

# **Through the Looking Glass**

## **The Politics of Advancing Nursing and the Discourses on Nurse Practitioners in Australia**

Clare Lynette Eden Harvey  
RN, BA (Cur), MA, MRCNA

A thesis submitted in total fulfilment of the requirements for the degree of  
Doctor of Philosophy

School of Nursing and Midwifery  
Faculty of Health Sciences  
Flinders University of South Australia

January 2010



# Table of Contents

<b>TABLE OF FIGURES .....</b>	<b>IV</b>
<b>DECLARATION .....</b>	<b>V</b>
<b>ABSTRACT .....</b>	<b>VII</b>
<b>LIST OF PUBLICATIONS AND CONFERENCE PRESENTATIONS (RELEVANT TO THE THESIS BUT NOT FORMING PART OF IT) .....</b>	<b>IX</b>
PUBLICATIONS .....	IX
CONFERENCE PAPERS .....	IX
<b>ACKNOWLEDGEMENTS .....</b>	<b>XI</b>
<b>PREFACE .....</b>	<b>XIII</b>
<b>ABBREVIATIONS AND EXPLANATIONS OF TERMS .....</b>	<b>XV</b>
<b>FORMATTING OF QUOTES.....</b>	<b>XIX</b>
<b>CHAPTER 1 - A WHITE RABBIT: NURSE PRACTITIONERS AND THE DREAMS OF A PROFESSION.....</b>	<b>1</b>
NEW CONCEPTS IN OLD SHOES .....	2
THE AUSTRALIAN JOURNEY .....	5
THE PROFESSIONAL AND CLINICAL DISCONTINUITY .....	7
SEEKING ANSWERS TO QUESTIONS .....	9
EXPLORING THE DISCOURSE OF THE NURSE PRACTITIONER JOURNEY.....	12
RESEARCH OBJECTIVES .....	13
RESEARCH FOCUS.....	15
SUMMARY OF CHAPTERS.....	15
<b>CHAPTER 2 - CONVERSATIONS TELLING THE STORY: CRITICAL DISCOURSE ANALYSIS .....</b>	<b>17</b>
IDENTIFYING DISCOURSE: SHAPING IDENTITY .....	19
CRITICAL SOCIAL THEORY .....	20
LANGUAGE AND TEXT .....	22
TRADITION, CULTURE AND NETWORKS – NPS AND THE DOMINANT SOCIAL ORDER .....	24
EXAMINING DISCOURSE .....	27
FRAMING NURSE PRACTITIONER REALITY .....	29
ANALYSIS IN CDA.....	32
ASSUMPTIONS.....	33
EXPLORING DISCOURSES.....	34
<i>Ethical Considerations.....</i>	<i>35</i>
<i>Interviews .....</i>	<i>36</i>
<i>Participants.....</i>	<i>37</i>
<i>Consent.....</i>	<i>39</i>
<i>Question Format .....</i>	<i>40</i>
<i>Protection of Participants.....</i>	<i>40</i>
<i>Field Notes .....</i>	<i>41</i>
<i>Examination of Technical Literature .....</i>	<i>42</i>
<i>Period of Data Collection of Media and Studies for this Study .....</i>	<i>43</i>
<i>The Media .....</i>	<i>43</i>
<i>Data Storage .....</i>	<i>44</i>
<i>Limitations .....</i>	<i>45</i>
SITUATING NPS .....	47
<b>CHAPTER 3 – SETTING THE STAGE.....</b>	<b>49</b>

THE GOOD DOCTOR .....	50
ANGELS OF MERCY .....	52
NURSE PRACTITIONERS IN AUSTRALIA.....	55
MODELS OF CARE.....	61
GROUNDING IN NURSING.....	63
AUTONOMY .....	68
CENTRE STAGE.....	71
<b>CHAPTER 4 – NOT A NORMAL NURSE.....</b>	<b>73</b>
THE COMPLEXITY OF NURSING TITLES.....	74
SKILL MIX .....	78
NEITHER NURSE NOR DOCTOR.....	79
ABANDONING NURSING .....	86
SEARCHING FOR AUTONOMY .....	92
<b>CHAPTER 5 - THE INVISIBLE NURSE .....</b>	<b>95</b>
NURSING: A TRADITION OR A PROFESSION?.....	96
PAYING DEARLY TO HOSPITALS .....	99
SILENCE OR VOICE? .....	101
THE LEGISLATION ILLOGICALITY .....	103
PHYSICIAN’S ASSISTANT OR NURSE PRACTITIONER – WHAT’S IN A NAME? .....	105
LEARNING FOR LIBERATION OR COMPLIANCE? .....	106
PRODUCTS OF DISCOURSE.....	110
THE TOUCH CERTIFICATE .....	113
THE ALLIANCE OF GROUPS .....	116
<b>CHAPTER 6 - LUKEWARM DEFENDERS: NURSE PRACTITIONER IMPLEMENTATION .....</b>	<b>119</b>
ORGANISATIONAL HEGEMONY .....	120
THE EMPLOYMENT CONUNDRUM .....	124
LEADER IN NAME ONLY.....	132
YOU NEED TO BLEED SOME MORE.....	135
NURSES IN MANAGEMENT – PUPPETS OR LEADERS?.....	138
<b>CHAPTER 7 – THE CORKSCREW PATH: THE POLITICAL ECONOMY OF HEALTH.....</b>	<b>145</b>
PENNY WISE AND POUND FOOLISH.....	147
MEDICAL APARTHEID .....	148
ANOTHER FENCE TO JUMP - THE MEDICARE ACT .....	154
OLD CONTESTS – NEW FOCUS .....	158
GATES IN PLACE - CLINICAL PRACTICE GUIDELINES .....	166
JUNIOR MEDICAL DOCTOR OR ADVANCED NURSE?.....	170
BEYOND OLD CONTESTS.....	173
<b>CHAPTER 8 - THROUGH THE LOOKING GLASS.....</b>	<b>179</b>
THE ROYAL ‘THEY’ .....	181
NURSING AS ALTRUISM VERSUS NURSING AS COMMODITY.....	182
MODERATED LOVE.....	187
BRING BACK THE MATRON.....	193
‘GOD LOVE DOCTORS’ .....	199
SPHERE OF INFLUENCE – PEEPING INTO LOOKING GLASS HOUSE.....	202
THE SONGS AND THE TUNES .....	204
<b>CHAPTER 9 - DANCING TO THE TUNE .....</b>	<b>211</b>
REFLECTIONS .....	212
STRENGTHS OF THE STUDY .....	214
LIMITATIONS OF THE STUDY .....	215

SHIFTING THE SANDS.....	217
CONCLUSIONS.....	220
<b>REFERENCES .....</b>	<b>223</b>
<b>APPENDICES .....</b>	<b>245</b>
APPENDIX 1 - LETTER TO THE NURSING AND MIDWIFERY REGULATORY AUTHORITIES AUSTRALIA .....	245
APPENDIX 2- LETTER OF INTRODUCTION .....	245
APPENDIX 3 - INFORMATION SHEET .....	245
APPENDIX 4 - CONSENT FORM.....	245
APPENDIX 5 - INTERVIEW QUESTION GUIDE .....	245
APPENDIX 6 - AUSTRALIAN NURSING AND MIDWIFERY COUNCIL COMPETENCY STANDARDS FOR NURSE PRACTITIONERS (2006).....	245
APPENDIX 7- AUSTRALIAN AND NURSING MIDWIFERY COUNCIL COMPETENCY STANDARDS FOR REGISTERED NURSES (2006) .....	245
APPENDIX 8 - AMA POSITION STATEMENT REGIONAL/RURAL WORKFORCE INITIATIVES (2005) .....	245
APPENDIX 9 – LETTER OF APPROVAL - FLINDERS UNIVERSITY OF SOUTH AUSTRALIA SOCIAL AND BEHAVIOURAL SCIENCE ETHICS COMMITTEE.....	245

## Table of Figures

FIGURE 1 FAIRCLOUGH (2001, p. 62) CONSTRAINTS ON DISCOURSE AND THEIR STRUCTURAL EFFECTS.	30
FIGURE 2 INTERPRETATION OF THE AUSTRALIAN REGISTERED NURSE USING THE ‘NOVICE TO EXPERT’ BENNER MODEL (2001) .....	75
FIGURE 3 CONCEPTUAL FRAMEWORK OF NURSING CAREERS IN AUSTRALIA (RESEARCHER’S INTERPRETATION) .....	77
FIGURE 4 A MONTAGE OF THE ACTIVITIES AND THE INFLUENCE OF WOMEN DURING THE AMERICAN CIVIL WAR. AN ETCHING BY WINSLOW HOMER (DOLAN COLLECTION) CITED IN (DOLAN ET AL. 1983, p. 184) .....	97
FIGURE 5 ROLL OF HONOUR FOR MEMBERS OF A LOCAL CHURCH WHO FOUGHT IN THE TWO GREAT WARS. PHOTOGRAPHED BY THE RESEARCHER WITH PERMISSION (JUNE 2008) .....	98
FIGURE 6 ‘CARDIOTHORACIC SURGERY’ DIVISION OF SURGERY (PRINCESS ALEXANDRA HOSPITAL ANNUAL REPORT 2006 – 07, P. 33) .....	122
FIGURE 7 ‘HEALTH HEARING PRIORITY’, (MATER ANNUAL REVIEW 2006, P. 21) .....	122
FIGURE 8 ADVERTISEMENTS FOR NURSING MANAGERS (GOVERNMENT OF SOUTH AUSTRALIA, 2009. THE ADVERTISER, SATURDAY APRIL 25, 2009) .....	141
FIGURE 9 ORGANISATIONAL CHART SOUTHERN HEALTH, ACCESSED JULY 2009 .....	142
FIGURE 10 ADVERTISEMENT (THE WEEKEND AUSTRALIAN 2009, P. 14) .....	143
FIGURE 11 HEADLINES IN AUSTRALIAN NEWSPAPERS (SHINE 2001; VERGHIS 2000; MOAIT 2000; ROBINSON 2002).....	151
FIGURE 12 CARTOON DEPICTING THE TURF WAR BETWEEN DOCTORS AND NPS (ROYAL COLLEGE OF NURSING 2005).....	165
FIGURE 13 NURSE PRACTITIONER AS A HYBRID HEALTH CARE WORKER .....	207

## **Declaration**

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

I had a name change part way through this thesis. Because of this, mention of my previous surname of Turner is sometimes made.

---

**C. L. E. Harvey**

---

**Date**





## **Abstract**

Nursing has a tradition of subservience and obedience. History provides an account of secular and religious orders of nursing shaping a view of virtuous and tireless dedication in carrying out the doctor's orders. Nurse Practitioners were first introduced to the health care system in the 1960s as a solution to the medical shortage being experienced in United States of America at that time. They assumed clinical tasks, traditionally regarded as doctor's work. Since then the Nurse Practitioner movement has expanded globally.

Australia introduced the Nurse Practitioner role in 1998, heralding a new era in the health system of that country. Its introduction has created diverging views which are influence role implementation. This study examines social and political discourses that are affecting the development of Nurse Practitioners in Australia, using text and language to identify discursive practices. It has set out to determine whether Nurse Practitioners have the autonomy that professional nursing leaders have described in policy, or whether the introduction of the role has merely shifted nursing's sphere of influence within a traditional health care system.

Using Fairclough's notion of power behind discourse, the language and discourses of Nurse Practitioners were explored in relation to what was happening around role development and how Nurse Practitioners positioned themselves within the environment where they worked. The use of a Critical Discourse Analysis has allowed for the various social, historical and political perspectives of nursing to be examined. Fairclough's three levels of social organisation have been used to identify the divergent discourses between the truths of implementation of the role at individual and organisational level and comparing it to that of the rhetoric of health policy.

The discourses surrounding the creation of this advanced nursing role have been the focus of analysis. This analysis has revealed how role development is controlled by powerful groups external to the nursing profession. The dominant discourses use the traditional health care divisions of labour to maintain control through a financially driven focus on health care which does not necessarily revolve around clinical need. Further complicating the position of Nurse Practitioners is the internalisation of those

dominant discourses by the nurses themselves. It reinforces Fairclough's view that the dominant power lies behind the discourse, using the system itself to maintain a status quo, rather than overtly opposing it.

Nurse Practitioners, despite being held out by the nursing profession as clinical leaders, are not able to influence change in health care or in their own roles. The results have further shown that nursing managers do not have an influence over the direction that health care and nursing takes. Further research is necessary to examine the broader leadership role of nursing within health care nationally and internationally, in order to establish the real position of nursing within the decision making framework of health care service development.

## List of Publications and Conference Presentations (Relevant to the thesis but not forming part of it)

### *Publications*

**Turner\* C**, Keyzer D & Rudge T, 2007, Spheres of influence or autonomy? A discourse analysis of the introduction of Nurse Practitioners in rural and remote Australia. *Journal of Advanced Nursing* 59(1), 38–46

**Turner C** & Keyzer D, 2002, Nurse Practitioners: A Contract for Change and Excellence in Nursing, *Collegian Vol* 9(4), 18 – 23

\* Former name of author

### *Conference Papers*

<b>Year</b>	<b>Conference</b>	<b>Title of Paper</b>
2009	International Council of Nurses Congress Leading Change: Building Healthier Nations Durban South Africa	Sphere of Influence or Autonomy? A Critical Discourse Analysis of the Nurse Practitioner in Australia
	International Council of Nurses Congress Leading Change: Building Healthier Nations Durban South Africa	Poster presentation An Evaluation of the Nurse Practitioner Endorsement Process: Does it Ensure Safe Clinicians? (Co-author)
	Australian College of Nurse Practitioners 5 <sup>th</sup> Annual Conference October 2009, Auckland New Zealand	Lukewarm Defenders: The Nurse Practitioner Journey
2008	Australian Nurse Practitioner Association Conference Melbourne	Stepping Stones and Stumbling Blocks - The Influences affecting Nurse Practitioners in Australia
	Australian Nurse Practitioner Association Conference Melbourne	Nurse Practitioners in Victoria: Reviewing the Journey through Legislation and Authorisation (Co-author and presenter)
	Invited speaker - School of Nursing University of British Columbia Vancouver Canada	Through the Looking Glass - The Discourse of Nurse Practitioners in Australia
2004	International Nurse Practitioners Conference, Groningen, Holland	Development of Nurse Practitioners – An Australian Outback Experience
2002	Rural Critical Care Conference,	Progress on the Nurse Practitioner

<b>Year</b>	<b>Conference</b>	<b>Title of Paper</b>
	Albury	Development in the Far West Area Health Service
	AARN Conference Sydney	Nurse Practitioners in the Far West, NSW: A Contract for Change and Excellence in Clinical Nursing Practice

## Acknowledgements

In memory of Mom, Dad and David  
who all passed away before this study reached its final chapter

There are times when we know that we could not have got to where we are on the journey of life without the support of others around us. This is one of those times. There are many people who have assisted me in completing this study, through practical, academic or emotional support, or combinations thereof. I would like to acknowledge these people now.

My appreciation goes to all those Nurse Practitioner pioneers who bravely shared their inner most feelings and their experiences willingly for this study, despite what they were telling me would be controversial alternatives to accepted nursing views.

My principal supervisor, Professor Trudy Rudge, rescued me after commencement of the study. Trudy has been amazing in her ability to put me right on track to the completion of the thesis. She has been the back bone without whom I may well have given up.

Throughout this study, from its inception, Professor Dirk Keyzer, not only believed in my vision, but openly supported and encouraged it. As a mentor and supervisor, Dirk has been an enduring and encouraging adviser and friend.

I also want to thank Dr Anita De Bellis who, because I had two external supervisors, became the 'on campus' supervisor in the last 18 months of the study, and to Shaun Bowden, a friend and colleague, for being a sounding board in times when I questioned my own ability and reasoning.

There are others who deserve a place in this thesis. David Turner, my late husband had immense enthusiasm and gave me so much encouragement for my work. That encouragement gave me space to extend myself and to challenge 'the what is' in order to look at the 'what could be'. He passed away six months into this study.

I want to acknowledge Paul Harvey, who, from the beginning of a new relationship, has frequently taken second place to my thesis and, with understanding has allowed me to persevere. He has also willingly assisted in the editing and formatting process of the thesis.

To my son Dale, thank you for being patient with a mother who has always been studying and for always being there on the journey.

Finally I want to acknowledge all those nursing and medical teachers and mentors in my early nursing years who believed in, and encouraged, the full potential of nursing, not only because we worked under difficult conditions, but also because they sanctioned debate around professional and clinical boundaries. Without them, I would not be the nurse I am today nor would I have ever considered tackling this challenging study in the way I have done.

## Preface

This study has been fraught with personal tragedies and professional challenges. It has its beginnings in my early life as a nurse back in the bush war of Rhodesia, now known as Zimbabwe. As nurses and civilians at that time, we contributed to the war effort because there were no military hospitals and civilian hospitals became their substitute. As such my nursing training was a mixture of the tragedy of war and the routine of surgical and medical patients. In this unusual situation we, as student nurses were delegated responsibility far beyond what our training and nursing regulations supported. As such, we learned the value of accountability and responsibility very early on, in order to practise safely and effectively within logistical and professional challenges that the situation imposed upon us.

These reflections only crystallized in my consciousness many years later when I was involved in developing the newly created Nurse Practitioner role in the outback of one state in Australia. My own values and outlook of what nurses are capable of doing, which were so natural and normal to me, came crashing down around me when I realised that this role, with all its potential to provide expert and valuable care to communities that were far away from the specialist centres, was unable to do so because of the obstacles being thrown in its way. What for me seemed a simple matter of development became the most complex challenge that I have encountered in my nursing career. From this the seeds for this study were sewn.

I never anticipated uncovering the hidden discourses that have emerged from this study. What started out as questions around why the Nurse Practitioner role was struggling to progress in Australia, became a study fraught with politically charged findings. As a result of this I have had to reflect on my own position as a nurse and a leader in my various professional nursing roles, because I am as much a part of that system that has created the political and economical web as those involved in this study, either directly through interviews, or indirectly through the examination of literature relating to Nurse Practitioner role establishment.

This study views the position of Nurse Practitioners from one lens only, using the chosen theoretical framework to uncover the discourses behind those obstacles that

we are all aware of but are not sure why they exist. Some nurses may not like what has been revealed and others may welcome the findings from this study. Either way, this study always had one objective in mind, to uncover issues influencing Nurse Practitioner role implementation in a way that supports nursing sustainability for the future.

I owe it to the Nurse Practitioner pioneers who participated in this study, to share their views and truths about their role.



## Abbreviations and Explanations of Terms

ACT	Australian Capital Territory is the territory in which the seat of federal government is located.
AMA	Australian Medical Association is an industrial organisation for doctors in Australia
ANF	Australian Nursing Federation is an industrial organisation for nurses in Australia.
ANMC	Australian Nursing and Midwifery Council is the guiding policy body for nursing in Australia. They are not a regulatory authority rather they develop overarching policy and regulatory recommendations for states and territories to adopt.
APN	Advanced Practice Nurse is the umbrella term recognised by the International Council of Nurses as those nurses who are considered advanced in their field of practice. They include, but are not exclusive to, Nurse Practitioners, Clinical Nurse Specialists and Clinical Nurse Consultant.
CDA	Critical Discourse Analysis is a methodology used by social researchers.
CNC	Clinical Nurse Consultant is a nurse who has considerable clinical experience in a chosen field of health. The actual scope of practice differs in Australia between the states, in the way it is configured in terms of education, clinical practice and co-ordination.
CNS	Clinical Nurse Specialist is a clinical expert in the chosen field of practice. The scope of practice differs between states in Australia.
CPG	Clinical Practice Guidelines are clinical advisory documents developed to support evidence based clinical practice.
DON	Director of Nursing is a person who is in charge of a nurse workforce in a hospital or health care facility. There are many different titles that mean the same thing and the scope of work has expanded to include service budget and human resource management.
EN	Enrolled Nurse is a nurse who has undergone a tertiary level diploma course and is allowed to work as a practical nurse following admission to the role on a nursing and midwifery regulatory authority. Recently extensions to their practice have endorsed them to take on tasks that are normally considered within the scope of practice of a Registered Nurse. Enrolled Nurses are mentioned in this study but their role is not examined in this thesis.

- GP General Practitioner is the term given to medical doctors who work in the community and who provide a general health care service to the public.
- ICN International Council of Nurses – “The International Council of Nurses is a federation of national nurses’ associations, representing nurses in more than 128 countries...Operated by nurses for nurses, ICN works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce”.  
<<http://www.icn.ch/abouticn.htm>> accessed 5th November 2009
- NMRA Nursing and Midwifery Regulatory Authority is a board promulgated by a nursing or health professional act and is charged with maintaining public safety by maintaining a register of nurses and regulating training and practice. In Australia each state and territory has a NMRA. This is set to change with a national registration scheme anticipated for implementation in 2010/ 2011. Also known as Nurses Boards.
- NP Nurse Practitioner a protected title by legislation. It is a Registered Nurse who demonstrates advanced nursing practice skills and has been registered by a nursing and midwifery regulatory authority to practice as such.
- NSW New South Wales is a state in Australia
- NT Northern Territory is a territory within Australia
- NUM Nurse Unit Manager is the general term for a clinical manager in charge of a clinical unit or department. There are numerous iterations of nurse/clinical managers in terms of job description and title. All have similar scopes of practice.
- PCA Patient Care Assistant is a person who has undergone a short training period after which they can carry out basic nursing duties. In some countries the training is more formal and they are also on a role. In Australia they are not regulated. Also called Care Assistants or Nursing Assistants.
- QLD Queensland is a state in Australia
- RAN Remote Area Nurse – Nurses working in the remote regions of Australia are often called Remote Area Nurses. They are also called Rural and Remote Nurses or Outback Nurses.
- RCNA Royal College of Nursing Australia is a professional organisation for nurses in Australia.
- RN Registered Nurse is a nurse who has undergone an undergraduate degree leading to the registration by a nursing and midwifery

regulatory authority.

SA	South Australia is a state in Australia
TAS	Tasmania is the only island state of Australia
VIC	Victoria is a state in Australia
WA	Western Australia is a state in Australia
WHO	World Health Organisation – “WHO is the directing and coordinating authority for health within the United Nations. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.” < <a href="http://www.who.int/about/en/">http://www.who.int/about/en/</a> > Accessed 5 <sup>th</sup> November 2009



## **Formatting of Quotes**

Times New Roman font size 12 with 1.5 line spacing has been used throughout this thesis.

Short text quotes and field note quotes are identified by the use of parenthesis within the main body of text.

Where long sections of text and field notes are quoted, these are identified by separating them from the main text using single line spacing with no parenthesis.

Participant interview quotes are identified by the use of italics.

Short participant interview quotes are kept within the main body of the work in italics with no parenthesis.

Longer participant interview quotes are separated from the main body of text using single line spacing and italics with no parenthesis.



# Chapter 1 - A White Rabbit: Nurse Practitioners and the Dreams of a Profession

In this war at any rate at its commencement, some members of the Royal Army Medical Corps appear to have had difficulty in divesting themselves of the old traditions of the Service, which are undoubtedly antagonistic to the employment of nurses in military hospitals (Royal Commission on South African Hospitals, August 1900 cited in Bassett 1992, p. 20).

This excerpt was written during the South African Boer War (1896 – 1902). At that time, nurses were being sent from British Colonies such as Australia, to assist in caring for the casualties from that war. It tells of the resistance to the introduction of nurses into the military hospitals, at a time when the traditional workforce of these hospitals was orderlies and doctors<sup>1</sup>. With the initiation of the role of Nurse Practitioner (NP), nursing is experiencing similar resistance today. In 2000, some 100 years after the Boer War, the first NP was endorsed in Australia by the Nursing and Midwifery Board of New South Wales. This role was set to take on tasks considered extensions to practice that are not normally undertaken by a nurse. Doctors, represented by the Australian Medical Association (AMA) were opposed to the concept of NPs from the very beginning, as this media release, some four years later shows,

Plans to let nurse practitioners - senior nurses who are trained to perform basic medical procedures - work nationally could be delayed because the Australian Medical Association remains opposed to the idea. Nurse practitioners currently work in NSW and Victoria and could be introduced in South Australia and Western Australia within the next 12 months... The AMA's opposition puts it at odds with other medical groups, including the Doctors Reform Society of Australia and the College of Nursing. But chairman of the AMA's council of general practice, David Rivett, is worried the nurse practitioners could deny doctors the opportunity to properly assess patients (Pirani, The Australian May 2004, p. 3)

The differences in eras but the similarities in outlook suggest that the role of the nurse has not changed over time.

---

<sup>1</sup> The term 'doctor' in the medical sense is a title given to a person who has completed a bachelors degree in medicine and surgery, and should not be mistaken with the academic title of 'doctor' that is awarded to a person who has completed a higher degree such as a PhD at university in any discipline. Other names that medical doctors are called include physician, resident and intern. In this thesis, the title of 'doctor' is used because this is the title that is universally used when referring to a physician in Australia.

## *New Concepts in Old Shoes*

...the sister<sup>2</sup> has to go round with the surgeon, take his orders, pass the dressings – the orderlies fetch and carry and clean up after dressings. It is puzzling to define the work the sister does (Lempriere papers, letter to her family Wynberg, 16 April 1900 cited in Bassett 1992, p. 18).

Traditionally nurses have always been considered subservient to doctors, with confusing views of what a nurse really does, depending on what part of society the nurse is viewed from. The Lempriere letter goes on to say that “She [the sister] has all the anxiety and the worry”. A hundred years later the people of Wanaaring, New South Wales, said much the same thing when describing ‘their sister’, the first NP of Australia (Shine 2001). Although the NP is allowed to undertake extended practice<sup>3</sup>, the perceptions and attitudes of others toward the nursing profession does not seem to have changed. There are examples of the adaptability of nurses internationally throughout history, where nurses accept extensions to their practice in the absence of a doctor, and who are not acknowledged for this work (Farmborough 1974; Bassett 1992; Keyzer et al. 1995; Hegney 1996; Hegney et al. 1997; Hegney 1997). The present day remote regions of Australia are a perfect example of this. There are few doctors willing to endure the isolated outback conditions. Many health services in these regions are run by nurses who work alone with the only access to medical support being considerable distances away (Hegney et al. 1997; Gardner 1998; Sinclair 2000).

NPs, it was thought, could fill the remote health care gap with the formal approval and supportive legislation, to undertake what is currently considered as nurses practising outside of their scope of practice (Sinclair 2000). Experienced nurses in the remote areas currently do the job with tacit approval by the health services that employ them, using protocols and standing orders to purportedly comply with the legal aspects of nursing practice. Despite the legitimizing of remote nursing work with the advent of the NP, the road to establishing NP positions has been slow with these same remote areas having the least uptake. Instead NP roles have taken hold in

---

<sup>2</sup> The term ‘sister’ has been until recently, the title given to a registered nurse. It is in fact still used by some remote outback communities in Australia.

<sup>3</sup> Extended practice is the term used in nursing commonly to describe additional competency based tasks that nurses can undertake. They are frequently tasks that the health service requires the nurse to undertake. They are often technical in nature or cross professional boundaries and regularly involve additional learning and development.



the metropolitan areas where in comparison, there is no shortage of medical support. Given that the reason for developing NPs in Australia was to service the needs of remote communities, it is puzzling that NPs have become more prevalent in metropolitan regions, the reasons for which have not yet been explored in this country.

The role of NP first emerged in the United States of America (USA) in the 1960s, in response to a shortage of doctors at that time. Because of this shortage of doctors, nurses were trained to take on additional clinical tasks that were normally in the domain of doctors so that nurses could fill the clinical gaps created by the shortage (Asubonteng et al. 1995). Tasks included activities such as prescribing medication, undertaking comprehensive clinical assessments, and ordering diagnostic tests, activities that were normally within the scope of practice of a doctor. Before this time, nurses were unable to undertake activities that initiated treatment or diagnosed illness (Kerfoot 1989; Hill et al. 1994; Busen & Englemann 1996; Bowles & Cassidy 1997; Barton et al. 1999; Castledine 1999).

Because of the traditional views of nursing which assumes nurses play a supportive role in health care delivery, it became necessary to ensure the clinical and professional safety of NPs when taking on the extensions to nursing practice. USA thus protected the title of NP through legislation, bringing with it a set of rules and standards that describe the role in terms of scope of practice and the rules of engagement within the workforce (Ford 1991; Asubonteng et al. 1995; Wilson 2005). This paved the way for a new clinical leadership and autonomous component to nursing where nurses could direct care rather than facilitate it. From these beginnings, the role of the NP began an in time, the professional, education and clinical processes have progressively reflected the advanced nature of that practice.

Since then, other countries such as Australia, Canada and United Kingdom, have mirrored efforts to establish NP roles with varying success. Despite the fact that the USA experience emerged out of an economic need and a shortage of doctors, nurses internationally have viewed this role as progress in terms of gaining recognition for nursing as a profession rather than an occupation (Asubonteng et al. 1995; Barton et al. 1999; Gardner et al. 2004). Whereas the traditional view of nursing has been coloured with caring and dedication synonymous with terms such as the 'angels of

mercy', 'lady with the lamp' and 'Nightingales', nursing as a profession saw the NP as the white rabbit. The voices promoting the NP saw it as something plucked from the hat and developed in a way that could provide the profession with a new look that would break free of the traditional shackles, to stand as an equal to those of other health professionals, such as the doctor. A review of the literature has shown however that there is significant dissent over the NP role, which has hindered its implementation. Subjects for debate have revolved around professional boundaries, scopes of practice and financial constraints (Dowling et al. 1995; Busen & Englemann 1996; Catalano 1996; Cukr 1996; Catalano 2003; Cameron & Thompson 2005). Neither has the contentiousness of the role declined. Despite the extended period that the NP has been in existence in the USA the role is still fraught with professional and legislative hurdles which prevent the role from realising its full (Ahrens & Padwojski 1990; Asubonteng et al. 1995; Busen & Englemann 1996; Chambers 1998; Armstrong 1999; Catalano 2003; Affara 2006).

This truth was reinforced for me on a field study I undertook to USA and Canada in 2008 (Field Note 18). In USA, NPs are still struggling in some states, to prescribe medication. For instance in Connecticut, NPs are required to have a supervising doctor who oversees all the prescribing of medications. Although the actual control and supervision of this activity has variations between the contexts of NP practice and also the geographical situations, the fact remains that although endorsed to prescribe, these nurses do so under medical supervision.

NPs that I met in Connecticut related a case where a NP set up a paediatric service in a country town, with the only paediatrician in that town as her medical supervisor. The practice very quickly expanded and became a much needed and well used service. Two years after opening the practice, the NP was forced to close it, because her medical supervisor moved away, and there was no-one to take his place. As a result the NP was not legally allowed to practice. Such activities raise questions of why restrictions are created to prevent the continuance of a nursing service that obviously supports the delivery of essential care to a population that would otherwise have to travel considerable distances to access similar health care services.

Canada's NP development has followed a similar rocky road. Having started on the same track as USA, also in response to medical shortages, the whole development

was phased out with a change of health strategy in that country some years ago. It has only recently re-emerged as a health priority to meet the growing needs of the population in the face of medical shortages and escalating health costs (de Witt & Ploeg 2005; Nhan 2007; Canadian Nurses Association 2008).

### *The Australian Journey*

Nurse Practitioners (NP) in Australia first emerged in 1990 when the first ever NP Committee was convened. Only in 1998 was the first 'NP Framework for Practice' circulated in New South Wales (NSW) (Nurse Amendment Act (Nurse Practitioner) 1998). NPs were first authorised in 2000, although none were actually employed as such until 2001, when the first NP was employed in Outback NSW (Australian Nursing Federation 2001). It took 11 years of negotiation, pilot projects and steering committees to get to this point (New South Wales Health 1995; Pivetta 1999; Turner & Keyzer 2002). Whilst the original pilot projects in NSW (New South Wales Health, 1995) were situated across a variety of contexts in practice, the general view was that NPs were best suited to the more remote regions where access to medical care was difficult and very often the Registered Nurse<sup>4</sup> (RN) in the health service<sup>5</sup> was the first and only entry into the health care system.

Now 19 years on, this country is only just beginning to embrace NPs although the uptake has been slow and hurdles to achieving this status for nurses are significant. Contrary to early belief, the rural and remote regions have been slow in developing NP positions, whilst, as previously indicated, metropolitan acute and specialist settings have taken up the opportunities sooner than anticipated. What is interesting to note is that metropolitan areas do not experience physician shortage such as that which is seen in outback areas, and in areas of predominantly poor socio-economic populations. Overall however, the uptake of NPs to be employed in positions is problematic and Australia finds itself with more endorsed NPs than positions available for employment.

---

<sup>4</sup> A Registered Nurse is a nurse who has been registered by a nursing and midwifery regulatory authority to practice as such. In Australia, the role is prepared by a baccalaureate degree and is legislated to work within a defined scope of practice. This is discussed in more detail in Chapters 3 and 4.

<sup>5</sup> The term health service is used synonymously throughout this thesis with the word health care, organisation and hospital.

Since the final report of the steering committee in NSW (New South Wales Health 1995) and the Nurses Amendment Act (Nurse Practitioner) 1998, the various states and territories of Australia have worked towards establishing the framework for NPs with varying degrees of success. Some of the states have followed the NSW example developing pilot studies to establish the need for NPs (South Australian Government 1999; Victorian Government 1999; Australian Capital Territory 2002; Queensland Government 2003) whilst others have gone on to develop the framework but have only just begun to progress the legislation and endorsement processes (Nursing Board of Tasmania 2006). The actual endorsement and employment of NPs has been much slower, with Tasmania (TAS) only just commencing the process in 2008, whilst NSW has been endorsing NPs since 2000. All the states have slightly different application criteria for authorisation<sup>6</sup> and requirements for creating NP positions in the health services. Variations on the theme include preparing a business case and drug formulary, which has to be endorsed by the Minister for Health or equivalent authority, developing clinical practice guidelines (GPG) which inform clinical practice and preparing the scope of practice in the service in which the NP will be employed (Nurses Board of Western Australia 2003; Nurses and Midwives Board of New South Wales 2004; ACT Nursing and Midwifery Board 2006; Nurses Board of South Australia 2006; Nursing Board of Tasmania 2006)<sup>7</sup>. Although the varying frameworks are established across Australia, hurdles to NP practice have hindered development with anecdotal conversations citing obstacles to practice and progress ranging from, but not inclusive to, lack of provider numbers<sup>8</sup>, professional boundary issues, lack of understanding of the role and budget constraints. Although the emerging Australian research focuses on comparing the NP role to other health professional roles such as the resident/registrar, and identifying budget savings that the role may create, nothing really focuses on the realities that are emerging from the cultural and labour challenges that this new role is creating within the health care system.

---

<sup>6</sup> Authorisation and endorsement is one and the same thing. Nursing and Midwifery Regulatory Authorities (NMRA), also known as Nurses Boards, differ across the country in how they refer to the registration of NPs.

<sup>7</sup> Each state in Australia is governed by its own legislation. Whilst the Federal Government manages the national agendas and the territories of Australia, each state is self governing.

<sup>8</sup> Since commencing this study the current Federal Government, in 2009, announced their intention to progress with Nurse Practitioner provider numbers. To date the Bill has not been passed in the Federal Parliament due to opposition to it and this is discussed in Chapter 7.

## *The Professional and Clinical Discontinuity*

In 2001 I was employed as a NP Project Officer, commencing my work with the first NP to be employed in this country. I very quickly found that what was stated as support for the role in government press releases did not translate to its establishment in practice. This study therefore has its beginnings in the Outback of NSW where the introduction of NPs seemed the panacea to the problems that are encountered daily in providing comprehensive and accessible health care to small and isolated communities.

In May 2001, the Minister for Health (New South Wales Health 2001) announced the appointment of the first authorised NP to an approved position at Wanaaring in NSW. Like many small outback towns, Wanaaring has a population of less than 150 people, additional to a widely distributed isolated farming population that is serviced by any amenities in the town. The town is accessed by dirt roads which are frequently impassable in the very wet or the very dry conditions. The clinic is run by one nurse and is supported by the Royal Flying Doctor Service<sup>9</sup> (RFDS) whose base is in Dubbo, some 500kms away. The nearest town is Bourke, 200kms away, also a small farming support town with a multi purpose health service of about 50 beds. Although the Bourke has a group of doctors servicing the town inhabitants and the hospital, their services do not include Wanaaring other than to accept non-urgent referrals for general consultation. Specialist referrals and emergencies are dealt with by the RFDS.

Initially the creation of this new clinical role represented the recognition that many senior nurses in clinical practice wanted for the work they did, particularly in the rural and remote areas where they worked on their own and beyond the RN scope of practice out of necessity<sup>10</sup>. Once the excitement of the first NP appointment settled,

---

<sup>9</sup> The RFDS is a not for profit organisation that was founded out of a particular need of servicing isolated communities in Australia. Doctors and nurses are employed to 'fly in and fly out' providing supportive clinical services to those communities on a pre-determined regular basis. A significant part of their work is also emergency retrieval.

<sup>10</sup> Remote Area Nurses (RAN) work in small or solo practices with the distant support of doctors in neighboring larger towns or with the Royal Flying Doctor Service. They are often the first and only access that the community has to health care. Nurses in these situations have to deal with clinical presentations that are normally managed by a doctor. Their scope of practice is supported by standing orders and protocols, however, they have to make the clinical assessment and convey this over the phone to a doctor. The grey boundary of practice thus exists in the clinical assessment of a patient by the nurse.

nurses began to realise that to become a NP was more than just being the most senior and experienced nurse in the health service. Initial enthusiasm soon transformed into a challenge to develop a sustainable model of advanced practice with appropriately educated and prepared nurses. This proved far more complicated and convoluted than originally anticipated, not only because of the reluctance of nurses in remote regions to undertake the education and endorsement processes required for NP, and the challenge that remote study and development has, but also because of operational and professional factors that began to emerge.

Examples of this are found in the convoluted community consultation process that was required to establish the approval for the position within the area health service<sup>11</sup>, the many other health professionals who were involved in the approval process and the extended reports that had to be written to both the local health service and to the state Minister for Health before the position was established and a person employed (New South Wales Health 2005; New South Wales Health 2001). Additional to this, once community approval was gained, there was a lengthy process for Clinical Practice Guideline<sup>12</sup> (CPG) development, requiring approval by the state Minister for Health. Without CPGs a nurse is not able to practice as a NP even after endorsement and employment as such (Turner 2000; Turner & Keyzer 2002). The reality of implementation was far from easy, yet the public were made to believe that the employment of NPs would be a simple process as indicated in one newspaper article which said that,

“the whole package [for NP employment] is then bundled off to the health department for approval. The formalities satisfied, all that remains is for the individual nurse practitioners to be recruited to the approved local positions” (Hand 2001).

In assisting with the development of NP positions and the preparation of nurses for these advanced practice positions, it became evident that there were inexplicable influences that were affecting the progress of NP development in these remote communities. What was conveyed as a simple step by step process to authorisation

---

<sup>11</sup> Because of Australia’s vast and isolated areas where there are vast differences between the densely populated coastal regions and sparsely populated inland regions, some states have set up designated jurisdictions of health service management based on population density. In this way groups of hospitals and health centres are managed collectively. These are called area health services.

<sup>12</sup> Clinical Practice Guidelines are documents that are developed to guide and inform the clinical practice that the NP will undertake. For NP practice, development and approval is determined by a local multidisciplinary committee before they receive final approval by the state Minister for Health or the delegated representative.

and employment was anything but this. It seemed that the nurses working towards these NP positions were not able to progress nor did they have any influence on role development. This is despite the fact that nurses form the largest and most evenly distributed health profession working in rural and remote Australia and provide a higher proportion of health care than in urban and metropolitan zones (Hegney et al. 1997; National Rural Health Alliance 2002). In the light of this apparent dominance of nurses in the workforce, together with the declared effectiveness that the NP role has with its supporting legislation, the poor uptake of NPs into the workforce seemed incongruent.

### *Seeking Answers to Questions*

My experiences in the outback of NSW as NP Project Officer prompted me to undertake a search of the literature in an attempt to gain some understanding into the social and cultural nature of NP development. I found little data on the subject and almost nothing relating to advancing nursing in rural and remote Australia. Although some Australian researchers have examined aspects of role development (Keyzer et al. 1995; Hegney et al. 1997; Hegney 1998; Lumby & Picone 2000; Hegney et al. 2002; Gardner et al. 2004), little outlines the impact of change in introducing the new role of NP from the cultural and social perspectives related to the division of labour in health services where NPs now find themselves in. Because the role is new, it remains unclear what real impact it will have on health care and how the social, economical and political influences will affect the future of the role establishment and its sustainability within such an environment.

The anecdotal evidence points to barriers that clearly affect how the role is developed within the accepted division of labour in health care delivery. These range from a divergence in role expectation by the public, by nursing and by other health professionals, to the types of extensions to practice that place NPs in a situation where their scope of practice challenges the accepted professional boundaries and institutional directives. Differences are further compounded by the tensions between state and federal legislation, particularly evidenced in the inability of the NP to order of x-rays and prescribe simple medication that can be dispensed outside of the hospital within which the NP is employed. This is because the Medicare Act 1973, a

Federal legislation, does not allow NPs to obtain provider numbers<sup>13</sup> which would allow them access to the same patient subsidies tariffs that doctors have. One significant example of practice differences includes CPG restrictions. The development and ratifying of these are based on agreements reached between locally based doctors and other stakeholders such as pharmacists and scientists. Not only are CPGs tied to divergent local and legislative directives, but because they are a mandatory requirement for the clinical practice of NPs, the individuality of them and the dependence on local agreement, more often make them restrictive rather than empowering. In addition, each clinical presentation that a NP wants to become involved in at an advanced practice level requires a CPG, without which NPs cannot practice at that level. This creates a mixture of nurse/NP practice even when the incumbent is endorsed as a NP. This requirement is unique to Australian NP practice. In other countries, the focus is more on the development of a formulary required for prescribing and tasks which NPs are able to manage within a health care team. Further to this some Australian states refer to the CPGs as protocols, which are by definition even more restrictive in nature than CPGs and refer to clinical processes that are approved by a doctor (Western Australia Government 2003). Nurses working particularly in rural and remote practice have indicated that the restrictions placed on the scope of practice of the NP stifles clinical decision making. There are those experienced nurses who are eligible to apply for endorsement as a NP, and who say that it is not worth the effort or the stress to do so.

In the rural and remote context there is also the debate over the division of labour between the NP and other nursing roles which are deemed advanced, including the Practice Nurse and the Clinical Nurse Specialist (New South Wales Health 1995; Mahnken et al. 1997; Lumby & Picone 2000; Sinclair 2000). Despite the international discussion that the investment in the health of populations should be accompanied with an acknowledgement of the important roles nurses play in all aspects of health care delivery at strategic, operational and functional levels of the organisation (Rolfe & Fulbrook 1999; World Health Organisation 2000), there appears to be a lack of consensus beyond the level of rhetoric, and this is becoming evident with NP implementation throughout Australia. This divergence of opinion begs the question of whether role development is really being supported and developed by nurses, and how much influence those who hold power in the health

---

<sup>13</sup> This is examined further in Chapter 7.



services have. The emerging issues indicate more of a political and social influence to NP progress than a clinical one. The political and social influence of role development can be identified in the Nurses Amendment (Nurse Practitioner) Act 1998 and the documentation issued by NSW and Victoria in regard to authorisation to practice as a Nurse Practitioner (Nurses and Midwives Board of New South Wales 1998; Health Professions Act 2005 Victoria).

These documents outwardly stress activities and language suggesting that the new role be defined in terms of the absence of medical staff and the taking on extended clinical tasks which are normally within the medical scope of practice. Nurses have always argued that taking on a specific task did not in itself constitute expert or advanced levels of nursing practice (Hegney 1997; Goolsby 2001; Heartfield 2006). If advanced nursing practice can only be defined in terms of medical practice, then the question must be asked whether the existence of nursing really has the recognition of professional status or whether it remains a semi profession to others, and this position has been alluded to in the literature (Etzioni 1969; Wearing 1999; Cullen 2000; Keyzer 2001). The initiation of the NP role with its emphasis on extended knowledge begs the question of what nurses perceive to be nursing knowledge and whether or not nurses think of such knowledge as 'nursing' or 'medicine'. This is an important focus for attention in the creation of new nursing roles and the search for a new identity in a changing division of labour, where individuality and the possession of knowledge dictates perceived social worth and perhaps continuing existence of nursing as a profession (Castells 1996; Mahnken et al. 1997; Keyzer 2001).

The introduction of the role of NP services across Australia raises many questions about the definition of the role, its acceptance by the public and other health care professionals, the management of change by the health care organisations and the nurses' access to the education required to prepare and support the nurses in their new role. Much of the present problems faced by nurses seeking to develop this new role appear to come from the way in which the government, the medical profession and the nurses are presenting it to the public and to each other. Adding to the complexity of change, nursing professional issues relating to the clarification of the boundaries between NPs and registered nurses, as well as between NPs and General Practitioners (GP), are also impacting on the development of the position.

The journey of advanced nursing in Australia paints a picture of social interaction where powerful influences affect nursing, just as these influences shape the way in which health services are delivered. The question that needs to be asked is who really owns the directions that nursing takes and is the introduction of the NP introducing autonomy into nursing practice or is it merely shifting the sphere of influences that nurses already have? Whilst the overt obstacles are identified in the processes for development it is not clear why they have been created in this way and who is the dominant force behind their creation. In essence the questioning embedded in this thesis highlights how ‘the white rabbit’, seen by many in the profession to be forging a path to fulfil the profession’s dreams of becoming equally respected and acknowledged for their contribution to health care, has been thwarted by differing perceptions and diverging beliefs about nursing and what it stands for, from both within and outside the boundaries of the profession.

### ***Exploring the Discourse of the Nurse Practitioner Journey***

It is against the initial truth of NP development that that the need to undertake this study became evident. Despite legislation and policy being promulgated for NP practice, NP implementation has been slow and arduous. At a census in 2008, there were 300 NPs endorsed across Australia and less than half of these were employed as such, and this is after 12 years of discussion and a further eight years of implementation, a total of 20 years from the beginning of the movement in Australia. Public debate, especially taking place in articles from The Australian Medical Association (AMA) has indicated significant opposition to the implementation of the NP nationally (Australian Medical Association 2003; Australian Medical Association 2005b). There is also a dearth of literature emerging from Australia which examines these diverging discourses of NP implementation, yet the lack of NP establishment over eight years is evidence to the continuing blocks to the role.

If systems are in place for NP development and the role is not being taken up, there is a need to explore the social nature of role implementation so that an understanding of the political and organisational influences affecting the advancement of nursing can be established. The questions I ask centre around who owns nursing if NPs cannot establish their role despite policy and legislation being in place for them to do so? Why is it that organisations are reticent to embrace the role when the cost

effectiveness of NPs has been demonstrated in other locations? Are nurses really able to become autonomous practitioners as the Australian policies suggest? Are NPs merely shifting their sphere of influence within what is a traditional health care system? In this system, are nurses beholden to the final medical endorsement of care delivery, even when that care is initiated by the nurse?

### ***Research Objectives***

It is for these reasons described in the previous section that this study seeks to critically analyse the technical literature on the advancement of nursing knowledge and practice and how the language and views within it impact on the way in which the NP role is developing. In order to understand the way nurses are situated in health, it is important to understand how the influences from the past affect nursing today. Analysing the discourse around the NP role can be assisted by exploring the history of ideas that have given rise to the present attempts to advance nursing practice. I sought to explore, compare and analyse the development of the NP in Australia, identifying the barriers and facilitating factors, which are creating and defining the advancement of nursing practice and the knowledge required for it.

Because the study sought to examine the social interactions and their influences on NP role development, the experiences of NPs themselves in establishing their role in a health service were explored. The study examined the language and actions of NPs in relation to what was happening around them and how they positioned themselves within the environment in which they worked. Wardaugh (2002, p. 219) says that “the relationship between language and culture is that the structure of language determines the way in which speakers of that language view the world.” In the case of NPs, using a methodology which uses language to determine the social context lent itself to understanding the position NPs found themselves in. The way in which people use or adopt language assists a researcher in understanding the influence that society has on their position within it (Scollon 2001a; Wardhaugh 2002). To do this I chose Critical Discourse Analysis (CDA) as a framework.

CDA is a branch of Critical Social Theory which examines society, the social order and the effects this has on individuals. It takes into account historical issues of domination and social struggles, providing a critique on society whilst looking for new possibilities of social action (Creswell 1998; Meyer 2001; Scollon 2001b; Van

Dijk 2004; Anievas 2005). In the case of NPs this allowed an examination of role implementation in what is termed a traditional health system. CDA allows the analysis of the overt and covert structural relationships between social power, control and dominance as these are manifested in language (Wodak 2001). The context that NPs are positioned in are those institutions delivering health care as a sub system of society.

Language in this setting, is defined as the written and spoken word, the social processes that such language communicates and influences, and the objects of such texts and action that groups or individuals create as their realities within the institution (Fairclough 2001a; Scollon 2001b; Wodak 2001). For instance in this study texts were examined for converging and diverging discourses in professional and policy literature, media reports and field notes. These were supported by interviews that explored NP experiences and which then compared the language across all written and spoken texts. Such a variety of textual sources is crucial in identifying differences between nursing policy and NP development. Using Fairclough's approach to discourse as social practice that is produced by a social order, conversations and texts were examined to identify subject positions or subjectivities within them. These positions were then analysed to identify how they developed and how they exposed the operation of knowledge and power through the differences between the rhetoric of NP progress and the actual implementation of their roles (Fairclough 2001b). This approach was used because the observational evidence from field notes indicated that what was being endorsed at policy and strategic level did not appear to be supported or implemented in the health services at the organisational or clinical practice level. Fairclough (2001b) suggests that discourse and practice are constrained by interdependent networks within which actors operate and which represent the social order, in this case, health care. Language is a form of social practice and is conditioned by the social order. People speak, write and interpret the world around them from the social frame of reference so that it is not merely a reflection or expression of social processes, but is a part of those processes and practices (Fairclough 2001b). Fairclough's approach facilitated the exploration of discursive practices around claims to autonomy in nursing practice from three levels of health hierarchy, namely state, regional and local. It allowed an examination of differences in perception of the NP role and to understand the possible sources directing these developments from an Australian perspective.

## ***Research Focus***

The focus of this research was to examine the position that NPs take within the organisational environment of health so that those social and political aspects that have an influence on role development in Australia can be exposed. This was done by using text and language to identify influences on discursive practice. Autonomy became the focus of the study because this word is used throughout the technical literature when distinguishing between what nurses do to what NPs do at their acknowledged advanced level of practice. As Hickey (2000) suggests, the practices of autonomy are not deemed a significant aspect of nurse's practice because traditionally, nurses merely carry out doctor's orders in support of care. With the change to advanced practice this became the salient characteristic of NP practice and signalled advanced nursing practice. The way that this term operates to define NPs is further explored in Chapter 3. This thesis examines how NPs in the context of nursing as a profession with a history and as a subset in the health workforce, have developed. It seeks to locate how NPs are positioned, and how this positioning is dependent on, and informed by, other dominant discourses.

## ***Summary of Chapters***

Because CDA advises that language manifested as speech and text, shapes the discourse of social reproduction, literature as supporting text is used in analysis (Fairclough 1995; Scollon 2001a; Van Dijk 2004). Chapters therefore do not follow the conventional research process; rather they are guided by discourses emerging from the interviews conducted in the study, the approach to which is supported by the more alternative CDA paradigm (Fairclough 1995; Scollon 2001a; Van Dijk 2004). The thesis therefore does not follow the traditional chapter sequence; rather these aspects are interwoven to form part of the text around discourses that appear from the conversations of NPs. In this way literature is reviewed throughout the chapters and not in a single chapter. Discussion and analysis occur in combination with data collection.

In chapter 2, the research framework is discussed. The choice of methods is explored, including their limitations, and the position that the researcher takes in a CDA study. Methods used were interviews of NPs, the analysis of technical literature

including media, policy documents and field notes. These are explained in detail in this chapter.

In chapter 3, the history of nursing is explored in a way that sets the stage for this study, outlining the traditional views of nursing and how nursing is situated in the contemporary health care service. In this chapter, the legislation and the Australian Nursing and Midwifery Council Competency Standards for Nurse Practitioners are introduced as the basis for analysis throughout the study. This chapter will also review and operationalise the notion of autonomy, which becomes an element of NP practice around which discourses form.

At the beginning of Chapter 4 nursing roles or titles used in Australia and how they work within the health care system are outlined. This information was included here rather than earlier in the thesis, because it also forms part of the discourse that frames how NPs talked about their roles and their identity as nurses.

Chapters 4, 5, 6, 7 and 8 review the various discourses outlined by NPs, the technical literature and field notes. Using Fairclough's (2001b) orders of discourse, three levels of social organisation are examined, this being individual, organisational and wider social orders interrelated with NP practice and development. Discussion is interwoven throughout the chapters with the relevant literature. Literature therefore follows the discourse being described by NPs, unfolding it in a way that has allowed for the analysis of language in interviews and in the technical literature.

Finally, in chapter 9, the discourses are summarised and reflected upon, drawing together the explanations and positions that have emerged and how they affect the way in which the NP role is being established in Australia. It reviews the research and examines the effectiveness of the methodology in relation to the original questions that initiated this study, remembering that the information in this study is only one interpretation based on a particular research framework.

## Chapter 2 - Conversations Telling the Story: Critical Discourse Analysis

Resistance and change are not only possible but continuously happening. But the effectiveness of resistance and the realisation of change depend on people developing a critical consciousness of domination and its modalities, rather than just experiencing them (Fairclough 2001b, p. 3).

This chapter will examine the theoretical framework that was chosen for the study and the reasons why the particular orientation was identified as appropriate. The methods used for the study will be explored. The focus for research is social in nature, because as discussed earlier, NPs in Australia are a relatively new group of nurses and their impact on the division of labour in health care delivery is largely unknown. It can be assumed then that the introduction of this new role will have an impact on the status quo of the health care workforce. Porter-O'Grady (1999) says that any new role or activity sets in motion anxiety that comes about through the challenge to accepted organisational behaviours. In the case of NPs they can now undertake some of what is normally viewed as doctor's work, Although the Australian experience is only a few years old in comparison to the global experience, hurdles affecting progression of the NP show strikingly similar trends to the international situation. The complexities of global issues affecting NP practice have recently been highlighted by a survey undertaken by the International Council of Nurses (ICN) examining international NP development (Affara 2006). The survey identified poor role clarification, uncertain identity, mistrust between nurses, scope of practice conflicts and varying levels of autonomy in practice, to name just a few from a considerable list of identified hurdles common to all countries.

Although international and national literature has clearly identified obstacles to practice, there are few studies that have gone behind the overt themes to explain the impetus and power behind them, and to clarify the position of the NP within the web that has been cast around their practice. Hence, when seeking to identify factors for this study there were not only themes to examine but there were also themes behind themes. For instance, when asking others why the progress and ability to implement the NP role is so difficult when legislation and policy for practice has been endorsed, many nurses, including NPs, were unable to articulate the issues. Despite agreeing that NPs could play a very important role in enhancing existing models of care, citing

comprehensive care, continuity of care and an ability to do what doctors do not have time to do, they were unsure of how NPs could 'fit' into the current health care system. Fairclough calls this the power behind the discourse (Fairclough 2001b, p.52) where it is not so much what is individually perceived, but how a powerful discourse enforces constraints on practice and thus social relationships within them. In the case of the implementation of the NP role, the traditional models of care that have been accepted by health care institutions are challenged. Fairclough contends that the effects of those constraints are such that social identities, as well as their knowledge and beliefs about such identities, are influenced in practice. In this way the discourses in a social order such as health care delivery are so accepted as part of everyday life that the players within it fail to identify the hurdles. This is because the powerful discourses that are driving the system are legitimised thoroughly in organisational activities, language and policies. These ways of thinking and practising become universalised and are accepted as daily practice of those working within an institution (Fairclough 2001b; Scollon 2001a; Scollon 2001b).

Social interaction therefore, became the central point through which this study attempted to understand the reasons behind the NPs' struggle to progress. The web of social interaction however, was too large for one study so in choosing the framework it was important to examine one element of the social aspect of NP development. Based on what was not being examined in the literature, I chose to examine the social discourse of nursing within health care from the perspective of NP autonomy, where autonomy, described by Gardner (2004), is the ability of NPs to practice as professionals in their own right. The study set out to explore the practices that took place between policy and the implementation of NP role in Australia using autonomy as the object of the study<sup>14</sup>. Data was drawn from documents relating to policy and that was compared with the experiences of NPs in developing their role. In order to examine this, CDA was chosen for this study so that the various social influences that affect the development and definition of nursing autonomy could be included in analysis.

---

<sup>14</sup> In Chapter 3 I discuss autonomy in the context of how nursing as a profession uses this term to identify levels of practice between junior nurses and those more experienced nurses such as NPs. In this study, the definition of autonomy is not debated; rather it examines how it is used when describing the work that NPs do from that which is accepted as routine and accepted nursing practice.



## *Identifying Discourse: Shaping Identity*

CDA takes into account the social, historical and contextual environment of the subject, and the power struggles that occur between those in dominant positions and those who are organised within it (Fairclough 2001b; Scollon 2001a; Wodak 2001). It has already been identified that the role of the nurse in the history of health care has been one of subservience to the doctor (Chiarella 2002; Nelson & Gordon 2004). Furthermore, it is well documented that medicine has traditionally directed and designed models of care (Moore 1970; White 2002). Based on White's (2002) premise of medicine directing how models of care are constructed, it is reasonable to accept that the roles and functions of other health care workers and the models of care used have a biological and a social function. The outcome of this arises from political and economic pressure that has been created through medicine's control over the language relating to the human body and its related diseases.

Using Fairclough's (2001b) idea that truth claims are directed by those who have the power to influence activities such as the outcomes of health care delivery, then there are directions influencing health care delivery and the promise that the development of NPs have in that arena, which requires illumination. The status quo of traditional divisions of labour in social systems such as health care when viewed from the perspective of a critical social theory, are maintained when the activities of the system are formed and conformed by its most powerful groups. These systems become challenged when anything new is introduced, thus disturbing the equilibrium (Fairclough 2001a; Fairclough 2001b; Scollon 2001a; Scollon 2001b). If this is the case then it stands to reason that those groups who control the production of knowledge and the policy directions, will be highly influential in the paths of implementation of new roles such as NPs. Accordingly, history, politics and tradition influence and mould the way people view their world in society (Fairclough 1995; Fairclough & Wodak 1997; Fairclough 2001b; Wodak 2001; Wardhaugh 2002). Health as a system within society is no exception to this moulding and so the past, the politics and institution of health will have an influence in shaping the implementation of NP roles.

By using the analysis of practices of autonomy as the object of study, the aim was to compare the discourses in policy at a strategic level with those that emerge in the

implementation of the NP role at a local level about how autonomy is thought to be in operation. In this way, the social influences shaping the NP role are explored, exposing how NPs position themselves within this environment in order to achieve their status within the social constraints of health care. Because the study of language is central to comprehending social action, CDA is positioned within the social theory paradigm, and more specifically uses critical social theory concepts such as power, conflict and alienation.

### ***Critical Social Theory***

CDA sits under the umbrella of Critical Social Theory relying predominantly on qualitative methods for data collection. Creswell (1998, p. 13) sees qualitative research as,

...an intricate fabric composed of minute threads, many colours, different textures and various blends of material. The fabric is not explained easily or simply. Like the loom on which the fabric is woven, general frameworks hold qualitative research together.

As such, researchers in the qualitative realm study in the social setting from which meaning is drawn in order to analyse situations in the real world as opposed to the structured and scientific environment of randomised controlled trials and quantitative data analysis (Creswell 1998; Robson 1998). Creswell further contends that qualitative research uses a variety of methods involving interpretive and social approaches to the subject matter, and which explore a social or human problem in a way that exposes a complex and holistic picture, based on detailed views of the participants. Although critical social research has traditionally been termed an orientation rather than a tight methodological school, social research investigates those human phenomena that do not lend themselves to quantitative methods, because they cannot be controlled in a way that reduces variables in the subject under study, to measurable means (Carspecken 1996).

Social research concepts assume that all thought is fundamentally mediated by power relations that are socially and historically constituted, and these facts cannot be isolated from the domain of values or separated from social relations (Carspecken 1996; Scollon 2001b; Van Dijk 2004). Language is central to the formation of subjectivity and in any society there will always be those who are privileged and

those who are oppressed. Language forms the thread through which the various social orders accept their social status as inevitable, natural and/or necessary (Fairclough 1995; Scollon 2001b; Wodak 2001; Van Dijk 2004). Carspecken (1996) notes that because social research examines the real world, no research can be entirely objective and results tend to be skewed to the value orientation of the researcher. He argues that what is accepted as “neutral objective science” (1996, p. 7) is not at all neutral, and is biased in favour of those groups who hold the power and the knowledge. With each round of “objective findings” it is necessary to have those affected groups protest against the findings to force re-examination; and so science is profoundly political.

It is against this backdrop that most critical social researchers undertake their studies. Critical social theorists advocate an epistemology that is alternative to what is drawn from traditional research. These theoretical perspectives are derived from those early pragmatists such as Immanuel Kant, John Dewey and William James who shared a value orientation and concern over epistemological issues relating to social structure, culture and social reproduction (Carspecken 1996; Creswell 1998, Horner & Westacott 2001). These early theorists questioned the legitimacy of the scientific method, and argued instead that our own past and value orientation affect the way in which we accept and see things.

James rejected scientism suggesting that it does not allow researchers to view the real life phenomena because of the very unyielding point of reference in which research is undertaken. He argued that not all knowledge can be studied in the customary scientific way and that real world knowledge cannot always be supported scientifically (Carspecken 1996; Horner & Westacott 2001). Kant in the century before James, argued that claims of natural science cannot always bring together morality and religion, and that humans have a free will based on their own position in the world and their experiences (Kant 1781a; Kant 1781c; Horner & Westacott, 2001). He argued that what science gives us relates only to the world that we see with our senses and as such cannot be the ultimate truth in all cases.

Any real research therefore needs to accept that people are rational and responsible human beings capable of making moral decisions about what they do, and so it is not just experience but also the perception of it, that assists in the creation of new

knowledge (Kant 1871b; Horner & Westacott 2001). Based on Kant's premise, NPs are rational and responsible and so in order to understand the context and situation of their progress, research needs to draw data from the real world situation in which the NPs are working. Any analysis needs to include value orientation, beliefs and experiences of the subject in the context of the wider social and historical environment (Fairclough 1995; Fairclough 2001b; Van Dijk 2004). Using a critical social framework to guide this study, analysis should include empirical knowledge, opinioned knowledge, beliefs and values; and how these are represented in the language that is used in nurses' experiences and the language that is used in the sources shaping these experiences.

### ***Language and Text***

Although language in social research articulates what is viewed as the truth and knowledge that creates and perpetuates the threads of society and culture, Foucault (1966) argues that the history behind what comes to be seen as truth is closely related to the way in which operations and relations of power have been transformed over time. From such an assertion, he suggests that society looks back on its origins in order to plan for the future, in a way that allows history to inform our knowledge and our view of today. This premise supports the traditional underpinnings of contemporary nursing. Foucault describes this as the "order of things", where the understanding of information has been handed down through history by a continuation of facts that are generated in text and action by powerful groups in governments, educational institutions and reinforced and perpetuated through media. Other theorists have supported this position as well (Foucault, 1966, Danaher et al., 2000, Scollon, 2001b). In agreement with Foucault's version of history as discontinuous, social linguistics also contend that history is discontinuous and written by the dominant groups of the time. These pasts shape the way we view the contemporary world, so that we not only learn and accept the world as it is from a constructed past, but we also view the world from our own individual experiences in a world created by those with, and in, power (Fairclough 1995; Fairclough 2001b; Wodak 2001; Van Dijk 2004; Van Dijk 2005).

In the context of nursing, our contemporary situation has largely been shaped over 100 years since Florence Nightingale and others like her established schools of nursing. Here nursing supervisors who were from middle class families developed

and enacted social perceptions of the doctor's handmaiden in order to conform to social norms of the day (Dolan et al. 1983; Buresh & Gordon 2000; Wall & Nelson 2003; Nelson & Gordon 2004). This, mixed with the religious and secular orders' influences in the 19<sup>th</sup> and early 20<sup>th</sup> centuries (Dolan et al. 1983), has created a tradition and view of nursing which is challenged by the belief that autonomy is possible in advanced nursing practice roles such as the NP. It can be argued that the conformity to the accepted social expectations is perpetuated through language as the means of expression of social discourse as the status quo, and any new terms or texts created by nurses in advanced roles will in turn challenge the traditional status quo of health care.

Language therefore, is used to explain ourselves, our feelings and our thoughts and it becomes either an individual speech act or a discourse that constitutes the position we take within the environment around us. Language, as the spoken and written word creates the social discourse that acts as a lens through which we make sense of things and shape the understanding of ourselves and our capacity to distinguish what is of value, or right or wrong (Foucault 1966). In so doing using these discourses, we perpetuate the dominant discourse, endorsing, without thinking, the knowledge that is driven by power brokers and their truth claims couched in taken for granted discourses (Foucault 1966; Danaher et al. 2000; Fairclough 2000).

This premise is supported by later theorists who situate themselves in socio-linguistic studies (Fairclough & Wodak 1997; Wodak 2001). If the power behind the action, in other words the discourse, is to be understood, then the analysis of language in text and speech, and how it is used to portray the position that NPs take, will allow an understanding of the hidden agendas manifested in the discourses that are created within the texts of, and about, NP development. This is because CDA allows the researcher to look behind the taken for granted discourses to uncover those more persuasive texts and actions that are unconsciously accepted through social conditioning (Foucault 1966; Fairclough 1995; Fairclough 2001a; Scollon 2001b), and which may be the reasons for the seemingly inexplicable lack of progress in NP establishment, despite the national declarations that this nursing role can enhance existing health care services.

This study engages in the actual world of nurses and the society to which they belong, and identifies the influences that shape their roles and their work. The understanding of conversations from NPs, the texts from technical literature and from media, allow the analysis of the context, showing that the language used and its focus or development provides a discursive lens into the development of NP roles and how they have come to position themselves within the health care system.

This health care system itself however is not only constructing meaning from tradition and history, but it is also grappling with the explosion of information through media, which has created differences in identity within globally influenced economics and information networking (Castells 1997). The identity and the position of NPs have been caught up in this change, where expanding internet networks have allowed for global transference of knowledge. This in turn has impacted on how nursing is viewed and also challenged, in a transforming health care system.

### ***Tradition, Culture and Networks – NPs and the Dominant Social Order***

If an identity such as being a nurse is created through meaning and experience (Castells 1996) then Fairclough (2001) says that meaning and experience is communicated and transferred by action and text which, according to Scollon (2001b), are socially mediated. In other words, action and text is the point at which text, social action, experience, social identity and social conformity converge. For instance, the long-established identity of nursing as a social group of dedicated and selfless servants in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries emanates from a time commonly referred to as the Industrial Age. Since this time, global changes in technology, power relations between genders and economic status, to name but a few of the significant forces, have transformed society from the Victorian industrial age to a more liberated society - emerging in the 1960s - when society as a whole questioned these previously set traditions controlling societal norms (Castells 1997).

At that time information technology was developing giving rise to a sense of knowledge and freedom never before experienced. At the same time, Henderson (1967) was defining nursing, liberating nursing to take on a more active role in health care but still conforming to the conventional view of selfless woman derived from the Industrial Age. The first NPs were also emerging in USA. Not only was the

identity of nursing grappling with a new age, but so too was health care, where roles had to be reviewed in order to replace others which were in short supply. Shortly after these events, essential services became economic units where the finance of supply and demand dictated the division of labour. Management and control of the business units was streamlined, made possible many have argued, through the emergence of the Information Age and with it, its access to information and to knowledge through the explosion of Internet networks (Castells 1996; Bloom 2000; Keyzer 2000).

These connections are important to understand when examining the social construct of NPs in the contemporary environment. As Castells (1997, p. 1) suggests,

Our world, our lives are being shaped by conflicting trends of globalisation and identity. The information technology revolution, and the restructuring of capitalism, has induced a new form of society...by the networking form of organization. By the flexibility and instability of work, and the individualisation of labour...This new form of social organisation, in its pervasive globality, is diffusing throughout the world.

According to Castells, in this new form of social structure, tradition is at odds with the rapid transformations that occur, and with these rapid changes that are brought about through the expanding global networks, social identity and roles that are created within that social construct, are challenged. Castells (1997, p. 6) suggests that identity refers to “the process of construction of meaning on the basis of a cultural attribute...that is given priority over other sources of meaning” and there are inexorably many identities for one person and this becomes a source of conflict both to the individual and also to the way they incorporate society’s values. Roles on the other hand are defined by,

Norms structured by the institutions and organisations of society. The relative weight in influencing people’s behaviour depends upon the negotiations and arrangements between individuals and these institutions (Castells 1997, p. 7).

Castells states that identities can also be created by the influences of dominant institutions but this only occurs when the individuals themselves internalize them. Although both can occur at the same time, identities are a stronger source of meaning than roles because of the internalisation that occurs with identities, that does not

necessarily occur with roles. Castells suggests therefore, that “identities organise meanings and roles organise functions” (Castells 1997, p. 7).

In the network society heralded by the Information Age, Castells (1997, p. 7) contends that meaning is organised around a primary identity which is “self sustaining across space and time” and communicated through networks. These may be either individual or collective. The construction of identities builds from history, productive institutions, and power establishments such as government, by which collective meanings are created according to the social and cultural determinants of society. The creation of these identities always takes place within power relationships that are legitimized by prevailing institutions that are ideological centres. I would contend that such a centre would be, as Taft and Nanna (2008, p. 275) suggest, where “health care policy derives from the interplay of social needs, economic forces, technology, and public policy”.

Here dominant orders rationalise and extend their authority. In this new era, Internet, media and the ability to access knowledge is important in order to participate in developing identities and challenging the roles within the dominant order. Knowledge through text within networks becomes important. This is supported by Ovsianikov and Monakhov (2007, p. 61) who say that,

A system of education should be seen as an ideological institution: it produces the ideas, socially significant ideals, worldview positions, and hopes that they go together to make up the future society as a whole and the destiny of individuals...Outwardly, of course, Internet education is an instrumental pedagogical tool, but even today it has been recognized that its mastery leads to systemic changes in content, not only in education but also in society as a whole.

If we consider that a health professional will need to read at least 19 articles every day for 365 days a year to keep up to date, then the argument that states that the Information Age is “creating a culture where data drives decision making with timeliness and impact. Today’s educators are data rich but information poor” (Hall 2004, p. 32), because they can only construct a partial view of the subject, given the enormous amount of rapidly changing information available to them.

This is an important point to consider when developing a methodology to examine the social and cultural position that NPs take within health care today, and in relation



to the formation of a new highly contested identity of that role. Their location in the system is not only influenced by history, tradition and experience, but also by the contemporary culture which is being manipulated by the immense amount of data available to challenge, support or direct NP roles and their identity. The link between social relations and discourses is therefore mediated through text within a network system that is the contemporary health care system.

In examining the position of NPs within health, methods ought to be used which unpack the identities to understand what is happening, why it is happening, from what and by whom, within a social mix of tradition, history, rapidly changing environments and economic change, which is the hallmark of the information age. If socialisation takes into account all those external variants in an environment, then their influence on how the identity of a new role such as the NP is being formed needs to be explored. This can be done through examining the relationship between identity and role, by exploring texts which both contain and produce social reality, because these texts, through their grammatical arrangements, are the most fundamental element of social exchanges that are legitimised and internalised through networks, which are in turn, controlled by the governing groups (Fairclough 2001b; Scollon 2001a).

### *Examining Discourse*

CDA regards language as part of social practice and it is thus concerned with analysing covert and overt relationships of dominance, power and control as manifested in text, speech and action (Wodak 2001). As a methodology, it critically examines spoken and written texts as a critical account of social processes and structures within which people are constituted as social subjects such as NPs in the health care system. Eriksen (2001) contends that people are social products developed and shaped by society; however, society is also created by those within it. Therefore, the totality of social institutions and status of relationships makes up the social structure of society. This includes such institutions as education, health, government and the family unit, all of which interact with each other, inform and influence each other, based on the policy, the history and the directions of those who direct the society as a whole. The social structure we live in can therefore be seen as a matrix of social order with language being the common thread through it. Health care forms part of that matrix and the role of the professions, such as doctors and

nurses within it, shape, and are shaped, by society. These social processes are influenced and created by experiential, relational and expressive meanings of interaction that are reflected in text as written, spoken and enacted discourses (Fairclough 2001b; Scollon 2001a; Wodak 2001).

CDA is often referred to as a group of methods to which many established social disciplines such as anthropology, cognitive psychology and sociology have contributed (Fairclough & Wodak 1997). Wodak and Meyer (2001, p. 2) defined CDA as fundamentally “concerned with analysing opaque as well as transparent structural relationships of dominance, discrimination, power and control as manifested in language”. Fairclough and Wodak (1997) suggest that the main tenets of CDA are to address social problems in the face of discursively produced power relations. Society and culture is historical and ideological; and is played out in discourses that form the link between texts and society (Scollon 2001a). Porter-O’Grady (1999) contends that any change to the status quo in a team of professionals is noisy and creates a sense of chaos. Chaos creates instability and insecurity during which new directions emerge out of the rise of different discourses, positions and changes in the associated rhetoric. In such a situation, in establishing new boundaries the influences of those with power will seek to control the direction of change for their continuing benefit (Porter-O’Grady 1999, Eriksen 2001). CDA is interpretive and explanatory in its examination of language, text and action and as such contends that the creation and enactment of discourse is a form of social action (Fairclough 2001a; Scollon 2001b; Van Dijk 2005) diagnostic of the power relations forming and formed by them. Using the examination of texts in this way allows an explanation of discourses around NP implementation and its affect on role autonomy.

CDA is not a specific direction of research and does not have a unitary theoretical framework (Van Dijk 2005), and so there are many types of CDA which are theoretically and analytically quite diverse. Most kinds of CDA ask questions about the way discursively formed structures are played out in the reproduction of social dominance (Scollon 2001b; Wodak 2001; Van Dijk 2005). In the case of nursing accepted as traditionally subservient to medicine, in exploring the level of autonomy that NPs enjoy, or do not enjoy, the social place of nursing in relation to ongoing medical dominance, can be examined. Other discourses that impact on the creation of the NP relate to the discourses around gender in the long-established view related to

doctors as men and nurses as women, because in this analysis, nursing is women's work and therefore submissive (Moore 1970; Keyzer et al. 1995). Using CDA methods in data collection and analysis, it was anticipated that those elements could be identified and explained in a way that would support the nursing profession and its progress to advanced practice within the contemporary health social structure. In seeking clarity around the operations of a variety of discourses in practice, Scollon (2001b, p. 157) contends that,

a critical study of social practice and discourse cannot restrict itself to the study of discourse or social practice alone because the significant meaning of both discourse and social practice lies in the linkages among them in the production of the nexus of practice.

In the case of the nurse working at an advanced level in roles such as the NP, the relationships, expectations and the context of practice form the links. The study of discourse and associated social practices is thus inherently personal and subjective because these outline those links which require exploration (Scollon 2001b) around which the NP identity is being created.

### ***Framing Nurse Practitioner Reality***

As discussed earlier the objective of this study was to examine the discursively set operations of policy (texts and implementation) relating to NPs and the context of NP practice played out in the various locations where these roles were implemented. To do this the notion of autonomy<sup>15</sup> of NP practice formed the focus for the examination in relation to how NPs position themselves within health care. The framework chosen was based on the notion that all discourse is social practice (Fairclough 2001b). So in the case of NPs, the study sought to understand how the NPs coped with implementing their role in the context of the traditional social environment they worked in and how the practices that emerged, compared with the strategic directions set out in legislation and policy. The premise for this study therefore was that NPs act and behave in the way that society (and nurses), has shaped nursing. In exploring the introduction of the role of NP the aim was to explore what challenges such a change wrought in the social institution of health care as these professional boundaries are tested. In testing these traditionally accepted boundaries, the question is asked if the NPs position themselves in a way that supports their easy acceptance

---

<sup>15</sup> Discussed fully in Chapter 3

within the existing health system, thus maintaining the accepted discourse that does not challenge or question the traditional subservience of nursing.

Fairclough (2001b) contends that language use is a socially conditioned process and the study sought to listen to the experiences of the NPs so that the process of how they position themselves within the context of their social environment could be analysed. Fairclough (2001b, p. 19) states that social phenomena are linguistic, and that language activity, which goes on in social contexts, is not just the reflection of the social process, it is a part of it. In the case of the NP experiences, what they say and how they say it not only becomes the process of social production, it also becomes the product of social conditioning. Text is produced through a process of interpretation, where it becomes an interpretation of that social environment itself. The two processes are integral to how texts work, but are integrated into social practices by how these processes are made possible through language. In other words, discourse or language is the text which displays social interaction and context. The systematic constraints on discourse and the way in which the social relationship respond to it create social identities within the system. The process has long term effects on knowledge and beliefs that are produced and interpreted in the text, and the relationship between language and power can be analysed, specifically the power behind any discourse (Fairclough, 2001b). By studying structural effects of text as exhibited in knowledge and beliefs, the social relationships and perceived social identities, the content of what is said, and the relationships that are referred to, can provide an insight into who has the use of power and how that power operates.

Constraints	Structural effects
Contents	Knowledge and beliefs
Relations	Social relationships
Subjects	Social identities

**Figure 1 Fairclough (2001, p. 62) Constraints on discourse and their structural effects**

Fairclough's interpretation and assumptions of discourse as social interaction and interpretation has been chosen as the research framework for this study. Using this approach, the language that NPs use in the social context was examined in order to

understand how NPs position themselves and are positioned within the hierarchy of health care. Because language is centrally implicated in power and is replicated through roles and identities, it allows for clarification of the position and location of individuals (such as NPs) within it (Fairclough 2001b). Fairclough further contends that language has an internal and dialectical relationship with society and that linguistic phenomena are also social phenomena. Whenever people speak, read or write, they do so in ways which are determined socially and the nature of this is based on historical social associations and struggles. Text is therefore socially generated by internalised social actions and norms. Because social systems are defined as a set of social relationships that are created and re-created through regular interaction, it makes sense to suggest that the boundaries of the system lie at the points where interaction decreases significantly (Eriksen 2001; Fairclough 2001b). This allows the researcher to identify the conflict arising between discourses from the intersections of those boundaries.

Boundaries are not always absolute but are relative to a kind of social context or a set of activities. Relationships between subsystems within the broader systems that make up a social order, such as nursing as a subset of the health workforce within the health care system, is of great importance when studying social aspects, since it aims to understand the intrinsic connections between different social institutions and activities (Eriksen 2001; Fairclough 2001b; Scollon 2001a). Language and text therefore help to maintain status quo in relationships and situations so that traditional acceptance is perpetuated. Likewise, the variances to common themes, terms and phrases, assist in identifying the internalisation of a system into everyday practice. In the case of NPs, this study identifies the extent to which NPs situate themselves within boundaries prescribed by policy, by analysing what NPs say and how they say it, and if they do not conform to the accepted discourse, what discourse they use and how they position themselves within that.

When examining changes to the system following the introduction of a new role such as the NP, the changes to status quo as reflected in language processes, also reflect dominant discourses in political actions and changes in ideology (Rabinow 1997; Fairclough 2001b). Discourses therefore, involve social conditions which Fairclough (2001b, p. 20) calls the “social conditions of production and the social conditions of interpretation”. This incorporates three levels of social organization. The first level is

the immediate social situation that is the environment in which discourse occurs, and which directly relates to how NPs view themselves in their immediate environment. For NPs, this is the operational or local level of implementation within the health services that employ them. Fairclough states that the second level involves the social institution, in this case the health services. Interactions between the professionals within the clinical team, the wider management structure and the policies that drive the service, are examined and compared against what the NPs are articulating in their experiences. The final and larger level of social situation is society as a whole. This takes into account, not only the public view of the situation, but also the strategic view of health care as manifested in strategic plans, legislation, and state and national policy, relating to NPs. In studying the discourses in operation in such a situation, Fairclough concludes that in seeing language as both producing discourses and as social practices, the researcher is committing to analysing texts and the relationship between them, the processes within which they are found, and the social conditions in which they operate.

### ***Analysis in CDA***

Corresponding with the three dimensions of discourse Fairclough (2001b, p. 21) states that there are three dimensions or stages of analysis. The process of analysis initially looks at text, identifying and describing the changes that occur between stages. The second and third stages examine the cognitive processes of participants and the relationship this has between the transitory social events and the more durable social structures which shape, and are shaped, by these events.

Stage one examines the formal properties of text at each level of social organisation. In the case of the texts surrounding the implementation of the NP, it is concerned with the differences between the levels of understanding of autonomy as described in policy, the way policy is interpreted and actualised, and the understanding of it by the public as described by the media. The second stage involves interpretation of text in relation to the social interaction that follows the text at the three levels. At operational level the analysis looks at the experiences that NPs have in managing their practice within the operational teams, and how this team's interpretation of policy has influenced the levels of practice autonomy of NPs. In the second and third levels of social organisation, analysis examines the authors of policy, the objectives and the background to the policy, and how these are interpreted. Media is used to

examine the wider social view and interpretations made about the role of the NP. The final stage is that of explanation during which the relationship between interaction and social context is examined, and the effects this has on the processes of production and interpretation at the three levels.

### *Assumptions*

All research designs are based on methodological assumptions that arise from philosophical underpinnings (Patton 1990). Focusing on the autonomy of NPs, the study examines the influences that each level of social organisation is having on the role implementation that occurred and the autonomy that is produced such a change, and how the NPs position themselves in their talk about their practice as this relates to how they are able to manage their work. The assumptions therefore in this study, are that CDA will assist in understanding divergent and convergent discourses that are formed and conformed, around the implementation of the NP role, as the analysis moves between these three levels of social organisation. Such an analytical approach diagnoses the positions that nurses who are seeking to become or to act as a NP take, in order to be accepted in their working environment. In so doing it is possible to understand the position that NPs take in establishing themselves, and to identify whether NPs have gained autonomy in their practice, or whether they have merely shifted nurses' sphere of influence.

Fairclough (2001b) suggests that in CDA the relationship between discourses and social structures is not one way and so the means by which NPs describe themselves will also have an affect on how the wider social organisations view them. As mentioned previously the relationship between social structures and discourse is dialectical, and as such, an understanding is important in terms of analysing the power relationships and control over discourse, by institutional and societal power brokers (Fairclough 2001b). Social structures thus determine social practice and are also the product of social practice. Using this approach the complex and invisible relationships that occur within and between the three levels of production can be examined. So, in understanding where NPs fit within the health system, the text, language and processes that take place between the three levels of social structure, can be examined. The three levels in this instance comprise of the operational aspects of NP implementation, the policy informing NP development and societal perceptions as viewed from public literature such as media articles and reports,

annual hospital reports and similar public information relating to NPs. This allows an analysis of the discourses in policy and reality in relation to the autonomy NPs are afforded in their role.

### *Exploring Discourses*

CDA is not a single approach to research and so qualitative methods from other research disciplines are used when collecting data for CDA (Wodak 2001). Meyer (2001, p. 23) supports this notion by contending that CDA is “not a well defined empirical method but rather a cluster of approaches with a similar base and similar research questions”. Meyer says that CDA follows ethnography and many other forms of qualitative research, in that data collection is not considered to be a specific phase that must be completed before analysis begins.

Because social researchers share a value orientation of concern about social inequalities, they direct their work towards positive social change. Data collection looks for indicators to particular concepts and in this study the concept in question relates to the autonomy NPs have in their practice. The centrality of this concept was noted first in the literature, and then in the policy and standards, and finally it was explored in other texts produced by the study. For such a process to occur, analysis is often concurrent with data collection, which allows social researchers to explore the real world social structures involving interactions between the society, text and its context. This supports the creation of new knowledge or refinement of existing assumptions, rather than merely describing social life (Carspecken 1996; Wodak 2001).

The central themes of Critical Social Theory explore social institutions and their transformations through interpreting the meanings of social life, the historical problems of domination, alienation and social struggles with a critique of society and the suggestions of new possibilities (Creswell 1998). In ethnographic studies, the design needs to include methods that will elicit information on how people respond to change, how they interact and how they form networks, so that the researcher helps participants to examine the conditions of their existence (Creswell 1998; Van Dijk 2004). In the case of nursing and its progress to advancing practice, the data and methods used need to provide the opportunity to identify discourses that influence direction and change within a social system. Scollon (2001b) suggests that all action



is mediated by social influences, which creates discourses that influence production and reproduction of socio-cultural histories and structures, in accordance with social norm and tradition. The use of social research methods for data collection, which allow for the analysis of inter-subjective data, will allow data to focus on the object of autonomy; and the resultant status of NPs within health, can be analysed based on Fairclough's three levels of social organisation (Fairclough 2001b).

Using Fairclough's three levels of social organisation, different qualitative methods of data collection were chosen at each level of social organisation in order to observe how interactions occur between the different levels of data through interviews, policy documents, policy implementation and health care practices. In this way information could be gained to allow an analysis of the differences between policy and reality of NP implementation using dimensions of discourse at each of these levels. This approach would allow the identification of the dominant discourses in language and their effects in and on action from three levels of health between its rhetoric and reality. By revealing the operations of discourses in this manner, the power behind the discourse which influences NP development can be identified. This study used interviews with NPs, analysis of technical literature in policy documents, legislation and regulations and media articles pertaining to NP implementation with a focus on autonomy as the subject for analysis.

### **Ethical Considerations**

Ethics approval was obtained from the Flinders University of South Australia Social and Behavioural Science Ethics Committee (Appendix 9). Because nurses were approached as consenting professionals in their individual capacity, no ethics approval was sought from any other hospital or institution. There was no patient or client involvement and no minors under the age of 16 years used in this study. All participants were consenting adults and professionals in nursing.

As part of the ethics application at Flinders University, the researcher needs to consider any cultural aspects that may impact on the study's outcome. No personal cultural or ethnic background information requests formed part of this study. Participants of the study included NPs from all ethnic and religious backgrounds

with the common factor being registered NPs or NP candidates<sup>16</sup>. Individual backgrounds were therefore not considered. Because the target population was endorsed NPs it was accepted that all participants would be able to speak English, this being a criteria of any nurses' registration in Australia.

## **Interviews**

Fairclough (2001b) contends that there is always hidden power behind discourses which holds together the whole social order. This power is an inherent part of all text, language and action. The use of interviews in CDA allows language to be viewed as a form of social practice (Fairclough 2001b). Language is a social process and it is socially conditioned by other (non-linguistic) parts of society (Fairclough 2001b; Scollon 2001a). This suggests that whenever people speak, listen, read or write they do so in ways which are socially determined, and therefore have social effects. Likewise, language activity goes on in social contexts and as such, is not just a reflection of social processes and practices but is a part of it (Fairclough & Wodak 1997). In this sense, disagreements or differences in standpoints can be seen as preliminaries to the tensions emerging in the views of the autonomy NPs have from real practices, and from the politics surrounding role development.

Interviews are a social process which is governed by rules of practice. By listening to, and interpreting the language and content of language in interviews in this study, the reflection and expression of social practices and processes from the participants' perspective could be analysed. In the case of NPs, the language and social actions serve to understand the threat to the status quo of health care where traditions and practices are being questioned, changed or modified with the introduction of a new nursing role. The social threat and standpoints in conversation and discourse that Fairclough (2001) suggests, is not so much standpoints, but rather they are politics in action. Politics, he contends, partly consists in the disputes which occur in language and over language. In using the interview method to uncover the perceptions of autonomy by NPs, an understanding of the politics of nursing and within nursing, can be gained. Both these aspects are created by the challenge to the status quo of health care and the change models of care that the introduction of NPs has created and

---

<sup>16</sup> An NP candidate is used in some states for those nurses who are either endorsed already as NPs or are preparing for endorsement, to be employed into a project position whilst the role is being developed. How this is constructed is dependent on state policy and also the organisational need.

shaped by the rules of language use. It will also provide a window into how NPs are enrolled in and implicated in the context as well as the sustaining of the status quo.

## **Participants**

The study interviewed NPs from across Australia. Participants were sought by means of calling for volunteers through purposeful sampling (Babbie 1992; Polit & Hungler 1995). Although purposeful sampling was deemed judgemental (Polit & Hungler 1995), for the purposes of this study, it was necessary to select the specific category from the nursing population, that being NPs. At the time of undertaking the data collection for this study, there were less than 300 NPs endorsed across Australia, a handful of whom were working in rural and remote areas. Because there were a small number of endorsed NPs opportunistic sampling methods were also used in which leads (Patton 1990, p. 179) from my own field work was used. I also used field notes to support claims of NP interviews and this allowed for broader information collected thus complementing the small sample size (Patton 1990).

Although the study initially sought to examine the discourses of rural and remote nurses it became apparent that there were too few endorsed NPs practising in rural and remote health and not only would their anonymity have been compromised, but also the target population was too small for interview selection. It also became apparent very early on in the study, that the issues emerging in the rural and remote context were no different from those which other NPs were experiencing. The participants for interviews were therefore drawn from the total population of NPs working in Australia.

Participants were sought for interviews by sending a letter addressed to the registrar of all the NMRA's of Australia requesting assistance with the distribution of packages. The registrars of the NMRA's were asked to distribute the packages included to all endorsed NPs in their state. Initially, 50 packages were sent to eight NMRA's. They included South Australia (SA), Northern Territories (NT), Western Australia (WA), Queensland (QLD), New South Wales (NSW), Tasmania (TAS), Victoria (VIC) and Australian Capital Territory (ACT). Each package included a letter of introduction (Appendix 2), information on the study (Appendix 3), a consent form (Appendix 4) and a self addressed and stamped envelope for return to me as the researcher.

Responses from the nurses' boards were limited because of the initial intention of targeting rural and remote NPs. ACT, NT and Qld all returned the packages with an enclosed letter stating that they did not have any NPs working in rural and remote areas. SA returned the packages stating that they did not undertake the distribution of such material and advised me to contact the South Australia Nurse Practitioner Association<sup>17</sup>. Victoria, through a telephone call to me, requested that they keep the packages because although they did not have endorsed rural and remote NPs at the time, they would send packages off as NPs were endorsed. WA also telephoned me to say that they had sent packages out to all NPs as they had no way of knowing the NP classifications. As Tasmania has not yet endorsed any NPs, they were unable to send out any packages. NSW, by telephone, declined to send out any packages.

With such a poor response to my distribution requests, the search for participants was expanded by sending packages to the Australia Nurse Practitioner Association for distribution. This association also declined to send packages and so I used my own field of knowledge to invite participants to participate (Patton 1990).

A total, 60 packages were eventually sent out. From those 20 were returned, and following preliminary contact, eight NPs proceeded to interview. No direct contact was made with the eight potential participants until receipt of the signed consent was secured. Once consent was signed, the participants were contacted by email, to arrange for a telephonic interview. Where participants lived close by, I arranged to meet them in person. Those participants living more than 200kms away were interviewed on the telephone.

Although not formerly interviewed, a NP, who had heard about this study, later came forward and voluntarily signed consent for information to be used, because she wanted to share some insights relating to her journey to NP endorsement<sup>18</sup>.

Participation in interviews was voluntary and the information provided to the target population clearly outlined their rights as a voluntary participant to the study. Letters

---

<sup>17</sup> The South Australia Nurse Practitioner Association in fact no longer existed when this advice was given by the Nurses Board of South Australia. They had already amalgamated with the Australian Nurse Practitioner Association.

<sup>18</sup> Although information from this participant was used in Chapter 7, it has not been included as a part of the interview process; data has been referred to as a field note.

(Appendix 1) were sent to all NRMAs in Australia asking the registrars to send out a pre-printed package of information which included a letter of introduction (Appendix 2), information on the study (Appendix 3) and consent forms (Appendix 4), to every endorsed NP working in Australia. In this way objectivity in choosing participants was maintained. Potential participants were asked to sign the consent and return to the researcher in the pre-stamped and self addressed envelope.

Australia covers a vast expanse and so it was not practical to travel to all the participants' sites of work and to view their actions in body language as well as in spoken form. It was therefore accepted that most of the interviews would be conducted over the telephone. Although this reduced the ability to understand the total discourse of the moment (Scollon 2001a) the use of field notes were used to support the information that was given (Fairclough 2001a; Scollon 2001a; Wodak 2001) in understanding the physical situations and physical language that would have been portrayed, had a face to face interview been undertaken. Although, the optimum is to interview face to face, it was not appropriate to further limit the already small sample to areas which were more accessible. By accepting the telephone interview, a broader and more objective sample size could be used.

Of the eight participants, seven were endorsed as NPs but only one was employed into the substantive role. The others were employed in a variety of advanced clinical practice roles. All had successfully completed a master's degree. The information relating to the participants' positions is discussed in Chapter 4.

## **Consent**

Once the consents were signed and returned, participants were contacted by phone or email and interview times were arranged. A time was set of not more than one hour for the interview, further information relating to the study was offered and any questions relating to the interview process and the study were answered. Interviews were taped using a digital recorder held to the speaker phone. The transcript was then transferred to a computer as a wave file, stored and coded, so that the identity of the participant remained anonymous after the interview and during the analysis of the data. Because of the smallness of the sample population all data from analysis that could have linked the participant back to the area in which they worked was removed. Although it would have been interesting to further extrapolate data to link

themes to states and territories in which nurses worked as a comparison of attitude and approach to NP development, this could be a study in itself and it would not have protected the anonymity of the population in this study due to the smallness of numbers.

## **Question Format**

The guide used for interview questions (Appendix 5) was simple and semi-structured. This gave participants enough freedom to discuss and explore issues that they saw as important to them in their practice. Where discourses were beginning to emerge in the interview and where nurses returned to specific topics, prompts were given to allow for further exploration and explanation. In this way it was anticipated that freedom of speech would assist in identifying common references to stories, ‘party line’ comments that reflect organisational view points, and phrases and words that reflect the NPs’ perceptions of their abilities and standing in the organisational structure (Scollon 2001b; Linde 2005; Van Dijk 2005). In this way systemic constraints on the content of discourses and on the social relationships that supported them were identified, and how these impacted on NPs’ identities of themselves within the institution (Fairclough 2001b).

## **Protection of Participants**

All participation was voluntary. Participants were allowed to withdraw from the study at any stage of the interview and they were allowed to read the transcripts following the interview. A transcript and a CD recording of the interview were sent to each participant for their own keeping and examination. No participant withdrew after consent was signed, and none requested changes to the transcript of the interview.

Whilst Australia is vast in its geographic expanse, the nursing population is comparatively small and the specific group of nurses targeted for this study even smaller. With the use of purposive and snowball sampling the target for interviews was 10 nurses working in advanced practice. Despite broadening the target population to all NPs in Australia, the need to maintain anonymity was still of concern because of the small target population. This was maintained by removing all information from the analysis that may lead readers to identify names of participants

and areas of work. All information that could have identified the participant or the area and location of work was removed from the data. All participants understood that the information given to them would be used in the analysis of data in the thesis, and subsequent presentations and articles.

A professional transcriber used by Flinders University was employed to undertake the transcription of the interview recordings. All participants were sent a copy of both the transcription and the recording, and were asked to check them and identify any sections that required adjustment or were not to be used in the analysis of data. No participant changed any of their transcripts or recordings. Recordings and transcripts were then shared with my supervisors so that interpretation of text and action remained objective.

In cross referencing information that was shared by the participants with data from technical literature, media and information relating to health services was not taken from the health services in which participants worked. For instance, when I sought information from hospital annual reports, none of those documents were from the health services identified by participants. This was specifically done so that not only was participant's anonymity maintained, but evidence from other sources of literature supported the triangulation and objectivity of information. There were times when information from state policy may have been from the same state as the participant but care was taken not to identify this in discussion. I also separated myself from the demographic information in my analysis by coding interviews and using only pseudonyms to identify participants when unpacking the information from the interviews. Codes related to the interview number and a pseudonym which I assigned to each participant.

### **Field Notes**

Qualitative research uses many forms of data collection which provide a diverse range of information. Field notes are often made by the researcher in the course of qualitative fieldwork, and can include observations of participants, locations or events. These may constitute the whole data collected for a project or they may add to it (Babbie 1992; Robson 1998).

The research diary is a point for all of the diverse elements of data collection and can include past experience, observations, readings or ideas. Schatzman and Strauss (1973) suggest that the role of field notes is to arrange activities and ideas that will augment the data collection process. Newbury (2009) states that field notes become short and reflective sections of analysis that assist in explaining or interpreting the data as well as being able to assist in describing findings. There are no rules over what to include in field notes and they can include information such as thoughts on a topic, reflections from meetings, observations and notes on methodology. Notes can include unresolved problems or questions which serve to further expand on a particular topic or data.

Field notes from my own experiences were used in this study in the analysis of text and interviews, where such information would enhance analysis. In terms of CDA approaches, it is appropriate to include the experiences of the researcher as they are as much a part of the text and the context as other sources of data collection (Fairclough 2001a).

### **Examination of Technical Literature**

In Fairclough's three levels of social organisation, the examination of the technical literature applies to collection of data from the second level of social organisation, which involves the wider matrix for the discourse, in this case, health care as a system. Fairclough (2001b) suggests that technical literature relates to the power and access to discourse and so by analysing technical literature a view of who has the power behind the discourse can be uncovered. Fairclough suggests that certain controls are inherent in any social group, created and maintained by those with the dominant power in the group and by those who have access to the discourse.

Technical literature provides the framework to legitimise NPs and to develop the new role, but it also provides the constraints which are ordered and controlled by those in power. Using autonomy as the object of analysis, a review of the policy and legislative documents which have been developed to support NP implementation, should reveal the extent to which NPs are supported in practice, and who affords that support. The data gained from this could then be compared with the information given by NPs as to what was really happening in practice. In analysis, genres or actions which regulate the action of NPs, discourses relating to the language used



and the context in which they are used, and the styles or phrases used, link discourses to the importance that policy makers place on issues such as autonomy of NP practice (Fairclough 2001b).

### **Period of Data Collection of Media and Studies for this Study**

Using this framework described, pilot studies, policy and legislative documents were chosen from the Australian context from the period January 1991 to December 2008. This period was chosen because this is the time that the NP movement has been in existence in Australia, to the time that the writing up of this thesis began. Some documents from 2009 were included during the final discussion process, where it related to policy changes directly connected to the data in this study.

Documents were examined for the direction that allowed NPs to practice autonomously. The nature of the text and content of it was then compared to the language used by NPs and how it was explained, with the aim to seeking the diverging and converging discourses that are evolving between policy and practice. Only literature that was freely available in the public domain was used and therefore no application for documents through the Freedom of Information Act 1982 was required.

### **The Media**

The scope of the media is far reaching. One only has to look at the television 'soapies' on medical practice and hospitals, newspapers, documentaries and cartoons to understand the influence it has on public perceptions and understanding of topics such as health care. Within research relating to social order, practices, semiotics and critical theory, the role of the media provides a huge source of information to be analysed, deconstructed and dissected (Cotter 2005). Fairclough (2001b) sees media as a site of discourse that operates as an intermediary where participants are separated by place and time. The discourses in use in media summarize the news story and the text, and the process involved in producing those texts (Scollon 2001b; Cotter 2005). In both areas, researchers look for text that encodes values and ideologies that impact on and reflect the society at large. Fairclough (2001b) comments that media practices present one sided texts providing a specific interpretation to a mass audience, who is then left to interpret its meaning. He further contends that the nature of the power relations in media is unclear, because

there is a hidden power not always revealed in seemingly transparent stories. This is because the “media product takes on some of the nature of the commodity between producers and consumers” (Fairclough 2001b, p. 41). Moreover, a single text on its own is insignificant but the effects of media power operate accumulatively working through the repetition of themes and text to form opinions and perceptions in the readership.

Interpretation, Fairclough (2001b) suggests, sees text as a resource in the process of interpretation. An explanation is then created in which the relationship between the interaction and the social context is developed. Jager (2001, p. 33) further advises that CDA be based on Foucault’s discourse theory in which questions on what knowledge is communicated, how is it passed on, and what impact it has on the discourses present, and to the subject, in this case NPs. If one considers the views of Jager (2001) and Fairclough (2001b) then the overall question in analysis targets the effect the language and text has on the overall understanding, in this instance, the NP role and the importance ascribed to the level of autonomy that the NP is afforded in society.

In deciding how many articles to review, Fairclough (1995) states that the number of texts in the media is not important, rather it is the common agenda and the nature of the text that is central to a productive analysis of a situation. Because CDA is very much about making the connections between social and cultural processes on the one hand, and properties of text on the other (Van Dijk 2004), articles are examined for themes of common and/or specific discourses. Media articles for this study were randomly chosen from records between the years of 1991 to 2008. The basis for selection of the articles was their focus on NP development, implementation or evaluation. Media forms open to public readership were chosen and included newspaper articles, magazine articles and web based information. The subject for analysis was the reference to NP autonomy examining the text that was used to describe it and how this related to the overall perception of the NP role.

## **Data Storage**

Interviews were conducted using a digital recorder to record the information. This information was then transferred as a wave file and stored on a personal computer at home which is used solely by me. All other paper based information and a back up

data disc relating to participants was stored in the locked cabinet. In accordance with university research rules, all data is to be stored in the locked cabinet for a period of 5 years. Following completion of the thesis, the information was transferred to university storage. Information relating to the data was removed from my personal computer at the end of the study and stored on a CD Rom together with all other information. As with all doctoral studies, the final thesis is made available to the public via the Flinders University Library.

## **Limitations**

There are some alerts which need to be recognised when using the social science research methods. CDA investigates the power relations which are socially and historically continuous (Babbie 1992; Fairclough 1995; Carspecken 1996) and these facts can never be isolated from the domain values. The findings must make the fact or value distinction clear and must also have a precise understanding of how the two interact (Carspecken 1996). My own orientation as a nurse and my nursing knowledge of the issues and hurdles relating to NP implementation had the potential to cloud judgement, and which could have prevented a true understanding of the issues revealed in the data. The role of my supervisors in this aspect of the study was to assist in allowing me to step back from the data and to view it from different perspectives. There were times during the data collection and analysis periods, when I needed to step away from the data completely in order to maintain my objectivity, because of the sensitive information that was being presented to me. Using Fairclough's three levels of social organisation assisted in providing enough triangulation of data across three different perspectives to ensure that objectivity was maintained.

Despite strategies to maintain objectivity, CDA always places the researcher at the centre of the activities in real world research (Robson 1998; Scollon 2001b; Wodak 2001) and it must be remembered that CDA researchers play an advocacy role for groups under domination. Fairclough (1995) says that in seeking participants and data the researcher needs to be mindful of the threats and attacks that may eventuate when exploring the status quo of dominance and organisations of health care. Fairclough (1995) comments that although CDA comes under attack to the point where CDA researchers are hesitant to use their basic theoretical concepts such as 'power', 'ideology' and 'class', these developments are linked to the defeats and

retreats of those who are part of the political movement in which the study is situated. Any opposition can be seen as very much a part of the political and ideological struggle in which the issues are not new (Fairclough 1995). My various roles as experienced clinical nurse, nurse manager, nurse educator and nurse researcher forms part of this study and the politics within it.

In most cases of research, the researcher has to find methods for data collection that will support objectivity and triangulation (Babbie 1992; Creswell 1998). By using Fairclough's three levels of organisation, and using methods of interview, review of the technical literature and media, triangulation of data was achieved. I did feel that my work as a NP Project Officer at the beginning of this study would have compromised my position as researcher, and this was discussed in the early stages with my supervisors. However, by the time I was ready to collect data, I had been working in a different role for more than 12 months and so this position was no longer an issue<sup>19</sup>.

At the time of conducting interviews, I was in the position of Director of Nursing. I made a point of not disclosing this to participants and to present myself as a novice researcher only. Although I did not realise it at the beginning of the interviews, this was an expedient step to take because every participant referred to manager conduct in some way. I believe that if they had known my position, participants would have withheld some truths during the interview process. For me as the researcher however, I found that I had to step away from the data and I had to discuss my own feelings relating to disclosures around manager behaviour, with my supervisors. Again using Fairclough's (2001b) three levels of organisation, I was also able to use triangulation of data to maintain my objectivity.

Whilst methods of data collection need to be objective and to acknowledge the bias of the researcher (Patton 1990; Babbie 1992), the CDA stance seems a paradox. In this case therefore I had to reflect on my own profession, my viewpoints in it and the role I played in understanding the data that was collected, knowing its subjectiveness whilst seeking to become objective as facts were revealed. There were times through the analysis process that I found this difficult to do as I am also a nurse, and there were times in the study that I needed to step away from my research for a while.

---

<sup>19</sup> I revisit this in Chapter 9 when strengths and limitations of the study are discussed.

When I came back to it, I did so through discussion and debate with my supervisors. In this way I was able to tap into their diverse experience and objectiveness which helped me to maintain my own objectivity.

### *Situating NPs*

CDA has been used to situate the NP and the role it plays within the social context of nursing, in health care and in the society at large. CDA allows examination of text and action in order to understand how the cultural, political and the historical perspectives of health and nursing influence the development of the NP role. Based on the CDA approach, the discourses were examined using three main concepts, these being the concept of power, history and ideology (Wodak 2001). In the case of the NPs, the words that NPs use to describe their work, allowed analysis of how they locate and position themselves within the health system, and whether their level of practice reflects a degree of autonomy in practice as stated in legislation, or merely a shift in their sphere of influence as a situated player still dominated by others within health care organisations.

Analysis made use of Fairclough's model of social integration where the role of the NP can be viewed from three levels; local level, policy or health care level and society (Fairclough 2001b). The analysis of discourses at these three levels supports the creation of new knowledge by illuminating discourses that influence NP development. It was anticipated that this new knowledge would afford nurses and health professionals a greater understanding of the discourses influencing NPs in a way that supports positive and meaningful collaboration for future development.

The proceeding chapters provide a description and discussion of conversations from NPs, and text from technical literature, that build a picture of the discourses around the role of NP. Each chapter will examine particular discourses beginning with the personal perceptions from the participants, and finishing with the global discourses that emerge from the data that are shaping and influencing NP development. These chapters will examine the experiential, relational and expressive values of the text at each level of discourse, and then finally integrate this information focusing on how the convergent and divergent discourses that are revealed impact on the NPs ability to practice autonomously. As previously noted, this thesis does not follow a conventional research path, but rather follows the CDA approach, where each

chapter includes the analysis in the findings and the debate, and uses supporting literature to further explore and discuss the those conclusions.

Chapter 3 will set the stage for the rest of the study by examining the historical and traditional discourse of nursing and health care. The legislative and professional framework of NPs is also outlined and explored. Finally, the notion of autonomy as the object of this study will be investigated as central to the position that NPs take in contemporary health care practices.

## Chapter 3 – Setting the Stage

These messages are so pervasive that they create a social feedback loop that reinforces and then reproduces the 19<sup>th</sup> century view that nurses are sentimental workers who may even act as agents of a higher power (God or the physician) (Gordon & Nelson 2005, p. 66)

This chapter provides the background to which NPs today are developing. It examines the historical perspectives of health as a social system and nurses as members of that system. Fairclough (2001) states that historical influences inform and shape the form of contemporary social structures. From such a perspective it can be asserted that history contributes to those discourses that are forming and informing the NP role. Following on from this, the development of the NP is examined both globally and nationally in Australia in order to provide the context of this study. The chapter also explores the notion of autonomy within the nursing context as this is central to discussion in later chapters.

When I first started working with NPs in Australia in 2001, I used to ask people in conversation, what they thought an NP was. I would get various answers around a common theme, for instance, that NPs are nurses who could do what doctors can do. In other words, the social perception of the NP had been set as a medical replacement rather than a nurse who has advanced nursing skills. This led to the question as to why there is a difference between how nurses view NPs and how they actually appear to be in society?

To take that further into the social view, Horner and Westacott (2001, p.133) say that “our values are intimately connected to the way we understand the world and to the things we think are significant about it”, therefore, to those members of the public who are not nurses, they describe what is known to them and what is important to them and not what nurses necessarily view as the truth about the role of the NP. This view is taken from somewhere, and Horner and Westcott (2001) suggest that the outlook seen by society is the dominant analysis accepted by that society. As such “power is the ability to make things happen and in the social and political context it means getting people to do one’s will” (p. 171). In the case of nursing, history tells of nurses being a subordinate labour force in health care based on perceptions of dedicated and selfless single women working for secular and religious orders (Nelson

2001; Hart 2004; Nelson & Gordon 2004). In the last 100 years of this history, the views revolve more around medicine as the central point of that care and nurses, now paid individuals rather than selfless carers, undertake orders resulting from that central care.

### ***The Good Doctor***

The profession of nursing has been traditionally a subordinate role to that of the doctor. The role of the doctor has driven health care and how it is delivered (Friedson 1971; Gordon 2005). According to Friedson (1971) medicine is not merely one of the major professions; it has gone further than that, using as its central task, the management of diagnosing and treating illness. In this way it has developed a systematic connection with science and technology, through which a complex division of labour, including nurses, has evolved around it in order to assist in the work they do. Nurses are, in this hierarchy, “behind the scenes players” (Buresh & Gordon 2000, p. 37). Medicine's knowledge about illness and its treatment is considered to be definitive and, according to Friedson, there are no representatives of occupations which are in direct competition to it. Friedson suggested that the perceptions that doctors as central to care, has created the idea of supremacy, which is not merely one of public status but is also one of professional authority. However, Masterson (2002, p. 333) noted that,

...defining the health care team is becoming problematic...as new members from a range of backgrounds such as counsellors and community development workers are increasingly being recruited and new models of organizing, managing and delivering services are also being developed.

The dominance of the doctor however is still reinforced in many ways. Research shows that medical students remain versed in the status of medical superiority and nurses work in a way that reinforces this (Becker et al. 1961; Etzioni 1969; Cockerham 1992; Chiarella 2002; Hart 2004; Cameron & Thompson 2005; Gordon & Nelson 2005). There are instances related where nurses manipulate the situation, in which they tell doctors what to do in a way that the doctors believe they have come to the decision, where nurses are not at the strategic or management table, and where they do not speak out when there are issues of health care delivery to be discussed (Keyzer et al. 1995; Buresh & Gordon 2000; Chiarella 2002; Jones 2003; Gordon & Nelson 2005). A common story supporting this conception is told by



many nurses where a new medical intern<sup>20</sup> on a ward seeks collaboration with experienced nurses who advise them on what drugs they should be considering for a patient. The intern then prescribes the drugs and nothing more is said about it. Nurses often take a position of virtue in the society of health care where, as one nurse said, “I do not need credit for my work...working with patients is reward enough” (name not disclosed, cited in Buresh & Gordon 2000, p. 33).

It is interesting to note that the current social position of the medical profession only developed in the mid 19<sup>th</sup> Century (Friedson 1971; Hart 2004). Before this time, there were many healing professions but none were called medicine. It is during this time that the rise to a profession and its dominance occurred. As the industrial age developed, doctors assumed the leadership roles of hospital superintendents and developed a workforce to support the increased demands on curing illness (Dolan et al. 1983; Hugman 1991; Keyzer et al. 1995). Nursing became part of that workforce and doctors encouraged the development of nursing, but on their terms. Moreover, they had control over its status and education (Friedson 1971; Nelson 2001). Nurses were seen as there to carry out the doctor’s orders and not to develop expanded nursing practices (Hart 2004; Gordon 2005).

It is within this environment that nursing has developed and during the 19<sup>th</sup> century, at the same time that medicine developed into an acceptable and powerful profession, nursing was attempting to release itself from its traditional status of women’s work and doctor’s handmaiden (Moore 1970; Friedson 1971; Bassett 1992; Keyzer et al. 1995; Borthwick & Galbally 2001; Nelson 2001; Catalano 2003; Leonard 2003; Nelson & Gordon 2004; Gordon & Nelson 2005). Because of the control that medicine had over health professionals that served to carry out the work generated by the doctor, history shows us that nurses have never broken free of this perception; they have merely shifted the tasks around in different ways (Keyzer 1997; Nelson & Gordon 2004). It could be argued then, that in developing and advancing nursing today, the profession is faced with the tradition of power of all that medicine still has in the policy making arena of government, as well as the tradition of medicine being so autonomous that they have monopoly over all health care directions and strategy.

---

<sup>20</sup> A medical intern in Australia is a medical doctor who has recently qualified to practice and is still novice in the clinical situation. Most public hospital departments have resident interns who manage the day to day activities of clinical decision making under the supervision of a more senior doctor who is available for consultation in more complex clinical situations.

This is supported by conversations with one of my supervisors at the very beginning of the study when he said,

Advanced practice nurses especially NPs are rebels because they are the ones who question and challenge the boundaries and look for new ways of doing things. They are often not liked by management and are normally passionate about their work and patient care (Field Note 1).

The difficulties nurses face in being heard in the clinical setting was also reinforced by a nurse who once worked with me, who said,

What I hate about not being in charge since the birth of my kids is that I no longer have a voice. Being ‘just a nurse’ on the floor means that you cannot have your say and often are not informed of changes being made (Field Note 2)

### *Angels of Mercy*

The beginnings of nursing as an occupation can be traced back to the Roman Matrons who cared for the sick (Dolan et al. 1983) however nursing is also a concept that is used in any contact where someone cares for someone else. Examples of this are a mother nursing a child and a daughter nursing her dying father. Whilst neither of these situations requires a specifically trained person called a nurse, the carers in this situation are the nurses and this supports the dictionary meaning which states that “[a] nurse – a person employed to look after sick people, cares for the sick, nurtures” (Allen 1990, p. 339). From the early centuries until reformists such as Nightingale and Fry (Dolan et al. 1983; Gordon & Nelson 2005), nurses arose from the religious orders whose mission was to serve, as a part of the vows they took they were to be self sacrificing, caring for the sick poor above all else (Hart 2004; Nelson & Gordon 2004; Gordon & Nelson 2005).

The image of nursing therefore became coupled with the angels of mercy, peopled by individuals who were altruistic, dedicated and hard working. Nursing has also been, and remains a predominantly female profession (Bloom 2000). Because of this not only are social views created by nurses from dedicated religious orders, they are also of women’s work because it is viewed as ‘natural’ that women care for and nurture others as part of their role in society (Dolan et al. 1983; Keyzer et al. 1995; Nelson 2001; Hart 2004; Gordon & Nelson 2005).

The real beginnings of nursing as we know it today in Western societies began in the mid nineteenth century with the emergence of the industrial reforms in Western Europe. The industrialisation forced women, who had previously remained at home working in family production, to seek work external to the home (Dolan et al. 1983; Nelson 2001; Hart 2004). Because of the social norms of the time, women were not able to nurse because they were not allowed to be in public on their own. Nursing therefore continued to be carried out by women in religious orders and by the emergence of lower class women, typically servants who worked in the poor houses and homes for the insane or displaced (Dolan et al. 1983; Nelson 2001). Whilst the religious order remained respectable in the public view, the nurses working externally to those orders were viewed as women of disrepute, and such images of drunken women working as nurses have been effectively portrayed in the writings of Charles Dickens. It was not until the women such as Nightingale, herself a well educated middle class single woman, played a part in the nursing reforms in the early nineteenth century, that nursing came to be recognised as a more respectable occupation. To do that however, Nightingale had to create a position of respectability similar to that of the religious orders, and nurses continued to be viewed as angels of mercy, dedicated and self sacrificing single women (Dolan et al. 1983; Nelson 2001; Nelson & Gordon 2004; Gordon & Nelson 2005). This view of nursing has been perpetuated throughout the twentieth century, reinforced by the nurses working in the world wars, where discipline, sobriety, dedication and being unmarried were important (Russell 1954; Farmborough 1974; McBryde 1979).

From their very earliest days, nursing leaders have struggled to place authority for nursing activities in the control of nurses. With the doctors in control, nursing reformers downplayed nurses' knowledge and skills and emphasized their virtue and ethics in order to maintain nursing at a middle class and respectable profession (Hart 2004; Gordon 2005). The very success of the nursing leaders of the time to create the first mass profession for women, put nurses in the paradoxical position of playing an important role in health care whilst playing down the work nurses really did (Gordon & Nelson 2005). Women were not allowed to become managers and so nurses could be recruited to supervise patients but were not allowed to have a say in the management of the hospital. The privileged status of the doctors was represented by their exemption from rules of conduct set out for other employees in the hospital system (Rafferty 1996).

The developing division of labour in health care during these early years of formerly recognised nursing and medicine became the norm. The nurses' task was restricted to observations and basic care, now termed activities of daily living, and the acting out of specific doctors orders based on the observations done by nurses and a nursing assessment based on caring activities (Rafferty 1996). This created the subordinate role of the nurse and placed the profession into the technical division of labour surrounding medicine. Nightingale mirrored the gender and class constraints, which characterized contemporary attitudes towards nursing both in society and in health care at that time (Rafferty 1996). Friedson (1971) notes that one of the major variables mediating inter-professional relations is the function of autonomy, that is, the degree to which work can be carried out independently of organisational referral or referral by other occupations including doctors. Doctors, for the last 100 years, have held the privilege of not only exclusively holding this right, but determining how it will function in the business of health care.

Whilst Friedson's work is considered as classical, more recent research indicates that this opinion still exists (Barton et al. 1999; Buresh & Gordon 2000; Borthwick & Galbally 2001; Dingwall & Allen 2001; Angus & Nay 2003; Jones 2003; Allen 2004; Copnell & Bruni 2005). The more autonomous the occupation and the greater the overlap of its work with that of medicine, the greater the potential for conflict, legal or otherwise, and this is true of the new role of NP. These facts have been described in the evaluation of NP roles, to the point where the question has been asked as to what point does "an expanded nurse become a doctor?" (Brook & Crouch, 2004, p. 211). Role boundaries have been especially questioned where NP roles have replaced junior doctors on a rotational roster, such as seen in specialist units like emergency, critical care and neonatal intensive care (Hill et al. 1994; Cooper et al. 2002; Kinnersley et al. 2005; Kirkwood et al. 2005; Ettner et al. 2006; Williams & Jones 2006; Woods 2006). Research indicates that when measured against their medical counterparts, NPs provide equal if not better care. Whilst parameters for comparison centre around budget related activities such as time taken to review patients, number of diagnostics tests used, number of patients seen per day and so on, Woods (2006, p. 43) contends, that in the case of neonatal NPs,

The findings ... in those cases where ANNPs<sup>21</sup> are employed to fill the void left by medical staff that they are capable and effective in taking on an advanced role in the assessment and management of neonates.

This means that the power of doctors as leaders in clinical care is being challenged and possibly even undermined (Barton et al. 1999; Borthwick & Galbally 2001; Kernick & Scott 2002; Cameron & Thompson 2005; Faresjo 2006). The fact that the view of NPs taking on the role of doctors is supported by research, only serves to create discord in professional boundary issues as alternate models of care are created. Although the role of NPs is stated as an extension to nursing by nurses (Australian Nursing and Midwifery Council 2006a), the evidence shows that the NP role is being supported as a medical substitute through the way legislation is framed and operated. It is at this cross roads, that NPs find themselves caught up in a conflict with what is traditionally accepted as a nursing role and what is perceived as challenging the status quo of health care delivery in which the doctor is supreme.

### ***Nurse Practitioners in Australia***

In order to practice as a NP in Australia, nurses have to be registered with the Nursing and Midwifery Regulatory Authority<sup>22</sup> (NMRA) first as a Registered Nurse (RN) and then as a NP. Each state or territory in Australia has its own legislation, and nurses are registered in accordance with the Nurses Act or Health Professions Act of the state in which they work. Under the relevant act, the NMRAs are charged with ensuring the safety of the public by maintaining a register of nurses, and by ensuring practice standards through accreditation of education courses, and the investigation of complaints and incidents relating to the conduct of nurses. Because the title of NP is protected through legislation, the NMRAs must endorse NPs and accredit educational standards which lead to the endorsement of NPs. Some NMRAs in Australia have only recently set up the systems and processes to assess academic programs which lead to the endorsement of NPs, although their actual endorsement processes have been in place for some time.

The legislative requirements for the NP are not clear and with the different nursing or health professions acts, each state has placed different emphasis on aspects of the role. All the state acts have slight variations to the following definition,

---

<sup>21</sup> Advanced Neonatal Nurse Practitioner is equivalent to what is referred to as NP in this study.

<sup>22</sup> State and territory Nursing and Midwifery Regulatory Authorities (NMRA) register and monitor nursing, their work being enacted through legislation promulgated by that state or territory.

**Nurse practitioner** means a person authorised by the Board under this Act to practise as a nurse practitioner. (Nurse Amendment Act 1998 (Nurse Practitioner) NSW)

Variations become more evident after the definition but they still do not provide a clear outline of what the protected title of NP actually means. For instance the Australian Capital Territory (ACT) focuses on the control of the role and its scope of practice, which clearly outlines the chief executive's mandate within an organisation to seek ministerial approval for the type of work the NP will undertake in the health service concerned,

### **Scope of practice for nurse practitioner position**

(1) If the chief executive approves a position as a nurse practitioner position, the chief executive must, in writing, approve a scope of practice for the position.

(2) An approved scope of practice is a notifiable instrument  
(Health Regulations 2006 Australian Capital Territory)

The legislation in ACT further directs the level of education preparation and years of experience for the NP that can be found in another piece of legislation. It still does not identify the role of NP,

A person meets the requirements for registration in the specialist area of nurse practitioner if the person—

(a) is a registered nurse; and

(b) has graduated from a master of nurse practitioner program approved by the board or another nursing and midwifery regulatory authority; and

(c) graduated from the program, or practised nursing in the area of nurse practitioner, within the 5-year period before the day the person applied for registration. (Nurse Practitioners Legislation Amendment Bill 2003, Australian Capital Territory)

In Victoria, the legislation focuses largely on the prescribing component of the role, but does not clarify anything else aside from providing a similar definition to the one already quoted previously,

If the Board is satisfied that a registered nurse referred to in subsection (1) is qualified to obtain and have in his or her possession and to use, sell or supply the Schedule 2, 3, 4 and 8 poisons within the meaning of the **Drugs, Poisons and Controlled Substances Act 1981** that are approved by the Minister under that Act with respect to a category of nurse practitioner, the Board may endorse the registration of the nurse with that category of nurse practitioner and specify in the endorsement the approved Schedule 2, 3, 4 or 8 poisons that the nurse practitioner is qualified to obtain and to have in his or her possession and to use, sell or supply subject to that Act and the regulations under that Act. (Health Professions Act 2005, Victoria)

The only Act that outlines three clinical extensions to the NP practice can be found in Western Australia. After much the same definition they direct that,

A code of practice referred to in subsection (1)(b) is to contain only information recommended by the Commissioner, as defined in the Health Act 1911 section 3(1), with respect to the functions of nurse practitioners, including —

(a) the possession, use, supply or prescription of poisons, as defined in the Poisons Act 1964 section 5(1), by a nurse practitioner;

(b) the requesting, or undertaking, of diagnostic testing or therapies;

(c) the undertaking of treatments by a nurse practitioner; and (d) such other functions as are necessary or convenient with respect to the practice of nursing as a nurse practitioner and the conduct of a nurse practitioner, and anything incidental or conducive to those functions

(Nurses and Midwives Act 2006 Western Australia)

These extensions to nursing practice clearly position the NP within the medical paradigm of care, because until this point, the only professionals who were allowed to prescribe, order diagnostic tests and assess patients, were doctors. Until this legislative mandate, nurses facilitated care, they did not direct it and this point is made clear in the Competency Standards for Registered Nurses (Australian Nursing and Midwifery Council 2006b). It is with this unclear legislative information that NPs in Australia were introduced in 1998. It is not surprising then that a radio interview with a member of parliament for South Australia commenced discussions with,

The South Australian Government today joined New South Wales in allowing nurses to perform minor operations, and to prescribe some drugs (Coleman 1999)

Based on the evidence from these transcripts both the public opinion and the legislation have placed the role of NP as a medical replacement role, rather than a nursing role. The interview in question also discussed the fact that the new role of NP “integrates the role of the nurse with the role of the doctor” thus in the first years of NP development in Australia, the impression that NPs could replace doctors was being accepted through the messages in the legal and media texts. The media upheld this confusion with images of NPs being portrayed as pseudo doctors. This created diverse messages for both public and health professionals with examples such as, “doctoring up the nightingales” (Barrett 2001), “Enter a new breed, neither nurse nor doctor” (Dunn 2004) and “Australia finally has its first authorised 'Super Nurses'” (Moait 2000).

Some five years after the promulgation of the first legislation for NPs (Nurse Amendment Act (Nurse Practitioner) 1998, NSW), the Australian Nursing and Midwifery Council released their Competency Standards for NPs (Australian Nursing and Midwifery Council 2006a)<sup>23</sup>. This document aimed at situating the NP in a nursing paradigm whilst complying with the legislation, thus attempting to provide a framework from which NPs could develop. This document arose out of a nursing funded project between New Zealand and Australia in which the core role, competency standards and educational requirements of the NP were explored with the objective being to develop a set of competency standards for NPs (Gardner et al. 2004). However, given the time frame between the release of the first piece of legislation in 1998 and the introduction of this document in 2006, the media<sup>24</sup> had already created the view that NPs were similar to doctors.

The first page of the Australian Nursing and Midwifery Council (ANMC) Competency Standards for NPs<sup>25</sup> makes the claim to being the leading national policy document to be used for everything to do with NP development, practice, assessment, conduct, education and authorisation. As such the ANMC has set a standard by which anyone wishing to practice as a NP, employs a NP or educate a NP does so using this document and so it has become the accepted standard of practice for NPs.

Whereas state legislation does not provide clear guidance except to address three technical extensions to practice related to the medical terms of reference of prescribing, referring and assessing patients (Nurses and Midwives Act 2006 Western Australia) the ANMC NP Competencies<sup>26</sup> has been created as an exclusively nursing document, making a point of saying that the standards within it are “YOUR standards”, by the emphasis on your in capitals, directly addressing it to

---

<sup>23</sup> The Australian Nursing and Midwifery Council (ANMC) was established in 1992 to facilitate a national approach to nursing and midwifery regulation. It is funded by the state and territory NMRAs and the Federal Government. It undertakes policy work relating to regulatory and practice standards supporting the regulation of nursing in Australia. Governance of the ANMC comprises of representatives from all the state NMRA Boards of Directors.

<sup>24</sup> The role of the media is referred to in a number of chapters in this study with reference to the discourses being discussed.

<sup>25</sup> It should be noted that the ANMC Competency Standards for Nurse Practitioners is the first edition which was released in 2006. They have not yet been validated or revised.

<sup>26</sup> The ANMC Competency Standards for Nurse Practitioners, for the purposes of this study, will be referred to as the ‘ANMC NP Competencies’.



the NP. The document positions the NP within a nursing framework; these standards “include the national competency standards for the registered nurse and build on the core competency standards for registered nurses and midwives”<sup>27</sup> and this immediately puts the Standards at odds with the medically focused legislation. These Competencies are based on the assertion referred to in the NP Standards Project that the “Acts and regulations are set down by parliament and provide the broad legal framework within which the Nurse Practitioner may practice” (Gardner et al. 2004, p. 8), remembering that legislation refers only to medical extensions to what or how this might be defined as “nursing” practice.

The definition on page one of the ANMC NP Competencies<sup>28</sup> positions NPs as leaders working “autonomously”. According to The Concise Oxford Dictionary of Current English, the meaning of autonomous refers to “independent, self-government, self-directed, self sufficient” (Allen 1990, p. 31). However, the ANMC definition of a NP also says that NPs work “collaboratively” which refers to “combined, joined or mutual behaviour” according to the dictionary (Allen 1990, p. 93). According to this definition NPs must work in a self directed manner, but must also jointly work with other health professionals in an “extended and advanced clinical role”, the word ‘extended’ referring to a larger role and ‘advanced’ meaning more complex or difficult situations. It further illuminates the idea of working together, as equal partners in health care delivery. This implies that although a nurse, NPs can lead clinical decision making and not just facilitate it as nurses are purported to do. NPs can provide care with “innovative and flexible care delivery which compliments other health care providers” (Australian Nursing and Midwifery Council 2006a).

The definition outlined here situates NPs as a nurses, who traditionally facilitate care, as equal partners in health care delivery, being able to direct and lead that care, as they are,

“not only the most senior clinical role, but a nurse practitioner also provides health service leadership from the perspective of a senior clinician. Key elements of clinical leadership are the need to guide and influence care delivery systems through engagement in policy development either directly at local organisation and local

---

<sup>27</sup> Appendix 7 ANMC Competency Standards for Registered Nurses

<sup>28</sup> Appendix 6 provides a copy of the full Competency Standards for NPs.

government level or through active engagement in the policy work of their professional organisation (Australian Nursing and Midwifery Council 2006a).

This is a paradox because, according to the ANMC RN Competencies, nurses provide care through “the co-ordination, organisation and provision of nursing care” through “collaboration with the individual/s and the multidisciplinary health care team” (Australian Nursing and Midwifery Council 2006b). Nothing in the ANMC RN Competencies indicates leadership beyond the immediate activities related to the provision of nursing care, yet the ANMC NP Competencies say that NPs can go outside the norm of nursing practice because they lead care, despite the fact that they are “grounded in the nursing profession’s values, knowledge, theories and practise” (Australian Nursing and Midwifery Council 2006a) This premise proposes another type of health care professional because nurses can now lead care, and in terms of the legislation NPs take on extensions to practice that are normally the doctor’s remit. What has been created is a hybrid model incorporating a nurse and doctor. The idea of “complementing health care providers” is also an illogical statement, because all nurses compliment other health care professionals in the work they do. A nurse does not have to be a NP to do that.

The ANMC NP Competencies sets out three separate standards under which performance indicators are discussed, and by which NPs are to practice. They provide the reader with aspects of the role of NP, firstly that NPs practice is an “extended”<sup>29</sup> clinical role, but that that they are “grounded in nursing” and that they are “leaders in health care”. The specific text in the document suggests an alternate model of care to that which is traditionally accepted within the current nurse/doctor division of labour. It condones the accepted nursing behaviour under which NPs take on medical tasks, made acceptable because these medical extensions are seen as advancing nursing. The extended tasks are described in medical language in legislation and in nursing language through the ANMC document. Although they are suggesting a different ‘nursing’ role with a ‘collaborative, innovative, complimentary and flexible’ model of care, the ANMC NP Competencies uphold the medical model of care as the underpinning starting point for NPs. Nurses are being enabled to do more than nursing but are constrained by remaining within a nursing framework,

---

<sup>29</sup> Extensions to practice in nursing are accepted as tasks that are learned and are not normally part of the nurses’ scope of practice. This is different to the notion of ‘expanded’ which means the broadening of the professional element of practice.

based on the accepted doctor/nurse relationship. In order to understand the differences between medical and nursing models of care, I will explore these terms further in this next section.

### *Models of Care*

The notion of being ‘grounded in nursing’ refers to the difference between medical models of care and nursing models of care. A model, according to (Allen 1990, p. 319) is a “representation or a pattern”, therefore NPs follow a pattern set by the accepted social and professional role of a nurse. The medical model is an accepted norm in health care, which seeks to identify the causes of illness, focusing on diagnosis and treatment (Aggleton & Chalmers 1987; Kassirer 1993). The nursing model on the other hand, identifies the health problems and seeks to provide strategies such as education and supportive care to the person, family and/or community affected by the problem (Wimpenny 2002; Eriksen 2001). In this way medicine is referred to as illness focused whilst nursing is wellness focused. Therefore, the activities of ordering diagnostic tests, prescribing medication and referring patients to other specialists, is not part of the work of the nurse, it is a function of the doctor within the medical model of care during the process of identifying the causes of illness, diagnosing the cause of that illness, and prescribing treatment related to their assessment.

This places the NP outside of the nursing framework but it also is outside of the medical framework because, in accordance with the ANMC NP Competencies, NPs do the nursing work as well as ‘extensions’, which are medical tasks. It suggests that NPs adopts both the medical and the nursing models of care. The taking on of extended tasks is sold to the reader through the use of the word ‘leadership’. The leadership role of NPs is described as,

The nurse practitioner is a leader in all dimensions of nursing practice. This is not only the most senior clinical role, but a nurse practitioner also provides health service leadership from the perspective of a senior clinician. Key elements of clinical leadership are the need to guide and influence care delivery systems through engagement in policy development either directly at local organisation and local government level or through active engagement in the policy work of their professional organisation (Australian Nursing and Midwifery Council 2006a, p. 2)<sup>30</sup>

---

<sup>30</sup> Referred to in Standard 3 of the ANMC NP Competencies

If one attempts to keep NPs in the nursing paradigm then ‘leadership’ suggests that NPs “assist others to change and cope with change in an environment” (Porter-O’Grady 1992, p. 15). In this context, the “leaders in health care” referred to in the ANMC NP Competencies definition of a NP may either refer to the nurse patient relationship referred to in the nursing model of care, or it could suggest that NPs take the lead in major health care decisions and organisational planning which has not traditionally been a nursing concept except for those nurses who have moved into such activities as governmental policy. The generic term of ‘senior clinician’ in the ANMC NP Competencies removes the nursing component from the sentence creating confusion in the idea of NPs being nurses. Yet the ANMC NP Competencies remind the reader that the NP is a “leader in all dimensions of nursing practice” (Australian Nursing and Midwifery Council 2006a). Dimensions of nursing practice however, merely allow nurses to be in control of nursing care, and not in any broader health care activities.

The idea of leadership does allow for more understanding from a nursing perspective in the first standard of the ANMC NP Competencies however, by stating the following,

#### STANDARD 1

Dynamic practice that incorporates application of high level knowledge and skills in extended practice across stable, unpredictable and complex situations (Australian Nursing and Midwifery Council 2006a)

The dictionary definition of ‘dynamic’ is that which “is characterised by force or personality, ambition and energy or concerned with energy or forces that produce motion” (Allen 1990, p. 158). In the context of this standard, NPs are described as responding to a variety of conditions and clinical presentations that require a certain knowledge and skill, which will assist in the recognition of changing clinical environments. This is consistent with Porter O’Grady’s reference to leadership because NPs assist others to cope with a changing environment. It is also consistent with the nursing model of care where the role of the nurse is to assist others to deal with changing situations they may face. The notion of a ‘dynamic’ NP in this instance is consistent with leadership in the context of nursing leadership and the nursing model of care. Consistent with the legislation, the use of extended tasks referred to as prescribing assessment and referral, can assist the NP in managing

complex situations and this is especially true for those nurses who work in the rural and remote regions of Australia. It legitimises the role they play in health care provision in the absence of a doctor. Whether or not this is appropriate in the metropolitan situation where there is significantly more medical staff and less need for nurses to have extended medical skills, could be debated. This is particularly so when considering the ANMC's second NP standard.

## STANDARD 2

Professional efficacy whereby practice is structured in a nursing model and enhanced by autonomy and accountability  
(Australian Nursing and Midwifery Council 2006a)

Standard 2 refers to “professional efficacy”, meaning “power or capacity to produce a desired effect” (Merriam-Webster 2008, online), and this is advised within the context of a nursing model. This means that leadership for NPs is consistent with the context of practice and the role of the nurse, because every health care professional, including nurses, have a scope of practice within their job description, which allows them to practice within a range of activities set out by the organisation. This standard also refers to the word ‘autonomous’, which is also used in the definition, autonomous referring to NPs being “self directed” (Allen 1990, p. 31). In this instance, any professional can act in a dynamic and autonomous manner, within the scope of the work that they do, so by saying that NPs must be dynamic and autonomous only suggests that the NPs do the work they are directed to do, and does not relate to any broader leadership role of a ‘senior clinician’ leading change. NPs like any other health professional must be accountable for the work they do within their context and level of practice. Being grounded in a nursing framework but requiring responsibility for the extended medical tasks, could cause confusion in the workplace, especially where the work of junior doctors and NPs overlap.

### ***Grounded in Nursing***

If the standards suggest that NPs work in a nursing model and do the work of a nurse but also the work of a NP by being ‘dynamic’ and ‘autonomous’, then the context of those terms within the role of the nurse should be understood. Registered Nurses<sup>31</sup>

---

<sup>31</sup> Throughout this study ‘nurse’ and ‘registered nurse’ are synonymous and are used interchangeably. Other roles such as enrolled nurses, patient care assistants or nursing assistants are also called nurses. They are of a lesser qualified category of nurse and their roles are not examined in this study. Nurse Practitioners are first Registered Nurses.

(RN) are nurses who have undertaken a university degree or an advanced diploma, depending on the country. In Australia all RNs have to complete an undergraduate degree which leads to the registration of their scope of practice by a NRMA, which is informed by legislation provided by a nurses or health professions act in the states of Australia. Probably the most common definition of nursing is that of Virginia Henderson who suggested that to nurse is to,

...assist the individual, sick or well in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible. The nurse in addition helps the patient to carry out the therapeutic plan as initiated by the physician and the nurse is also a member of the team and helps others to plan and carry out the total program whether it be for the improvement of health or recovery from illness, or support in death (Henderson 1967, p. 15).

This definition outlines the activities of the nurse as being supportive in nature and not able to initiate treatment but merely following orders by “carrying out the therapeutic plan as initiated by the physician” and “helps others to plan and carry out the total program”. It does not support the notion of NPs who, according to ANMC, are authorised to “function autonomously and collaboratively in an advanced and extended clinical role”. Even during the period that Henderson’s definition was being touted as the truth about nursing, USA was already introducing the advanced nursing role of NP, and so the tension between nurses carrying out orders handed down by a doctor, and NPs working in a nursing model but being autonomous in their practice, is evident.

In view of the statement that the ANMC states that NPs build “on the core competencies of the registered nurse” I reviewed the ANMC RN Competency Standards (Australian Nursing and Midwifery Council 2006b). There is no definition provided for the RN in this document, rather it provides a “description of the registered nurse on entry to practice”, meaning their registration under the Nurses Act. They provide “four domains of practice these being professional practice, critical thinking and analysis, provision and co-ordination of care and collaborative and therapeutic practice”. Words used to describe the RN include,

....demonstrates competence in the provision of nursing care as specified by the registering authority’s license to practice, educational preparation, relevant

legislation, standards and codes, and context of care (Australian Nursing and Midwifery Council 2006b).

The description of the RN merely refers to the legislation. When I looked for the definition of a nurse in the legislation, I found that this was vague, for example “nurse means a registered or enrolled nurse” (Nurses Act Queensland 1992) and “nurse means a person who is registered or enrolled under this Act” (Nurses Act South Australia 1999), so really it does not provide any definition of a nurse or what the nurse does. “Context of care” refers to the type of presentations and area that a RN is employed in but does not indicate what these contexts are. Provision of care suggests carrying out orders which is consistent with Henderson’s definition. The ANMC description continues to inform us that a RN,

...practices independently and interdependently assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and health care workers. Delegation takes into consideration the education and training of enrolled nurses and health care workers and the context of care (Australian Nursing and Midwifery Council 2006b).

‘Independent’ functions of a nurse refer to those activities that the RN carries out within the RN scope of practice, this being the “provision of care”, being a compilation of activities that is informed by the ANMC Competency Standards for RNs and the job description set by the organisation employing the RN. ‘Interdependent’ refers to the activities that the RN undertakes within a team of health workers, such as those referred to in the description (Serle 1987), and to which they are accountable within their nursing scope of practice. The explanations in the ANMC document does not provide information that suggests the RN takes a leadership role outside that of the nursing team with the authority to delegate, nor does it provide any notion of health care leadership. The leadership role of a RN is described as,

The registered nurse assesses, plans, implements and evaluates nursing care in collaboration with individual/s and the multidisciplinary health care team so as to achieve goals and health outcomes. (Australian Nursing and Midwifery Council 2006b)

This suggests that the ‘independent’ practice of the nurse relates to the nursing activities and needs of the patient, ‘nursing’ meaning “caring for or nurturing” (Allen 1990, p. 255) and to which the RN has the authority, under license, to initiate and

perform, delegating tasks and activities to those less qualified such as the Enrolled Nurse (EN), who are regulated, and Patient Care Assistant (PCA) who are not regulated. So although we are no more informed as to what the RN does, we do know that nurses are grounded within the nursing model in which the return to wellness through the nursing (caring) interventions of the RN is their leadership activity (Clifford 1995; Benner 2001; Buchan & Calman 2004; Sibbald et al. 2004). The ANMC RN Competencies further refers to the leadership qualities of the RN by stating that,

The registered nurse takes a leadership role in the coordination of nursing and health care within and across different care contexts to facilitate optimal health outcomes. This includes appropriate referral to, and consultation with, other relevant health professionals, service providers, and community and support services. (Australian Nursing and Midwifery Council 2006b)

Therefore RNs do not initiate treatment, rather they co-ordinate nursing care within a group of other health care professionals. This fits with the traditional view in which nurses carry out orders and ensure that the nursing care of a patient is properly assigned, rather than being critical thinkers who make decisions based on the scientific assessment of patients (Nelson 1997; Nelson & Gordon 2004).

If one returns to the NPs, grounded in a nursing framework and building on competencies for RNs, it does not support the notion of leaders in health care, able to influence any major decision making process into the direction of health care, as the ANMC NP Competencies suggest. It contradicts the 3<sup>rd</sup> NP Standard which says that NPs undertake “Clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health service “(Australian Nursing and Midwifery Council 2006a). It creates the tension and the paradox between what is viewed as a nurse and what defines the new role of NP, when traditionally nurses do not influence health care (Becker et al. 1961; Johnston 1972; Gordon 2005). This tension has been identified in other studies as well.

In a study by Huey & Hartley (1988), 3500 nurses were surveyed, in which nurses identified the fact that they were allowed to exercise judgement in a way that they were given delegated authority in clinical decision making, not autonomy. These earlier findings are consistent with later research in which the silence and invisibility of nursing in leadership roles is described (Buresh & Gordon 2000; Allen 2004;



Copnell & Bruni 2005; Perron et al. 2005; Atkins 2006). Despite these tensions of diverging discourses between the nurse and the NP, the role of the NP is still supposed to become an equal partner in the delivery of health care in Australia, as outlined in the ANMC NP Competencies, and also in how Australian State governments advertise the role such as is demonstrated in this Government media release,

The Minister for Health, Craig Knowles, today announced that the NSW Government would be creating specialist nurse practitioner positions in Emergency Departments, Intensive Care Units and Mental Health Service...A Nurse Practitioner offers expert advanced nursing care that may include ordering diagnostic tests, prescription of some medications and referring patients directly to specialists for higher level care. For the first time Nurses in the metropolitan region will be able to provide a higher level of care to patients. Doctors in the Emergency Department at the Hospital have said that the appointment of a Nurse Practitioner will speed up diagnosis and treatment for patients who have less complex conditions but have to wait for extended periods whilst sicker patients are seen first. In light of the increase of attendances at Emergency Departments this year, this will be an important step in providing better patient care (Perry 2002).

This particular expert gives an additional boost to NPs saying that they are 'specialist' NPs, so although the ANMC have already stated that NPs are leaders in health care at all levels; the article raises that to another level. The statement then immediately brings it back to the role of the traditionally known nurse by saying that they will provide "expert advanced nursing care", 'expert' meaning "proficient" (Allen 1990, p. 176) and 'advanced' meaning "complex" within the context of nursing (Allen 1990, p. 7), in other words, the nursing model. The media release then switches from the nursing model to the medical model in which the NP will "speed up diagnosis and treatment for patients by ordering diagnostic tests, prescription of some medications and referring patients directly to specialists". The paradox and confusion that this media statement raises, makes the NP out to be a nurse who is more than a NP, but is still a nurse who can also take on the role of the doctor. This contradicts the ANMC Competencies of both the NP and the RN, and it also challenges the traditionally accepted role of the nurse and the doctor in which the nurse takes orders from the doctor. The ANMC NP Competencies attempt to clarify this with the use of the word 'autonomy'.

## *Autonomy*

I introduce the concept of autonomy here because of the importance that policy appears to have placed on this word when differentiating between what a nurse does and what a NP does. Although it is used in the ANMC NP Competencies to describe the leadership and advanced role of the NP, it is also influenced by social norms. The word ‘autonomy’ comes from the Greek word ‘autos’ which means “self” and ‘nomos’ which means “rule, governance or law” (Gaylin & Jennings 2003, p. 28) in other words, self governance. However, there are many definitions and aspects to autonomy that could be argued and debated around the thought that autonomy relates to a certain freedom of will to do what one wants to do. Kant referred to autonomy as the individual will or intention, which directs judgement and choice (Kant, 1781) however Gaylin and Jennings (2003, p. 29) suggest that,

Autonomy is not a single idea but a cluster of closely related, overlapping ideas...there are various ways of seeing autonomy, various guises in which it can reveal its moral meaning. Conceptual analysis of the kind we are engaged in here is rather like the meeting of the blind man and the elephant. Each man sees (feels) a different aspect of the beast. Only taken together do these partial perspectives tell us what we want to know.

Autonomy is almost an indefinable term in relation to nursing, even though it is frequently used when differentiating what nurses do in advanced practice roles such as the NP. It refers to something that nurses do not normally do, but which the NP is allowed to do in their ‘advanced’ role. This however, is an anomaly when considering a patient’s journey through any health care system. No health worker practices autonomously because everyone relies on someone else to share activities around care delivery. For instance care is provided either directly or indirectly through the services of a pharmacist, a doctor, a nurse, a ward clerk, and so on. All these people rely on each other to do the work they are allocated to do, the sum of which makes up the total care of the patient.

The contextual reference of autonomy when describing NPs has been used internationally as can be seen in the following statement,

The development of autonomy is essential to the successful implementation of the role of nurse practitioner. This shift in behaviour represents a significant divergence

from basic education in nursing and, for most Nurse Practitioner students, creates a frightening role crisis (Hickey et al. 2000, p. 39).

Australia's nursing profession is no exception to the rule when adopting the word 'autonomy' to describe advanced nursing practice, such as that demonstrated by a NP, and it is this use of the word that we now examine. For example the ANMC states that,

[A] nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role (Australian Nursing and Midwifery Council 2006a).

This statement immediately sets apart autonomy as being a specific activity that NPs can do. If this concept of autonomy is used to describe a particular attribute in nursing, then what nurses perceive as autonomous practice may not necessarily be as others view it. Much of the literature in nursing refers to autonomy in the same context as job satisfaction and retention of the nursing workforce, rather than identifying what autonomy actually means in nursing. Some researchers suggest that the facilitating of nurses' autonomy, in relation to workforce retention and job satisfaction, depends on the way in which nurses are allowed the freedom to make decisions and as such is that related to leadership (Mrayyan 2004). This thought is echoed through the ANMC NP Competencies when they describe NPs as leaders of health care. Throughout the document, leadership, collaboration and autonomy are referred to as attributes of NPs. Mrayyan (2004, p. 333) recommends that in order to enhance nurses' autonomy there must be education in such subjects as "communication, leadership, conflict resolution and decision making". As much as autonomy is discussed in nursing, the literature does not actually define autonomy and what it really means to be an autonomous nurse. The view of autonomy suggested by Mrayyan (2004) refers to job satisfaction and when nurses are satisfied, they remain in the profession and that this choice makes such practice autonomous practice. This does seem to be limited to nurses having a choice about their personal professional future. However, another view of autonomy suggests a more controlling perspective or perhaps a pseudo freedom of speech and the exercising of supposed judgement.

Hickey (2000) suggests, autonomy is not 'natural' to the nurse, because of the traditional acceptance that nurses carry out the orders of a doctor, therefore there is

the belief that they do not have to make decisions on matters relating to the care of the patient. However, this concept is argued by others who say that everyone has an element of autonomy because even a nurse, who takes an order, must make decisions on how to carry out that order and is legally bound to ensure public safety rather than merely follow the order. MacDonald (2002, p. 196) captures this thought by saying that "...professional autonomy means allowing professionals to have substantial control over professional practice, including significant room for exercise of their judgement". This could be true, depending on which way one views autonomy. From one point of view, following a doctor's order is never an autonomous act and that even acceptance of that order means that the act is directive and therefore the nurse is never free to make a choice over how to carry out that order. However, Gaylin and Jennings (2003) suggest that one cannot have autonomy or freedom of choice without having a set of rules in society which allow people to make choices in the first place – a more contemporary view on autonomy.

Writers in nursing see autonomy as "self-assertion, critical reflection, liberty, self-rule, dignity, integrity, and self-knowledge" (Dworkin 1988, cited in Caldwell et al. 2003, p. 168) and this includes "freedom from coercion and provision of full access to information about the choices available" (Paulson et al. 2002 cited in Caldwell et al. 2003, p.168). In other words, people are free to make a decision based on choices available to them, and from the freely available information that is provided during this process. 'Free' in this context remains within a social context however and therefore the question needs to be asked as to how free this really is. According to Lentner (2005, p. 746) autonomy is a "social construction" which allows people within a society to question the government and the leadership in ways that actually contribute to the control of the same people, by those in power. This is made possible because the people who question the power have also been moulded by that power, so that they are socialised by those in government and they adopt the ideology or the way of life that is accepted by the society at large, through such government controlled institutions, policies, legislation (Fairclough 2001b). Gaylin and Jennings (2003) support this view when they refer to the fact that society requires rules within which people are free to make choices.

Lentner's (2005) perspective focuses on an analysis of past powerful states dating back to the Greeks where those in power have manipulated this notion of autonomy,

specifically to keep the discourse of that power operative and dynamic. Lentner says that by allowing people to have their say about how their society is governed or managed, within the societal constraints, represents hegemony. Hegemony, Lentner (2005, p. 738) suggests, represents the ability to,

...maintain power and the perpetuation of the dominant ideology through leadership, discussion and bargaining without the use of force or coercion because the people, within the constraints of the existing power will make decisions based on what their knowledge base is, around the rules and constraints imposed upon them.

Through representation and collaboration within a society which is in fact bound by the norms of that same society, the notion of free speech actually maintains the ideology of the governing system without the use of force, whilst allowing people to think they have autonomy and freedom to have their say, and as such, contribute to the management of the system (Lentner 2005). In the case of the NPs, having autonomy in their practice, the boundaries under which they are enabled needs further exploration, which is why this study focuses on autonomy when analysing discourses that are directing change brought about by the introduction of NPs into the health system.

Other social researchers such as Foucault and Fairclough support Lentner's argument by suggesting that what we are exposed to on a daily basis becomes what we adopt unconsciously in our responses to activities around us. Therefore we internalise how we are to speak within dominant discourses (Foucault 1966; Fairclough 2001b). For NPs, their belief system around the notion of autonomy is first set in a traditional foundation in which the nurse carries out the doctors' orders, and does not take on those tasks that are normally accepted as that within the doctors' domain. The ANMC NP Competencies support this too in grounding the NP in a nursing framework. The advent of the NP with its belief of autonomy has social context in what can be argued is still the traditional health care system.

### ***Centre Stage***

The stage is therefore set for confusion and diverging perceptions of what the NP can or cannot do in the social order of health. By the very confusing definition of NPs, it challenges the existing definitions and discourses of nurses and nursing, and it transgresses the professional boundaries of what is accepted as medical domains of

practice and nursing domains of practice. If Fairclough (2001b) says that institutions are social orders which rely on a complex network of interdependent actions and interactions, which form the realities of what people accept and understand within the system, then health care and the perception of NPs is being shaped by those networks which encircle health care services in Australia. This notion is supported by the question I asked of people initially in conversation as to who or what a NP is. Their view is based on what they believe to be the truth about health care, based on the information disseminated through the networks and informants of health care. Because nurses are subservient, the NP must be the same as a doctor, because they can do things that doctors normally do, not nurses.

Chapter 4 begins the analysis of the data from participants' conversations and the technical literature that allows the broader social examination of the networks that surround those NP stories. This chapter focuses on how the NPs view themselves within the context of their work. The discourses that emerge in this chapter relate to how the NPs position themselves within their environment in terms of generic workers and not nurses.

## Chapter 4 – Not a Normal Nurse

It appears, then, that for these first level nurses working in acute hospital environments, the perception of role change was not one of expansion. Rather it was represented by a shift in practice from junior resident house officers to nurses of some technical activities and a corresponding delegation of nursing care activity to care assistants (Jones 2003, p. 12)

This chapter examines how discourses operate to reveal how in becoming an NP, these practitioners avoid positioning themselves as nurses, and in so doing, uncover a misuse of their skills and position as senior nurses in health care organisations. The conversations provide an insight into the diverse perceptions of others to the NP role, and the contradictory experience of NPs unable to meet the expectations described by the ANMC, in what was expected to be an expanded nursing practice role. Much like the evidence described by Jones (2003), the data exposed a shift in role delegation rather than in expanding practice.

In chapter 3, I set the stage for this study, situating the NP from the perspective of the Australian Nursing and Midwifery Competency Standards for NPs (Australian Nursing and Midwifery Council 2006a) and the legislation directing NPs, which is the regulatory framework. The position that ANMC NP Competencies takes is one of exclusivity; exclusive to the practice of NPs embedded in nursing practice, yet the document holds out to be inclusive of national endorsement processes, educational preparation and operational planning and implementation of NPs. Whilst the standards document is descriptive, the legislation is not, and even though it makes provision for the title of NP to be protected, the state acts in which the NP is embedded do not provide a clear description of the scope of practice within a nursing context. Based on this minimalist legislation, the ANMC NP Competencies illustrates the role as an esteemed nursing leader, remaining within a nursing framework. This action, based on the language in the document, positions the NP as a co-ordinator of care within a team managed by others more influential, yet proclaiming the role to be an influential leader of health care delivery. It is this paradox that engages the rest of this study.

Because the ANMC NP Competencies have been created as the accepted benchmark for autonomous and advanced practice for nurses in Australia, by reading this

document it could be assumed that nurses working at the level of NP would be viewed as clinical leaders within their organisation. The holders of that title in that case, would themselves behave in a manner comparable to this standing in society. In the interviews I conducted with NPs, this view was not evident. The word ‘nurse’ appeared to be avoided, and these clinical leaders described themselves in very general terms around clinical or expert care relating to the clinical discipline or the medical model of care within which their practice was positioned.

The participants were initially asked three questions<sup>32</sup>;

1. Were they authorised as a NP?
2. If they were not in a NP position, what position were they employed in now?
3. How did they view their practice?

Whilst all participants referred to patients as central to the work they do, they had a view of themselves that was external to nursing. This view was despite the fact that in all but one of their position titles, the word ‘nurse’ appeared. Out of the eight participants, all were endorsed<sup>33</sup> as NPs but only one was employed as such, the others were in positions such as Clinical Nurse Consultant (CNC), Nurse Unit Manager (NUM) and Clinical Nurse Specialist (CNS). One was called an Information Manager but doing the work of a CNC. All participants had a Master of Nursing qualification and one had a PhD. All the roles referred to are viewed as advanced practice nursing roles, but none have the breadth of practice or the regulation of title, as the NP. Nursing roles and titles present a confusing array of variation which often means similar or same roles. In order to understand the discussions of the participants, the roles and titles commonly used in Australia are examined.

### ***The Complexity of Nursing Titles***

The Registered Nurse hierarchy in Australia is complex, in which roles such as CNC, CNS and NUM all form part of advanced practice nursing but have different functions based on a ratio of clinical, education or management functions. RNs work according to competencies and levels of practice based on experience in nursing. The

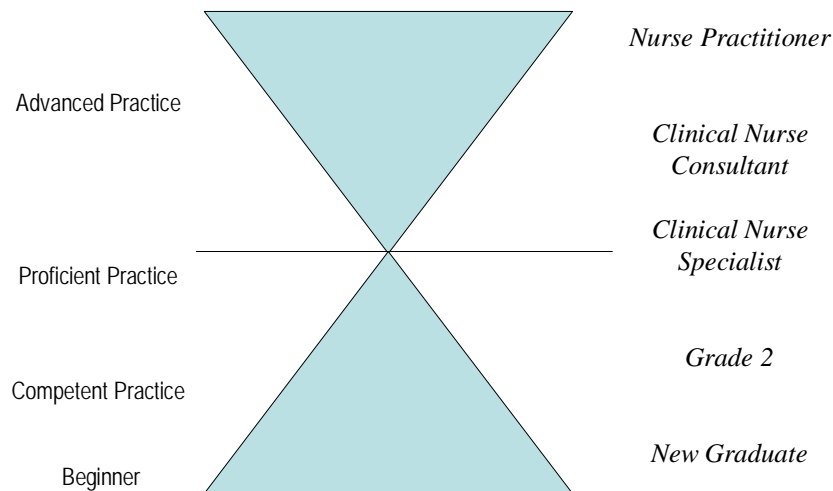
---

<sup>32</sup> Appendix 5

<sup>33</sup> In Australia, NPs are either endorsed or authorised to practice. The terms are interchangeable depending on the state the NP works in. Through endorsement or authorisation, NPs are registered to practice by the NMRA in the state under the Act.



system can best be described using the Benner (2001) ‘Novice to Expert’ structures with graduate RNs being the most junior and NPs having the most senior status in clinical practice.



**Figure 2 Interpretation of the Australian Registered Nurse using the ‘Novice to Expert’ Benner Model (2001)**

It is generally accepted that the CNS practice is highly focussed on a specialty. These nurses frequently take the ward or unit based clinical leadership and support role on a shift by shift basis. New graduates on the other hand have a larger theoretical knowledge of nursing activities as a whole, but have not yet consolidated their learning in the clinical and practical setting. As RNs progress to CNS roles, they are considered to be senior and experienced. In the USA, CNSs form part of the Advanced Practice Nursing roles<sup>34</sup> (APN). In Australia, although CNSs are often the most senior clinical nurses on a ward, they are not formally recognised as APNs. If this role is matched to the Benner model, CNSs consolidate their specialist knowledge as they begin to look outwards to the broader health care environment, and how this affects the clinical environment within which they work, in other words, their nursing practice is expanded to include insights from a much broader view of health care. By the time nurses progress from CNS to CNC, they have begun

<sup>34</sup> Advanced Practice Nurses (APN) is a term widely used internationally to describe registered nurses that are deemed advanced either by role title, experience or education preparation. These roles include CNS, CNC and NP roles. The International Council of Nurses is encouraging this delineation.

to look at the whole patient journey rather than a small episode of care within their own specialty field. An example of this is a cardiac intensive care nurse who will begin to look beyond the intensive care unit and will begin to consider what happened to the patient prior to admission to intensive care, and planning for what happens after intensive care.

Using the Benner model superimposed on the standards that the ANMC NP Competencies provide, the NP therefore has a global view of their practice and is able to draw from this broad and expert knowledge in a way that informs clinical practice. CNCs on the other hand are accepted as APNs because they are often used as an expert clinical resource across a particular clinical discipline, teaching and supporting the less experienced staff, and trouble shooting in difficult clinical situations. Their title is not protected like that of the NPs, which means that organisations can create positions such CNCs to suit their needs. This creates many variations on a theme with CNCs and CNSs based on organisational need. In some Australian states the CNC role is used as the stepping stone to NP practice, but in other states, it is merely a step on the experiential ladder. CNCs can therefore be as experienced as NPs and as senior in the hierarchy, but are used for different aspects of nursing practice.

In Australia positions revolve around the titles, but the variations in job description is enormous both within the Australian states in accordance with individual organisational need, and also nationally. For example, CNCs generally have a large clinical teaching and clinical policy development role in Victoria, whereas in South Australia they have a larger clinical management role. CNSs in Victoria are recognised on a personal achievement level but have little significance in the role they play in clinical leadership whereas in other states, they are positioned as shift team co-ordinators and are delegated responsibilities around unit or ward nursing policy development and the mentoring of junior nursing staff. The easiest way to conceptualise the variations can be demonstrated in a table,

<i>Clinical</i>	<i>Management</i>	<i>Academic</i>
	Director of Nursing Operational Manager	Dean Professor
Nurse Practitioner (NP)	Business Manager	Academic Lecturer
Clinical Nurse Consultant (CNC) (Advanced)	Clinical Manager (NUM) (Advanced)	Clinical Nurse Educator (Advanced)
<i>Clinical</i>		
CNS years 5 onwards (Proficient)		
RN years 2 – 5 (Competent)		
Graduate (Beginner)		

**Figure 3 Conceptual framework of nursing careers in Australia (Researcher’s interpretation)**

Despite broad titles, the roles and functions are dependent on the organisation’s structure and requirements, and within organisations, there are variations in the functions of RNs under the same titles. For instance in one hospital, a CNS can be the co-ordinator of discharge planning from acute to long term care, another can be in an ICU liaison role and yet another can be assessing patients in pre-admission clinics. All have the same title but their actual position descriptions are considerably different. This is supported by the ANMC RN Competencies which state that,

The registered nurse provides care in a range of settings that may include acute, community, residential and extended care settings, homes, educational institutions or other work settings and modifies practice according to the models of care delivery (Australian Nursing and Midwifery Council 2006b).

Whilst experienced nursing positions are considered APNs, none have the authority to be entitled NP because the title and the role is protected by legislation. Paradoxically, where an endorsed NP is employed in a position such as a CNC or CNS, the job description and the absence of CPGs that is required for NP practice does not allow the NP to practice as such, despite the fact that the person is endorsed to practice as a NP by the NMRA. This effectively prevents the NP, employed in another APN position, from being able to use those extensions to practice that NPs have not only been educationally prepared to do, but have also been afforded the

authority to do so through legislation. Health services argue skill mix as the reason for not using the NP skills in these cases. This is because nursing staff daily allocations in health services is minimalist in approach. It uses the lowest level of nurse, with the appropriate clinical skills, to do the job. The approach is financially focused with the objective being to provide best possible care at the lowest cost<sup>35</sup>. In relation to the use of NPs, when they are allocated to a nursing roster, the argument is that a CNS can do the job because they are a cheaper option.

### ***Skill Mix***

In organizations internationally as well as in Australia, the concept of skill mix is used to describe the mixture of the types of roles and positions, according to level of expertise that are required to meet the specific needs of a population group being cared for. This has also been described in the OECD report entitled 'Skill-Mix and Policy Change in the Health Workforce: Nurses in Advanced Roles' (Buchan & Calman 2004). According to this report, the APN is just one of many occupational groups that support health care needs, and positioned within this group are NPs and CNSs (Buchan & Calman 2004). The International Council of Nurses (ICN) supports this view by encouraging nurses to embrace the concept of all these roles and titles being inclusive of the APN group (International Council of Nurses 2001). In Australia, although recognised as experienced nurses the APN concept has not been adopted with any uniformity. In other reports, it has been demonstrated that market driven health care services has lead to a plethora of different nursing roles, focusing on task requirements of the job rather than actual clinical or professional skills (Keyzer 1997; Kernick & Scott 2002). Researchers have shown that nurses are frequently used in bridging health care delivery gaps and filling medical roles that are vacant (Keyzer 1997; Sibbald et al. 2004; Rashotte 2005; Woods 2006) and this is particularly evident in the rural and remote context of Australia where nurses have for years been the backbone of the health care service in these communities (Keyzer et al. 1995; Hegney et al. 1997; Mahnken et al. 1997).

More recently, the emergence of neonatal NPs and NPs working in the Emergency Department (ED), has created a situation whereby NPs have filled gaps on the junior medical staff rosters, and this is being evidenced across Australia. Whilst it is known that this is occurring, there is little research on the outcomes of these roles in

---

<sup>35</sup> This is discussed in Chapter 7

Australia, however randomised control trials in United Kingdom (UK) and USA have shown that NPs provide good outcomes, the assessment of which have been measured against a medical model of care (Hill et al. 1994; Dahle et al. 1998; Reveley 1998; Sakr et al. 1999; Mundiger et al. 2000; Cooper et al. 2002; Woods 2006)<sup>36</sup>. There are indications now emerging in Australia to suggest that NPs in this country are also being measured against budgetary and medical models of care. This fact was demonstrated by Joe, the only participant to be employed as a NP,

*My seen by times, you know from...you know... whether my patients are seen within the ACHS indicators, length of stay in the department, do I get my patients out faster than the residents, then we have risk management ones what we call the call backs...fractures on x-rays that sort of thing (Joe, Interview 3, p. 6).*

The outcomes for Joe's role were measured on how well he did with budgetary indicators, benchmarked against the doctor in the department doing the same work, and based on length of stay of the patients, which is budget driven. It is within this environment that participants described their role in general terms and not in nursing terms, and in doing so, identified the reticence of organisations to implement the NP role.

### ***Neither Nurse nor Doctor***

Throughout the conversations that I shared with participants in their interviews, I had a sense that the participants were not claiming to be a nurse, but nor were they doing this in a conscious way. Jane, authorised as a NP but working in a CNC role, responded to my questions in this way,

*Well I'm currently a clinical expert in managing the care of patients both before and after [procedure], and that can include requiring [task related activity to specific clinical procedure].... My role is to oversee their care whilst they are in hospital. I also have a role as administrator, a researcher and educator so it's my job to educate both staff and patients on all aspects of care involving [activities of the service]. But I'm also here in terms of research maintaining databases, and benchmarking other units and looking at clinical outcomes and such like, so it is huge, it's quite diverse day to day in terms of what we are doing and how we manage it (Jane, Interview 2, p. 2).*

Jane did not refer to herself as a nurse, rather she described herself as a *clinical expert*, and then described additional tasks that related to administrative functions

---

<sup>36</sup> This is elaborated in later chapters

rather than clinical ones. However, based on the ANMC RN Competencies Jane was fulfilling the requirements of a nurse because she was co-ordinating care. As an endorsed NP, nowhere in her description did she refer to her role as a clinical leader or a person who operated in an advanced or extended role as described by the ANMC NP Competencies. She referred to herself as a clinical expert but in the way she described it, she could have been talking about any health professional such as a physiotherapist or an occupational therapist, all are clinical experts who can manage research, oversee care and educate. Jane also made mention of the administrative tasks such as maintaining databases which really could be performed by an administrative assistant. In her capacity as a CNC, she was fulfilling the educational function, which many of these positions demand.

Jane's responses not only highlighted her avoidance of the nursing role, but it also highlighted the diversity of organisational expectations in relation to workloads these positions have. She was in charge of caring for patients, she also educated, co-ordinated, and managed what appeared to be extensive administrative activities. She confirmed this throughout her interview in various ways. The way in which Jane described it also indicated a tacit acceptance of the workload and her lesser nursing position to that of a NP. When asked to expand on this aspect Jane said,

*I've worked in my area for ten years, as a clinical nurse consultant... I think that the role is very diverse here, the responsibilities are huge, we run a 24 hour emergency nursing service, and we're the front line for all of the patients. We have an extended role that was unrecognised and a lot of what Nurse Practitioners and their role you know kind of encompasses is part of what we've done but never been recognised for (Jane, Interview 2, p. 3).*

Jane, a NP and therefore a leader, who has the authority according to the ANMC NP Competencies, to influence health direction, was not employed as one, yet she identified her work as comparable to that of a NP. The leadership component of the NP role was therefore not demonstrated by Jane, nor was any acceptance of the NP role evident in the organisation, because they were using Jane as a CNC despite her legal standing as a NP. Although she referred to the nursing service they ran, Jane still did not explain what the role of the NP or the CNC really meant in the context of the clinical work she did in reference to a nursing paradigm. She talked around the role in terms of what the NP *kind of encompasses*. When asked to give an example of her work she described it in this way,

*Well if a patient is unwell, they can present at any stage, Monday to Friday, just turn up as an ad hoc/clinical review. There are medical staff here, that can be called, but they're not immediately there, it's been our role to assess them, and start initiating facts with medical back up, but often we have been left here by ourselves and we have to make decisions as to whether we call people in to come and see them and what kind of blood tests and chest x rays they need. You are working at times with very junior residents<sup>37</sup> on the ward who have not met these kind of patients before and aren't really competent to make definitive clinical decisions. So you have to foresee that, but we don't have any authority to do that, so it always has to be medically supported, but we are often finding ourselves in a situation having more lot more knowledge than some of the medical staff themselves (Jane Interview 2, p 2, 3).*

Jane described her work in the context of a general health role in a way that still did not make reference to being a nurse; rather she discussed doing the work in relation to doctors. She talked about *initiating facts with medical back up*. Whilst the definitions of NPs encompass all that Jane referred to, she did not identify herself in terms of a nurse; her approach was medically focused and not grounded in nursing as the ANMC NP Competencies describes for NP roles. Jane made mention of the fact that although she was *initiating diagnostic tests* and assessing patients in the absence of a doctor, she did not have the authority to do so, yet as a NP these tasks have been legitimised and she could have done them in her independent function as a NP. Because of organisational constraints, Jane was not allowed to do this and was forced to rely on doctors less experienced than her to plan and manage care, despite her rightful ability to manage the patients as a NP if she had been employed as one.

Not only was Jane demonstrating that she did not view herself as a nurse, but she was also highlighting a set of constraining practices bound by a particular discourse that prevents NPs from being employed into NP positions. By employing NPs in different roles, they do not have the authority to act as a leader in health, despite their legitimised expertise. The professional standing of NPs is therefore undermined, and it can be argued that they are also being exploited, in that they are paid and employed into less significant roles. By constraining the NPs through a different scope of practice and job description, NPs are forced to conform to the traditionally accepted doctor/nurse relationship where the authority and direction of doctors, even when most of the work is being done by the nurse, who could be, if allowed to do so, manage the clinical activity in their legally authorised capacity as NP. The

---

<sup>37</sup> Junior medical doctor

organisation, in the case of Jane's conversation, had chosen to duplicate services by keeping doctors, as junior as they were, central to patient care instead of using the skills of a NP.

Fairclough (2001b) suggests that these tensions provide us with evidence of changing power relationships in which a new order, such as the NP, continues to be controlled by those who still hold the power within the system. Despite the fact that authority has been given to the NP, in Jane's case, she was unable to use it, constrained by processes that drive the organisation. In the case of health care, doctors have traditionally been the power brokers (Friedson 1971; Johnston 1972; Hofoss 1986; Kassirer 1993; Leonard 2003). Avoidance of the use of NP skills maintains the balance of power and the status quo through the enduring traditional practices (Fairclough 2001b).

The experiences related by Jane were not isolated. All the participants related similar views and Joe, who was the only participant to be employed as a NP, had clearly adopted the traditional medical model and operated under, and used this discourse,

*I think people think that senior [department] nurses automatically become nurse practitioners don't understand the transitional process ...you know where you are going from all your nursing skills into medical skills....medical knowledge and the application of that (Joe, Interview 3, p. 8).*

Joe had a view that NPs transform into something from the nursing to medicine through a *transitional process*. Joe's view indicates a total adjustment to a medical model of thinking and practising. The point to be made here is not so much that Joe has made a shift to a more medical way of thinking, but that he has not identified himself in a form of statement that would be described and positioned by the ANMC NP Competency standards. This is in spite of Joe's educational preparation that is based on the ANMC NP Competencies, and that he had undergone a rigorous assessment for authorisation, based on the same competency standards, remembering that the ANMC NP Competencies state that,

These competency standards provide you with the framework for assessing your competence, and are used by your state/territory NMRA<sup>38</sup> to assess competence as part of the annual renewal of licence process...Universities also use the standards

---

<sup>38</sup> State and Territory Nursing and Midwifery Regulatory Authorities who register and monitor nursing, their work being enacted through legislation



when developing nursing curricula, and to assess student performance (Australian Nursing and Midwifery Council 2006a).

Joe did not use these statements or similar ones like it to make his known his position or positioning by regulatory discourses rather he strongly related his transition to NP practice as movement, but a movement to medicine away from nursing. Sally (Interview 5, p. 13) in her interview supported this 'not a nurse' outlook when she said, *Yeah, yeah, I sort of, I'm jumping into things, yeah, like jumping in, trying to think how it would be different to like be a normal nurse on the ward.* Sally demonstrated a view that she was not a *normal nurse* and that the work she did was different. Yet, she too had been prepared for her role as a NP based on the ANMC NP Competencies, which state that NPs are "grounded in nursing". When Joe was asked to give an example of what he did in relation to that of a medical officer. In his response he described the intermingling of medical and nursing models of care,

*...if you get two patients both roll their ankles on the dance floor, one comes in and sees the registrar and one sees me...I do the nursing and medical assessment and treatment of the patient, put the back slab on, teach him to use the crutches look at the discharge plan...where as the resident will read the nurses' assessment, assess the patient send them off... ah yeah, have a fracture whatever, get the nurse to put the plaster on, get the nurse to teach him how to use the crutches, get the nurse to do the discharge process so the doctors are only seeing them for one third of their total Journey... (Joe, Interview 3, p. 8, 9)*

Joe described himself as doing *nursing and medical assessment and treatment* so positioning himself as something other than a nurse or a doctor. Joe did not use the point identified by the ANMC NP Competencies which says that "key elements of dynamic practice are comprehensive assessment ability including advanced physical assessment and an analysis of the person context", and in this way he did not identify himself as a NP as described in the ANMC NP Competencies, rather he was doing the work of both professions but, and this is the important point here, being compared only to the medical work in his role. The fact that he did both was not part of the calculation when time taken was the only measure of his effectiveness. He was saying that if the registrar's costs were added to by the nurse needed to complete the task, then the cost outcomes of this assessment and the case would be different. I will return to the economics of this case later in the thesis. Consistent with the legislation and the public view of NPs discussed in chapter 3, Joe's responses indicate an adoption of the common view of NPs. They are replacing the work of doctors as

NPs, and they are not ONLY nurses. This is a trend emerging across Australia, particularly in EDs and Neonatal Intensive Care, where NPs are replacing registrars but are still employed as NPs. This is discussed more fully in subsequent chapters. The paradox of the ANMC NP Competencies has meant that Joe positioned himself into the socially accepted view of NPs, and not the nursing statements that have been outlined in the ANMC NP Competencies.

What is also of concern was Joe's workload in the organisation that employed him. The organisation allowed Joe to operate in multiple capacities: in the capacity of a NP, in the capacity of a doctor and in the capacity of a RN. What was not evident was the underlying reason for this in Joe's discussions. It seemed as if Joe was implicitly agreeing with the enormous workload across what can be argued as three different clinical roles<sup>39</sup>. It also provides an insight into the segmented care practices where role delineation prevents health care workers from working together with the patient as central to that care. Joe's experiences were consistent with Jane's where she too had multiple facets to her work, even although she was not employed as a NP. Joe, in a similar manner to Jane, described his role as transgressing both medical and nursing work. The way Joe explained his work indicated a complete and unconscious acceptance of both the exploitation of his willingness to work in this way by his employers, and with transference of practices from nursing to medical care he was working in, based on the ANMC NP Competencies.

The notion of not being a nurse, was not only viewed and articulated by the nurses, it was also reinforced by employers such as the case with Cindy,

*...we were employed as medical officers, but not as doctors, we're called medical officers as opposed to [occupation] officers, we were given certain rights to prescribe certain medications, we have a standing order that we can give people antibiotics and so on. And yeah, that right was taken away because of structural changes, management changes, so they decided that we're not, no longer medical officers, we are nurses ...and we are not covered by those standing orders (Cindy, Interview 6, p. 4).*

Cindy was an authorised NP, who, under legislation may prescribe, yet she was not allowed to do so, because she was a nurse as viewed in the traditional sense, and in accordance with the ANMC RN Competencies. The organisation used its own

---

<sup>39</sup> This is expanded on in Chapter 7

agenda to dictate what a NP or nurse could or could not do. When employed as a medical officer, that is, in a medical model, Cindy could prescribe, yet because she was now working as a nurse, despite the fact that she was a NP, she could not do so, because the statements above, position her within the tradition of the organisation of labour in health, where nurses cannot prescribe, they can only carry out orders. Yet, if the organisation had wanted to, they could have followed the ANMC NP Competencies in conjunction with the state legislation in order to develop the role from medical officer to NP, with what seems like little change or impact to the organisation. Given that Danaher et al (2000, p. 36) defines institutions as “a relatively enduring and stable set of relationships between different people and between people and objects”, the fact that this organisation did not allow Cindy to prescribe as a nurse, but could do so as a medical officer, supports the notion that the organisation is maintaining an accepted set of practices that are kept in place through discourses embedded in a medical model instead of making a simple change to an existing position. It supports Fairclough’s (2001b) argument that the maintenance of traditions remain as evidence of power made opaque by the operations of discourses within that continue to control the people who are employed, despite evidence to suggest that activities could be managed differently.

Bill related similar experiences regarding the employer’s active avoidance of a nursing role despite the fact that the role required a post graduate nursing qualification,

*This current job was actually advertised as a public health manager and then when we got the position they'd changed the title to information manager, and it was a brand new job, and, out of the job, the qualifications, you required a clinical nursing qualification preferably post graduate and in doing so, we, all of us, all the, were there as an information manager in every state, we'd all presumed that this was a nursing position, similar to a clinical research, clinical data nurse position, so when I started, I asked the question, 'Are there any nurses employed in [service] and where are they?' ...and the immediate answer was 'No, there's no nurses employed in the [service]'* (Bill, Interview 8, p. 1).

Not only was this organisation falsely advertising and employing people into positions that were not what was applied for, but they were exploiting the expertise of the nurse by utilising their knowledge and skill, but not acknowledging that they were an APN, and this was reinforced when Bill was asked to describe his role,

*I'm currently the information manager for the [service] screening programme, it's a project with the department of ... [service]... part of my job at the moment is to contact providers when they deliver a service, for somebody with [clinical presentation] (Bill, Interview 8, p. 1)*

Bill described his role as supportive with some need of advanced clinical assessment skills and also listening and counselling skills when talking to the clients. Despite this, when asked why he had been employed as a nurse, requiring proof of registration, yet he was not in a nursing role, Bill (p. 3) said *one of the supervisors turned to me and said 'But you can't practice as a nurse in this role, because you're not allowed to diagnose'* suggesting that if Bill had not been a nurse, it would have been acceptable for him to diagnose. The perception therefore, was that any APN role was categorised in terms of the medically focused diagnostic model and other aspects of the role were not considered, so the use of advanced nursing skills, despite legislation to support them, was not the preferred choice.

The responses by participants suggest conformity to the rules and procedures within the institution of health care and this Foucault suggests, maintains the hierarchy within it (Foucault 1972). The tradition of nursing, interconnected with legislation focussing on the medical extensions to practice, together with the nurses' own acceptance of the situation supports Fairclough's (2001b) position that people conform to positions made available to them by dominant discourses. Also, this positioning contributes to the continuation of the power relations embedded in the status quo. With reference to autonomy, NPs may be challenging the traditional boundary in their role development, but they do so within the limits of social acceptance set by tradition. This supports Letner's comments about autonomy as being a representation and collaboration within a society which is bound by the norms of that same society (Lentner 2005).

### ***Abandoning Nursing***

These examples provide evidence of positions where NPs are adopting the 'not a normal nurse' approach in order to locate themselves in organisations that have not embraced the role of NP. In order to maintain their professional space within the health care team, they have used general speech and action which was perceived as acceptable to the team within which they work. The notion of NPs abandoning their nursing identity to become part of the team has been demonstrated in another

Australian advanced practice nursing study as well. In a study undertaken by Gardner et al. (2006) the views of nine advanced practice nurses (not NPs) in acute hospital settings was examined. Although this study did not examine the discourses in practice, it revealed that nurses described their work as ‘managing’ patients in a way that related to the service or clinical discipline and not specifically nursing. Although one could argue that this is precisely what the multidisciplinary care of patients is all about, it needs to be remembered that the principal document guiding NP practice in Australia states that,

The nurse practitioner standards are core standards that are common to all models of nurse practitioner practice. They can accommodate specialty competencies that are designed to meet the unique health care needs of specific client/patient populations (Australian Nursing and Midwifery Council 2006a)

Despite the ‘core standards’ of NP practice and RN practice that the ANMC provides for nurses and their employers, organisations implement roles that do not comply with these standards, suggesting that the ANMC standards do not hold any influence on the directions of health care workforce planning external to the nursing profession. The dilemma therefore, for any nurse wanting to take on a new role such as the NP that challenge the accepted boundaries and discourses of organisations is significant and isolating. This is in spite of the rhetorical support provided by state legislation and national professional standards. Whilst some participants have attempted to clarify their roles using the adopted language of their organisation or team, others have compartmentalised their role,

*As it is now I manage the unit, and I'm one of those very hands on clinical type managers, I spend a lot of time clinically and then do my work afterwards. For the NP bit, it'll be, with my advanced assessment skills, so it's picking up things and ... you know, for a routine [procedure], picking up on other things that may change the procedure that they're going to have and also highlight other health concerns that the GP or the specialist hadn't, the person hadn't actually told them, or they hadn't had, you know, in their five minute consultant the chance to pick up. And also educating and advising the community on the importance of screening for [clinical presentation] and all that sort of [presentation] related health (Sally, Interview 5, p. 2)*

Sally was authorised to practice as a NP but was in the position of a Nurse Unit Manager<sup>40</sup> (NUM). She was also preparing a business case for the NP role at the time of the interview. She talked about her nursing role as the *hands on clinical type* and then suggested she did *her other work afterwards*, assuming that this means the managerial aspect of her work. Her *NP bit* involved *picking up things* that may alter the course of a surgical procedure, relating this aspect of her role to something other than clinical nursing, which she did as *hands on clinical* during the normal daily routine.

Sally's responses reinforce the notion that NPs are measuring themselves against the medical model, and not the nursing focused ANMC NP Competencies, and again, the organisation has been shown not to have embraced the authorised NP they have, rather employing her into a different APN role of NUM. Traditionally the role of the NUM and NP are both nursing roles and are regarded as operational, one clinical the other clinical management, but Sally's comments outlined a view that managers and NPs were different in some way to a clinical nurse. It can be argued that the confusion of what a NP really is and why the participants are struggling to define themselves in the nursing paradigm goes back to the lack of clear definition. The nurse is described in ANMC RN Competencies as,

The registered nurse provides evidence-based nursing care to people of all ages and cultural groups, including individuals, families and communities. The role of the registered nurse includes promotion and maintenance of health and prevention of illness for individual/s with physical or mental illness, disabilities and/or rehabilitation needs, as well as alleviation of pain and suffering at the end stage of life (Australian Nursing and Midwifery Council 2006b).

And in the ANMC NP Competencies as,

A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role (Australian Nursing and Midwifery Council 2006a)

The confusion lies with the fact that there is a tension between the nursing role of caring for people based on health promotion and health maintenance, and the legislative mandate of NPs, which describe only the medical extensions that were

---

<sup>40</sup> Nurse Unit Managers are unit based managers whose role it is to manage the operational activities of that unit. It includes all aspects of clinical, professional and organisational and human resource activities.

discussed in Chapter 3, and which situate the NP into the medical model because they can prescribe and order diagnostic tests. Constantly throughout the interviews, participants perpetuated this position and view of themselves, building on the picture that NPs are not what could be termed 'normal nurses'.

Andy, who was an authorised NP but working in a community nursing role described his previous role in this way,

*I wasn't the nurse in charge as much as I did it, but I was consistently doing most of the advanced therapy, like diabetes management and education, and a lot of that involved initiation of general care originally (Andy, Interview 7, p. 3).*

Andy described the work he did in terms of *general care* and *advanced therapy*. In nursing terms, general care can be provided by anyone who is deemed a carer, and it is also used in nursing to describe the basic care that a person requires such as washing, feeding, and toileting etc, commonly referred to as activities of daily living. Advanced therapy in this sentence could be referring to the activity of any health professional much like that description provided by Jane. Therefore, Andy described his NP role in general terms, not really providing any detail of advanced or even extended nursing activities as defined by the ANMC NP Competencies. He too, was employed in a CNC role, not a NP one, despite being authorised to practice as a NP.

The participants' response to their situation is not confined to this study. Not only are nurses a product of tradition, but contemporary health care is pushing for the generic approach where care revolves around the patient need and not the professional boundary (Cameron & Thompson 2005; Faresjo 2006; Craig & Smyth 2007). This approach to health care delivery suggests that the best person for the job is allocated by competency and not by profession (Dowling et al. 1995; Bloom 2000; Bushy 2000; Borthwick & Galbally 2001; Cameron & Thompson 2005; Faresjo 2006). In a special commission inquiry in one state in Australia recently, generic roles were confirmed as the model of choice in relation to health care cost, quality of delivery and safety of patients. The findings advised that,

- (a) that clinical education and training should be undertaken in a multi-disciplinary environment which emphasizes inter disciplinary team based patient centred care;
- (b) that the education and training be delivered by the most appropriate and suitable person regardless of the profession or specialty of the individual, and including, where appropriate, non-clinically trained personnel (Garling 2008, p. 11).

Although this model of care has been fostered for cost containment reasons, the system contradicts itself in that if the system were to have generic workers, then the NP as part of that system, could still address service delivery gaps with nurse led clinics, review and follow up, triage 3, 4 and 5<sup>41</sup>, and so on, yet the NPs, whilst legislated to diagnose, order pathology tests and prescribe, cannot yet do so. Although Faresjo (2006) contends that co-ordinated teams and inter-professional competence is the way of the future, with health professionals being educated in a multidisciplinary unit, he notes that Australia is a long way from that because of the obstacles created by current inter-professional beliefs and attitudes. This notion is supported by the special commission as well,

Similarly, many experienced doctors and nurses, in the latter years of practice, would welcome a career as clinical leaders and health system leaders. They are a resource of rich experience. But they would need to be trained to make the transition (Garling 2008, p. 10).

The NPs in this study unconsciously support the concept of the generic worker in their conversations because they do not comply with the 'nurse' paradigm that the ANMC NP Competencies prescribe. Given the current environment of generic worker, then the position held by the ANMC NP Competencies as the core standard by which everyone should be developing the NP role, highlights the lesser value of nursing in health care, because the organisations employing the NPs are clearly not following those standards. It also indicates a lack of insight by the ANMC into the future directions of the workforce in health care today. As an unevaluated and recently published document, it captures no explanation of this trend in generic health worker. The tension created for NPs therefore, is between the nursing rhetoric positioning NPs as exclusive to nursing, and the truth of NPs having to position themselves in health system that is directing care with a generically trained and employed workforce. NPs are caught up in a systemic change happening to them and not by them, or inclusive of them. The role conflict that emerges opens nurses to exploitation in the work they do, so that this continues the tendency to use nurses as gap fillers created by other health worker shortages<sup>42</sup>.

---

<sup>41</sup> The triage system is a category system to assess the severity of the clinical presentation used in emergency departments to streamline the care of patients without compromising those who urgently require care. This is referred to again in Chapter 7.

<sup>42</sup> This is explored further in Chapter 7.



This notion is supported by Perron et al. (2005) who assert that nursing is a product of bio-politics where nurses become the vehicle through which the dominant health care views are enacted. It supports the idea of the subservient nurse who should be seen and not heard unless spoken to by the doctor (Etzioni 1969; Dolan et al. 1983; Buresh & Gordon 2000; Hart 2004). Fairclough (2001b) says that often a person or group of people will describe themselves in a way that others, working in the same system or related systems, will want to hear. He contends that discourse and practice are constrained by interdependent networks which he calls 'orders' (Fairclough 2001b, p. 24), and these orders are structurally maintained by whoever makes up the dominant group, and are unconsciously endorsed through practice and action, by the subordinate groups (Fairclough 2001b).

The participants in the study who describe themselves in terms that would be used by a generic health worker, are implicated in their own containment. Their struggle with who they are professionally in accordance with ANMC, in an environment where differing clinical expectations abound, thus becomes an internal battle and not an external one. Their discourses allow them to position themselves within the traditional model of health that accepts that the dominant person is the doctor with nurses and allied health workers carrying out the work ordered by the doctor. Dingwall and Allen (2001) suggest that health professions tend to look back on historical and traditional practices as a way of legitimising current changes. In this setting the nurse is traditionally the subservient workforce, used to taking orders from the doctor, and filling gaps in clinical care delivery (Herdman 1994; Buresh & Gordon 2000; Mahnken 2001; Mannion et al. 2005). Fairclough, and Dingwall and Allen's belief of adopting the dominant discourse to position them within the health system, is therefore appropriate in the case of NPs. Other studies have shown this to be an identified nursing approach.

In a study undertaken by Copnell and Bruni (2005), it was identified that nurses experienced difficulty in managing change to clinical practice, and the interplay between several dichotomies of abstract and concrete, self and other shaped their responses. This approach was adopted so that any conflict that emerged as a result of the divergence from the dominant views could be ameliorated. In this way nurses reaffirmed the dominant ways of the unit, in which the study was placed. NPs are

shown to be unintentionally doing a similar thing, where, in order to be accepted, they lose their nursing identity to become just one of the health care team, despite having the education and endorsement to practice nursing differently.

### ***Searching for Autonomy***

This chapter has explored participant conversations around their personal experiences of becoming a NP in their health services. It has also drawn on research where reference to the powerlessness of nurses to develop a leadership role in clinical practice has been demonstrated. Consistently, participants have demonstrated that they are not being used effectively, and their expertise is being exploited by the organisation employing them in alternate roles to NP. In this environment NPs are powerless to achieve their endorsed status and practice. The language used by participants provides an insight into both their inability to influence change in their workplace but also the adoption of accepted discourses of their organisation. They not only relate their powerlessness to progress the role of NP, but they also use language that suggests an unconscious or conscious decision to distance themselves from the role of a nurse. This, Fairclough (2001b, p.29) suggests is because “language is both a site of and a stake in class struggle and those who exercise power through language must constantly be involved in struggle with others to defend (or lose) their position”. Participant conversations in this study suggest that health services, through the maintenance of existing divisions of labour, appear to be perpetuating the dominant discourses. Simultaneously NPs give the impression of acquiescing to this hierarchy by accepting employment into alternate positions to NP and by removing themselves from the nursing discourses. Conversations outline a duplication of service where NPs and their demonstrated expert knowledge could provide a cost effective and efficient solution to service delivery. This is ignored, instead accepting the reliance of less knowledgeable junior doctors provides an example of this.

The conversations that the NPs have shared in this chapter provide an insight into a health care environment has not yet allowed the NP into the inner leadership circle. It suggests that legislation and professional standards do not hold weight against the dominance of what is currently the operational engine of health services. Fairclough (2001b, p.30) states that in contemporary society there are many ways in which a dominant discourse is perpetuated. It is often not through coercion but through

consent that this occurs because the ideology which supports it is embedded in everything people do through institutional activities. This in turn colonises players' thinking and actions "through integrating people into apparatuses of control which they come to feel themselves to be a part of". NPs, by avoiding their nursing foundations, are perpetuating the ideology of health care in saying that, although they are able to take on some of the work that junior doctors do, they can only do that if they do not refer to themselves as a nurse. Likewise, the organisational approach maintains this discourse because NPs are tacitly vetoed through employment into alternate senior nursing roles. This prevents NPs from adopting a leadership role, thus the traditional line of the subservient nurse is maintained. This supports findings from other research relating to the subservient position of nursing (Buresh & Gordon 2000; Nelson & Gordon 2004). The direction that nursing is taking in effect, fails to develop an autonomous clinical practitioner.

Although it is considered an essential element of a profession (Cullen 2000) the notion of allowing autonomy has not been recognised by organisations that employ these NPs nor have NPs been enabled to practice in ways that would demonstrate autonomy. NPs seem unable to fulfil the leadership and decision making feature of autonomous practice through the maintenance of the organisational constraints on nursing practice. These constraints are manifested in organisations' unwillingness to employ participants as NPs, and in their medically focused benchmarks of NP evaluation, disregarding the nursing context of practice.

Likewise, participants themselves appear unable to influence and therefore lead change in clinical models of care that reflect the autonomous practice of NPs. Instead they have departed from the accepted nursing paradigm in their attempts to be accepted. Not only is the status quo of health care maintained, but NPs have been effectively neutralised in their ability to lead and manage care. There has been no recognition of their endorsement or use of their expertise in a manner described by both NP legislation and the ANMC.

In Chapter 5 the conversations from participants are further explored, together with technical literature, to examine discourses operating to preserve the invisibility of nursing in health care services. Texts examined further reinforce the subservient and traditional role of nurses. Analysis of such texts explains why, in this first

examination of the language that participants use to describe themselves, a view that they constitute a variation of nursing identity.

## Chapter 5 - The Invisible Nurse

Discourse and practice are constrained not by various independent types of discourse and practice, but by interdependent networks which we can call ‘orders’ – orders of discourse and social orders...Power at these levels includes the capacity to control the orders of discourse... (Fairclough 2001b, pp. 24, 25)

In chapter 4 insights into how the participants were viewing themselves in their role as NP were examined. NPs described themselves in language relating to generic health workers rather than situating them in the nursing paradigm. They adopted words that reinforced medical or clinical identities, not a nursing one. Based on the three levels of social order referred to by Fairclough, the chapter examined the position of NPs as the first level of order, and how they interacted with the “interdependent networks” around them.

What began to emerge in these conversations with NPs was the misuse of their nursing skills in the workplace. They also gave the impression of their tacit approval of this exploitation. The role of NP as leader, influential in changing health care practice was not evident and in contrast their conversations were shaped by a discourse which suggested an invisibility of what is traditionally identified as a nurse. In the last decade, this invisibility has been identified and made evident through the work of such authors as Buresh & Gordon (2000) and Gordon and Nelson (2005). The visibility however, is not in nursing’s favour, rather it outlines the extent to which nurses are silent both in the public view and also in the organisational environment. Although there has been a move to raise the visibility of nurses the trend remains one that silences the impact of nursing in the health care system. For instance, nurses have been known to become cohesive in industrial action around salary and nurse to patient ratios (Hart 2004; Iliffe 2007), but they have been silent on professional issues such as how these discourses evident in this study with NPs have an impact on their ability to be visible as an active part of the health care service delivery.

Buresh and Gordon’s (2000) work on empowering nurses supports how this silencing operates. In a workshop held in the USA to encourage nurses to develop strategies for inclusion into health care decision making processes, they found that many nurse leaders did not approve of promoting nursing. During discussions a professor of

nursing became quite angry, suggesting that nursing was “caring work and caring is best undertaken in silence” (Buresh & Gordon 2000, p. 32). In other instances nurses argued that in order to improve the professional status of nursing, the word “caring” should be removed from nursing. They suggested that “caring” was “not professional” and as a result of this the word “nurse” was “tainted” because “nurse” is synonymous with “caring”. They concluded that the word “nurse” be removed from the title “Nurse Practitioner” in favour of something “new” that would sound “more professional” (Buresh & Gordon, 2000, p. 17). In these instances, nurse leaders have provided a view that to care and to be a nurse is to be silent, and that if nurses want to be professional practitioners who practice with autonomy, then they cannot be considered as a nurse. In these examples the tradition of nursing as a silent and invisible workforce is maintained, not by organisations or other professionals, but by nurses themselves.

This chapter will examine invisibility in nursing in the light of Fairclough’s (2001b) levels of social organisation. It will examine how this is impacting on the way in which the role of NP is developing, despite the legitimisation of the leadership and autonomy component of the NP role which has been endorsed through the adoption of the ANMC NP Competencies in all activities relating to the NP. It will do this by exploring the positions of nurses within the health service structure not only from the NP’s perspective but from other technical literature that maintains the analysis of how the webs of texts develop and maintain the invisibility of nursing in the way they work and the manner by which they are employed and managed within the health system.

### ***Nursing: A Tradition or a Profession?***

The practice of nursing has been created around nursing as an activity as well as its professional status (UK Department of Health 1999). Nursing as a profession reflects the scientific nature of nursing, in which nurses and the practice of nursing is governed by professional standards, regulation and legislation. Nursing as a profession undertakes the aspects of nursing as an activity within the nursing scope of practice; scope of practice meaning those activities which nurses undertake within their role as a nurse, as established by professional standards and legislation. Nursing as an activity is experienced at some point by everyone and it can be carried out by anyone who undertakes nursing (Dolan et al. 1983; Hofoss 1986; Clifford 1995;

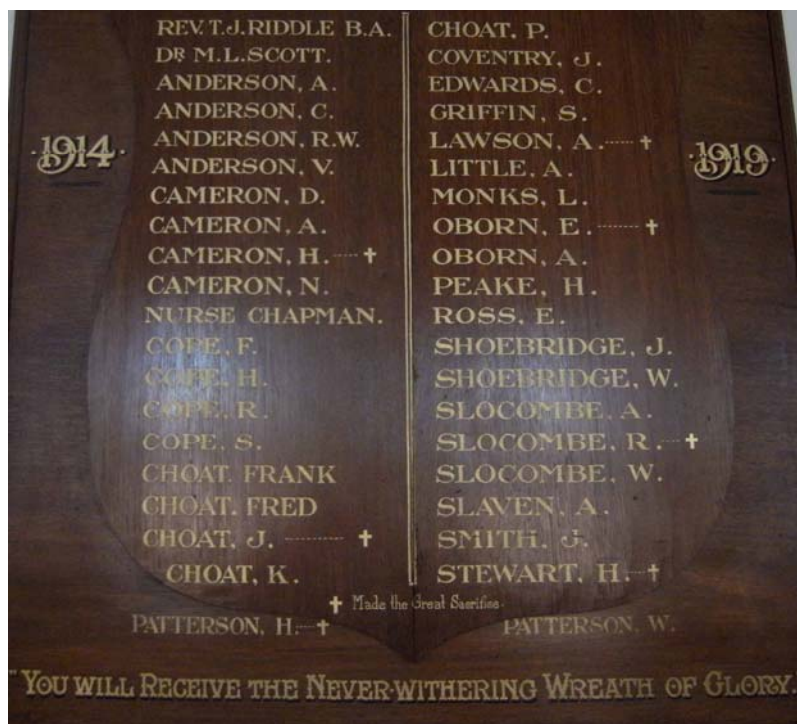
Hegney 1997; Kitson 1999; Chiarella 2002; Hart 2004). Nursing as a profession becomes confused with nursing as an activity because nursing has been undertaken by every woman, since nursing was first described in the early centuries (Dolan et al. 1983; Hart 2004). The definition of ‘nursing’ is “nurturing or caring” (Allen 1990, p. 339) and has always been synonymous with women’s work throughout the centuries (Leonard 2003). This view has been perpetuated over time through the influences of the religious nursing orders and later the secular orders which were run by single, pious and dedicated women (Dolan et al. 1983; Nelson & Gordon 2004). Examples of the dedicated and pious nurse are demonstrated in many nursing history texts and images (McBryde 1979; Dolan et al. 1983; Keyzer et al. 1995). Nurses a century ago were to be widows, nuns or unmarried young women, did not take a salary and were affiliated to a religious cause of some kind (Dolan et al. 1983; Rafferty 1996; Hart 2004). The images of nursing range from physical tasks of making people comfortable, to those carried out under the direction of a doctor, working tirelessly, selflessly and invisibly (Keyzer et al. 1995; Nelson & Gordon 2004).



**Figure 4 A montage of the activities and the influence of women during the American Civil War.  
An etching by Winslow Homer (Dolan Collection) cited in (Dolan et al. 1983, p. 184)**

Public attitudes and perceptions are also influenced by the media’s portrayal of nursing and the myth that it creates around the image that Florence Nightingale, who

left the nursing image in her legacy as the ‘hand maiden’, ‘Lady with the Lamp’ and ‘dedicated angel’, women who worked hard in a veil of invisibility caring for the poor and the sick, images that have been discussed and described by numerous nursing authors (Dolan et al. 1983; Rafferty 1996; Chiarella 2002; Hart 2004; Gordon & Nelson 2005). These images have local examples such as this honour role displayed in a church,



**Figure 5 Roll of Honour for members of a local church who fought in the two Great Wars.**

**Photographed by the researcher with permission (June 2008)**

Whilst the doctor ‘Dr M. L. Scott’ on this honour role has both his title, his initials and his surname inscribed, ‘Nurse Chapman’ is not so clearly identified and is not afforded the grace of identifying initials. As Rafferty (1996, p. 29) suggests, nurses in this era had to observe lady like behaviour and accept their servitude,

Nursing textbooks of the period [Nightingale period] were not only technical manuals but pedagogical tools outlining the social niceties to be observed in dealings with patients and doctors.

This view of nursing is also described in this excerpt from a nurse’s biography in the 1950s,



The newer school of nursing education and its dreams of the day when student nurses should be enabled to lead a more normal existence, with more humane hours, more leisurely academic training and less routine drudgery were unknown to her. That students were paying dearly to hospitals in long nine, ten and sometimes twelve hour days of heavy labour for training they received....was all part of becoming a nurse (Russell 1954, p. 90).

Although not so apparent in contemporary nursing, nurses remain invisible in many ways and it is well documented that the more skilful the nurse is, the less likely their activities will be recognised so that their contribution to health care is not acknowledged (Hegney 1996; UK Department of Health 1999; Chiarella 2002; Gordon & Nelson 2005). It is also accepted in the present-day environment that nurses will prompt the doctor or highlight changes in patient condition and offer clinical management options so that the full worth of their contribution to care is never documented. This is particularly evident in remote areas or where doctors are novice in a particular clinical setting (Hegney et al. 1997; Buresh & Gordon 2000; Hart 2004). The latter has already been demonstrated by the participants of this study chapter 4, where, although they were endorsed NPs, seven out of the eight participants were employed into different nursing roles in which they were reliant on more junior doctors for decisions made in the management of care. It meant that although endorsed to work as NPs through a NMRA, participants were unable to legitimately do so under the current workforce employment structure.

### ***Paying Dearly to Hospitals***

Participants and information from technical literature in this study have supported the notion of the invisible nurse. In so doing, some of the NPs have paid dearly to the hospitals in which they work, because they have tirelessly pioneered on in their efforts to establish NPs roles. They have also been exploited in the additional workload they carry without financial or professional recognition. The invisibility of nursing thus prevails.

Mary (Interview 1) endorsed this observation when she described a very isolating and emotionally crippling journey to NP authorisation at the hospital that she was employed at during her studies. Such a situation occurred because the role was not supported by that hospital. For a period of some two years, Mary had not only studied in her own time, but had continuously attempted to develop the NP role at the hospital. She achieved no merit for her attempts and her experiences resulting from it

were so negative that instead of subjecting herself to further stress, she changed not only her job but town as well,

*I've actually moved my whole family from [town] to [town], I have sold my home of 20 years, my husband has left his job of 20 years, my daughter who's 18 moved with me, so I've given up a hell of a lot and so I have to make it work, and I will, you know (Mary, Interview 1, p. 9).*

Through her enduring vision of becoming a NP, she continued stoically and silently, at great personal cost accepted the hardship without complaint. This severe isolation is described in an age when The Australian Human Rights Commission Act 1986 is embedded in health employment policy in order to provide a safe working environment for all employees.

There are two aspects of this story that are of grave concern. Firstly, that a nurse who, by ANMC standards should be providing leadership “by incorporat[ing] the impact of the nurse practitioner service within local and national jurisdictions into the scope of practice” (Australian Nursing and Midwifery Council 2006a), was so prevented from fulfilling this competency standard. She had to leave town and despite the legislation that is meant to safeguard her rights as a human, was not able to function because of the emotional and physical toll the attempts at developing the role had on her and her family. Despite the move Mary, at the time of the interview was still not practising as a NP, although she had been authorised for 18 months and in spite of this great personal upheaval in her attempts to become employed as a NP. Not only was her struggle to achieve NP status silent, but the organisation’s approach to her vision showed a lack of respect for the role that the NP can have in the service, nor did it respect Mary as a person or a professional. Conversations in the previous chapter from Bill (Interview 7) and Sally (Interview 5) also support this evidence with their similar unfavourable experiences. Developing their roles came at personal and professional cost, in services that did not apparently understand or support it. The silence of nurses is thus sustained. Buresh and Gordon (2000 p. 17) comment that, “at the moment, nurses are seen more, and may be appreciated more for who they are and not for what they do, for their virtues rather than their knowledge and action”. However the experiences of the NP participants seem far more draconian and invisible than even can be gauged by this remark. It goes beyond the comments by these authors who say that it is no longer whether nurses are ‘visible’ or

'invisible' but rather if they are 'silent' or have a 'voice' (Buresh & Gordon 2000, p. 4). NPs have a rhetorical voice by means of the ANMC NP Competencies and the legislation, but they are silent in truth at the second level of the social order that Fairclough (2001b) refers to, because the health services are not allowing NPs any voice at all. In fact the dominant discourse is not only silencing them but it is impacting on every sphere of their lives, not just their professional life.

### ***Silence or Voice?***

The tensions between the silence and voice of nursing have been declared in other ways globally. In an attempt to raise the profile of nursing as a profession, and to provide a global definition of nursing, the World Health Organisation (WHO) defined nursing in terms of,

...helping people to determine and achieve their physical, mental and social potential, and to do so within the challenging context of the environment in which they live and work (World Health Organisation 2000)

While the definition supports Henderson's (1967) view of the supportive nurse, the WHO moved nursing from a vocation and caring activity to a profession by suggesting that "a framework of shared competencies [are] established that show[s] the value of collaboration between nursing and midwifery with other disciplines" (World Health Organisation 2002, p. 27). The WHO stated that nursing also includes the planning and giving of care, curing illness and rehabilitation; and encompassing the physical, mental and social aspects of life as they affect health, illness, disability and dying (World Health Organisation 2000). This contradicts Bill's (Interview 8) experiences where his supervisor told him that he could not work in a nursing role because he was *not able to diagnose*. In respect of the future direction for nursing, the WHO advised the development and utilisation of nursing knowledge at all levels of the organisation and in different models of health care delivery. This supports the approach outlined by the ANMC NP Competencies where NPs provide "clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health service", yet this was not evident in Mary's, Bill's or Sally's experiences with their employer's view of advanced nursing practice as described in this chapter, and in the previous one.

The interviews show considerable divergence between what is said in text and policy and the interviews between nurses as individuals developing a new role. Their experiences outline the effect these tensions are having on NP development in a health system that is clearly not embracing the role. Fairclough (2001b) refers to these power relations and actions in the struggle for dominance, where alliances develop between institutions involved with those traditionally in power and who seek to maintain their position by creating barriers to change. As such the NP role becomes the site of struggle between the powerful conventional view and the new concept with its probable change to existing models of care.

The essential object of contention can be examined through the differences between the role of the customary nurse who fits the traditional nurse position, and the so called autonomous nurse, the NP, that does not fit the traditional view of health and nursing. Despite the fact that the role of the nurse is described as supportive, the role of the NP expects an autonomous person thinking and acting independently, initiating treatment rather than supporting it, but still working in the nursing framework (Australian Nursing and Midwifery Council 2006a).

If the traditional role of the nurse is to assist and support other professionals in achieving wellness in those requiring health care, then the fact that nursing as a profession expects NPs to practice within the nursing framework but asks them to work 'autonomously' and 'collaboratively', creates a tension in expectations. This tension arises because NPs are expected to initiate treatment and take control of the management of a patient which is normally the domain of the doctor. This new way of nursing creates a divergence to what is accepted as the traditional position for nurses and structure of health care thereby creating conflict for NPs who may practice independently. If Fairclough (2001b) contends that players adopt the dominant discourse in the order as a way to maintain stability of that order, then the introduction of NPs is challenging that order. The power base is being threatened creating a situation in which the NP role has become the site of the power struggle between an accepted dominant discourse and its alternative that the NP brings. The struggle then will permeate into anything to do with a new order establishment

The academic preparation, the legislation relating to NPs and NP involvement in research activities are such sites of struggle, and despite the ANMC NP

Competencies, the positioning of NP legislation and education remains within the accepted discourse of health, which supports the medical model as the order, perpetuating the tradition of the subservient or invisible nursing order, which then affects the role of the NP in developing autonomy in practice.

### ***The Legislation Illogicality***

In order to become a NP, nurses are required to complete a master's degree in nursing, in which the role and functions of NPs within a nursing framework are explored. Whilst not actually legislated as such, the curricula of NPs is informed by the ANMC NP Competencies and is adopted by the NMRAs, which are guided by this document and the state legislation such as this example,

Qualifications, training and experience required for nurse practitioner

For the purposes of section 32(c) of the Act, a registered nurse may apply for an authorisation to practise as a nurse practitioner if he or she –

- (a) has successfully completed an accredited nurse practitioner course; or
- (b) has the qualifications, training and experience in the area of practice of a nurse practitioner that the Board considers to be at least substantially equivalent to an accredited nurse practitioner course (Tasmania Nursing Regulations 2005)

Although not stated in legislation, NMRAs in Australia require evidence of completion of a master's degree that focuses on advanced practice nursing, diagnostics and pharmacology, based on the medical model of care, in other words, the technical extensions to advanced nursing practice rather than the expanded aspects of it (Department of Health Western Australia 2003; ACT Health 2005; Queensland Nursing Council 2005; Nurses Board of South Australia 2006). So although it is nationally expected that NPs are positioned in nursing through the ANMC NP Competencies, the state legislative and the academic institutions focus on the technical extensions to that practice, and not the professional aspects of it. This is demonstrated in the following legislative extract,

...**scope of practice**, for a nurse practitioner position, means the manner in which the nurse practitioner who occupies the position may practise as a nurse practitioner, including, for example, the aspects of practice that the nurse practitioner may perform as a nurse practitioner.

#### **Examples for scope of practice**

1. prescribing particular medication
2. referring patients to other health care professionals
3. ordering particular diagnostic investigations

(Health Regulations 2006, Australian Capital Territory)

Firstly, this definition contributes to the confusion in nursing because it says nothing substantial about it, particularly the role of NP for which it was written. It does not outline the role of the NP as nurse, nor does it provide a clear indication of what this role should be. It merely provides examples relating to extensions to practice by prescribing medication, referring patients to other professionals, and ordering diagnostic investigations. Nowhere is there a reference to the expanded practice in a nursing context as intended by the ANMC NP Competencies. The technical examples given are applicable to any health professional who has undergone extended technical training. Further on in the text, this legislation refers to the definition of the nurse from the territory's Nurses Act, which states that a "nurse practitioner means a person who is registered as a nurse practitioner under the Nurses Act 1988" (Health Regulations 2006 Australian Capital Territory).

This definition still does not describe the NP, but at least it does suggest that the role of NP is a nursing role, because it is cited in the Nurses Act of that state. It also highlights the fact that the NP role is a protected title by the legislation. So on the one hand the NP is aligned to any other health professional with extensions to practice, and in the same document, is referred to as a 'normal nurse', remembering that the NP role has been created around the ANMC NP Competencies (Australian Nursing and Midwifery Council 2006a). A further search of the legislation did not reveal anything more substantial as this excerpt suggests,

Subject to s25A of the Poisons Act 1971 a registered nurse, where the registered nurse is authorised under the Nursing Act 1995 to practise as nurse practitioner, may possess and supply narcotic and restricted substances (Nursing Board of Tasmania 2007).

Further to this finding I searched all the legislation relating to nurses and drugs and poisons regulations and acts in Australia to see if I could find something that described the role of the NP in a more detailed manner. All definitions and scopes of practice focused on similar aspects; NPs were authorised to practice under the Nurses Act or Health Professionals Act, depending on the state or territory, and some referred to the three extensions to practice; diagnostics, prescribing and referral. The silence of the nursing voice is evident, and the alignment to the medical model is reinforced. This silence extends to the introduction of new positions that mirror that of the NP.

## ***Physician's Assistant or Nurse Practitioner – What's in a Name?***

Extensions to practice do not position the NP into a defined role or specialty area. Anyone can develop extensions to their practice through the achievement of clinical competencies as is seen in the role of Physician's Assistant (PA). Australia is currently trialling this role in one state, and although it has been in existence for some 40 years globally, it is new to Australia. Information on this trial says that the PA is a "complementary practitioner" who has "proven to be an efficient and cost effective means to deliver health care and demand for growing services" (Jolly 2008, p. 1). The PA is defined as,

...health care professionals licensed, or in the case of those employed by the federal government they are credentialed, to practice medicine with physician supervision. As part of their comprehensive responsibilities, PAs [physician assistants] conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and write prescriptions. Within the physician-PA relationship, physician assistants exercise autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services. A PA's practice may also include education, research, and administrative services (Jolly 2008, p. 5).

This description mirrors that of the NP and, if both roles are examined, definition differs only in the fact that NP are not under the supervision of doctors like PAs are. These similarities create confusion between roles as well as blurring of boundaries, because activities related to extensions to practice, are similar. The description of the PA refers to autonomy much like the autonomy of the NP described in the ANMC NP Competencies. The PA and the NP follow parallel clinical activities but one, the PA, is managed by doctors, the other, the NP is grounded in a nursing framework, even though the legislation does not specify this, but does describe those tasks normally attributed to the domain of doctors. It reinforces the influences of medicine in determining roles and responsibilities that support their traditionally superior role. Although the NP role is legislated and has been in existence in Australia since 2001, the health care system is, nine years later, trialling another role, which is supervised by doctors, the result of which could leave the NP role outdated. Of note, is the ease at which the PA may qualify. The PA role is a two year graduate entry education preparation undertaken in a School of Medicine, whilst the NP not only has to achieve RN status (three years undergraduate study), but must also have between three and five years experience and must provide evidence of working at an

advanced level (which is not clearly defined). The educational and experiential preparation between these two similar roles is skewed in favour of the PA, yet they are similar in clinical scope of practice.

Despite the fact that NPs can essentially do the job that Jolly (2008) describes for the PA, the role of NP is pushed aside for the role of the PA, suggesting that nursing is not effective as a 'complementary' and medically managed position, nor is nursing, it can be suggested, as a profession either visible, political enough or respected enough. This reinforces the findings of Buresh and Gordon (2000) where nurses continue to perpetuate the silence because the focus of caring that nurses have promoted continues to contribute to their silencing. The contesting discourses here of complementarity and interdependence with autonomy continue to have the effect of removing nursing from the agenda for the management of the medical workload. If nursing did have the professional standing and the credibility within the health care environment such as described by the ANMC NP Competencies where they are said to "actively participate[s] as a senior member and/or leader of relevant multidisciplinary teams" (Australian Nursing and Midwifery Council 2006a), then NPs would be forging new boundaries and new models of care with the other health professions, and not being sidelined by another new role such as the PA. This supports Fairclough's (2001b) assertion that dominant power controls more powerless groups who then challenge the boundaries of that power when creating something different to the accepted norm. NPs are in fact challenging that boundary between dominance and subservience manifested in the accepted roles of doctor and nurse in a traditionally driven health care system. The dominant discourse that expresses the powerful position creates a struggle on all fronts, including trialling similar roles that will do the job of NPs but will remain within the supervision of that medical power. Order is thus maintained (Fairclough 2001b). The education of NPs is grounded in this nebulous legislation and the ANMC competencies for NPs and for RNs that fail to articulate what exactly is 'nursing' about this clinical role.

### ***Learning for Liberation or Compliance?***

This chapter has thus far examined the invisibility of NPs in policy and legislation. I now want to examine the education of NPs. In his three levels of discourse Fairclough (2001b) says that part of the maintenance of the social order occurs through the ordering of the discourse throughout social institutions. He contends that



“a whole range of social institutions such as education, the law, religions, the media and indeed the family, collectively and cumulatively ensure the continuing dominance of the ruling class” (Fairclough 2001b, p. 27). Based on the legislation that focuses only on the medical model of care, the nursing regulatory authorities have made it a requirement that NPs are prepared through a master’s degree. Fairclough (2001b, p. 27) contends that “institutional practices which people draw upon without thinking often embody assumptions which directly or indirectly legitimize existing power relations”. In the case of NPs, the assumptions should be drawn from the legislation, given the protected nature of the title NP.

Using the World Wide Web, I searched universities in Australia for courses that lead to the registration of NPs. What I found in all the courses was that the underpinning document used was the ANMC NP Competencies, but the actual curricula were based around the three medical extensions to practice. The ANMC document itself does not actually state that NPs should be master’s prepared, rather it focuses on standards of practice such as,

...dynamic practice that incorporates application of high-level knowledge and skills in extended practice across stable, unpredictable and complex situations (Australian Nursing and Midwifery Council 2006a)

The only aspect that suggests that NPs should be educated at a master’s level is the need for the clinical expertise to manage complex and unpredictable situations. Three NMRA’s have had a clause in which, for a period of time, registered nurses who could provide evidence of practicing at an advanced level, and provided they undertake a pharmacology module at a master’s level, may apply for authorisation to practice as a NP without a master’s degree. This period however, has a finite time limit, after which all NMRA’s will require a NP to have a master’s degree. The question I asked is if the legislative framework is so vague, how have the universities planned for the education of the NPs?

I reviewed the curricula outlined on the university websites of master’s degrees leading to the authorisation of NPs of seven Australian universities. Commonly, topics in the master’s programs included activities around,

- Evidence based practice or research in health care which prepares NPs for their research role in terms of developing clinical practice guidelines, participating in quality improvement initiatives and research activities.
- Leadership in health in which, as the pinnacle of the nursing workforce, NPs are expected to lead the way in clinical practice and expertise in accordance with the ANMC NP Competencies.
- Extended nursing practice which relates to detailed anatomy, physiology and pathophysiology, advanced clinical assessment and clinical decision making.
- Diagnostics relating to laboratory testing and radiology imaging which assist in the diagnosis and assessment process of clinical practice.
- Pharmacology and pharmacokinetics which prepares the NP for prescribing and managing drug therapies.

Only one curriculum included a topic called ‘Transition to Nurse Practitioner’ (Curriculum 1) in which the political, economic and organisational issues around NP development are explored. Other curricula appeared to include aspects of this in their leadership topics. All the masters programs stated their core topics in terms of the extensions to practice and follow the position of this example,

The Master of Nursing (Nurse Practitioner) will provide students with the detailed knowledge and skills required to provide professional leadership in contemporary clinical nursing specialties. Expert speakers from nursing, pharmacology, radiology, pathology, physiotherapy and other disciplines will contribute to the course. Students must have five years post-registration experience in their specialty and be employed by an appropriate agency. It is expected that students would complete the core units (Health Assessment and Diagnostics, Therapeutic Medication Management and Evidence-based Guideline Development for Clinical Practice) in the first year and complete their specialty units in the second year (Curriculum 2).

This course acknowledges that the program prepares nurses for clinical nursing practice, yet it only provides examples of the medical model with speakers being invited to teach from other disciplines such as pharmacology. It also makes particular mention of the fact that students must complete health assessment, diagnostics and medication management in their first year of study, the emphasis again falling on those extensions to practice from within the medical model of care. Reinforcing this is the specialty units mentioned that relate to a practicum, in which the nurse works with a mentor, usually a doctor, in their place of work. So despite the fact that both the WHO and the ANMC support the notion of a nursing workforce that is grounded

in nursing and supports the care of individuals, families and communities, the focus of master of nursing curricula is around those three extensions to practice; medication prescription, diagnosis and advanced assessment, normally the scope of practice of a doctor.

Curriculum 3 details generic topics and also the extensions to practice,

#### Nurse Practitioner

The School offers an articulated study pathway to assist you to meet the [Regulatory authority] requirements for endorsement as a Nurse Practitioner. The program is incorporated within the MANP [Master of Arts Nurse Practitioner] and includes five subjects in the second year to complement the [Regulatory authority] accredited therapeutic medication management education modules (Pharmacology and Therapeutics 2 and Applications of Clinical Pharmacology 2). These subjects provide you with generic and specialist advanced practice knowledge and skills in health assessment, history taking, diagnostic interventions, referral and integration of care within multidisciplinary services, decision making and patient education.” (Curriculum 3)

So again, whilst the national nursing professional body (ANMC) requires NPs to be grounded in nursing and the statement by this university only refers to extensions to practice for academic preparation. Another example of extensions to practice external to the nursing framework can be seen in this course description,

In this unit, students will be given the opportunity to study in-depth pharmacokinetics, pharmacodynamics and therapeutics in order to identify the effects of medications on physiological, biochemical and pathophysiological processes. The key pharmacological characteristics of drug classes and specific nuances of individual drugs across the lifespan will be explored in order to optimise therapeutic effects and minimise adverse events. On completion of this unit students will be expected to use critical thinking and problem solving skills to prescribe, administer, monitor and evaluate medications in accordance with commonwealth and state legislation and policy (Curriculum 2)

This curriculum states that the content of teaching complies with the legislation, yet as the data has shown legislation does not provide clear guidelines, so the evidence contradicts the statement from this university. Despite the legislation and the university courses which state that NPs can prescribe, the Medicare Act 1973 does not make provision for NPs to obtain a provide number or have the benefits afforded through the Pharmaceutical Benefits Scheme (PBS)<sup>43</sup>. The data from the university

---

<sup>43</sup> In the recent national budget (2009) the Federal Government has made provision for NPs to access the PBS, but has not identified the amendments to the Medicare Act, which will be an essential element of any change in this regard. This is explored in Chapter 7.

curricula supports Fairclough's contention that institutions perpetuate the language and focus of any dominant discourse. Even though the legislation is unclear, and the ANMC hold out to have the core standards for NPs to develop, the universities have focused on a medical model for their teaching, some of which cannot actually be achieved because NPs cannot prescribe without a provider number.

In spite of the very technical nature of academic teaching, universities offering the master's program leading to authorisation as a NP, do require, as an entry to the course, evidence of registration as a nurse. Although many of the subjects follow an extended medically focused pathway, students still have to prove that they are a nurse. The measure for the concept of advanced practice in nursing is that nurses have to provide evidence of practice in their areas of clinical specialty for between three and five years as a RN. Thus the legislation says nothing in particular about a NP, except that they can prescribe, refer and order diagnostic tests, yet the regulatory authorities and the universities focus the role on nursing by using the ANMC NP Competencies, requiring evidence of registration and currency of practice, and including topics such as research, evidence-based practice and leadership.

Given that NPs are educated within a nursing frame of reference but legislation measures achievement on medical extensions to practice, it is not surprising that the views of the NPs interviewed show a diverging discourse of what is alleged around the role of the NP. It contributes to the tension created about role development and its challenges on those traditional boundaries of health care. The question is, does this analysis indicate a personal shift away from 'the normal nurse', or are all nursing institutions attempting to make space for the NP within a paradoxical environment between what the profession expects of them and what health care views as the role of NP? Fairclough (2001b) contends that we are all products of our society in that we adopt discourses and behaviours that society sets.

### ***Products of Discourse***

This study uses Fairclough's analysis of power in three levels of society and I have used autonomy as the focus of NP practice. Fineman (2004, p. 9) says that autonomy is an "ideological conformation of the dominant notions of independence and self sufficiency" which supports Fairclough's view that dominant groups perpetuate their power through ideology assimilated and adopted by people. Such a position is

perpetuated through the language of institutions such as legislation, policy and universities. Institutions such as health care have an overall accepted discourse in terms of national processes but each local authority or organisation has an internal set of rules and norms which are determined by those who have the power in those institutions. The social norms become such when the prevailing discourse is adopted, even if they are presented as a value such as autonomous practice in the case of the NPs. Nurses are subjects within the discourses of health care and work under what is accepted as normal processes. They conform to it in order to work in relative harmony and this has been shown to occur in other studies which, although such works do not outwardly discuss autonomy, examine aspects of nursing such as skill mix, team work and nursing image (Clifford 1995; Busen & Englemann 1996; Hegney 1997; Armstrong 1999; Barton et al. 1999; Atkins 2006; Ettner et al. 2006; Gardner et al. 2006). As Scollon (2001b) suggests tension occurs when there are differences in the views between what is accepted by the dominant group and that which deviates from it or challenges it.

In the case of the NPs, we return to the divergence between tradition and advancement, in other words RNs as traditional nurses and NPs representing advancement. NPs are portrayed as nurses, but taking on tasks that are normally accepted as doctor's work, therefore they cannot really be considered nurses in the traditional sense. The tension in the language between social institutions of legislation, the ANMC, the universities and what NPs are experiencing in health services, provides a window through which to view the conflict that is taking place at the point where the boundaries of innovation and tradition meet. This has been demonstrated in all the data that was examined throughout this study. The national nursing framework for NPs maintains its paradoxical view keeping NPs moving between autonomous and dependent positions through holding to the position that the NP is grounded in nursing, therefore remaining unquestionably interdependent rather than independent or autonomous. It is small wonder then that in order to make a space for themselves in the health care system, NPs appear to be removing themselves from nursing as they relate to the work they do at their place of employment. Becoming generic or invisible, may be the participants' way of adapting to, or complying with, the dominant discourses in a way that they can work in a modified nursing position. In this way they will be accepted while maintaining the status quo of the 'normal nurse' who remains invisible. This neutralises the

potential struggle that challenges the accepted view of the normal nurse to that of the NP. Creating a new role like the NP, which challenges the long-established nursing role, raises the visibility of nursing which is a divergence to what is viewed as the 'normal nurse' (as invisible), and will create tension at the boundaries of what is accepted as normal. Whilst NPs remain small in number, their impact on the health system is enormous, not because of the clinical enhancement their services potentially provide, but because of the challenges they have created to the status quo of the health workforce. This only serves to magnify the invisible nature of nursing, when one considers that nursing forms the largest body of health care workers in the world (Swerissen & Duckett 1997; Bloom 2000; World Health Organisation 2002) yet it is only when a small number of that group challenge accepted boundaries of order that nurses are noticed.

In 1995 a total of 584100 people were employed in the Australian health care system. Of this 76% were women and 60% were nurses compared with 11% medical practitioners (doctors) (Clinton & Scheiwe 1998). The fact that Australia has only recently, in 2008 appointed its first ever Chief Nurse indicates the lack of influence that nursing has had regarding national health strategy. Even at this level nursing is invisible. I searched the World Wide Web for information emanating from the Office of the Chief Nurse of Australia that may be supporting and promoting nurses. I found nothing. There is not even a web site for this eminent nursing position. The only information I could find relating to communication and leadership from the Chief Nurse of Australia came from a media release by Minister for Health and Ageing at the inauguration of the appointment,

The Health Minister Nicola Roxon today congratulated Rosemary Bryant for her appointment as Australia's chief nursing officer.

As Commonwealth Chief Nurse (CCN), Ms Bryant will be a strong voice within government on all issues relating to Australia's 200,000-strong nursing workforce. She will also contribute to the maternity services review being conducted by the Government. Nurses are the backbone of Australia's health system. Everybody relies on nurses at some point in their lives, whether in hospitals, clinics, aged care facilities or schools.

This announcement recognises just how important they are. There has been a Chief Medical Officer since 1985 – it's time nurses got the recognition they deserve, too (Kelly 2008).

When one considers the enormous change in health care services that Australia is experiencing, such as the strategic directions in primary health (National Health &

Hospitals Reform Commission 2009), and the changes that are impacting on nursing, such as the role of the PA and the legislative inconsistencies of the NP role, the Chief Nurse's silence on nursing issues in Australia is deafening. It supports the opinions of others who suggest that the invisibility of nursing at a strategic level as well as at the local health service or local level is widespread. Studies show that despite the growing awareness of the importance of nurses, they still do not actively participate in strategic directions of health care<sup>44</sup> (Wigens 1996; Wade 1999; World Health Organisation 2002; Weinberg 2003; Productivity Commission 2005). The silence of the Chief Nurse on Australian nursing matters perpetuates a silenced nursing leadership in this country. Simultaneously, traditional and invisible nurses are not autonomous and they perpetuate subservient nurse discourse. In this environment NPs cannot succeed because they are boundary challengers, boundaries which nurses themselves are perpetuating. The idea of nurses shifting their sphere of influence within the traditional health social order rather than increasing their autonomy was reinforced when I sought out information on how nurses were portrayed in public documents such as annual hospital reports.

### ***The Touch Certificate***

I undertook a search on the World Wide Web for annual reports and strategic plans of hospitals in Australia. Of the 17 documents that I reviewed, only one mentioned the role of the NP and few had a comment or a section on the nursing workforce. Five of the reports I reviewed highlighted nursing briefly in relation to links to graduate nursing initiatives and other educational activities for example the hospital's affiliation to a tertiary institution for education and training. One annual report told a nursing story which cultivates the virtuous nurse image as the normal nurse,

So we took John home and he was overwhelmed at being able to spend his final days there. He called us his '[hospital] Angels of Mercy'. One thing that stood out clearly in this situation was the nurses' commitment to help John achieve his wish to be at home: what started out as 'a few days to live spilled over to weeks...' (Report 1, p. 14)

This annual report was written in 2006. The "Angels of Mercy" provide a picture of the dedicated nurse of the secular and religious orders of the last century. The same hospital perpetuated this view of nursing in this statement,

---

<sup>44</sup> Leadership in nursing is also examined in Chapter 6.

In 2006 the [Hospital] Touch' program was introduced to recognise staff members and volunteers who have received written appreciation from patients, clients, visitors, and the general public for their work. Those acknowledged are presented with a [Hospital] Touch Certificate and if the same person is acknowledged on multiple occasions, they are awarded a [Hospital] Touch badge. Staff members have responded well to the program with a large number already receiving a badge (Report 1, p. 39)

'Touch', 'appreciation' and awarding a badge for this behaviour merely reinforce the image of the traditional subservient nurse. Although the nurse is made visible in the context of receiving a reward for caring, the real work of contemporary nursing is lost in the altruism surrounding the traditional caring act. It tells of a nurse who is nurturing and caring, but does not provide an image of a professional in their own right, who is prepared with a minimum of a bachelors degree, is regulated and professionally prepared to perform functions, which assist in the multidisciplinary clinical management of a patient, as referred to by both the WHO and the ANMC.

I did find references to organisational practice development activities which involved nurses such as this example,

The (Hospital) Nursing Research Centre undertakes and supervises an increasing amount of high quality research studies in collaboration with nurses across clinical areas (Report 4, p. 15)

Research is undertaken in 'collaboration' with nurses, which suggests that nurses do not undertake the research themselves. It portrays to the public an image that nurses play a supportive role in research, they do not undertake the research. The image is one of support to another, rather than what the ANMC Competencies and the WHO suggests forms part of the professional practice of nursing. The picture painted by the annual report is in direct contradiction to what the ANMC NP Competencies suggest in Competency 3.2 in which NPs "engage[s] in and lead[s] informed critique and influence at the systems level of health care" (Australian Nursing and Midwifery Council 2006a).

Supporting the image of nurses not undertaking research was the fact that none of the participants in this study referred to any research activities related to their practice. Jane referred to her work as *maintaining databases* which is an administrative



product of research, not research itself. Amy referred to research only in the context of her professional career change,

*I did the PhD because I thought I'd go back into academia, I worked with a research centre at the university for a year doing project work and decided that you know, I just didn't want to go back to that, I mean, I loved the research side of it, but, I didn't need the academia (Amy, Interview 4, p. 18).*

The interesting aspect about Amy's comment was that she did not correlate the need for academia i.e. research, to overlap and compliment clinical practice. Despite her experience as an academic, she failed to identify the theory-practice research opportunity that is essential in evidence based practice, a corner stone of clinical leadership and therefore NP practice. Her responses indicated a way of practice that supported the notion that nurses don't undertake research, they merely support it. Another health service's annual report did make mention of nurses in research by stating that "part-time senior nurses have been employed in each Clinical Care Unit at [hospital] to nurture and support nursing research" (Report 11, p. 33). However, the dedicated nurse line prevails in the 'nurturing' of research. If nurturing is caring then nurses are caring for and fostering the research, not undertaking the research. Despite education that suggests otherwise, health services have perpetuated the traditional nursing image and throughout all the reports, such as this example,

The growing body of international literature on school nursing models indicates recent interest in measuring the impacts of school nursing on student health. Working in collaboration with the School Nurses Association of (state), this project aims to clarify the role of school nurses in (state) and subsequently facilitate ongoing monitoring and evaluation of school nurses' daily activities (Report 2, p. 18).

Doctors were researching what school nurses do; school nurses appeared not to take any part of the research except to be the subject of it, in a time where nurses as professionals have the education and authority through the ANMC policies, to initiate and undertake research activities. This particular section went on to discuss the links with GPs and that the GPs would be undertaking the research in collaboration with the state School Nurses Association, again nursing supporting research, not doing it. Nursing is thus visible, but in the subservient traditional sense, where they play a supportive role in research, not an active one. The real ability of nurses to work in what is termed 'advanced' practice is not given any credence because although the ANMC competencies insist on initiation of research and

practice evaluation, this is not the case in the statements above. Given the diversity and range of this particular hospital's services and the fact that it did indicate employment of a NP, the reference to nursing is limited. There was no reference to the work of the NP at all, yet NPs are meant to be leaders in health care, supported by the ANMC in Standard 3 of the NP Competencies and visible in this aspect of their work. The statement provides a comparison with what is required and what is possible in practice,

The nurse practitioner leads through any of a number of roles including researcher, clinical teacher, case co-ordinator, and spokesperson, and in this capacity may take responsibility for assisting the public, policy makers and other health care professionals to understand the nurse practitioner role. In so doing they draw from the relevant evidence base to influence the quality and nature of services provided (Australian Nursing and Midwifery Council 2006a).

Nurses, quite clearly in this text, are leaders, yet the collated data of this study has not provided evidence to support this statement, let alone a picture of nurses researching their clinical practice. Therefore the dominant power is supported by ideologies across social institutions, through hidden discourses that manifest in nurses believing they are playing a leading part in health care development yet they comply with the traditional subservience accepted for the nurse role. This confirms Fairclough's (2001b, p. 26) point,

...social structures at societal and institutional levels determine discourse. The way in which orders of discourse are structured and the ideologies which they embody, are determined by relationships of power in particular social institutions and in the society as a whole.

### ***The Alliance of Groups***

The power that is controlled by the dominant group is supported and maintained by what Fairclough (2001b, p. 27) refers to as an "alliance of groups". He further says that institutional practices, which embody these dominant groups, become naturalized in the way they are adopted throughout all the threads that make up the practice of the groups within the alliance. The legislation, the nursing curricula and the annual reports have provided information which demonstrates that nursing remains invisible because it conforms to the dominant discourse. No room is made for self governance and independence in this alliance and therefore it is my contention that NPs will continue to struggle to be recognized as an important part of

the health care system. Participants have clarified how their invisibility continues in the way they are treated and excluded from decision making processes within the health services in which they work. In support of this positioning, the texts developed in support of the role maintain the dominance of discourses less than helpful to the full implementation of the NP role. Instead they confine nursing practice through a structural framework of exclusion leading to a continuing invisibility of nurses in clinical practice.

The silence in nursing became evident when all the social institutions were examined. The silence does not mean that nurses are not 'seen or heard' but their silencing is obtained through a lack of acknowledgement of their contribution to practice. The autonomy that is viewed as a key characteristic of their professional position in the ANMC and other literature relating to NP policy and process does not eventuate. They are silent because those seeking to be NPs perpetuate the accepted and traditional view of nursing through conforming to the unquestioned practices of nurses within the system. Legislation authorises extensions to NP practice, which could be extensions to any other health care professional's practice as well. Education focuses on achieving skills based on these extensions whilst it avoids the change management process and skills development that is so essential in making change to what is accepted as normal nursing practices. Annual reports perpetuate the traditional line of health care divisions of labour. The evidence provided in these discourses supports Fairclough's contention of a power behind discourse (Fairclough 2001b) which is manifested in the traditional view of nursing that now, in contemporary society, sanctions nurses to be used as a commodity within the prevailing lens of discourses that dominate health care in the medical dominance and the purported hierarchies of health service provision<sup>45</sup>. Whilst it is said that NPs have the authority to practise in a way that moves nurses from supportive roles to decision making roles, the health services are holding them back by reinforcing the status quo of what people have known and are comfortable with. Change is noisy and change follows a path of the dominant discourse if the management of that change is not carefully and strategically planned and managed (Porter-O'Grady & Wilson 1998; Fairclough 2001b).

---

<sup>45</sup> This is also examined in Chapters 6 and 7.

This chapter has demonstrated, that despite the legislation, the policy and the education of NPs, they are still viewed as subservient workers who nurture and support clinical practice. The research component of education is merely rhetoric and is not implemented in the health service. Legislation is vague and focused on technical extensions to practice which does not reinforce the nursing voice, framework of practice of the claimed policy and clinical practice guidelines of the ANMC standards. It merely reinforces the medical model of care, where nurses support doctors.

In the following chapter, I continue to examine the discourses of health services as the second level of social order. However I expand this exploration to include the leadership and direction that organisations provide, how these directions impact on NPs as the first level of social order and how the rhetoric of the third level, that is policy, confirms the dominant discourses of health. I do this principally around the leadership role of nurses with reference to the role that nurse managers have in supporting change in the nursing workforce such as that which we see in the development of the NP role. This discourse is examined because NPs in their interviews consistently referred to their nurse managers as being more obtrusive than supportive.

## Chapter 6 - Lukewarm Defenders: Nurse Practitioner Implementation

It ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. Because the innovator has for opposition all those who have done well under the old conditions and lukewarm defenders among those who may do well under the new (From 'The Prince' Machiavelli 1505 in translation by W. K. Marriott 1908, p. 24)

Like Machiavelli's Prince, NPs find themselves introducing a new order to health. In a health service that has maintained a status quo in the division of labour for the best part of a hundred years, NPs represent the 'new' way. As Wearing (1999, p. 206) points out, nurses in Australia have always been "seen and not heard" due to the patriarchal dominance of doctors who have control over technical, economic and management of health care resources. Part of this control is embedded in the legacy of the Nightingale time which remains in operation in hospitals throughout Australia today. Based on the principles of change management, those 'under the old conditions' will not be keen to let go of the power, and those who are 'lukewarm defenders' will be hesitant in making change. This is because there is a fear of instability in the workplace resulting from changes over which players may have little control (Porter-O'Grady 1999; Fairclough 2000; Eriksen 2001). In the case of introducing any change to health services, the process becomes even slower because the hierarchy of decision making generally follows a process driven path to completion.

An example of this is provided from my own experiences when I was the Nurse Practitioner Project Officer for a remote area health service. The time it took to establish a NP position in principle, from community consultation to health minister approval, was up to two years (Field note 8). These process driven activities in themselves are discourses that create obstacles for change and it could be argued that they are also used by those in power to delay or avert change that is not tolerable by the old order. Fairclough (2000, p. 30) says that "as well as being determined by social structures, discourse has effects upon social structures and contributes to the achievement of social continuity or social change".

This chapter will explore the discourses affecting NP implementation at the second level of social organisation, which is the operational level of health care. The study examines texts in those institutions responsible for employing NPs. The texts and interviews identify discourses that splinter the continuity of health care delivery between the three levels of social organisation and within which influence how the NP role is being enabled.

### ***Organisational Hegemony***

Health care in Australia is a complex web of federal and state funding and is based on some basic concepts which has been captured in a document called 'Australia's Health, 2006' and these include,

- availability and accessibility of services and programs
- appropriateness or relevance of interventions
- effectiveness of interventions in achieving the desired outcomes
- responsiveness of the health system to individual or population needs
- degree to which care is integrated and co-ordinated

(Australian Institute of Health 2006, p. 6)

These concepts are incorporated in activities that are included in determinants of health such as socioeconomic factors, and health and well being indicators for example such measurements as life expectancy and disability. Activities around such measurements include the health care resources required for addressing them. The strategies outlined include interventional approaches, research activity and systems of health care delivery. The document does not outline any health workforce division of labour rather it focuses on the appropriateness of the service offered (Australian Institute of Health 2006, p. 5). An assumption could be made that the central point of care can be provided by the most appropriate practitioner. Therefore NPs, who are now legally and professionally part of the health care system can deliver care where clinical need is appropriate, as much as doctors and any other allied health professional can and do. In spite of the information provided in the document, the funding for health appears not to take cognisance of this. In order to understand the situation, the funding arrangements for health have to be examined.

Funding for health comes from both government and non-government sources and is driven by those determinants of health mentioned, and this encompasses the division of private and public health delivery. In Australia, 90% of the funding is still drawn

from either state or federal government sources despite the emergence of private health (Swerissen & Duckett 1997; Australian Institute of Health 2006). The Australian Federal Government provides most of the funding for services provided by general practitioners and medical specialists<sup>46</sup> and other professional services<sup>47</sup> that are covered or partly covered by Medicare, aged care services, pharmaceuticals which are covered or partly covered by the Pharmaceutical Benefits Scheme (PBS) and through Specific Purpose Payments (SPPs) to the states and territories. NPs, although legislated and endorsed to prescribe by state legislation, cannot access funding from Medicare, PBS or SPPs<sup>48</sup>. The Federal government, and state and territory governments, jointly fund public hospital services and this includes the contractual and employment arrangements of the health workforce (Swerissen & Duckett 1997; Australian Institute of Health 2006). Local governments finance some of the health services from their own general-purpose funds that are provided by state governments. It becomes difficult to determine who funds what in any particular health service, especially as their public reporting structure does not always outline the budget sources clearly (Australian Institute of Health 2006).

Reporting for health generally combines the funding so that when examining any hospital annual report the source of the funding is not always clear. Within the funding and reporting structure workforce is not delineated in detail, rather remains as nursing, allied health, medical and other. However new doctor services always get a mention as does new services or new major equipment. Such changes as introducing a new nursing specialist role like the NP do not get a mention, despite the fact that the trend for Australia in health care delivery is focusing on the provision of care by the most appropriate professional (Australian Institute of Health 2006; Roxon 2008). On examination of 17 annual reports, nurses (not nursing) were featured in the context of new technical or departmental innovations such as the installation of a new MRI scanner, or the expansion of a department. Faces of nurses were portrayed as symbols, in such examples as nurses dressed in operating theatre attire, or a nurse holding new equipment.

---

<sup>46</sup> Medical specialists are those doctors who have specialised in a particular health discipline for example cardiology, orthopaedics or oncology.

<sup>47</sup> Other professional services include examples such as physiotherapy, occupational health or psychology services that provide fee for service to the public. Nurses are not included in this list.

<sup>48</sup> Medicare, PBS and SPP are examined in more detail in Chapter 7.



**Figure 6 ‘Cardiothoracic Surgery’ Division of Surgery (Princess Alexandra Hospital Annual Report 2006 – 07, p. 33)**



**Figure 7 ‘Health Hearing Priority’, (Mater Annual Review 2006, p. 21)**

The actual content of the reports around these images outline future directions for the hospital, innovation, reduction in hospital bed days, re-admission rates and other similar cost reducing activities. Nowhere did they talk of new models of care which would involve the introduction of this new clinical specialist called the NP, despite evidence to suggest that NPs can support cost reductions and effectiveness in service delivery (Ahrens & Padwojski 1990; Dahle et al. 1998; Armstrong 1999; Cooper et al. 2002; Allen & Fabri 2005). One annual report complied with the Australian Health (2006) report by saying that one of their objectives was in “strategic workforce planning to get the right skills in the right place at the right time” (Report 5, p. 36) however the NP role was not mentioned. There was one reference to NPs being part of a workforce project,



During 2006-07 (area health service) has also made some significant workforce enhancements across the Area Health Service. These include the appointment of additional medical officers under (area health service) Specialist Services Plan for the disciplines of mental health, surgery, paediatrics, gastroenterology, and obstetrics and gynaecology, the appointment of additional district medical officers and the recruitment of additional allied health staff. The introduction of the role of nurse practitioners has also been advanced as well as the ongoing work for the nursing workload project (Report 12, p. 6).

The NP role is considered in the context of nursing, not as a specialist within services. If NPs were really the leaders or specialists of clinical practice as suggested by the ANMC, it would be appropriate to be reading about NPs in this report under their heading of “Specialist Services Plan” and this was not the case. The same report had one paragraph relating to the recruitment of NPs,

Seventy-three sites across (area health service) have been designated nurse practitioner sites for emergency care. Appointments for nurse practitioners will commence by mid-2007 with up to 25 nurse practitioners appointed by mid 2008. Scholarships are being implemented to increase the number of nurse practitioners available for recruitment. In addition, 14 scholarships have been made available to mental health nurses to complete specific mental health nurse practitioner training (Report 12, p. 54).

Although this superficially reports the NP role it does so within the traditional view of nursing. The reference to “training” rather than “education” in this excerpt reinforces the view of nursing, even at NP level being a vocation and not a profession, and certainly not a specialist in health care delivery. At the time of writing this chapter, there was no evidence to suggest that this health service had met even a fraction of their goal of 25 NPs by mid 2008. In cases such as this, there would have been funding allocated to this project from state departments. The actual outcomes of this activity revolves around budget allocation to services involved in the project which is not always clearly identified.

Although hospital financial reports are provided to the general public and are easily accessible on the World Wide Web, the financial reporting is of a general nature and does not provide the finer detail or the complexity of the financial spreadsheet or accountabilities. The complex funding arrangements do however, become important when trying to make sense of who really has the responsibility for developing new

roles such as NPs. When reviewing the hospital annual reports, the NP as a new and innovative role providing opportunities to different and perhaps cost effective models of care is not evident. Given that hospitals are driven by cost containment, yet the development of the NP role as a means to obtain this is not evident. It suggests a hegemonic struggle in which the central discourses remain influenced by medical dominance rather than financial savings, despite the overt financial focus to reports. This is also in spite of research that is emerging indicating that NPs provide a good cost effective and alternative model of care (Ahrens & Padwojski 1990; Dahle et al. 1998; Cooper et al. 2002; Allen & Fabri 2005; Kinnersley et al. 2005; Kirkwood et al. 2005; Ettner et al. 2006). Notwithstanding all the checks and balances in place for NPs to progress through state legislation, the ANMC's competency framework for the development of the NPs and the NMRAs processes for endorsement, NPs are not actively promoted as a part of the health care system. This hegemony is further reinforced when examining the processes for employment of NPs.

### ***The Employment Conundrum***

The individual hospitals and health services are responsible for the employment of NPs. One would assume that with the competencies, the endorsement processes and the legislation in place, it would simply be a matter of managing the human resource element of recruitment much like any other new position within the hospital service. When examining the data relating to NP employment, this was clearly not the case. NPs being interviewed for this study related a convoluted process of role establishment and employment. This entailed the writing of a business case, the development of clinical practice guidelines<sup>49</sup> (CPG), the setting up of interdisciplinary team committees to manage development and the construction of a job description and scope of practice. All this had to have been achieved before the individual NP could even apply for employment into the position. Many times, this work was initiated by the individual wishing to become a NP rather than the organisations wanting to employ a NP. These approaches to NP employment seemed

---

<sup>49</sup> Clinical practice guidelines (CPG) are used in health to provide information on a particular clinical presentation; for assessment, diagnosis and the provision of a standardised treatment plan for the presentation. The relationship between CPGs and NPs is discussed further in Chapter 7.

excessive in the light of usual human resource approaches to establishment of new roles and recruitment of staff<sup>50</sup>.

I undertook a random World Wide Web search of Australian hospitals for information that may lead me to understand human resource processes peculiar to NPs and also any information relating to the creation of new positions. What I found was standard human resource management practice. If there is a vacancy the health service follows the standard recruitment and induction processes. This includes all vacancies from doctors to support staff such as cleaners. Where specialist doctors are contracted through a fee-for-service arrangement to the hospital rather than being employed into a salaried position, it is done through checking the credentials of the doctor, through negotiation of the financial arrangement and by agreeing on a period of tenure. Nowhere was there an indication that other health professionals were required to undertake those processes expected of NPs. It could be argued that the NP process of employment contravenes the Equal Employment Opportunity Act<sup>51</sup> that each state in Australia has enacted. It can be contended that this exclusive process for the employment of NPs forms the control over what nurses can or cannot do when moving outside the accepted discourses of nursing. The impression is supported by Foucault's comments of power being more effective when it is hidden as a part of the institutional processes. Such powers then become difficult to challenge because they are no longer overt through direct obstruction to a change such as that with the employment of NPs (Foucault 1978; Danaher et al. 2000). They are instead the use of the processes of the system to slow down change or put bureaucratic hoops in front of those undertaking the processes. Joe outlined this when relating his journey to employment as a NP,

*... once you have finished your approved masters program, the nurses board automatically registered you there is no presentations or portfolios or you know panel interviews or any of the sort of thing however you cannot practice as a NP unless you are working in a designated authorised area which is a separate process and that's where the health service has to present a business case to the health department and the business case needs a look at the scope of practice, the risk management strategies, the KPIs the clinical practice protocols and all that and once the health department has signed off on that the health service can employ a*

---

<sup>50</sup> Employment processes in health care follow a set pattern of recruitment and induction practices. Where new positions are established, they do not require the prospective incumbent to manage or co-ordinate role development and implementation.

<sup>51</sup> Each state and territory in Australia has its own Equal Employment Opportunity Act.

*NP ...and then once you are employed in a designated area you can practice and exercise the right you have under the legislation (Joe, Interview 3, p. 1).*

Clearly, the process that Joe had to follow went beyond a routine human resource recruitment process, and it also demanded expectations far beyond that which any specialist doctor is required to undergo for a contractual fee-for-service arrangement as well. If we consider that the NP is merely another step on a nursing clinical career pathway, then the extreme demands placed on developing the role becomes suggestive of a discourse emerging within the local organisational sector, which is actively opposing it. On the other hand, if we view the NP as a specialist role in nursing, much like the specialist doctor, then one would have expected a process similar to that which specialist doctors undergo when arranging a contractual agreement with a health service.

The unique employment process is further endorsed by my own field notes in the various positions I have held at different hospitals. By asking individuals at NP conferences, this aspect has also been endorsed. All conversations lead to the same conclusion of an exclusive and exhaustive process for NP employment (Field Note 10). In the hospital in which I worked at the time of conducting the interviews for this study, NPs were required to work as a NP candidate, during which time a project was set up to develop the position. This activity generally took 12 months, during which time the NP candidate prepared for the endorsement process and, with the support of a designated project officer, developed the job description, the clinical practice guidelines and the scope of the position. The final outcome of the project and the decision to establish the role was dependant on funding allocation and an ability to maintain a financial status quo, rather than the real clinical value of the position. The NP position was not extra to the staffing roster; it replaced another role, usually a RN position on the staff budget (Field Note 7)<sup>52</sup>. The extended and convoluted approaches to NP development are not confined to the hospitals alone. They are supported by policy evidenced in NMRAs and state health processes as well.

Exhaustive endorsement and role implementation processes can be demonstrated in all states and territories. All have similar processes which include all or some of the

---

<sup>52</sup> This is discussed further in Chapter 7

following activities either individually or in combination with the NMRA endorsement process,

- Professional portfolio
- Business case which in some instances has to be signed as approved by the employer, whilst some boards ask for a letter of support from the employer.
- Formulary of drugs that the NP will use in daily practice
- Job description
- Clinical Practice Guidelines
- Evidence of education and ongoing learning
- Case studies
- Clinical viva with a panel which included a nurse, doctor and pharmacist

On the surface, these requirements do not seem much, until they are examined further. The amount of preparation and work to put this application together was considerable. For example, the Western Australian (WA) NP guidelines consisted of a detailed and very comprehensive outline of what was expected in terms of developing the business case and clinical practice guidelines (Western Australia Government 2003). The work and preparation to collate the requirements from this document was significant and would have taken a considerable amount of time, research and effort for the individual to develop. From my field notes (Field note 9), nurses have said that the final document for these submissions exceed 90000 words (similar to a larger size PhD thesis in the Australian setting). As if the actual process was not enough, the outline from WA had this paragraph at the beginning of the document,

The template contains sections which must be included in the application however, additional information to assist the Director General of Health to consider the application may be incorporated. It is important to note that the application including the business case and clinical protocols must be signed off by the most senior officer of the health service/organisation (Western Australia Government 2003, p. 3).

In addition to the required information, other information may have been required to be included, in order to convince the assessors of the worth of the position and the person; and this was in addition to the master's degree that NPs were required to successfully complete, the endorsement process individuals were required to achieve, and the legislation that each state has for the practice of NPs.

WA is not the only state where individual NP positions are endorsed by the Director General of Health. NSW, SA and Victoria have similar requirements, so that NPs cannot just be employed according to local need, they have to have the endorsement of the highest authority in the state in the health care bureaucracy. It remains a conundrum then as to why NPs have to jump through so many hoops to become employed, whereas nowhere else could I find anything that remotely resembled this process with other health professional role establishment or employment. As if to add insult to injury, Joe described his experiences in more detail,

*...part of my designation process I had to establish a reference committee within the hospital so all the key stakeholders had to be represented and part of their role was to review and authorise my CPGs... Yeah I had to do everything... write the business case, write my CPGs, organise and run the reference committee, convene the meetings... (Joe, Interview 3, p. 4)*

Not only did he have to prove himself to the state hierarchy, Joe also had to drive the process for role establishment in his hospital before he could officially be employed as a NP; yet he had been endorsed by the state NMRA as a NP some time earlier. It must also be highlighted that these nurses were rostered onto clinical shifts. Much of this work was done in their own time or by limited project time allocations. Jane related similar experiences to Joe when she outlined how the whole process of NP development in her hospital was not well co-ordinated and in fact, there was little leadership from her nursing superiors, or processes that supported new role development,

*It [the business case] has gone into the Nursing Director at the beginning of the year and it's still going around and about<sup>53</sup>. You have to contain clinical protocols<sup>54</sup>, in order to get the area designated and to have the appointment approved. That is very difficult, there isn't actually a committee set up, which could be very beneficial if there was one committee with people from pharmacy, microbiology, radiology, they had a representatives where any of these policies could go direct to that group of people, what is happening you are having to identify individuals each time, so there are Nurse Practitioners in accident and emergency here that have used a completely different group of people, because of the committees with different staff, it is just that the process is long and drawn out (Jane, Interview 2, p. 5).*

---

<sup>53</sup> The business case had been submitted 11 months prior to the interview taking place.

<sup>54</sup> This participant uses the term clinical protocols instead of clinical practice guidelines. The interchange of these terms is becoming alarmingly consistent in policy documents of some states as well.

Some participants were employed as a NP candidate as part of a pilot project which was funded by state governments, however, once the project funding was terminated, the participants found themselves doing other jobs despite working hard in the project to develop their NP role. The NP candidate position funded by the project either reverted back to the original position of the incumbent or was adapted to become a CNC or CNS position, rather than continuing the work that had commenced in the project,

*Well the pilot project was completed in June of last year and I helped the organisation to write the mission for the new contract, this is the transition care unit, but by then, I'd had enough, and I guess I was aware that it was going to be a continuation of the same with a primarily administrative role, and I really didn't want that (Amy, Interview 4, p. 4).*

Although Amy was supported by a national project, the local organisation chose to change it to what they required, rather than what the funding was designed to do, in developing a NP role. Not only was the national leadership undermined, but so was the NP leadership in enhancing health outcomes in a particular context of care, as recommended by the ANMC NP Competencies. According to Fairclough (2001b, p.40) this is an example of “gatekeeping” where socially dominant groups control a valued objective by manipulating the content of what is said and done in a way that social relations within the organisation believe that, as in Amy’s case the role described should be an administrative one rather than a clinical one, despite national directions suggesting otherwise.

Further examples of this can be found in my own field notes (Field Note 7), where project funding had been allocated by state government for the planning, implementation and evaluation of a position that worked between the emergency department (ED) and aged care facilities. It was identified that general practitioners<sup>55</sup> (GP) were overworked and were not attending to calls from aged care facilities. Sometimes it was a simple matter of a urinary tract infection which, if attended to in good time, would merely require a short course of antibiotics. Because of the clinical need to manage minor illness promptly in order to avoid complications, the aged care facilities were sending their residents to the ED for review and treatment, instead of waiting sometimes days for the GP to attend the patient in the facility. Being triaged

---

<sup>55</sup> General Practitioners are medical doctors in the community and are considered the first access to health care for the public and are the accepted as the providers of primary health care in the system.

at Category 5<sup>56</sup>, these elderly people not only had a considerable wait to see the doctor in ED as well, but were frequently left on an uncomfortable transport trolley for the duration of their ED stay. The project set in motion a call system in which the NP candidate in the ED not only reviewed the residents being sent to the ED, but also provided telephonic advice to the staff of the residential care facilities and reviewed the ill patients on site before any transfer to hospital was initiated. After 12 months of statistics that indicated that more residents were remaining in the aged care facilities rather than being sent to the ED, the project ceased with the termination of the funding allocation. The nurse concerned returned to her CNS position in the ED. It has recently been made known to me that this project, three years later, has been implemented not with a NP as the project suggested, but with a CNS who works under the orders of a Registrar in ED. What should be a single NP role that could provide a cost effective service, has effectively been blocked with the employment of a Registrar and a CNS to do the same job that one NP could have done effectively.

Amy supported this trend when she described how she had moved jobs because of the termination of the pilot project and the funding, and she was now working for another organisation, preparing and developing the NP role in that service. Although she described herself as happier and more secure, her conversations revealed that she was still working on contract, which could terminate at any time, based on funding and need. Her position demonstrates that whilst NPs are held out to be clinical and professional leaders, Amy was in control of neither aspect of her position,

*So, that's where I'm up to at the moment is I've finished the medication system review and that report is working its way through the system. My contract, short term contract was extended to the end of June, so June quarter I'll be working on the implementation of the recommendations for the medication system review and writing the business case proposal for the nurse practitioner position (Amy, Interview 4, p. 10).*

Amy was employed on a fixed term contract, which although this had been extended for her to continue the work she was doing, suggests that there was not the commitment from the organisation to actually employ a NP. Amy was no more able to demonstrate leadership and self governance than any other RN or project officer employed to complete a task.

---

<sup>56</sup> Triage Categories 1 – 5 are used in the assessment of patients admitted to an ED. Category 1 is the most severe requiring immediate attention, and Category 5 is the least urgent. Category 4 and 5 patients can wait up to 24 hours and more before being seen by a doctor.



Mary described similar experiences when she told me that she *got funded through a public health scholarship and, it wasn't written down, it wasn't on paper, but I managed to get one day a week or, but it was really how I managed my time* (Mary, Interview 1, p. 4). It was almost as if Mary had been awarded a scholarship by the state government, only to undertake a project that was not really significant or important to the service she was employed in, which, incidentally was funded by the same state government that awarded Mary her scholarship to develop the NP role in the first place. Foucault (1978) describes this as the use of power which now functions separately from that which originally authorised that power. In other words, power now functions in terms of relations between different fields and institutions within the state, driven by separate discourses driving the work a local level. The state itself no longer holds that power. It becomes the figurehead of that power through the players within it who perpetuate the status quo, because they no longer are directed to uphold the state as a supreme leader, but they now manage aspects of it through policy within the local institution (Foucault 1978; Rabinow 1997; Fairclough 2001b). These examples identify the reticence of organisations to embrace the NP position because, although the state has defined its support, those in power within the actual organisations have a different view. The dominance of a discourse, which is not supportive of NPs, is such that implementation processes do not meet with any organisational or equal employment opportunity processes that hospital human resource systems normally follow. A separate system outside any normal processes has been constructed in a way that marginalises NPs and sets them apart from, and by, the system within the organisation. This is augmented by the processes for endorsement which focuses on those extensions to medical practises.

The discourses that have emerged through text and conversations, has shown that in spite of the state, legislation and professional endorsement processes in place, there is a reticence to embrace the NP role. Such reticence demonstrates covert powers in operation, which prevent role implementation, despite all the legitimate and sanctioned support. Fairclough (2001b, p. 23) calls this “felicitous ambiguity”. Felicitous in the dictionary refers to “exhibiting an agreeably appropriate manner or style, well suited for the occasion” and ambiguity meaning “an expression whose meaning cannot be determined from its context” (Merriam-Webster 2008). Block (1993) contends that by the very nature of humans, our leaders are placed in a

function that others decide upon within an organisation. Leaders are thus restricted in what they can do so that desired results for change are not achieved often. The effect of this is localised authority and privilege that does not allow others to take ownership and responsibility for any vision for change that is promoted (Block 1993; Fairclough 2001b; Scollon 2001b). This is true of nurses with particular reference to the role of NPs. They are struggling against processes that hinder their attempts to succeed. Focusing power and purpose at one point within an organisation has, over time, the impact of destroying the culture and the very outcomes that were intended (Block 1993; Fairclough 2001b). The fact that nursing as a profession is focusing on promoting and implementing the NP, directly challenges the power base that is held by medicine in the health care system (Cockerham 1992; Clinton & Scheiwe 1998; Fairclough 2000; Dingwall & Allen 2001; Leonard 2003; Mumby & Clair 2004; Cameron & Thompson 2005).

On the one hand we have a senior nursing role that is enabled to influence and lead health (Australian Nursing and Midwifery Council 2006a) and on the other hand, the evidence suggests that this is far from the case, and that the NP is as much powerless as any other nurse in the health care system. The complex web of texts that are emerging around the NP role belies the belief in the NP as a self-directed professional and a leader in health care, such as that which is described by the ANMC. The traditional hierarchies and dominance of medicine is sustained by the organisations where nurses are attempting to implement this role. In this next section I examine the position of NPs as leaders where nursing, through the ANMC Competencies assert that NPs are leaders, but the concept of which is rhetoric only, because it is not demonstrated nor is it actively supported in the health care environment.

### ***Leader in Name Only***

The ANMC NP Competencies frequently use the word ‘leadership’ or ‘leader’ to describe the influence that NPs are to have on clinical practice. Although the ANMC NP Competencies do not use the word leadership in their definition of the NP, it outlines the leadership role in Standard 3 of the Competency Standards by saying,

Clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health service.

The nurse practitioner is a leader in all dimensions of nursing practice. This is not only the most senior clinical role, but a nurse practitioner also provides health service leadership from the perspective of a senior clinician. Key elements of clinical leadership are the need to guide and influence care delivery systems through engagement in policy development either directly at local organisation and local government level or through active engagement in the policy work of their professional organisation. The nurse practitioner leads through any of a number of roles including researcher, clinical teacher, case co-ordinator, and spokesperson, and in this capacity may take responsibility for assisting the public, policy makers and other health care professionals to understand the nurse practitioner role. In so doing they draw from the relevant evidence base to influence the quality and nature of services provided (Australian Nursing and Midwifery Council 2006a).

There are some immediate contradictions within this information. Firstly, NPs are “the most senior clinical nursing role” which suggests that their role is focused on clinical development only; however the Standard also suggests that the NP is also the leader in all dimensions of nursing practice which contends that NPs must become involved in, and influence other aspects of nursing practice such as education, research and management, as well as the practising of nursing. In the performance indicators relating to this Standard, NPs are informed that they should engage in “clinical collaboration that optimises outcomes for patients/clients/communities” which is different again from the notion of leader rather it is collaboration that suggests they work with a team, influencing directions but not necessarily leading them. The dictionary defining collaboration as “to work with another on a project and leading as showing the way, going ahead or directing” (Allen 1990, p. 93).

The ANMC NP Competencies describe NPs as leading through involvement in any number of roles including “researcher, clinical teacher, case co-ordinator and spokesperson”. This suggests then that NPs have significant workloads, not only in clinical practice but also in that which positions them as teacher and manager. Not only are the organisations exploiting NP skills as the previous chapters have uncovered, but the ANMC NP Competencies condone it. The final section of the Standard describes the NP undertaking these various leadership functions in order to “take responsibility for assisting the public, policy makers and other health care professionals to understand the nurse practitioner role”. This suggests that the real leadership role of the NP is point of care and professional, rather than as a role that actively develops strategies.

The point of care is reinforced in the Performance Indicators of Standard 3 which states that NPs must “actively participate[s] as a senior member and/or leader of the relevant multidisciplinary teams and establish[s] effective communication strategies that promote positive multidisciplinary clinical partnerships”. Communication strategies refer to the collaborative or participatory context of the role rather than a leadership one. The professional leadership is outlined in the next performance indicator of Standard 3, which begins by contradicting the previous performance indicators suggesting that NPs must engage in health strategy, but then outlines activities that involve, critiquing, evaluating and promoting the role of the NP, rather than being a health care strategist,

Competency 3.2 - Engages in and leads informed critique and influence at the systems level of health care

Performance indicators

- Critiques the implication of emerging health policy on the nurse practitioner role and the client population
- Evaluates the impact of social factors (such as literacy, poverty, domestic violence and racial attitudes) on the health of individuals and communities and acts to moderate the influence of these factors on the specific population/individual
- Maintains current knowledge of financing of the health care system as it affects delivery of care
- Influences health care policy and practice through leadership and active participation in workplace and professional organisations and at state and national government levels
- Actively contributes to and advocates for the development of specialist, local and national, health service policy that enhances nurse practitioner practice and the health of the community

(Australian Nursing and Midwifery Council 2006a)

Verbs such as, “critiques, contributes, evaluates” focus on evaluation rather than leading health care. The notion of influencing “health care policy and practice through leadership and active participation in workplace and professional organisations and at state and national government levels” is rhetorical when examining the experiences of the participants for this study. They have shown that they are unable to influence their own employment as a NP without overcoming significant organisational hurdles first. The ANMC NP Competencies also suggest that NPs are clinical leaders who collaborate with other health care providers in order to achieve effective clinical outcomes and to promote the role of the NP. Leadership therefore is contained within the notion of collaboration and communication of professional and clinical directions and evaluation of these aspects rather than

leading them. Collaborative activities of the NP also provide advice to all “levels of government” but they do not lead those policy directions.

This idea of leadership therefore becomes confused, because, as discussed in the previous chapter, NPs, according to the ANMC NP definition are ‘autonomous’, are ‘accountable’ and practice in ‘advanced’ and ‘extended’ settings. These terms are used to describe self governance (autonomy), and leadership in the nursing context by the ANMC. At the same time, state legislation through their Nurses Acts/Health Professionals Acts, refer only to NPs’ medical clinical extensions to practice and not to any leadership aspect of the role (Nurses Act Queensland 1992; Nurse Amendment Act (Nurse Practitioner) 1998; Nurses Act 2004). Therefore, if NPs cannot lead the clinical team in establishing the NP role because of the hurdles they face within the system, who then is leading the way in changing models of care?

If the nursing hierarchy and professional career pathway is examined, NPs and Directors of Nursing<sup>57</sup> (DON) are essentially the two roles in an organisation that should, by description, have the authority to develop new clinical nursing roles such as the NP. DONs are supposed to lead nursing as well as manage the operational and financial components of the service or department. They therefore provide the structure, standards and leadership in any new role or service development. Yet, participants in this study related hurdles in organisational systems by which nursing managers control NPs. This could be, part of the organisational control where DONs lead in name only and do not appear to have any authority to develop nursing roles like NPs. The extent to which DONs were perceived as unsupportive of NP development emerged in the interviews.

### ***You Need to Bleed Some More***

When examining the conversations of the participants, the importance of leadership and NPs’ need for the support from nursing management became evident but which was also not forthcoming. In fact participants related the obtrusive and sometimes indiscernible role that the nurse managers had when directing or guiding NP development. These actions affected NPs’ ability to proceed with the formal role establishment process. Frequently participants related their disappointment at how

---

<sup>57</sup> DON is a nurse manager who is in charge of a health service. In the context of this study, DONs include nursing managers at all levels of the organisation.

ineffectual DONs were in this process. Mary described how the nursing managers responded to her needs as a NP candidate,

*Well when I started the course there wasn't going to be a job for me anyway. A bit mixed actually, the managers were absolutely um ...not very happy um... about it um... about it most of my opposition came from the director of nursing um and the next level down. When I first started I was actually a manager of the department and we had a rotational manager position in the department and they, I was actually a manager and um I...you know ...we had a NP steering group when the course first started and they went from saying ah yeah, yeah, we can support you, .and this will keep you happy, um what's the word I am looking for um... it was just um we do not really support this NP....and you will we really prepared for this??...but, what my manager said to me when I was doing the course...um I was a level 3 manager and my manager was a level 4 who was really next in line to the director of nursing um she said that NP would only be north of the 25<sup>th</sup> parallel ...which is basically remote area nursing and you may find a job there and she was very derogatory ... very, very unsupportive (Mary, Interview 1, p. 5).*

Mary described a very isolating journey with no assistance or support from the organisation she worked for. She described the lack of support and total disrespect she endured from her manager. Joe also referred to the *nursing executive* not *providing support* whilst other participants displayed mixed views relating to professional and organisational impediments imposed upon them. As much as the content of conversation varied, it emerged as manifestations of the lack of support from the DON. For example,

*...my nursing director, you know my immediate boss...you know...she wants the service to succeed....but she has this belief that you succeed in your time ...you know ...you haven't bled enough...you need to bleed some more... (Joe, Interview 3, p. 4)*

When asked to expand on what sorts of things made him *bleed some more*, he stated,

*Well things like if I want to go to a conference...well, yes fine off you go but just make sure its in your own time...you know...those sorts of things.....um...you know...pressure to keep pushing out the KPIs and show that the service, you know...she's obviously got to prove from a financial perspective the service is valuable so there is a lot of pressure to demonstrate that I can compete with the residents in terms of productivity and be better at it than them, but you know I think that that senior nurses who have that role just don't get what it is ...they don't get what nurse practitioners do.....you know we are not in it to be competitive against the doctors we are in it to provide a more holistic service to patients.” (Joe, Interview 3, p. 6)*

Not only did he identify the competitive nature of evaluation between the doctor role and the NP role, but he was also expected to manage everything to do with the NP

implementation, with no provision of time allocation. It outlines the extent to which the local health services do not support NP role development. Nor was the DON's direction providing leadership or support to the emerging nursing role. Other activities reinforce the notion of the unsupportive DON,

*...I had a meeting with the director of nursing, he said "Yes, yes, we're going to look into it, we're doing this and that at the moment, we're doing some protocols and guidelines at the moment, yes, once we've finished it, we look into this, ...And then I went to the director, the managing director of the health services, I said 'How's the business case going?' he said 'What business case?'... 'Are you still keen on being a nurse practitioner?' (Cindy, Interview 6, p. 5)*

The same participant described how, despite the fact that she was an endorsed NP, she was essentially ignored by the DON in a workshop actually held by state government representatives visiting the health service to promote NPs in the workplace,

*And then the final straw, when someone from [the state department] actually tried to do some form of brain storming, they had all the managers one day and all the clinical nurses on the other day, looking at, how to improve health services...And this lady actually mentioned the nurse practitioner, trying to get people interested and so on and so forth, which is all really good, I mean, I've been trying to do that myself, ...Not once was I introduced to her, the whole management knew that I was registered [as a NP], not one person said 'Oh by the way we have one registered nurse'... not once was I introduced, not once was I told what's going on, ...I went and approached her at morning tea and she said 'Oh are you interested in doing the course?' and I said 'Well actually I'm registered'... 'Oh no one told me that' I said 'Oh that's okay' and she said 'Oh we can do so much and rah, rah, rah' and I just thought to myself, no, I don't think they're ready for us yet, this is so much muck around, it's the frustration of it, I feel like I'm talking to a brick wall all the time... (Cindy, Interview 6, p. 6)*

These examples present a discursive operation that both accepts and does not accept NPs. This is supportive of Fairclough's (2001b) theory of how discursive power operates. On the one hand, nurses are already authorised as NPs but not employed as such, keen to commence planning and implementation, with local management not supporting it, whilst the state governments continue to promote the role such as seen in the media release previously quoted in which the Minister for Health, Craig Knowles outlined the plan to expand NP employment (Perry, 2002).

Yet Cindy was confronted with phrases such as *are you still keen on being a Nurse Practitioner* when she was already authorised as such. It not only suggested a total

lack of support for role development by the DON, but also begins to identify differences in views between local (organisational) level and state level of government, even with the provision of state government funding to the local organisational health services for NP development. Whilst the participants for this study have targeted the DON as the object of obstruction, I suggest that we view them as employees operating in the same system that is constraining NPs. Neither of these roles has the authority to lead or direct change relating to role development or new models of care. They may have the title but they remain constrained by the hidden dominant discourses that prevent them from fulfilling the leadership potential.

### ***Nurses in Management – Puppets or Leaders?***

If NPs and DONs are constrained by hidden dominant discourses then we need to examine the alleged power that DONs are given in order to understand the discursive effect that NPs refer to. Although DONs have an assumed power by virtue of their position in health such comments as *...my director of nursing up there actually came to me and said straight to me, there is no role for nurse practitioners here and there never will be* (Sally, Interview 5, p. 4) suggest that either the DON was not interested in the role of NP, or the power held was a pseudo power with the DON being as much directed by those external to nursing as the NPs. It describes leaders in nursing as adopting the routine practice and position directed by more dominant discourses within which they are employed. The powerlessness that DONs portray through their perceived indifference towards NP development is as much a symptom of the hidden power constraining them as those experienced by NPs. Other authors have reflected on this sort of organisational behaviour as well. They outline the powerlessness of subservient groups even when they have the title that suggests autonomy and leadership (Weinberg 2003; Hoque et al 2004; Perron et al. 2005; Cooke 2006; Viitanen et al. 2007; Orrock & Lalwer 2008).

In a recent Australian study this pseudo power was clearly identified during one state's health restructure. It showed how nursing managers were totally ineffectual in leading change despite the very senior management roles they held. Many of those affected were well qualified to do the management job, holding both business and nursing degrees. Managers lost their jobs as a result of the change process, and those remaining in employment described personal and professional consequences that significantly affected both their psychological and physical wellbeing. Conversations



told of bullying, persecution and public humiliation by their superiors (Orrock & Lawler 2008) and examples of this are quoted as,

Not only did we find that the role of the senior nurse manager had been effectively deconstructed in a now contested and redefined health care system, but more disturbingly we uncovered common stories of dehumanising workplace abuse... (Orrock & Lawler 2008, p. 5)

Whilst Orrock and Lawler describe experiences of managers during a period of change, similar lack of control has been described in the routine activity of health service management processes<sup>58</sup>. Such authors as Hoque et al. (2004) have showed how managers were rewarded with what was considered earned autonomy based on their conformity to organisational performance indicators, which invariably were based on budget factors. The organisations concerned converted clinically focused roles into manager roles and gave the incumbents the responsibility of managing a budget, thereby providing them with a pseudo business unit in addition to their clinical responsibilities. This approach to management of health services is commonplace and most states in Australia adopt it as a routine activity. It is often undertaken without sufficient training in the business of managing a budget. Many of the nurse managers described by Orrock and Lawler would have experienced this as a new manager, only undertaking further education on their own volition rather than that required by the health service. This trend has been well described by recent research emerging out of the National Health Service changes in the UK (Bolton 2005; Cooke 2006). As Hoque et al. (2004) contended the myth then, was to ensure that managers were afforded autonomy but only on the organisation's terms, so they had all the responsibility of the budget with no real authority to manage it. This, Fineman (2004, p. 9) suggests, frees people through governmental structures which still control them in a way that employees think they have more autonomy but in fact, they do not. If the view held that nurses do not hold a dominant role in health care then the additional activities bestowed upon them does not change the fact that they remain a subservient workforce despite the organisationally declared autonomy in managing their work. It supports the idea that NPs and DONs are both products of a health care system that continues to 'give' autonomy to nurses with conditions attached. These conditions are directed by those who remain the traditional directors of health. Based on the evidence of text and conversation, the DON then is a

---

<sup>58</sup> Health service management is the common term used when referring to the management of health related business activities. Nurse Managers are frequently called Health Service Managers.

figurehead creating a paradoxical powerless/powerful position. It is powerful in controlling nurses on a clinical level but powerless to initiate strategic change in nursing or in models of care. NPs see DONs as being *up there* and not in touch with either clinical need or potential and actual professional (nursing) contributions to that care,

*... you know I think that that senior nurses who have that role just don't get what it is ...they don't get what nurse practitioners do.....you know we are not in it to be competitive against the doctors we are in it to provide a more holistic service to patients* (Joe, Interview 3, p. 6).

The actions of the DONs appeared to take the position of maintaining status quo of the organisation to the detriment of nursing progress and indeed the development of more cost effective models of care.

When I examined organisational charts from the annual reports that I reviewed on the World Wide Web, I found that not one DON was called this. Other titles included Private Hospital ICU Unit Leader or Clinical Support Services Leader. Advertisements in the newspapers supported this observation where managers (who were nurses) were termed clinical service co-ordinators.

**Nursing/Midwifery**

**CLINICAL SERVICE COORDINATOR**  
**Rogerson Operating Suite – Recovery/Anaesthetics Team, CYWHS**  
 – WCH campus  
**Indicative Total Remuneration: \$97,126 – \$101,406 – Perm F/T**  
**(rostered over 5 days) – RN3**

Rogerson Operating Suite Services requires a self directed motivated leader to provide pivotal coordination of patient care delivery within the Recovery/Anaesthetic service. Key responsibilities of this position include clinical leadership, fiscal and human resource management. The CSC is responsible for initiating evidence based practice changes, improving patient care outcomes and service provision and ensuring ACCORN/ANZCA guidelines are maintained. Job Ref: 2571

**NURSING CLINICAL SERVICE COORDINATOR**  
**Neonatal Intensive Care Unit and Neonatal Retrieval Service,**  
**CYWHS – WCH campus**  
**Indicative Total Remuneration: \$97,126 - \$101,406 – Perm F/T –**  
**RN3/RM3**

You'll coordinate patient care delivery within the Neonatal Intensive Care Unit (NICU) and the Neonatal Retrieval Service. Your main focus will be the line management, coordination and leadership of nursing team activities to achieve continuity and quality care to babies requiring neonatal intensive care. You'll have demonstrated competence in neonatal nursing practice and experience in leadership and management roles. Job Ref: 2641

**CLINICAL SERVICE COORDINATOR**  
**Rogerson Operating Theatre – Scrub/Scout Team, CYWHS –**  
**WCH campus**  
**Indicative Total Remuneration: \$97,126 - \$101,406 – Perm F/T – RN3**

Surgical Services requires a self directed motivated leader to provide pivotal coordination of patient care delivery in operating room service. Key responsibilities of this position include clinical leadership, fiscal and human resource management. The CSC is responsible for initiating evidence based practice changes to improve patient care outcomes and service provision and ensuring ACCORN standards are maintained. Job Ref: 2637

**CLINICAL SERVICE COORDINATOR**  
**Child and Family Health, CYWHS – Northern Metropolitan Region**  
**and Country South Region**  
**Indicative Total Remuneration: \$97,126.09 - \$101,405.53 –**  
**Perm F/T – RN/RM3**

With previous experience in a leadership and management role, you'll undertake pivotal coordination of a high standard of service delivery across a large geographical area within a community health setting. You'll have the proven ability to perform effectively under pressure and meet deadlines, whilst working independently under minimal supervision. Demonstrated experience in a leadership and management role is essential. Job Ref: 2724

**Phone 1300 882 992**

6 The Advertiser careerone.com.au Saturday, April 25, 2009

**Figure 8 Advertisements for nursing managers (Government of South Australia, 2009. The Advertiser, Saturday April 25, 2009)**

There were some hospitals that had a Chief Nursing Officer, but their portfolio included other departments such as acute services, pastoral care, patient transport and medical photography among a rather long list of portfolios. An example of this generic approach can be seen in the following organisational chart.

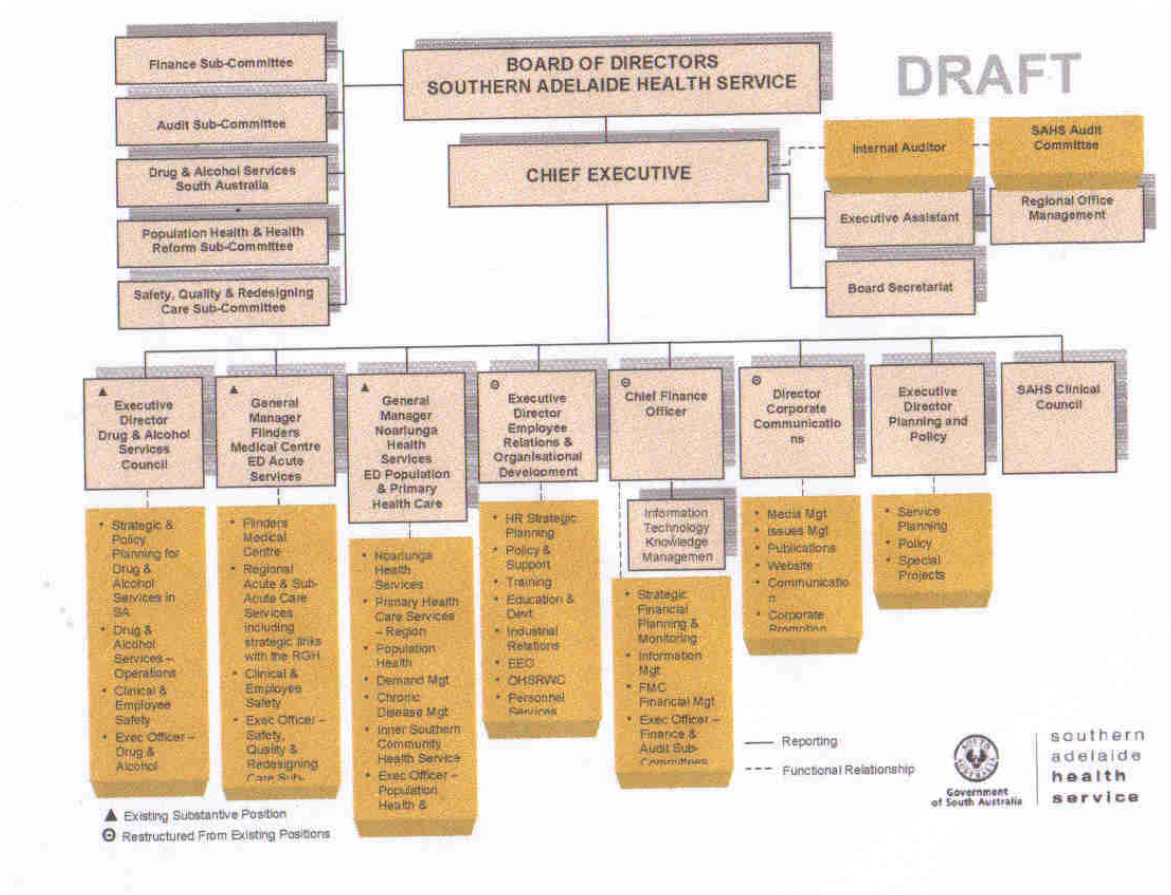


Figure 9 Organisational Chart Southern Health, accessed July 2009

The rationale for this structure was created under a similar approach to the rationalisation of services described by Orrock and Lawler (2008) which I refer to later. The aims of the new structure stated,

- It is lean and avoids duplication;
- Utilises the expertise within the region;
- Complementary to the Department of Health's reform agenda; and
- Creates a seamless regional approach to our leadership.

(Swann online, accessed July 2009)

Nursing does not feature in this structure at all, although it does not preclude nurse managers from applying for the jobs outlined. Other nursing executive jobs, although entitled as such, have very large and diverse management portfolios. In a recent advert for a regional Executive Director of Nursing, the information described a dynamic leader, "leading the nursing workforce and contributing to a strong executive team", the work of which included "general management, nursing strategy, workforce planning, quality and education, not to mention planning leadership and management to ensure the highest standards of care".

**BENDIGO HEALTH**  
Regional service, local care

*Bendigo Health is an equal opportunity employer*

## **Executive Director of Nursing (Chief Nursing and Midwifery Officer)**

**Bendigo Health Care Group**

- Regional leader and influencer of change
- Strong new strategic direction
- Be part of building our new hospital
- Competitive salary package

Covering a large area of country Victoria, this health service has a reputation for providing high level integrated acute, aged, rehabilitation, psychiatric and community support services through a multi-campus environment. It is a challenging and stimulating professional environment.

This is an exciting time for Bendigo Health. We will be building history with the development of a new major regional teaching hospital servicing the needs of the communities of Bendigo and North West Victoria. We also have a new and exciting Strategic Plan launched in 2008 with a focus on enhancing service; enabling people; achieving sustainability; building leadership; developing partnerships; improving quality and supporting education.

The Executive Director of Nursing will be leading a nursing workforce of around 1500 and is expected to be a key contributing member of a strong executive team reporting to the CEO. This is an opportunity to make a difference to our communities through our re-development and the implementation of the new strategy. Currently the role also manages a significant operational division of the Group. It includes responsibility for Surgical Services, Women's Health & CHERC. Some aspects of the role are currently under review but we expect the role will continue to have significant operational responsibilities in addition to Nursing.

The Nursing role centres on general management, nursing strategy, workforce planning, quality and education, and providing the planning, leadership and management needed to ensure the highest standards of care so that nursing services meet stakeholders needs in a changing and challenging health environment.

Relevant nursing qualifications are essential. Experience as a Director of Nursing, preferably in Victoria, is important and we're after a professional who has influenced direction rather than just managed a status quo operation. Experience in a complex public referral or teaching hospital is sought.

Applicants with an interest in academia will find a close working relationship with the Bendigo campus of LaTrobe University and an opportunity could exist for a professorial appointment for an applicant with the appropriate credentials.

**Figure 10 Advertisement (The Weekend Australian 2009, p. 14)**

The advert suggested that this role of executive director could also become a professional chair with a local university. The portfolio for the position is considerable and would be a challenge to manage all aspects of it effectively. By creating such a large portfolio, it could be argued that the role of DON in this case, is rendered ineffectual and therefore not a threat to the existing status quo of hospital management and operational strategy.

Whilst the notion of powerlessness of DONs does not in itself identify the power behind the institution, Fairclough (2001b) suggests that activities such as this appear as a symptom of that power, and the position that DONs take, forms part of what Foucault (1972) calls 'truth games' being played. In this situation the hidden power

uses the concept of 'management' represented in this case by the DON, to perpetuate the operations of powerful discourses.

This chapter has outlined the powerlessness of nursing leaders in a health care system that has not allowed it to develop within the same rules of the game that human resource activities provide for the other professional disciplines employed in health care. We have seen discursive activities that give nurses pseudo power within the system governed by politics and economical indicators which support Fairclough's theory of power hidden using the orders of social discourse in order to maintain it. Fairclough (2001b) says that this power is maintained through the "constraints on access based on formality" (p. 54). Formality, Fairclough (2001b, p. 54) says, "is best regarded as a property of social situations which has peculiar effects upon language forms...with restricted access" created by those with "high social prestige". It creates an environment based on management practices, and then takes clinically adept professionals and puts them into exclusive management roles driven by different discourses to that of the clinical practices. It creates an imbalance in the ability of those employed into these roles, to effectively practice within an environment which has a different frame of reference and a different set of rules. The new set of formalities created by the management process challenges the values and beliefs of nurses as experts in the science of health because they can no longer speak the same language that they are familiar with. This, Fairclough (p. 54) says, imposes "constraints on practice associated with the exercise of power" which impedes a manager's capacity to exercise control on "practice, subjects and relations", thus maintaining the dominant discourse. Orrack and Lawler (2008, p. 1) support this position when they say that,

...current health services management ideology represents an intrusion into, if not a challenge to, the values and beliefs of professional nursing and that this has the effect of placing senior nurse managers in the nexus of conflicting ideologies.

In the chapter 7, I focus the pseudo power in health and the real power that exists. I also examine the role that media plays in reinforcing the dominant discourse. I examine the acts with reference to their constraints on NP practice and so I draw in all levels of Fairclough's social organisation that is used as the framework for this study, so that the large political economy of health is described.

## Chapter 7 – The Corkscrew Path: The Political Economy of Health

I should see the garden far better,' said Alice to herself, 'if I could get to the top of that hill: and here's a path that leads straight to it -- at least, no, it doesn't do that -- ' (after going a few yards along the path, and turning several sharp corners), 'but I suppose it will at last. But how curiously it twists! It's more like a corkscrew than a path! Well, this turn goes to the hill, I suppose -- no, it doesn't! This goes straight back to the house! Well then, I'll try it the other way.'" (Lewis Carroll in Alice through the Looking Glass in Oxenbury 2005, p. 33)

It is well known that doctors maintain power relations in a health system to their benefit and with this power they have traditionally directed the focus of that system (Etzioni 1969; Friedson 1971; Dolan et al. 1983; Friedson 1994; Buresh & Gordon 2000). Although the DON's approach to NPs has been examined in the previous chapter, the position they take within what is the traditional discourse in health needs to be examined further. Despite the states' legislation supporting NPs, it can be contended that NPs will not have a straightforward or easy path to development until the transitional balance of power shifts in a way that they are acknowledged as an integral part of the health care workforce.

From the early 19<sup>th</sup> century, doctors have controlled health care delivery both in structure and policy and nurses have been seen as the dedicated and virtuous public servant (Dolan et al. 1983; Friedson 1994; Chiarella 2002). Nurses, even in the contemporary environment, have worked around the system, playing the professional games that are well documented around the relationships between doctors and nurses (Friedson 1971; Cockerham 1992; Friedson 1994; Dingwall & Allen 2001; Copnell & Bruni 2005). This was also demonstrated in the conversations by participants of this study in how they position themselves, view themselves, and in what they have experienced with the change processes, all this harkens back to the state of play during the Nightingale era. Nightingale attempted to change the system in the hospitals in the Crimea, where she was met with considerable resistance by those with power, the doctors, rather than those in power, the state, who had given her the authority to change the way care was delivered to soldiers fighting in the war (Dolan et al. 1983).

Although portrayed as a leader of her time, Nightingale, as a chief of care, met with resistance from those with power despite the fact that she represented the system in power. By developing a process for nursing, Nightingale positioned herself in such a way that she achieved changes to care and to the status of nursing but never lost the shackles of the effects of particularly powerful discourses (Dolan et al. 1983; Nelson & Gordon 2004; Gordon & Nelson 2005). Nightingale had effectively positioned nursing, not as an autonomous professional but as a subordinate worker to the doctor. In this Nightingale system, the nurses as ‘chief of care’, as DONs, remained dependants of the doctor as ‘superintendent’<sup>59</sup>. So although much was achieved in progressing nursing as a profession, much was also kept the same, with the stereotypical portrayal of nurses as guardian angels, lady of the lamp and virtuous carers perpetuated (Gordon & Nelson 2005).

The Nightingale system of nursing has prevailed across the western countries many of which were former British Colonies. It still has an influence on contemporary nursing. Like our predecessors, NPs have been enabled whilst being constrained within a system ruled by those with power and not those in power. The conversations initiated by the NPs being interviewed for this study, outlined experiences, which reflect the opinion that the DONs position themselves in a way that allows the profession to move forward, whilst simultaneously constraining it. Their actions suggest that they do not have the power that their role as manager of nursing asserts. Joe reflected this when he said,

*I guess the things that I would like to see done differently, but its out of my scope of influence, so you know its about support in that role, its about getting the nursing executive to have a better understanding of the nurse practitioners ...um they have this belief that it is just a cost saving exercise and its about nurses taking over the world and it's like they just don't get it... (Joe, Interview 3, p. 6)*

Discussions from participants in Chapter 6 have provided evidence to support this view. NPs are being positioned within a service in a way that maintains the status quo and the hegemony. Not only are DONs conforming to the budgetary line in their discourses, but they are also supporting the traditional and hierarchical Nightingale system. Doctors are still chosen above NPs to do work that could be done by NPs.

---

<sup>59</sup> Superintendents were medical doctors who were in charge of hospitals. Nurses were managed by matrons, who in turn, answered to the superintendent. This was a traditionally accepted structure from Nightingale times to around 1980 when hospitals shifted from services to business units.



Although budget has been cited as the restrainer to prevent NPs from progressing much of the health care budget is spent on doctors who remain more expensive than NPs.

### ***Penny Wise and Pound Foolish***

An example of preference to doctors over NPs was provided from a rural facility, where doctors are on call for the emergency department (ED). Doctors for the after hours roster were drawn from a major tertiary hospital which was a mere 50kms away and which also had a 24/7 retrieval team<sup>60</sup>. Back in the rural ED, doctors on call had a remuneration package of \$700.00 per week night and \$900.00 per weekend night, which was additional to their normal employment and pay package. The doctors slept on the premises and were only called by the RN on duty if it was deemed clinically necessary. Most of the call consisted of triage 3, 4 and 5 categories which could have been dealt with by the NP. In this case a NP could have cost the service \$1.50 per hour extra from the RN salary scale, a difference of around \$650.00 per night in cost savings. In reviewing trends it was noted that the number of emergencies requiring advanced life support was not significant. Despite the cost constrained environment of rural facilities, the service declined to review the skill mix and roster. The suggestion made was that the service reviews the clinical presentations after hours to the ED in order to plan a roster mixed with NPs and doctors, based on the retrospective trends of admissions, which would have created significant cost savings. The service could have used the retrieval team from the tertiary hospital like other country services do if required for more serious presentations. At the time of writing this had not been done, despite having an endorsed NP working as a CNS in their ED<sup>61</sup> (Field Note 12). Although NPs are declared as a cost effective solution to an ever upward spiraling health budget, there is evidence that services choose to pay for doctors to avoid the introduction of NPs. In defense of maintaining doctors in an ED facility, at great cost, the AMA have stated that substituting doctors would reduce the quality of the health service (Australian Medical Association 2005c). This suggests that NPs are a second rate option despite the fact that the measurement, the control and the evaluation of NPs

---

<sup>60</sup> Retrieval teams consist of a doctor specialised in trauma and emergency management, and critical care nurses. They are on call 24 hours a day and fly out to stabilise and transport patients to the tertiary health facility for further care.

<sup>61</sup> The nurse in question has left the nursing profession altogether because of the extreme difficulties she faced in preparing for, and developing, the NP role. It included harassment and workplace bullying by nurse managers related to their aversion towards the NP role.

has indicated that this is not the case. International research findings have shown that NP performance outcomes have consistently met the measurements against medical criteria, financial criteria as well as from satisfaction surveys of clients and organisations that stress positive outcomes on all associated events (Hill et al. 1994; Dahle et al. 1998; Allen & Fabri 2005; Ettner et al. 2006).

With the evidence on favourable NP performance, and with the checks and balances in place, in the form of the legislation, the ANMC NP Competencies, CPGs and key performance indicators, it could be argued that there are sufficient controls on NPs to deem them safe to practice in Australia. Yet, the health services continue to be penny wise and pound foolish, choosing to ignore the opportunity that the NP role presents, by instead, maintaining, supporting and perpetuating the status quo of health care management and division of labour, even at considerable increase in costs to the public health system, and therefore, the public tax dollar. Not only is the NP slave to professional control and tradition, but they are also a commodity in a business driven system largely dictated to by medicine.

The paradox for examination however, is that although medicine appears to have control over the current financially driven health system, they are no longer in their former positions as superintendents and therefore do not appear to have the legitimate power to make organisational and financial decisions. This role has been superseded by Chief Financial Officer (CFO) who decides how the funding will be allocated. Yet, health services and the management of them still revolve around the doctor who remains the central figure around which health dollars revolve, despite the plea for health policy to seek more cost effective ways to deliver care than currently exists, in a constrained health budget. Doctors, at \$650 per night extra are still being employed instead of using the considerably less expensive NP to do the same job.

### ***Medical Apartheid***

It was at this point in my data analysis that I questioned why, if doctors are no longer in power, do they still have so much power? If CFOs are now in charge of the hospital fiscal management, why is it that NPs, as a cheaper alternative are not being employed, when the battle cry is to seek less expensive options to care delivery? Contained within this inquiry were the questions around the fact that DONs do not

support or advocate for the development of NPs. Despite the reticence of DONs and health services to change models of care for any approaches that offer cost effectiveness, Nicola Roxon, the current federal Minister for Health recently supported change by saying that,

...without change, Australian Government spending on health is projected to almost double as a proportion of GDP over the next forty years, with spending on medicines projected to grow the fastest of all health factors (Roxon 2008, p. 4).

In the 1980's, Australia moved from the conventional government service to the business unit. Medical Superintendents were replaced with the CFOs. Many of the CFOs then, and still are today, employed for their financial ability and not for the knowledge of the health care system. The orientation and induction of CFOs into the workplace is largely conducted by the medical superintendent<sup>62</sup>. This is still the case today, where orientation is conducted by the chief medical officer (CMO) in an organisation. For example, in one hospital recently the new CFO had previously worked in an organisation for a local water management organisation. With no health care experience, the CFO had to learn the culture and business of health from someone. In this case it was the CMO who was the head of the medical services (Field note 13). This means that the traditional power of the doctor is perpetuated and the power behind the accepted health service discourses remain the doctor.

The Australian hospital funding is also doctor centric, based on a supply model rather than a demand model, and so hospitals are funded on the episodes of care that a doctor can provide for in the service (Clinton & Scheiwe 1998; Bloom 2000; Eriksen 2001). For example, acute care is funded in case weights. It is a financial model that reimburses the cost of patient care based on the type and mix of patients treated by a hospital. It is ascertained from specific inpatient data collected by hospitals and correlated by state governments, from which financial reimbursement is provided by applying the funding formula principles to each inpatient episode based on annual data provided by the hospital. The central person in the management of care is the doctor, so hospitals can only provide the service if they have the doctors to do the work, in other words the doctors are the suppliers, without whom

---

<sup>62</sup> Medical superintendents are now called chief medical officers. Although the hierarchical system is flattened in contemporary health care structures, chief medical officers still tend to enjoy a superior position, not only in relation to clinical issues, but also in the general operational aspects of modern hospitals.

the hospital could not attract the funding under the present system (Gardner 1998; Australian Federal Government 2009b). Therefore, if one were to argue that a NP clinic, for example in diabetes management, was to be implemented, this could not attract funding on its own and therefore could not be implemented and funded without being embedded within the service provision from a doctor<sup>63</sup>. So nurses therefore are users of funds whilst doctors are the suppliers of funds, which is one reason why NPs are struggling to get established in the system. Roxon put this situation very succinctly,

There is a longstanding historical 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, p. 7)

This “longstanding anomaly” has become the norm in the general public perception as much as it is the central point around which funding for health services is managed. It is also supported and encouraged by the media.

Following the employment of the first NP, a newspaper ran an article entitled “Super Nurses Make History” in which the NP role was portrayed as “super” with “new power to undertake activities that are normally the domain of doctors” (Papadakis & Haberfield 2003). Although it is not portrayed as a guardian angel, the notion “super nurse” does draw consideration to similar concepts. It also challenges the existing status quo of the health system in which nurses are the subservient workforce and doctors traditionally, are dominant. By saying that NPs will do some of the work of doctors, directly challenges the status quo and so, according to Fariclough (2001b) the struggle between powers is set. The work referred to also cannot be fulfilled under the current health service funding arrangements, despite the future directions this government is suggesting. Doctors reacted to the article by saying that,

They [Australian Medical Association] were particularly worried about allowing nurses to order diagnostic tests and prescribe drugs – the corner stone of general practice (Papadakis & Haberfield 2003)

---

<sup>63</sup> The Rudd Government (2009) appears to be putting in place steps to reduce this discrepancy but at the time of writing, the future model has only just been brought out for consultation. There has already been opposition to the document from the AMA.

In reality, the AMA are not so worried about the clinical ramifications, rather by allowing NPs a foot in the prescribing door, doctors would lose the financial advantage as well as the dominant position they currently hold in health care (and attested to by the current Minister in power). NPs have in essence, identified a challenge to the “cornerstone” of their position within health care, and that is financial gains. With the legislation and endorsement processes in place to approve the NP’s work in medical extensions to practice, there is no reason why NPs cannot be managing certain aspects of care, except the funding arrangement does not allow it. The societal perceptions of the debate between doctors and NPs become confused, because the media focus on the professional boundary issues that are fueled by the AMA, and this takes the focus off the funding arrangements, which prevent NPs from practising as they are legitimately able to do within the health care system.

Fairclough (2001b) suggests that the role of the media in these situations is to build images as an ideological construct through which the accepted social order prevails. The media has done this by telling the public that these people called NPs cannot replace that good traditional doctor, by reinforcing the other accepted social image of nurses being carers. The media has thus contributed to the confusion around NPs whilst maintaining the view of dominant doctors and subservient nurses. Consistent with the dominant discourse battle to maintain its position, the media has advertised this “super nurse”, but within the discourse supporting the dominant health care group. The following headlines show the NPs as excellent nurses who will support health care, but the doctors really remain the safest source of health care delivery,

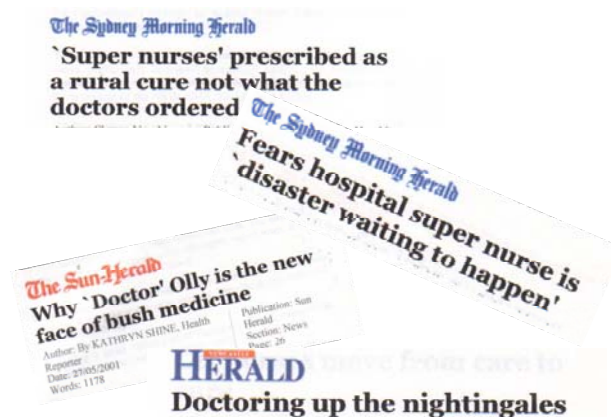


Figure 11 Headlines in Australian newspapers (Shine 2001; Verghis 2000; Moait 2000; Robinson 2002)

These newspaper headlines show clearly the medical model mixed up with the traditional virtuous nurse image, which downplays any idea of the NP being an autonomous leader, and supporting the antipathy of the medical profession to NPs. It reinforces the accepted social order (Fairclough 2001b). The headlines convey the message to the public that nurses who work outside the accepted social order of what is viewed as nursing, are not safe and are a risk to the public. Reinforcing this notion was a statement by the AMA and which was published in the Sydney Morning Herald, which said, “this attempt to improve nurses’ conditions is nothing more than an unproven and ad hoc experiment with patients’ lives” (Robinson 2002). In this same article the health minister of the time countered these claims by saying that “these highly experienced and highly qualified nurses will now be able to use all of their skills as nurse practitioners rather than working with one hand tied behind their backs” (Robinson 2002).

As if trying to placate both sides of the debate The Age newspaper ran an article with the heading, “Enter a new breed, neither nurse nor doctor” (Dunn 2004). Their attempts fueled the debate rather than placated it, as they undermined the role of the NP and nursing as a profession by suggesting that NPs are not nurses. The article also reinforced the perception that NPs are taking over doctor’s work, by describing extended medical tasks rather than focusing on the potential expert clinical nursing role,

...prescribing medication, admitting patients to hospital and ordering and reading diagnostic test are tasks usually performed only by doctors, but they are among the duties a new highly trained cohort of nurses will carry out... (Dunn 2004)

As already described in the previous chapter, the real potential and position of NPs remains poorly described and supported by nurse managers, so that their tacit compliance at what is said in the media, perpetuates the silencing of nursing and its conformity to dominant discourses that do not acknowledge NPs. The response to Dunn’s article by doctors included such comments as “nurse practitioners are wannabe doctors and nurses have a simplistic view on patient care” (Pollard 2006), clearly undermining NPs. It should be remembered that the legislation in all states in Australia that govern the NP role refer only to those medical extensions to practice, when defining the NP, that doctors are now suggesting make NPs “wannabe

doctors”. The AMA’s position on NPs directly contradicts and undermines the Health Minister through legislation enacted by government, which allows NPs to practice within that extended scope of practice. It has sent a message to the public, who very often read the media before any statutory document, that doctors are the highest authority in health care, over even that of legislation. Another article attempted to promote the NP with this headline, “Why Dr Olly is the new face of the bush” (Shine 2001) and went on to provide views from the public by quoting a community member who said, “there are not many people I take my hat off to, but I take my hat off to Olly. She is one of the best sisters<sup>64</sup> we have ever had” (Shine 2001). However, all it really did was to reinforce the Nightingale image of a virtuous and dedicated ‘nursing sister’ on the one hand, and portray the NP as a doctor on the other.

The public view of nurses was confirmed in my role as NP Project Officer in an outback area health service. In undertaking community consultation for NP positions, members of communities referred to nurses as ‘their sisters’. To them the title did not matter nor did the notion of a nurse as leader of health care. As long as they did not lose any more of ‘their nurses’ and as long as they were able to access the health care that they would not have if the ‘sisters’ were not there. This particular community had a part time doctor and their comment was that if ‘their nurses’ could stand in for the doctor from time to time then they would keep her as she would ‘have a life’ (Field Note 14). Again, the public see the nurses as part of the system supporting the doctor, not providing the care as a health practitioner in their own right.

Paradoxically, despite this public debate on the worth of the NP, and as governments continue to promote the NP, the funding arrangements remain the same, setting up for Fairclough’s (2001b) felicitous ambiguity. Such a janus headed situation allows people to think that the government is supporting NPs in such public statements as,

..million dollar models for Nurse Practitioners .....this project began mid-last year to support our nurses in maintaining their high level of skills in an environment where health care has changed greatly, and will continue to do so for up to 10 years (Pivetta 1999).

---

<sup>64</sup> A sister was the term used by the nursing profession to identify RNs. This term was phased out in the 1980s in Australia with the introduction of the business unit of care. Some remote communities still use terms such as ‘sister’ and ‘matron’.

In fact they have not changed the essential aspects of hospital systems and funds that would allow such a change to happen. Eight years after this statement, there was no evidence of progress, with NPs struggling with issues around financial resources for role development cited as a major obstacle to the establishment of NP roles and their subsequent sustainability.

Other media articles also present the notion of support and co-operation by state and national institutions in such phrases as, "...The health care system has taken a major leap forward with the appointment of Australia's first Nurse Practitioner" (Australian Nursing Federation 2001) and "Nurses are vital for a healthy Victoria" (Department of Human Services 2003). Yet this is not the case because funding arrangements and dominant discourses do not allow it. Other aspects of government ambiguity can be seen in the Medicare arrangements and the Pharmaceutical Benefits Scheme where NPs are yet to have access to Provider numbers, despite the fact that state legislation has provided the legal framework for prescribing.

### ***Another Fence to Jump - The Medicare Act***

The Medicare Australia Act 1973 was established as a universal health safety net to provide the Australian public with affordable, accessible and high quality health care. Medicare was established based on the understanding that all Australians should contribute to the cost of health care provision according to their income and as such is financed through income tax and a Medicare levy (Medicare Australia 2008a). The system provides a number of health care benefit schemes and services on behalf of the Federal<sup>65</sup> Government, the important ones in terms of this study, being the Pharmaceutical Benefits Scheme (PBS), Practice Incentives Program (PIP).

These services make provision for Medicare benefits to patients on fees paid to private practitioners and the PBS makes provision for a range of prescription medications to be made available at affordable prices to all Australian residents and those overseas visitors who are eligible to access health services. The system is managed through the allocation of licensed provider numbers, which allows a range of registered practitioners to prescribe subsidised medicines and diagnostic tests such as x-rays and blood tests. Without this licence a practitioner may prescribe medicines

---

<sup>65</sup> Federal and Commonwealth are synonymous; they refer to the national government of Australia as separate from the individual state and territory governments.



and order tests, but the patient will pay the full rate for the service. The other aspect of Medicare is that it provides indemnity insurance support to practitioners<sup>66</sup> who have been allocated provider numbers. Nurses are not included in the scheme, however many doctors registered in Australia can enjoy the financial benefits of the scheme (Australian Federal Government 2009a). Other allied health professionals may also obtain provider numbers for example physiotherapists and dieticians. Aboriginal Health Workers are also included in this category.

I reviewed the documents relating to the scheme, the Act itself and also the Medicare Benefits Schedule Book (Medicare Australia 1973; Medicare Australia 2008b). Nurses are not included in the Medicare benefits, and as such, despite having the state legislation and endorsement to support prescribing and ordering of diagnostic tests, NPs cannot obtain provider numbers. Nowhere was a nurse mentioned in their own right. The only nurse that featured was the Practice Nurse who is an employee in a GP practice, in other words doing the work under direct supervision of the doctor and who is paid out of the practice money rather than for their work,

ii.100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or registered Aboriginal Health Worker (Medicare Australia 2008b)

This gap in the legislation seriously hinders the NPs' ability to do the job they have been endorsed to undertake, and undermines their clinical autonomy as an advanced practitioner. The gap ensures that NPs remain restricted to working within the public health service under whose provider number they may prescribe and order diagnostic tests, provided the health service has these facilities within its organisation. NPs cannot work out in private practice as a result of this, and cannot give a prescription to a patient to take to a community pharmacy. This can be overcome in most major metropolitan hospitals where pharmacy and diagnostic facilities are available in the hospital. It becomes problematic in regional and remote areas, where health facilities contract out to community pharmacies and diagnostic laboratories or to services in another regional town. NPs in these cases are forced to refer the patient to a GP, which negates the reasons for having the NP employed in the service. They become an expensive commodity and the patient is handled by two practitioners for the same

---

<sup>66</sup> Practitioner in this context is any professional who sets up a practice in order to deliver health care services. In this way, hospitals, as much as private GPs have provider numbers.

presentation. Participants confirmed my findings. Yet, when I refer back to the evidence provided in Chapter 1, NPs were originally introduced to provide better access to health care in isolated outback communities, in areas where doctors were absent. They were never intended for metropolitan areas when they were first announced. Although the legislation, professional bodies and government of the states made provision for this new role in health care in the bush, the evidence shows that the omissions of nurses in the Medicare Act have effectively neutralised any efforts at change in workforce structure, particularly in the outback where NP services were intended. The social order is maintained through the operation of felicitous ambiguity (Fariclough 2001b).

Bill endorsed the Medicare Act anomalies, by describing his own concerns about Medicare in this conversation,

*I also looked at the Medicare Act and the policies and procedures and all the surrounding documentation in Medicare looking for, well, where are the nurses and what's happening, and that comes up about the provider numbers, because one of my, part of my job at the moment is contact providers when they deliver a service, for somebody with [illness]. So I actually looked up all the providers in [state] and I have complete access to the data base and have a look at who they are, what their qualifications are<sup>67</sup>, etc. and I discovered that there are all sorts of people with provider numbers, but, to get your provider number, the only one that can use the nursing title, in accessing the provider number, is a mental health nurse in [state], everyone else, who you know is a nurse, adopts a new title, to disguise their nursing, so that they can get a provider number, and to give you a couple of examples, we've got diabetes educator, home services diabetes nurse educator, which we're used to, which is a post graduate qualification, quite empowering, you know, does many of the things that a nurse practitioner would be doing, if they are in private practice, they drop the title nurse, call themselves a diabetes educator and we will give them a provider number. Another one, ...<sup>68</sup> therapist, and you think, oh, ... therapist, why would they want a provider number, well, they can get a provider number for PBF scheme, you know, the pharmaceutical benefits scheme, because they need to write scripts so that a customer can then take a script into the association that gives out the ..., get the ... at a discount price, through the pharmaceutical benefits scheme. So we'll give the ... therapist a provider number. Well, I don't know of a ... therapist that's not a nurse. So that I found interesting (Bill, Interview 8, p. 2).*

If the discourse that Bill reveals is extrapolated to other nurses, then they have to disguise their identity in order to do the work they are prepared and educated for and

---

<sup>67</sup> The work that this participant undertook involved research which gave him access to health care data bases.

<sup>68</sup> The title of the role is too specific to the context of this conversation and it has been removed to protect the participant.

this is certainly supported when reading the Medicare guidelines for allied health services (Australian Federal Government 2009a). No other profession that I could find has to go to these lengths to practise effectively and in the way that they are legally allowed to do in accordance with state legislation and professional endorsement processes. When I checked this with the Medicare Benefits Schedule (MBS), this was indeed the case, for example, in regard to immunisation, the MBS states that,

Immunisation services provided by a practice nurse (item 10993) Item 10993 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where an immunisation is provided to a patient by a practice nurse on behalf of the medical practitioner (Medicare Australia, 2008b, p. 714)

Practice nurses are nurses<sup>69</sup> who work for a general medical practice. Although much has been done to standardize their scope of practice, there is still a great diversity of responsibility, decided upon by the doctors within the general practice they are employed by. For example, some practice nurses merely take bookings and contact patients, whilst others are running follow up clinics in much the same way that NPs would do, except that practice nurses are salaried workers and do not get any of the Medicare financial benefits from the work they do, neither are they endorsed as NPs. The payments are given to the doctor who has the provider number and under whom the nurse works in a supervised clinical arrangement. Practice nurses are not prepared for, nor have the legislative authority to order any tests or prescribe. So NPs cannot provide the basic primary and preventative health care such as immunisation, because they do not have a provider number. Practice nurses can manage this under the direction of the doctor. There are many aspects of NP practice that are stifled because of this. Amy identified her frustration at not being able to practice as a NP in the facility she worked at for this very reason. She simply said that the major obstacle for her was,

*...not having a Medicare provider number and PBS, I couldn't expand my role. ...and then without any provider numbers or anything like that, ..., the whole thing is... well then who funds for it, and I can't actually write any pathology or anything because then they'll get charged the whole whack. In many ways I felt that I was functioning as a clinical nurse specialist or clinical nurse consultant (Amy, Interview 4, p.7).*

---

<sup>69</sup> Practice nurses can be registered or enrolled nurses. The enrolled nurse role is not discussed in this study.

Amy had to refer the patient to the GPs for any work relating to prescribing and diagnostic testing. When searching the policy, I found that The Productivity Commission Report (2005) also identified the Medicare Act as a barrier,

There are also regulatory and funding barriers to the wider practice of nurse practitioners, for example:

... as there is limited opportunity for nurse practitioners to operate under the Medicare Benefits Scheme, it is difficult for such roles to exist, when clients who use a nurse practitioner are required to pay full fees (Productivity Commission, 2005, p. 40).

The felicitous ambiguity (Fairclough 2001b) is exposed. Whereas the government is promoting the NP, publicly claiming to support the role, is providing scholarships to nurses who are studying in the Master of Nursing (Nurse Practitioner) programs, yet they prevent NPs from practising because the funding arrangements, created by the Federal Government, prevents them from doing so. This is despite state legislation having made provision for NPs to prescribe and order diagnostic tests. The resistance to change by amending federal legislation to make provision for the legally and professionally endorsed NP to achieve the tasks they are authorised to do, is significant<sup>70</sup>. This was also identified by the Productivity Commission which stated that “the experience with nurse practitioners also illustrates that such major change can be very difficult to progress in the face of opposition from key workforce groups” (Productivity Commission, 2005, p. 41), meaning, no doubt, the doctors and CFOs. By not allowing NPs to achieve those aspects of their work that is legally acceptable, they cannot be the autonomous professionals that the ANMC NP Competencies lead us to believe.

### ***Old Contests – New Focus***

The influence that doctors have over preventing NPs succeeding has been magnified by media releases and communication statements, particularly from the AMA, government statements and parliamentary communications. The Productivity Commission Report made reference to the outcome of such unhelpful behaviour,

While the State-based reviews produced a variety of evaluative material relating to different nurse practitioner roles, this material could have been better used and roles

---

<sup>70</sup> It should be noted that the Rudd Government (2009) has announced funding to allow NPs to obtain provider numbers. The process will require a change to the Medicare Act. The last update on this matter was that the new bill had failed to gain support on the first hearing in Parliament.

implemented earlier, had there been a greater level of coordination and a core body providing impetus to the task. The second area of difference is that the accreditation of education and training, and registration of nurse practitioners, would be undertaken nationally, avoiding the fragmentation evident today. A third difference relates to nurse practitioners' scope of practice — under the Commission's proposals, a more transparent process would have taken place to assess the appropriate level of access for nurse practitioners to the MBS and PBS (Productivity Commission 2005, p. 301).

Although this report was published in 2005, the MBS and PBS system has still not commenced the process for the necessary amendments to incorporate the NP into them. At a recent Nurse Practitioners' Conference the key note speaker was Roxon who is Australia's current Minister for Health. She told the audience how aware she was that the legislation was hindering NP implementation and that it was important to rectify this. However, she said that it would not be an easy or quick process because of the other stakeholder's opposition, again reinforcing the fact that the doctors have the power to slow at the very least or completely veto such a change (Field note 15). This was confirmed in information provided in the Productivity Commission Report which outlined some of the responses from the AMA in relation to the development of the NP role,

Many doctors and pharmacists have been reluctant to accept the introduction of nurse practitioners, expressing concern over a number of issues, including with prescribing. Recently, the AMA has stated that patients are being 'short-changed' when offered care by a nurse practitioner instead of a GP: When GPs examine a particular ailment, they are assessing the whole person. ... [Nurse practitioners] don't have the diagnostic ability to analyse patient history and look at symptoms with regard to total systems in the body. Nor can they work out management plans for an individual that take into account the whole person (Productivity Commission 2005, p. 42).

The AMA has been opposed to the NP from the beginning and has used the media at every opportunity to publicly denounce the NP in favour of the medically employed Practice Nurse such as this statement,

### **New MBS Item Needed To Cover General Practice Nurses Working Under GP Supervision**

AMA President, Dr Mukesh Haikerwal, said today that the AMA wants more general practice nurses working in general practice under the supervision of GPs, but a new Medicare Benefits Schedule (MBS) item number is needed to maximise their impact on patient care. Dr Haikerwal said the Government must provide a single MBS item number for all clinical tasks carried out by general practice nurses (Australian Medical Association 2005d).

The interesting thing is, if the AMA really wanted to “maximise their impact on patient care” they would be considering contracting NPs into their practice who are far more skilled and prepared for the job than practice nurses are<sup>71</sup>. This is by virtue of the rigorous preparation and legislative authority that NPs have, and which practice nurses do not have. This play on words describing the Practice Nurse being able to undertake the same activities as the NP is what Fairclough (2001b, p. 87) calls “naturalization”. Fairclough says that,

...the naturalization of the meanings of words is an effective way of constraining the contents of discourse, and, in the long term, knowledge and beliefs. The naturalization of interactional routines is an effective way of constraining social relations which are enacted in social relationships. The naturalization of subject positions self-evidently constrains subjects, and in the longer term both contributes to the socialisation of persons and to the delimitation of the ‘stock’ of social identities in a given institution or society. Naturalization then, is the most formidable weapon in the armoury of power and therefore a significant focus of struggle.

The language used by Dr Mukesh Haikerwal in the AMA statement suggests that NPs cannot do the work of doctors, however practice nurses, under medical supervision can. It suggests that NPs cannot practice safely despite the fact that they are educationally prepared in the business of diagnostics, prescribing and ordering diagnostic tests, within a specialty practice area. The position taken, fueled by the media, perpetuates the medically dominant ideology and reinforces the belief that NPs cannot be safe in clinical practice. The hidden factor in all of this is that what NPs may do is threaten the financial security of GPs, rather than their lack of ability to provide safe and effective clinical expertise. By using NPs, they would have to be equal partners in the practice with NPs, thus enjoying the financial benefits of the MBS and PBS system as much as the doctors do; whereas the practice nurses are employed with a salary determined by the GP practice. Their position in this matter was confirmed in the following AMA media statement,

General Practice Nurses are defined as those nurses employed to work within a general practice setting as a member of a general practice team. The AMA does not support the “independent nurse practitioner” as reflected in the variety of State/Territory legislated roles for nurses where levels of independence remove the general practitioner as central to delivery of primary care. General Practice Nurses (GPN) make a valuable contribution to the profession of general practice and, while

---

<sup>71</sup> There are NP candidates preparing for practice in GP practices at the time of writing. It is not yet known if they will be employed by the GP in the same manner as the Practice Nurse, or whether they will be allowed to practice as an independent practitioner in partnership with the GP.

their role is complementary to that of the general practitioner, it is integral and adds value to the delivery of primary health care services in the general practice setting.

The clinical roles of the General Practice Nurse may only be undertaken under the direction of the general practitioner in accordance with agreed practice protocols and where the General Practice Nurse is appropriately skilled and trained to undertake specific tasks. The role of the General Practice Nurse must not include

- Formulating medical diagnosis
- Referring patients to specialists
- Independent ordering of pathology or radiology
- Prescribing medication and issuing repeat prescriptions”

(Australian Medical Association 2005a)

The AMA, who are to all intents and purposes one of Australia’s most successful union or industrial body, and who hold out to be representative of the medical population, clearly indicate their distaste for the competition that NPs represent to their standing in health care delivery. So sure is the AMA of their standing as superior to all others, that I found this position statement on their website,

The AMA is pushing the Government to pave the way for more general practice nurses to ease the impact of doctor shortages around the country, but strongly warns against the introduction of independent nurse practitioners. At its weekend meeting, the AMA Council of General Practice (AMACGP) reaffirmed its position that quality care for patients and access to that care is best achieved in a setting that is coordinated by GPs. AMACGP Chair, Dr Rod Pearce said a move to independent nurse practitioners would dumb down the Australian health system.

The best way to ease the pressure on the general practice workforce is to build primary care settings in which nurses are an integral part of the general practice team, Dr Pearce said. The right way to go is to have nurses complement and assist the work of the GP, not have nurses become a substitute for GPs. General practice nurses help doctors see more patients and spend more time with patients who have chronic or complex illnesses – but they do so as part of the general practice team under the supervision of a GP.

Accrediting nurses to go out and independently diagnose, prescribe and refer patients is the wrong way to go. Independent nurse practitioners cannot and should not replace the expertise and care provided by GPs. It would be consigning patients in areas of workforce need to inferior health care. The State Governments endorsing independent nurse practitioners are looking for an easy, and vastly inferior, solution – which is also an irresponsible and dangerous path to follow

(Australian Medical Association 2005c)

The fact that the AMA deems that they can influence the government with such a harrying campaign, provides an indication of just how secure they believe their position is in their power over the government. Yet still, the role that NPs can actually play in health was highlighted by the Queensland government when it first

announced that they would be introducing NPs into their health system by stating that NPs,

...Target specific communities or groups to encourage health prevention, health promotion and self- maintenance of individual health care.

- Develop inter-disciplinary partnerships across services to develop models that share resources and services of expert nurse practitioners.
- Build on existing health care services and provide quality health care in partnership with the patient, the area medical practitioner and other key health workers in the designated area of practice.
- Prevent unnecessary hospital admissions by providing appropriate medical care to patients, thus allowing them to remain in their preferred place of residence.
- Reduce waiting times in emergency and outpatient departments (Queensland Government 2003).

It has contradicted the AMA's position on NPs, yet the evidence presented in this study, indicates that whilst the governments in Australia openly support the NP, they are not following through by changing the necessary legislative and funding processes for this to occur. Nurse leaders have also attempted to clarify the AMA's position on NPs,

### **Nurses no longer the doctor's handmaiden**

A recent media release from the AMA called upon the Federal Government to extend the Practice Nurse Incentive Program to all general practices in the country. It is heartening to see the important role of the practice nurse acknowledged by the AMA. It is disappointing, however, to find in the same press release practice nurses portrayed merely as 'helping doctors see more patients'. Practice nurses offer a wide range of clinical and health promotion services and improves the quality of care received by patients. The deception of nursing as a servant of medicine is not only regressive and offensive to the many thousands of nurses who play a key role in primary healthcare teams in Australia, but once again reinforces the dated image of nursing. It is of particular concern that this negative attitude is resurrected at a time when healthcare systems around the world are facing a critical shortage of nurses (Nelson 2005).

Unfortunately, this statement was not released to the general public, but rather distributed in a local nursing journal. Whilst the AMA was broadcasting their opinions publicly in the newspapers and on the World Wide Web, the nursing responses were being circulated within a population that was already sympathetic to the contemporary issues of nurses. The fact that the dominant group has free access to the public media, and nurses, who are seen as traditionally invisible, have circulated their responses only to those affected by the AMA's position, reinforces the silencing of nursing. It does nothing to raise the public profile of nursing, or to



correct the inconsistencies in the information provided to the public by those opposed to nursing change and so a dominance is perpetuated and as Fairclough (2001b, p. 42) says,

Producers [the media] exercise power over consumers in that they have sole producing rights and can therefore determine what is included and excluded, how events are represented and even the subject positions of their audience.

This means that “the effects of media power are accumulative, working through the repetition of particular ways of handling causality and agency” (Fairclough 2001b, p. 45). With the emergence of the network society and the accessibility of the Internet to a larger global population, this is even more significant than simply the media releases that have emerged from the AMA in the newspapers. Not only are their media releases and position statements used and reproduced by newspapers, but they are also displayed on the Internet, further reinforcing the traditional ideology of the central medical figure around which health care revolves.

I undertook a search on the AMA Website under ‘Media Releases’. There were 31 media releases from July 2000 to February 2008 and not one had any form of support for the NP role, in fact they were distinctly opposed to anything the governments were attempting to introduce, other than what they wanted. Their whole approach to tackling the problem in public was very high handed and unduly forceful, suggesting an overly protective strategy in the protection of status quo. One position statement said this,

**From the President – The battle starts now**

'High hopes were once formed of democracy; but democracy means simply the bludgeoning of the people by the people for the people.' – Oscar Wilde, *The Soul of Man Under Socialism*, 1891.

Ask any doctor these days and I reckon they will agree with Wilde's cynical view of democracy. There is very much a sense that we are being 'bludgeoned' by the competing ideologies of our democratically-elected politicians. The politically-motivated desire to force doctors to bulk-bill or to compromise their principles with unsatisfactory 'no-gaps' products; the overt push by one end of the political spectrum to introduce managed care; the control of GP training being wrested away from the profession; the progressive demedicalisation of hospital management; politically expedient but inappropriate substitution of doctors with nurse practitioners or other allied health professionals; and the encouragement of big corporate players to move in and take over general practice.

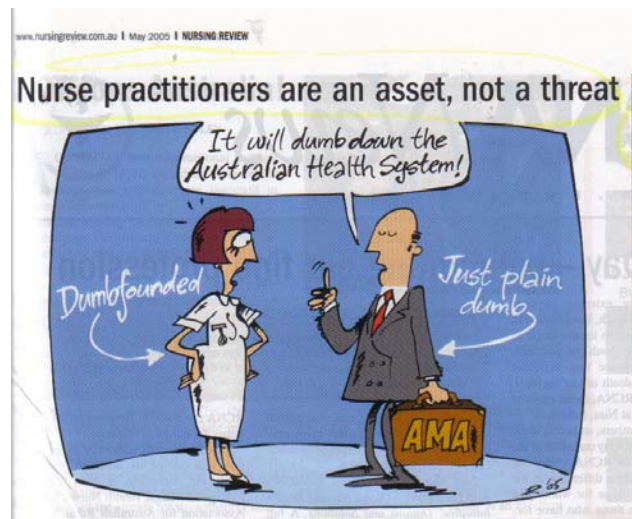
There has never been a time more threatening to the future of medical practice in this country.

(Australian Medical Association 2000)

The language of this statement suggests an arrogance and surety of their position, in relation to the government and everyone else connected to health care. Whilst nursing as a profession has been talking about a new advanced nursing role, supported, in theory by health care departments, a role that can provide clinical support in areas where there are gaps in current health services, the AMA are telling of doctor substitution. The gaps, it seems, are where NPs are actually being employed, and in doing so this is exactly what they are doing. The fact is that most NPs in the Australia are not in remote services as predicted, but in EDs that are overflowing to record capacity and beyond, much of which is in the triage 4 and 5 categories after hours<sup>72</sup>. This is because GP practises largely run a 9 – 5, 5 day week service, although there are practices that open until 9pm. Such a situation contradicts the AMA's position in which they attest that GPs provide an essential and first line service. Hospitals have state and nation wide key performance indicators to meet in EDs and it includes waiting times set by national trends. Extend these times and hospitals lose funding through penalties imposed upon them by the state governments. The current workload in EDs across the country with the after hours triage 4 & 5 presentations means that the national time limits are often blown out, to the funding detriment of the hospitals concerned. The hospital solution to this has been the employment of NPs to manage the triage 4 and 5 patients. This has emerged because the GPs, who the AMA claims to represent, choose their hours of work, after which the public has only one access to care available to them, and that is the ED. This situation becomes a contradiction in terms of essential services and who manages them because the GP, who claims to be the first line of care, is only this in what is termed normal working hours. Despite NPs now beginning to show their worth in acute services, nurses still play down their worth.

---

<sup>72</sup> Hospital services refer to after hours as being when most community related health services close, this being between the hours of 5pm and 9am on weekdays, and the 24 hour periods of weekends and public holidays.



**Figure 12** Cartoon depicting the turf war between doctors and NPs (Royal College of Nursing 2005)

This cartoon was printed in a nursing journal and not in the public newspapers, evidence that nurses remain silent in outlining what nurses really do. Despite the fact that NPs can prove their effectiveness in places such as EDs, the way nurses noiselessly respond to opposition as the AMA reinforces that which has been highlighted in Buresh and Gordon's (2002) studies where conversations from nurses attending their workshops described a preference not to speak out. One such conversation documented in their research, suggested that nurses internationally do not stand up for what they believe in because "such public communication will lead to a narcissistic self-aggrandizement" (Buresh & Gordon, 2000, p. 32). If NPs are emerging as a worthwhile role in addressing gaps in health care, then there is no need to hide. Nurses should be stating their worth publicly, yet evidence shows that this does not happen.

The silence has been reflected in other ways when one considers that NPs were first discussed and planned for as far back as 1990, and the first NP was employed in 2001, which means that state legislation was already in place for NPs to practice, yet there are so many issues to deal with today. The fact that in the years between 2001 and 2009, these debates on funding and legislative support is still being argued, the NP is not the clinical leader that nursing as a profession says it is, nor is it autonomous. The dominant discourse, with the symptoms of medical control does determine how the NP role has and continues to develop. Together with the preference for silence in nursing they keep NPs as subservient workers with no

change to models of health care delivery anytime soon contrary to professional nursing and national health care strategy. NPs remain within the traditional model of nursing that is used to support the work that doctors do. They remain dependant, not autonomous. Another symptom of these powerful drivers is the requirements for NPs to work under clinical practice guidelines (CPG). CPGs form a major part of NP scope of practice and nurses cannot practice as NPs until these guidelines are in place.

### ***Gates in Place - Clinical Practice Guidelines***

CPGs were implemented as part of the NP scope of practice from the very start of the NP movement in Australia. CPGs are methodically produced statements which provide a guide and a process of clinical support to the NP regarding the management of care in a particular situation of diagnosis, based on context of practice (Goolsby 2001; Victorian Government 2006). Australia has adopted this approach for NP practice, and in some states NPs are required to have CPGs in place prior to becoming endorsed with the NMRAs. Other states will sanction the NP, but they cannot practice as such until the CPGs have been approved by the Minister for Health. In Victoria's publication on CPGs for NPs, it has been stated that "guidelines help to define the role and scope of practice of the nurse practitioner's clinical practice" (Victorian Government 2006, p. 5). The guidelines also include the formulary from which the NP may prescribe and it outlines the lists of diagnostic tests that the NP can order. CPGs are evidence based, and the rationale for them is to improve the quality of health care delivery whilst reducing ineffective or harmful interventions so that patients receive the best interventions available at the time (Victorian Government 2006). CPGs are not meant to hinder clinical judgement but rather are there as a support to an approach to care and should be utilised by the whole team, not just one person within that team. Confused with CPGs are clinical protocols, pathways and standing orders. Whilst none of these are the same, CPGs may incorporate all of them (Goolsby 2001; Wallin 2005). Already, there is confusion in definition. There are some states that actually use the term 'protocols' rather than CPGs, for NP practice (Western Australia Government 2003). This confusion has manifested in participant conversations as well, reinforcing the view that players within a particular environment will adopt the most common discourse. In other words, the ideology promoted by the covert power of medicine is perpetuated because "the orders of discourse are ideologically harmonised internally

or at social level with each other” Fairclough (2001b, p. 25). Jane (Interview 2, p. 7) said that she worked *within certain clinical guidelines and that from a legislation point of view, I’m only covered to practice at a level that is covered by the protocol. If I go outside of the protocol I won’t be covered*, identifying the confusion between the two terms caused by the interchangeable use of both protocol and CPG in her discussion.

Protocols are more prescriptive in nature than CPGs and are used as standing orders for RNs to initiate treatment, on doctor’s orders, in other words, the nurse maintains the position of subordinate in this instance. CPGs on the other hand allow for experiential and individual decision making within what is a guide to best practice, so anyone using the guidelines, should have the authority to make decision based on individual judgment, which NPs have. Immediately there is confusion between these processes when developing the NP position. The protocols call for restrictions in practice rather than supporting practice and Jane confirmed this. She was only allowed to work as a NP within those areas that had a guideline. This was confirmed in my own experience as a NP Project Officer (Field note 16). Part of my job was to assist in the development of CPGs. Not only were they exhaustive in their preparation, but they also had to be supported by a local group which included a pharmacist and a doctor, and they had to be reviewed by the state government pharmaceutical committee, then the health minister of the state, before being operational. This process took anything up to 2 years for one CPG. This meant that, in accordance with good evidence based practice, the CPGs were already outdated before they were implemented in practice. It also meant that for every clinical presentation that the NP wanted to manage, a CPG had to be developed and go through the same process each time. So, for anything else external to the agreed CPGs, the NP was not allowed to work as a NP, they had to revert to the scope of practice of a RN. The example above meant that the NP in question, was only allowed to treat minor cuts, respiratory tract infections and urinary tract infections in the NP role, everything else had to be treated as a RN, requiring endorsement and support for the final decision making by a doctor some 600kms away.

More recently, some states have attempted to make things easier by posting all the approved CPGs on their health website, and from which NP candidates in that state, can draw from when choosing what CPGs they will work with, the rationale being

that these CPGs have already been endorsed by the minister. This is still a lengthy process nevertheless, because those individuals are still required to follow the process of endorsement from the state. One state has made an even more significant move to having formularies approved by the minister for health, which then gets posted on the website for use by categories of NPs. The list is then updated regularly rather than having to review individual guidelines. The guidelines in this state then, whilst still in use and lengthy, are in control of the local health services, and therefore do not require ministerial approval, only local approval. The state endorsed formulary then gets added to the guideline.

Participants referred to the CPG preparation as tedious in development. The final outcome of what could or could not be used was also determined by a local committee, which comprised of doctors and pharmacists from the health service. The reliance on others for the final CPG development was confirmed in state Government Assembly readings where a speaker was noted to say that “the role of nurse practitioners will be specified in the protocols and will actually support doctors” (Nurses Amendment Bill 2002 Western Australian Government, p. 3803). Joe confirmed this reliance by relating his experiences around the development of his CPGs, which not only outlined his reliance on doctors and pharmacists to approve them in their own time and way, but also how he was used as a go-between in a turf war between the pharmacists and the doctors,

*... part of the process of designation is that the formulary component of the CPGs is signed off by the chief pharmacists... ...so he's got the CPGs ...delays in reviewing them... then he submits them to the drug sub committee which is a hospital committee set up... with doctors who then pulls apart the protocols...comment on it and its become a bit political because the drug sub committee is saying we disagree with this antibiotic regimen....but my CPGs have been reviewed signed by the trauma committee, the head of plastic surgery, the head of our department ...well they say they disagree with them and they are not signing them off so the drug sub committee are using me as a means to trying to get to the doctors who they see as working beyond what they think are the correct guidelines and are using me as a political football... (Joe, Interview 3, p. 10)*

Although this behaviour was not explicit obstruction to the development of the NP, it did provide an indication of the degree of control that doctors and pharmacists had over approving nursing activities. It seemed that the turf war was more important than approving CPGs for NP practice. This demonstrated a situation in which the discourse of the players identified the hierarchy of dominance (Fairclough, 2001b),

and the NP CPGs were not as important as the argument between the other professionals involved with CPG development. What is significant in this also, was the participants' acceptance of the need for CPGs without much question. In other words they were adopting the dominant discourse without even realising they were doing it (Fairclough 2001b). This is also evidenced in Joe's comment when he said that after the approval process he had *CPGs that allow me to practice either independently or collaboratively with the [department] specialists* (Joe, Interview 3, p. 2).

If CPGs are developed to support practice in a way that encourages inquiry and support in application (Goolsby 2001), then the way in which CPGs are being developed for NPs is not for the ease of practice. CPGs in this instance become a symptom of the powerful discourses; doctors' control over health and financial funding processes that are supportive of it. In her speech, the minister for health identified this clearly,

We must move beyond old contests – like the fight against government intervention in health services. And we must move beyond false contests, too – like the imaginary trade-off between a greater role for nurses and safe, strong patient care; or the battle between public and private health; or the division between State and Commonwealth health responsibilities. These false divisions – often the sites of dramatic political battle - have created significant problems in the way that health services in this country are delivered. They have led to government regulation which is often poorly matched to its alleged aims, and ensured that the health landscape is dotted with badly designed markets (Roxon 2008, p. 6)

Yet, at the NP Conference recently, she also acknowledged that the process of change will not come easily (Field note, 15). In response to Roxon's speech, 'The Australian' newspaper published an article entitled "Doctors told to reform or lose pay" in which they outlined Roxon's position on health care reforms (Ryan 2008). Ryan (2008) quoted the AMA as saying that "they [Australian Medical Association] are at war over her [Nicola Roxon] support for giving nurse practitioners more prescribing and diagnostic rights, traditionally the domain of doctors under PBS and Medicare". The hurdles relating to the CPGs are only one symptom of this dominant discourse in operation. As if these hurdles have not been enough to deter the NP from practising, the evaluation of NPs shows a marked skewing towards medical dominance as well. What has emerged is that NP effectiveness has been measured

against financial and medical indicators, but the base line rules are not the same as those provided for doctors.

### ***Junior Medical Doctor or Advanced Nurse?***

The evaluation of NP work is one such example of a symptom of power which is not in support of NPs. Whilst the nursing as a profession has clearly documented competencies that relate to NPs enhancing care within a nursing framework (Australian Nursing and Midwifery Council 2006a), the requirements are set for NPs to prove their worth benchmarked against doctors. Joe spoke about his evaluation and key performance indicators when he referred to it in financial terms such as 'seen by' times and patients' length of stay (Joe, Interview 3, p.6). Although the organisation expected Joe to be measured against the registrars, he was also expected to do both the nursing and the medical work whilst the registrar just did the medical work (pp. 8 & 9). This approach only serves to reinforce the unique expectations of one category of employee in a system that is supposed to have standard human resource practices. NPs are expected to do the job of two different professionals yet are employed to do the job of one. This puzzle is not only endorsed by the human resources departments, but also by the NPs themselves, reinforcing the traditional nursing stance, which supports not only the silencing of the nursing voice, but also the notion of bleeding some more, referred to in Chapter 6, in order to advance. It reinforces the fact that NPs are dependent on others to function and they are also used as a financial commodity in a cost cutting exercise. When asked what he would like to see happen differently Joe said,

*I guess the things that I would like to see done differently but its out of my scope of influence so you know it about support in that role, its about getting the nursing executive to have a better understanding of the nurse practitioners ...um they have this belief that it is just a cost saving exercise and it's about nurses taking over the world and it's like they just don't get it... (Joe, Interview 3, p. 8)*

His frustration around the nursing executive not understanding what he did further reinforced the ineffectual leadership that DONs seem to have in the organisational system. The DON, who is the leader of nurses in any organisation, in the case of Joe, allowed NPs to be measured against registrars, which is acceptable if the base measurements were equal; but they are not, the NP did the nursing and the medical work whilst the registrar did the medical work and had a nurse to assist with the entire activity. And the DON endorsed this and the NP accepted it.



The symptoms in the operations of dominant discourse thus have emerged. Firstly that NPs are a commodity to be managed in financial terms and the commodity measured not as a nursing role but one restricted to outcomes comparable only to the tried and accepted medical model of care. Nowhere, was there evidence of measuring effectiveness of outcomes from the patient's perspective or from the real financial value of patient throughput which was measured in the length of stay of the patient in the department. In Joe's example the NP was perceived as more expensive because he took longer with his patients yet, he did the work of two people and he did it comprehensively, treating the whole patient throughout the episode of care, and not just parts of it. Jane tried to described her worth from a patient outcomes perspective,

*.....but also from the patient's perspective, if I know what needs doing as if I have a patient whom I think might have (presentation), I know certain things need doing, if I am in a position to start and get those things done, then that patient is not going to sit for two or three hours, waiting for someone to sign off on a blood form or a chest x-ray form or an echo. It can all be done. By the time the doctor sees him I've got the evidence kind of support the diagnosis, and hopefully from those the effective and efficient out patient care, get them admitted without leaving sick people sitting in the corridor...My hope is that we'll be able to continue to expand the service and optimize clinical outcomes of patients who aren't waiting for treatment, to us it is obvious, it is needed (Jane, Interview 2, p. 7).*

Jane's perspective was focused on what the outcomes to the patient were; yet, Jane was still not operating in a NP position and was still struggling to get the documents prepared for approval. It appeared that what Jane was highlighting in actual patient outcomes was not important in her organisation to the final outcome of the role. A search of the literature indicated that what Joe and Jane were experiencing, is consistent with other NPs evaluation processes internationally. Joe's experience where length of stay and similar budgetary indicators have become the standard measure for NPs, based on what the doctor normally does (Busen & Englemann 1996; Dahle et al. 1998; Cooper et al. 2002; Horrocks et al. 2002; Kernick & Scott 2002; Kinnersley et al. 2005; Kirkwood et al. 2005). Cindy supported the holistic approach of being able to provide comprehensive and timely care to patients. It seemed though that it was not enough, because her position had not yet been approved, despite her proposed model outlining cost effective care. She said that her role could not only support effective patient outcomes within her unit, but that her work could also assist regionally,

*I can do direct referral to our [clinical] unit, which is traditionally has to be assessed by a nurse and a doctor, one hour each, I can cut that time down to being assessed by a nurse practitioner to make their decision, also there's some remote area who doesn't have a prescriber, we might go in, do a clinic, which they have traditionally seen a doctor over in say, for example, K.... [name of town] or something like that, or to do a clinic for a day or two, just to make sure that the clients in a remote are being looked after and have no other issues... (Cindy, Interview 6, p. 7)*

The act of developing a business case by no means guaranteed Cindy employment as a NP; it was viewed as a project and it seemed that her indicators were not yet convincing enough for the role to be implemented. Yet her proposed role was consistent with the streamlining of health services and cost reduction approaches.

Throughout these interviews there have been divergences between organisational expectations and nursing/clinical expectations, which have indicated a negative influence to achieving the full potential that the role can bring to health care delivery. The state and national vision of a holistic and advanced nursing role has become lost in the financial and medical dominance at the local level. It must be remembered that projects to develop NP roles are being funded by the very government that funds the health care organisations that are not supporting the NPs. One is supporting the NP by providing project funding; the other is not allowing that project to translate into a sustainable position for employment of a NP. This together with the internalisation of organisational discourses by the NPs, despite their anxiety at the tension it has created in their work, has set the stage for diverging expectations of what NPs are and should do. This internalisation processes emerges in the participants' conversations and positions them within the organisation in a way that gains approval of themselves, whilst still allowing them to become this professional called a NP. Fairclough (2001b) makes reference to this idea by saying that people adopt the dominant discourses in their daily practice because it is internalised and the norm. In the case of the NPs, they are conforming to competing discourses; the budget and its constraints on practice, and the traditional discourses in which nurses have always been the subservient worker.

The need for NPs to create a space to influence clinical decision making processes within an organisational environment which does not overtly support the role, may have commenced with these participants long before they embarked on their career

change, through their unconscious adoption of the traditionally accepted social order. What we are seeing is the subservient role of the nurse being changed in a way that threatens the traditional leader of health, the doctor, because, by the authority of legislation and professional policy, the NP can legitimately stand alongside the doctor as a leader in health. The use of medically and financially focused clinical indicators to measure the value of the NP, despite the allocation of unequal workloads, is one way of maintaining the control over NPs by that traditional order.

### ***Beyond Old Contests***

Since the emergence of NPs, international literature indicates a consistent similarity in NP performance indicators to that used by participants in this study. In the USA, the role of NP has constantly been measured against the medical model of care. The National Nursing and Nursing Education Taskforce (2005) undertook a search of the literature on how the NPs were measured. Over 1000 documents were reviewed for NP effectiveness, following which a cohort of NPs was asked to complete a questionnaire relating to their work. The results show that frequently the effectiveness of NPs was measured against patient satisfaction, bio-medical parameters such as morbidity rates, cost efficiency parameters for example seen by times, and chart audits based on the medical model. Nowhere in this literature was there reference to the nursing models, the comprehensive patient outcomes and the continuity of care that are described in policy documents both nationally and internationally (New South Wales Health 1995; South Australian Government 1999; Victorian Government 1999; Department of Health Western Australia 2003; Queensland Government 2003; ACT Health 2005; National Nursing and Nursing Education Taskforce 2005; Australian Capital Territory 2005; Australian Nursing and Midwifery Council 2006a). These general tenets are reflected in the ideal NP in this government statement,

The Nurse Practitioner role is intended to add value to health services and enhance the delivery of health care services.

The Nurse Practitioner is a Registered Nurse educated to function in an advanced clinical role. The scope of practice and tasks performed by the individual Nurse Practitioner will be determined by the context (or clinical area) in which the Nurse Practitioner is authorised to practice... (Queensland Government 2003)

The NP in reality is being directed to conform to measures that are medically and financially focused. The ideal of a professional nursing role achieving its potential is

not considered external to the policy documents around NP professional standards. So prevailing are finance and medicine in directing nursing that throughout the period of international and national NP development, randomised control trials (RCT) dominate, comparing the outcomes of NPs to doctors in many different practice settings. Of significance is the number of trials which are undertaken with no nursing input apart from the fact that the NP role is the subject of trial (Hill et al. 1994; Mundiger et al. 2000; Horrocks et al. 2002; Kinnersley et al. 2005; Woods 2006). Nursing outcomes were described in scientific phrases such as “no significant differences were found in patients’ health status... physiologic test results for patients with diabetes ( $p = .82$ ) or asthma ( $p = .77$ ) were not different” (Mundiger et al., 2000), and “...compared to the CR patients the RNP suffered from lower levels of pain ( $P < 0.0001$ ), had acquired greater levels of knowledge ( $P < 0.0001$ ). The articles still however, demonstrated a comparable outcome to clinical care delivery by NPs to doctors. The fact that NPs have withstood the rigor of scientific evaluation by their medical counterparts, using their gold scientific standards of RCTs, is significant. However, the underlying tenet maintains a dominance of medical and financial discourse, with nursing being the silent partner in relation to how the role is measured and implemented (also see chapter 4 and 6 for the way in which the role is evaluated).

There have been attempts to counteract medical and financial focus. Nurses have attempted to join in with RCTs (Ahrens & Padwojski 1990; Dahle et al. 1998; Cooper et al. 2002). However, consistent with RCTs, combined nursing and medical research teams have evaluated the role still using medical dominated parameters embedded in a cost benefit discourse. There are however, more references made to patient satisfaction and the quality of care, despite the consistent theme of cost value, related to a reduced length of stay, improved quality of documentation and examination times. More recently nurses have begun using other methodologies, specifically around social research, in an attempt to review the role of NP from a different perspective, in which the qualitative role of the NP has been examined, focusing on continuity of care, comprehensive care and value added aspects of care (Keyzer et al. 1995; Busen & Englemann 1996; Mahnken et al. 1997; Chambers 1998; Torn & McNichol 1998; Armstrong 1999; UK Department of Health 1999; Keyzer 2001; Perala 2001; Watts et al. 2001; Williams et al. 2001; Jones 2003; Buppert 2004; Gardner 2004; Perron et al. 2005; Affara 2006; Atkins 2006). Despite

the growing evidence showing the quality and cost effectiveness of the NP role using RCTs as well as social methodologies, the findings are not used or reported to substantiate the planning of NP roles. This was also noted as a concern in the Productivity Commission stating that evaluation and development “has been ad hoc, jurisdictionally based and drawn out” (Productivity Commission 2005, p. XXI) although the Commission also highlighted pockets of progressive development,

...recent experiences provide ample evidence of the problems of achieving major job redesign within the current regime. For example, the introduction of nurse practitioners to Australia — a profession which has existed in some other countries for forty years — has been a drawn out process and is still encountering resistance from parts of the medical profession (Productivity Commission 2005, p. XXI)

This variation in local organisational support has emerged throughout participants’ interviews, however, the full extent of the market driven forces controlling NP progress rather than the evaluation of what the role can do, was highlighted by the Productivity Commission,

...Also, as noted previously, health workforce shortages in rural and remote areas have encouraged a variety of innovation in job design and scopes of practice. For example the shortage of medical practitioners in these areas has been a key driver for the introduction of nurse practitioners in Australia.....Such initiatives offer the prospect of more timely provision of services or, in some cases, access to services that would otherwise have been unavailable (Productivity Commission 2005, p. 215)

Rashotte (2005) suggested that NPs are merely an instrument within the health care system which is to be used efficiently and effectively so that NP positions are only considered when there are no other options. This view was reinforced in that only one of the participants of this study was employed as a NP. The others, although authorised to practice as NPs were in different positions which although considered to be advanced have different responsibilities such as this conversation,

*I am actually registered as a Nurse Practitioner; I am not appointed as a Nurse Practitioner..... I’m currently a clinical expert in managing the care of patients .....I also have a role as administrator, a researcher and educator so it’s my job to educate both staff and patients on all aspects of care (Jane, Interview 2, p. 2).*

The notion of ‘clinical expert’ allowed Jane to operate at an advanced level but she was not allowed the authority and responsibility that NPs are afforded. Paradoxically, the cost effectiveness of the NP is useful in managing budgets as well. My field notes

have shown that some services have attempted to sustain the NP positions by placing NPs on the medical registrar's budget and roster (Field Note, 17). Although this allowed the NP to practice in the substantive role, it was held out to be a short term answer to a management problem. DONs suggested that it would only be managed in this manner while registrar positions remained vacant. This activity perpetuates the notion that NPs can only be employed when there are deficiencies or gaps in the medical service and this has also been identified internationally (Fairman 2009). The implementation framework used in many jurisdictions created contradictory tensions by suggesting that NPs work within a nursing framework as they are not substitutions for doctors as the AMA maintains they are (Australian Medical Association 2005c), but at the same time, health care organisations, managers and NPs are placed in registrar positions to overcome vacancies as it suits the financial management of the organisation. Through the constraints on budget, services have not only reinforced the AMA's fears, but they have merely repositioned the NP role so as to suit their financial needs. Although this position illustrates how the health care system needs and uses the role of NPs, they remain silenced as nurses because they are filling a vacancy in the medical workforce rather than undertaking an advanced nursing role that has merit in and of itself. The nursing aspect of the NP role is eroded by the manipulation of the NP scope of practice to suit present budgetary circumstances.

Whilst budget and the role it plays in maintaining controls in NP implementation prevails, it contravenes the professional line of what nursing as a profession is striving for and further highlights the powerlessness of nurses to initiate change despite the perceived authority they have for making that change. The divergent discourses reveal tensions between professional idealism, financial/professional dominance and local reality, which is challenging the status quo of what is known and accepted as truth claims within health as an institution. The emergence of a new role and therefore a new model of care and division of labour are challenging the existing legitimate power and discourse of health care institutions which supports Fairclough's (2001b) opinion that the powerful groups maintain the legitimate power. A planned new model of care and the tension this brings was also highlighted in international peer reviewed journal articles. One in particular sums up the experiences from another country succinctly,

A variety of driving forces and pressures have encouraged emergency nurses to augment their conventional nursing skills; skills which were previously often the province of medicine. Initially this involved managing the care of patients with minor injuries but more recently, and in line with North American trends, emergency nurses are diagnosing and managing patients with increasingly complex injuries and pathology. .... there is a need for continued debate on the future of the health care workforce, informed by research, to facilitate correct and cost effective decision-making. To effectively develop a workforce fit for the future and define advanced practice in nursing, interprofessional silos need to be challenged. The ideological mythology surrounding nursing in particular, needs to be exposed, to prevent an obsolete and introspective focus, rather than patient centred philosophy (Brook & Crouch, 2004, p. 215).

Although this article focuses on silos, it does highlight the need for change in order to make a space for the role of NP. Augmenting 'conventional nursing skills' with those that are traditionally the domain of medicine means that nursing has to let go of their traditional position to accommodate a role that straddles both nursing and medicine. This also means that medicine has to let go of some of their tasks as well. This chapter has shown that this shift in labour division occurs, not so much because of the negotiation between two professions, but because the economy of health requires it in order to produce what is termed cost efficiency in health care delivery. Nursing is made visible in this debate, but is also invisible because it has not yet fully been admitted to that negotiation table. NPs strive to become NPs because of their altruistic beliefs in their ability to enhance the care of patients but are blocked because of the way that the budget is allocated in health care agencies and by the focus on fee for service in the provision of primary care by doctors.

The Australian reality is that nursing as a profession is struggling in the shift of the division of labour, with the introduction of the NP. It could be argued that nursing leaders have, like Nightingale continued to guide a certain progression of NPs by accepting the conditions placed upon their implementation, not by professional collaboration but by what is allowed or imposed upon them. The views between the levels of government and a professional vision show divergences where the profession and national government declare support for the NP role through policy and legislation, but local services of health do not, using budgetary constraints and management veto as reasons for their resistance. This reinforces the traditional conformity of the nursing workforce within a traditionally medical led system, where nurses are unconsciously adopting the language and form of social convention in a way that positions NPs within a system which remains resistant to the new role,

whilst paradoxically holding out to support it. Brook & Crouch (2004a, p. 211) suggest that there needs to be a “process of conjugation between the two disciplines [which] has been driven by the demands and pressures on the health economy”, something that national strategy is advocating but has not yet been adopted in this country.

The traditional stance of nursing is another strand in the complex web of influence affecting NP development. The hidden influence of how and in what way discourses operate to maintain the status quo is made evident in this study. In Chapter 8, in reflecting on the discourses exposed in this study, I explore how values such as altruism in nursing implicitly guide and situate the aspiring nurse back into their traditional position as invisible, stoic and uncomplaining. This view is perpetuated by nursing leaders and the NPs themselves so that negotiation around shifting professional boundaries is further confounded by the positions that nurses take on nursing advancement, either consciously or unconsciously.



## Chapter 8 - Through the Looking Glass

'I don't know what you mean by "glory",' Alice said.

Humpty Dumpty smiled contemptuously. 'Of course you don't -- till I tell you. I meant "there's a nice knock-down argument for you!"'

'But "glory" doesn't mean "a nice knock-down argument",' Alice objected.

'When I use a word,' Humpty Dumpty said, in rather a scornful tone, 'it means just what I choose it to mean -- neither more nor less.'

'The question is,' said Alice, 'whether you can make words mean so many different things.'

'The question is,' said Humpty Dumpty, 'which is to be master -- that's all.'

(Lewis Carroll in *Alice through the Looking Glass* in Oxenbury 2005, p. 128)

Alice's confusion and questioning of the meanings of words and how they are used resonates with the experiences of the NPs in Australia. Like Alice, NPs in Australia are facing divergent expectations and interpretations of their role. Nor is the vision of the NP role from the nursing profession necessarily aligned to the interpretations of the wider health care system. Tradition and history play their part and language articulates what is viewed as the truth and knowledge in creating the fabric and views of a society. Foucault argued that the history behind the reality is closely related to the way in which relations of power have been transformed over time (Foucault 1972). He suggested that society looks back on its origins in order to plan for the future in a way that allows history to inform our knowledge and view of today in the way we think, speak and act. This assumption supports the traditional underpinnings of contemporary nursing as the knowledge of ideas is handed down through history, and manifests in the way nurses conduct themselves within the multidisciplinary team, as well as in their expectations about nursing (Buresh & Gordon 2000; Nelson & Gordon 2004). This chapter reflects on the discourses that have surfaced through the analysis of interviews and technical literature in the previous chapters. I use these reflections to explore how the value of altruism is embedded in nursing, having both negative and positive effects on how nursing is advanced. Altruistic values are positive because they serve to motivate NPs to succeed, but are negative in their effects because such beliefs mean that their arguments cannot be made in language that makes sense to the organisations that block their advancement.

In this study, I wanted to go beyond those stepping stones and stumbling blocks known to exist in advancing nursing and to peep through the looking glass at what lay behind the discourses that impact on nurses' development. I sought to analyse the

technical literature on the advancement of nursing knowledge and practice, and to explore the history of ideas that has given rise to the present attempts to advance nursing practice, with particular reference to the NP, and how these differ to the reality that NPs describe in their struggle to establish themselves in the workplace. Using a critical discourse analysis framework based on Fairclough's (2001b) interpretation of language and power on the three levels of social organisation, role development of the NP has been examined in this study. The premise for the study was that NPs act and behave in a way that society has shaped them and that this new role called the NP, challenges the health care institution by testing the boundary of nursing practice that is controlled by powers behind the overt discourses in health care.

What has emerged from the data, is a dichotomy between an altruistic vision of nursing as a profession in the value of the NP, and a truth claim of what the NP really is (or is not) in a commodity driven health care system. At the beginning of this study I suggested that nursing as a profession has not gained the autonomy it sought for NPs. I have argued that nursing has merely shifted its sphere of influence in what is still a traditionally driven health care system. Here nurses are located as a profession reliant on medical decision making in order for them to carry out their work. The doctor is portrayed as the leader in a clinical practice setting where it is still accepted that the medical model of care is the major framework. Traditionally, this powerful medical positioning has resulted in doctors being at the head of health services as much as at the helm of clinical decision making. In this organisational structure there is no space for a mixed medical/nursing role like the NP. From this study, evidence has emerged to suggest that, as Fairclough (2001b) contends, these power relations are usually hidden, but have become more overt as nurses are struggling against the norms resident in the established power equations.

The struggle that has arisen through the implementation of the NP role is as much out of the nurses' unconscious compliance to the dominant discourses, as it is out of the operation of dominant discourses themselves. These two opposing positions work simultaneously in shaping the implementation of this new nursing role. The outcome is in reality far less even than the shifting of the profession's sphere of influence, because both the NPs and their nurse managers who are supposed to support their

development, have struggled against these overt obstacles, and opposing discourses within which they operate.

This chapter will reflect on the discourses examined in previous chapters, and will use this information to examine the opposing forces that are working together to shape the NP role. In accordance with Fairclough's (2001b) levels of organisation, the discussion will broaden analysis to that of nursing as an order within healthcare as an institution, because, in this examination, NPs are merely one small part in the whole collage of perceptions and deceptions working to maintain the health care system as we know it. Yet it is this one small cog in the wheel, the NP, that has served as the catalyst for such a large public debate and a significant challenge to the status quo of the health care institution. The invisible nurses become visible not because of their professional or clinical worth, but because of their new hybrid role that challenges the status quo of a traditional health care structure.

### ***The Royal 'They'***

In my discussions with my supervisors, I have talked about 'they' who are not allowing NPs to progress; 'they' are dictating what nurses can or can't do. But who is 'they'? 'They' is not a magic rabbit hopping in and out of discourse boxes and hats. I have shown that this is not a simple matter. On the one hand 'they' is in reality the claims of those using discourses of health care driven by financial controls residing in a commodity oriented health care system. On the other hand 'they' is also the hidden power within the traditional structures of health care. Although this traditional power has overtly shifted to a chief financial officer, the covert control still remains with the doctor without whose services, health resources and funds cannot be allocated. And over and above the contest, the 'they' is the complex and intricate web of bureaucracy which drives the system and which has the power to allocate or withdraw funds based on statistics and trends of health, but which has no real control over operational activities as to how those funds are used.

Society has been led to believe that health care delivery is what is viewed in the annual hospital reports. The reports are consistent with Foucault's "notions of truth" (Rabinow 1997, p. 37) because these glossy magazines provide pictures of nurses with smiling faces, new equipment, new services and other good news stories and a financial report, which provides enough information to keep people happy but which

conceals the real utilisation of funds. By their very standing in society, health care institutions are given the authority to speak the truth through the CFO as representative of health care. But by speaking the truth in this way, what is maintained is the dominant ideology through which the institution of health and their web of texts exist across the three levels of social organisation that Fairclough (2001b) highlights. It also maintains covert authority to those traditionally in power and whose interests lie behind the claims, texts and discourses of health care. ‘They’ remain pivotal to funding and resource allocation, to maintaining the status quo of health care despite government policy directives and initiatives such as we have seen with the NP development. But this is not the only power that affects the NPs.

Another symptom of the systemic relations of power creating further complexity in the mix perpetuates the status quo of health care – specifically this is the role that maintenance of tradition plays. ‘They’ is also the NPs and other nurses involved with development of NP roles who through their own belief systems, perpetuate the subservient nature of nursing through the ways in which they act and describe themselves. Nelson and Gordon (2006 p. 19) referred to this when they said that nurses still rely on the “virtue script” which has not changed in 100 years of nursing. Fairclough (2001b) says that society, through the social institutions such as legislation and education, perpetuate ideology of the groups that dominate and adopt its discourses without realising ‘they’ are even doing this. In this way the status quo of the traditional leaders is maintained because all the players within the system adopt and use the discourses of the dominant power. Nursing, is a caring profession as such not only because of the traditional power brokers of health, but because the nurses themselves believe and ratify this.

### ***Nursing as Altruism versus Nursing as Commodity***

It is for this reason that I now focus on the two sides of a coin; firstly as viewed by nurses, and secondly as viewed by the economists of health, in relation to nurses and its definition as the caring profession. If health care is viewed from Fairclough’s (2001b) standpoint, then participants in a society, such as nurses in health care, unconsciously adopt the actions and language of the dominant power because they are exposed to them on a daily basis, and so the use of such words makes sense. As a result of constant exposure nurses internalise these discourses as their own. The influence of the past thus shapes the way they are and the way they position

themselves in that social order. In this way the political economy of health and the tradition of nursing are intertwined so that they together, they interact in the operations of the dominant discourses that affect the outcomes of any contest over the re-distribution of power, such as the NP role establishment.

The evidence in this study has shown that on the one hand there are those nurses who seek to advance their profession through the advanced practice role of NP, and on the other hand the traditional health care division of labour is maintained through the unchanged processes of resource allocation for health care, which they themselves accept as normal. Jane spoke of this when she referred to the fact that she was a NP but not working as one, still having to conform to the usual work practices embedded in the traditional nurse/doctor relationship despite the doctors being very junior and inexperienced.

*You are working at times with very junior residents on the ward who have not met these kind of patients before and aren't really competent to make definitive clinical decisions. So you have to foresee that, but we don't have any authority to do that, so it always has to be medically supported, but we are often finding ourselves in a situation having more lot more knowledge than some of the medical staff themselves (Jane, interview 2, p. 4)*

Joe also highlighted the traditional nurse/doctor relationship when he talked about the fact that he would not have got his NP role established without the doctors' support,

*The underlying theme that I got from particularly from one consultant who I have a very close working relationship as well as a personal friendship is that the reasons it took off the ground is that these guys have known me for a long time and so they trust my judgement and they are happy to run with it...you know God love doctors they very much personalise things and you are a good guy and we know you and you can do it but if we don't know you then we won't support it (Joe, Interview 3, p. 3).*

Mary, (Interview 1) told of a situation in Chapter 5, where she was unable to progress her role as NP, because the DON would not even consider such a change, because it went outside of the traditional health care workforce configuration in that organisation (Mary, Interview 1, p. 5)..Whilst the states and federal governments continue to promote NPs as a cost effective solution to escalating health care costs, the health services which still remain in the service of medicine through the funding allocation system, do not embrace it. Neither do they try to do things differently in a

system that although it says it wants change, has not reviewed the way in which it is funded in order to facilitate those changes. This process was described in Chapter 7. It is exemplified by Mary's statements, where the DON showed no desire to even consider the implementation of a NP role. There have been other examples of DONs not supporting change to facilitate NP role establishment throughout this study. The funding allocation still requires the medical episodes of service as the measurement of health care need and the consequent resource allocation. The AMA's unashamed and public conceit in their media statements reinforced this view that doctors hold the power in the health care system. This was evident in a document released by the AMA as a position statement that provided details of what the AMA believed the government should do to encourage doctors to work in rural and remote areas. Despite NPs being developed for this very geographic area by the government, the AMA have persisted in their lobby for more funding whilst discounting the potential of the NP role,

The AMA does not support a role for independent nurse practitioners. This, however, does not preclude the capacity for highly skilled nurses, working as part of a collaborative primary care team led by one or more GPs to be supported in the delivery of services to remote areas where access to health care is often very difficult. These nurses should:

- Have appropriate clinical experience and training
- Be supported through the provision of appropriate communication technologies to ensure that treatment can be properly co-ordinated with the supervising GP(s)
- Be governed by appropriate clinical decision making protocols developed by GPs in consultation with clinicians (Australian Medical Association, 2005, p. 8)

NPs do have appropriate clinical experience and training; they are able to properly co-ordinate treatment. NPs do not need clinical decision making protocols supervised by GPs because state legislation provided NPs with the authority to manage care within an identified scope of practice. They can work collaboratively with GPs and still achieve what the AMA is suggesting. The difference is that NPs do not need to be supervised by GPs or be employed by GPs to do this work. It can be contended then, that the role of NP, whilst being proclaimed the panacea that will accomplish nursing advancement simultaneously as it solves health care's financial woes, will only be realised as such if the actual funding arrangements and shifts in power bases are altered.

The conversations and technical literature in this study have provided examples of how nursing as a profession remains subservient within what are accepted discourses of relations in health care. Medicine remains pivotal to health care delivery where doctors are seen as the generators of health dollars, and other professions such as nursing revolve around them as mere costs in the health system as this system pays for nurses' labour. This has also been well documented in other studies that examine practical issues of NP role implementation and which situate the nurse in that traditional health care paradigm in Australia (Keyzer et al. 1995; Mahnken et al. 1997; Gardner 2004). The invisibility of nursing is exposed in how health services avoid sustainable implementation of NPs. As this study has shown, organisations accept funding for NP projects but do not make use of this opportunity to examine new models of care which involve the NP that would, in the long term, reduce the costs of health care provision. Instead, health services use the expertise of well trained nurses who are endorsed as NPs but employed into alternative nursing positions, so that these nurses do not have the authority to become fully functioning and autonomous decision making members of the health care team. This is not what was envisioned or anticipated for the NP role not only by nursing as a profession and by the government, but also by national and international research about the role. Van Offenbeek and Knipp (2004) demonstrate this attitude towards NPs in their Dutch study when they concluded that,

Innovative forms of advanced nursing practice can only enhance the effectiveness of care processes when they are embedded in a work structure that is internally consistent and adjusted to the task environment and the available skill-mix (p. 680)

In other words NPs can only progress by conforming to the existing health care structure of that country. Other studies have shown that nurses have been caught up in the debate around professional roles and divisions of labour which does not encourage the advancement of nursing practice, least of all the role of NP (Hegney 1997; Drayer & Brown 2000; Dingwall & Allen 2001; Kernick & Scott 2002; Jones 2003; Hoque et al. 2004; Copnell & Bruni 2005; Faresjo 2006). All too often though, nurses have perpetuated the situation by their silence and their belief in nursing as being governed by altruistic values because, as an American professor of nursing said, "patients and families will know that [what nurses do] naturally just from watching what the nurse is doing" (cited in Buresh & Gordon 2000, p. 32).

The breadth of the divergence between nursing as a commodity in a business driven health care system and the altruistic view of nursing is still governed by “the politics surrounding the professional groups and the larger policy landscape” (Fairman 2008, p. 185). If I refer back to the earlier chapters in which the history of nursing was explored, the focus of the altruistic view of nursing is in its particular definition of what counts as caring. This has been the single factor that nursing has tried to control in its endeavour to becoming a profession, suggesting that caring is what nurses do well. As previously discussed in Chapter 3, caring is also synonymous with women’s work and women care for people the world over and in all walks of life, it does not necessarily take a nurse to do that (Clifford 1995; Kitson 1999; Chiarella 2002; Fineman 2004; Nelson & Gordon 2004; Copnell & Bruni 2005; Gordon 2005). The difference is that nursing as a profession has attempted to capture the concept of caring in a scientific form known as the nursing process (Serle 1987; Keyzer et al. 1995; World Health Organisation 1996; Kitson 1999; World Health Organisation 2002). However, because of what Nelson and Gordon (2006, p. 25) call the “feedback loop” nurses continue to receive support from others when they perpetuate the “virtue script”, not because they embrace and use knowledge and science in their care for patients. The problem arises in the contemporary world of patient bed-days and randomised control trials, that caring as a motivation does not fit, nor does it remain in the control of the nurse (RN) because much of what formerly counted as the visible elements of caring component of the nursing work are being steadily given to less qualified workers such as patient care assistants (Dingwall & Allen 2001; Perala 2001; Jenkins-Clarke 2003; Hoque et al. 2004). It is this divergence in discursive effects that sets nurses apart from mainstream health care in the contemporary social order and it is this that I will explore in this chapter. These divergences are the crux to the delays to NP role acceptance and whilst this stand-off between two opposing positions continues, nurses will remain a commodity to be controlled and manipulated by those who are in charge of health care resource allocation. The concept of the altruistic nurse as caring no longer works, yet nursing leaders still talk about nursing, love and caring in the same sentence as if there is some naturalised ordering (see Chapter 5 for previous discussion of this).



## *Moderated Love*

In this following section I turn to an exploration of the way in which discourses about altruism have been used to position nursing and continue to contain its most recent advances. In Professor Leggs's oration at the 42<sup>nd</sup> Patricia Chomley Memorial Oration for the Royal College of Nursing Australia Conference, entitled 'Nursing: a Moderated Love', Legg (2008, p. 3) said "there are times when I actually do wonder why I am still a nurse". She went on to say that the reasons for her motivation were and still are, "the learning opportunities that one has, not in formal education, but learning from and being inspired by, other people". She told the audience that she had good role models when she trained some 40 years prior, and that,

They were hard working years, but we were trained and educated by women of vision and focus, who had sheer and utter dedication and commitment to patient care and to the development of us as young student learners and as professionals (p. 4).

The vision she refers to is the hard subservient work that indeed nurses of that time carried out under doctors' orders (McBryde 1979; Bassett 1992; Nelson & Gordon 2004). Dingwall and Allen (2001, p. 65) refer to this dedication and hard work as 'emotional labour' because service occupations such as nursing have to manage their emotions in ways that are consistent with the roles and tasks of the job, as part of the service offered by an organisation. Emotions in the labour of a caring workforce are therefore "subject to acts of management" (Hoschchild 1979, p. 551). Because jobs that require emotional labour are predominantly women's occupations, Dingwall and Allen (2001) suggest that the full worth of this work is not properly acknowledged or economically rewarded and open to exploitation (p.65). Dingwall and Allen (2001, p. 65) noted that,

Emotion work has also become a key element of the nurses' mandate, part of a claim to a distinctive jurisdiction in the division of labour in health care...and it justifies their status as a separate and independent profession, worthy of respect from any other health care profession.

Because of this mandate, health services both nationally and internationally have tried to measure and quantify caring to create a financial value (Bolton 2005; Cooke 2006; Orrock & Lawler 2008). This, according to Orrock and Lawler (2008, p. 1) creates the "fractured self" with nurse managers because of

...first the historical and continuing ethos of nursing as humanitarian, caring work; second, the increasingly technocratic expectations of health care systems and the people who control them; and thirdly, the consequent clash of values structures and ideologies that are at play in current western health care systems.

However, in the face of financially measured caring, such national leaders as Legg have continued to promote a view of altruism in her “re-enactment of the moderated love” which, she suggests is what will support nursing leaders of the future. Legg compared nursing leadership to a horse whisperer where horses are led through the need for connection. In this way she said, the new generation of nurses will be “soul seekers” (p. 8) and the attributes of a nurse leader will include,

Prophetic – in discerning the soul/spirit realities in a given situation  
Missional – in communicating the values/ethics of the profession  
Pastoral – shepherding the people by leading, nurturing and protecting  
Teaching – communicating the wisdom of care through engaged scholarship  
(Legg 2008, p. 9)

This view of altruism in nursing leadership and the future of nursing as ‘future makers and shakers’ is so discordant with the experiences that NPs are having in establishing themselves that I am left wondering if the CFO of a hospital or a clinical director<sup>73</sup> of a unit would be happy to be ‘whispered’ to in a ‘moderated love’ and if they would allocate funding to a NP based on these humanitarian ‘connections’ in the contemporary world of health. Although nursing has chosen caring to identify itself, this focus has prevented the profession from moving forward because such a value does not afford nurses a position of mutual understanding with the political economy of health care (Etzioni 1969; Moore 1970; Meiksins & Watson 1989). Dingwall and Allen (2001) contend that the ‘Golden Age’ of nursing in which care and dedication was mandated no longer supports nursing, because many of the identified caring tasks of yesterday such as bathing and feeding, are allocated to patient care assistant roles<sup>74</sup> today as a cheaper option to nursing care. Rather, as O’Brien (1994, p. 407) says “in essence, the [unacknowledged and under-renumerated] emotional labours of nurses are constructed as the key vehicle for realising health agenda developed by medical and administrative authorities.”

---

<sup>73</sup> This is usually a specialist doctor in the clinical discipline relating to the service. The role frequently has financial responsibilities as well.

<sup>74</sup> Patient Care Assistants (PCA) is one of many titles for carer assistants who have a short training program in the care of patients. They are not a regulated workforce and can be employed to undertake those manual tasks of practical caring support that used to be very much a part of a registered nurse’s role, termed activities of daily living.

If I refer back to Chapter 7 where the economic position of health care was examined, then agendas of others in the health care system such as the CFO, do not support the altruistic view that nursing holds. Yet, the altruistic position is still promoted by nurses without thought of what might constitute caring practices in the contemporary health care environment. Whilst the ANMC NP Competencies attempt to position the NP within that contemporary health care structure by stating that NPs “provide health service leadership” (Australian Nursing and Midwifery Council, 2006), the message is contradictory not only because there are leaders of nursing that tend not to enact it, but the very NP Competencies themselves are paradoxical because the same document refers to NPs as identifying “the values intrinsic to nursing”, which we know from the information in this study, refer to traditional and altruistic values of nursing. I contend that such a view provides no space for those extended practices that NPs have been awarded through legislation and which cross the traditional boundaries between nurse and doctor. The tension between what the NPs can do that traverses medical and nursing practice, and what nursing views as important in that practice has manifested in conversations such as this below from the participants,

*...don't forget that we are actually nurses with specialised fields, we are not doctor's substitutes, we're not pretend doctors, like people, you know, want us to think, you know, think we are. I think we have to look out, as nurse practitioner we look after a person holistically, not just medical, even though we have the medical skills, more clinical skills to look at their medical needs, we also have that nurturing undertone as the nurse, to look at other aspects of this person, which, I don't think the doctor actually has the time to do it. (Cindy, Interview 6, p. 9)*

Such a view is located within the visibility/invisibility debate from previous chapters because Cindy's attempt at identifying herself as a nurse presents a picture of a merged nursing and medical professional where the nursing component in the practices she describes are termed nurturing. We recall also that Joe, in the previous chapter, showed how he was measured against financial outcomes embedded in medically focused clinical performance indicators such as length of stay and episodes of care, rather than his ability to provide an enhancement in the care of a patient. The NP therefore has been set up against a backdrop of divergent views of how the role is to be worked or practised. The tension demonstrated in the participant conversations suggests that the ANMC's position on NP leadership and autonomy is not

necessarily what is supported by organisational directives. The real use of nursing as a commodity, despite so called contemporary advances in autonomy, was magnified by Professor Nelson, quoted in The Star Newspaper in Toronto recently,

If there's one thing nurses know, it's that tough economic times tend to mean cuts to the profession. This has been the pattern over the decades, where nursing from Toronto to Manchester to São Paulo has all too frequently been the health-care service sector that takes the hardest and deepest cuts when the economy takes a nose dive (Nelson 2009).

Managers in health care, many of whom are nurses, have had to conform to financial control. This has been referred to in the restrictive commodity of health in the British National Health System (NHS) where leaders of health are a part of a dependency culture that inhibits personal, organisational and economic success through the need to be constrained by financial indicators relating to health trends known as the balanced scorecard (Kaplan & Norton 1996; Hoque et al. 2004). Hoque et al. showed that autonomy or freedom to make decisions as a manager<sup>75</sup> was directly related to how well they did in financial key performance indicators. “Three stars” Hoque et al. (2004, p. 356) allowed managers a “range of freedoms” relating to the business of managing the service. In other words, managers were not actually free to make decisions although they were afforded ‘freedom’ based on compliance to budget indicators, and then only within certain jurisdictions set out by the NHS. Legg’s altruistic approach, much like those leaders mentioned by Buresh and Gordon (2000), would fail to have an impact in such a budget driven environment. As Nelson (2009) continued in the Toronto newspaper article,

Even today, when we finally have the data to show that quality nursing staff is strongly correlated with patient outcomes (including mortality), the question continues to be raised. The tradition of seeing nursing as a resource to be built up in good times and trimmed back in lean times dates back to the very beginning of professional nursing.

The impact that this use of nursing resource has on nursing was reinforced in a recent Australian state’s reform, which showed that nursing, despite the rhetoric of influence had no authority in health service outcomes. Managers are powerless to influence change and,

---

<sup>75</sup> Manager in this particular study was anyone in charge of a clinical unit, which included any health professional. Frequently the managers were (and are) nurses.

...not only did they [nurse managers] report a progressive deconstruction and subsequent demise of their role identity (that traces its provenance to the Nightingale Matron), but a perception of many of the study's participants of a new post-reform self was insignificant, worthless and of no value to the health care organisation (Orrock & Lawler 2008, p. 2)

In other words, the role nurses play remains invisible and silenced, even as nurses become managers of health care services. NPs, as much as their nursing managers, are unable to influence health policy as any successful implementation of NP positions would suggest, and contrary to ANMC views, nurses are pawns in the health care system, to be used in roles convenient to the organisation. This has been consistently demonstrated by the participants interviewed for this study. Their struggle to have any influence at all emerges in their conversations and in their inability to actually practice as NPs. This is because nursing services in Australia are factored into service provision within a health service revolving around access to medical services, and nursing leaders seem powerless to change this. Caring, therefore, as much as nursing leaders promote it, is not a factor to influence any change in the way health care is delivered and funded. As shown in Chapter 7, international examples of NP implementation show that the dominant theme for NP employment was cost efficiency rather than what nursing could contribute to that provision of care.

In Chapter 7, the way in which funding is allocated to health care services was examined. The positioning of medical and nursing labour was identified as located within a medically driven funding allocation of health care services. NPs under this arrangement are unable to offer their services to health care organisations as self-funded professionals who bring funding with them for the provision of care. . Because of this, there is no place for nursing leadership in its current use of both traditionally and altruistically situated discourse to influence how things happen or to enable individual nurses to break free of that system. The irony of the situation however is that NPs can provide a service similar to that of doctors because it is not actually the doctor that generates the need for a health care service in the first place. What is hidden under the current resource allocation (both tertiary and primary), is that the dollars follow the patients who seek access to health care and for which hospitals are funded, through their episodes of care, to pay doctors or hospitals that provide the care. This perspective on funding arrangements is not discussed anywhere, and although the AMA takes a line of argument on safety to demean the

NPs' skills and abilities, their argument is covertly financially driven, rather than clinically. NPs are a proven cost effective alternative and the AMA members would stand to lose income as a result of the NP role's full introduction as health service providers. Participants have talked about the fact that there is no budget for their positions, yet NPs do not represent a cost to health care services, in fact, as identified in the previous chapter, they can save money for the government because they are a less expensive option to care delivery. The system supported the continued medical dominance in the funding arrangements, and nursing has tacitly supported it through the use of an altruistic positioning taken by profession preventing NPs from reaching their financial and clinical potential.

Despite legislation and policy, this study shows that the NPs who participated in this study struggled to influence change, nor are they wholeheartedly supported by their nursing managers. Based on the findings in this thesis, there seems to be an element of inertia where those nurses in authority are not able to initiate new models of care that would support nursing as a profession, but also save the health dollar. What this suggests, is that nursing positions may have a title of authority and leadership, but they do not seem to have the legitimised authority that allows them to produce changes. This situation does not appear to be peculiar to Australia. The findings from this small in-depth study are replicated internationally (Asubonteng et al 1995; Arnold 2004; Bolton 2005; Cooke 2006). Concepts and phrases mobilised in nursing texts such as 'collaboration', 'autonomy', 'part of a strategic team', 'influencing policy', appear to be no more than rhetoric. These words are a constant presence in this thesis and amount to no more than subsumed titles and roles that have little ability to act with agency, that is with any 'autonomy' however that word is defined. Nurses as leaders whether they are NPs or nurse managers appear unable to achieve the autonomy that is their right through legislation and regulation. Also, they are not shifting their sphere of influence within the health care team structures. The status quo of a traditional health care order is thus maintained, in spite of the policy, the legislation and the government's media statements that support nursing involvement in changes to health care delivery.

## ***Bring Back the Matron***

The Australian experiences described in this study are not isolated from the global nursing perspectives either. As much as the international literature used in this study has shown that NPs find it difficult to influence health care change, so too is the management of nurses in other countries. The texts used in this study clearly outline this, but none as much as a recent National Health initiative in the UK, where manager roles were significantly changed in both title and job description. I have included a discussion on this UK experience because the events described there not only show how little influence nurses have but also how nurses themselves support and endorse, both tacitly and overtly, changes to their own profession even though the impact of that change is detrimental to progress in the nursing profession. The described situation in which nurses find themselves in the contemporary arena of health care is not exclusive to NPs. These effects occur to nursing more generally. NPs are just one component in the larger financially driven wheel of health care, where the altruistic and traditional view continues to be encouraged of nurses so as to be capitalised on by others. The NHS in the UK recently demonstrated how enmeshed the approach to nursing as a commodity is. In 2004, that country's government made a decision to change existing nurse manager roles to bring back what they described as the traditional role of the matron. This change was widely communicated as a cost effective solution to cutting infection rates.

Up until the 1980s DONs were called matrons. Under the former service focused health care system, matrons oversaw nursing services in a way that was practically focused around the maintenance of hygiene, nursing procedures and policies. With the advent of business units in health systems, DONs (the new matron roles) took on a range of other business related activities as well, and this has been discussed in Chapter 7. It is unclear in what followed as to how much of this significant change to a nursing role incorporated the views of senior nurses and was merely the manipulation of a tradition for the sake of an NHS led need to re-aggregate care. Moreover, there is much about this move by the government of the UK through the NHS that mirrors motivations and concerns that have led to the promotion of the NP role by Australian government. The description of the process for change outlined below warn of on-going difficulties for the implementation of NP roles if roles can be aggregated, disaggregated and dissolved for the meeting the ends of a

bureaucracy. The extent to which bureaucracy makes changes regardless of any governance or influence nursing managers may have in an organisation was outlined in a BBC News article recently.

The UK Government found it appropriate to place the matron back in service, not because nursing leaders wanted to lead with care, but because infection rates from MRSA<sup>76</sup> were soaring, and the Government believed that the reintroduction of the matron would assist in reducing the infection rates (BBC News 2008). The article stated that “senior charge nurses will assume the duties of matrons used to have as part of the Scottish Government drive to reduce hospital infections” (BBC News 2008) and that “all charge nurses would be put in charge of cleanliness to cut hospital infections”. The article did not give credit to the infection control processes that every hospital in the developed world should be following<sup>77</sup>. The article went on to say that,

...in some respects this is about going back to the future as the senior charge nurses will have the same responsibility for ward hygiene as matrons used to have – set in the context of 21<sup>st</sup> century environment (BBC News 2008).

The matron role was supported by others across UK and which had been implemented in other UK health services since 2004. For example, Arnold (2004) wholeheartedly supported bringing back “those straight-laced matrons” whilst Bolton (2005) described the new matron role as a “vital link between operational and strategic management” (p.5). What is interesting in these articles is the ignorance of what it means to be a person in charge of a clinical environment. A fundamental aspect of clinical practice, whether it is a nurse, a doctor or a cleaner, is cleanliness and infection control. It is part of the job of everyone in a clinical area, and the auditing of practice rests with the nursing director, charge nurse or others in charge of those places<sup>78</sup>. This point was also made by Woods (2005), quoted in The UK Telegraph, when she stated that the introduction of the matron into the NHS had not reduced hospital infection rates. In fact according to statistics, rates of infection had

---

<sup>76</sup> MRSA is Methycillen Resistant Staphylococcus Aureus which emerged as a hospital acquired infection a number of years ago. The infection has significant negative effects on ill and compromised people and has cost governments across the world millions of extra dollars in hospital expenditure.

<sup>77</sup> In most major hospitals in mainstream western health care the accreditation and quality standards require very structured infection control measures to be demonstrated and implemented.

<sup>78</sup> Whilst I have not referenced this, an examination of any reputable hospital policy in the context of what is termed the Western World, would reveal this information.



doubled since the introduction of matrons because the problem and the solution go “much deeper” than introducing a new role. Woods noted that the new matron role was “dreamed up by politicians” and its only “appeal” was that people can have that “sentimental attachment to nursing as it used to be 40 years ago.” Woods noted that infection control was “not rocket science” and it did not need a matron to do it. Kermode (1994, p. 112) commented that in large public hospitals such as this NHS example, “managers and bureaucrats use the tools of re-aggregating work, rationalisation of activities and staffing levels, re-organisation and re-structuring of organisations and awards as ways of controlling the productive process”, in this case, the reduction of MRSA infections. Kermode (1994, p. 113) noted that in these settings nursing has always been a part of the bureaucratic wheel and as such is subject to “consistent domination by another professional group and multiple layers of bureaucrats”. It is not surprising that the NHS went about changing roles in the way they did.

What the BBC article did not reveal was that these nurses, who were now being charged with managing cleanliness, had the responsibility of the unit budget under the business unit concept of health. Therefore, of concern was whether another layer of management was created or whether the manager workload merely increased in breadth of activity. Bolton (2005) confirmed that managers were expected to manage both the clinical and the fiscal aspects of unit management and that nursing had adopted these new directions as part of its “professionalisation project” (Bolton 2005, p. 7). However, nothing had in fact really changed, except the role title, because since the introduction of the neo-liberal business unit concept in health care in the 1980s, in Thatcherite reforms almost everywhere, nurse managers have been responsible for all clinical and financial activities at the ward or unit level, including the control of infection (Kermode 1994; Klein 1995; Antrobus 1999; Doolin 1999). The selling of the matron role was outlined in a document released for the purposes of introducing the matron role into the NHS entitled “A Matron’s Charter: an Action Plan for Cleaner Hospitals” (Department of Health 2004). In this document, the role of the matron is outlined clearly and commences with a quote on cleanliness by Florence Nightingale, followed by a “modern” matron’s statement,

“A clean environment is dear to all our hearts. As a Matron I know that it is my responsibility to take the lead in this; however, I cannot do it alone. Teamwork, clarity of role, and recognition of the value of the cleaning staff are all key to

improvement. I cannot over-emphasise the importance of a culture of good housekeeping and hygiene practice.” (Edwards, quoted in Department of Health 2004, p. iv)

Bolton (2005) identified language that had been used to sell the matron role with words such as “leadership” and “care co-ordinators”. The position taken by NHS strategists was that the matron role would be “high profile management” and would boost the public confidence in the NHS (Bolton 2005, p. 8). What was even more disturbing was that this change to job description came “following a review of the senior charge nurse, following concerns about recruitment and retention” (BBC News 2008). The leap from recruitment problems to changing a job description to combat infection which was costing the government significant amounts of public money is incongruent. The actions support Dingwall and Allen’s (2001) opinion of healthcare being delivered in a competitive environment where the tax dollar has to be shared around and where financial officers are the directors of change making assessments purely on the budget balance and not on patient need. The decisions being made in regard to the matron changes were endorsed by nursing leaders, thus approving the use of nursing as a commodity and not as a profession. It remains to be seen whether another health care professional group such as medicine would have allowed such changes to their role and scope of practice. If the very public debate that the AMA has used in Australia to protect doctors’ interests is evidence of this, it would not happen (Australian Medical Association 2000; 2003; 2005; 2006). The NHS example shows how change can reinforce the silencing of nurses and, as Bill noted in his interview when talking about the management of the service he worked in,

*These people have come from backgrounds such as communications, banking, you know, all sorts of things, nothing to do with healthcare and yet they're making decisions, enacting policies in the department of [service], turning it in to reality, that is having direct ramifications on the services of people (Bill, Interview 8, p. 15).*

Bill’s example, as much as the NHS workforce changes, has reinforced the silencing of the profession. Nurses accept their silencing by tacitly supporting the manipulation of nursing roles due to budget need, hidden in the language of support and caring, and so become a commodity of health care resource allocation rather than as a professional group whose skills are needed for effective, safe clinical practice.

Bill highlighted silencing from the NP perspective, supporting Kermode's idea that nurses remain within a cycle of dominance by others,

*It is interesting in that, we talk about, you know, exclusion, not being recognised and not being there, and yet, by us not being there, it gives a real indication about how the government views the role of nurses, and how you know, no matter what we do, and all the fights we have, it's not changing. (Bill, Interview 8, p. 12)*

The development and intervention of the UK Matron role focused on nursing to resolve a cost issue; it did not affect medicine in any way. Yet it is a well-rehearsed argument that now locates cause for the rise of resistant bacteria to the medical over-prescription of antibiotics and presented Western health care systems with the problem of MRSA. From such a well-informed position then it is not merely unclean hospitals, as has been suggested through the media and through the nurses' tacit acceptance of this change that meant that the severity and rates of hospital infection have risen. As Woods (2005) confirmed the NHS lead the public to believe that "The buck would stop with the matron. But, according to many, this was an oversimplification of the matron's role and the root cause of MRSA..."

The examples demonstrate how nurses are constituted as a commodity and not as agents of care in their own right. They are subject to cost saving initiatives even when they are not the reason for the budget shortfall. Nurses' silence and dedication appears to have been an easier option for the CFOs to manage than doctors who, despite the difficulties on the financial front, remain in control and constantly and instantly contest any erosion or changes to their role. This situation has been evidenced through the language in media statements by the AMA in this study. The position of nurses and doctors in the traditional health care system is no different from 100 years ago. Because of this traditional acceptance of hierarchy, NPs in Australia are as much subject to role manipulation as exemplified by the UK Matron example. This has been demonstrated throughout this study, in the participants' inability to work as a NP and when they do work as a NP, their acceptance of larger workloads with medical indicators to assess their role value. Yet, government media releases have stated that NPs are a cost effective solution to escalating costs (Perry 2002; Sugden 2005). The AMA's position statements used in this study, and also in the example provided in Appendix 8, in which the AMA state that "a move to independent nurse practitioners would dumb down the Australian health care

system” show that the NP role is clearly not what they want, as they continue to denounce it and promote the Practice Nurse role as its alternative. The Practice Nurse, of course is employed by the GPs, and is supervised by them, whereas the NP would be an equal partner. The medical dominance in vetoing or supporting health care changes remains central to the health care system, despite consistent calls for cost reduction initiatives.

Despite the government seeking innovative ways to reduce costs, it is the very budgetary standpoint that is used as an excuse not to implement the role. The NP participants in this study have shown that their skills have been utilised in less confronting nursing roles such as the CNC or NUM role so that health services are gaining financially and clinically, by having the additional expertise of the NP skill without the cost or required authority. Cooke (2006, p. 223) supports these claims in an examination of what the author refers to as “seagull management and the control of nursing work”. Under the marketing guise of “improving public protection and empowering consumers of health” Cooke (2006, p. 224), showed that neoliberal NHS reforms embodied incongruous trends through “quazi-markets” and “managed competition”. This achieved the economic results of reduced length of stay of patients in hospitals, whilst simultaneously increasing the number of patients moving through the health system so that, in financial terms, the increased number of patients accessing the service whilst reducing the number of days a patient remains in hospital, reflected as a financially viable and productive business unit. The negative side of this financial activity occurs where nursing is used as the commodity by which these outcomes are achieved. The services are “getting more for less” because nurses now have heavier workloads, with patients with higher acuity levels<sup>79</sup> and there is a consequentially reduced caring component to the work because nurses are “now working on an assembly line”, rather than providing the “holistic care” to patients (Cooke 2006, p. 225). The income for doctors in this situation is not affected, in fact, because of the funding arrangements more doctors are essentially required in order to meet the increased demands for the service resulting from increased patient throughput.

---

<sup>79</sup> Patient acuity is a measure used to describe the severity of illness in a patient. The higher the acuity the more complex the illness presentation is and the more intensive the management of the patient requires.

In this funding arrangement, the NP, as a nurse actually does not cost the health care service anything because nursing is part of the funding arrangement based on medical episodes of care. Yet, actual cost containment focuses on the number of nurses required to care for patients, and relies on the supply of nurses to provide that care<sup>80</sup>. Therefore the supply and demand of nurses affects the number of patients a hospital can cater for. When the supply of nurses is reduced the number of patients admitted is reduced, therefore despite increased patient throughput hospitals cannot admit patients if there are no nurses to care for them. The commodity of nursing thus becomes the hidden pivot in the cycle of funding despite those same funding arrangements overtly focusing on medical availability. In this instance, the level of nurse and their cost becomes a focus of budget so that NPs are seen as an expensive option because lesser qualified nurses can be used to provide patient care.

This is the position that the NPs describe when they refer to the fact that they are being employed into lesser nursing roles. However, as discussed in Chapter 7, some health services are side stepping this problem by employing NPs on the junior registrar budget, such as those in neonatal intensive care units. Although their skill is being utilised, NPs in this situation are being removed from the nursing workforce and are being aligned with the junior medical workforce. So nursing still remains a commodity and nurses, regardless of their level of skill and standing, are moved around to suit both budget and need. By moving NPs to a medical roster, nurses are still being silenced because NPs are not being recognised as nurses in this instance. The doctors are still overtly accepted as the key to funding and health care delivery practices and NPs are still used as a commodity.

### ***‘God Love Doctors’***

The examples provided in this study support the evidence that has emerged within the small group of NPs who participated in my study. Whilst it is only one small group of nurses, their experiences together with other sources of data brings to the surface for examination the discourses dominating in the contested area of national health in Australia. This situation is replicated in other developed countries which are governed by a commodity driven health care system, and which still remains

---

<sup>80</sup> There are many ways to measure the nurse/patient ratios, all of which are under constant debate because they do not capture the intensity of nursing care required, rather they work on the financial allocation of bed days and patient throughput. The lowest nursing skill level becomes an important factor in reducing the cost of care.

medically driven by the way in which it is funded and managed. The medical control over what is the truth claim described as supporting best clinical practice, is really the fiscal business of health and has little to do with clinical. The AMA has used this truth claim to their financial advantage as the representative body of doctors in Australia. Whilst the AMA's views are not general to all doctors in Australia, their consistent anti NP media releases overshadow any supportive roles that doctors may be playing in NP development at an organisational level. As the data in the previous chapters has shown, the concern is not so much what NPs can do but what NPs can take away from doctors. The concern is if they obtain provider numbers that allow the NPs to practice in a fee for service arrangement, then these nurses are no longer part of the commodified nursing but rather they become providers of care. The AMA uses the argument that NPs do not have the educational preparation and ability to manage the uncertainties in clinical practice as shown in this statement,

Medical education and training are prerequisites for medical practice. Nurses and nurse practitioners' lack of medical education and training precluded them other than under medical supervision, from:

- a. requesting pathology tests;
- b. making medical diagnoses;
- c. requesting X-rays or other investigations;
- d. prescribing medication;
- e. referring patients to specialists; and
- f. deciding on the admission of patients to, and discharge from, hospital.

(Australian Medical Association 2004)

In fact, as discussed in earlier chapters, if one examines NP positions in such specialties as neonatal care, NPs are working in registrar positions, therefore they are by their very position deemed safe to practice. The Productivity Commission (2005) has also documented substantial evidence that indicates the reticence of the medical profession to support the development of NPs, and has in turn hindered NP role implementation further reinforcing medical dominance. This drawn out process and control over NP implementation by doctors that the Commission referred to was clearly highlighted by Joe in Chapter 7. Joe talked about the fact that if it was not for his relationship with the consultants, he would not have established his NP position, he played the doctor-nurse game (Friedson 1971; Cockerham 1992) without realising it. Further examples of veto imposed and influenced by doctors are seen in the wording in a gazetted code of practice for NPs which stated,

Before undertaking treatment of a client, a nurse practitioner should give due consideration to consulting with any other health care worker who may have additional relevant skills or knowledge (Western Australia Parliamentary Proceedings 2005, p. 4582).

This particular passage was discussed in the Council of the relevant state parliament with considerable debate ensuing over the condescending nature of the wording. Doctors present at the session did not see anything wrong with the wording, whilst nurses felt that,

...the proposed code moves to undermine the recognised level of expertise by requiring a Nurse Practitioner, before doing anything even if it falls within their scope of practice, to consider referring the patient to another health professional, possibly a doctor or radiologist for example (Western Australia Parliamentary Proceedings 2005, p. 4581)

This position that the nurses involved in the debate took was based on the fact that ANMC NP Competencies (Australian Nursing and Midwifery Council 2006a), locally developed CPGs and state legislation embedded within the state's Nurses Act already provided enough guidance for practice, without an additional constraint. The code, they argued placed further constraints to practice in such a way that it effectively neutralized the efficacy and clinical decision making ability of the NP in managing care. The request to either remove this clause from the document or to amend it was overturned (Western Australia Parliamentary Proceedings 2005). Jane (Interview 2, p.4) referred to this situation when she said that she was working with very junior residents who had not worked with the type of patients presenting to the unit where she worked. She found herself having more clinical knowledge than the registrars, yet no authority to act despite being legislatively able to do so. Like those nurses in the past, NPs have been enabled whilst being constrained within a system ruled by those with power and not those in power. The DONs, as much as the NPs, position themselves in a way that allows the profession to move forward, whilst simultaneously constraining it. Legg's (2008) 'moderated love' only reinforces this view and gives those in control the freedom to capitalize on the caring nature of nursing in making fiscal changes to a subservient nursing workforce, often using those same nursing managers to drive any change, hence the opinion by NPs that DONs are not supportive of their role.

Grint (1997) suggested that an important element of management is the way in which it has been constructed and this is dependant on the characteristics of the players within which it occurs. The position that the leaders in health care take will affect how management values and views resources, including the divisions of labour that are created, and how those human resources are used (Hewison 1999; Porter-O'Grady 1999). Legg's 'moderated love' does not allow nursing to be viewed as a contributing member of a cost constrained health care environment because caring, such as she described, cannot have a financial value except as an intangible asset<sup>81</sup>. Whilst the altruism of caring is maintained as the cornerstone of the nursing profession, nurses will continue as a commodity to be hired and fired around medical episodes of care not because they provide a caring environment but because their value, exposed as caring by nursing leaders, cannot be represented as contributing to the supply of health service delivery. What is perpetuated is that nurses have always provided the care that doctors prescribe and nurses have accepted this in the continued unconscious position they take, whether as a NP or a nursing manager at the executive table. Thus nurses in influential positions can only attempt to shift their sphere of influence, using the language and actions of that traditional power.

### ***Sphere of Influence – Peeping into Looking Glass House***

But oh, Kitty! now we come to the passage. You can just see a little PEEP of the passage in Looking-glass House, if you leave the door of our drawing-room wide open: and it's very like our passage as far as you can see, only you know it may be quite different on beyond. Oh, Kitty! how nice it would be if we could only get through into Looking- glass House! I'm sure it's got, oh! such beautiful things in it! Let's pretend there's a way of getting through into it, somehow, Kitty. Let's pretend the glass has got all soft like gauze, so that we can get through" (Lewis Carroll in Alice through the Looking Glass in Oxenbury 2005, p. 18)

In her first address as the Chief Executive Officer of Royal College of Nurses Australia (RCNA) wrote that "nursing leadership needs to be re-energised" (Cerasa 2009, p. 10). Cerasa adopted an altruistic line in describing how nurses as role models and leaders need to "nurture the new generation" and that "we need to inject new life into our profession and renewed passion into those who lead us forward". Her entire article was about 'nurturing' and 'mentoring' and was altruistic in much the same way as Legg's. She did state that our "future is bright" and that nurses "have never had as much respect on a political level" nor have nurses had "so much

---

<sup>81</sup> Also referred to in Chapter 5, where nurses were shown in pictures portraying other aspects of the organisation, rather than those related to nursing as a contributing member of a health care team.



time and attention from governments”, referring to the current Health Minister’s statements of providing greater roles for nurses in the health system (Roxon 2008). It should be remembered from earlier chapters that Roxon had also pointed out that it could be a long road of negotiation to change things because of the control that medicine has over the health system, particularly in relation to the legislation that still prevents NPs from having provider numbers (Field note 13). Roxon said that “by redressing the historical bias towards medical intervention and acute care, we will be redressing the historical bias against the traditionally female nursing workforce” (Roxon 2008, p. 8). However, no matter what approach the government takes, there remain three issues that prevent nursing from moving forward; the particular view of altruism that nurses have, the traditional remunerative environment of health care in which the doctor remains pivotal to how the finances of the system are organised, and the now neoliberal market driven nature of health care.

When Roxon talks about nurses, she talks about all levels of nursing, not just NPs. When Cerasa and Legg talk about nursing, they talk about all levels of nursing, not just NPs. The pivotal feature here is how nursing as a commodity and a profession will be used in the future and whether nurses will have a say in what actually happens. Despite leaders wanting to re-energise themselves, we are faced with many other nursing and non nursing roles that are eroding the NP and the RN role in what is termed cost effective use of the workforce; the patient care assistant, the GP practice nurse, the physician’s assistant and the extended practice of the enrolled nurse, to name but a few current health care initiatives that are being encouraged, funded and publicised as the solution to some of the health care cost blow outs and the nursing shortages we face in the Australian health care system. We are reminded of this manipulation of nursing by the recent advertisement in *The Weekend Australian* referred to in the previous chapter, for an Executive Director of Nursing, who has operational, workforce and nursing responsibilities but can also be a professional chair with academia (Chittenden 2009). The job, by description is so large that the person employed will not be able to focus on any one aspect of the role particularly well, effectively watering down the influence of nursing at the management table. As much as that job description was so large, it is no different from the reductionist approach the UK has taken with reintroducing the matron role. Both of these examples provide evidence of nursing leaders and nursing being used in the way wanted by the health care institutions. Nothing has changed. Nursing,

whether it is the NP, the manager, or the patient care assistant, is a commodity which is driven by financial and medical need, and not by nursing. Leaders can only “peep through the gauze of Looking Glass House” but cannot enter it.

Participants in this study have described the DONs as ineffective and this view has been supported by literature that has shown how DONs are not positioned to lead, but rather to comply with management directions which do not embrace change involving the nursing advancement that NPs represent. Nursing leaders and those who took part in the early pilot programs of NP programs would say that the implementation of NPs was to meet a health care delivery need particularly in the rural and remote regions of Australia (New South Wales Health 1995; Victorian Government 1999; Australian Capital Territory 2002; Department of Health Western Australia 2003; ACT Health 2005; Australian Capital Territory 2005). But, was it? The fact is that there are very few NPs in rural and remote areas, and there are significantly more in metropolitan specialist positions. The fact is, at the time of writing, there were only 300 endorsed NPs in this country, and of those, a significant number are not yet employed as NPs, and a very small number are employed in the very places that the NP movement commenced its life on; rural and remote Australia.

### ***The Songs and the Tunes***

This study has shown that there remains one dominant power behind the health care industry that informs and drives it, despite the cost of health care being labelled as an explicit discourse. This hidden power is medicine as an institution, whose public and institutional influence began just over 100 years ago. Fairclough (2001b, p. 30) says “as well as being determined by social structures, discourse has its affects upon social structures and contributes to the achievement of social continuity”. Therefore medicine, like all other players in the social order of health, act and behave in the manner that is interpreted and perpetuated by the institution itself over time.

Because these institutional symptoms are so entrenched in its traditional hidden power relations, nurses as much as doctors and other health care professionals act and behave in the way that the institutional knowledge and culture has determined. As Wodak (2001, p. 37) has noted, “no individual and no single group determines the discourse or has precisely intended what turns out to be the final result”. Although the symptom of covert power is supposed to be a focus on cost and budget, the

system relies on medicine to make possible that funding, so the traditional power brokers have not actually changed. Although doctors and nurses may not consciously view it in this way,

...as far as social world is concerned, social structures not only determine social practice, they are also a product of social practice, and social structures not only determine discourse, they are a product of discourse (Fairclough 2001b, p. 31)

Therefore, it can be argued that all the players work unconsciously in accordance with the prevailing ideologies that are in operation in the institutions of the social order, and which are manifested in the symptoms that are displayed as a result of it. It can be argued then that the contemporary view of the profession of nursing has been disguised in a dance that nurses, including NPs, perform with their medical colleagues, moving to the same tune but singing in a different key without realising it. That melody for the dance is the compilation of fiscal policy, health care tradition and nurses' view of themselves. This study has exposed the songs being played that beguile the NPs into believing that they can make a difference in the current health care environment. As Fairman (2008, p. 9) says,

The social status of nursing is based upon its historical perception of a woman's profession...[and this is]...part of an interrelated system that constitute[s] a central piece of social imagery around which institutions and technological systems such as health care are constructed and maintained.

Whilst it can be argued that, "nurses really do need to become indispensable by being truly multidisciplinary while retaining the central nurturing function in service delivery" (Pearson 2003, p. 629), nursing remains ambiguous about what 'nursing' and 'non-nursing' work is. Pearson's idea of 'nurturing' does not encourage nursing to move into a contemporary health care workforce because nurturing does not have a financial value and the value of nurturing is no longer a RN's function, it can be done by all levels of nursing. Thus "nurses are asked to justify their existence and describe their central importance...the virtue strategy is clearly not working" (Nelson & Gordon 2006, p. 27). On the other end of the continuum, nurses have created a space in science by embracing the technical and scientific paradigm in their education which Nelson and Gordon (2006, p. 26) call the "knowledge script". This knowledge script has manifested in NP practice through the legislation not endorsing the use of nursing activities, but rather medical activities, through the extended tasks of prescribing and ordering diagnostic tests. These activities, instead of progressing

nursing, have instead encroached on what is normally accepted as doctors' work. The traditional cycle of dominance emerges even in the creation of new nursing knowledge, and nurses, as much as the health system itself, has embraced it.

Despite this knowledge script transgressing the boundaries between nurse and doctor, as the previous chapters have highlighted in analysis by such authors as Buresh and Gordon (2000), nursing still holds onto the traditional caring factor as special to nursing. The paradox then is that nursing has used a medical knowledge script in order to advance as a profession, but at the same time still holds onto the virtue script through its leaders, who maintain that the virtue strategy is the cornerstone of the nursing profession. In their attempts to align with mainstream health, nurses in clinical, education and management have adopted the medical texts to identify their professional space and so the progression for NPs has been to impinge into the medical territory and those medical tasks which doctors identify as the cornerstone of their practice referred to in Chapter 7. One could argue that this is no different from PCAs encroaching on those aspects of nursing that nurses claim as the cornerstone of their practice, such as nurturance and caring (Dingwall & Allen 2001; Jenkins-Clarke & Carr-Hill 2003). The nursing profession has thus unconsciously given up the very cornerstone of its profession, the virtue script, whilst replacing it with a knowledge script that conforms to patterns of traditional health care dominance, in order to advance, whilst simultaneously still holding onto that same forfeited virtue script in its attempt to identify nursing as a profession.

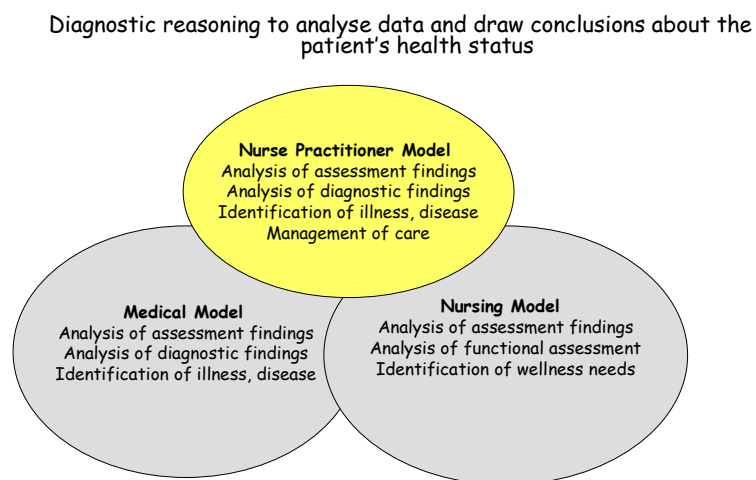
The root of the matter is that the scientific and technical nature of health care has been embraced by nurses in an attempt to shift their sphere of influence in health, but because nursing remains ambivalent in what it really wants as a profession, it has in fact, not shifted any sphere of influence at all. The world of health care is still managed by those external to nursing and nursing remains a commodity within it. The profession of nursing has tried to align science and caring in the university education for nurses, in other words attempting to keep the virtue script whilst including the knowledge script, and this has created tension between what NPs should be doing and what they really do. The resolution of that tension can only occur by making a space for NPs and nurses in the contemporary world of health care where nurses focus on what they can contribute to the clinical knowledge and

competence of care (not caring) rather than to professional knowledge and professional boundaries.

If we refer back to the declared autonomy in NP practice claimed by ANMC, then this becomes a negotiated space around professional boundaries and not just within a nursing boundary. Beil-Hildebrand (2002, p. 265) says that “professional autonomy characterises the outcome of negotiations between organised occupational groups and the state and not directly of class conflict at the workplace”. Class conflict, as has been revealed from the data in this study has merely set the NP apart, because in seeking to identify autonomy within the traditional nursing framework, NPs have been put at odds with the occupational groups with whom they work and interact on a daily basis. Fairman (2008, p. 185) says that,

Physicians and nurses still negotiate to define the borders of responsibility and authority for clinical care, and these contracts continue to be framed by the politics surrounding the professional groups and larger policy landscape.

Through the discursive positions of the ANMC, the legislation, the health services and the nurses, NPs have emerged as a hybrid health worker, evolved as neither nurse nor doctor (Fig 13). However as research has shown if used within the budget framework of health, NPs can be a cost effective professional and not just a commodity in health care.



**Figure 13 Nurse Practitioner as a hybrid health care worker**

This chapter has examined the discourses around the nature of nursing from the global health care context. It has examined how nurses, represented by NPs and also their nursing leaders, position themselves within the system, which perpetuates the altruistic position of nursing that has been accepted for the past 100 years, through the actions of the nurses themselves, as much as the institutions that are integral to health care delivery, such as education, financial funding arrangements and organisational structure. It has shown how, because of it, nurses themselves perpetuate the dominant discourses of health in which nursing is a commodity and doctors are the suppliers of health. Nurses and allied health workers revolve around the needs of that supplier.

Whilst the players of the role of superintendent have changed to the CFO, medicine still influences decision making, and nurses have supported it through their adoption of the accepted language and actions that work to maintain this position. As we have seen, this does not fit with the contemporary cost containment approaches in health care. As a result of this nurses have always been, and still are, a commodity in health, dictated by the supply and demand of illness, where the needs of the service revolve around the work generated by medicine. NPs in this model of service delivery may never succeed, simply because there is no provision for them to become suppliers of health care as their scope of practice has endorsed. In the current situation, NPs are being moulded according to service needs, based on the directives from traditional dominant power brokers. Their services would be best served by finding “new ways to concentrate power in the hands of the people who need it most to get the job done putting authority, responsibility, resources and rights at the most appropriate level for each task” (Hewson & Stanton 2003, p. 20).

It is not so much the traditional standing of professions that is important, or the space they hold in the social organisation of health, it is the health care needs of the community and how best those health care professionals can deliver them within the budget provided. The introduction of the NP has heralded an opportunity to break down the traditional barriers that prevent care being delivered because professional turf protection controls how the health dollar is spent rather than patient need.

There are more ways to think about how a society decides who should provide health care and how these decisions are negotiated than deferring to the typical, seemingly

monolithic characterisation of medicine and its concurrent cultural authority without tearing down physician's facility for what they do best – the intricate and painstaking ability to see relationships between patient symptoms and a particular diagnostic label (Fairman 2008, p. 194).

NPs are the catalyst for change. Now is the time for change in nursing in order to ensure the future of nursing as a profession in a cost effective model of interdisciplinary care and the role nurses play in the work that Fairman identifies as central to medical dominance. This chapter has exposed the intricate web of actions and texts that reinforce the hidden power of health care in a way that maintains nursing as a subservient commodity as long as they are seen as a part of service provision rather than clinical work.

In Chapter 9, the findings of this study are summarised, and reflected upon. I examine the efficacy of the research framework in exposing the truths around NP implementation and I reflect on the limitations and strengths of the study. Whilst this research does not offer solutions, it has exposed the discourses that influence the role of NP in Australia, and the professional boundaries at which they are situated.





## Chapter 9 - Dancing to the Tune

‘Will you walk a little faster?’ said a whiting to a snail. ‘There’s a porpoise close behind us, and he’s treading on my tail. See how eagerly the lobsters and the turtles all advance! They are waiting on the shingle--will you come and join the dance?’ (Lewis Carroll in Alice’s Adventures in Wonderland in Oxenbury 1999, p. 167)

This study has drawn together an abundance of information from the NP perspective and from the literature that informs and regulates NP practice. It has enabled the many stepping stones and stumbling blocks that litter the path of NP implementation to be examined and to identify those that are not what they may seem. Examples of these stumbling blocks are the clinical practice guidelines, the endorsement processes, the recruitment processes and the legislation informing NP scope of practice. These are major pieces of work that were written to enable NP practice but in fact have also hindered their practice.

As I reflect on this study, I am reminded of those reasons why I undertook the study in the first place. As a NP Project Officer, I had the privilege of working with the first NP employed into a position in Australia. What frustrated me but also saddened me was how this pioneer NP was played to the political tune of the time and how very soon after the hype of the great announcement was over the reality of the stumbling blocks of implementation became not only evident but also isolating. No longer was the fanfare of health care leaders there to assist us in establishing the role. I am reminded that in the eight years since that first position, the same area health service has just two out of a possible 15 positions filled because of the very issues that have emerged from this study. This study started out as one based in rural and remote Australia but the small numbers of NPs in these regions necessitated expanding the study to include all NPs endorsed in Australia. Although the population for this study remained small the views and positions of the participants, supported by technical literature, has shown that it does not matter where the NP is situated, the dance, the melody and the words to the songs remain the same.

This study sought to critically analyse the technical literature on the advancement of nursing knowledge and practice and how the language and views within it impact on the way in which the NP is developing. In order to understand the way NPs are

situated in health, it was important for this study to appreciate how the influences from the past affect nursing today by exploring the history of ideas that have given rise to the present attempts to advance nursing practice with particular reference to the NP.

The aims of the research were to examine the position that NPs take within the organisational environment of health and to identify the social and political hurdles that are affecting role development in Australia using text and language to identify discursive practice. As such this study examined the NP scope of practice in the context of nursing as a profession with a history and as a subset of health, in which the position of NPs is dependent and is informed, by larger and more dominant discourses. The Australian context of NP practice was examined by exploring the journey of NPs through their conversations in interviews, and through analysis of technical literature related to the NP. The information gained was used to examine the diverging and converging themes in practice between rhetoric of policy and the truth of implementation.

### ***Reflections***

Reflection is very much part of the nursing framework. As nurses we are taught always to reflect on our practice (Castledine 1999; Kitson 1999; Benner 2001; Chiarella 2002; Mantzoukas & Jasper 2004; Linde 2005; Perron et al. 2005; Legg 2008). We are told that as leaders we need to reflect on our past and examine our present in order to plan for our future. As clinicians, we are told to reflect on the day's work. In developing our portfolios for advanced practice, we are told to maintain journals and narratives of the work we do. When I reflect on discourses that have emerged from this study I am constantly reminded of our ties to the past. It is important to reflect on these ties because, as Wodak (2001, p. 7) comments,

The relevance of language use in institutional settings is reiterated, and a new focus on the necessity of a historical perspective is introduced...in which the concepts of power, ideology and history figure centrally.

Nursing as a professional body, has only been formalised for a little over 100 years. Women such as Nightingale, Fry and Fliedner are just a few of the nursing leaders who attempted to establish nursing as a respectable profession despite their orientation to the religious viewpoint of subservience and dedication. I am drawn to

the present with the notable leaders of nursing who are perpetuating that model of nursing in a world where NPs are trying to find a space in the market driven health care system. The tensions for NPs is thus created between the ANMC NP Competencies, which was developed by nurses for nurses, whilst trying to merge this nursing focused approach with the technical and medical extensions that identify NP practice in legislation and in the workplace. As such my reflection turns to the ANMC NP Competencies which were examined in Chapter 3.

The document in question was developed following a major research project in 2004, funded by the Australian Nursing and Midwifery Council, and the New Zealand Nursing Council, to develop standards and competencies for NPs (Gardner et al. 2004). The key feature of this is the fact that this document drew information from nurses. It did not include the contemporary human resource policies of health and its political economy where the budget is driving the search for more cost effective models of care. In fact the underlying tenet is entirely altruistic. It uses words that are ambiguous and confusing. In the face of serious nursing shortages and dwindling public funds, the reality of today's health care market is not one of progression of a profession because of what the profession wants or can offer, but on cost reduction. Because nursing is, and always has been, a commodity in health service delivery and not really in the centre of influence, the most obvious place for cost reduction to occur has been in the roles and levels of nurses and the ability to employ the most effective role of nurse for the least cost. This has made room for a multitude of alternate nursing roles and extensions to nursing practice. Despite these sign posts in health direction, discourses examined in Chapter 8 outline the extent to which nurse leaders hold onto nurses' altruistic past and Fairman's (2008) descriptions of the social status of nursing, which is based on historically determined perceptions of women's work.

However, this thesis goes beyond the social status of nursing, it exposes the political and economic drivers of health and how nursing has not caught up with the current state of play. The use of Fairclough's (2001b) three levels of social organisation has allowed for the exposure of positions that influence NP role development by identifying tensions at the boundaries of traditional health care authority in what is accepted as doctors' work and nurses' work. The theoretical framework sanctioned the examination of the inter-textual play between tradition, budget and policy, all

with their conflicting views on what the NP should represent in the health care workforce. Because CDA allows for literature to be used throughout analysis, I was able to draw widely on other studies with diverse theoretical frameworks, both nationally and internationally. This not only corroborated my data, but also strengthened its objectivity in analysis. I was also able to use this literature to uncover the hidden verities of the NP conversations, through the examination of similar and parallel issues that have been exposed by other researchers. I was able to compare them to the NPs views and the technical literature used in my study, between and within Fairclough's levels of organisation.

### ***Strengths of the Study***

CDA, and more specifically Fairclough's framework, has been a good choice for this study. It has allowed the examination of the hidden power relations within which nursing operates. It has allowed the rhetoric of policy to be exposed for what it is, and it sanctioned the identification and analysis of the symptoms of power that prevent NP from smooth implementation in their roles. More importantly, it has not only exposed the plight of NPs, but it has gone behind the lines to expose the real position of nurses and the profession of nursing in a politically and economically driven health care system. Whilst other theoretical frameworks would have uncovered the explicit social issues, they would not have enabled the depth of analysis of the social situation that CDA has. As Wodak (2001, p. 2) says,

CDA may be defined as fundamentally concerned with analysing opaque as well as transparent structural relationships of dominance, discrimination, power and control as manifested in language.

This point was apparent especially when I was seeking out literature that may assist me in finding the most appropriate theoretical framework for this study. In the beginning I explored many different critical social theory perspectives, but none answered the questions of why nurses were finding it so difficult to implement the new role of NP. Whilst we all, as nurses, know the overt structural impediments to nursing, nothing allowed me to go behind those barriers to see why they were such, and who was allowing them to block nurses' attempts at development. CDA allowed for this window to look behind those overt structures.

Because of my own naivety of the discourse surrounding me, I too was a victim of the dominant power and the adoption, without thinking, of the words made available in the discourses of that power. What this study did for me as a teacher of nursing, was to raise my awareness of the opacities as well as the more overt operations of power, of which I was also both a casualty and an active player. The difference for me was that I have always challenged the boundaries of nursing, often being referred to as a rebel. In fact I was merely challenging the traditional boundaries in my own attempts to shift my sphere of influence without understanding what was preventing me from doing so. This study has allowed me to understand the shackles that hold nursing back, and to figuratively break free of them, in so doing, I am now able to share the findings through teaching and through dissemination of the study.

The NPs in Australia today are also rattling those chains of tradition. They are challenging the boundaries of a traditional health care system and in so doing are creating a space for new models of care that will support changes to nursing and to the health care of Australia. What has become clear to me through this study is that NPs are nurses with passion and drive. Whilst they are unconsciously subservient in their attempts to become leaders, they are determined, with one thing in their central view, and that it is the people who are the patients and those others in their communities who rely on nursing services to achieve optimal health outcomes. The altruism of nursing is both strength and weakness in this instance. It is a strength because that is what keeps NPs focused on the work they do that revolves around their patients, and a weakness because they are conforming to the tradition of nursing and to the dominant discourses of health which hinder their ability to care for those very same patients that drive their desire to change models of care.

### ***Limitations of the Study***

A major limitation for this study for me was part of the very discourse that prevents nurses from succeeding. Over the period of this study, I have changed jobs three times, firstly because of my own career choices and secondly because of the findings emerging from this study. When I first commenced the study, circumstances at two of the organisations and my positions within them were such that it became clear to me, that what I was finding in my data was in direct conflict to the beliefs of the organisations within which I worked. For me to have completed this study in either of those positions would have been detrimental to both myself and the participants of

this study and to the dissemination of the findings. I would have come up against extreme pressure to maintain silence on my findings because they directly related to, and conflicted with, the organisations where I was employed. For me, being employed in a university at the completion of this study has allowed me the freedom to pursue the analysis in the correct environment for both objectivity and for the dissemination of these sensitive findings.

CDA theorists such as Wodak, Scollon and Fairclough tell us that as a CDA researcher we are a part of the study. I have found this difficult in the light of the fact that I have been a nurse holding senior positions and which are the very subject of a significant aspect of the data in this study. This was most difficult in my role as a DON. During my time in this position I carried out all the interviews for this study. I was careful not to say that I was a DON, when introducing myself to participants, saying only that I was a doctoral student. If participants had known the position I held, I am of the belief that much of the information that they shared with me would not have been told. Likewise, in listening to that information I had to be very careful not to comment, but to maintain my objectivity by listening and encouraging. This was the time that I needed my supervisors most. I found myself having to debrief on how I was feeling about the information that I was told, and also how that information was raising the truths about my own work as a DON. I found that I had to step away from the whole study at this point and it was during this time that I made the decision to move into a university position, so that I could deal with the data in a more objective manner. In effect, I have succumbed to those very dominant discourses that control nursing. However, by being in a university setting, I have also given myself space for the freedom of speech that is so necessary to complete this thesis, and to share its findings with a broader nursing and health care community.

Another limitation to this study was the smallness of the sample size available for interview. Although CDA allows for a diverse selection of methods for data collection, I found that the small number of participants that I was able to interview limited access to direct experiential knowledge. The information from participants afforded a rich and detailed description of what was actually happening at the coalface of NP implementation and was integral to analysis of the discourses at all three levels of organisation. Although Fairclough (2001a) does not advocate for any number or levels of samples in the information gathering process, rather he refers to

the saturation of data as the indicator for how much is 'enough', I do believe that more could have provided further in-depth examinations of how those uncovered discourses were at play in the real world situation of NP practice. Although I believe that saturation was reached in terms of evidence to demonstrate common experiences, I enhanced information with parallel experiences in both national and international encounters where it supported participant descriptions.

### *Shifting the Sands*

I once had a mentor who said that if you are facing a mountain, you need to take one slope at a time. Once you have reached the top of the slope, stop and celebrate your success, but remember that the summit is where you want to go. Changing how nurses are positioned in health care is a very large mountain. The path to the top of that mountain is winding with traditional, political, economic and professional stumbling blocks at every turn. Not only are the stumbling blocks in the way nurses view themselves and therefore allow changes to occur to them, but also in how the rest of society views nursing, that is not congruent with the potential of nurses in health care delivery. The discourses uncovered in this study have identified just this.

In order to make changes, change must be embraced. In order to embrace the changes, leaders have to have already done that in their minds and have the summit in sight. To do that leaders of nursing in this country must share a common vision and they need to be visible. Whilst the Chief Nursing Officer of Australia has just become president of the International Council of Nurses, in her role as national leader in Australia, there is no evidence of her leadership relating to the Australian health care issues that are not only changing the face of health care delivery, but are doing to significantly impact on how the nursing workforce is utilised. This was made evident when I was writing up the last chapters for this study when I attended a nursing conference which was entitled 'Nursing – a Sound Investment for Healthy Returns'. I mention it here, because the experience reinforced the discursive environment between policy and nursing as a profession, which continues in its silencing of the nurses, and only reinforced the findings of this study. A keynote speaker of the conference was the current Minister of Health, Nicola Roxon. She took the opportunity to launch the discussion document 'National Health and Hospitals Reform Commission Report' (National Health and Hospitals Reform Commission 2009). Roxon spoke extensively of nursing and the role this profession

could be playing in the delivery of health based on ‘better patient access’ through the use of competence and skills of the health care workforce which is not limited by professional boundaries. When I reviewed this report later, it supported much of what has been referred to in this study in stating that “we have a fragmented health system with a complex division of funding responsibilities and performance accountabilities between different levels of government. It is ill-equipped to respond to these challenges” (National Health and Hospitals Reform Commission 2009, p. 3) and that “the system is provider focused, rather than patient focused” (p. 51). Recommendations from this report included,

[We recommend] a new education framework for the education and training of health professionals:

- moving towards a flexible, multi-disciplinary approach to the education and training of all health professionals;
- incorporating an agreed competency-based framework as part of broad teaching and learning curricula for all health professionals” (National Health and Hospitals Reform Commission 2009, p. 31)

Whilst this document and Roxon fully endorsed the potential that nurses have for reforming health care, the Chief Nurse of Australia, also at the conference, was unable to articulate strategies of nursing change when questioned in a subsequent panel discussion on workforce strategies for the future, despite the national health reform document in question being readily available.

For leaders to change, they have to understand why they should change. As Hoque et al. (2004) suggests, nursing leaders need the freedom to make change and not just the freedom to do what they are told. They must be conscious of the discourses they use and how it is used, and how they adapt to it and how they position themselves within it. It is for this reason that national and international research has to be undertaken using the same framework that has been used in this study in order to broaden the search for new ways to support nursing and to explore those discourses that are used by, and also constrain, nurses and nurse leaders. Awareness needs to be raised on those powers that are constraining them in the way that I have raised the awareness to the powers constraining the developing NP role.

It is the contention and evidence of this thesis that once nursing leaders ‘see’ the discourses, they can change the way they operate within them. I believe that for nursing to advance, this body of work is essential. I say this because, in my search



for supportive literature for this study, I found few studies that examine health care discourses in relation to the affect they have on nursing, and the subsequent position that nurse leaders take in the health care system. Whilst the overt symptoms have been constantly identified, there is little that drills down to the discourses and power behind those symptoms. Researchers like Buresh and Gordon (2000), Nelson (2004) and Fairman (2008), have identified much of the historical issues surrounding the tradition of nursing and their work has supported the findings of this study, but it has not identified those factors hidden from view, that drive those issues. This work is essential for further research that will not only inform nurses but will also expand on my small Australian study.

But changing the outlook of leaders in nursing is not the only recommendation to arise from this study. If I refer to the previous chapters where the funding of health care was discussed, I outlined the fact that although the overt structure of funding is based on the medical episode of care, nursing does have a pivotal role in any cost containment exercise. Overtly this is achieved in the current economical focus of health care in the way nurses are used as a commodity based on patient numbers rather than patient care. Covertly nurses become managers of that care as much as doctors in legitimised roles such as NPs. As I have shown, medicine, through the voice of their industrial organisation, the AMA, has taken a line that NPs will provide a second rate health care system because they are ill educated for the role and unsafe. This diversion detracts from the real issue of how much it costs the health care service to keep a doctor, and what value their service brings to patient care. Research has already shown that such roles as NPs can direct care if the access to health care funding was based on patient need and not service provision and they can do so at far less cost than doctors can. Whilst as Fairman (2008) says, there will always be a place for those specialists in medicine, research has also shown that NPs can become a cost effective alternative in many health care delivery situations, and this has been exposed through the literature used in this study. Further research therefore needs to build on the findings from this study, and from those others referred to in it, to expose the position of medicine in health care service delivery and its contributions to it, in relation to cost and overall clinical outcomes, and the potential of nursing roles such as NPs.

## *Conclusions*

There were doors all round the hall, but they were all locked; and when Alice had been all the way down one side and up the other, trying every door, she walked sadly down the middle, wondering how she was ever to get out again. Suddenly she came upon a little three-legged table, all made of glass; there was nothing on it but a tiny golden key, and Alice's first idea was that this might belong to one of the doors of the hall...on the second time round, she came upon a low curtain she had not noticed before, and behind it was a little door about fifteen inches high: she tried the little golden key in the lock, and to her great delight it fitted! (Lewis Carroll in Alice's Adventures in Wonderland in Oxenbury 1999, p. 19)

I found this study both challenging and inspiring. It was challenging because I never anticipated the position of nurses that emerged from the data and it was inspiring because it provided me with insights into why NPs behave the way they do. It allowed me to develop a deeper understanding of the difficulties that NPs face, and it allowed me to 'see' why it is occurring. I am enlightened by the experience and I believe that now I can go forward in my teaching, armed with a different view, a view on which I can assist others to develop skills to deal with the opacities of power that they face in their daily practice, and to which they do not yet have the insight into. In some small way, I hope that by exposing these discourses to students, I will be able to help change nursing in the future, in a way that allows NPs to become an integral part of the decision making processes of health care delivery, and not just a spectator of it.

Expanding on this study is essential with regard to the broader leadership of nursing and in the way that the funding of health marginalises nursing and prevents this profession reaching its full potential. What I have found in relation to this is the symptoms of hidden power, and what has been exposed in this small study, unquestionably runs far deeper in the broader environment of health.

This study is crucial also because it contributes to necessary change in the way nursing students are socialised. Until the hidden power and its symptoms are exposed, change will not occur because nurses will continue to adopt those dominant discourses silencing them without even realising it. The political economy of health will continue to use nursing as a commodity without nurses' consent or active participation.

I hope that this study, and those studies that follow it, will be tiny golden keys that assist our nursing pioneers in developing the role of NP, to do the job they are so capable of doing.



## References

- ACT Health 2005, *Nurse Practitioners in the Australian Capital Territory - The Framework*. In ACT Health (ed). ACT Govt. Canberra, viewed 7<sup>th</sup> April 2008, <<http://www.health.act.gov.au/c/health?a=dlpubpoldoc&document=853>>
- ACT Nursing and Midwifery Board 2006, *Application for Re-registration/Registration as a Nurse, Midwife or Nurse Practitioner*. Canberra, ACT Nursing and Midwifery Board, viewed 5<sup>th</sup> July 2008, <<http://www.actnmb.act.gov.au/documents/Registration%20Form20%20October%202008.pdf>>
- Affara, F 2006, 'Swot Analysis: Advanced Nursing Practice (APN) Becoming Recognised as a Valid Part of Nursing and Health Care Provision Globally'. *International Nurse Practitioners Conference*. Sandton, South Africa.
- Aggleton, P & Chalmers, H 1987, 'Models of Nursing, Nursing Practice and Nurse Education'. *Journal of Advanced Nursing*, 12, 573 - 581.
- Ahrens, T & Padwojski, A 1990, 'Economic Effectiveness of an Advanced Nurse Clinician Model'. *Nursing Management*, 72j - 72p.
- Allen, J 2004, 'The Whereabouts of Power: Politics, Government and Space'. *Geografiska Annaler*, 86b, 19 - 32.
- Allen, J & Fabri, A-M 2005, 'An Evaluation of a Community Aged Care Nurse Practitioner Service'. *Journal of Clinical Nursing*, 14, pp. 1202 - 1209.
- Allen, R E (ed.) 1990, *The Concise Oxford Dictionary of Current English*, Oxford, Oxford University Press.
- Angus, J & Nay, R 2003, The Paradox of the Aged Care Act 1997: The Marginalisation of Nursing Discourse. *Nursing Inquiry*, 10, pp. 130 - 138.
- Anievas, A 2005, Critical Dialogues: Habermasian Social Theory And International Relations. *Politics*, 25, pp. 135 - 143.
- Armstrong, P 1999, The Role of the Clinical Nurse Specialist. *Nursing Standard*, 13, pp. 40 - 42.
- Arnold, S 2004, *Bring Back Those Straight-Laced Matrons*, The Independent, Viewed 17<sup>th</sup> November 2008, <<http://www.independent.co.uk/opinion/commentators/bring-back-those-straightlaced-matrons-533441.html>>

- Asubonteng, P, McCleary, K & Mungus, G 1995, Nurse Practitioners in the USA - Their Past, Present and Future: Some Implications for the Health Care Management Delivery System. *Health Manpower Management*, 21, pp. 3 - 10.
- Atkins, K 2006, Autonomy and Autonomy Competencies: A Practical and Relational Approach. *Nursing Philosophy*, 7, pp. 205 - 215.
- Australian Capital Territory, 2002, *The ACT Nurse Practitioner Project. Final Report of the Steering Committee*. Canberra, Department of Health.
- Australian Capital Territory 2005, *Nurse Practitioners in the Australian Capital Territory. The Framework Part 1*, Canberra, ACT Health.
- Australian Human Rights Commission Act 2009* (Australian Federal Government)
- Australian Federal Government (2009) *Allied Health Services under Medicare*. Department of Health and Ageing, Canberra, viewed 3<sup>rd</sup> March 2007, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/Allied+Health+and+Dental+Care+initiative>>
- Australian Institute of Health, 2006 *Australia's Health*, Canberra, viewed 6<sup>th</sup> April 2008, <<http://www.aihw.gov.au/publications/index.cfm/title/10321>>
- Australian Medical Association, 2000 *Top Stories Review*, Ausmed Online, viewed 12<sup>th</sup> June 2007, <<http://www.ama.com.au/web.nsf/doc/shed-5exgtg>>
- Australian Medical Association 2003, *Position Statement on Nurse Practitioners*, Victoria, viewed 12<sup>th</sup> June 2007, <<http://www.amavic.com.au/policynurselobby.htm>>
- Australian Medical Association, 2005a *General Practice Nurse – 2005*, AMA Media Release, viewed 12<sup>th</sup> June 2007, <<http://www.ama.com.au/web/nsf/doc/ween6lv6vw>>
- Australian Medical Association, 2005b *General Practice Nurses Make Perfect Sense (But Independent Nurse Practitioners Don't)*. AMA Media Release, viewed 12<sup>th</sup> June 2007, <<http://www.ama.com.au/node/1964>>
- Australian Medical Association 2005c, *New MBS Item Needed to Cover General Practice Nurses Working under GP Supervision*, AMA Media Release, viewed 12<sup>th</sup> June 2007, <<http://www.ama.com.au/node/2018>>
- Australian Nursing and Midwifery Council 2006a, *National Competency Standards for the Nurse Practitioner*, Canberra, Australian Nursing and Midwifery Council, viewed June 2007, <[http://www.anmc.org.au/userfiles/file/competency\\_standards/Competency%20Standards%20for%20the%20Nurse%20Practitioner.pdf](http://www.anmc.org.au/userfiles/file/competency_standards/Competency%20Standards%20for%20the%20Nurse%20Practitioner.pdf)>

- Australian Nursing and Midwifery Council 2006b, *National Competency Standards for the Registered Nurse, 4<sup>th</sup> edn*, Canberra, Australian Nursing and Midwifery Council, viewed June 2007, <[http://www.anmc.org.au/userfiles/file/competency\\_standards/Competency\\_standards\\_RN.pdf](http://www.anmc.org.au/userfiles/file/competency_standards/Competency_standards_RN.pdf)>
- Australian Nursing Federation 2001, *NSW Appoints Australian's First Nurse Practitioner*, Australian Nursing Federation, viewed January 2004 <[http://www.anf.org.au/html/news\\_national.html](http://www.anf.org.au/html/news_national.html)>
- Babbie, E 1992, *The Practice Of Social Research*, California, Wadsworth Publishing Company.
- Barrett, R 2001 *Doctors Resist Super Nurses*, In Australian Broadcasting Commission, Ed. Australia, PM Archive, Monday, 22 January, 2001.
- Barton, T, Thorne, R & Hoptroff, M 1999, The Nurse Practitioner: Redefining Occupational Boundaries? *International Journal of Nursing Studies*, 36, 57 - 63.
- Bassett, J 1992, *Guns and Brooches - Australian Army Nursing from the Boer War to the Gulf War*, Oxford, Oxford University Press.
- BBC News 2008, *Matron Role Returns to Fight MRSA*, BBC News, Scotland, viewed 17<sup>th</sup> November 2008 <<http://www.news.bbc.co.uk/go/pr/fr/-/1/Hi/Scotland/7669300.Stm>>
- Becker, H, Geer, B, Hughes, E & Strauss, A 1961, *Boys in White - Student Culture in Medical School*, New Brunswick, Transaction Books.
- Beil-Hildebrand, M 2002, Theorising Culture and Culture in Context: Institutional Excellence and Control. *Nursing Inquiry*, 9, 257 - 274.
- Benner, P 2001, *From Novice to Expert. Excellence and Power in Clinical Nursing Practice*, New Jersey, Prentice Hall.
- Block, P 1993, *Stewardship: Choosing Service over Self-Interest*, San Francisco, Berrett-Koehler Publishers.
- Bloom, A L 2000, *Health Reform in Australia and New Zealand*, Melbourne, Oxford University Press.
- Bolton, S 2005, 'Making Up' Managers: The Case of NHS Nurses, *Work, Employment and Society*, 19, 5 - 23.
- Borthwick, C & Galbally, R 2001, Nursing Leadership and Health Social Reform, *Nursing Inquiry*, 8, 75 - 81.

- Bowles, N & Cassidy, A 1997, Developing Practitioners, *Nursing Management*, 4, 8 - 9.
- Brook, S & Crouch, R 2004 Doctors and Nurses in Emergency Care: Where are the Boundaries Now? *Trauma*, 6, 211 - 216.
- Brooks I, 1997, Call My Bluff: Multiple Interpretations of an Organisational Process, *British Journal of Management*, Vol 8, 269 – 282.
- Buchan, J & Calman, L 2004, *Skill Mix and Policy Change in Health Workforce: Nurses in Advanced Roles*, Paris, Head of Publications Service OECD.
- Buppert, C 2004, *Nurse Practitioner's Business Practice and Legal Guide*, Massachusetts, Jones & Bartlett Publishers.
- Buresh, B & Gordon, S 2000, *From Silence to Voice*, London, Cornell University Press.
- Busen, N & Englemann, S 1996, The CNS with Practitioner Preparation: An Emerging Role in Advanced Practice Nursing. *Clinical Nurse Specialist*, 10, 145 - 150.
- Bushy, A 2000, *Orientation to Nursing in the Rural Community*, London, Sage Publications.
- Butler, P 2001, *Matrons Make a Comeback on the Wards*, The Guardian UK, Viewed 17<sup>th</sup> November 2008, <<http://www.guardian.co.uk/society/2001/apr/04/nhsstaff.health>>
- Caldwell, C, Wasson, D, Brighton, V, Dixon, D & Anderson, M 2003, Personal Autonomy: Development of a Nursing Outcomes Classification Label, *Journal of America Psychiatry Nurses Association* 9, 167 - 172.
- Cameron, P & Thompson, D 2005, Changing the Health-Care Workforce, *International Journal of Nursing Practice*, 11, 1 - 4.
- Canadian Nurses Association (2008) *Signposts for Nursing*. Ottawa, Canadian Nurses Association.
- Carroll, L 1865 – 1898, *Alice's Adventures in Wonderland*, Illustrated by Helen Oxenbury 1999, 1<sup>st</sup> edn, Cambridge, Massachusetts, Candlewick Press.
- Carroll, L 1865 – 1898, *Alice through the Looking Glass*. Illustrated by Helen Oxenbury 2005, 1<sup>st</sup> edn, Cambridge, Massachusetts, Candlewick Press.
- Carspecken, P 1996, *Critical Ethnography in Educational Research*, New York, Routledge.



- Castells, M 1996, *The Information Age: Economy, Society and Culture. The Rise of The Network Society*, Oxford, Blackwell Publishers.
- Castells, M 1997, *The Information Age: Economy, Society and Culture. The Power of Identity*, Oxford, Blackwell Publishers.
- Castledine, G 1999, 'Development in the Role of the Advanced Nursing Practitioner: A Personal Perspective', In *Advanced Nursing Practice*. Oxford, (eds) G Rolfe, & P Fulbrook, Butterworth Heinemann.
- Catalano, J 1996 *Contemporary Professional Nursing*, Philadelphia, F. A. Davis Company.
- Catalano, J 2003 *Nursing Now! Today's Issues, Tomorrow's Trends*, Philadelphia, F.A. Davis Company.
- Cerasa, D 2009, *RCNA News: Chief Executive Officer's Report*. RCNA Nursing Review, viewed 30<sup>th</sup> January 2009, <<http://www.nursingreview.com.au>>
- Chambers, N 1998, *Nurse Practitioners in Primary Care*, Abingdon, Radcliffe Medical Press.
- Chiarella, M 2002, *The Legal and Professional Status of Nursing*, London, Churchill Livingstone.
- Chittenden, T 2009, *Bendigo Health Executive Director of Nursing (Chief Nursing and Midwifery Officer)*, The Weekend Australian Adelaide, 28 February 2009.
- Clifford, C 1995, Caring: Fitting the Concept to Nursing Practice, *Journal of Clinical Nursing*, 4, 37 - 41.
- Clinton, M & Scheiwe, D 1998, *Management In The Australian Health Care Industry.*, Melbourne, Longman.
- Cockerham, W 1992, *Medical Sociology*, New Jersey, Prentice Hall.
- Coleman, M 1999, *Doctors and Nurses Break Down the Barriers*. Wednesday, 24<sup>th</sup> November, 1999, Australian Broadcasting Commission.
- Cooke, H 2006, Seagull Management and the Control of Nursing Work, *Work, Employment and Society*, 20 (2), 223 – 243.
- Cooper, M, Lindsay, G, Kinn, S & Swann, I 2002, Evaluating Emergency Nurse Practitioner Services: A Randomised Controlled Trial, *Journal of Advanced Nursing*, 40, 721 - 730.

- Copnell, B & Bruni N 2005, Breaking the Silence: Nurses' Understandings of Change in Clinical Practice, *Journal of Advanced Nursing*, 55, 301 - 309.
- Cotter, C 2005, 'Discourse and Media', In *The Handbook of Discourse Analysis* (eds) D Schiffrin, D Tannen & H Hamilton, Oxford, Blackwell Publishing.
- Craig, J V & Smyth, R L (ed.) 2007 *The Evidence-Based Practice Manual For Nurses*, Edinburgh, Churchill Livingstone.
- Creswell, J 1998, *Qualitative Inquiry and Research Design. Choosing Among Five Traditions*, California, Sage Publications.
- Cukr, P 1996 Viva La Difference! The Nation Needs the CNS and NP as Separate Roles, *Online Journal of Issues in Nursing*.
- Cullen, C 2000, Autonomy and the Nurse Practitioner, *Nursing Standard*, 14, 53 - 56.
- Dahle, K, Smith, J, Ingersoll, G & Wilson, J 1998, Impact of a Nurse Practitioner on the Cost of Managing Inpatients with Heart Failure, *Excerpta Medica*, 686 - 688.
- Danaher, G, Schirato, T & Webb, J (eds.) 2000, *Understanding Foucault*, Sydney, Allen & Unwin.
- Department of Health and Ageing, *Australian Refined Diagnosis Related Groups (Ar-Drgs)*, Canberra, viewed 3<sup>rd</sup> March 2009, Canberra, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-ardrg1.htm>>
- Department of Health, 2004, *A Matron's Charter: Action Plan for Cleaner Hospitals*, COI Communications for the Department of Health NHS, Viewed 17<sup>th</sup> November 2008, <[www.dh.gov.uk/publications](http://www.dh.gov.uk/publications)>
- Department of Health Western Australia 2003, *Guideline Framework for the Implementation of Nurse Practitioners in Western Australia*, Perth, Department of Health Western Australia, viewed 30<sup>th</sup> March 2004, <<http://www.health.wa.gov.au/home/>>
- Department of Human Services 2003, *Nurses are Vital for a Healthy Victoria*, Government Medial Release, 8<sup>th</sup> November 2003, Melbourne, <[http://www.dpc.vic.Gov.au/web\\_notes/newsmedia.nsf/0/65](http://www.dpc.vic.Gov.au/web_notes/newsmedia.nsf/0/65)>
- Dingwall, R & Allen, D 2001, The Implications of Healthcare Reforms for the Profession of Nursing, *Nursing Inquiry*, 8, 64 - 74.
- Dolan, J, Fitzpatrick, M & Herrmann, E 1983, *Nursing In Society. A Historical Perspective*, Philadelphia, Saunders Company.

- Dowling, S, Barrett, S & West, R 1995, With Nurse Practitioners, who Needs House Officers? *British Medical Journal*, 311, 309 - 313.
- Drayer, M A & Brown, M A 2000, Surviving the Proving Ground: Lessons in Change from NP Pioneers, *The Nurse Practitioner*, 25, 60 - 71.
- Dunn, A 2004 'Enter A New Breed, neither Nurse nor Doctor', *The Age*, Melbourne, viewed 5<sup>th</sup> April 2004  
<[http://newsstore.theage.com.au/apps/viewDocument.ac?page=1&sy=age&kw=nurse+practitioners&pb=all\\_ffx&dt=selectRange&dr=10years&so=relevance&sf=text&sf=headline&rc=10&rm=200&sp=nrm&clsPage=1&docID=AGE040703HJ5P67DQS3L](http://newsstore.theage.com.au/apps/viewDocument.ac?page=1&sy=age&kw=nurse+practitioners&pb=all_ffx&dt=selectRange&dr=10years&so=relevance&sf=text&sf=headline&rc=10&rm=200&sp=nrm&clsPage=1&docID=AGE040703HJ5P67DQS3L)>
- Dworkin, G 1988, *The Theory and Practice of Autonomy*, Oxford, Cambridge University Press.
- Eriksen, T H 2001, *Small Places, Large Issues*, London, Pluto Press.
- Ettner, S, Kotlerman, J, Abdelmonem, A, Vazirani, S, Hays, R, Shapiro, M & Cowan, M 2006, An Alternative Approach to Reducing Costs of Patient Care? A Controlled Trial of the Multi-Disciplinary Doctor-Nurse Practitioner (MDNP) Model, *Medical Decision Making*, 26, 9 - 17.
- Etzioni, A 1969, *The Semi-Professions And Their Organisation*, New York, Collier-Macmillan Ltd.
- Fairclough, N 1995, *Critical Discourse Analysis. The Critical Study of Language*, Edinburgh Gate, Pearson Education Ltd.
- Fairclough, N 2000, *New Labour New Language?* London, Routledge.
- Fairclough, N 2001a, 'Critical Discourse Analysis In Social Scientific Research', In *Methods of Critical Discourse Analysis*, R Wodak & M Meyer, (eds), London, Sage Publications.
- Fairclough, N 2001b, *Language and Power*, Edinburgh Gate, Pearson Education Ltd.
- Fairclough, N & Wodak, R 1997, 'Critical Discourse Analysis' In *Discourse as Social Interaction*, T Van Dijk, T (ed), London, Sage.
- Fairman, J 2008, *Making Room in the Clinic*, New Brunswick, Rutgers University Press.
- Faresjo, T 2006, 'Interprofessional Education - To Break Boundaries and Build Bridges', in *The International Journal of Rural and Remote Health, Research, Practice and Policy Online* <<http://rrh.deakin.edu.au/6:602>>
- Farmborough, F 1974, *Nurse at the Russian Front*, London, First Futura Publications.

- Fineman, M A 2004, *The Autonomy Myth - A Theory Of Dependency*, New York, The New Press.
- Foucault, M 1966, *The Order Of Things*, London, Routledge Classics.
- Foucault, M. 1972, *The Archaeology of Knowledge*, New York, Parthenon Books.
- Foucault, M 1978, *The History of Sexuality. An Introduction*, Penguin Books.
- Foucault, M 1980, 'Truth and Power' In *Michael Foucault: Power/Knowledge*, C Gordon, C. (ed), Hertfordshire, Harvester Wheatsheaf.
- Freedom of Information Act* 1982 (Australian Federal Government)
- Friedson, E 1971, *Profession of Medicine. A Study of the Sociology of Applied Knowledge*, New York, Dodd, Mead & Co.
- Friedson, E 1994, *Professionalism Reborn: Theory, Prophecy and Policy*, Cambridge, Polity Press.
- Gardner, G 2004, Issues in Nurse Practitioner Developments in Australia, *Cancer Forum*, 28, 132 - 134.
- Gardner, G, Carryer, J, Dunn, S & Gardner, A 2004, *Nurse Practitioner Standards Project: Report To Australian Nursing Council*, Canberra, Australian Nursing Council.
- Gardner, G, Chang, A & Duffield, C 2006, Making Nursing Work: Breaking Through the Role Confusion of Advanced Practice Nursing, *Journal of Advanced Nursing*, 57, 382 - 391.
- Gardner, H (ed) 1998, *Health Policy in Australia*, Melbourne, Oxford University Press.
- Garling, P 2008, *Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals*. Sydney, Government of New South Wales.
- Gaylin, W & Jennings, B 2003, *The Perversion of Autonomy*, Washington D.C, Georgetown University Press.
- Goolsby, M 2001, Evaluating and Applying Clinical Practice Guidelines, *Journal of the American Academy of Nurse Practitioners*, 13, 3 - 6.
- Gordon, S 2005, *Nursing Against all Odds*, New York, Cornell University Press.

- Gordon, S & Nelson, S 2005, An End to Angels, *Australian Journal of Nursing*, 105, 62 - 68.
- Government of South Australia 2009, *Community Health Careers*, The Advertiser Careerone. Adelaide 25 April 2009, p. 6.
- Grint, K 1997, *Leadership: Classical, Contemporary and Critical Approaches*, Oxford, Oxford University Press.
- Hall, D 2004, Preparing for the Data Deluge, *Learning and Leading with Technology*, 32, 33 - 35.
- Hand, D 2001, New Territory, *Nursing Standard* 15, 18 - 19.
- Hart, C 2004, *Nurses and Politics. The Impact of Power and Practice*, Hampshire, Palgrave Macmillan.
- Heartfield, M 2006, *Specialisation and Advanced Practice Discussion Paper: A Select Analysis of the Language of Specialisation and Advanced Nursing and Midwifery Practice*, National Nursing and Education Taskforce. Melbourne.
- Health Professions Act 2005 (Victoria)*
- Health Regulations 2006 (Australian Capital Territory)*
- Hegney, D 1996, The Status of Rural Nursing in Australia. A Review, *Australian Journal of Rural Health*, 4, 1 - 10.
- Hegney, D 1997, Extended, Expanded, Multi-Skilled or Advanced Practice? Rural Nurses In Australia, 1991 – 1994, *Collegian*, 4, 22 - 27.
- Hegney, D 1998, Disciplinary Power and its Influence on the Administration and Supply by Nurses in Rural Areas of Australia, *International Journal of Nursing Practice*, 4, 144 - 140.
- Hegney, D, Mccarthy, A, Rogers-Clark, C & Gormon, D 2002, Why Nurses are Attracted to Rural and Remote Practice, *Australian Journal of Rural Health*, 10, 178 - 186.
- Hegney, D, Pearson, A & Mccarthy, A 1997, *The Role and Function of the Rural Nurse in Australia*, Canberra, National Library of Australia.
- Henderson, V 1967, *The Nature of Nursing*, New York, Macmillan.
- Herdman, E 1994, *The Deskillling of Registered Nurses: The Social Transformation of Nursing Work in A New South Wales Hospital, 1970 – 1990*, School of Nursing, University of Wollongong, NSW.

- Hess, R 2004, From Bedside to Boardroom - Nursing Shared Governance, Online *Journal of Issues in Nursing*, 9, <[http://www.nursingworld.org/ojin/tpc23\\_1.Htm](http://www.nursingworld.org/ojin/tpc23_1.Htm)>
- Hewison, A 1999, The New Public Management and the New Nursing: Related by Rhetoric? Some Reflections on the Policy Process and Nursing, *Journal of Advanced Nursing*, 29, 1377 - 1384.
- Hewison, A & Stanton, A 2003, From Conflict to Collaboration? Contrasts and Convergence in the Development of Nursing Management Theory (2), *Journal of Nursing Management*, 11, 15 – 24.
- Hickey, J, Oumiette, R & Venegoni, S 2000, *Advanced Nursing Practice: Changing Roles and Clinical Applications*, Baltimore, Lippincott.
- Hill, J, Bird, H A, Harmer, R, Wright, V & Lawton, C 1994, An Evaluation of the Effectiveness, Safety and Acceptability of a Nurse Practitioner in a Rheumatology Outpatient Clinic, *British Journal of Rheumatology*, 33, 283 - 288.
- Hofoss, D 1986, Health Professions: The Origin of Species, *Social Science and Medicine*, 22.
- Hoque, K, Davis, S & Humphreys, M 2004, Freedom to do what you are told: Senior Management Team Autonomy in NHS Acute Trust, *Public Administration*, 82, 355 - 375.
- Horner, C & Westacott, E 2001, *Thinking through Philosophy, an Introduction*, Cambridge, Cambridge University Press.
- Horrocks, S, Anderson, A & Salisbury, C 2002, Systematic Review of Whether Nurse Practitioners Working in Primary Care can Provide Equivalent Care to Doctors, *British Medical Journal*, 324, 819 - 823.
- Hochschild, A 1979, Emotion Work, Feeling Rules, and Social Structure, *The American Journal of Sociology*, Vol 85, 551 – 575.
- Huey, F & Hartley, S 1988, What Keeps Nurses in Nursing: 3,500 Nurses tell their Stories. *American Journal of Nursing*, 88, 181 - 188.
- Hugman, R 1991, *Power in Caring Professions*, London, Macmillan.
- Iliffe, J 2007, ANF Supports Tasmania's Stand against Insulting Pay Offer, *Media Release: Australian Nursing Federation Federal Office*, Canberra, Australian Nursing Federation
- International Council of Nurses 2001, *The ICN Workforce Forum Report*, Geneva, International Council of Nurses.

- Jager, S 2001, Discourse and Knowledge: Theoretical and Methodological Aspects of a Critical Discourse and Dispositive Analysis. In *Methods of Critical Discourse Analysis*, (eds), R Wodak & M Meyer, London, Sage Publications.
- Jenkins-Clarke, J & Carr-Hill, R 2003, Workforce and Workload: Are Nursing Resources Used Effectively? *Nursing Times Research* 8, 238 - 248.
- Johnston, T 1972, *Professions and Power*, London, Macmillan.
- Jolly, R 2008, *Health Workforce: A Case for Physician Assistants?* Canberra Parliamentary Library <<http://www.aph.gov.au/library>>
- Jones, A 2003, Changes in Practice at the Nurse-Doctor Interface. Using Focus Groups to Explore the Perceptions of First Level Nurses Working in an Acute Care Setting, *Journal of Clinical Nursing*, 12, 124 - 131.
- Kant, I 1781, *Critique of the Power of Judgement*, Translated P Guyer 2006, New York, Cambridge University Press.
- Kant, I 1781a, *Foundations of Metaphysics of Morals*, Translated L Beck 1985, New York, Macmillan.
- Kant, I. 1781b, *Critique of Practical Reason*, Translated T K Abbott 1996, New York, Prometheus Books.
- Kaplan, R & Norton, D 1996, *The Balanced Scorecard*, Boston, Havard Business School Press.
- Kassirer, F E 1993, Medicine at Centre Stage, *The New England Journal of Medicine*, 328, 1268 - 1269.
- Kelly, S 2008, *Australia's Chief Nursing Officer Announced*, Media Release Minister for Health and Ageing, Canberra, Department of Health and Ageing <<http://www.health.gov.au/internet/ministers/publishing.nsf/content/mr-yr08-nr-nr097.htm>>
- Kerfoot, K 1989, Reinventing Nursing Through Entrepreneurism, *Nurse Economics*, 5, 278 - 280.
- Kermode, S 1994, The Organisation: a Problem for the Professionalisation of Nursing, *Contemporary Nurse*, 3 (3), 110 – 117.
- Kernick, D & Scott, A 2002, Economic Approaches to Doctor/Nurse Skill Mix: Problems, Pitfalls and Partial Solutions, *British Journal of General Practice*, 53, 42 - 46.
- Keyzer, D 1997, The Advanced Nurse Practitioner and the Rural Doctor, *Australian Journal of Rural Health*, 5, 184 - 189.

- Keyzer, D 2000, *Nurse Practitioners*, Plenary Paper, General Practice into the New Millennium, Wonco Conference. Christchurch, New Zealand.
- Keyzer, D 2001, *The Politics of Nursing: The Case of the Nurse Practitioner in New South Wales*, Department of Rural Health, University of Sydney.
- Keyzer, D, Hall, J, Mahnken, J & Keyzer, K 1995, *Gum Tress and Windmills*. Deakin University, Warrnambool.
- Kinnersley, P, Anderson, E, Parry, K, Clement, J, Archard, L, Turton, P, Stainthorpe, A, Fraser, A, Butler, C & Rogers, C 2005, Randomised Controlled Trial of Nurse Practitioner versus General Practitioner Care for Patients Requesting "Same Day" Consultations in Primary Care, *British Medical Journal*, 320, 1043 - 1048.
- Kirkwood, B, Pesudovs, K, Loh, R & Coster, D 2005, Implementation and Evaluation of an Ophthalmic Nurse Practitioner Emergency Eye Clinic, *Clinical and Experimental Ophthalmology*, 33, 593 - 597.
- Kitson, A 1999, The Essence of Nursing. *Nursing Standard*, 13, 42 - 46.
- Legg, S C 2008, *Nursing: A Moderated Love*. In Royal Collage of Nursing Australia, The 42nd Patricia Chomley Memorial Oration. Perth.
- Lentner, H 2005, Hegemony and Autonomy, *Political Studies*, 53, 735 - 752.
- Leonard, P 2003, 'Playing' Doctors and Nurses? Competing Discourses of Gender, Power and Identity in the British National Health Service, *The Sociological Review*, 218 - 234.
- Linde, C 2005, 'Narrative in Institutions', In *The Handbook Of Discourse Analysis*, D Schiffrin, D Tannen. & H Hamilton, (eds), Oxford, Blackwell Publishing
- Lumby, J & Picone, D 2000, *Focus on Nursing: Clinical Challenges*, St. Leonards, Allen & Unwin.
- Macdonald, C 2002, Nurse Autonomy as Relational, *Nurse Ethics*, 9, 194 - 201.
- Machiavelli, N 1505, *The Prince*, Translated W K Marriott, viewed November 2008 <<http://www.constitution.org/mac/prince.pdf>>
- Mahnken, J 2001, *Rural Nursing and Health Care Reforms: Building a Social Model of Health*. Rural and Remote Health, Deakin University, <[http://www.regional.org.au/au/rrh/2001/011214\\_104.htm](http://www.regional.org.au/au/rrh/2001/011214_104.htm)>
- Mahnken, J, Nesbit, P & Keyzer, D 1997, *The Rural Nurse Practitioner. A Pilot Project to Develop an Alternative Model for Practice*. Deakin University, Warrnambool.



- Mannion, R, Small, N & Thompson, C 2005, Alternative Futures for Health Economics: Implications for Nursing Management, *Journal of Nursing Management*, 13, 377 - 386.
- Mantzoukas, S & Jasper, M 2004, Reflective Practice and Daily Ward Reality: A Covert Power Game, *Journal of Clinical Nursing*, 13, 925 - 933.
- Masterson, A 2002, Cross-Boundary Working: A Macro-Political Analysis of the Impact on Professional Roles, *Journal of Clinical Nursing*, 11, 331 - 339.
- Mcbryde, B 1979, *A Nurse's War*, London, Hogarth Press.
- Medicare Australia Act 1973* (Federal Government of Australia)
- Medicare Australia 2008, *Medicare Australia, Agency Resources and Planned Performance*, Australian Federal Government.
- Medicare Australia 2008a, *Medicare Benefits Schedule Book*, Australian Federal Government.
- Meiksins, P F & Watson, J M 1989, Professional Autonomy and Organisational Constraint, *The Sociological Quarterly*, 30, 561- 585.
- Merriam-Webster 2008, Merriam-Webster Online Dictionary, <<http://www.merriam-webster.com/dictionary/>>
- Meyer, M 2001, 'Between Theory, Method and Politics; Positioning of the Approaches', In *Methods of Critical Discourse Analysis*, eds R Wodak, & M Meyer, M, London, Sage Publications.
- Moait, S 2000, Doctoring up the Nightingales, *Newcastle Herald*, 14 June 2000.
- Moore, W 1970, *The Professions; Roles and Rules*, New York, Russell Sage Foundation.
- Mrayyan, M 2004, Nurses' Autonomy: Influence of Nurse Managers' Actions, *Journal of Advanced Nursing*, 45, 326 - 336.
- Mumby, D & Clair, R 2004, 'Organizational Discourse', In *Discourse as Social Interaction*, (eds) T Van Dijk, London, Sage Publications.
- Mundiger, M, Kane, R, Lenz, E, Totten, A, Tsai, W, Cleary, P, Friedewald, W, Siu, A & Shelanski, M 2000, Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians, *Journal of The American Medical Association*, 283, 59 - 68.
- National Health and Hospitals Reform Commission, 2009, *A Healthier Future for all Australians*. Australian Federal Government.

- National Nursing and Nursing Education Taskforce, 2005, *Nurse Practitioners in Australia: Mapping of State/Territory Nurse Practitioner (NP) Models, Legislation and Authorisation Processes*. Melbourne, National Nursing and Nursing Education Taskforce.
- National Rural Health Alliance (2002) *Report on Nursing in Rural and Remote Areas*.
- Nelson, S 1997, Pastoral Care and Moral Government: Early Nineteenth Century Nursing and Solutions of the Irish Question, *Journal of Advanced Nursing*, 27, 6 - 14.
- Nelson, S 2001, *Say Little, Do Much: Nurses, Nuns and Hospitals in the Nineteenth Century*, Philadelphia, University of Pennsylvania Press.
- Nelson, S 2005, *Nurses no Longer the Doctor's Handmaiden*. Nursing Review, May 2005 edition, Royal College of Nursing Australia.
- Nelson, S 2009, *Do we really need all these Nurses?* The Star Newspaper Toronto, viewed 1st November 2009 <<http://thestar.com/printarticle/599226>>.
- Nelson, S & Gordon, S 2004, The Rhetoric of Rupture: Nursing as a Practice with a History, *Nursing Outlook*, 52, 255 - 261.
- New South Wales Health, 1995, *Nurse Practitioner Project Stage 3 - Final Report of the Steering Committee*, Sydney, Department of Health.
- Nhan, J & Zuidema, S 2007, Nurse Practitioners in the Northern Alberta Renal Program, *CANNT Journal*, 17 (2), 48 – 50.
- Nurses Act 2004* (Australian Capital Territory)
- Nursing Act 1992* (Queensland)
- Nurses Act 2006* (South Australia)
- Nurse Amendment Act 1998* (Nurse Practitioner) (New South Wales)
- Nurses Amendment Bill 2003* (Australian Capital Territory)
- Nurses Amendment Bill 2002* (Western Australian Government)
- Nurses and Midwives Act 1991* (New South Wales)
- Nurses and Midwives Act 2006* (Western Australia)
- Nurse Practitioners Legislation Amendment Bill 2003* (Australian Capital Territory)

*Nursing Regulations 2005 (Tasmania)*

New South Wales Health, 2001, *Nurse Practitioner*. Sydney, New South Wales Health.

New South Wales Health, 2005, *Policy Directive: Nurse/Midwife Practitioners in NSW*. Nursing & Midwifery Office, viewed November 2005  
<[http://www.health.nsw.gov.au/policies/pd/2005/PD2005\\_556.html](http://www.health.nsw.gov.au/policies/pd/2005/PD2005_556.html)>

Newbury, D, 2009, *Research Issues in Art, Design and Media*, Birmingham Institute of Art and Design, Birmingham City University, The Research Training Initiative, viewed August 2009  
<<http://www.biad.bcu.ac.uk/research/rti/rtc/rtrc.html>>

Nurses and Midwives Board of New South Wales, 1998, *Nurse Practitioners in New South Wales: Information for Applicants*. (Revised 2006), Sydney,  
<<http://www.nmb.nsw.gov.au/Nurse-Practitioners/default.aspx>>

Nurses and Midwives Board of New South Wales, 2004, *Nurse Practitioner and Midwife Practitioner Application Guide*. (Revised 2006), Sydney,  
<<http://www.nmb.nsw.gov.au/Nurse-Practitioners/default.aspx>>

Nurses Board of South Australia, 2006, *Application Pack for Authorisation as a Nurse Practitioner 4<sup>th</sup> ed.*,  
<[http://www.nmb.sa.gov.au/reg\\_nurse\\_practitioner\\_endorsement.html](http://www.nmb.sa.gov.au/reg_nurse_practitioner_endorsement.html)>

Nurses Board of Western Australia, 2003, *Nurse Practitioner Information and Application Guide*, Revised 2005 Ed. Perth.

Nursing Board of Tasmania 2006, *Application Pack for Authorisation as a Nurse Practitioner*, Hobart,  
<<http://www.nursingboardtas.org.au/domino/nbt/nbtweb.nsf/v-lu-all/Registration+and+Enrolment?OpenDocument>>

Nursing Board of Tasmania 2007, *Standards of Medication Management for Nurses and Midwives*, Hobart, viewed March 2008,  
<[http://www.nursingboardtas.org.au/domino/nbt/nbtweb.nsf/v-lu-all/Publications~Nursing+Code~Standards+of+Medication+Management+for+Nurses+and+Midwives+2008/\\$FILE/Medication\\_Management\\_WEB.pdf?OpenElement](http://www.nursingboardtas.org.au/domino/nbt/nbtweb.nsf/v-lu-all/Publications~Nursing+Code~Standards+of+Medication+Management+for+Nurses+and+Midwives+2008/$FILE/Medication_Management_WEB.pdf?OpenElement)>

O'Brien, M 1994, The Managed Heart Revisited: Health and Social Control, *The Sociological Review*, 392 - 411

Orrock, M & Lawler, J 2008, The Fractured Self: Deconstruction of Role Identity as a Consequence of Health Care Reform, *International Journal of Interdisciplinary Social Sciences*, Vol 3, <<http://www.SocialSciences-Journal.com>> .

- Ovsiannikov, A A & Monakhov, S V 2007, The Social Effectiveness Of Internet Education. *Russian Education & Society*, 49, 61 - 86.
- Papadakis, M & Haberfield, I 2003, Super Nurses Make History. *Sunday Herald Sun*, Melbourne.
- Patton, M Q 1990, *Qualitative Evaluation and Research Methods*, Newbury Park California, Sage Publications Inc.
- Paulson, R I, Post, R L, Herinckx, H A & Risser, P 2002, Beyond Components: Using Fidelity Scales to Measure and Assure Choice in Program Implementation and Quality Assurance, *Community Mental Health*, 38, 119-128.
- Pearson, A 2003, Multidisciplinary Nursing: Re-Thinking Role Boundaries, *Journal of Clinical Nursing* 12, 625 - 629.
- Perala, M L 2001, Nursing In The New Millennium: Full Utilisation Of The Potential Benefits Of Nursing For Society, *International Journal of Nursing Practice*, 7, 61-62.
- Perron, A, Fluet, C & Holmes, D 2005, Agents of Care and Agents of The State: Bio-Power and Nursing Practice, *Journal of Advanced Nursing*, 50, 536 - 544.
- Perry, P 2002, *Roll out of Specialist Nurse Practitioners*, in Government Media Release, New South Wales Health, <<http://www.health.nsw.gov.au/archive/news/2002/September/05-09-02.htm>>
- Pirani, C 2004, *AMA Blocks Nursing Plan*. The Australian, Sydney, viewed 7<sup>th</sup> May 2004, <<http://www.theaustralian.news.com.au/printpage/0,5942,9450278,00.html>>
- Pivetta, S 1999, *Million-Dollar Models For Nurse Practitioners – Knowles*, in Government Media Release, Department Of Human Services, Melbourne, viewed 24 January 2008, <<http://hnb.dhs.vic.gov.au/web/pubaff/medrel.nsf/LinkView/2451A1BED77FECA84A25696000DD74F?OpenDocument>>
- Polit, D & Hungler, B 1995, *Nursing Research Principles and Methods*, Philadelphia, J.B. Lippincott Company.
- Pollard, R 2006, *Doctors Vow to Stop Nurses Taking Their Jobs*, The Sydney Morning Herald. n.d.
- Porter-O'grady, T 1992, *Implementing Shared Governance: Creating a Professional Organisation*, St. Louis, Mosby Yearbook.

- Porter-O'grady, T 1999, Quantum Leadership: New Roles For A New Age, *Journal of Nursing Administration*, 29, 37 - 42.
- Porter-O'grady, T & Wilson, C 1998, *The Healthcare Team Book*, Missouri, Mosby.
- Productivity Commission 2005 *Australia's Health Workforce Productivity Commission Research Report*, Canberra, Federal Government of Australia.
- Queensland Government 2003, *Nurse Practitioner Project*, Queensland Health, viewed 15<sup>th</sup> June 2004,  
<<http://www.health.qld.gov.au/nursing/pracproject.asp>>
- Queensland Nursing Council 2005, *Policy on the Regulation of Nurse Practitioners in Queensland*, Brisbane, viewed 17<sup>th</sup> November 2006,  
<[http://www.qnc.qld.gov.au/assets/files/pdfs/policies/Policy\\_on\\_th\\_%20regulation\\_of\\_nurse\\_practitioners\\_in\\_Queensland.pdf](http://www.qnc.qld.gov.au/assets/files/pdfs/policies/Policy_on_th_%20regulation_of_nurse_practitioners_in_Queensland.pdf)>
- Rabinow, P (Ed.) (1997) *Ethics: Essential Works of Foucault 1954 - 1984*, London, Penguin.
- Rafferty, A M 1996, *The Politics of Nursing Knowledge*, London, Routledge.
- Rashotte, J 2005, Knowing The Nurse Practitioner: Dominant Discourses Shaping Our Horizons, *Nursing Philosophy*, 6, 51 - 62.
- Reveley, S 1998, The Role of the Emergency Nurse Practitioner in General Medical Practice: An Analysis of The Role, *Journal of Advanced Nursing*, 28, 584 - 591.
- Robinson, M 2002, *Fears Hospital Super Nurse is 'Disaster Waiting to Happen'*, Sydney Morning Herald, Sydney, 6<sup>th</sup> September 2002,  
<<http://www.smh.com.au/articles/2002/09/05/1031115911711.html>>
- Robson, C 1998, *Real World Research*, Oxford, Blackwell Publishers.
- Rolfe, G & Fulbrook, P (eds) 1999, *Advanced Nursing Practice*, Melbourne, Butterworth Heinemann.
- Royal College of Nursing (2005) *Nurse Practitioners are an Asset, not a Threat*, RCNA News, Nursing Review, viewed 15<sup>th</sup> March 2006,  
<<http://docs.google.com/gview?a=v&q=cache:2OSw8FTRABgJ:www.cdnm.edu.au/pdfs/Nursepractitioners.pdf+Nurse+Practitioners+Are+An+Asset,+Not+A+Threat&hl=en&gl=au&sig=AFQjCNHR72yHILnHk-yCntVezFHTPQOe8A>>
- Russell, S M 1954, *A Lamp is Heavy*, London, Angus & Robertson.

- Ryan, S 2008, *Doctors Told To Reform Or Lose Pay*, *The Australian*. Sydney, viewed 5<sup>th</sup> March 2009, <<http://www.theaustralian.new.com.au/story/0,25197,24373781-5013871,00.html>>
- Sakr, M, Angus, J, Perrin, J, Nixon, C, Nicholl, J & Wardrope, J 1999, Care of Minor Injuries by Emergency Nurse Practitioners or Junior Doctors: A Randomised Controlled Trial, *Lancet*, 354.
- Schatzman, L & Strauss, A 1973, *Field Research: Strategies for a Natural Sociology*, Englewood Cliffs, Prentice Hall.
- Scollon, R 2001a 'Action and Text', In R Wodak. & M Meyer (eds) *Methods of Critical Discourse Analysis*, London, Sage Publications.
- Scollon, R 2001b *Mediated Discourse: The Nexus of Practice*, London, Routledge.
- Serle, C 1987 *Professional Practice: A South African Nursing Perspective*, Durban, Butterworths.
- Shine, K 2001, *Why 'Doctor' Olly is the New Face of Bush Medicine*. The Sun Herald, 27<sup>th</sup> May 2001, News section, p. 26.
- Sibbald, B, Shen, J & McBride 2004, Changing the Skill Mix of the Health Care Workforce, *Journal of Health Services Research and Policy*, 9, 28 - 39.
- Sinclair, I 2000, 'NSW Ministerial Advisory Committee on Health Services in Smaller Towns (Sinclair Report)', Report to the Minister in *Health, a Framework for Change*, Sydney, New South Wales
- South Australian Government 1999, *Nurse Practitioner Project Report*. Adelaide, Department of Human Services.
- Swerissen, H & Duckett, S 1997, 'Health Policy and Financing', In G Gardner (ed) *Health Policy in Australia*, Melbourne, Oxford University Press.
- Sugden, F. (2005) Minister Says Nurse Practitioners a Must for a Superior Health System Australian Healthcare Association  
[http://www.aushealthcare.com.au/news\\_details.asp](http://www.aushealthcare.com.au/news_details.asp)
- Taft, S & Nanna, K 2008, What Are The Sources Of Health Policy That Influence Nursing Practice? *Policy, Politics, & Nursing Practice*, 9, 274 - 287.
- The Hon. Nicola Roxon MP 2008, 'The Light On The Hill: History Repeating', In *Annual Ben Chifley Memorial "Light on the Hill" Dinner*. Panthers Leagues Club, Bathurst, NSW.
- Therapeutic Goods Regulation* 1990 (Australian Federal Government)

- Torn, T & McNichol, E 1998, A Qualitative Study Utilizing a Focus Group to Explore the Role and Concept of the Nurse Practitioner, *Journal of Advanced Nursing*, 1202 - 1211.
- Turner, C 2000, *Annual Nurse Practitioner Project Report*, Broken Hill Far West Area Health Service NSW.
- Turner, C & Keyzer D 2002, Nurse Practitioners: A Contract for Change and Excellence in Nursing. *Collegian*, 9, 18 - 25.
- UK Department of Health 1999, *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*, London, UK Government.
- Van Dijk, T (ed.) 2004. *Discourse as Social Interaction*, London, Sage Publications.
- Van Dijk, T 2005, 'Critical Discourse Analysis', In D Schiffrin, D Tanne, & H Hamilton (eds) *The Handbook of Discourse Analysis*, Oxford, Blackwell Publishing.
- Van Offenbeek, M & Knipp, M 2003, The Organisational Performance Effects of Nurse Practitioner Roles, *Journal of Advanced Nursing*, 47 (6), 672 – 681.
- Verghis, S 2000, 'Super Nurses' Prescribed as Rural Cure not what the Doctor Ordered, *The Sydney Morning Herald*, Sydney, n.d.
- Victorian Government 1999, *The Victorian Nurse Practitioner Project: Final Report of The Taskforce*, Department of Human Services, Melbourne.
- Victorian Government 2006, *A Guide For Developing Clinical Practice Guidelines for Nurse Practitioners in Victoria*. Department of Human Services, Melbourne.
- Viitanen, E, Wiili-Peltola, E, Tampsi-Jarvala, T & Letho, J 2007, First-Line Managers in University Hospitals - Captives to their Own Professional Culture? *Journal of Nursing Management*, 15.
- Wade, G H 1999, Professional Nurse Autonomy: Concept Analysis and Application to Nursing Education, *Journal of Advanced Nursing*, 30, 310 - 318.
- Wall, B & Nelson, S 2003 Our Heels are Praying very Hard all Day, *Holistic Nurse Practitioner*, 17, 320 - 328.
- Wallin, L 2005, Clinical Practice Guidelines in Nursing, *Awhonn Lifelines*, 9, 248 - 251.
- Wardhaugh, R 2002, *An Introduction to Sociolinguistics 4th Ed.*, Oxford, Blackwell Publishing.

- Watts, T, Jones, M, Wainwright, P & Williams, A 2001 Methodologies Analysing Individual Practice in Health Care: A Systematic Review, *Journal of Advanced Nursing*, 35, 238 - 256.
- Wearing, M 1999 'Medical Dominance and the Division of Labour in the Health Professions', In C Grbich (ed) *Health in Australia, Sociological Concepts and Issues*, Australia, Prentice Hall.
- Weinberg, D. B. (2003) *Code Green*, London, Cornell University Press.
- Western Australia Government 2003, *Western Australia Nurse Practitioner Business Case and Clinical Protocol Templates*, Perth, Department of Health.
- Western Australia Parliament 2005, *Western Australia Parliamentary Proceedings Council*. Perth, Western Australian Government.
- Wilson, K 2005, The Evolution of the Role of Nurses: The History of Nurse Practitioners in Pediatric Oncology, *Journal of Pediatric Oncology Nursing*, Vol 22 (5), 250 – 253.
- White, K 2002, *An Introduction to the Sociology of Health and Illness*, London, Sage Publications.
- Wigens, L 1996, The Conflict Between 'New Nursing' and 'Scientific Management' as Perceived by Surgical Nurses, *Journal of Advanced Nursing*, 25, 1116 - 1122.
- Williams, A & Jones, M 2006, Patients' Assessments of Consulting a Nurse Practitioner: The Time Factor, *Journal of Advanced Nursing*, 53, 188 - 195.
- Williams, A, Mcgee, P & Bates, L 2001, An Examination of Senior Nursing Roles: Challenges for the NHS, *Journal of Clinical Nursing*, 10, 195 - 203.
- Wimpenny, P 2002, The Meaning of Models of Nursing to Practising Nurses, *Journal of Advanced Nursing*, 40, 346 - 354.
- Wodak, R 2001, 'Introduction: Critical Language Study', In R Wodak & M Meyer (eds) *Methods of Critical Discourse Analysis*, London, Sage Publications.
- Woods, J 2005, Is Matron a Match for MRSA? The Telegraph, Viewed 18<sup>th</sup> November 2008, <<http://www.telegraph.co.uk/health/healthnews/3315057/Is-Matron-a-match-for-MRSA.html>>
- Woods, L 2006, Evaluating the Clinical Effectiveness of Neonatal Nurse Practitioners: An Exploratory Study, *Journal of Clinical Nursing*, 15, 35 - 44.
- World Health Organisation 1996, *Report of the WHO Expert Committee on Nursing*. Geneva, WHO, viewed 16<sup>th</sup> June 2007, <[http://www.who.int/hrh/nursing\\_midwifery/en/](http://www.who.int/hrh/nursing_midwifery/en/)>



World Health Organisation 2000, *Nursing Beyond the Year 2000 - Report of a WHO Study Group*, Geneva, WHO, viewed 16<sup>th</sup> June 2007, <[http://www.who.int/hrh/nursing\\_midwifery/en/](http://www.who.int/hrh/nursing_midwifery/en/)>

World Health Organisation 2001, *Summary Document. Strengthening Nursing and Midwifery. Progress and Future Directions*, Geneva, WHO, viewed 16<sup>th</sup> June 2007, <[http://www.who.int/hrh/nursing\\_midwifery/en/](http://www.who.int/hrh/nursing_midwifery/en/)>

World Health Organisation 2002, *Strategic Directions for Strengthening Nursing and Midwifery Services*, Geneva, WHO, viewed 16<sup>th</sup> June 2007, <[http://www.who.int/hrh/nursing\\_midwifery/en/](http://www.who.int/hrh/nursing_midwifery/en/)>



## **Appendices**

*Appendix 1 - Letter to the Nursing and Midwifery Regulatory Authorities Australia*

*Appendix 2- Letter of Introduction*

*Appendix 3 - Information Sheet*

*Appendix 4 - Consent Form*

*Appendix 5 - Interview Question Guide*

*Appendix 6 - Australian Nursing and Midwifery Council Competency Standards for Nurse Practitioners (2006)*

*Appendix 7- Australian and Nursing Midwifery Council Competency Standards for Registered Nurses (2006)*

*Appendix 8 - AMA Position Statement Regional/Rural Workforce Initiatives (2005)*

*Appendix 9 – Letter of approval - Flinders University of South Australia Social and Behavioural Science Ethics Committee*