasing the AMA. However, the AMA ultimately refused to approve the *Final Report* (see p. 241) and the AMA's opposition to the NP role has remained relatively unchanged. Based on Roger's (1995) categories for people's willingness to change, the AMA represents either the group categorised as laggards who strive to maintain the status quo or the rejectors who actively oppose the introduction the NP role. Thus, the findings suggest that here is no value in trying to appease the AMA during any future developments in the NP role. Rather, resources should be directed towards engaging and educating health professionals whose concern may be due to a lack of information about the role, and who may be more receptive to accepting the role.

In addition to accepting that, with the introduction of any new innovation there will be a period of disruption, there will also have to be acceptance that some nurses, health professionals and others will continue to reject the NP role. As in other industries, demarcation disputes in health care are not uncommon. For example, the Australian Dental Association does not support the idea of para-professional dental therapists, anaesthetists do not support GP anaesthetists and podiatrists challenge the right of beauticians trimming the toenails of elderly people (Paterson, 1996).

A surprising result was the extent of the grieving for the "good old days" from doctors (see p. 202) and even some nurses (see p. 209). Apparently some doctors and nurses have held on to a more traditional view of nursing. There are those who have not embraced nursing's growth into a profession and so have particularly resisted developments such as the NP role. For these people, the NP role brought further uncertainty. NPs and stakeholders related how they, and others, had not accounted for the deleterious influence of the workplace culture in some of the health care organisations, a finding corroborated by others (e.g., Turner et al., 2007).

The findings in this study provide information only relating to the early implementation of the NPs. However, an Australian-wide survey of NP practice conducted in 2007 reports considerable variability between health care settings regarding the restrictions placed on the application of the NPs' extended practice skills. One-quarter of employed NPs were still awaiting approval of their clinical practice guidelines and there was considerable variation in

the level of restriction across geographical and clinical settings. The lack of approved guidelines reportedly accentuated the NPs' invisibility because despite consultants having none or little contact with a patient, they would be credited in an audit with the work performed by an NP (Gardner, Gardner, Middleton, & Della, 2009). The survey also found that 81.2% of NPs worked in metropolitan areas. While this geographical distribution is reflective of the RN population (Gardner, Gardner, Middleton, & Della, 2009), it is possible that, despite the need for NPs in rural or remote areas, the low numbers could be due to a higher level of resistance to the NP role than in metropolitan areas.

Black, Rafferty, West and Gough (2004) point out that research can be a useful tool to help resolve some of the workforce challenges of the health care system. They propose a number of recommendations for nation-wide research into workforce issues that are particularly relevant for future research into the implementation of the NP role. These recommendations are:

- studies to describe the content of jobs, divisions of labour among professionals and comparison with what is permitted or expected;
- identification of the appropriate roles and responsibilities of each profession and, thus, expectations of their contribution;
- evaluative research on substitution of one profession for another and its impact on the delivery and outcome of health care;
- evaluation of new developments, including roles and ways of providing services, on inter-professional relationships;
- analysis at health system level to understand impact of changes in skill-mix and use of different professions on distal as well as proximal parts (i.e. recognising health care systems as complex adaptive systems);
- understanding public perceptions of professions including how and when these perceptions are formed and extent to which existing perceptions impede attempts to change the use of the workforce;
- understanding how patients decide which type of professional to consult and patient and professional views of changes in skill-mix

(Black, Rafferty, West, & Gough, 2004, p. 63-64)

Many of the decisions that were made during the early development of the NP role occurred because the nursing leaders had to grasp opportunities as they presented, and as such the need for haste meant there was the need for pragmatism. In addition, many of the events that unfolded, and their effect during the development of the NP role, could not have been foreseen or even controlled, highlighting the need for pragmatism in the politics of health care. These issues will now be discussed.

8.3 Pragmatism in the politics of health care

The third key area of learning from the early NP experience involves the pragmatic nature of decisions that had to be made during the evolution of the NP role. Whether this was good or bad is not the issue under consideration, in this section; it is the fact that it was such a reality for both NPs and stakeholders, and was so prevalent within the data. The development of the NP role in NSW was a process of intense negotiation and compromise (see p. 234). Compromises were necessary because of the disparate visions and vested interests of those involved in the negotiations, in conjunction with the need to keep the negotiations progressing. The ultimate question was not whether the NP role could be introduced as originally intended but whether it could happen at all. The danger was that missed opportunities might not re-occur. It was a question of now or when, if ever. Kingdon (1995, p. 166) describes these opportunities as "policy windows" and argues that these policy windows only stay open for short periods. Thus, action must take place when the window is open, and if participants do not take the advantage of opportunities they may slip away completely or they must wait until, or if, the next opportunity comes along. In hindsight I would contend the visionary nursing leaders who took the opportunity were right to do so, even if the circumstances did not exactly match their vision.

The development of the NP began at a nursing conference in 1990 because a nurse asked the then Health Minister whether he supported the NP role. This one question triggered a cascade of events leading to the introduction of the NP all over Australia by 2007 (see chapter 2, p. 105).

In a relatively short period of time between 1990 and 1998 the NP role was legislated and the title of NP protected through the *Nurses Amendment (Nurse Practitioners) Act 1998*

(NSW). There were four committees, four reports had been generated and 10 pilot projects were undertaken that provided both argument and evidence for future jurisdictions wishing to introduce the NP role[18]. A Senate Inquiry into Nursing in 2002 later recommended that both Commonwealth and State Governments support the development and introduction of NPs across Australia (Commonwealth of Australia, 2002a). By 2007 the NP role had been legislated and the NP title protected in all Australian states. By December 2009 there were 129 authorised NPs in NSW, and one midwife practitioner (A Fry, personal communication, NSW Nurses & Midwives Board December 17, 2009). At the end of 2008 there were approximately 300 registered nurse practitioners working in Australia (Department of Health and Ageing, 2008c).

The need for haste necessitated pragmatism that I would argue bordered on expedience. Most of the nursing stakeholders acknowledged that significant compromises were required to progress the development of the NP role, but progress it they did. The nurse leaders compromised in undertaking the pilot projects that ultimately delayed the development of the NP role. The AMA expected that the pilot projects would fail and were seen as a way to end the NP movement (see p. 238), but ironically their ultimate success disarmed the AMA's argument that NPs would deliver second-class health care. The success was particularly convincing to the State Government and the positive outcomes from the pilot projects increased the Government's confidence in the NP role. Any change argued from data is much more effective than arguing merely from opinion or one's own agenda (Diers, 2004). While there is a plethora of literature attesting the effectiveness of the NP role in the US and other countries, the data from the pilot projects provided evidence in the Australian context. It has also been recommended that NPs collect as much data as possible about their everyday practice because this is why nursing in the US has been so successful in resisting those not supportive of nurses delivering primary care (Diers, 2004).

However, the outcomes were less than perfect for the pioneer NPs who struggled to live out the compromises that the leaders made, which raises several issues about the pragmatic choices the nurse leaders made. These pragmatic decisions primarily relate to the need for the NPs to collaborate with doctors and, in particular, the involvement of doctors in the

[18] See Appendix I which provides a chronology of events from 1990-2010

development of the NPs' clinical practice guidelines. As with the requirement for clinical practice guidelines, whilst the nurse leaders were able to avoid their inclusion in the legislation, state government policy stipulated that doctors must be involved in determining local agreed need before a NP position could be created. However, based on the experiences in the US, the nursing stakeholders knew that it would be easier to change state government policy than state legislation (see p. 236).

On the other hand, the nurse leaders would not compromise when the medical stakeholders argued for NP committee unanimity for local agreed need before an NP position could be established. Doubtless the development of the NP role benefited from the past experiences in the US, Canada and UK. The Australian nursing leaders knew that it was important to restrict use of the NP title to authorised NPs, so they would not give ground on the issue. This restriction avoided the problems that occurred in the UK, and US because of the unprotected NP title in those countries. From the US, Canada and UK experiences, the Australian nurse leaders realised the importance of legislating to regulate the NP title so that the NPs' practice would not depend on the permission of doctors, and not leave the NPs open to legal challenge. The nurse leaders were successful in these two important initiatives. However, the degree of opposition and obstruction that occurred at the local regulatory level by some doctors was unexpected, as also highlighted by Appel and Malcolm (1999).

It seems fair to say that many of the events that unfolded, and their effect during the development of the NP role, could not have been foreseen or even controlled. In introducing any new role into the health care system there will always be uncertainty. During the development of the NP role there were two major restructurings of the AHSs and a state government election (See Appendix I). The first restructure was in rural and remote NSW and involved the reduction of twenty-three District Health Services to eight rural AHSs during the time of the pilot projects and this posed a significant challenge for all involved. Some of the health care settings that were keen to participate in the pilot projects were unable to do so. For the health care settings that did participate they did so under extreme pressure as their management structures were being changed (see p. 238).

The second health service restructuring involved rural, remote and also metropolitan AHSs. Seventeen AHSs were amalgamated into eight and this was taking place as the NP role was first being implemented after the authorisation of NPs had been achieved (see p. 167). This significant and disruptive restructure meant that managers' responsibilities and

accountability increased dramatically (Liang, Short, & Lawrence, 2005). Health care restructuring of AHSs in NSW has resulted in senior managers no longer working on-site, and as a consequence they are less able to provide direct leadership. Restructuring has also been shown to cause higher turnover, stress, pressure and burnout among managers, especially those in senior management positions (Liang, Short, & Lawrence, 2005). In addition, research has shown that changes that occur in organisations, such as those associated with an AHS restructure, usually require deep-seated adjustments to the existing sub-cultures of doctors, nurses and other health professionals (Braithwaite & Westbrook, 2005).

The significance of these restructures on the NP movement appears to have received minimal attention. However, the issue also slipped beneath my radar early on in this study. The NPs did not mention the restructuring of the health care service, rather those that were affected spoke about initially having management support but that it dramatically decreased when their manager left and was replaced by another. It wasn't until I interviewed the stakeholders that I became aware of the restructuring of the AHSs. Thus, it became clear that an important negative influence on the implementation of the NP role was the change that occurred within management with the AHS restructuring.

It is possible that the managers new to the organisations following the health service restructure were not as well informed about the NP role as their predecessors, and as such this may have negatively influenced their support for the role. While the restructuring of the AHSs could not be controlled, the findings indicate that, when introducing a new role into a health care system, it is importance to monitor ongoing changes that are occurring within the health care system or organisations and anticipate their possible influence.

The findings from this study also revealed the influence of the state government election on the early development of the NP role (Stage 3) that was not fully appreciated at that time (see p. 240). Before the election the current state Liberal Party were reticent to challenge the AMA because it was concerned that it would lead to industrial action. Following the election, the new incoming state Labor party (See Appendix I), that had been in opposition for many years, lacked confidence and experience in government, and as such was also at that time hesitant to upset the AMA. Also, the AMA is usually considered to be more closely aligned with the Liberal party and as such may have grasped any opportunity to attack the new incoming state Labor government.

Kingdon (1995, p. 165) states "when you lobby for something what you have to do is to put together your coalition, you have to gear up, you have to get your political forces in line, and then you sit there and wait for the fortuitous event." The nurse leaders did precisely that. The state government was under pressure to reduce excessive waiting times in metropolitan hospital emergency departments. The nurse leaders used this political imperative as an opportunity to argue successfully to move NPs into metropolitan NSW (see p. 246). As Kingdon (1995, p. 165) states "advocates lie in wait with their solutions in hand… like surfers waiting for the big wave."

Another breakthrough in the development of the NP (which does not relate to the period under study, but which is worthy of comment nonetheless) followed the 2007 Federal election when the Federal Labor party was elected to govern (See Appendix I). The nursing and midwifery professions had waited decades for a federal health minister to challenge the power of the AMA (Osmond, 2008). The new Federal Health Minister argued that, historically, the AMA had typically opposed any health care reforms. She declared that, "there is a longstanding anomaly here. Our health system, including funding for health services, is organised almost entirely around doctors, despite the fact that many services are now safely and ably provided by other health professionals - nurses, psychologists, physiotherapists, dieticians and others" (Roxon, 2008). Thus, another opportunity arrived whereby the nurse leaders lobbied the Health Minister for MBS and PBS reimbursement privileges for NPs. On May 12, 2009 the Federal Health Minister announced that the 2009-2010 Federal Budget would allocate $59.7 million over 4 years to provide access to the MBS and PBS for NPs to help improve the flexibility and capacity of Australia's health workforce, and improve patient access to services (Department of Health and Ageing, 2009b).

The Federal Health Minister described June 24, 2009 as another historic day for NPs. Legislation was introduced into the Parliament allowing NPs and midwives access to the Medical Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) for the first time in Australia from 1 November, 2009 (Department of Health and Ageing, 2009c).

The AMA responded to the new NP Legislation with a media release stating, "We have been assured by the Government that nurse practitioners and midwives will work collaboratively with medical practitioners to deliver quality care and ensure patient safety under the new arrangements" (Australian Medical Association, 2009a, n.p). On 26 June, 2009, the AMA

informed its membership that a letter had been sent to the Federal Health Minister stressing the importance "for the AMA to work with the Government to get this policy right so that patient care does not become fragmented and that safety and quality is [*sic*] not undermined" (Australian Medical Association, 2009b, n.p). However, the AMA's lack of strong objection to the new legislation contrasted to its usual response to government announcements about the NP role.

Nevertheless, as is so often the case with the pragmatics of health care, there was another twist in the development of the NP role. On November 5, 2009, despite the lessons learned because of the difficulties the NPs were experiencing in collaborating with some doctors, the Federal Government announced its decision to amend the *Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009* (Cth) to specify a requirement that midwives and NPs collaborate with medical practitioners (Department of Health and Ageing, 2009d).

On the same day the AMA declared, "we made it clear to the Government that without a requirement in law that there be collaborative arrangement between midwives, nurse practitioners and doctors then the legislation did not have any safeguards to ensure continuity of patient care, nor did it have any protections against the fragmentation of patient care services" (Australian Medical Association, 2009c).

A week later the ACNPs responded with a media release commending the government on including a legal requirement for a collaborative arrangement. The College stated "nurse practitioners have always sought to have a strong collaborative arrangement with medical practitioners… it is therefore gratifying that the AMA, after many years of resisting collaborative arrangements with nurse practitioners, have now seen the wisdom of this." (Australian College of Nurse Practitioners, 2009).

However, the College of Nursing saw the proposed Amendment as "reneging by the Minister on legislation proposing legitimate autonomy of practice for NPs and eligible midwives. In expressing her disappointment, the Chief Executive of The College believed that the health Minister bowed to pressure from the AMA to limit the authority of NPs (Osmond, 2010).

On 18th November, 2009 an AMA media release entitled, *GP groups united on collaborative care* revealed that the AMA formed a general practice coalition, calling it the United General Practice Australia, comprising the Royal Australian College of GPs, the AMA, the Australian General Practice Network, the General Practice Registrars Australia, the

Australian College of Rural and Remote Medicine and the Rural Doctors Association of Australia. The group called for the "united endorsement of collaborative care arrangements between health professionals to deliver the best possible health outcomes for Australian patients" (Australian Medical Association, 2009d). The terms "collaborative practice" and "collaborative care" were replaced by "formal collaborative care arrangements". On the 16th December, 2009 the AMA and RACGPs released another media release with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists calling on the Senate Community Affairs Committee that was inquiring into the *Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009* (Cth) to support the Government's amendments to the Bill requiring midwives and NPs to work under formal collaborative arrangements with medical practitioners (Australian Medical Association, 2009e). At the time of writing the *Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009* (Cth) is still under consideration by the government and the Australian Nursing Federation and the ACNP continue to negotiate with the government. Also, the ACNP is currently developing a definition for collaboration. In addition, the organisation is arguing for collaboration between NPs and all health care professionals as is the case in Canada (see p. 42) rather than solely on NP-doctor collaboration (H. Gosby, personal communication, ACNP, April 1, 2010).

Again, as with the pragmatics of health care, there had been a delay in the introduction of the legislation to allow NPs and midwives access to the MBS and PBS. Because of the risk of the Liberal Party again returning to Government with the upcoming Federal elections at the end of 2010 and stopping the legislation, the Australian Nursing Federation and the Australian College of Nurse Practitioners had been aggressively lobbying to expedite the legislation. On February 23, 2010 The Australian Nursing Federation, Australian College of Midwives and ACNP in a joint media release called on the senate not to delay in passing the Legislation (Australian College of Nurse Practitioners, 2010).

On March 16, 2010 the Federal Government announced that the Legislation had been passed to give NPs and midwives access to MBS and PBS reimbursements (Department of Health and Ageing, 2010a). Even though MBS and PBS will now be legally available to NPs, there are at least four working groups/committees currently examining the issue of non-medical prescribing, with NPs and eligible midwives being the first non-medical groups to be addressed (Australian Health Practitioner Regulation Agency, 2010; Department of Health

and Ageing, 2010b; Department of Health and Ageing, 2010c; National Health Workforce Taskforce, 2010.

Another development that is also about to occur is national regulation of NPs and national standards for the education of NPs. From July 1, 2010, members of the nursing and midwifery professions (including NPs) in Australia will all have to meet the same education and standard requirements to be registered as Australia is finally moving to a system of national registration and accreditation for 10 health professions, including nursing and midwifery (Nursing and Midwifery Board of Australia, 2010).

Chapter 9 – Conclusion

This study provides the only detailed history of the development of the NP role in NSW. The claim for uniqueness is made because the thesis documents the key events in the development of the role not only through documentation, but also through first-hand accounts of stakeholders and the NP pioneers intimately involved in its development. The data obtained from the interviews with the stakeholders and pioneers provide both accurate information in relation to the history and experiences of the NPs and information about the affective side of the development of the role, which can be lost in written documents.

> *That's why I'm really glad to be doing this interview because the history of it is going to be so important, to know what we fought for, you know… and also be known as the first state in Australia to do it.* [NP6]

Changes in the health care environment in Australia, and more specifically, NSW required concomitant changes in the approach to health care, and also in the existing roles, functions and status of health care professionals. This provided the opportunity for the introduction of a new nursing role such as that of the NP. The successful development of the NP role in NSW shows what can be achieved when nurses unite. Despite considerable adversity the nurse leaders and other supportive stakeholders were able to make the role a reality in a relatively short period of time, when compared to the development of the role in other countries such as the U.S, Canada and U.K. The role continues to evolve rapidly as evidenced by my having to amend the discussion chapter as it was being written to keep pace with changing events.

Of course, the pioneer NPs themselves were pivotal to the success of the role. Despite the uncertainty they experienced as they strove for authorisation, and during implementation of their new role, they remained resilient. The NPs were not overly daunted by the uncertainty that came with entering uncharted waters. Rather, they embraced it as an opportunity. Their resilience was fuelled by their unyielding belief that the NP role would provide a better health care service for their patients by improving the quality of, and access, to patient care; a belief that was shared by those stakeholders supportive of the role. The pioneers not only exhibited a strong commitment and passion for nursing, but they also wanted more from it. In addition to their readiness to leave behind the constraints of traditional nursing and to

function more autonomously, they saw the NP role as increasing the visibility of nurses' practice. Importantly too, the pioneers saw the NP role as providing increased recognition for their practice, decision-making and judgment capabilities. The NPs also possessed a strong sense of responsibility to pioneer the role for their less experienced or younger colleagues and they were acutely aware of the responsibility for nursing in general that came with pioneering the role. Also, many had their own, more personal, reasons for pioneering the role.

The disparate visions and vested interests in relation to the NP role inevitably affected the development of the role. Stakeholders who had a 'sense of gain' and supported the NP role saw its benefits for the health care system, and for nursing. Those who fought to maintain the status quo were ultimately driven by a sense of 'loss and fear'. A particularly strong stimulus to this sense of loss and fear was concern about the effect of the NP role on health care professionals within and outside nursing. Thus, because of the differing visions and vested interests, there was much interplay between those trying to maintain the status quo and those who were trying to counterbalance their sense of loss and fear. As a consequence the development and implementation of the NP role became a process of negotiation and compromise that ultimately impacted the way the NP role was developed and enacted. However, it was because of the lessons learnt during this process that the NP role was credited as having a significant impact on nursing's political growth. Effective collaboration between doctors and the NPs was seen to be critical to the success of the NP role. However, there was dissonance between the perceptions of nursing and medicine about the meaning of collaboration. Medicine's perception of collaboration was more aligned with the notion of supervision. Some individual doctors, and organisationally most notably the AMA, fought hard to maintain medicine's dominance and power within the NSW health care system, and more specifically, control of and self-imposed supervision over nurses' practice. As highlighted in Chapter 3, history is also concerned with the examination of the influence of tradition, and further complexities arose in understanding its historical legacy in relation to the NP role. The findings illuminated that some doctors had not adapted to the growing professional status of nursing. They were not only resistant to further professional developments in nursing, such as those associated with the NP role, but they were still grieving for their ministering angels and handmaidens. In addition, doctors have historically valued their status within the community as leaders of health care. The increased status and power of other health care professionals, such as NPs, was perceived as a threat to doctors'

status. Furthermore, the status and power differential between medicine and nursing was seen by some NPs and stakeholders as a contributor to the lack of confidence and sense of entitlement felt by some nurses, which in turn contributed to medicine's continued domination over nursing.

However, the influence of tradition was not limited to health professionals outside nursing. Before the development of the NP role many nurses (including myself) had not contemplated that there could be another way for nurses to function. The findings indicate that there are still many nurses who have not adapted to the advancement of nursing. As a consequence, they also hanker for the supposedly good old days, and strongly opposed new developments such as the introduction of NPs. In particular, there remain nurses in management positions who have retained a more traditional view of nursing, its practice, and its place within the health care hierarchy. As such these managers were seen to function in a manner similar to a hospital matron and were less likely to support advanced practice roles and increased autonomy for nurses. It was these managers, who also strove to maintain their authority and status within the health care hierarchy, that were particularly obstructive to the introduction of NPs.

The findings attest to significant disruption to professional-working relationships with some health care professionals torn between their personal, professional and organisational commitments. Long-term professional relationships between the NPs, nurses, doctors and managers were challenged. This was especially true for NPs working in small remote or rural communities, despite the belief of some stakeholders that, it would have been easier to introduce NPs into these areas because of the already identified need for improved health care.

Managers were in the undesirable position of being caught between supporting the NPs, and if they did so, having the GPs threatening to leave town. In addition, managers were already benefiting from the *de facto* NPs' practice without having to reward them financially at the increased level of an NP. Furthermore, there was no funding for the AHSs to cover costs associated with the NPs' extended skills such as prescribing, and their working after-hours shifts.

The NPs had to decide whether to take on the doctors, or avoid provocation. NPs who revolted against the doctors were met with hostility from them, but it is also clear from the

findings that the NPs valued their existing professional relationships with their medical colleagues and as such, were hesitant to confront the doctors and preferred stability above all else. The few pioneers that decided not to work as an NP, or to continue to work in an NP position, found the opposition to the role and obstruction from those within or outside nursing too overwhelming.

In addition to the utility of historical inquiry for examining, explicating, describing and interpreting past events, history has the potential to reconstruct our views of the present, and the future (Holmes, 2008). There were many lessons learnt from the development of the NP role in NSW.

It is critical to educate the public so that old stereotypical images of nurses can be replaced with those of the contemporary nurse. It is necessary to engage the public earlier rather than later on in the development of a new role such as the NP. This helps to garner support and also to educate the public so that people are knowledgeable about the role and its value. To engage the public it is also necessary to engage the media. The majority of the NPs enjoyed the recognition and personal satisfaction that came with pioneering the role, moving from relative obscurity to being familiar and visible. However, the findings suggest that not all of the NPs were comfortable being in 'the spotlight.' Because of the political nature of the role, NPs require education in using and managing the media and also education about managing themselves in the politics of health care. Ideally, newly introduced authorisation processes should be piloted, evaluated and amended before, not during, their implementation. The preparedness of those likely to apply should be assessed and detailed information and ongoing support should be provided.

There is a need for clarity in the terminology that is used in introducing a new nursing role. It is important for terms underpinning a new role to be defined and agreed upon within nursing before engaging in discussions with others. It is also important for those pioneering a new nursing role to have a clear understanding of the terms used to describe their role. This will help avoid arduous debates about their meaning, enhance communication, prevent inconsistent conceptualisations and also help prevent those less supportive of the role applying their own interpretation.

The study's findings demonstrate the need to assess an organisation's readiness when introducing a new nursing role. Role implementation is affected by the role acceptance and support of management, nurses, doctors and other health care professionals. Innovations such as that of the NP role that challenges traditional boundaries of nursing practice are more likely to cause some disruption especially during early implementation. There needs to be an assessment of the environmental conditions to support role implementation. Barriers need to be identified, and strategies developed to help facilitate the role. Planning and preparation before the role is implemented is essential. It is important to provide organisations with guidance about the introduction of the NP role, and to advocate for policies that support continued NP role development. The NP role is more likely to be seen as valuable when it is integrated and when the goals and outcomes of the role are clearly linked not only to the organisation's goals but also the of the health care system's goals. Information should be provided about the role to nurses, doctors and other health professionals to help alleviate fear and uncertainty about the role. It is essential that sustained support is available for NPs, especially those who do not have physical contact with their NP peers. Ideally, the resources needed for the introduction of role should be negotiated prior to the implementation of the role. During the implementation of a new role constant monitoring of indirect factors (such as a health system restructure or change in government) that may positively or negatively affect its development or implementation is required.

In relation to future research, a number of recommendations for nation-wide research into the implementation of the NP role are made. They are:

- examine health outcome data to make explicit the value of the NP role to the health care system;
- understand public perceptions of the NP role, including how and when these perceptions are formed, and extent to which existing perceptions impede attempts to change the use of the workforce;
- understand how patients decide which type of professional to consult, and patient and professional views of changes in skill-mix, and
- examine the divisions of labour among professionals and compare what is permitted versus what is expected.

Whilst the current research was concerned with documenting the history of past events in the development of the NP role, I also found myself in the midst of complicated, confusing and interwoven events at the local, state and national levels *as they were unfolding*. It can be particularly challenging examining history when the researcher does not know how it is going to turn out (Little, 2010). As acknowledged in Chapter 3, despite my being a RN and a proponent of the NP role, I entered the research with little knowledge or emotional investment in relation to the NP movement. However, over time I did become emotionally involved in the lives and struggles of the pioneer NPs. During the early development of the role I felt particularly challenged by the uncertainty as to whether the role would ultimately succeed. To illustrate the extent of my concern and uncertainty, on the 5th anniversary of the first authorised NP, I spoke to a health reporter from the Sydney Morning Herald newspaper to highlight that there had been no reported adverse events relating to NP practice and also to acknowledge increasing support by some medical practitioners since the introduction of the role into the NSW health care system. This contact culminated in an article entitled "Old wounds begin to heal as pioneering nurses mark their first five years" (Pollard, 2005, p. 5). Pollard wrote: "Despite dire predictions from doctors' groups - especially the Australian Medical Association - the sky has not fallen... and there is also a sense that old obstructions are finally breaking down" (Pollard, 2005, p. 5). However, my concern for the NP movement extended beyond the medical profession. I had become similarly frustrated at times by the apparent ambivalence by some within nursing in relation to the NP role. This compelled me to write an article that was published in the NSW Nurses' Association's magazine *The Lamp* entitled "Nurse Practitioners advance against the odds" (Foster, 2005). In essence, I had become increasingly torn between 'being a researcher' and 'being a nurse' and found myself questioning whether it is permissible for a researcher to try to 'change' history by meddling in the present. After all, as a researcher I was expected to document an unbiased representation of the history of the development of the NP and a criticism for the conduct of this research could be that I had become 'overly involved,' given that I was now lobbying for NPs to be supported in the media and by their peers. As Fairman and Mahon (2001) assert, the level to which a researcher becomes biased may be influenced by "the extent the interviewer belongs to the reality under investigation" and it is fair to say that as over time I felt an increasing sense of 'belonging.' The Foucauldian approach of a 'history of the present' is based on the insight that we always write 'from the inside out', in the sense that we cannot shake off our context in the present (Foucault, 1970a; Foucault, 1970b). But of course it can be argued that this is the special skill that is required of the historian, to

acknowledge and control one's situatedness in the context of accurate historical research (Holmes, 2011). In addition, it is the rigour of historical research, and use of comprehensive empirical data that avoids history being misconstructed to the point where it becomes "at best a piece of fiction, at worst an act of persuasion" (Black & MacRaild, 2000, p. 163). To these aims, I have acknowledged my bias in relation to the NP role. I was meticulous in my management of the data, and it was sourced from a wide range of perspectives through the NP and stakeholder interviews, and primary sourced document analysis. Thus, the reliance of the reader on my interpretations is minimised, and also allows the findings to 'speak for themselves.' In addition, throughout the research I maintained a decision trail to record key decisions made during the course of the research, for example, the need to interview further stakeholders, and a reflective journal to record new insights, introspections, feelings and reactions. Maintaining a reflective journal was cathartic in the sense that it helped me to 'purge' emotional tension especially following some of the interviews, and during times that I found to be particularly challenging. Importantly too, my supervisors read the interview transcripts, and thus were able to provide valuable critique on my interpretation of the data throughout the analysis and writing of this thesis.

In coming to my own conclusions about the development of the NP role, I have also been torn between my admiration and respect for the nurse leaders who were able to make the NP role a reality and a sense they demonstrated a level of naivety about the extent of resistance to the role that ultimately ensued, given the resistance to the role in other countries. In hindsight, however, the nursing leadership was challenging a health care system unlike the US and UK. The traditional hegemony of doctors in Australia meant that they were even more threatened as they had much to lose. Doctors' income in the UK is generally less threatened by the NP role because doctors are funded through the national health system. While health care is privately funded in the US, many NPs were able to fill gaps in the delivery of public health care to the uninsured that doctors were not particularly interested in. In contrast, doctors in Australia had much to lose both within the private and public health care sectors and until this time have successfully been able to exclude all others from encroaching on their traditional territory.

When I first began my PhD journey the management of the major teaching hospital in which I currently work did not support the NP role, even declaring that an NP would never be employed. However, today in this hospital there are NPs working in areas such as pain

management and the emergency department. These NPs enjoy considerable autonomy and their excitement and passion with their role is palpable if not contagious. Within the neonatal unit in which I work there are currently four NP candidates being well supported both in the work setting and also in their studies while undertaking an NP-specific master's degree.

I believe that since the introduction of the NP role in nursing, there has been a renewed sense of hope, pride, entitlement, confidence and even a degree of audacity that comes with the feeling that anything is possible.

Despite the considerable adversity that the NPs' faced as they implemented their role, not one of them said that they would not have taken up the challenge to pioneer the role had they known the problems that they ultimately encountered. This is testament to their tenacity and commitment to nursing and to their patients. As one NP exclaimed in a typically Australian fashion when asked if she would do it all again:

> *Bloody oath I would have* [NP1]

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Appendix A: Ethics information and consent

INFORMATION SHEET FOR PARTICIPANTS

(Key Stakeholders)

The Construction of the Nurse Practitioner Role in NSW:
An Ethnographic Study

Researcher: Ms Jann Foster
RN.,CM.,Grad.Dip.Ap.Sc.,Grad.Cert. (Research), M.H.Sc.(Ed.), PhD Candidate, University of Western Sydney.

The purpose of this study is to document the history, and explore the development of the Nurse Practitioner role in New South Wales. It is anticipated that the findings from this study will provide a critical analysis of the historical processes inherent in the development of the role, an understanding of the experiences and processes by which authorised Nurse Practitioners in NSW gained their professional status and provide a cultural perspective of disciplinary changes within traditional structures. To achieve this aim, the subject of discussion will be directed towards your perceptions of the role of the Nurse Practitioner.

The procedures involved in this study are as follows:

- I will ask you to sign a consent form prior to the commencement of the study. You will retain a copy of the consent form.
- We will arrange a mutually convenient time and place for the interviews.
- The audio-taped interview will take approximately 1 to 1½ hours. You, the participant, set the pace of the interview.
- To commence the conversation, I will ask you to respond to the following question "can you describe your own or your organisation's position in relation to the Nurse Practitioner role; and what has been your involvement or interest, in the development or implementation of the role". You may be asked to illustrate your answers with specific instances. Other questions will be guided by your answers.
- During the conversation, the researcher may ask you for clarification of certain issues.

As a participant, your rights and privacy are respected. In particular:

- You decide what information you give and you may decline to answer any question.
- You will be able to, at any time, temporarily or permanently, terminate the conversation and switch off the audiotape without giving a reason.
- A numeric coding system will only be used for participant identification. At no time will your identity be recorded. Any names identified during the interviews will be given a pseudonym during analysis of the data. Your name will not be used in any reports that emerge from this study.

- All information will be treated with absolute confidentiality, and data stored in secure conditions.

- All information you provide will only be accessible to the researcher and her supervisors. Lists of people who participated or declined to participate will only be available to the researcher and supervisors.

- Your participation in this study is entirely voluntary and you may refuse to participate from the study at any stage without adverse consequences. Your decision to withdraw will be respected by the researcher.

- If you feel distressed during the interview, it can be terminated temporarily, and you decide if you wish to continue the interview.

- Your involvement in the study finishes at the conclusion of the interview.

- There will be no financial or any other form of remuneration for participation.

- The research is **not** affiliated with or sponsored by any Government department, agency or commercial interest within or outside the University of Western Sydney.

If you would like to participate, please return the signed consent form in the self-addressed envelope, or if you have any enquiries regarding this project, please feel free to contact Ms. Jann Foster on (02)9529.0714 / 0414.502724 email:

Address: Jann Foster, 8/50-52 Fraters Avenue Sans Souci NSW 2219.

NOTE: This study has been approved by the University of Western Sydney (UWS) Human Ethics Review Committees (HERC). If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officer (tel: 02 45701 136). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

INFORMATION SHEET FOR PARTICIPANTS

(Nurse Practitioners)

The Construction of the Nurse Practitioner Role in NSW: An Ethnographic Study

Researcher: Ms Jann Foster

RN.,CM.,Grad.Dip.Ap.Sc.,Grad.Cert(Research), M.H.Sc.(Ed.),

PhD Candidate, University of Western Sydney.

Thank you for your interest in this study that is designed to document the history, and explore the development of the Nurse Practitioner in New South Wales. It is anticipated that the findings from this study will provide a critical analysis of the historical processes inherent in the development of the role, and an understanding of the experiences and processes by which accredited Nurse Practitioners in NSW gained their professional status. To achieve this aim, the subject of discussion will be directed towards your perceptions and experiences during and following accreditation as a Nurse Practitioner.

The procedures involved in this study are as follows:

- I will ask you to sign a consent form prior to the commencement of the study. You will retain a copy of the consent form.
- We will arrange a mutually convenient time and place for the interviews.
- Each audiotaped interview will take approximately 1 to 1½ hours. You, the participant, set the pace of the interview.
- To commence the conversation, I will ask you to respond to the following question "can you describe the process by which you became a Nurse Practitioner". You may be asked to illustrate your answers with specific instances. Other questions will be guided by your answers.
- During the conversation, I may ask you for clarification of certain issues

As a participant, your rights and privacy are respected. In particular:

- You decide what information you give and you may decline to answer any question.
- You will be able, at any time, to temporarily or permanently, terminate the conversation and switch off the audiotape without giving a reason.
- A numeric coding system will be used for participant identification. At no time will your identity be recorded. Any names identified during the interviews will be given a pseudonym during analysis of the data. Your name and that of the institution in which you work, will not be used in any reports that emerge from this study.

However, because of the small number of Nurse Practitioners in NSW, there is a possibility that you may be identified simply as a result of participation.

- All information will be treated with absolute confidentiality, and data stored in secure conditions.

- All information you provide will only be accessible to the researcher and supervisors. Lists of people who participated or declined to participate will only be available to the researcher and supervisors.

- Your participation in this study is entirely voluntary and you may refuse to participate from the study at any stage without adverse consequences. Your decision to withdraw will be respected by the researcher.

- If you feel distressed during the interview, it can be terminated temporarily, and you decide if you wish to continue the interview.

- Your involvement in the study finishes at the conclusion of the final interview.

- There will be no financial or any other form of remuneration for participation.

- The research is **not** affiliated with or sponsored by any Government department, agency or commercial interest within or outside the University of Western Sydney.

If you would like to participate or have any enquiries regarding this project, please feel free to contact Ms. Jann Foster on (02)95290714/0414 502724, j.foster@bigpond.net.au.

Address: Jann Foster, 102C Ida Street, Sans Souci NSW 2219

NOTE: This study has been approved by the University of Western Sydney (UWS) Human Ethics Review Committees (HERCs). If you have any complaints or reservations about the ethical conduct of this research, you may contact the UWS Ethics Committee through the Research Ethics Officer (tel: 02 45701136). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

CONSENT TO PARTICIPATE IN RESEARCH

(Stakeholder and Nurse Practitioner Participants)

I, the undersigned, hereby declare that I am participating in one interview for the study titled 'The Construction of the Nurse Practitioner in NSW: An Ethnographic Study' being conducted by Jann Foster for the degree of Doctor of Philosophy.

I further acknowledge that the nature and aims of the research and my involvement have been explained fully and to my satisfaction. I have read and understood this and accompanying information that has been provided to me, and my questions about the research and my involvement have been answered satisfactorily.

I am aware and acknowledge that:

- I may withdraw my consent to participate at any time, including during the interview, without penalty or repercussions, in which instance the interview will terminated immediately and no information I have provided will be retained by the researcher or anyone else.
- I may elect not to answer any question I prefer not to answer, and may withhold any information I prefer not to divulge.
- Any information I provide about myself or anyone else will be anonymous and will not be identifiable from any presentation of the results.

I understand that this research conforms to the expectations of the NHMRC for ethical research, and has been approved by the UWS HERCs.

Name (print): _____

Date: _____

Signature: _____

Signature of researcher: _____

Appendix B: Framework for NP services: Process for accreditation of NPs in NSW

1.1 Guidelines for the Process of Accreditation of Nurse Practitioners	
1.1.1	A Nurse Practitioner Accreditation Committee be established by the Nurses Registration Board of NSW with composition as stated in 3.2.4 of the Nurse Practitioner Project Stage 3 Final Report of the Steering Committee
1.1.2	Recognition be given to the role of the nurse practitioner in NSW, including the title of 'nurse practitioner to be reserved for accredited nurse practitioners only
1.1.3	Recognition for the accreditation as a nurse practitioner (context of practice) be granted for a 3 year period after which re-accreditation will be necessary
1.1.4	The Nurses Registration Board NSW Accreditation Committee to review the applicants demonstrated experience against the essential criteria (specific to context of practice)
1.1.5	Accreditation as a nurse practitioner (context of practice) be granted for a 3 year period after which re-accreditation will be necessary
1.1.6	Applications for accreditation as a nurse practitioner should be in writing to the Nurses Registration Board NSW. The Nurses Registration Board NSW should determine costs associated with process of accreditation, application format and process for appeal
1.1.7	The Criteria for Accreditation to be reviewed by the Nurses Registration Board NSW within 2 years of securing legislative amendment and recognition for the role of nurse practitioner
1.1 Criteria for Accreditation as a Nurse Practitioner in NSW	
1.2.1	A registered nurse on List A in NSW
1.2.2	Relevant post registration qualifications or equivalent, enabling expert practice in the context in which accreditation is sought
1.2.3	Demonstrated 5000 hours of current practice in advanced practice role, articulating competency standards for the advanced nurse clinician and specialty standards in the context in which accreditation is sought
1.2.4	Demonstrated skills and knowledge associated with the identified privileges relevant to the context of practice, including pharmacology and clinical assessment
1.2.5	Demonstrated ongoing professional development ie. Attendance and active participation at relevant seminars/workshops/conferences
1.3 An Example of the Accreditation Process for Nurse Practitioners in NSW	
Given that the criteria was established and approved, the process may be:-	
Step 1	Application considered by Nurse Practitioner Accreditation Committee
Step 2	Applicant recommended to Board as meeting requirements for accredited nurse practitioner
Step 3	Approved by Board
Step 4	Applicant receives accredited nurse practitioner authority
1.4 Proposed Role of the Nurse Practitioner Accreditation Committee	
The Nurse Practitioner Accreditation Committee will be established by the Nurses Registration board NSW to further refine the criteria for accreditation of nurse practitioners and to make recommendations to the Nurses Registration Board NSW. The Proposed responsibilities of this committee will include:- • Expansion on the Draft Criteria for Accreditation as a Nurse Practitioner in NSW, including assessment processes • Providing advice on requirements for individuals to achieve accreditation • Liasing with relevant specialist nursing associations on issues related to accreditation of nurse practitioners.	
1.4 Proposed Role of the Nurse Practitioner Accreditation Committee	
• All nurse practitioners working as employees will be covered by their employer through vicarious liability • All nurse practitioners working in the public sector not covered by vicarious liability must carry personal indemnity insurance • The NSW Health Department recommends that nurse practitioners working outside the public sector who are not covered by vicarious liability have personal indemnity insurance • The Nurses Registration Board NSW will provide relevant information concerning professional indemnity to all applicants. (NSW Department of Health, 1998, pp.1-3)	

Appendix C: Principles for the development of clinical guidelines for NP practice by health services

The principles outline the guiding process for the development of clinical guidelines by the multidisciplinary team at the local level, the importance of consultation with relevant professional organisations and the process for approval.

Developed by the multidisciplinary team[19] (including relevant representation from the medical, nursing, pharmacy and allied health professions), clinical guidelines will address specific clinical presentations and guide the nurse practitioner in clinical assessment, clinical management and evaluation.

Formulary[20] developed as part of the clinical guidelines will require approval by the Director-General, NSW Health.

Approval by the Director-General, NSW Health will not be given unless the local group developing the clinical guidelines demonstrate that the steps outlined above have been followed.

2.1 Principles

The clinical guidelines for nurse practitioners developed by a local health service shall:-

2.1.1	Follow the principles outlined in the NH& MRC document Guidelines for the Development and Implementation of Clinical Practice Guidelines including; • the development and evaluation of clinical guidelines should be outcome focused and based on the best available evidence; • the process of development should: be multi-disciplinary and include consumers; be flexible and adaptable to varying local conditions; and should include a consideration of resources; and • the relevance and currency of the guidelines should be evaluated and updated regularly.
2.1.2	Relate to the clinical context of practice in which the nurse practitioner is accredited
2.1.3	Be aligned with professional standards for the management of particular clinical presentations
2.1.4	Be reviewed as part of the health service quality management strategy[21] in response to changing practice
2.1.5	Include clearly delineated professional links for consultation and review between the nurse practitioners and nominated medical practitioners
2.1.6	Include ongoing evaluation against best practice for appropriateness, safety and consumer satisfaction
2.1.7	Specify:- • the particular substances to be prescribed as part of a nurse practitioner formulary; and • diagnostic investigations that a nurse practitioner is authorised to initiate locally
2.1.8	Include a process for approval by the local health service[22] and other relevant bodies as required (NSW Department of Health, 1998, p.4-5)

[19] The development of the clinical practice guidelines had to be developed by the multidisciplinary team at the local level.

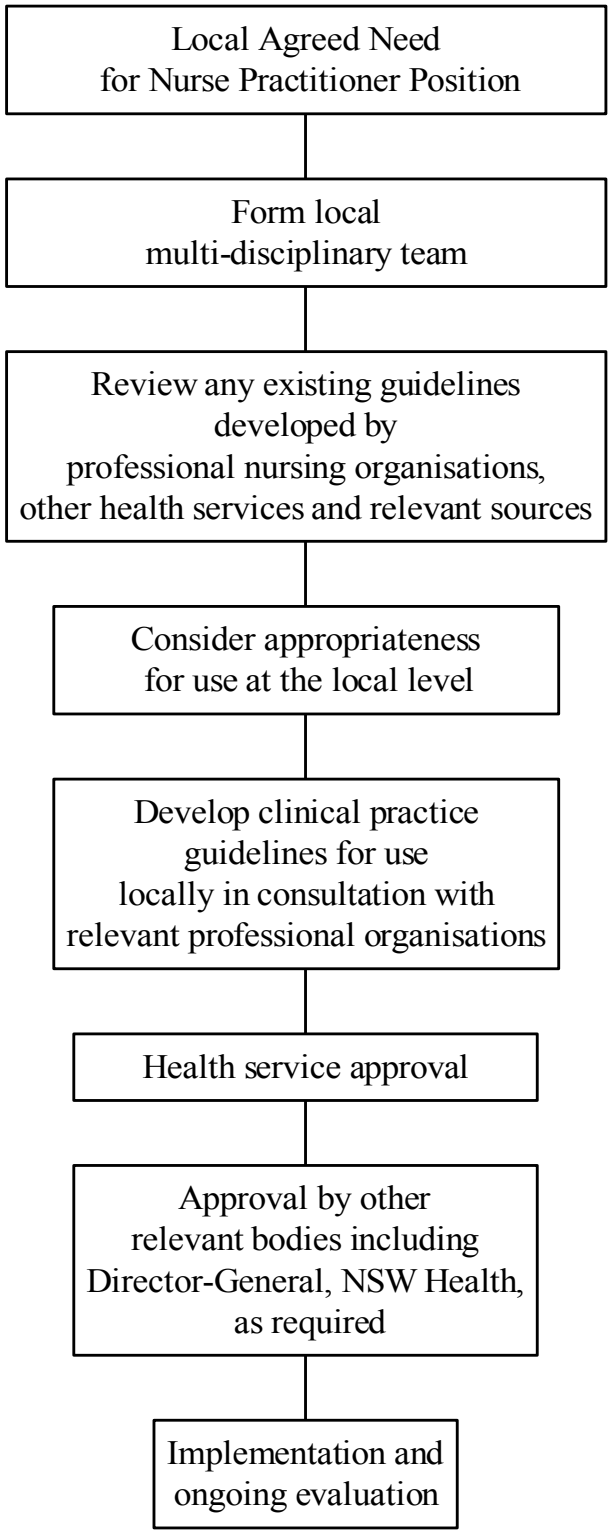
[20] It was the formulary part of the clinical guidelines that required approval by the NSW Director General.

[21] The clinical guidelines were to be incorporated and evaluated as part of the management strategy at the local level.

[22] The clinical guidelines had to be approved by the local health service, and the Director General.

Appendix D: Flowchart for the development of clinical guidelines for NPs by health services

NSW Department of Health (1998, p. 6)



Appendix E: Required legislative amendments and recommendations to enable NP practice

3.1 Amendments to the Poisons and Therapeutic Goods ACT	
3.1.1	To grant prescribing and supply rights to nurse practitioners for substances set out in Schedules 2,3, and 4 of the Act.
3.1.2	Insert a requirement that in exercising these rights a nurse practitioner must operate within an approved formulary
3.1.3	Define "approved" to mean approved by the Director-General NSW Health
3.2 Amendments to the Nurses ACT	
3.2.1	Recognition of the title "nurse practitioner" in legislation, with the use of the title to be limited to registered nurses accredited by the Nurses Registration Board NSW
3.2.2	A requirement that nurses wishing to retain accreditation under these provisions apply to the Board for re-accreditation every three years, or at the end of their period of accreditation, whichever period is shorter
3.3 Amendments to the Pharmacy ACT	
3.3.1	Amendment of Section 28 of the Pharmacy Act to recognise that pharmacists will be able to dispense medications on a prescription of a "nurse practitioner"
3.3.2	Amendment of Section 28(1) of the Pharmacy Act to allow nurse practitioners to dispense medications with the same limitations as those imposed on medical practitioners
3.4 Other Action	
3.4.1	There is a need for consistency in the development of nurse practitioner formularies. As such there is a requirement for formularies to be approved by the Director-General following advice from expert advisors. *As the role of the nurse practitioner develops, and as clinical guidelines are evaluated and consolidated, it may be appropriate for the function of review and development of the formularies to be returned to the professions involved. The approval process is to be reviewed no later than at the end of five years after the commencement of the amendments proposed to the Poisons and Therapeutic Goods Act.*
3.4.2	A working group be established to consider the question of nurse practitioner prescription and supply of Schedule 8 medications. *As it is recognised that in a number of areas of practice (for example, midwifery and palliative care), nurse practitioners may need access to Schedule 8 medications, the issue needs to be addressed.*
3.4.3	As Nurse Practitioners will be initiating medications according to an approved formulary and context of practice, further discussion will be required as to the process used to advise community pharmacists of the formulary from which a particular nurse practitioner will be able to prescribe. The Department of Health will consider this issue as part of the administrative process. (NSW Department of Health, 1998, pp. .7-8)

Appendix F: Assessment criteria chart for NP accreditation

Health Assessment **Diagnosis** **Therapeutic Management** **Evaluation**	Relevant specialist anatomy and physiology. Relevant specialist pathophysiology. Relevant specialist pharmacology. Relevant specialist health assessment skills. Prioritisation/Triage Differential diagnostic skills. Complex problem solving skills. Ability to carry out judicious ordering, reading and interpretation of pathology and radiology tests. Relevant specialist understanding of therapeutic case management. Relevant specialist applied pharmacology. Relevant specialist prioritisation/time management skills. Stabilisation skills. Judicious referral strategies. Relevant specialist counselling skills. Outcome measurement and interpretation skills.	**Accountable Practice** Advanced risk management skills; legal parameters of practice; teamwork; cultural awareness skills; communication skills; code of professional conduct; code of ethics.	a) A registered nurse in NSW plus authorisation to practice midwifery if appropriate. b) Relevant post registration qualifications or the equivalent that enables them to be an expert nurse in the area (context) in which recognition is sought. c) 5000 hours of current (within the past 5 years) practice in advanced practice role appropriate for the area (context) for which recognition is sought. d) Achieved competency standards for the advanced nurse clinician and specialty standards in the area (context) for which recognition is sought. e) Relevant professional development through participating in, and attendance at appropriate workshops, seminars, and conferences. Any other information/experience considered by the applicant to be relevant for the application.

Source: Nurses Registration Board of NSW, 1999

Appendix G: Media Documents

Author	Date	Title	Source/Type	Location	Summary and comments
Overs M	31 Jul '92	Paper endorses stronger role for nurse practitioners	*Australian Doctor, p4* Article in medical newspaper	National	"they [nurses] could never cope at this intellectual level"
Editorial	31 Jul '92	Nurse practitioners pushing for power	*Australian Doctor, p4* Article in medical newspaper	National	"NP role is frightening push for power"/"fragment health care". "Nurses think better than GP, good as a specialist".
Editorial	1 Aug '92	Concern over nurses	*NSW Doctor, p7* Article in medical newspaper	NSW	""Role causes concern". AMA NSW will submit reply [*to Discussion Paper*]
Arnold P	1 Aug '92	Nursing paper not the answer	*NSW Doctor, p5* Article in medical newspaper	NSW	Nurses determined to overthrow "handmaiden image".
Buhagiar T	4 Aug '92	The time has come to pull up our socks	*Australian Doctor, p6* Article in medical newspaper	National	"Strong threats to our profession mounted by handful of nurses". "[NPs] with inflated opinions of their abilities who want to dabble in the doctors' prerogative"
Kwong AYM	14 Aug '92	Four years not enough	*Australian Doctor, p9* Article in medical newspaper	National	Nurses "dabble in areas not trained for"
Demou T	21 Aug '92	'Determined' nurses worry AMA	*Australian Doctor, p2* Article in medical newspaper	National	NP role reduce health care standards/less qualified/ depth of understanding superficial/waste economic resources.
Buhagiar A	28 Aug '92	General Practice must repel invaders	*Australian Doctor, p6* Article in medical newsletter	National	The RACGP sees NPs as invaders
Buhagiar A	11 Sep '92	Eyeing off the patients is not on	*Australian Doctor, p10* Letter in medical newspaper	National	AMA see NPs turfing their role
Harrigan P	26 Jun '93	Round the world: Australia-Nurse practitioners	*The Lancet, vol.* 342, *no.26, p1652*	International	"The movement to elevate the status of nurses has received a boost". AMA opposed to less qualified than Drs to replace Drs role.
AMA	1 Jan '94	Nurse Practitioners	AMA Website & position statement	National	Drs cannot be replaced by NPs/ lack medical education/ Drs should not be legally resp. for independent NPs.

Author	Date	Title	Source/Type	Location	Summary and comments
Wilkins M	22 May '94	Nursing Duties	*Sunday Telegraph* Article in newspaper	NSW	Health Minister: NP program created to speed up health care services in areas like A&E/country areas not because of lack of Drs.
Patty A	22 May '94	Nurses' caring role widens	*Sun Herald, p13* Article in weekly newspaper	NSW	NP role to expand roles normally performed by doctors " where nurses work collaboratively with Drs" AMA: full evaluation needed before approval given.
White D	June '94	The Nurse Practitioner	*The Lamp, vol.51, no.4 pp. 4-5* Letter to Editor	NSW	Letter from RN: "traditional hierarchy of health care will continue to hamstring nursing".
Meppem J	Aug '94	The Nurse Practitioner	*The Lamp, vol. 51, no.7, pp. 9-10* Letter to Editor, nursing association newsletter	NSW	Reply to Russell-White letter from NSW Chief Nursing Officer: concern over letter which portrays bleak view of the NP Project.
Denning L	Aug '94	no title	*The Lamp, vol.51, no.7, p9* Letter to Editor, NSW Nurses' Assoc. newsletter	NSW	Letter from nurse: "I am totally opposed to the idea of the Nurse Practitioner. Am I alone in this view?"
AMA	24 Apr '96	Nurse practitioner project flawed	AMA Website Media release	NSW	AMA reports that NP pilot project flawed
AMA	1 May '96	Branch rejects flawed nurse practitioner report'	*NSW Doctor, pp.24-25* Article in medical newspaper	NSW	AMA reports that NP pilot project flawed
AMA	17 May '96	The NP Project	Letter to AMA Membership	NSW	AMA writes letter to its members that independent report found NP project flawed.
Collins J	1 June '96	President's report	*The Lamp, vol. 53, no. 5, p19*	NSW	24 April, 1996 a historic day for nurses with release of the Final Report of the NP Project Stage 3. "Validated and legitimised what we as nurses have been doing for centuries"
Editorial	24 Jan '97	Patient Care is still top priority, says AMA	*Australian Doctor, p4* Article in medical newspaper	National	AMA concern with NP role about patient care
Tattam, A	24 Jan '97	Nurses' encroach on GPs' domain	*Australian Doctor, p6* Article in medical newspaper	National	NP role turfing GP role. "Discussions over the role of NP are often clouded by confusion over definitions, autonomy and scope of practice"
Jopson D	20 Sep '97	Nurses may prescribe drugs under new laws	*Sydney Morning Herald, p5* Newspaper article	NSW	Focus on prescribing power of NPs.

Author	Date	Title	Source/Type	Location	Summary and comments
Hull D, Lim YB, Sheen, A.	24 Sep '97	Difference between doctors and nurses	*Sydney Morning Herald, p14* Letter to newspaper	NSW	NPs "alarming", "grave concern", "barefoot Drs", "no medical training", "want to play Drs", "trained monkey", "lower health standard".
Barker R, Anderson M, JensenJ	26 Sep '97	Nurses-the right prescription	*Sydney Morning Herald, P22* Letter to newspaper	NSW	Focus on NP prescribing rights.
Hull D	30 Sep '97	The goal - improved patient care	*Sydney Morning Herald, p14* Newspaper article	NSW	Nurse reply. NP role to improve health care
Yoong L	10 Oct '97	Doctors must resist the push by nurses	*Australian Doctor, p21* Letter to medical newspaper	National	NPs not capable, "health of community will be compromised"
Jopson D	21 Oct '97	Nurses to fight for right to diagnose, prescribe	*Sydney Morning Herald, p8* Article in newspaper	NSW	Focus on NP diagnosis, prescribing.
Anastaso-poulos C., Vale S	31 Oct '97	Nurses threaten to 'take to streets'	*Australian Doctor, p9* Article in medical newspaper	National	NP role "ludicrous".
Gunn A	13 Mar '98	Nurse Practitioners are a benefit not a threat	*Australian Doctor, p4* Article in medical newspaper	National	Support for NP role by Doctors' Reform Society "The assertion that nurses cannot make judgments simply ignores reality".
Chulov M	23 Aug '98	Set for country practise	*Sydney Morning Herald* Article in newspaper	NSW	NPs to be introduced into country areas.
AMA	25 Aug '98	Government's cave-in to nurses a black day for rural health	Website Media release	NSW	As title suggests
Humphries D	26 Aug '98	Medical profession divided as nurses diagnose & prescribe	*Sydney Morning Herald, p2* Article in newspaper	NSW	Doctors divided over NP role. Health Minister: "NPs will provide an extra health service". AMA: "cheap solution". RACGP: "it only formalises process already in place & established by need". RDA: "gravest concern allowing nurses to fill a diagnostic role – they aren't trained for it".
Editorial	26 Aug '98	Rural communities to benefit from influx of special nurses	*Northern Daily Leader, p8* Article in newspaper	Local	NP role benefit to rural areas.
NRHA	28 Aug '98	NSW Decision on NPs will advance an important issue	NRHA Website Media release (multidisciplinary alliance)	National	Multidisciplinary support for NP role
Patty A	11 Oct '98	$56,000 for supernurses angers AMA	*Sun Herald, p30* Article in weekly newspaper	NSW	AMA upset over funding for NP role

Author	Date	Title	Source/Type	Location	Summary and comments
Gunnedah G	1 Sep '99	Nurse practitioners	*Rural Doctors Association newsletter,* Article in medical newsletter	NSW	Nurse Practitioner role not supported as specified in the Nurse Practitioner Act.
College of Nursing NSW	29 Oct '99	New Role for Nurses-Nurse Practitioners for 2000	CON NSW Website Media release	NSW	Proclamation today of the Nurse Amendment (Nurse Practitioner) Act 1998. NSW Health Min. to consider 40 positions.
NSW Health	29 Oct '99	Nurse practitioners to start in rural NSW	NSW Health Website Media release	NSW	Proclamation of the legislation governing NP practise. "NPs to provide a complementary service to doctors"
Coleman M	24 Nov '99	Doctors and nurses break down the barriers	*ABC Radio National: Life Matters* Transcript	National	"The demarcation line between Aust. Drs & nurses, traditionally a strict one, is slowly breaking down". AMA: substantial risk to patients /concern territory being invaded/ "biggest concern is giving nurses power to prescribe"
Woollard L	1 Dec '99	RDA (NSW), AMA AND RACGPs oppose Nurse Practitioner Legislation	*Rural Doctors Association newsletter, attachment B* Article in medical newsletter	NSW	"all medical organisations consider this legislation [concerning NPs] unworkable in its current form"
Radio National	2 Dec '99	Nurse Practitioners	*ABC Radio National: Life Matters* Transcript.	National	Discussion with RN and President RDAA about NP role. Nurses say doctors in country towns are afraid of competition with nurses.
RACPG	12 Dec '99	Nurse practitioners: RACGP Position Statement. Council Minutes 42/3	RACGP Website & Position statement	National	"Supports role of NP within context of primary health team", "opposes concept of 'independent' NP", "supports development of a nationally consistent collaborative model of practice for NPs"
AMA	19 May '00	Nurse Practitioner: Briefing notes	AMA Website Briefing Notes	NSW	NP role described.
AMA	22 May '00	NSW Government prescribes peril for patients and health care	AMA Website Media release	National	"Arguments for NPs unscientific, flawed, biased". "quality of health care under severe threat. Need clear role definition"

Author	Date	Title	Source/Type	Location	Summary and comments
AMA, RDA, RACGP	22 May '00	Joint position statement on Nurse Practitioners	AMA, RDA, RACGP Websites & Joint Position Statement	NSW/Nat.	AMA, RDA and RACGP "call on NSW Minister for Health to review NP Legislation". NP concept based on 'biased and unscientific research'.
Moait S	14 Jun '00	Doctoring up the nightingales	*Newcastle Herald, p9* Article in newspaper	Local	NP 'threat to quality of health care'. About NSW medical profession "shameless attempt to entrench professional privilege at the expense of better health service delivery"
ANF	1 Jul '00	NSWNA defends nurse practitioners	ANF Website Media release	National	Medical profession must see NPs as a 'fact of life' and work cooperatively following NP legislation. "Drs do not own the health system"
AMA	14 Jul '00	Nurse practitioners	AMA Website –GP Network News	National	AMA aims to deter states from introducing NP legislation through participation in ongoing evaluations by governments.
Davies J A	22 Jul '00	The medical divide	*The Age, p49* Article in newspaper	National	Drs: 'patients' lives at risk' with NP. AMA: "Medicine and nursing are two entirely different disciplines; you can't interchange them." AMA scared 'junior nurses' may be NPs.
Shine K	19 Nov '00	Few takers for jobs as nurses fear backlash	*Sun Herald, p34* Article in weekly newspaper	NSW	NP roles hard to fill due to strong opposition from drs. 'Super- nurse concept' More nurses willing to go to rural areas than drs.
CON NSW	13 Dec '00	First Nurse Practitioners Authorised	CON Website Media release	NSW	First Nurse Practitioners Authorised, Jane O'Connell and Sue Denison
NSW Health Dept.	13 Dec '00	Nurse Practitioners a Reality in NSW	NSW Health Website Media release	NSW	'12 December, 2000 will go down as an historic day for Australian nursing'. Registration of the first 2 NPs in NSW.
Verghis S	26 Dec '00	Super nurses' prescribed as a rural cure not what doctors ordered	*Sydney Morning Herald p9* Article in newspaper	NSW	NPs portrayed as "super nurses by media"
Barrett R	22 Jan '01	Doctors resist super nurses	*Radio ABC: PM* Radio broadcast transcript	National	NPs portrayed as "super nurses by media".

Author	Date	Title	Source/Type	Location	Summary and comments
CON	1 Feb ’01	First nurse practitioners authorised	CON Website Media release	NSW	The Minister for Health agreed to establish up to 40 NP positions across [rural & remote] NSW.
Lumby J	1 Feb ‘01	First nurse practitioners authorised	*Nursing.aust, vol.2, no.1, p1* CON newsletter	National	“white-anting of the NP role by a few individual doctors”
Courtney D	24 Apr ’01	Doctor says use of nurse practitioners ignores reality	*Australian Doctor, p35* Article in medical newspaper	National	Drs seen as authoritative figures on issue.
CON NSW	11 May ’01	Back of Burke gets first NP	CON Website Media release	NSW	Ms Olwyn Johnson as been authorised and employed as a generalist (remote) NP.
NSW Health Dept.	11 May ’01	Nurse practitioner-An Australian first	NSW Health Website Media release	NSW	Announcement of the first practising NP in NSW
Haxton N	12 May ’01	Nurse practitioners appointed in NSW	*Radio ABC* Radio broadcast transcript	National	NSW first state to appoint NP, nurses to have “more clinical power”/will “revolutionise nursing”.
AMA	15 May ’01	Nurse practitioner is recognition of the state of health in the bush	AMA Website Media release	NSW	Drs & nurses have very different roles, cannot replace one another.
The Black Opal Advocate	16 May ’01	Olwyn Johnston Nurse Practitioner-An Australian First	*The Black Opal Advocate, p19* Website	Local	Article covering appointment of the first practising NP in NSW.
NSWNA	May ’01	Opposition to NP concept	*NSWNA Website Newsfront: Prof. News*	NSW	Article to dispel myths on NP role circulated by AMA. “NP research not biased”
NSWNA	May ’01	What evidence supports the development of NP roles?	*NSWNA Website Newsfront: Prof. News*	NSW	Article providing overview of NP Projects
Shine K	27 May ’01	Why DoctorOlly is the new face of bush medicine	*Sun Herald, p26* Article in weekly newspaper	NSW	Interview with NP
Editorial	27 May ’01	It's not about turf: AMA	*Sun Herald, p6* Article in weekly newspaper	NSW	AMA denies turf war with NPs
NRHA	19 Jun ’01	Rural health careers in the spotlight	NRHA Website Media release	NSW	NP role a “politicised topic”.
CON NSW	1 Aug ’01	Practice nurses vs nurse practitioners	CON Website Media release	NSW	Provides differences between the two roles.
Davies J	15 Dec ’01	Super nurse' debate divides medical ranks	*The Age, p30* Article in newspaper	VIC	Portrayal of NP as “super nurse”. Reports “division in medical ranks for support of NP role”

Author	Date	Title	Source/Type	Location	Summary and comments
Editorial	1 Feb '02	No title	*The Daily Telegraph, p9* Article in newspaper	NSW	"RDA is supportive of putting nurses in as part of a team with a doctor", without consultation system is destabilised, the relationship between the nurse & doctor become conflictive". "doctors are being kept out of the loop". AMA: "Nurses a cheap alternative"
Swan N	23 Apr '02	Nurse Practitioner	*Radio ABC: Health Dimensions*. Radio transmission transcript	National	NP role essential part of hospital care/ new breed of nurses/ power to perform doctor's/strong argument to introduce in city hospitals.
College of Nursing NSW	2 May '02	Nurse Practitioners	CON Website Media release	NSW	"Nurse practitioners have been shown to be safe, effective and sorely needed by international & local research"
Lumby J	1 Jul '02	The UK leads the way	*Nursing Australia, p7* Article in nursing newsletter	NSW	"So-called rural 'crisis' in the country would be eased if roll out of NPs was given safe passage by Drs"
NSW Health Dept.	5 Sep '02	NSW AMA out of step with leading doctors	NSW Health Website Media release	NSW	"AMA had 9 years to put its case" against NPs. Provides extensive list of 6 specialist doctors, CEOs, academics and nursing associations all in support of NPs.
NSW Health	5 Sep '02	Roll out of specialist nurse practitioners	NSW Health Website Media release	NSW	Announcement that specialist NP positions in EDs, ICUs, Mental Health Services in "Sydney, the Hunter and the Illawarra". The first position in ED of the Children's Hospital at Westmead.
College of Nursing NSW	5 Sep '02	Nurse practitioners-a timely initiative	CON Website Media release	NSW	NSW Govt. to create NP positions in EDs and ICUs in metropolitan hospitals.
NSW Nurses Assoc.	5 Sep '02	Nurse Practitioners are coming to the city-first positions to be created in metropolitan EDs and ICUs	NSWNA Website Media release	NSW	NSW Govt. to create NP positions in EDs and ICUs in metropolitan hospitals. Restriction of NPs to rural and remote areas inhibited the role.

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AMA	5 Sep '02	Nurse practitioner plan a disaster	AMA website Media release	NSW	NPs are an "ad-hoc experiment with patients' lives", "who will supervise and take responsibility for the clinical decisions of NPs", "should undertake the appropriate training if want to do work of doctors". "AMA misled that NPs would only be employed where medical services limited".
ABC Online	6 Sep '02	New positions for nurse practitioners	ABC News Online Article on website	National	Introduction of NPs into metropolitan hospitals.
Robinson M	6 Sep '02	Fears hospital super nurse is a 'disaster waiting to happen'	*Sydney Morning Herald, p4* Article in newspaper	NSW	Portrayal by media NPs "super nurses". AMA: "who will supervise the NPs and take responsibility for their decisions". "Unproven ad hoc experiment". Alternate view by doctors: NPs "add to the quality of patient care"
AMA	6 Sep '02	Ad-hoc experiment will not solve nursing crisis	AMA website Media release	NSW	NP role with create "patient confusion". "Ultimately a doctor will have the responsibility". " AMA needs to be satisfied that patients won't be put at risk"
Field A	6 Sep '02	Specialist nurses to work in region	*Illawarra Mercury, p7* Article in newspaper	Local	Local newspaper coverage of introduction of NP into local area.
Tydd M & Field A	7 Sep '02	Union defends use of nurses	*Illawarra Mercury, p15* Article in newspaper	Local	Nurses' Union defends NP role
McDonald A	7 Sep '02	Letters: Doctors' club has only itself to fear	*Sydney Morning Herald, p52* Letter in newspaper	NSW	From a Dr's perspective: "AMA only see potential damage to their vested interests"
Lumby J	12 Sep '02	Let nurses move from care to cure	*Sydney Morning Herald p11* Article in newspaper	NSW	Support for nurses to move to "cure" role. Inference that nursing is not traditionally a "curing" role.
Editorial	18 Sep '02	If nurses want to become Drs then they should do medical degrees	*Nursing Weekly, p.5* Article in nursing newspaper	National	As heading states. Author of statement cited as Gullotta, J. Vice President, NSW AMA

Author	Date	Title	Source/Type	Location	Summary and comments
Editorial	18 Sep '02	Well, they might be better than nothing	*Nursing Weekly, p5* Article in nursing newspaper	National	Gullotta, VP, NSW AMA cited. "NP plan dangerous". 'We do not see role for NPs in metropolitan hospitals". "Who is going to take responsibility of NPs". NPs "better than nothing in remote areas"
Editorial	24 Sep '02	Anachronistic restrictions a waste of talent	*Nursing Weekly, p4*	National	Waste of talent and expertise to limit practise with anachronistic medication and prescribing restrictions
Gosby H, Turcato D & Scott J	1 Oct '02	Best foot forward-nurse practitioners just do it	*The Lamp,vol.59, no.9, pp.14-15* Article in NSW Nurses' Assoc. newsletter	NSW	Interviews with newly appointed NPs.
National Nursing Organisations	1 Oct '02	National consensus statement on nurse practitioners in Australia	Consensus Statement by National Nursing Organisation (alliance of nursing organisations)	National	Agreement of roles of NP, "complementary to other health care providers"
ABC TV Online	15 Oct '02	George Negus interviews David Lindsay regarding nurse practitioners	*Radio ABC: Health Dimensions* Radio broadcast transcription	National	Interview with a nurse practitioner describing the role of a NP, as opposed to a "traditional nurse".
ABC News Online	31 Oct '02	Claim nurses' skills not used properly in regional Australia	*Radio ABC: NewsOnline* Radio broadcast transcription	National	Opposition from the medical profession makes Government processes slower.
Editorial	22 Nov '02	Nurse practitioner benefits overstated	*Australian Doctor, p10* Article in medical newspaper	National	AMA refutes value of NPs
ABC Online	12 Dec '02	Govt relaxes rules to tackle nurse shortage	ABC News Online	National	"The NSW Govt is trying to attract another 92 NPs to the public health system by easing the entry process"
Wilson P	31 Jan '03	Nurse practitioner push widens	*Australian Doctor* Letter in medical newspaper	National	Nurse practitioner title used interchangeably with practise nurse title
Lumby J	4 Feb '03	Regarding article *Nurse practitioner push widens*	*Australian Doctor* Unpublished Letter to the Editor	NSW	"difference between nurse practitioner and practise nurse is still unclear to doctors despite the two roles being very different"
Saunders C	21 Feb '03	Consumers fearful of nurses replacing GPs	*Australian Doctor, p3* Article in medical newspaper	National	Practise nurse and nurse practitioner title used interchangeably. "the AMA calls for State Govts to reappraise their support of NPs"

Author	Date	Title	Source/Type	Location	Summary and comments
Costa C	27 Feb '03	Practitioners extend role for nurses	*Sydney Morning Herald, p32* Article in newspaper	NSW	Drs Reform Society: "We are shocked and amazed that nurses aren't included in the primary care team" BUT against NPs hired on a fee-for-service or independent basis. "We want NPs hired on salary basis, making them part of the GP team"
Editorial	27 Feb '03	Super nurses or nurse practitioners are about to become a force in Australia's health care system	*Sydney Morning Herald, p32* Article in newspaper	NSW	Media portrayal of NPs as "super nurses". AMA: "Drs should not accept legal responsibility for errors caused by medically supervised independent NPs". "This may lengthen the already long list of insurance issues faced by doctors"
MarksonS	2 Mar '03	Helen's at the head of a nursing breakthrough	*Sunday Telegraph, p9* Article in careers section of newspaper	NSW	"Unlike regular nurses, Ms Gosby can prescribe some medications, initiate diagnostic investigations and make referrals-all without the aid of a doctor". NP: "I was originally the CNC and I worked with a team of doctors. Now I see, treat and discharge patients. I only invite the doctors into a consultation if I need assistance in a more difficult case".
Scott, J	6 Mar '03	Nurse on the road	*ABC Radio: Health Matters*	National	Interview with NP. NPs in regional and remote communities.
Lumby, J	11 Mar '03	Regarding article *Consumers fearful of nurses replacing GPs*	*Australian Doctor* Unpublished Letter to the Editor	NSW	"Practise nurses and NPs discussed interchangeably. 'It would be like blurring the roles of a resident medical officer and a specialist medical clinician".
College of Nursing	1 Apr '03	Australian Nurse Practitioner's Association (ANPA) Established	CON Website Media release	NSW	"The Aust. Nurse Practitioner Association (ANPA) was formally established at Tambar Springs on 1 April, 2003"
Editorial	14 Apr '03	Nurse plan alarms after-hours GPs	*Australian Doctor, p12* Article in medical newspaper	National	Concern NPs working after hours will affect after hours GP practises
Wood M	29 Jun '03	Super nurses flex their power	*Sydney Morning Herald p38* Article in newspaper	NSW	Media portrayal of NP role as "super nurses"

Author	Date	Title	Source/Type	Location	Summary and comments
Rural Doctors Assoc.	1 Jul '03	Rural & Remote Nursing Practise	Rural Doctors Assoc. Website & Position statement	National	Position statement on practise nursing & advanced nursing practise.
Dow S	10 Jul '03	GPs slowly welcome NPs	*Sydney Morning Herald p4* Article in newspaper	NSW	14 NPs in NSW and expected to treble next yr. "stiff resistance…climate is changing"
Pollard R	16 Jul '03	Nurse practitioners the way of the future, says expert	*Sydney Morning Herald, p7* Article in newspaper	NSW	NPs "increased access to health care and helped to retain nurses in the system"
Thompson D	1 Sep '03	Negotiating the future: The development of family health nurses and family NPs in remote and rural Australia	*Aust. Family Physician vol.32, no.9, pp.753-754* Article in medical journal	National	The RACGP has yet to support the 'independent nurse practitioner', instead supporting 'role interchangeability'-focus should be on whether " a person with this role can practice competently rather than focus on what professional tribe should have a given right to fulfil this role"
Ridley M	12 Sep '03	Doctor rejects claims	*Coffs Harbour Advocate p5* Article in newspaper	Local	NP role "clearly ridiculous, nurses are there to nurse"
Wood M	21 Mar '04	Doctors fight chemists on child jabs	*Sun Herald, p37* Article in weekly newspaper	NSW	Doctors against pharmacists giving immunization injections at their chemist.
"Tracy"	2 Apr '04	Where is the NP role heading?	*RCNA Website Discussion Forum*	National	Interest in NP role by nursing student in final year of studies following progress of NP role development
"Robert"	6 Apr '04	Where is the NP role heading? Reply	*RCNA Website Discussion Forum*	National	"Many nurses would say this role has taken a long time to come about. It is interesting to ask why it started in the remote/rural areas first. What pushed the move in the end, was it a nursing issue or lack of doctors?"
Barbary J	28 Jun '04	Nurse Practitioners: Reply	*RCNA Website Discussion Forum*	National	"Not so very long ago, within living memory for many nurses still practising, a simple blood pressure was considered beyond the scope of a 'mere' nurse and had to be carried out by a doctor, now most BPs are carried out by machines and meanwhile nurses do all sorts of things generally considered the realm of doctors"

Author	Date	Title	Source/Type	Location	Summary and comments
Dunn A	3 Jul '04	Enter a new breed, neither nurse nor doctor	*The Age, p13* Article in newspaper	VIC	Portrayal of NP role by media "neither nurse nor doctor". Focus on "tasks" performed by NPs
McGregor C	23 Aug '04	NB: NP means a very well-trained nurse	*Newcastle Herald, p9* Article in newspaper	Local	Explains the qualifications of a NP. NPs described as 'stop-gaps' in bringing medical care to remote areas.
Lindsay S	9 Sept '04	On the job: Elaine Ford Nurse Practitioner	*Sydney Morning Herald, p9* Health & Science	NSW	Overview of NP's role in practise
Pollard R	23 Oct '04	Cure for sick system	*Sydney Morning Herald* *p35* Article in newspaper	NSW	Health system reform. Expanding NP role to provide more primary care.
"Daver"	19 Nov '04	Where is the NP role heading? Reply	*RCNA Website Discussion Forum*	National	"This country is so far behind in nursing it's a real joke!… medical domination has resisted any change or advancement"
Pollard, R	13 Dec '04	Doctors resist forensic role for nurses	*Sydney Morning Herald*, *p3* Article in newspaper	NSW	Proposal to train nurses to collect forensic evidence. Criticised for taking away roles traditionally held by doctors.
ACM	1 Jan '05	Midwifery and the Nurse Practitioner	Aust. College of Midwives Website & Position statement	National	ACM not supportive of Midwife Practitioner role
Graham J	6 Jan '05	The sickness in our public hospitals	*Sydney Morning Herald, p6* Letter in newspaper	NSW	Doctor calls to wind the clock back 40 years to a time when there were "compassionate" nurses. "A passion for the job is what matters"
Beetson R	9 Jan '05	Forget halcyon days, we need to move forward	*Sydney Morning Herald, p6* Letter in newspaper	NSW	Reply Graham article: John Graham's opinion is "simplistic and patronising".
Borton C	9 Jan '05	No title	*Sydney Morning Herald, p6* Letter in newspaper	NSW	Reply Graham article: "Graham's opinion wins nostalgia prize"
Lumby J	11 Jan '05	Nurses know their place-and it's not back in the 1960s	*Sydney Morning Herald, p6* Article in newspaper	NSW	Reply Graham article. "Nurses well-educated expect to be treated as colleagues of doctors, not as handmaidens"
Pembroke L E	13 Jan '05	Mechanical nursing	*Sydney Morning Herald, p6* Letter in newspaper	NSW	"Nurses not my colleagues, nurses have difficulty relating to the basic yet most important needs of patients, nurses are medical mechanics"
Day B	18 Jan '05	No title	*The Australian* Article in newspaper	National	Call by Dr for return to hospital-based training for nurses.

Author	Date	Title	Source/Type	Location	Summary and comments
Adamson J	17 Feb '05	Nurses on path to recovery	*Sydney Morning Herald, p8* Article in newspaper	NSW	"Nurses seen more as colleagues…More mature relationship"
Bidinost M	26 Feb '05	Practitioners pioneer a new level of care	*The Age, p38* Article in newspaper	VIC	AMA: NPs not as highly trained as doctors, shouldn't perform doctor's duties.
Kiejka J	1 Mar '05	Nurses' right of reply: Indenture and low-pay no solution to nursing shortage	*The Lamp, vol.62, no.2, p30* Article in NSW Nurses' Assoc. newsletter by NSWNA Assist. General Secretary	NSW	Reply Graham article: returning to the "dark ages of ridiculously long shifts, low wages and unsafe working conditions is absurd"
AMA	4 Apr '05	General practise nurses make perfect sense (but independent nurse practitioners don't)	AMA Website Media release	National	AMA: Terms used- complement, supervision, substitute, dumb down health, independent, dangerous alternative.
CON	Spring '05	Nurse Practitioners and Practise Nurses: Same difference?	*Nursing.aust*, *vol.6, no.3, p1* Discussion piece	National	Reply to AMA saying NPs dumb down health care. The move to expand the practise nurse role way of avoiding having more NPs.
Lumby J	5 Aug '05	New roles and new relationships	*CON Website Media Release*	NSW	Workforce already changing, boundaries already blurred
Lumby J	Spring '05	New roles and new relationships	*Nursing.aust, vol.6,no.3,p12*	NSW	AMA emphasis on education preparation for practise. Should move to maintenance of knowledge & skills
AMA	15 Apr '05	Health system review must be based on the medical model, not the economic model	AMA Website Media release	National	"Health care should be based on medical model not economics. Any review must be about the medical infrastructure & medical workforce first & foremost"
Lumby J	16 Apr '05	Nurse practitioners make a difference, and we need them: Let nurses prescribe patients' drugs and manage their illnesses	CON Website Media release	NSW	Rather than focus on traditional roles, we need to be thinking about how to tap into the skills and experience of practitioners across healthcare.
Lumby J	17 Apr '05	Let nurses prescribe patients' drugs and manage their illnesses	*Weekend Australian, p19* Article in weekly newspaper	National	As above
Deans of Nursing & Midwifery	18 Apr '05	Nurse practitioners are an asset not a threat	Media release	National	Refute AMA "NPs dumb down health care, provide inferior health care". AMACGP see NPs as threat.

Author	Date	Title	Source/Type	Location	Summary and comments
AMA	19 Apr '05	Nurse-initiated discharges not the solution	AMA Website Media release	NSW	NP discharges. "What happens if a patient collapses and dies at home after a nurse-initiated discharge? who will take the responsibility then?"
Nursing & Midwifery Reg. Board	1 May '05	Our first Midwife Practitioner-Debbie Lamers	*NMB Update, p17* Article in organisation newsletter	NSW	First Midwife practitioner authorised
IliffeJ	3 Jun '05	ANF supports AMA call for item number for nurses	ANF Website Media release	National	ANF pleased AMA support for practise nurses but concern regarding NP.
AMA	3 Jun '05	New MBS item needed to cover general practise nurses working under GP supervision	AMA Website Media release	National	Emphasis on "Nurses working under GP supervision"
Lumby J	1 Jul '05	No title – health section	*Weekend Australian* Article in weekly newspaper; cited on CON NSW website	National	Quotes doctor "we'll have to watch them (NPs), they'll breed like rabbits"
NRHA	19 Jul '05	Let's make more of advanced nursing practise-new report	NHRA Website Media release by National Rural Health Alliance	National	'"APNs can make major contribution to improved health outcomes"
Stafford A	26 Jul '05	Physicians, heal thy self-importance	*Financial Review p61* Article in finance newspaper	National	Queensland optometrists won battle for the right to prescribe eye drops. AMA: "cutting corners by expanding role of 'non-clinicians'". AMA cited as major influence in "shaping the health system".
Rogers T	28 Jul '05	Medical subs won't work	*Financial Review,* p. 59 Letter in finance newspaper	National	AMA: NPs "substitute doctors"
AMA	1 Aug '05	AMA position statement on independent nurse practitioners 2005	AMA Website & Position statement	National	AMA does not support NP project. See NP as a substitute for GP. Who is to take the blame for "errors of unsupervised NPs"
AMA	3 Aug '05	AMA rejects role substitution and task substitution proposals to address medical workforce shortages	AMA Website Media release	National	NP role "doctor substitution"
Truscott J	4 Aug '05	New role for nurses worth trying	*Financial Review* p. 59 Letter in finance newspaper	National	Important to note "NPs work in collaboration with doctors". NPs represent 'new models' in health care, "safe, effective and cost efficient"

Author	Date	Title	Source/Type	Location	Summary and comments
AMA	24 Aug '05	AMA rejects independent nurse practitioners as medical workforce solution	AMA Website Media release	National	"Irresponsible decision by NSW Govt. to have NPs"
Editorial	25 Aug '05	AMA wants nurses kept in their place	*The Daily Telegraph,* p. 2 Article in newspaper	NSW	"Drs say NPs no substitute for doctors".
Pollard R	30 Aug '05	Losing patience	*Sydney Morning Herald, p. 16* Article in newspaper	NSW	AMA maintains absolute authority by saying no to NPs. Doctors losing patience with AMA stance on NPs… "AMA rejects NPs as medical workforce solution"
Pollard R	30 Aug '05	Plan for doctors, nurses to swap roles	*Sydney Morning Herald, p3* Article in newspaper	NSW	Federal Health Minister supports practise nurses/Opposition Fed. Health Minister supports NPs
Pollard R	30 Aug '05	In the front line	*Sydney Morning Herald, p6* Article in newspaper	NSW	Interview with NP: "doctors follow line that has been fed to them".
ANJ	1 Oct '05	Nurse practitioners: forging new paths in care	*Australian Nursing Journal, vol.13 no.4, p22* Article in nursing union journal	National	Overview of NPs in Australia
Lumby J	1 Oct '05	Nurse practitioners and practise nurses: Same difference?	*Nursing.aust* Article in College of Nursing NSW newsletter	NSW	Article highlighting interchanging use of NP and practise nurse titles by AMA
Pollard R & O'Malley N	12 Dec '05	Doctor substitutes for a leaner health system	*Sydney Morning Herald p2* Article in newspaper	NSW	Portrayal of role by media as "doctor substitute". AMA: "any change in health would endanger patient safety"
AMA	12 Dec '05	Hospital reform group echoes AMA (NSW) concerns	AMA Website Media release	NSW	NPs must "not be allowed to compromise patient safety" "should work under supervision of drs"
Kimbell R	12 Dec '05	Nurse practitioners-a different perspective	*NSW Doctor, p10* Article in medical newspaper	NSW	Written by RN who studied medicine. Not supportive of NP role.

Appendix H: I'll tell you a lovely story

I'll tell you a lovely story (clearing throat). I was walking across the street the other day, about six months ago, and an elderly man came up to me and asked me would I help fill out some forms because he was going in for knee joint surgery, and I said, "Yes." Now I've also been interested in the past in adult literacy and adult eduction and when we got up into the office I said to him, "Do you have a problem with reading and writing?" because he wanted me to do everything, and he sat there and he cried and I said to him, "When you get this knee done I've got access through TAFE [college] to an adult literacy officer and if you like I'll take you in there and we'll see what we can do to help you," and he had the knee joint done and he did well with his rehab and I brought up the issue of the literacy and he was mad keen so I said to him, I'd pick him up at half past eight one morning on the road. I'd lined it up with the adult literacy office in TAFE. He was waiting for me since eight o'clock and we went into town and, um, he's now in a program. He has a home tutor in [name of remote town], he goes to the library, an hour and a half before the library opens, he gets four and five books and he's still reading children's books and he writes down the words he doesn't know, he takes home, ah, talking books, a talking book every week and five books that he's reading and I said to him the other day, "Have you been doing any fishing Don?" He said, "I haven't got time for fishing." He said, "I've got five books to read this week." Now what's going to turn his life around more the knee joint surgery or learning how to read? and you see that's what I think a nurse practitioner has to do. "They have to, we have, we should have the knowledge and the resources to explore people's needs in their whole of life situations, not just in that short time because I believe that a nurse would've been working within the parameters of her work had she filled out the paperwork, not questioned him about his literacy and, um, take the stitches out when he came home from hospital. That's really all that was asked, but this man's had a whole lifetime change, ah, you know and when I think about retiring I get this wonderful buzz when I think about what's happened to this man.

Appendix I: Key events in the development of the NP role 1990-2010

Date	Key Event
Aug 8/9 1990	New South Wales Nurses (NSW) Association Annual Conference. NSW Health Minister Peter Collins (Liberal Party) (Mar 1988-June 1991) indicates in-principle support for independent nursing practice.
	Key events during Nurse Practitioner Stage 1
Sept 1991	*NSW Department of Health Taskforce – The Independent Nurse Practitioner Task Force established by Judith Meppem, NSW Chief Nursing Officer.*
Jan 1992	Establishment of Nurse Practitioner Working Party – representative from nursing organisations.
June 1992	Release of *Nurse Practitioners in NSW: The role and function of Nurse Practitioners in NSW (The Discussion Paper).*
	Key events during Nurse Practitioner Stage 2
March 1993	Establishment of Stage 2 Nurse Practitioner Working Party – Multidisciplinary representation chaired by independent consultant to consider and further develop issues from the *Discussion Paper*.
Jun 30 1993	*Nurse Practitioner Stage 2, Vol. 1 & 11 (The Review)* presented to Ron Phillips, NSW Health Minister.
Sep 22 1993	*The Review* endorsed by NSW Health Minister and released for public circulation.
	Key events during Nurse Practitioner Stage 3
Nov 1993	Establishment of Stage 3 Nurse Practitioner Steering Committee – Multidisciplinary representation.
1993/1994	Management structure of Rural Health Services being reorganised. Six (6) non-metropolitan regions expanded into 23 District Health Services.
Jan 1994	Expression of Interest for Nurse Practitioner Pilot Research Projects circulated in the national, state and local press and key nursing and medical publications.
Aug 1994	Overview of pilot projects circulated by Judith Meppem, NSW Chief Nursing Officer.
Sept 1994	Nurse Practitioner Pilot Projects commence.
March 1995	NSW State Government elections and change in Government. Labor Party elected to Office.
1995	23 District Health Services were reduced to 8 Rural Area Health Services.
Dec 1995	*The Nurse Practitioner Project Stage 3: Final Report of the Steering Committee (The Final Report)* presented to Andrew Refshauge, NSW Health Minister.
March 2 1996	Commonwealth Government elections and change in Government. Liberal Party elected to Office.
April 1996	Stage 3 *Final Report* approved and released for circulation by Andrew Refshauge, NSW Health Minister.
	Implementation of Nurse Practitioners in NSW
Feb 1997	Andrew Refshauge, NSW Minister for Health establishes Implementation Process for NPs in NSW.
Aug 1998	Framework for Nurse Practitioner Services in NSW released for circulation.
Nov 2 1998	Nurses Amendment (Nurse Practitioner) Act 1998 assented to by NSW Parliament.
Early 1999	NP Accreditation Committee formed.
Oct 29 1999	Nurses Amendment (Nurse Practitioner) Act 1998 – Proclamation of Act.
Feb 2000	1st meeting of NSW Nurse Practitioner Steering Committee.
Dec 12 2000	1st Nurse Practitioners authorised by the Nurses' Registration Board of NSW.
Dec 13 2000	Craig Knowles, NSW Health Minister announces authorisation of Jane O'Connell & Susanne Denison as first NPs in NSW (and Australia).

Date	Key Event
May 11 2001	The NSW Health Minister announces that Olwyn Johnson named as first NP to take up a position in NSW.
Sep 5 2002	Roll out of specialist NPs into Metropolitan Sydney announced by Craig Knowles, NSW Minister for Health.
April 1 2003	Australian Nurse Practitioner's Association (ANPA) formally established. President: Jane O'Connell, Vice President: Amal Helou, Treasurer: Rochelle Firth, Secretary: Lorna Scott, Committee Members: James McVeigh, Cheryl Davidson.
July 2004	Restructuring of the State's health administration including the amalgamation of 17 Area Health Services into 8 AHSs announced.
Oct 2005	Inaugural conference of ANPA held in Canberra
Feb 6 2006	$5.5 million funding for 60 new NP positions to increase the number of NPs in NSW public hospitals announced by NSW Health Minister John Hatzistergos
March 10 2006	Amendment to the Poisons and Therapeutic Goods Regulation 2002, the Poisons and Therapeutic Goods Amendment (Health Practitioners) Regulation 2006 allows NPs possess, use, supply or prescribe drugs of addiction (Schedule 8).
April 2 2006	Health Minister announces the new amendments to the Poisons and Therapeutic Goods Act
July 30 2006	NSW Minister for Health John Hatzistergos announces there are 102 NPs across NSW (Transitional NPs and authorised NPs)
Aug 2006	Launch of ANPA website in partnership with the College of Nursing
Nov 24 2007	Commonwealth Government elections and change in Government. Labor Party elected to Office
Dec 2007	NP role legislated, and the NP title protected in *all* Australian states.
April 30 2008	Australian College of Nurse Practitioners first media release
June 28 2008	Appointment of first National chief Nursing & Midwifery Officer, Rosemary Bryant
Dec 2008	Approximately 300 registered NPs working in Australia.
Jan 22 2009	Australian Nurse Practitioners Association endorsed the forming of a company called the Australian College of Nurse Practitioners (Ltd)
May 12 2009	Federal Health Minister announced that the 2009-2010 Federal Budget would allocate $59.7 million over 4 years to provide NPs access to the MBS and PBS.
June 24 2009	Legislation introduced to Commonwealth Parliament to allow NPs and midwives access MBS and PBS.
Dec 2009	129 NPs authorised, and 1 midwife practitioner in authorised in NSW.
Jan 1 2010	Determined that all applications under pathway 2, for authorisation as NP must complete Masters degree specific to the NP's clinical practice context.
Mar 16 2010	Federal Government announced that Legislation passed to give NPs and midwives access to MBS and PBS reimbursements.
July 1 2010	National registration, education and standard requirements for NP practice introduced.