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UCD School of Nursing, Midwifery and Health Systems

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Abstract

Background: The Irish health service, in common with health services across the world, faces the challenge of operating within economic constraints while responding to changing demographics that increase demand for health and social care services. Within this dynamic environment, nurses, especially Advanced Nurse Practitioners (ANP), are experiencing new challenges. Whilst nursing and medicine have established systems of disciplinary practices that produce nurses and doctors within historically-contingent role boundaries, these boundaries are becoming more fluid and porous. ANPs constantly negotiate these boundaries, offering the possibility of a new and potentially more liberating identity for them within the healthcare system. Uncertainty about the ANP identity results in the full potential of the ANP role not being realised and, consequently, ANPs are underutilised. This study aims to understand how ANPs are positioned within current nursing and health systems by making explicit the discourses that construct the ANP role and how they both enable and constrain it.

Methods: The study is based on a critical discourse analysis (CDA) of healthcare professionals' language-in-use. To gain an analytic purchase on participants' language-in-use, James Paul Gee's Tools of Inquiry and Building Task Frameworks were employed. In addition, Barry Oshry's Organic Systems Framework (OSF) was applied to deepen the analysis and to help identify how the patterns of relationships and processes inherent in human systems manifest in language. Data were elicited from a literature review and document analysis as well as seven in-depth interviews and four focus groups involving twenty-nine participants including twelve ANPs, two staff nurses, eight nurse managers, one director of nursing and one nursing project officer, three medical doctors and two allied healthcare professionals.

Findings: Language-in-use established that ANPs add value to the healthcare system from both a monetary and non-monetary perspective and highlighted the centrality of nursing to the ANP role. Language-in-use constructs an identity for ANPs as a medical substitute, an inferior role, yet an innovative addition to the system and a threat to existing structures. Language-in-use constructs tensions between independence and autonomy, on the one hand, and collaboration and control, on the other. Findings show that when hierarchical structures and professional self-interest dominate, systemic processes and relationships are impacted, resulting in a healthcare system that is out of balance. Whilst nursing research and professional scholarship are seen as central to the ANP role, discourses related to these elements were not prevalent in this study. Instead, ANPs are busied by the demands of the clinical aspect of the role, and the ANP role itself is based around the performance of tasks that are mastered by experience rather than erudition.

Conclusions: This study alerts healthcare professionals to the ways in which discourses influence opinion and frame the ANP role. To meet the demands of an ever-changing, dynamic healthcare system, it is vital that ANPs are supported and allowed to 'advance'. When Conversations and Discourses disparage the ANP role, they should be challenged. We need to move away from positioning ANPs as a marginal and contested presence in the health system and instead see their role as making an important and necessary contribution to it. ANPs need to clearly articulate their role, the value that it adds to the healthcare system and demonstrate how it aligns with and complements other healthcare professionals' roles. ANPs need to become

more visible and vocal, and more engaged in policy formulation. They should recognise and harness the tremendous strength and rich diversity that they collectively represent. This is key to maximising the ANPs potential and strengthening their distinctive contribution to the healthcare system.

Statement of original authorship

I hereby certify that the submitted work is my own work, was completed while registered as a candidate for the degree of Doctor of Philosophy, and I have not obtained a degree elsewhere on the basis of the research presented in this submitted work.

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I would like to thank my supervisor, Professor Martin McNamara, whose patience, guidance, wit and support made my research journey possible. I am also grateful to my Research Studies Panel, Dr Rita Smith and Dr Deirdre O'Donnell, for their knowledge and advice.

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Abbreviations

AAFP	American Academy of Family Physicians
AHP	Allied Health Professional
AMP	Advanced Midwife Practitioner
ANP	Advanced Nurse Practitioner
CDA	Critical Discourse Analysis
CNS	Clinical Nurse Specialist
ED	Emergency Department
EWTD	European Working Time Directive
GP	General Practitioner
GST	General Systems Theory
HSE	Health Service Executive
ICN	International Council of Nurses
IEHG	Ireland East Hospital Group
LOD	Language of Description
NCNM	National Council for the Professional Development of Nursing and Midwifery
NMBI	Nursing and Midwifery Board of Ireland
OSF	Organic Systems Framework
SSM	Soft Systems Methodology
UK	United Kingdom
WHO	World Health Organisation

Section one: Setting up the Study

In Chapter One, I set the context for the study and provide the background to the ANP role, nationally and internationally. I discuss my location as a researcher and outline the study's rationale, research questions and aim. In Chapter Two, I present the literature review. Chapter Three sets out my epistemological and ontological beliefs and presents the conceptual and methodological underpinnings of the study. I show how systems theory, in particular the works of Barry Oshry, are relevant to and significant for this study. Chapter Four provides an overview of Discourse Analysis and Critical Discourse Analysis (CDA), drawing, in particular, on the works of James Paul Gee. The final chapter presents the research design for the study.

Chapter 1 Introduction to the study

1.1 Introduction

This thesis began with an area of personal and professional interest. Working as an Advanced Nurse Practitioner (ANP) for the past twelve years, I have always been intrigued as to how the role is perceived by my ANP, nursing and medical colleagues, and by its positioning within the healthcare system. Though relatively new to the Irish healthcare system, the ANP role has undergone significant transformation since its inception, transcending both nursing and medical paradigms. From my own experience and discussions with colleagues, I believe there to be considerable confusion concerning the role, not just in the public sphere but also in the health services where ANPs are becoming more prevalent.

This role confusion has a profound impact on the ANP role. I believe that without definitional clarity, boundaries are difficult to ascertain, the full potential of the ANP is not realised and, consequently, the role is underutilised. These contextual factors prevent ANPs developing and performing their role, which, I feel, has resulted in marked resistance to it and somewhat of an identity crisis for the ANP. This study is concerned with making the nature and extent of this confusion explicit and exploring its impact. The aim of the study is to gain an understanding of how ANPs are positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it.

1.2 Background

The Irish healthcare service, in common with healthcare services across the world, faces the challenge of operating within economic constraints while responding to changing demographics that increase demand for health and social care services. The population of the Republic of Ireland has been increasing for almost fifty years following a hundred-year decline (Central Statistics Office, 2016). It is expected that by 2026, the population will have increased by at least one million people (Central Statistics Office, 2016). Ireland's population structure, currently with one person in ten over 65 years of age, is set to change considerably in the coming years and it is

projected that by 2036, one person in four will be over 65. The Irish Health Service Executive (HSE), established by the Health Act 2004, is the nation's biggest employer with over 67,000 direct employees, and another 35,000 in funded health care organisations. Since its establishment, the HSE has been the subject of criticism for inefficiencies, cutbacks and service cancellations. Against this backdrop, hospitals have been facing difficulties staffing their departments with medical and nursing staff due to the shortage of junior doctors (Mudiwa, 2016) and the impact of moratoriums on the recruitment and promotion of nurses from 2009 to 2015. Reasons for shortages in medical numbers are multifaceted and include emigration of newly-qualified doctors and the difficulties for non–European Union doctors in obtaining working visas. Additionally, the Organisation of Working Time Act came into force in 1997, which mandated a reduction in the number of continuous hours junior doctors could work (Government of Ireland, 1997). While the recent, controversial moratorium on the recruitment and promotion of nurses has ended, the HSE still has difficulties recruiting and retaining nurses with over 1500 vacancies currently (Ní Sheaghdha, 2019). Experts argue that staff face stressful environments with long hours due to these staff shortages (Connor, 2021). The situation has been further exacerbated during the Covid-19 pandemic. A recent survey undertaken by the Irish Nursing and Midwives Organisation (2021) paints a bleak picture of how emotionally and physically taxing Covid-19 has been on Irish nurses and midwives showing that almost 70% of nurses and midwives are considering leaving the profession, with 25% likely or very likely to leave the profession within the next 12 months.

The number of nurses and midwives registered with the Nursing Midwifery Board of Ireland (NMBI) stands at just over 78,000 with less than 0.7% (n=524) registered as an ANP or Advanced Midwife Practitioner (AMP) and 0.25% (n=195) candidate ANP/AMP positions (Office of the Nursing and Midwifery Services Director, 2022). The Department of Health (2019) proposes that advanced nursing and midwifery practice will expand significantly within the next five years to 2% of the nursing and midwifery workforce. Within the Ireland East Hospital Group (IEHG), of 4,500 nursing and midwifery staff, there are 75 ANP/AMP positions and 24 candidate ANP/AMP positions, correlating to 1.7% and 0.5%, respectively, of the nursing and midwifery workforce (Gallagher, 2021). It is therefore timely that a critical analytical review of the discourses pertaining to the ANP role, its positionality and identity be conducted.

Within the dynamic healthcare environment, nurses, especially ANPs, experience new challenges. Advanced nursing practice roles are in the neophyte phase in Ireland in comparison to other jurisdictions such as the United States (US) and the United Kingdom (UK). Nurse Practitioners have existed in the US for over fifty years with the first nurse practitioner training programme conceived in 1965 by Loretta Ford, a nurse, and Henry Silver, a physician. The concept of advanced nurse practice soon spread to Canada (1960s-70s), the UK (1980s) and Australia (1990s). The National Council for the Professional Development of Nursing and Midwifery (NCNM) established the first Irish frameworks for role development of ANP/AMPs in 2001, with the first ANP accredited in 2002. Defining advanced practice is problematic due to the diversity of ANP roles internationally. The internationally recognised definition is a:

> "...registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in s/he is credentialed to practise. A master's degree is recommended for entry level."
>
> (International Council of Nurses, 2002)

It has been claimed that this definition is somewhat ambiguous and does not provide enough clarity (Schober, 2013) resulting in considerable role diversity among countries with respect to the level and content of education, scope of practice, regulation and title protection (Wilkinson, 2007).

The development of advanced practice roles was part of the strategic development of the overall health service (NCNM, 2007). The Office of the Chief Nurse recently argued that developing ANP roles enables the health service to address emerging and future service needs (Department of Health, 2019). From its initial conception in Ireland, ANP posts were developed in line with service needs and in the interest of providing quality, integrated patient care. The roles have received strong multi-disciplinary and management support, which was seen as essential in their successful development and implementation. The establishment of clinical career pathways provided nurses and midwives with a 'promotional ladder' for professional development whilst remaining in clinical practice (O'Shea, 2008; Stanley, 2005). Others argued that the role was not a promotional opportunity but instead a strategic attempt to 'bridge the gap' opened up by the reduction in doctor numbers (Fitzpatrick and Wallace, 2009).

This ‘bridge’ versus ‘ladder’ argument is consistently debated in the literature pertaining to the ANP role; however, consensus on the issue remains elusive. Furthermore, the debate raises the broader, more critical point about the usefulness of such binaries. Arguably, it will have been a dynamic mix of both, dependent on time, geography, politics and so on. These are the very discourses that I wish to explore and critically scrutinise.

Positionality refers to the individual’s “location within shifting networks of relationships, which can be analysed and changed” (Maher and Tetreault, 1994). Nursing and medicine have historically established systems of disciplinary practices that produce nurses and doctors within defined role boundaries. These boundaries are now becoming more fluid and porous, and ANPs constantly negotiate them. This offers the possibility of a new and potentially more liberating identity for nurses and nursing within the healthcare system. Conversely, one could argue that this emerging identity, rather than being liberating, could be regarded as a ‘constraining shackle’.

The role threatens the established boundaries for both nursing and medicine. Interested parties may perceive this as a threat rather than an opportunity and try to impose limiting boundaries and other contextual restraints that prevent the ANP role from developing and realising its full potential. Some authors argue that this tenuous new identity is a true ‘hybridisation’ of nursing and medicine (e.g., Rashotte, 2005), resulting in an integrative and innovative role within the system. This boundary porosity was particularly evident within Ireland when, in March 2006, the then Minister for Health, Mary Harney, introduced primary legislation to provide for prescriptive authority for nurses and midwives and, in June 2007, facilitated the introduction of nurses’ prescribing of medical ionising radiation (X-Ray). This initiative built capacity rather than exchanging it, just as power is arguably being expanded rather than being taken from one side and given to another, an important point that is frequently overlooked. Previously the preserve of medicine, the introduction of prescriptive authority was seen as a significant milestone in the evolution of the nursing profession. Whilst prescriptive authority for nurses is limited to certain drugs that are agreed collaboratively between nurse prescribers and other interested stakeholders including doctors, it permits nurses to increase their autonomy allowing them greater flexibility within their roles (Moore, 2008).

ANPs have found that they sit not necessarily outside the traditionally understood role of the nurse but rather at the intersection of medical and nursing domains to the extent that these themselves are bounded (Lowe, 2017). This tenuous position can affect relationships and the interplay of nurses with other nurses, and with other health professionals within the healthcare system (Willetts and Clarke, 2014). A range of diverse terminology is used to describe the ANP, including “physician extenders”, “physician assistants”, “non-physician providers” and “midlevel providers”. Poghosyan et al. (2012) argue that these descriptions do not adequately represent the professional identity of the ANP and suggest that they tend to marginalise the expertise of these practitioners by classifying them as a level beneath physicians. Lack of clarity about the knowledge, skills, scope of practice and expertise of ANPs contributes to the misrepresentation of the role and affects the development of their overall professional identity. In a recent study exploring key stakeholders' perceptions of ANP roles, Casey et al. (2017) revealed a ‘mixed bag of messages’ and a general lack of understanding of the ANP role. This lack of clarity could also be identified as positive as it creates more room for manoeuvrability and creativity. It is timely therefore, to examine how discourses position ANPs, the diverse influences that shape the role and how ANPs integrate and negotiate them to construct meaningful and purposeful professional identities in a range of contexts.

1.3 Location of Researcher

My own personal experiences of working as an ANP for the past twelve years have sown the seeds of the present study. I have long argued the need for the profession to become more autonomous and less reliant on the medical sphere in the health service. Rather than perpetuating the stereotypical ‘angel of mercy’, I am of the opinion that nurses need to step forward and ensure that their perspectives are fully reflected, and their voices heard in the development of future health policy. As ANPs, we need to inculcate this both in our peers and junior colleagues. Before this, we first must determine how health professionals and the wider society perceive the ANP role and identify extant discourses and how they construct the role. Additionally, we must examine the patterns of relationships and processes at play in those discursive constructions, and we must, as members of the healthcare system, understand how

we experience ourselves, our relationships with others and the healthcare system we are part of.

Research, I believe, plays a pivotal role within the field of nursing. It questions and provides insight into our clinical and professional practice. It has long been the basis for developing and improving our nursing skills. Within the ever-changing healthcare environment, the need to justify one's practice is greater now than it has ever been. Nursing excellence can only be achieved when one continually questions one's practice and strives to change and advance traditional roles. I believe by doing this the nursing profession can be further enhanced and nurses further empowered.

Over the years, I have continuously struggled with which paradigm or worldview I believed I was rooted in. Reading around the topic, this wavering of alliance is somewhat resolved. Exploring the positivist approach of empiricism, it is evident I have no allegiance to it due to the fact that I believe the world has many more facets than just what we as humans experience through our senses. In my opinion, concepts such as anguish, pleasure, sorrow and many others could never be explored if one was to take a true positivist approach. My own personal perspective is that each person views the world uniquely with their own environment interpreted exclusively. When a person acts and interacts in a given context, people recognise that individual as acting and interacting as a certain “kind of person” (Gee, 2000). I align myself to the assumption that we can only know reality from our own perspective of it – an element of an ‘à la carte’ interpretivist approach. The interpretivist paradigm emphasises that how one person sees the world can only be appreciated when one considers the context through which their world is being viewed. Put simply, one needs to look through that person's ‘lens’ to explore and gain an understanding of their world. This lens can change from moment to moment in an interaction, can change from context to context and can be ambiguous or unstable. Being recognised as a certain “kind of person” in these given contexts is what Gee (2000) suggests is meant by ‘identity’.

1.4 Rationale, research aim and questions

It has become apparent to me over the past number of years, whilst working as an ANP, the widening disparities between the ANP role and the traditional nursing role.

The ANP sits at a crossroads between the medical and nursing domains. At times rejected by the world of nursing and at others shunned by the medical sphere, the role of the ANP has never been as obscure. This ambiguity is further compounded by the considerable misperception concerning the ANP role that is evident amongst nurses, medics and the public. The lack of a universal ANP definition as well as confusion about boundaries and levels of practice, autonomy and preparedness of ANPs hamper the integration of the role into the health service. The Department of Health (2019) and O'Connor et al. (2018) argue that introducing more ANPs to the health service will have major benefits such as improved timely access to services, hospital avoidance, reduced waiting lists and integration of services. Others suggest that the introduction of more ANPs will: 'medicalise' and erode the traditional nursing role (Griffin and Melby, 2006; Currie and Crouch, 2008); encroach upon medical 'territory' and deskill doctors (Higgins et al., 2014; Casey et al., 2017); increase litigation (Delamaire and LaFortune, 2010; Harmer, 2010); and undermine patient care (Wall, 2017).

Examining these discourses, it is of no surprise that when advanced nursing practice is debated numerous questions arise, for example,

- What value does the ANP role bring to the healthcare system?
- How is the 'nursing' dimension of the ANP role realised?
- By and through what discourses have ANPs and the wider healthcare system come to know, understand, construct and utilise the ANP role?
- Considering the current discursive positioning of ANPs, what potentially significant issues might extant discourses be minimising or excluding?

This study will examine these questions in the Irish context, utilising a discourse analytical approach to explore the discourses in circulation around the role and how they position and construct the professional identity of the ANP. The aim is to understand how ANPs are positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it. I believe that by identifying these discourses, it may contribute to the more effective utilisation of ANPs (Burgess and Purkis, 2010).

1.5 Structure of Thesis

The thesis is divided into three sections. The **first section** sets up the study. The literature review is presented in Chapter 2. In this chapter, the literature on the discourses pertaining to the ANP role and identity are reviewed. In addition to critiquing literature that was sourced from a review of the national and international literature, I review a diverse range of other texts, including newspapers, radio broadcasts, social platforms as well as online news sites in order to provide 'a window on public opinion and lay interpretation and projection of nursing' (Fealy, 2005, p.18). Seven discourses were discerned:

- What's in a name? Defining the ANP
- Where is the Nurse?
- The 'Advanced' Component of the ANP Role
- Career Preparation and the ANP
- Filling a Gap: Poor Substitution or Distinctive Contribution?
- Barriers and enablers to realising the potential of the ANP role
- Resistance to the ANP Role.

In Chapter 3, I outline the epistemological and ontological beliefs that provide the conceptual and methodological underpinnings of my study. I discuss my personal stance and commitments. The origins and development of my conceptual framework for the thesis will be discussed. Systems Theories, General Systems Theories (GST), Soft Systems Methodology (SSM) and Oshry's (2018) Organic Systems Framework, and how they are relevant to and significant for Irish Healthcare Systems and my thesis, are discussed.

In Chapter 4, I provide an overview of critical discourse analysis, examine the key concepts of the approach and discuss the key analytic tools utilised to interrogate the textual and conversational data that constitutes the study's empirical base. In particular, I consider the contributions and works of James Paul Gee (2010) with a particular focus on his analytic tools of Building Tasks and Tools of Inquiry.

Chapter 5 sets out how these methods were implemented for this study. I outline the rationale for undertaking a case study approach and the pathway taken from the

elicitation and co-construction of the data, its management, analysis and interpretation. Finally, I show how transparency, rigour and ethical principles for conducting studies concerned with discourse analysis were ensured throughout the study.

Section two comprises an account of data transformation. Instead of the literature being seen as a separate component of the research process, a critical discourse analysis of the literature forms part of the empirical base of the study. Hence, in chapter 6, I apply Gee's (2011) critical discourse analytic methods to the literature review primarily by applying his framework of analysis to each of the selected empirical studies in the review.

In chapters 7, 8 and 9, I shed light on the ANP role, what it says about itself, what others say about it, how and to what effect, and I examine how ANPs and others both produce and are positioned by Discourses. To gain an analytic purchase on the participants' language-in-use and what that language-in-use is doing, I employ Gee's Tools of Inquiry in chapter 7 and his Building Tasks in chapter 8. Chapter 9 applies Oshry's (2018) Organic System Framework to the findings presented in Chapters 7 and 8. This allows me to see the patterns of relationships and processes inherent in human systems and how these are manifest in language. Approaching the data from different angles, the lenses of Gee and Oshry, allows me to see what language constructs and how, as well as looking at the patterns of relationships and processes at play in those constructions.

The **final section** features the discussion. The section is structured by the four research questions that the study sought to address and I will show how the study's findings address the study's central aim: to gain an understanding of how ANPs are discursively positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it. Limitations and delimitations of the study are outlined and recommendations, including opportunities for further research and scholarship are proposed.

Chapter 2 Literature Review

2.1 Introduction

In this chapter I outline the search strategy and search terms utilised to gather the literature and research studies that are used within this thesis. I provide the databases and the timelines that were employed in this study. The literature review has stimulated my thinking and has provided a wealth of ideas and perspectives.

Parahoo (2014, p. 89) states that a literature review involves the critical reading of the relevant literature to discover how it may be useful to the current research. Reading through this literature I was able to explore the discourses that are in circulation around the ANP role and how these discourses position and construct the professional identity of the ANP. In addition to critiquing literature that was sourced from a review of national and international literature regarding ANPs, I review a diverse range of other texts, including newspapers, radio broadcasts, social platforms as well as online news sites. The discourses that originated are presented in sections 2.3 to 2.9 in this order:

- What's in a name? Defining the ANP
- Where is the nurse?
- The 'Advanced' component of the ANP role
- Career preparation and the ANP
- Filling a gap? Poor substitution or distinctive contribution
- Barriers and enablers to realising the potential of the ANP role
- Resistance to the ANP role.

2.2 Literature Search Strategy, Timeline, and Inclusion and Exclusion Criteria

An initial preliminary search of PubMed (Medline) and the Cumulative Index to the Nursing and Allied Health Literature (CINAHL) was undertaken to identify key terms, subject headings, and alternative terminology in relation to the subject area. This was followed by a comprehensive search of these two databases in addition to the following online databases: Wiley Online Library, The Cochrane Library of Systematic

Reviews, EBSCO Search Engine, ResearchGate and Lenus, and The Irish Health Repository. Based on the literature, the key words for searching the database were nurse practitioner, advanced, advanced practice nursing, role, discourse, nursing and identity. The electronic search was limited to studies conducted in the previous sixteen years (2006-2022) in order to focus on the most recent findings. However, I explored and included literature prior to this date that I felt was seminal and relevant to the discussion. These seminal pieces were frequently referenced in the studies located and therefore would weaken the review if excluded. To provide insight into the views of nurses, medical doctors, allied health professionals (AHP) (i.e., radiographers, physiotherapists, occupational therapists etc.), healthcare managers and administrators, articles, commentaries and editorials in their specific press and journals were incorporated into the review. Newspapers (Nexis ®, Irish Newspaper Archives), radio broadcasts, social platforms (including Facebook, Twitter) as well as online news sites were also included to provide 'a window on public opinion and lay interpretation and projection of nursing' (Fealy, 2005, p. 18). The inclusion criteria required that the articles were in English and published between January 2010 and February 2022. Articles that explored specifically the Clinical Nurse Specialist (CNS), Nurse Consultant and AMP role were excluded as I wished to explicitly focus on discourses relating to the ANP role.

Seven discourses emerged:

- What's in a name? Defining the ANP
- Where is the Nurse?
- The 'Advanced' Component of the ANP Role
- Career Preparation and the ANP
- Filling a Gap: Poor Substitution or Distinctive Contribution?
- Barriers and enablers to realising the potential of the ANP role
- Resistance to the ANP Role'.

2.3 What's in a name? Defining the Advanced Nurse Practitioner

In this section, I highlight the key debates around defining the ANP and related concerns such as excessive nomenclature, role ambiguity and the fragile, contested multiple identities of the ANP.

In recent years, and internationally, it has become evident that there has been a rise in the number of nurses holding advanced nursing practice positions. The International Council of Nurses (ICN) (2017) estimate that at least seventy countries either have, or are considering introducing, advanced nursing roles. It is no surprise then, that discourses concerning 'advanced nursing practice' and 'nurse practitioners' are becoming more evident in medical and nursing journals and publications. According to the ICN an Advanced Practice Nurse is:

> '…a registered nurse who has acquired the expert knowledge base, complex decision making and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practise. A masters level of degree is recommended for entry level.'
>
> (International Council of Nurses, 2017).

Regardless of this definition and an emerging awareness of the role, there appears to be considerable confusion within the literature as to the definition of these terms (Li et al., 2013, Higgins et al., 2014). This confusion is further exacerbated by use of different titles for the same functions and the fact that use of the same title does not automatically relate to the same function or grade (Lovink et al. 2021). This confusion can have a profound impact on the identity of the ANP (Burgess and Purkis, 2010). Cashin et al. (2015) stress that critical to endorsement of the ANP role is the need to achieve definitional clarity. Delvin et al. (2018, p.114) argue that definitional clarity is essential, suggesting that ANPs need to adopt a philosophical perspective to describe what 'nourishes and defines them' and to initiate 'reflections on the ANP's true nature and ability to engage in change'. Without this definitional clarity, clinical and professional boundaries may be difficult to ascertain (Niezen and Mathijssen, 2014) and this in turn can give rise to confusion for other health professionals who may be uncertain as to the extent of the ANP's expertise (Stasa et al., 2014).

Integration of the role into the health service is hampered by the lack of a universal definition of what the ANP role comprises. Lowe et al. (2012) suggest that the confusion concerning the definition of the ANP role has created problems not only for ANPs but has also created profound challenges for the nursing profession as a whole in terms of defining 'what it is that nursing is and does'. This definitional vagueness transcends the health field into the public and the academic arenas. Academic

institutions may have difficulty in designing and marketing degrees (Casey et al., 2017c) and patients are confused about what an ANP is and does, and do not understand the intricacies of the role (Dean, 2013, Aleshire et al., 2012). Definitional clarity of the ANP role has not been helped by the proliferation of roles and titles that Jones et al. (2015) state have emerged as a result of local needs to fill workforce gaps, rather than as a result of national body regulation and planning.

Conversely, the development of the ANP role in Ireland was part of the strategic development of the overall health service rather than in response to a need to fill workforce gaps (NCNM, 2007). Unlike other countries, such as the UK, where it is not illegal for anyone to call themselves a nurse or variants thereof such as advanced nurse practitioner, even with no nursing qualifications (Leary, 2020), in Ireland, the ANP title is protected by national standards and a regulatory framework, and extended practice is supported by legislation. Within these standards and frameworks, the core concepts underpinning the ANP role are autonomy in clinical practice, expert practice, professional and clinical leadership, and research (NCNM, 2007). Utilising these core concepts as pillars, the NCNM (2007) defined the ANP as ‘an autonomous practitioner, who is responsible for advanced levels of decision making, managing a caseload, and who demonstrates clinical and professional leadership and advances clinical practice through research'.

Regardless of the definitions provided by the ICN and the NCNM, confusion about the role abounds (Casey et al., 2017a, Casey et al., 2017c). Stasa et al. (2014) propose one possible way of resolving this ambiguity is to reduce the amount of nomenclature related to the ANP role such as ‘expanded practice’ and ‘extended practice’. Other authors argue, however, that having a vague and elusive definition of the ANP role facilitates the role development of self-directed individuals, allowing for the definition of the individual’s own priorities in different domains (Jokiniemi et al., 2012). Begley et al. (2013) argue that, whatever definition is used, a philosophical approach that articulates the nature of the discipline should guide advanced nursing practice. This view is supported by Wilson et al. (2015) who argue that a discipline should not be defined by a set of tasks so as to suggest that certain tasks are forever to be performed by ANPs and other tasks performed by doctors, as these skill-related task lists do not reflect the critical thinking of nurse practitioners, nor the uniqueness of the profession.

Instead, they are a recipe for rigidity and inflexibility and a cumbersome and costly health system that will fail to address consumer needs. Irrespective of this confusion and ambiguity, it is essential to focus on the nursing nature of the ANP role and define it in terms which will provide unity and which are clear to colleagues and the public (Lowe et al., 2012).

To summarise, whilst the ICN and Irish nursing bodies have provided definitions for an ANP, it is evident that confusion still prevails amongst health professionals and the public. This confusion has resulted in difficulties ascertaining clinical boundaries and profoundly affects the ANP identity. There is a balance to be struck: too restricted a definition may constrain innovation and too loose a one may make role enactment difficult and hinder communication with various stakeholders on the ANPs' actual and potential contribution to health systems, impacting, in turn, on the ANP role. In the next section, I explore the literature that focuses on the nursing component of the ANP role.

2.4 Where is the Nurse?

Reviewing the literature, it is apparent that preserving the ‘nursing' dimension in advanced practice is a somewhat contentious and divisive issue. The following sections examine the nursing aspect of the ANP role. I first explore the identity of the nurse, which, unsurprisingly, is intrinsically linked to that of the ANP. I consider the historical nursing persona and stereotypes that have prevailed in previous years and potentially still exist today. Secondly, I identify the key issues related to identifying the nurse and nursing aspects of the ANP role and highlight the key issues that impact and influence the identity of the ANP, including the medical profession and particular models of health care delivery.

The first ANP/AMP role was accredited in the Republic of Ireland in 2001 and there are currently 512 ANPs in 53 specialities and 12 AMPs registered with the Nursing and Midwifery Board of Ireland [NMBI] as well as 176 candidate ANPs and 19 candidate AMPs currently in training (Office of the Nursing and Midwifery Services Director, 2022). However, Poghosyan et al. (2012) have argued that the professional

identity of ANPs remains unclear for many healthcare professionals, policy makers, stakeholders and the public.

Previously the 'brand' of nursing was considered to be strong, nursing was seen as having a clear identity and Harmer (2010) argues that people knew what a nurse was and what a nurse did. Conversely, that view could be contested, on the grounds that whilst certain nursing roles were widely understood, others such as mental health and intellectual disability nursing remained elusive. Cingel and Brouwer (2021) challenge the idea that the nursing identity is unchangeable and the notion that a ‘nurse will always be a nurse’ and argue that nurses themselves reinforce stereotypes and images in order to fit into what is expected. Ten Hoeve et al. (2014) identify a number of these images, including negative stereotypes, that have been associated with nursing over the past 150 or so years, from Angel of Mercy (1854-1919), Girl Friday (1920-1929), Heroine (1930-1945), Mother (1946-1965), Sex Object (1982) to Careerist (1983-Present). Whilst ten Hoeve (2014) ascribes dates to these stereotypes many of these images co-existed and arguably still do. The authors argue that the media has played a significant part in perpetuating these stereotypes which has resulted in nurses being viewed by the public as female and caring and not autonomous and experienced healthcare providers in their own right. Many examples from the media include depictions of nurses working as the doctor's ‘handmaiden’, at the patient’s bedside performing repetitive and routine tasks to online depictions of nurses being ‘sexual playthings’, ‘witless, incompetent individuals’ and the ‘underdogs of the healthcare system’ (Kelly et al., 2012, Harvey, 2011; Burns, 2019). On the other hand, some media sources depict more positive and disruptive representations such as nurses portrayed in television programmes like ER and Nurse Jackie. Dillard-Wright and Shields Haas (2021) suggest that it is only through positively promoting nursing will we rid ourselves of the pernicious identities of handmaidens, heroines and angels.

Apold (2015), in her discussion piece, argues that as ANPs we have fought hard to divest ourselves of sentimental and ‘sweet’ markers of an identity that has never served the image of who we are or want to be. Archibald and Fraser (2013) further assert that we must show evidence of our origins within the ever-expanding need for ANPs, which they argue, is related to, yet distinct from medical practice. In contrast, in her editorial, Lowe (2017) argues that ANPs continually emphasise the ‘nursing’ in

the ANP role despite their expanded and extended scope of practice perhaps because they are afraid of being seen as ‘nurses who practice in doctors' clothing’ (Li et al., 2013, p. 5). This defensiveness may arise because ANPs are positioned by, and are positioning themselves with reference to, the extant discourses in circulation; these are often implicit and elusive, however, and need to be made explicit and then critiqued and countered. Wood (2020, p.50) argues that ‘the loss of the central unifying focus of the discipline and discipline-specific knowledge risks losing the very identity that forms the basis and relevance for nurse practitioner practice’.

Ten Hoeve et al. (2014) argue that nursing historically has been seen as inseparable from, and inferior to, the medical profession. This is in contrast to the beliefs of the founder of modern nursing, Florence Nightingale (1820-1910), who viewed nursing as an independent profession that was not subordinate but equal to the medical profession (Nightingale, 1860). This perceived subaltern identity is not facilitated by the variety of terminology that is used to describe ANPs such as ‘physician extenders’, ‘midlevel providers’ and ‘non-physician providers’ as well as phrases describing their practice such as ‘expanded’ and ‘extended’. Poghosyan et al. (2012) stress that these terms were introduced by medicine to imply that ANP roles evolved to serve as an extension of a physician rather than as a natural and inevitable evolution of the nursing role in response to the growing complexity of individual and population care. Referring to ANPs as ‘mid-level’ erroneously suggests that ANPs provide mid-level care compared to the ‘higher level’ of care provided by a doctor (Newhouse et al., 2011). This viewpoint fails to recognise that doctors are not a homogenous group but provide different levels of care at different levels within their own occupational hierarchies. The referring of individual health professionals as ‘non-physician providers', Poghosyan et al. (2012) argue, is most divisive as it undermines the professional identity of not just ANPs but other multidisciplinary practitioners who make valuable contributions to the health service. Discursively describing something with reference to lack, deficit or absence is especially problematic, if not egregious, as it constructs a lack, absence or inferiority relative to a dominant referent, such as non-white, non-male, non-Christian, non-heterosexual and so on.

Laperrière (2008) suggests that the word ‘expanded’ should be ‘reserved to refer to roles in which nursing skills are drawn upon’ and the word ‘extended’ should refer to

‘roles when nursing is not a prerequisite and where tasks are essentially medical’. How an individual ANP could distinguish between roles when nursing is and is not a prerequisite is not explored by the author and the distinction, arguably, adds to rather than resolves the confusion. Regardless, Lowe (2017) concurs with Laperrière’s position, arguing that even though, as ANPs, we align our practice with nursing skills derived from a nursing paradigm, we also need to recognise that our identity and facets of our practice are derived from the traditionally medically aligned model of health care delivery as well as models from the social care and psychological arenas. This is a complex and difficult role that Brook and Rushforth (2011) refer to as a ‘hybrid model’ integrating practices from medicine, nursing and other health professions. Chulach and Gagnon (2016) concur that ANPs occupy a space between the cultures of nursing and medicine; however, they propose that this positioning creates instability and uncertainty for the ANP role and may increase identity threat. Laperrière (2008) contends that professional identity is fluid and constantly changing and argues that it is imperative that nurses find their voice and move away from the ingrained ‘handmaiden’ identity and instead establish a professional identity and role clarity to ensure effective utilisation of ANPs (Burgess and Purkis, 2010, Harvey, 2011). Carryer (2020, p. 3577) argues that if nurses are going to make a positive impact on the healthcare system, they need to be viewed as ‘powerful and not to be trifled with.’ Leary (2021) believes the lack of nursing voice is secondary to what she refers to as ‘whitecoat washing’, where the media speak to medics about nursing issues rather than speaking directly to nurses about nursing. (Ng, 2021) argues that this has become much more blatant during the Covid-19 pandemic and highlights the prominence of medics on television and radio panels when discussing largely nursing issues.

Interestingly, and in summary, it is impossible to review the literature concerning nurses and the ANP identity without medicine dominating the discussion. This marked domination has resulted in nursing been seen as inseparable from, and inferior to, the medical profession. This in turn has created difficulties for ANPs establishing a professional identity and clarifying their role. By constantly using medicine as a point of departure and reference, even if to oppose or challenge it, we give it great discursive and actual power. ANPs should draw on more than medicine in conceptualising their

role. Within this advanced role, the next question to which I now turn is ‘where is the ‘nurse’ in all of this?’.

The NMBI is committed to protecting the concept of advanced practice within a philosophical nursing paradigm (NMBI, 2017). This commitment is echoed by Carryer and Adams (2017) who clearly articulate ANPs' allegiance to a nursing philosophy of practice which informs their attention to presenting health and medical problems. ANPs were emphatic that they did not become ANPs in order to be more like, or a substitute for, medical practitioners, but instead drew on nursing as their basis for practice (Carryer and Adams, 2017). A common theme in the literature was expressed by ANPs who portrayed themselves as being a nurse first and an advanced practitioner second (Burgess and Purkis, 2010). As nurses, ANPs emphasised they were grounded in disciplinary values, theories, and knowledge. As advanced practitioners they integrated advanced competencies and skills into everyday practice. In her editorial, Lowe (2017) argues that ANPs prefer to be known for their advanced skills which she suggests are derived from a nursing paradigm. Other authors argue that ANPs are being ‘steered’ toward medicine and away from the nursing roots of ANP practice as they strive for acceptance from other professions (Henderson, 2015). However, in her opinion piece, Apold (2015) argues that, rather than ANPs becoming more like medics, they are instead coming into their own, advanced practitioners committed to keeping nursing issues central to the care of patients.

These issues have been debated since the birth of the ANP role. Mishler (1984) talks of two life worlds – that of the patient and that of medicine. Paniagua (2011), however, proposes that there is a further medico-nursing world – and notably not a healthcare-nursing world – in which ANPs must act to achieve their goals. The author suggests that this medico-nursing world consists of working predominantly within a medical framework and environment, while at the same time finding opportunities to incorporate important nursing skills. Several authors have warned of the perils of ANPs working within this ‘medical framework’, concerned that the ANP could become medicalised and lose the caring focus that is fundamental to nursing (Kerr and Macaskill, 2020, Street and Cossman, 2010). This outlook could be questioned, especially when one considers that not all ANPs work closely with their medical counterparts, such as those ANPs employed in the community, prison settings and

other contexts. However, in their large-scale national study evaluating ANP and CNS roles, Begley et al. (2014, p.4) found that caring remained a fundamental part of the ANP role with study participants suggesting that whilst medics 'aren't very good at the caring piece', ANPs were lauded for the holistic and educative approach and the resulting impact on patients' quality of life. This holistic approach is consistent with findings from a study by Enzio et al. (2020), in which ANP practice was identified to be evidently different than that of medical care. This finding is supported by Li et al. (2013) who found that senior doctors, nurses and ANPs agreed that ANPs embraced a more holistic model of patient care.

This holistic element includes emphasising health promotion, health maintenance and preventive care with authors noting that ANPs ask more questions and offer more information and options than their medical counterparts (Canadian Health Services Research Foundation, 2011). This is affirmed by Carryer and Adams (2021) who believe ANPs are grounded in primary healthcare, with a focus on cultural safety, social determinants of health, health literacy, wellness and the fundamental notions of holism into their practice. In a study comparing ANPs and General Practitioners (GPs), Paniagua (2011) observed that ANPs interwove expert nursing skills throughout each patient examination. The study identified that GPs work in a different style to that of nurses, with ANPs working to diminish social distance from patients rather than creating it. The authors argue that this positions ANPs more in line with nursing than with medicine. This is reaffirmed by Enzio et al. (2020) who contend that patient involvement is central to the ANPs approach to care and that ANPs consider the interaction of all factors and do not examine health problems in isolation. From a medical perspective, Li et al. (2013) found that medics agreed that the nursing background of ANPs meant that they were more likely to spend time explaining the disease and care processes and were more mindful of the non-clinical attributes of a patient likely to affect aftercare outcomes such as their socioeconomic circumstances. Carryer and Adams (2017) imply that for ANPs to remain true to the tenets of nursing philosophy, they must embrace a person and family-centred collaborative approach to their work.

Summarising, it appears that identifying the nursing element of the ANP role is a sensitive subject. Whilst nursing organisations are committed to protecting the nursing

element of the ANP role, others argue that the role is being steered toward the medical paradigm. Central to the identity of the nurse is caring and a holistic approach. Some ANPs appear to monopolise these caring and holistic elements of their role and in doing so suggest that other health professionals do not care or consider the whole person. An essential step in advancing and identifying the role of ANPs is to examine the delivery of quality and efficient healthcare with other health professionals. In the next section, I provide a review of the literature pertaining to the 'advanced' element of the ANP role and of the discourses related to ANPs' career preparation.

2.5 The 'Advanced' Component of the ANP Role

In this section, I examine the advanced element of the ANP role and underline the main issues concerned with career preparation. I highlight what is advanced about the ANP role; namely, the difficulties in identifying what is 'advanced' as well as the ambiguity concerning the autonomy of the role, in addition to the difficulties and discourses that are related to career preparation.

The development of 'advanced nursing practice' is commonly viewed as a driver for the evolution of nursing (Laperrière, 2008); however, what is 'advanced' about the role remains ambiguous and raises some questions specifically when one considers 'advanced in relation to what?'. Jones et al. (2015) suggest this ambiguity may be related to many current ANP roles having their origins in specialist nursing roles, which has resulted in the 'advanced' component of the role not being entirely clear. In their study, exploring the perceptions of key stakeholders of the roles of specialist and advanced nursing and midwifery practitioners, Casey et al. (2017c) suggest that clarification between these two roles is achieved somewhat in terms of higher order tasks such as making diagnoses and undertaking more of a leadership role. This finding is supported by Begley et al. (2013), who in a large-scale national study, found that an advanced role required greater clinical and professional leadership in addition to undertaking comprehensive skills in patient assessment. However, Elliott (2017) argues that more organisational support structures are required to realise the professional leadership capacity of ANPs. The issues of diagnosis and leadership are a matter of degree and somewhat difficult to pin down. It is not that clinical nurse

specialists do not assess, diagnose or lead, so again we are left with the query as to when does ANP practice become ‘advanced’? Heale et al. (2015) propose that in many cases, the advanced aspect of the role includes an expanded scope of practice that traditionally belonged in the medical domain. Here again, we are confronted by a preoccupation with medicine, a concept Ulrich (2010) identifies as functioning with “one foot in medicine and one foot in nursing”.

Whilst relative to each individual practitioner, autonomy or independence has always been central to the concept of the ANP role. It is a key theme whenever the advanced aspect of the ANP role is explored with authors arguing that a higher degree of autonomy, authority and accountability distinguishes the role from other nursing roles (Slevin et al., 2013, Melby et al., 2011). Maylone et al. (2011) stress that increased autonomy is essential for the advanced role of ANPs, arguing that it is an essential component of their clinical practice and necessary for them to practise to the full extent of their skills and knowledge. However, this viewpoint is not universally accepted. Cashin et al. (2015) reported that the use of the word autonomy is problematic, particularly for professionals in other disciplines who think that nursing should be part of a collaborative arrangement of patient care. Whilst Begley et al. (2013) recognise that the advanced role requires autonomous clinical decision-making, they underscore that the ANP plays a pivotal role within the multidisciplinary team, improving case management and processing patients through the system more efficiently. Personally, I believe that autonomy, even for the most senior professional, will always be relative.

In addition to focusing on the clinical element of the advanced role, other authors emphasise that the advanced aspect of the role is seen as enhancing service delivery and building the capacity of the nursing and midwifery professions (Coyne et al., 2016). Arguably, one could contend that enhancing service delivery and building capacity is the responsibility of all nurses. The literature supports the concept of a multidimensional role for advanced practice that incorporates expert practitioner, educator, researcher and leader (Slevin et al., 2013). Begley et al. (2013) concur, acknowledging that as part of the advanced role, ANPs contribute to the development of curricula and guidelines (national and international), teach at Master’s Degree level nationally, set up national fora for networking and sit on high-level national and international committees. Casey and O’ Connor (2021), in their editorial, emphasise

that the application of relevant research and management skills is required to effectively perform their role and is key to ensuring evidence-based practice. Ryder and Jacob (2021) concur, believing that the clinical leadership role of the ANP is suitably placed to lead the translation of evidence-based knowledge in the clinical practice setting. However, the World Health Organisation's (WHO) global nursing strategy mentions evidence-based practice, but competence in 'evidence generation' is deemed relevant only to nursing leaders (WHO, 2016). It is unsurprising then that in their inductive qualitative study exploring ANPs' views on leadership and research, Ryder et al. (2019) found that ANPs fear research and the research process.

Summing up, it is evident that there is considerable ambiguity concerning what is advanced about the ANP role with some authors suggesting that it is related to increased autonomy and clinical independence whereas others suggest that it is more related to competences such as leadership. Arguably, the extent to which diagnosis and leadership feature is a matter of degree and somewhat hard to pin down. The same can be said for autonomy and independence when one considers that these concepts will always be relative for all practitioners. The next section explores the discourses related to career preparation for the ANP, as well as the issues which have arisen from the introduction of the role.

2.6 Career Preparation and the Advanced Nurse Practitioner

The final report of the Commission on Nursing (Carroll et al., 1998) 'A Blueprint for the Future', recommended the establishment of clinical career pathways that would allow nurses with extensive expertise and appropriate educational qualifications to advance to the level of ANP while remaining in clinical practice. Findings from Kerr and Macaskill's (2020) narrative inquiry into ANPs' perceptions of their role and identity identified ANPs dissatisfaction with management roles which in turn motivated a desire to return to clinical practice. The role was intended to retain experienced clinical nurses in practice and enable them to achieve better outcomes for patients by improving quality and services (Gerrish et al., 2012). Maten-Speksnijder et al. (2014) support this position, implying that the ANP role offers good career prospects in clinical patient care while Delamaire and LaFortune (2010) report that the role increases the

attractiveness of the nursing profession. From an Irish perspective, Wall (2016) reports that the Irish Government recognised the role that advanced nursing practice has on attracting and retaining nurses, to the point that the then Minister for Health, Simon Harris, said his department would be producing new policies to 'radically reduce' the length of time it took for a nurse to qualify as an advanced nurse practitioner. However, evidence from the literature indicates dissatisfaction with the way that the career pathway is configured.

Cronenwett et al. (2011) observe that there is clear bias toward ANP roles in some areas of nursing such as medical and emergency nursing or in sub-sets of these areas of practice, particularly disease-specific programmes. Other clinical areas such as mental health, intellectual disability, primary care, care of the aged and midwifery remain relatively underdeveloped (Department of Health, 2019) and nurses in these areas have fewer clinical career progression opportunities. Kenny (2015) argues that it is not only poor working conditions and recompense that cause nurses to leave the Irish health service but also limited career prospects. MacNamee (2017) indicates that nearly 14,000 Irish-qualified nurses and midwives have left Ireland for other health services since 2010. In an effort to counteract this, the Department of Health (2019) sought to create a critical mass of ANPs and AMPs through a developmental pathway for graduate and specialist nurses and midwives in addition to streamlining current educational structures. The required critical mass of ANPs and AMPs was calculated by comparing the number of nurses in advanced practice roles as a proportion of all nurses in countries that had the longest experience of using them. These countries included the US, Canada, UK, Netherlands, Australia and New Zealand. Comparing these ratios, a target of 2% of the nursing/midwifery workforce at ANP/AMP level by 2021 was decided. This percentage would yield approximately 700 ANP/AMPs registered with the NMBI providing full episodes of care across the health service. As of March 2022, 524 ANP/AMPs were registered with the NMBI (Office of the Nursing and Midwifery Services Director, 2022).

The Department of Health (2019) proposed that the new timeline for commencing an education and training programme to become an ANP/AMP be two years from initial registration rather than the five years of post-registration experience in the area of interest previously required. This reduction has been met with considerable resistance

from both medics and ANPs. The Irish Medical Organisation (2017) in their submission to the Department of Health expressed concerns that with this change a nurse could not have the same skills as a GP who has undergone five years of medical and four years of specialist postgraduate training. Disquiet was also evident among ANPs during workshops in July 2017 discussing the draft policy, with one ANP voicing alarm at the proposal and the Advanced Nurse Practitioner Emergency Forum (2017) expressing concern about the possible impact on the ANP role and identity. What failed to be acknowledged was that a nurse will have four years education to initial registration and then a minimum of four more years by the end of the formal educational preparation as an ANP. In their study, Corbally and Lee-Deutsch (2019) found that whilst nurses who have successfully completed their undergraduate training can practice nursing globally, ANPs in Ireland are not able to provide cover for an ANP colleague in another nearby hospital because of restrictions on their practice. The authors refer to this as a ‘restriction by advancement’ and an irony of advanced nursing practice in Ireland.

In summary, one can see from the literature that the introduction of the ANP role into the Irish health system has favoured certain specialist areas over others, which has led to poor career opportunities and slow progression in certain nursing specialities. Fortunately, this has been recognised by nursing bodies as well as by the Department of Health and policy is being implemented that will more fully utilise the nursing and midwifery contribution to benefit the health service. Notwithstanding this, both the nursing and medical professions have voiced appreciable concern with, and opposition to, some recent developments. The next section examines the nature of ANPs’ contribution to the health system and examines debates concerning whether the ANP role should be viewed as filling a 'gap' or as making a distinctive contribution to the health services.

2.7 Filling a Gap? Poor Substitution or Distinctive Contribution

In this section, I explore the main discourses in circulation concerning the contribution of the ANP as well as the issues of role substitution and role contribution. I also consider discourses pertaining to cost, efficiency and effectiveness.

One of the earliest discourses concerns the question of role substitution and filling the 'gap' left by a scarcity of doctors. A shortage of physicians is due to many factors, including emigration of newly qualified doctors and the implementation of the European Working Time Directive (EWTD), which mandated a reduction in the number of continuous hours junior doctors could work. Because of the medical dominance within the healthcare system (Currie et al., 2012), decision makers at most tiers of the health system tend to think of medical solutions to health problems. Corbally and Lees-Deutsch (2019, p.497) highlight that in some settings '…it was almost impossible for managers to make a "business case" for an ANP as this would mean losing a medical staff member. Carryer and Adams (2017) argue that is it no surprise, then, that ANPs are thought of as medical substitutes. This belief system has resulted in a number of comparative studies that have confirmed the quality and safety of ANP practice when compared with medical practitioners (Stanik-Hutt et al., 2013, Swan et al., 2015, Thompson and Meskell, 2012). However, these studies detract from the focus on the distinctive value ANPs can potentially add.

The Cochrane Collaboration has produced numerous comprehensive reviews pertaining to substitution of doctors by ANPs. One review, citing more than three dozen studies, suggests patient care outcomes are similar, with ANPs consistently scoring better on subjective measures of quality, such as patient satisfaction (Delamaire and LaFortune, 2010). More recent research has affirmed that ANPs engender high levels of patient satisfaction and increased enablement of patients, leading to higher levels of patient engagement and empowerment (Frost et al., 2018). These results stand in contrast to arguments from both the World Medical Association and the Standing Committee of European Doctors that warn that task substitution by ANPs may carry the risk of lower quality of patient care (Maten-Speksnijder et al., 2014). Hoskins (2012) contends that the medical profession has always voiced safety issues with role substitution because they are fearful of losing their central role within health care. Bauer (2010, p. 229) emphasises that 'every study published in peer reviewed journals has [sic] concluded that ANPs can be substituted for doctors in a significant portion of medical services – ranging from 25% in some speciality areas to 90% in primary care – with *at least* comparable outcomes'.

Other authors, when discussing role substitution, are affronted by the terminology that is used, such as role substitution being defined as the ‘allocation of clinical responsibilities to lesser or more narrowly trained health professionals with or without medical supervision’ (Yong, 2006, p. 27). Lowe et al. (2012) contend that the ANP role is not a substitute for a doctor but is instead an extension of the practice of nursing care. Whilst they appreciate that historically in some situations, the ANP was introduced to meet health service gaps and was implemented due to the short supply of medical doctors, they contend that subsequently, appointments of ANPs have been created to more effectively use existing skilled human resources (Department of Health, 2019), to relieve Emergency Department (ED) overcrowding (Melby et al., 2011) and to meet the needs of others in targeted areas of need and specialities like aged care, mental health and respiratory care (Department of Health, 2017). Reflecting on independence in ANP practice, Weiland (2010) advocates that measuring ANP performance against the physician is inappropriate as the philosophical approach of the ANP is distinctive and ANPs are not doctor substitutes or so called ‘yellow pack doctors’ but are instead independent providers with a unique approach to health care. This outlook is supported by Carryer and Adams (2021) who argue that viewing ANPs as medical replacements will do nothing to improve the health outcomes and persistence inequities that persist in healthcare systems throughout the world.

Whilst Scanlon et al. (2016) contend that ANPs are highly competent, others suggest that ANPs are unable to provide services for patients with ‘complex’ conditions (Htay and Whitehead, 2021, Fraze et al., 2020, Newhouse et al., 2011). DiCicco-Bloom and Cunningham (2015) refute this suggestion, posing the question 'what is ‘complex’?' Whilst they admit that there is evidence that ANPs do care for less complex cases than their medical colleagues, they suggest that this is secondary to organisational design rather than by choice. Norris and Melby (2006, p. 260) state that organisational policies and processes result in doctors being reluctant to ‘accept that nurses should be allowed to undertake certain advanced skills’. In any case, ANPs are seeing ‘complex’ patients. At a recent ANP conference in Waterford, Ireland, titled ‘Not So Minor Injuries’, ANPs working in EDs, highlighted the complexity of the supposedly ‘non-complex’ patients that they see who present with, for example, amputated digits, dislocated shoulders and undiagnosed carcinomas (Power and Phillips, 2017). Begley

et al. (2014) suggest that reluctance from medics is secondary to a lack of understanding about the role and concerns about expansion of nursing into areas that are traditionally the domain of medicine.

Given that the costs of healthcare are expected to continually rise, Bauer (2010) argue that it is only right that health care institutions should look elsewhere for high quality practitioners at a lesser cost than physician-based health care. Archibald and Fraser (2013) propose that ANPs have a distinct role in filling this 'gap', because they are appropriately educated and have the ability to provide the cost-effective and high-quality care that health care systems require. Bauer (2010) states that sound economic analyses and strong evidence have shown that costs relating to care can be reduced by allowing the substitution of ANPs for more expensive health professionals, without diminishing quality. This view is supported by numerous governments throughout the world, including the Netherlands, whose government believes that role substitution by ANPs will raise standards of quality and efficiency in health care (Zwijnenberg and Bours, 2012). This efficiency discourse and especially debate concerning cost dominates the literature.

In their large-scale research study, Begley et al. (2010) demonstrated conclusively that the care provided by ANPs was cost neutral. Other research investigating cost comparisons between ANPs and doctors have found similar results (Kilpatrick et al., 2014, Swan et al., 2015, Kostas-Polston et al., 2015). Aleshire and Wheeler (2012) identified that rather than being cost neutral, lower costs were associated with ANP care, stating that the average cost of an ANP primary care office visit is approximately 25% to 30% less than the average physician primary care office visit. This finding is apparent in the research undertaken by Bauer (2010) whose evidence shows that ANPs provide care of equal or better quality at lower cost than comparable services provided by other qualified health professionals. In a similar vein, Albers-Heitner et al. (2012) showed that nurse-led outpatient care for individuals with chronic illness tended to have more positive healthcare costs in comparison to doctors. SARS-CoV-2 has brought to light the role that nurses and ANPs can provide to the healthcare system, especially in the primary care setting, where for a long time before the Covid-19 pandemic, shortages in general practice were taking their toll. McCarthy (2020) writing

for the Irish Times believes part of the solution is giving nurses and ANPs more responsibility.

In their clinical study, Skinner et al. (2013), investigated the replacement of junior level doctors by ANPs in a cardiac intensive care unit and found that with adequate training and appropriate support, ANPs can provide a safe, sustainable alternative to the traditional medical staffing model, increasing training opportunities for doctors and reducing costs. Markewitz (2013) disputes this finding, suggesting that the substitution of doctors by ANPs does not reduce costs because in most European countries ANPs earn as much money as junior doctors. This view is supported by Maten-Speksnijder (2014) who notes that, whilst ANPs' salaries are *less* than those of doctors, cost saving is offset partly by other factors, such as longer consultation times, more referrals to other doctors or higher recall rates, and, in some cases, more tests ordered. Reviewing studies completed in twelve developed countries, including the Republic of Ireland, Delamaire and LaFortune (2010), found that whilst the care provided by ANPs was cost neutral with respect to salaries, this is offset partly or entirely by other factors, again including longer consultation times and higher incidence of referrals to other physicians. Conversely, Martin-Misener et al. (2015) suggest that as ANP salary differentials and productivity vary from place to place, cost savings can be achieved in some situations. Other studies report that specialist nurses have a positive impact on individuals living with chronic illness which results in fewer and shorter re-hospitalisations, reduces burden on consultant outpatient clinics and lowers levels of cost (Moore and McQuestion, 2012, McGlynn et al., 2014). This finding is reinforced by Casey et al. (2017b, p. 4) who suggest that having an ANP role in the community could 'replace hospital appointments and in turn free up hospital resources to deal with other issues'. In their comparative study, Thompson and Meskell (2012) found that ANPs have equivalent if not better diagnostic skills, increased awareness of pain management and a greater impact on reducing waiting times compared to their medical counterparts. Laurant et al. (2019) argue that whilst role substitution has the potential to reduce doctors' workload and direct health care costs, achieving such reductions depends on the particular context of care. Delamaire and LaFortune (2010) propose that the impact of the ANP role on cost depends on whether it is introduced to substitute for activities that were previously undertaken by doctors or to provide supplementary, complementary or value-adding services.

Weiland et al. (2010), consider a different angle when discussing cost implications with the ANP role. In their exploratory study investigating ED doctors' perceptions of ANPs, they advocate that whilst employing ANPs may result in higher salary costs, they were deemed a worthwhile investment given that there is less turnover compared to medics rotating through departments. Conversely, Li et al. (2013) examining the impact of ANPs on care delivery in an ED setting, found that ED clinical directors queried the cost effectiveness of ANPs in the time-sensitive ED setting, implying that ANPs could not match the patient throughput achieved by junior doctors despite the increased cost of such positions. This opinion has been contested by numerous researchers who claim that ANPs significantly reduce the waiting times and length of stay of patients in the ED (Roche et al., 2017, Jennings et al., 2015, Thompson and Meskell, 2012) and the contribution of ANP roles to the Irish health service has led to rapid access to care and seamless patient flow across services (O'Connor et al., 2018). Cost reductions are also claimed for ANPs in other clinical areas such as cardiac intensive care units (Skinner et al., 2013), and primary care settings (O'Kelly and Foy, 2010). Nevertheless, Gantly (2017) and the Irish Medical Organisation (2017) assert that there is no evidence to suggest that nurse-led patient care is more cost effective than the traditional model. Furthermore, Razavi et al. (2021) suggest that lower costs associated by some with ANP care is primarily driven by lower service volume, whilst Maten-Speksnijder et al. (2014) suggest that whilst ANPs can achieve outcomes similar to those of medical management, evidence concerning cost effectiveness is scarce, and recommend that more research is required to investigate outcomes related to cost.

In summary, there is considerable discussion regarding the ANP role and the perceived substitutive role for doctors. This perception is not surprising, given that there is significant evidence to show that health systems consistently think of medical solutions to health problems. Unfortunately, the argument for this substitution is weighed heavily with discourse pertaining to cost. Carryer and Adams (2017) observe that the conflicting evidence concerning potential cost savings may be because cost comparisons are challenging to make, influenced as they are by a combination of easy to measure and some more difficult to measure important long-term outcomes. Whilst some authors argue that ANPs are cost effective, others dispute this, suggesting that

any cost savings are offset by their longer consultation times, increased referrals and test ordering, and higher recall rates. There is ample evidence to show that ANPs raise standards of quality and efficiency in healthcare systems; however, medical professionals remain unconvinced, voicing concerns around safety issues and lower quality care. Cost and the ANP role tend to be considered in absolute terms rather than in relation to key measures such as access, turnover, quality and other key performance indicators. An essential step in clarifying and advancing the role of ANPs is to examine the barriers and enablers to realising the potential of the ANP. In the next section, I review the literature pertaining to these barriers and enablers.

2.8 Barriers and enablers to realising the potential of the ANP role

In this section, I examine the barriers and enablers to realising the potential of the ANP role that are evident in the extant literature.

Health systems internationally are under mounting pressures as a result of complex issues including ageing populations, the epidemic of chronic conditions, rising public expectations and the challenges of cost containment. The need for a fit for purpose workforce that addresses these complex issues has never been so urgent. Carryer and Adams (2017) argue that this workforce should be able to respond to increasing levels of long-term conditions with responsive models of care. The WHO (2021) acknowledges that a new model of health care delivery is required to meet the current global health crisis. In Ireland, policy documents released by the Office of the Chief Nurse, Department of Health, suggest that a new proposed model of care is one that offers the individual, family and community choice (Department of Health, 2017). Carryer and Adams (2017) contend that enabling the ANP role can contribute to the transformation in care proposed by the WHO and Department of Health. This idea is further supported by Archibald and Fraser (2013) who suggest that ANPs are in an excellent position to address current shortcomings by increasing points of access to the healthcare system, emphasising education and disease prevention and delivering high quality, cost-effective care in a multitude of practice settings.

Previous studies have clearly demonstrated that ANPs have a positive impact on these shortcomings, as well as on patient outcomes and experiences (Zwijnenberg and Bours, 2012, Roche et al., 2017). This is reported not only by nursing groups: representatives with many frames of reference have suggested that ANPs should play even greater roles and be granted full practice authority (Stanik-Hutt et al., 2013). The provision of quality care by ANPs is linked with nursing being a socially responsive profession which is strongly influenced by the socio-political climate in which it functions (Archibald and Fraser, 2013). This viewpoint is supported by Lowe et al. (2012) who maintain that ANPs are key players in the drive for a more efficient workforce due to their capacity to negotiate issues of health and social wellbeing in a variety of settings. Based on their findings, Carryer and Adams (2017) argue that ANPs are key players because they hold true to their nursing education and approach patient assessment in a highly contextualised manner, mindful of the limitations of medical solutions to many presenting problems.

Despite this, public perceptions of the ANP role are mixed. Considering the barriers to the ANP realising their potential, Ten Hoeve et al. (2014), in their discussion paper, and Dahlborg-Lyckhage and Pilhammar-Anderson (2009), employing a discourse analytical approach, observe that the public perceive nursing as a low status profession that is subordinate to medicine, a profession that does not require any academic qualifications and lacks professional autonomy. A recent radio broadcast (The Brendan O' Connor Show, Raidió Teilifís Éireann 2021) shows that this discourse is also evident in Irish society. A panellist discussing issues with the Irish Leaving Certificate Examinations suggested that nursing was for individuals who could not get into medicine. In response, Ní Phríondragás (2021) tweeted that she was infuriated that this comment is glibly passed over and proposes that the host correct the 'assumption that nurses are just disappointed would-be doctors who didn't get enough points.' This adverse comparison to medicine, Chulach and Gagnon (2016) suggest, can lead to a feeling of professional inferiority.

When we consider what enables ANPs to realise their potential, Aleshire and Wheeler (2012) found that the majority of the public likes and trusts ANPs and sees them as a solution to limited access to care. However, the authors do recognise that, although continuously voted the most trusted profession, nursing and ANPs have struggled to

fully define themselves and their profession to the public. Carryer (2020), in an editorial, comments that this may be secondary to what and who we value within our discipline and asks is there any surprise then when nurses are rendered invisible, secondary to medics and closely aligned with religious and militaristic notions of women's work dating back more than a century. This issue of visibility was brought to light more recently during BBC Question Time, when the UK's then Health Secretary, Matt Hancock, commented that the Covid-19 pandemic had claimed the lives of four doctors and *some* nurses, giving the impression that nursing casualties were less important and not counted (Ng and Cockburn, 2020). Ten Hoeve et al. (2014) suggest that to improve their public image and obtain a stronger position in the healthcare system, nurses must increase their visibility, be self-assured and make better use of strategic positions to show the public what their work entails. Kosta-Polston et al. (2015) emphasise that ANPs must become politically engaged to implement the changes that health systems require to deliver quality, safe and cost-effective services. ANPs should be at the forefront, realising their potential, leading change and advancing health in an increasingly complex health system with ANPs preparing for changing health care environments and consumer demand (Ryder et al., 2020).

In recent years, it has been proposed that ANPs should play a greater role in evolving health systems (Stanik-Hutt et al., 2013) and, because experienced nurses and midwives are such a valuable resource to the healthcare system, a context must be created that allows nurses and midwives to provide comprehensive care to individuals, families and communities (Department of Health, 2017). However, Schadewaldt et al. (2013) and Crowe et al. (2017, p.73) argue that this may not be achievable as the health system is hierarchical in nature with 'physicians sitting at the top' and 'you do not cross them' discourses acting as barriers to ANPs realising their potential. These hierarchical structures are also discussed by Maylone et al. (2011) who suggest that they are frequently experienced by ANPs. Whilst doctors represent a relatively small proportion of the health service workforce, 2.7 per 1,000 population versus 12.4 nurses per 1,000 population (OECD, 2015), their voice is very much heard and this, Harvey (2011) argues, is why medicine continues to be the traditional 'power broker' of health care. Nonetheless, Hain and Fleck (2014) argue that this traditional medical hierarchical model of practice, which promotes physician dominance over the health care team, contributes to ineffective teamwork and comment that this model is no

longer fit for purpose due to factors such as the looming shortage of doctors, the expectations of new nursing graduates, the ageing population and the increase in patients living longer with chronic illnesses.

The WHO (2010) highlights the need for interprofessional working and contends that ANPs should collaborate with other health professionals to achieve best practice. A consultation document released by the Department of Health (2017), *Developing a Community Nursing and Midwifery Response to an Integrated Model of Care*, suggests that community networks that are inclusive of all relevant health providers will have 'robust governance, role clarity, accountability and responsibility to further enhance collaboration and communication…' (Department of Health, 2017, p. 41). Cashin et al. (2015), when developing standards for ANPs in Australia, found that the notion of collaboration was important to many ANPs, who considered that they made decisions within a team. However, these views were not unanimous, with other ANPs expressing the opinion that there should be more focus on the independent and autonomous role of the ANP. When asked, the ANPs feared that collaboration could make certain ANP practices, such as prescribing and referrals, unnecessarily challenging. Conversely, Kerr and Macaskill (2020) suggest that autonomy combined with collaboration may be the key to maximising ANPs' potential and enabling the role, strengthening their unique position in healthcare and making a difference for patients. This stance is evident throughout the literature with authors highlighting that collaboration between ANPs and physician colleagues improves quality and cost outcomes and can lead to increased professional satisfaction (Austin et al., 2021, Mustafa et al., 2021, McDonnell et al., 2015, Newhouse et al., 2011).

Collaboration was identified as a cornerstone of the ANP profession, even though relationships with other professionals could be challenging (Rashotte and Jensen, 2010). Burgess and Purkis (2010, p. 300) argue that ANPs resist these structures by committing to 'egalitarian power relations, whereby all team members are valued for their unique and significant contributions to decision making.' Correspondingly, Weiland (2008) suggests that, whilst the roles of both the ANP and physician are at once similar but quite distinct from each other, there is no reason that one group be independent and the other dependent. Burgess and Purkis (2010) stress that it is important for ANPs to champion collaborative relations at all levels of the health

system and, in turn, foster and enable role development. Evidence from the literature shows, however, that there are variable levels of collaboration with medical colleagues in health systems. Adams and Carryer (2021, p.22), in their institutional ethnographic study, found that antagonistic relationships exist within healthcare systems with professions in 'embattled positions.' DiCicco-Bloom and Cunningham (2015), in their qualitative study exploring the perceptions of primary care ANPs and primary care physicians, similarly found that most of the interactions between both professions were obstructive rather than collaborative. This undoubtedly impacts the ability for healthcare professionals to address the complex issues that are continually mounting in our healthcare systems.

In summary, health systems are changing and require a fit for purpose workforce that will address the many challenges it faces. ANPs are in an advantageous position to meet and positively address these complex concerns as they are aware of the limitations of medical solutions to health problems and recognise the potential of the ANP role. Despite this, barriers to realising the potential of the ANP are evident int the extant literature. Nursing is identified as a low status profession that is not seen as leading or independent but is instead subaltern to medicine. It is argued that this perceived subordinate position is due to the positional power of medicine and ANPs' relative invisibility has resulted in them struggling to define themselves and meeting resistance in the healthcare system. I now explore resistance to the ANP role.

2.9 Resistance to the ANP Role

The introduction of the ANP role has met resistance from both nursing and medical colleagues. Numerous reasons for nursing and medical resistance are now discussed. MacLellan et al. (2017) identify nursing resistance to the ANP role as coming from 'the enemy within' and reasons for this conflict include professional jealousy (MacLellan et al., 2017) nurse skill mix dilution (Hoskins, 2012), and unfair comparison (Hain and Fleck, 2014, Li et al., 2013). From a medical perspective, there are a number of reasons for resistance to the role including the supposed threat to the doctor's status and identity (Irish Medical Organisation, 2017), concerns related to overlapping role boundaries (Archibald and Fraser, 2013, Hoskins, 2012), loss of income (Begley et

al., 2014, Delamaire and LaFortune, 2010), potential to deskill doctors (Irish Medical Organisation, 2017; Donelan 2013,) concerns about ANPs' knowledge and competencies (Higgins et al., 2014) and concerns about litigation and liability (Weiland et al., 2010). Each of these will now be examined in turn.

2.9.1 Tall Poppy Syndrome

Discourses related to the role's autonomy and extension of service have resulted in opposition and lack of support from nursing leaders and colleagues. This is problematic when we consider that support from key stakeholders is an essential element in enabling ANPs' role fulfilment (Kerr and Macaskill, 2020; Health Service Executive, 2012). Powell and Davies (2012) maintain that nurses working in non-traditional roles may be mistrusted and hindered by nursing colleagues, as well as sometimes subjected to open hostility. Carryer (2020, p. 3578), in an editorial, believes that this hindrance and oppression is frequently taken up, maintained and exacerbated by managers who 'rarely take kindly to challenge or queries from nurses even when they are themselves nurses by origin'. Crucial aspects of nursing, such as the traditional role of the caring nurse, were seen as being eroded by certain aspects of the ANP role that was considered to be moving too far from the traditionally accepted nursing perspective (Griffin and Melby, 2006). Anderson et al. (2020) suggest that, as a professional group, nursing appears to hold a fixed identity of what it is to be a nurse to such an extent that deviation is seen as illegitimate.

MacLellan et al. (2017), exploring the transition experiences of ten ANPs, revealed this opposition and oppression with participants in their study. They argue that this hostility is secondary to professional jealousy and the ubiquitous 'tall poppy syndrome'. Evans et al. (2014) argue that nursing provokes feelings of anxiety, envy and jealousy and suggests that jealousy is related to feeling that others are getting what you deserve and hence rivalry occurs. This rivalry is further exacerbated when we see nursing identities being placed in a hierarchy. Professor Alison Leary (2016), Chair of Healthcare and Workforce Modelling UK, tweeted criticism of Dame Donna Kinnair, at the time Director of Nursing, Policy and Practice at the Royal College of Nursing, for suggesting that ANPs were 'further up the chain that other nurses'. Tye and Ross

(2000) suggest that rivalry can be attributed to some nurses' ambivalence towards the role, whereas Hoskins (2012) believes that conflict is a result of 'diluting' the nursing skill mix. In her discussion of the emerging ANP role in the emergency setting, Hoskins (2012) argues that removing senior nurses from the ED workforce results in reduced knowledge and leadership being available on the 'floor'. Arguably, this reduction in knowledge and leadership is not an inevitable consequence of introducing ANPs but suggests that their experience is somehow no longer available to the department. Reasons for this are manifold and include ANPs being heavily siloed and seen as separate to the main department, lack of training opportunities to maintain competencies such as Advanced Cardiac Life Support (ACLS) and Paediatric Advanced Life Support (PALS), and lack of knowledge from other nurses of their past work experience.

While Laurant et al. (2018) found ANP practice to be safe and effective, Andregård and Jangland (2015) argues that the role may lack acceptability and understanding, leading to underutilisation. Adams and Carryer (2021, p.21), in their institutional ethnographic study, found that ANPs felt they were being underutilised, like a 'thorough bred racehorse kept in the stables'. From an Irish perspective, these concerns were highlighted by Casey et al. (2017c) who found that nurses fear the ANP role will lead to underuse and deskilling of the ANP, whereby ANPs would no longer be competent in other skills that may be relevant to their area of practice. Kerr and Macaskill (2020) report a lack of organisational readiness, with nurses displaying a lack of understanding of the ANP role, resulting in practice-based tensions and a sense of isolation for the ANP. Evidence has shown that ANPs must 'endure several months of negativity and limited collegiality which would only be alleviated once certain unspecified, but significant "rites of passage" and "personal tests" had been successfully negotiated' (Jones et al., 2015, p. 6). This treatment may contribute to heavy siloing of the ANP role.

Hain and Fleck (2014) suggest that, considering this, it is not surprising that some ANPs can have poor job satisfaction. This dissatisfaction is further intensified by colleagues perceiving ANPs as 'nurses who practice in doctors clothing' and challenge the traditional nurse-doctor work dynamic (Li et al., 2013, p. 5). Laperrière (2008) found that ANPs often feel frustrated about unnecessary constraints on their capacity

to utilise their training and experience. Corbally and Lees-Deutsch (2019) found that, although ANPs are clearly at the peak of their career, they were clearly frustrated and restricted by virtue of their role. Li et al, (2013) maintain that this frustration is a result of ANPs feeling that their practice is constantly compared and judged with reference to doctors. Lowe et al. (2012, 2017) argue that whilst the comparability of outcomes for ANPs and physicians continues to be the cornerstone of any discourse relating to ANP practice, ANPs need to move on from this and recognise the significant role they play in the health system. Higgins et al. (2014) suggest that ANP activities can be constrained by interdisciplinary relationships, organisational culture and role isolation and argue that nursing leaders have a key role in supporting ANPs through countering the negative impact of professional isolation and expanding opportunities to move beyond local context and engage at regional, national and international levels.

2.9.2 Medical Resistance

One of the most recurrent discourses concerns the resistance from the medical field to the development of the ANP role. This resistance ranges from concern over safety issues associated with general task substitution (Hoskins, 2012) to vehement opposition with expressions of hostility, antipathy and disapproval (MacLellan et al., 2017). Concerns predominantly relate to the prescribing of medicinal products (Oxtoby, 2016), independent practice (Pulcini et al., 2010) and management of complex patients (Jakimowicz et al., 2017). Whilst McCleery et al. (2011) comment that physicians and ANPs receive very different training and it would be surprising if their competencies were identical, Bauer (2010) argues that those who favour restricting the use of ANPs on the basis of their more limited competencies have no data to support their position. He stresses that all published research studies unambiguously support the proposition that quality of care will be maintained – and possibly enhanced – if ANPs are utilised.

This opposition is not covert and is vigorously vocalised by numerous medical organisations. In the United States of America, Donelan et al. (2013) report that the Council of Medical Speciality Societies, which represents 34 physician organisations, and the American Academy of Family Physicians (AAFP) strongly oppose broadening

the scope of practice for ANPs. The AAFP further proclaim that ANPs should be supervised by physicians to ensure safe healthcare and that physicians remain the 'natural' leader of health care teams (Nardi and Diallo, 2014). This necessity for medical supervision is also seen within the Irish context, most notably when a new Rapid Injury Clinic was opened in Dublin, where emphasis was given in the press to 'experienced medics supervising these advanced nurse practitioners…' (O' Regan, 2010, p.11). The Australian Medical Association is strongly opposed to the ANP role, contending in all forms of media, that there is no place for ANPs in a health care system, arguing that ANPs do not require the training and education that the medical role demands (Weiland et al., 2010, Australian Medical Association, 2019). Carryer (2020, p. 3577), in her editorial, suggests that nursing is viewed by many as an 'essentially noncognitive endeavour' where 'hands-on-nursing practice supported by experience rather than scholarship' and the only way that nurses can be educated. Staying with nurse education and training, the UKs Department of Health and Social Care (2021), recently tweeted that applications to nursing *courses* in England have recently increased. Responding, Credland (2021) argues that 'it's not a course it is a degree! You would not say a doctor's course or a lawyer's course. Semantics matter.' Further trivialising of nursing is seen in the UKs General Medical Council (2018) annual *State of Medical Education and Practice Report* where language is employed that refers to doctors 'acting down' when they carried out tasks normally completed by nursing staff. In response, Carter (2018) acerbically tweeted that 'it is good to know our place as nurses is beneath doctors, not alongside them as degree educated professionals fulfilling our own unique role…'.

Resistance and fear mongering was apparent in the United Kingdom when medicinal prescribing rights were granted to nurses and pharmacists. The British Medical Association branded the development as 'irresponsible and dangerous' and declared that 'patients will suffer' as they contend, like the Australian Medical Association, that only doctors have the necessary diagnostic and prescriptive training that justifies prescribing rights (Holm, 2011). Barry (2011) argues that evidence to support the view that nurse prescribing improves patient care and facilitates service delivery is weak and suggests that nurses were naïve to believe that they should not be restricted in medicinal prescribing. Others are adamant that nurse prescribing was an irresponsible and dangerous move (Holm, 2011), reflected in a discourse around nurse prescribing

that constructed (or positioned) nurses as ‘under trained, under qualified people’ who were ‘jumped up, overestimating their ability and underestimating the risks involved in prescribing’ (Oxtoby, 2016, p.448). However, in their comparative study exploring the prescribing patterns of ANPs and physicians, Gielen et al. (2014) conclude that there is sufficient evidence that both ANPs and physicians prescribe similar drugs for common conditions in accordance with accepted medical practice. The authors found that ANPs are extremely competent, well-educated trained and skilful practitioners who are more likely to prescribe over-the-counter medications and provide more non-pharmacotherapeutic interventions for their patients than doctors.

Closer to home, Irish medical organisations have become quite vocal in recent years following the publication of proposals for expanding ANP services and reconfiguring community health services with nurses taking more of a leadership role (Department of Health 2019, Department of Health 2017). The Irish Medical Organisation (2017, p. 6) in their submission to the Department of Health on these draft policies propose that any ‘expansion of nursing services within the community setting should be aligned with services provided under a new GP contract’. They further recommend that the role of the GP be protected as gatekeeper to the health systems and coordinator of care as they suggest this will ensure more appropriate use of scarce healthcare resources. Carryer (2020) disagrees, urging a change in direction when considering future models of care especially when one considers that the medical model focuses on repairing the damaged or dysfunctional body which contributes to 10-20% of health outcomes. However, Wall (2017), argues that a nurse-led model will undermine GP care and risk further fragmentation and duplication of care. Jauhar (2014) writing in The New York Times, asserts that if we want more primary-care providers, ‘let’s have them be doctors’, saying that while there is an essential place for ANPs *in* medicine, they are part of a physician-led team and not doctors. Carryer and Adams (2021) warn against this alignment. In a recent editorial, they emphasise that such a move would ‘be completely antithetical to the essential values of the role which rests with the unique combination of a strong background in nursing with the addition of various medical skills and tasks previously under the…domain of medicine’ (Carryer and Adams, 2021, p.2).

Supposed threat to the doctor's status and identity

Bauer (2010) and Harmer (2010) both comment that an explanation for medical resistance may be related to the changes in health services which has resulted in many doctors feeling threatened by a loss of professional identity and autonomy. He argues that this has resulted in them 'struggling to maintain a professional role'. This view is reaffirmed by Street and Crossman (2010) who suggest that one plausible explanation for opposition to autonomous ANP practice is doctors' determination to maintain professional control over health services. Their analysis of physician's attitudes toward ANPs identified that doctors perceive that there has been a steady erosion of 'professional sovereignty' for the medical profession over the last number of decades. Street and Crossman (2010, p. 437) propose that 'the spectre of autonomous ANP practice may represent one area where physicians are still trying to hold the line and exercise their sovereignty that remains over professional and primary care provider/patient relationships'. Rather than highlighting the shared knowledge and skills that both medics and ANPs have, Lewy (2010) maintains that doctors are more concerned with emphasising the differences between the professions.

Emphasising these differences may be beneficial for the ANP role. Mary Casey, a university academic, speaking with McCarthy (2020), points out that patients may not want to bother a GP with what they consider minor complaints and may consider the nurse to be more on the same level as themselves. Delano Abbott (2010), exploring central questions about the role of professions in modern life, argues that all professions, not just nurses and doctors, are striving for 'jurisdiction' over their field of work, suggesting dominance over other professions within the same field and clear boundaries among those professions.

Overlapping Role Boundaries

Role boundaries are a contentious issue within discourses surrounding the ANP role. In their investigation of nurses', midwives' and key stakeholders' experiences and perceptions of nurses' scope of practice, Casey et al. (2015) highlight the difficulties that nurses encounter when negotiating role boundaries with other professions. This is particularly apparent in relation to medical roles. Lowe et al. (2012, p.681) established that there was significant resistance to ANPs crossing 'long established

boundaries' by some in the medical profession. They believe that it is inevitable that some functions historically completed by one healthcare group will ultimately be assumed by another and in turn redefine professional boundaries. Casey and O'Connor (2021) suggest that ANPs are best positioned to undertake these boundary spanning roles as they are competent and engaging leaders who improve services and develop practice in the healthcare system. Weiland (2010) argues that this is most evident within the primary care setting, as nurses have crossed boundaries in their professional practice, as a response to the social, political and economic landscape of healthcare, in order to better fulfil their role. In their study, Griffin and Melby (2006) discovered that there were significant differences in the attitudes between doctors and nurses towards the issue of overlapping role boundaries, however the authors failed to provide an explanation as to what these differences involved nor the consequences of these attitudes. Nevertheless, both groups indicated that crossing role boundaries causes difficulties and is 'troublesome' for both parties. Weiland et al. (2010) found that mixed feelings and resistance towards the ANP role arose from doctors believing that ANPs were undertaking work that was the domain of medics. They suggest that these 'turf wars' resulted due to a lack of role delineation and definition. These issues were also evident in research completed by Begley et al. (2014) who demonstrated that medical fears of overlapping roles are seen as a challenge to introducing ANP roles with one participant mentioning that within the medical profession there is an element of 'paranoia'. Lowe et al. (2012) dismiss this, arguing that so-called 'medical' functions are only a portion of what ANPs do. They expand their argument by emphasising that it is of no consequence whether these functions are seen as 'invading' medical territory, instead they stress that the aim of ANP practice is to provide advanced nursing care to groups of patients in a timely, appropriate, ethical and efficient manner. From a public discourse viewpoint, O' Doherty (2016), when discussing the annual number of patient doctor consultations in the Irish Examiner, points out that while ANPs may be seeing patients who in other countries may have been seen by doctors, they cannot be considered the equivalent of doctors.

Loss of Income and Litigation Concerns

In Casey's and colleagues (2015) study, a lack of monetary incentive was identified as a possible barrier to expanding nurses' scope of practice. In their discussion paper

exploring barriers to ANP practice, Hain and Fleck (2014) found that the majority of physicians believed that ANPs should not receive equal pay for providing similar services to those of doctors. Donelan (2013) found comparable results and proposed that this opposition to equal pay is consistent with doctors' perceptions that for any given service they provide a higher quality of care than ANPs. However, in the same study, ANPs' call for equal pay is based on their view that doctors do not provide a higher quality of care for any given service. Justification for equal pay for equal work is provided by Bauer's (2010) economic analysis and review of the literature, which identified that, of more than 100 published reports on the quality of care provided by both ANPs and doctors, not one study found that ANPs provide inferior services within the overlapping scopes of practice. This sound economic analysis, he argues, provides strong evidence that, without diminishing the quality of care, the substitution of ANPs for more expensive physicians can reduce costs.

The medical profession has also voiced concerns about legal liability in cases of malpractice under teamwork arrangements (Delamaire and LaFortune, 2010). This, Hoskins (2012) suggests, is secondary to worries over safety issues associated with task substitution and true inter-professional working. This is also seen within the Irish context. Kerrigan (2007), writing in the Irish Examiner about the delay in opening a new ED unit, cites the ED Consultant of the Mercy University Hospital, Dr. Chris Luke, as looking for very senior nurses who could deal with many of the minor injuries *without recourse* to doctors, freeing up valuable expertise and time for more serious situations. Harmer (2010) argues that physicians need not be concerned, as all practitioners, including ANPs, are accountable for their actions. Hooker (2010), analysing American data from 1991 through to 2009, clearly showed that ANPs do not increase liability claims or costs. Moreover, ANPs are shown to have lower rates of malpractice claims and lower costs per claim than their medical colleagues.

It is impossible to review the literature regarding the ANP role without meeting elements of resistance, both nursing and medical. Several reasons were provided for nurses resisting the role of the ANP including professional jealousy, nurse skill mix dilution, and the removal of skilled practitioners from the 'floor'. This resistance has been shown to lead to poor job satisfaction, frustration in utilising their training and role isolation. Medical resistance is derived from aspects of medical disapproval for

the role and autonomous practice including prescribing rights, supposed identity threat and fear of deskilling, ‘turf wars’, loss of income, and fear of litigation. Whilst some authors argue that these fears and beliefs are implicit, this review makes clear that they have real effects.

2.10 Chapter Conclusion

Critically reviewing the literature provided many insights and perspectives. This enabled me to better understand what studies had been undertaken in the past concerning the ANP role, and how the role is positioned and identified in the Irish context. It is apparent that confusion concerning the role still exists, particularly the definition of what an ANP is and does. It is evident in the literature that the professional identity of the ANP remains ambiguous, constrained by an identity that no longer serves the image of what a nurse is or wishes to be. This has resulted in issues with autonomy and professional practice boundaries in addition to resistance from medical and nursing colleagues. Whilst the literature has provided an understanding of the comparisons between ANPs and doctors such as cost, quality and services, gaps within the studies are apparent. From an Irish perspective, there is very little information concerning the positioning of ANPs in the current health system structures and about Irish ANPs working in the community setting. There is also a scarcity of studies, nationally and internationally, that have adopted a discourse analytical approach to explore this area. In the next section, I discuss the foundation and creation of my conceptual framework as well as outlining my own epistemological and ontological beliefs that provided the theoretical and methodological footings of my thesis.

Chapter 3 Theoretical Considerations

3.1 Introduction

This chapter outlines the epistemological and ontological beliefs that provide the conceptual and methodological underpinnings of my study. I first discuss my personal stance and commitments. Next, epistemological and ontological considerations are explored. The origins and development of the conceptual framework for the thesis are then discussed. Systems Theories, General Systems Theories (GST), Soft Systems Methodology (SSM), Organic Systems Framework (OSF) and how they are relevant to, and significant for, Irish Healthcare Systems and my thesis are discussed. The methodological considerations as they relate to CDA are discussed in Chapter Four.

3.2 Personal Stance and Commitments

As previously mentioned, my own personal experiences of working as an ANP for the past twelve years have sown the seeds of this study. I have long argued that rather than perpetuating the stereotypical 'angel of mercy', nurses need to step forward and ensure that their point of view is fully reflected in the development of future health policy. This viewpoint is consistent with current nursing policy and thinking in the HSE and Department of Health (Health Service Executive, 2020; Department of Health, 2019). ANPs need to support our peers and junior colleagues in contributing to policy development. Research plays a pivotal role in identifying how we do this as it questions and provides insight into our clinical and professional practices and the contexts in which they are enacted.

Research philosophy concerns the source, nature and development of knowledge. Whilst the idea of knowledge creation may appear profound, I am engaging in knowledge creation by completing this research study. Addressing the research philosophy and providing my own personal perspective of the world and research, involves formulating and being aware of my own beliefs and assumptions. This worldview is supported by Saunders et al. (2016) who propose that the research philosophy that one adopts will contain important assumptions about the way in which

one views the world and these assumptions will underpin the research strategy and the methods that are chosen for the project. Whilst research philosophies will be influenced by practical considerations, the main influence will be the relationship between knowledge and the process by which this knowledge is developed. I now turn to the two major ways of thinking about research philosophy: epistemology and ontology.

3.2.1 Epistemology

Epistemology concerns the question of what constitutes acceptable knowledge in a discipline or field of study (Bryman, 2012). A central issue concerning epistemological concepts is the question of whether the social world can and should be studied according to the same principles, procedures and ethos as the natural sciences. For what Saunders et al. (2016) refer to as the ‘resources’ researcher, reality is represented by objects that are considered to be ‘real’, whereas the ‘feelings’ researcher is more concerned with individuals' feelings and attitudes. Authors state that the ‘resources’ researcher is adopting what is referred to as a positivist position to the development of knowledge whereas the ‘feelings’ researcher is embracing an interpretivist perspective (Gray, 2004; Bryman, 2012; Saunders et al., 2016).

The doctrine of positivism is extremely difficult to pin down as it is used in a number of different ways. Bryman (2012, p.12) defines positivism as ‘an epistemological position that advocates the application of methods of the natural sciences to the study of social reality and beyond'. Exploring the positivist approach of empiricism, it is evident I have no allegiance to it as I believe that the world has many more facets than just what we as humans experience through our senses. In my opinion, concepts such as anguish, pleasure, sorrow and many others could never be explored if one was to take a true positivist approach. This outlook is supported by researchers critical of positivism who argue that rich insights into complex worlds are lost if such complexity is reduced entirely to a series of ‘law-like generalisations’ (Saunders et al., 2016). My own personal perspective is that each person views the world uniquely with their own environment interpreted exclusively. This worldview is evident in the work of Gee (2000) who suggests that when a person acts and interacts in a given context, people

recognise that individual as acting and interacting as a certain “kind of person”. I align myself to the assumption that we can only know reality from our own perspective of it. My research philosophy is therefore likely to be closer to that of an interpretivist.

Saunders et al. (2016) define interpretivism as an epistemology that is necessary for the researcher to comprehend differences between humans in our role as ‘social actors’. The term ‘social actors’ is significant as it recognises that we play a role on the ‘stage’ of human life. We interpret our everyday social roles in accordance with the meaning that we give to these roles and additionally interpret the social roles of others in accordance with our own set of meanings (Saunders et al., 2016). This interpretation ties in very much with the area of discourse analysis and more specifically the works of the prominent discourse analyst, James Paul Gee. The interpretivist paradigm emphasises that how one person sees the world can only be appreciated when one considers the context through which their world is being viewed. Crucial to an interpretivist epistemology is the empathetic stance the researcher must adopt. Saunders et al. (2016, p.9) contend that the challenge here is ‘to enter the social world of our research subjects and understand their world from their point of view.’ Put another way, one needs to look through that person's ‘lens’ to explore and gain an understanding of their world. This lens can change from moment to moment in an interaction, can change from context to context and can be ambiguous or unstable. Being recognised as a certain “kind of person” in these given contexts is what Gee (2000) suggests is meant by ‘identity’.

3.2.2 Ontology

Whilst epistemology is concerned with what constitutes acceptable knowledge in a field of study, ontology, on the other hand, is concerned with the nature of reality. Prior to clarifying the type of ontology used within my own study, I will provide a definition as the term is used with different senses in different communities (Guarino and Musen, 2015). Crotty (1998) defines ontology as ‘the study of being’ concerned with ‘what kind of world we are investigating, with the nature of existence, with the structure of reality as such’. Lincoln and Denzin (2005) state ontological assumptions are those that respond to the question ‘what is there that can be known?’ or ‘what is the nature of

reality?'. To a greater extent than epistemological considerations, ontology raises questions of the assumptions that I may have about the way the world operates and what commitments I hold to particular viewpoints. Two aspects of ontology reviewed are objectivism and subjectivism.

Objectivism is an ontological position that implies that social phenomena confront us as external facts that are beyond our reach or influence (Bryman, 2012). Social entities exist in reality to 'social actors' and the categories we use in everyday discourse are independent or separate from these actors. Simply put, the mind of the researcher is thought to be separate of the world of objects and what is being investigated. One can see from the definition that proponents of objectivism are realists. They contend that the world is prior to individuals and assert that it will still exist as an empirical entity, constructed of hard tangible and relatively immutable structures, independent of the cognitive efforts of individuals (Gill et al., 2010). This paradigm is contested by proponents of critical realism, such as Roy Bhaskar(1998), Ray Pawson (1997) and Nick Tilley (1997), who argue that social worlds constructed from human interactions acquire a social reality that must be studied in a way that recognises and respects its dynamic and interactive nature. As previously stated, I align myself to the assumption that we can only know reality from our own perspective of it. Therefore, my ontological outlook would be more subjective or aligned to what is often termed social constructionism.

Social constructionism ultimately has its origins in philosophy via symbolic interactionism and phenomenology. The key popularising text was Berger and Luckmann's, *The Social Construction of Reality* (Berger and Luckmann, 1966). The concept emerged as an attempt to come to terms with the nature of reality and is associated with the post-modern era in qualitative research (Andrews, 2012). It is seen as an umbrella term for a range of theories that focus on culture and is essentially seen as an anti-empiricist and relativist stance (Jrgensen and Phillips, 2010; Hammersley, 1992). Social constructionism views reality as being socially constructed (Wetherell et al., 2001).

Discourse analysis is just one among several social constructionist approaches, but Burr (1995) suggests that it is one of the most widely used approaches within social

constructionism. Following on from the interpretivist position, 'social actors' place many different interpretations on the situations in which they find themselves (Saunders et al., 2012). Dahlborg-Lyckhage and Pilhammer-Anderson (2009) suggest that social meaning is developed not only through discourses but also on the basis of a tangible reality in which the interaction between people and societal institutions are important. Burr (1995) warns about the difficulty of giving just one description that can cover all social constructionist approaches since they are manifold and diverse. Notwithstanding this, she lists four premises that are shared by all social constructionist approaches. They are:

A critical approach to taken-for-granted knowledge; the world should not be treated as an…

> '…objective truth but instead reality is only accessible to us through categories, so our knowledge and representations of the world are not reflections of the reality 'out there', but rather are products of our ways of categorising the world, or in discursive analytical terms, products of discourse.'
>
> (Burr, 1995, p.3)

This is reflected in the discourse analytical approach outlined by Gee (2011) who suggests that whenever we speak or write, we always and simultaneously construct or build six things or six areas of 'reality', a concept he refers to as 'Building Tasks', which will be discussed in more detail in chapter 4.

Historical and cultural specificity, which recognises that we are fundamentally historical and cultural beings and our views of, and knowledge about, the world are 'products of historically situated interchanges among people' (Gergen, 2009, p.267). This is evident within discourse analysis, which highlights how professional roles, knowledge bases and practices are produced and maintained in particular socio-historical contexts (Zeeman and Simons, 2011). This is again reflected in the works of Gee, specifically the concepts of situated meaning, intertextuality and big 'C' Conversation, again to be discussed later.

Link between knowledge and social processes, which Gergen (2009, p.268) proposes is our way of understanding that the world is created and maintained by social processes. Jörgensen and Philips (2010, p. 5) declare that knowledge is 'created

through social interaction in which we construct common truths and compete about what is true and false.' This is evident in the Gee's (2011) discourse analytic approach where we examine these social interactions studying 'language at use in the world, not just to *say* things, but *do* things.'

Finally the *link between knowledge and social action*, which suggests that within a particular worldview, some forms of action become natural, whilst others become unthinkable (Jŗgensen and Phillips, 2010, p. 5). Different social understandings of the world lead to different social actions, and therefore the social construction of knowledge and truth has social consequences (Burr, 1995; Gergen, 2009). Gee (2011, p. 12) alludes to this concept when he states that 'ways of looking at the world of talk and interaction help us study how building tasks are carried out and with what social and political consequences.'

Based on these ontological and epistemological positions, a discourse analytical approach appears to be an appropriate methodology consistent with my commitments and the research focus of the thesis. The following section discusses the conceptual framework selected for this study and the rationale for its selection.

3.3 Conceptual Framework

The approach to discourse analysis that I propose is justified with respect to first, the philosophical premises; secondly, the conceptual framework; third, methodological guidelines on how to approach the research domain; and fourth, specific techniques for analysis. I now focus on the conceptual framework.

Before discussing the framework, to provide guidance and clarity, it is necessary to provide a brief overview of what I refer to when discussing the framework. Firstly, I acknowledge the interchangeable use of the terms 'conceptual' and 'theoretical' frameworks. Whilst it is recognised that the use of these frameworks is part of research, there is a paucity of literature about how these frameworks should be used (Green, 2014). Theory has been defined as 'an organised and systematic set of interrelated statements (concepts) that specify the nature of relationships between two

or more variables, with the purpose of understanding a problem or the nature of things' (Fain, 2003, p. 103), while concepts are defined as 'symbolic statements describing a phenomenon or a class of phenomena' (Fain, 2003, p. 108). Parahoo (2014) provides some guidance suggesting that a theoretical framework is used when research is underpinned by one theory and a conceptual framework draws on concepts from various theories and findings to guide research.

Regardless of definitions and terminology, utilising a framework is of unquestionable value. They have been described as the maps, scaffolds and frames for studies (LoBiondo-Wood and Haber, 2006; Rocco and Plakhotnik, 2009; Merriam, 1998). Irrespective of this, I personally believe that frameworks must be held lightly and not treated as sacrosanct. In my own study, I am not testing validity or relationships among concepts, instead I am using a framework to provide perspective and insight. Frameworks can help to ensure that research projects are coherent and focus the mind on what the research is attempting to achieve, however I am cognisant that occasionally a synthesis of one or more frameworks might be enlightening so a critical approach is employed. This will ensure that I am not blind to other perspectives and possibilities. In my own opinion, it is a matter of interpretation as to which term is used to describe and discuss the actual framework. For simplicity and to prevent confusion I will use the term conceptual framework when discussing the 'scaffold' of the thesis.

3.3.1 Selecting the Conceptual Framework

The selection of my conceptual framework began with Pangbourne (2013, p. 89-90) who argues that:

> '…as we are thinking beings – Homo sapiens – we carry interests, preferences and interpretations of experiences in our heads, and inquiry begins with such concepts, whether we have made them explicit or are even aware of them.'

Considering this, regardless of what research I do, my conceptual framework is constructed from my own knowledge and interests that have emerged from past experiences, previous studies and this thesis. To that extent, I am personally invested in the framework as it provides a comprehensive, comprehensible, coherent and integrated context for my thesis. The framework has helped situate me and my

thoughts, making it easier to convey ‘how and why my ideas matter relative to some larger body of ideas embodied in the research, writings and experiences of others’ (Schram, 2006, p. 58).

A second element in the construction of the conceptual framework is the literature, what is already known and discussed about my research area. Pangbourne (2013) suggests that a conceptual framework cannot be fully developed until the researcher has ‘immersed’ himself in the relevant research; however, Herbert Blumer (1954) warns that direction can be lost if the researcher does not approach the literature with an intuitive sense of what the key elements of the conceptual framework should include, what he alludes to as ‘sensitising concepts’.

A third element of developing my conceptual framework involved the theoretical constructs that I have determined will ground my thesis and be generative [figure 3.1]. The theory that I felt held most promise whilst reading the research was that of systems, more specifically, the theories of general systems, soft systems methodology and organic systems framework as outlined by Ludwig von Bertalanffy (1901-1972), Peter Checkland (1930-) and Barry Oshry (1932-). I feel that these are most fitting and applicable to my own study, and each will now be discussed in turn. The bespoke approach employing CDA and the frameworks supplied by Gee (2010) will be discussed in detail in the following chapter.

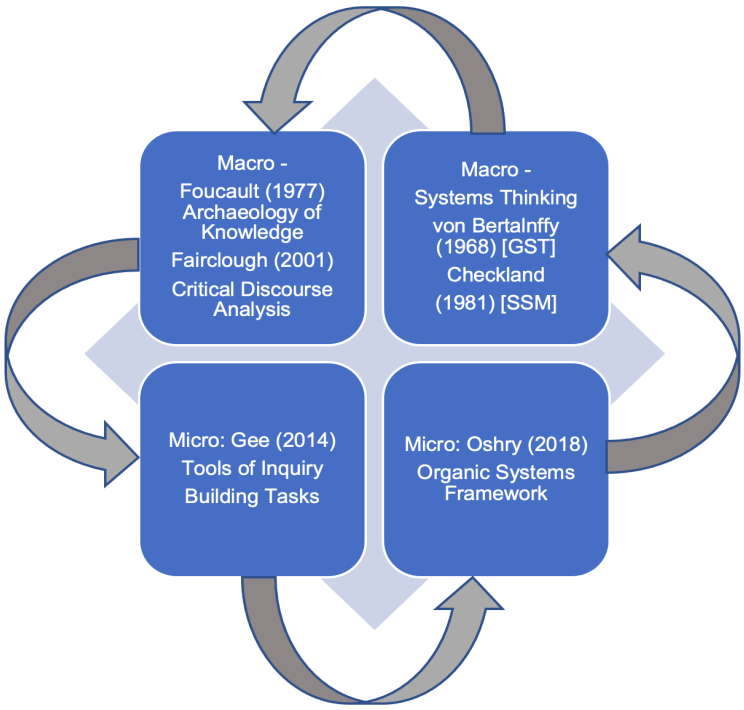


Figure 3.1 A bespoke approach to CDA and Systems Thinking showing key points of intersection with theoretical framework [Adapted from McNamara (2007)]

3.4 Systems Theory and Thinking

The word system has its origins from the Greek word *sunistánai*, meaning 'to cause to stand together' and is simply defined as 'a regularly interacting or interdependent group of items forming a unified whole' (Cordon, 2013, p. 13). This notion of thinking about things in wholes rather than parts is not a new concept. Aristotle (circa 384BC-322BC), whose work highly influenced Western philosophy, first expressed the basic tenet of system theory, arguing that the whole living body is much more than the sum of its body parts. This holistic outlook considers all aspects of the individual or system. Conversely, Descartes (1596-1650), a French philosopher, mathematician and scientist, had a different view of the body. According to Descartes, the mind is separate from the body – they are two separate entities. Employing this reductionist view, complexities in the world can be resolved by analysing and reducing phenomena to their simplest components. Medawar and Medawar (1977) argue that this reductive analysis is the most successful explanatory technique that has ever been used in science. However, multivariable systems have remained problematic within this framework (Frenk et al., 2010). Cordon (2013) concurs that the reductionist approach

is inadequate when dealing with organic, complex systems, as these types of systems are always changing. Whilst reductionism describes and details isolated and reducible issues, it fails to provide holistic solutions to real-world problems.

Friedman et al. (2007) contend that a health system is very much organic, complex and dynamic. Many of the challenges in global health are recognised as complex problems where simple reductionist blueprint approaches have had limited success (Adam and de Savigny, 2012; Paina and Peters, 2012). Thus, the holistic perspective first presented by Aristotle, has been revisited, and various theories on how systems work have emerged. As a field of inquiry and practice, systems thinking has origins in disciplines as varied as biology, physics, mathematics, management, sociology and computer science. The term is associated with a number of theorists and scientists including the psychiatrist, Ross Ashby; the anthropologist, Gregory Bateson, who established the field of cybernetics; the computer engineer, Jay Forrester, who launched the field of systems dynamics; and Peter Senge, who has popularised the learning organisation. The field has additionally been pioneered by a number of management thinkers, including Russell Ackoff, a pioneer in operations research, Ludwig von Bertalanffy, a leading biologist who developed General System Theory (GST), Peter Checkland, a British management scientist who devised Soft Systems Methodology (SSM) to provide a tool for investigating an unstructured problem situation (Peters, 2014) and Barry Oshry, a pioneer in the field of human systems thinking. I feel that the works of the latter three theorists, von Bertalanffy, Checkland, and Oshry are best suited to my study and the following sections provide rationale as to why I am of this belief.

3.4.1 Characteristics of Systems

Before examining the contributions of von Bertalanffy, Checkland, and Oshry, I believe it pertinent to afford an overview of the characteristics of systems. A more comprehensive definition of systems is provided by Anderson et al., (1999, p. 4) who state a system is ‘an organised whole made up of components that interact in a way distinct from their interaction with other entities and which endures over a period of time.’ These components can be seen as being micro-, meta-, or macrolevel

dependent on the system size and complexity. Applying these to my own study, microsystems can be understood to refer to small-size systems, such as individuals and couples. Metasystems focus on intermediate systems, which can include groups of nurses, doctors and patients. Macrosystems in turn focus on the larger systems, such as the health organisation itself, the general public and governing bodies. Regardless of which level is examined, Friedman and Allen (2014) argue that it must be viewed within the context of its broader community and its political context – again an idea which will become evident when the works of Checkland, Oshry and Gee are explored.

Each system is a unit of wholeness with a distinct property or structural limitation that delineates it from other systems, a property von Bertalanffy terms the system's boundary (Friedman and Allen, 2014). This boundary provides definition for the system in addition to making each unique, whilst some boundaries are clearly defined; others may be permeable. This is an interesting concept of GST and is pertinent to a study that is exploring discourses relating to barriers and boundaries.

Systems may be abstract or physical. Abstract in the sense of conceptual, a product of the human mind, that cannot be seen or identified as an existing entity. Contrastingly, physical systems have a material nature. Either system has the following main characteristics: subsystems, interrelations, boundary, purpose, environment, interface, constraints, input, output, feedback and throughput [figure 3.2].

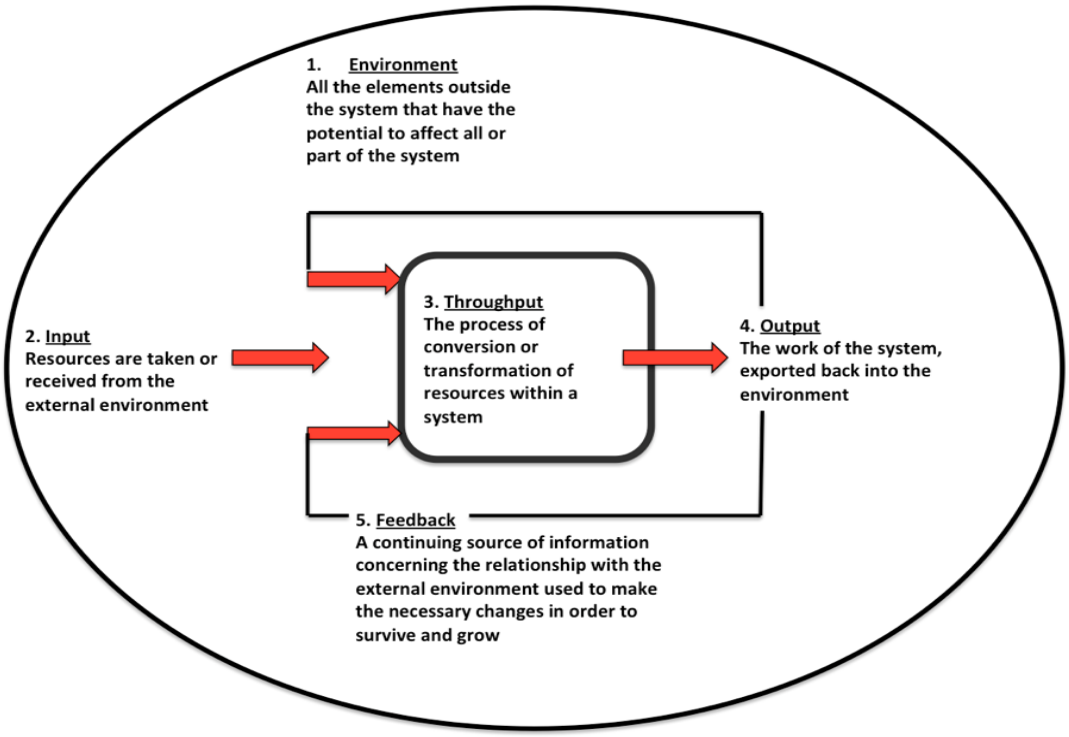


Figure 3.2 Systems Theory [Adapted from Katz and Kahn (1978)]

A **subsystem**, is a system which is part of a larger system, working parallel to each other or in a series with each other. Nursing staff and medical staff as organisations are subsystems of a hospital.

These subsystems are i**nterrelated**; that is, the function of one is somehow associated to the function of the other. Systems have **boundaries** within which all of its subsystems are contained and which establish the limits of the system, separating it from other systems. All the subsystems work together to achieve some overall **purpose**, the system's reason for existing such as patient healthcare.

A system operates within an **environment**, which is seen as everything outside the system's boundary. The environment surrounds the system, both affecting it and being affected by it. The point at which the system meets its environment is referred to as the **interface**. A system must face **constraints** in its functioning as there are limits to what it can do and how it can achieve its purpose within its environment – these constraints can be imposed from inside the system (e.g., lack of staff) or by the environment (e.g., restrictive prescribing secondary to regulation).

A system interacts with its environment by means of input and output. **Input** refers to anything entering the system from the environment (e.g., money, employees' time and effort), **output** is anything leaving the system crossing the boundary to the environment (e.g., better health services). Very often outputs' data are returned to the input of the system and used to regulate, evaluate and monitor the system's activity. Such a process is termed **feedback** and helps guide the system to achieving a more effective performance. Feedback can be negative, providing corrective feedback that helps maintain the system, or positive, which helps maintains the status quo.

Throughput is the process used by the system to convert inputs from the environment into products or services that are usable by either the system itself or the environment. Examples of products or services in the health system are plentiful and include diagnostics, caring and curing.

3.4.2 Contributions of Systems Theory to this Study

In the following section I provide an overview of the backgrounds and contributions of GST, SSM and OSF to the thesis. Considering the bespoke approach to CDA and Systems Thinking used within this thesis, figure 3.3 shows where Systems Thinking and the works of von Bertalanffy and General Systems Theory, Checkland and Soft Systems Methodology, and Oshry's Organic Systems Framework intersect with the theoretical framework and design. This section examines the systems element of this framework.

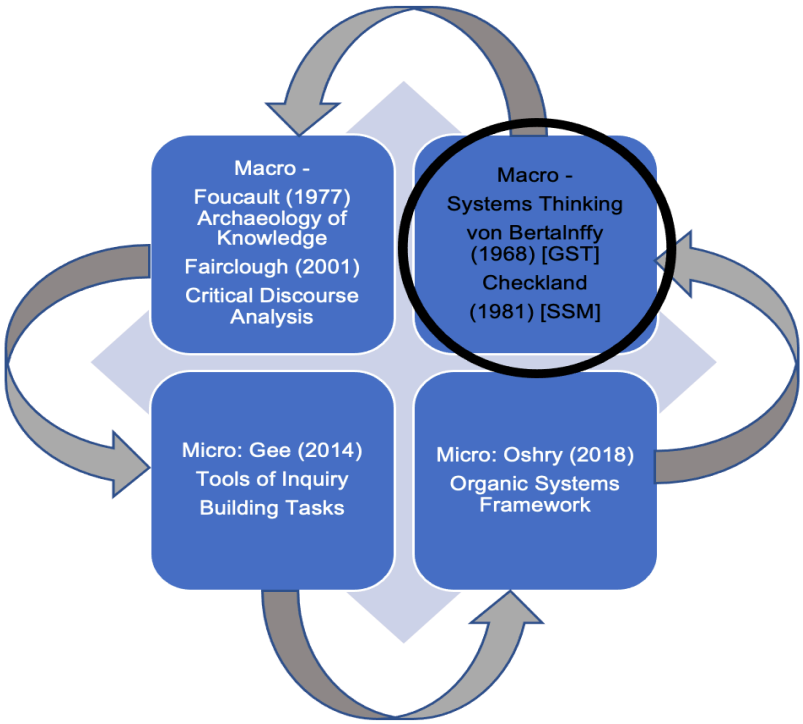


Figure 3.3 A bespoke approach to CDA and Systems Thinking showing key points of intersection with theoretical framework [Adapted from McNamara (2007)]

3.4.2.1 Ludwig von Bertalanffy and General Systems Theory

Ludwig von Bertalanffy, as mentioned above, is credited with being the originator of general systems theory (GST) which refers to a 'general science of wholeness' to simplify world complexity to the human mind and make it more understandable (Bertalanffy, 1968). According to Bertalanffy, it is crucial to look at systems as a whole, because in the past, science tried to explain observable phenomena by reducing them to an interplay of elementary units investigable independently of each other (Cordon, 2013). On commencing my studies, I initially wished to focus on the ANP role and identity in isolation but soon realised that this was impossible as the 'players' or 'social actors' (Saunders et al., 2016) within the system have such an impact on the role, hence an allegiance to systems thinking. The introduction of GST allowed the system to be examined as a whole, with its relationships, and interactions with other systems, as a mechanism of growth and change (Friedman and Allen, 2014).

Simply put, GST is about engaging with the richness and dynamism of the world around us and can be used to understand how things around us work. This outlook is

aligned quite significantly to the works of Gee and his take on discourse analysis, which will be discussed in the next chapter.

3.4.2.2 Peter Checkland and Soft Systems Methodology

Peter Checkland (1930-) is emeritus professor of systems at Lancaster University and a noted systems thinker. His SSM evolved as a response to the models developed by earlier system thinkers, including von Bertalanffy. Whilst von Bertalanffy had used biological systems as a way of trying to model human activity systems, Checkland realised that such human activity systems are too 'messy' to be modelled in this simple fashion. Chapman (2004, p. 40) identifies that a 'key feature of messes and difficult policy issues is that there are valid different perspectives on the issue or situation, which interpret information quite differently'. Checkland acknowledged that a better version of systems thinking needed to be developed which could incorporate the greater degrees of complexity that he recognised in larger, human activity systems. Beginning with the presumption that 'systems are in the eyes of the beholder' he constructed a model that recognised and worked with the problems and ambiguities inherent in a situation (Checkland and Scholes, 1990). These problems can be considered as either 'hard' or 'soft', each with unique characteristics requiring markedly different approaches to resolve. 'Hard' problems are well defined with 'what' and 'how' determined early in the research with a definite solution existing whereas 'soft' problems consider social and political elements that confound defining as well as resolving the problem (Checkland, 1981). A way of demonstrating this distinction between Checkland and his predecessors can be shown by looking at the degrees of complexity shown respectively by a computer's operating system and the workings of my own study setting, the Irish health service. The healthcare system is far less well defined and commonly understood than the workings of a computer, and views of health services will differ greatly dependent on the experience that individual has had of the system whether as a patient, doctor, nurse, manager or, indeed, an ANP.

SSM is based upon a single concept: that we model systems of purposeful human activity ('soft systems' – what people do), rather than data management or IT components (the more useful focus of system analysis or 'hard system'). To address

these ‘soft’ problems, Checkland developed the iterative approach of SSM that consists of the following seven distinct stages:

1. Define and understand the problem situation – enter the situation considered problematic
2. Express the problem situation – through rich pictures
3. Clarify what the system exists to achieve by defining root definitions of relevant systems of activity
4. Build conceptual models of the systems requirements to adequately address each of the root definitions
5. Compare these conceptual models with the real world
6. Identify feasible and desirable changes to improve the situation
7. Take action to improve the problem situation

[Adapted from Checkland (1981)]

This conventional seven-stage model of SSM is shown in figure 3.4 and is adapted from the original figure created by Checkland, (1981).

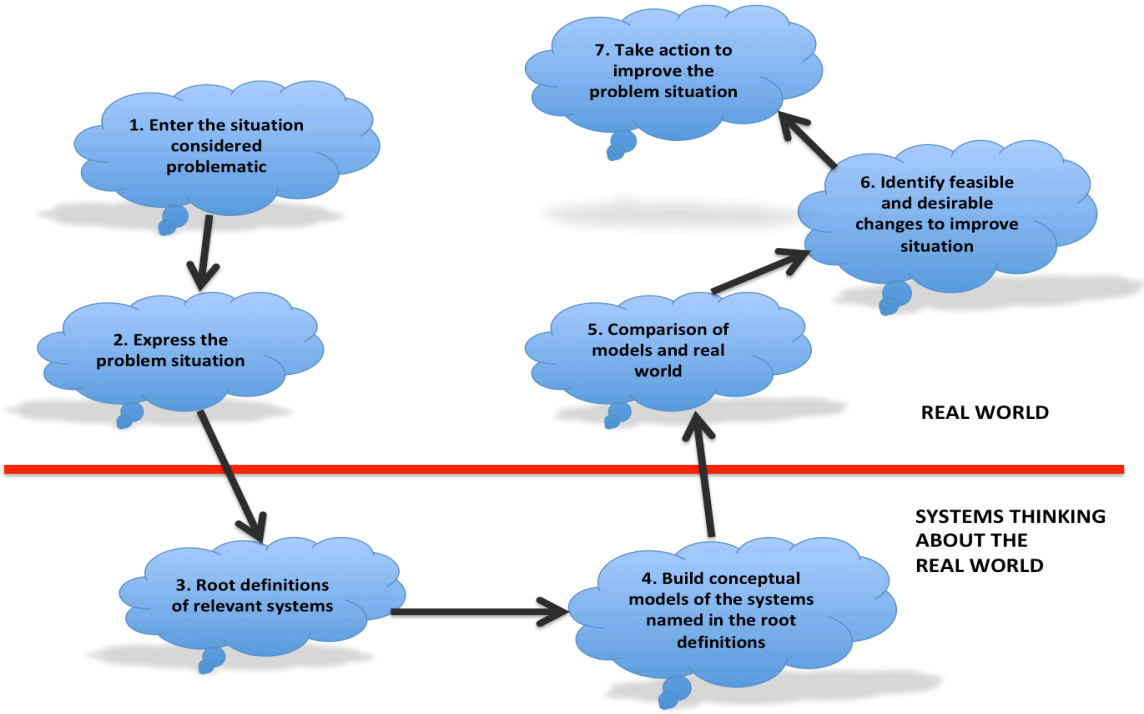


Figure 3.4 The conventional seven-stage model of SSM (Checkland, 1981)

Unlike previous system analysis tools, SSM questions what operations the system should perform, and more importantly, why (Gasson, 1994). The methodology is systemic rather than systems focused, calling upon the tradition of general systems

theory in acknowledging the disparate elements of a situation. Rather than trying to find root causes to solve problems, SSM permits the individual to just use logic to define what 'good' looks like and move towards it. With this in mind, one can see that SSM is a useful tool for analysis of approaches that wish to understand the connections, conflicts and discrepancies between elements of a situation rather than attempting to subsume all elements into a single perspective (Gasson, 2015) which makes SSM apt for this study. SSM ties in well with systems thinking as it invites all relevant stakeholders to participate in the process of improvement, taking account of their different perspectives, and this in turn, has the effect of engaging them in the change process and moving towards a process of continual improvement (Kalim et al. 2004).

3.4.2.3 Barry Oshry and the Organic Systems Framework

The OSF has evolved gradually out of Barry Oshry's experiences of witnessing a multitude of multi-class whole systems living out their existence and observing systems both from the outside – seeing the structure and processes of the whole – and from the inside – listening to the experiences of members within these systems. Oshry (2019) proposes that these direct observations are the foundation of his OSF. Considering OSF as a scientific paradigm, Oshry (2019, p.17) argues that it can be considered a 'serious candidate for scientific paradigmatic status' as it is based on criteria outlined by Thomas Kuhn (1996). These criteria include that the OSF is descriptive and predictive; it offers improved solutions to existing social system problems; and it opens up broad avenues for future research. These criteria and their interpretation tie in very much with the aims of this thesis. OSF dovetails and compliments the fields of GST and SSM in which "a system has come to mean an integrated whole whose essential properties arise from the relationships between its parts, and 'systems thinking,' the understanding of a phenomenon within the context of a larger whole" (Capra, 1996, p. ?). Oshry proposes that OSF meets this enlarged definition as it has a language for describing systems as wholes; it is a framework that allows us to understand and influence the widest range of system phenomena; how, as system members, we experience ourselves, our relationships with others, the

systems we are part of, other systems, and the relationships among systems, and it allows us to take more informed actions based on these experiences.

A key stance of Oshry's OSF is the ideology that whilst human beings are the most social of social creatures, we are blind to the workings of the whole systems of which we are part. We do not notice how the structures, relationships and processes of these whole systems affect our consciousness; that is, how we experience ourselves, others, and other systems. We don't see spaces as we fall in and out of them and in turn this blindness results in familiar disempowering scenarios with costs in personal stress, broken relationships, missed opportunities, diminished effectiveness and contribution, and destructive behaviours within and across systems. Oshry's life work (1999, 2007, 2018, 2019, 2020) has been concerned with transforming this 'system blindness' with all of its costs, into 'system sight' with all of its productive possibilities. McNamara and Teeling (2021) advocate that this human systems framework has the potential to strengthen and extend a key way of knowing for all health care professionals.

Applying this thinking to the healthcare system, we can see that some interactions in the system go well, others not so well; we feel close to some healthcare professionals and distant from others; we feel cooperative here and competitive there; we have our evaluations and judgements of others along with our emotions including comfort, discomfort, fear and love. Oshry (2020) believes that these experiences feel specific to these people and to our unique circumstances as if this is who these people really are. However, he argues that when we lift the veil and look beneath the surface of these day-to-day interactions, a very different picture emerges, one he suggests that has 'the potential for totally transforming our experiences of ourselves and others, and one that opens clear paths to creating satisfying and productive relationships, creativity and contribution' (Oshry, 2020, p. 13). What interactions happen below the surface are referred to as patterns of systemic relationships (what the whole is) and patterns of systemic processes (what the whole does). The following section outlines these patterns in more detail.

Whole Systems as Patterns of Systemic Relationships

As mentioned, on the surface we see ourselves interacting daily with others, Oshry (2020) notes that under this surface we see ourselves moving in and out of three key systemic relationships that determine essential properties of whole organisation systems – Top/Bottom, End/Middle/End and Provider/Customer [figure 3.5]. These patterns exist at all levels and in all types of social systems, existing in hierarchical and non-hierarchical systems. Regardless of our role and position in these social systems, we are continuously moving in and out of these relationships, sometimes on one side and sometimes on the other.

SYSTEMIC RELATIONSHIPS		
TOP/BOTTOM	END/MIDDLE/END	PROVIDER/CUSTOMER
		

Figure 3.5 Organic Systems Relationship [Adapted from Oshry, 2007]

Those at the top of organisations shape the overall system creating the right conditions for the organisation to flourish, to cope with threat and to recognise and seek out opportunities. In this environment, Tops have designated responsibility for the system, project or process whereas the Bottoms are members of this system, project or process. The Top World is a world of complexity, accountability and uncertainty and the Bottom World is a world of vulnerability and being disregarded. In these worlds, Tops feel responsible for success and become overburdened 'sucking it up', whereas Bottoms feel no responsibility and become oppressed by what they perceive to be remote, disengaged and indifferent managers at the top and middle of their organisations [figure 3.6].



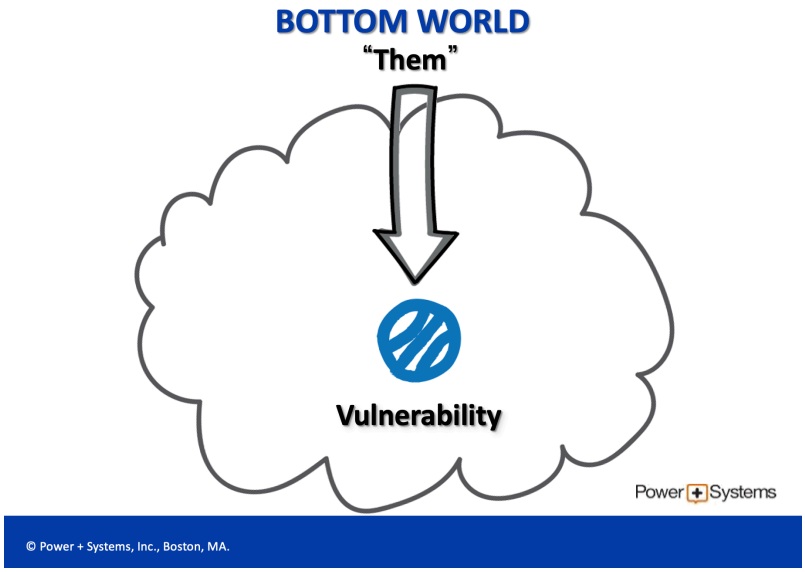


Figure 3.6 Top World and Bottom World (Power and Systems, 2018)

One consequence of this imbalanced relationship is that Tops' attention can become overly tied up coping with immediate issues to the extent that important longer-term, but not immediate issues, are not dealt with, issues that Bottoms may not even be aware of. Tops in turn become increasingly burdened, feel alone in their responsibility and are concerned that they may not be doing all that they should be doing. As a consequence of this sucking up by Tops, Bottoms are excluded from responsibility and are trained into incapacity. Examples of this relationship from practice, include the idea that ANPs are Tops in regard to the management of their cohort of patients, for example seeing all patients that attend the ED with minor injuries, and that this results in junior doctors as bottoms being trained into incapacity and not being able to deal

with these patients. From the other side, ANPs are seen as bottoms by the restrictions on their practice that are in play within the healthcare system, resulting in them becoming disenchanted with the ANP role.

At other times we see ourselves moving in and out of End/Middle/End relationships. In the middle, we can become torn between the conflicting agendas, needs, desires or priorities of our managers or Tops, on the one hand, and those who report to them, such as workers, on the other. The more burdened Tops become, the more they will look to Middles for support and the more unhappy Workers are, the more they will look to Middles to fix things. In this End/Middle/End relationship responsibility for success flows from both Ends to Middle with Middle feeling responsibility for resolving Ends' issues, with both Ends feeling no responsibility for success [figure 3.7].

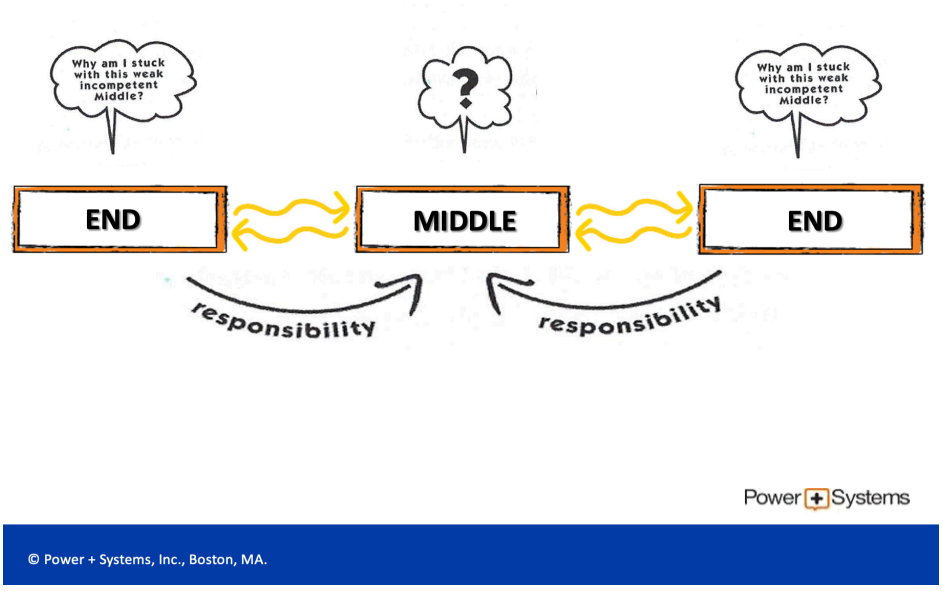


Figure 3.7 End/Middle/End Relationship (Power and Systems, 2018)

In this relationship in which the responsible Middle is continually stretched and torn between the demands of both Ends, it is not uncommon for Middles to become overwhelmed and burnt out, never fully pleasing either End and in turn dropping out of the relationship in anger and futility. Ends, on the other hand, who find it easier dealing with the Middle, find it more difficult when Middle is gone and unable to work with each other. Examples of this relationship in practice include ANPs being torn between the demands of the Director of Nursing and Consultants who each have their

own agendas as to what the ANP should be doing – this affects the ANPs as they cannot always get to certain elements of the role such as research, education and leadership.

We are in a Provider/Customer systemic relationship moving in and out of each of these roles, sometimes as the Customer looking to the Provider for services or products, and sometimes we are the Provider of these services and products. Again, comparable to both the previous relationships, similar outcomes occur in the Provider/Customer relationship; the Provider feeling responsible for delivery and the Customer seeing themselves as not responsible [figure 3.8].

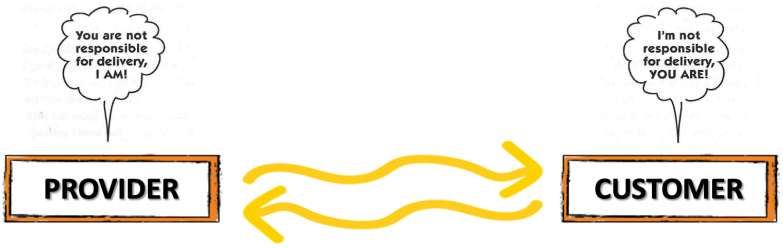


Figure 3.8 Provider/Customer Relationship (Power and Systems, 2018)

Problems occur within this relationship when Providers no longer continue to provide satisfactory services to the Customer. Customers, the ultimate validators of our systems, feel righteously done-to, neglected and short-changed, and complain about the inability of the system to respond appropriately to their needs. Providers in this environment of responsibility feel unfairly judged. An example of this from practice is where an ANP is identified as a Provider and feels responsible for the service that they deliver. Preoccupied with targets related to waiting times, hospital admissions and so on, considered to be a key part of their *raison d'être*, they feel unfairly judged when targets are not met for whatever reason, whether restricted guidelines and scope, and

by constant comparison to the medic. Equally, negative self-judgement may arise when ANPs cannot deliver on certain elements of their role such as research, education and leadership.

Through reading and learning about these relationships, it is apparent that there is considerable confusion and unawareness about what is occurring within the system. As mentioned, this inability to see the spaces we fall in and out of results in familiar disempowering scenarios with costs in personal stress, broken relationships, missed opportunities, diminished effectiveness and contribution, and destructive behaviours within and across systems. For Oshry (2007, 2018) systems thinking helps us overcome this system blindness by providing us with choices.

Oshry (2018) provides us with the analogy of two doors to explain these choices. Door A [figure 3.9] leads to the reflexive habitual and disempowering responses for Tops, Bottoms, Middles, Ends, Customers and Providers where we end up in the dysfunctional scenarios of organisational life that have been discussed. Door B [figure 3.10] leads us to more intentional behaviours and empowering responses, where we can do something about it and provide leadership that will build robust systems.

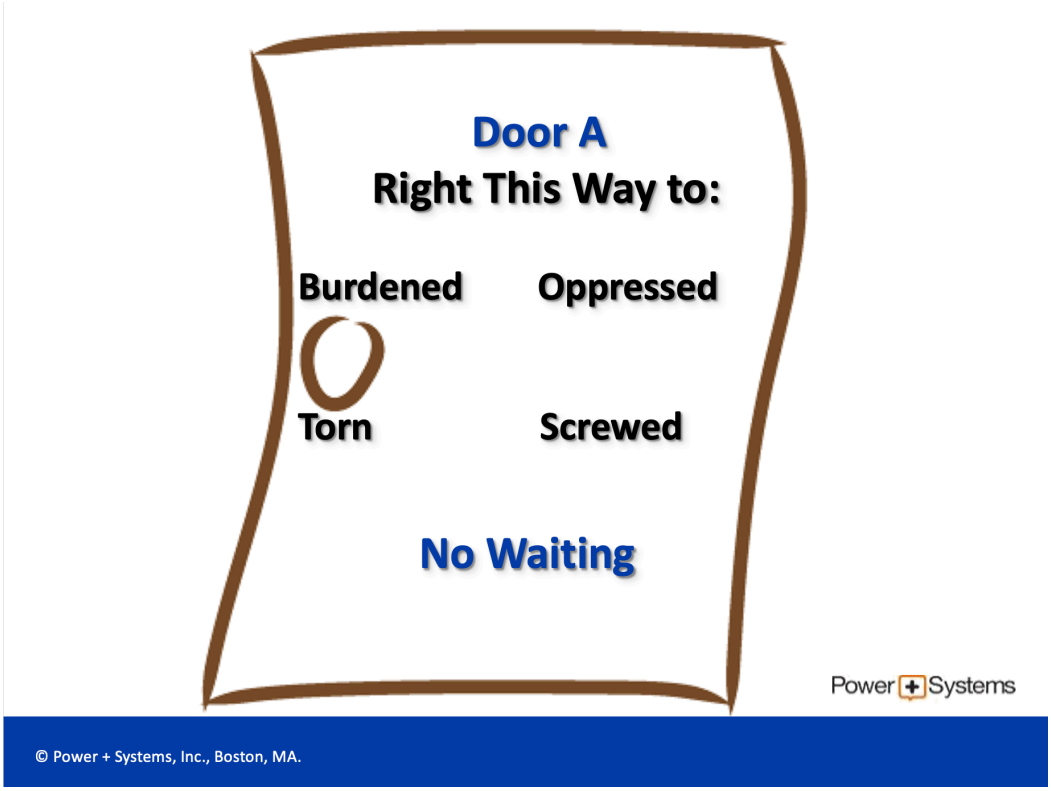


Figure 3.9 Door A (Power and Systems, 2018)

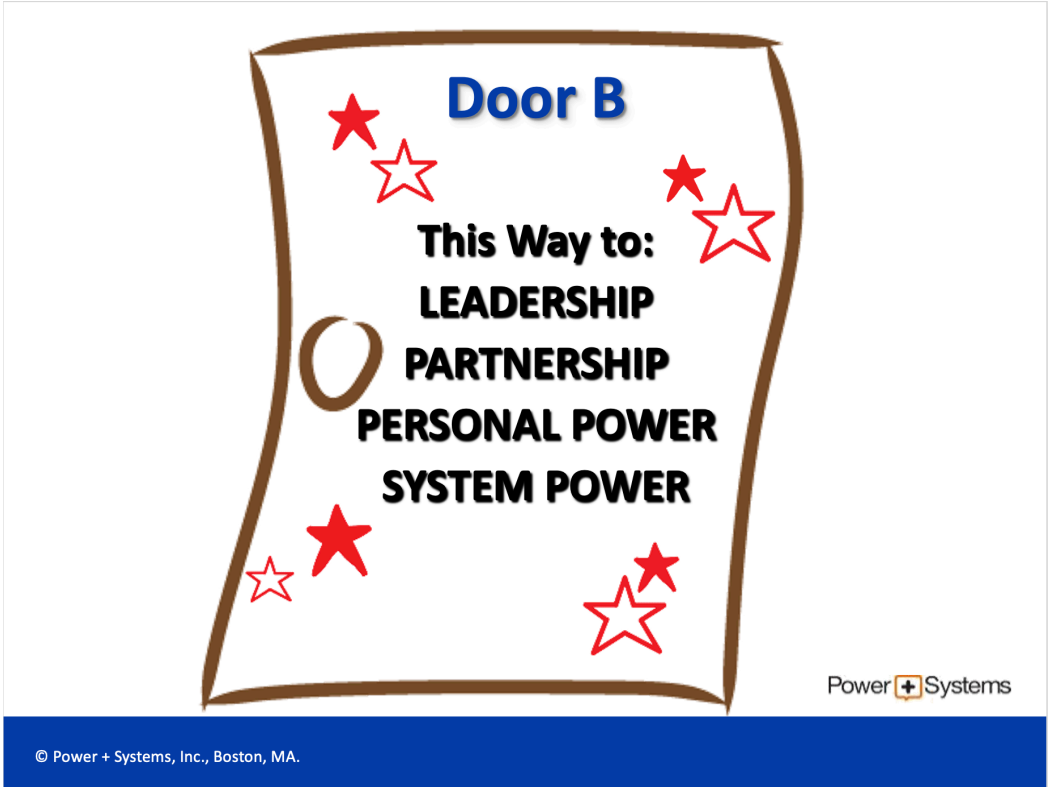


Figure 3.10 Door B (Power and Systems, 2018)

As Tops, moving through Door A, we will continue to suck up responsibility to ourselves and away from others, and become the burdened Top [figure 3.11, first row] or we can choose to enter Door B and be a Top who creates responsibility throughout the system [figure 3.12, first row]. Moving through Door A, as Bottoms we will continue to hold Tops responsible for our condition and the condition of the system and in turn become oppressed [figure 3.11, second row]. By selecting Door B, we can be Bottoms that are responsible for our condition and for the condition of the system [figure 3.12, second row]. For Middles, rather than opening Door A and sliding into the middle of other peoples' issues and becoming torn [figure 3.11, third row] we can instead enter Door B and be a Middle who maintains independence of thought and action [figure 3.12, third row]. Taking Door A, Customers will stay aloof from the delivery system, holding it responsible for delivery and in turn become the righteously done-to Customer [figure 3.11, fourth row], whereas by choosing Door B we can be a Customer who gets in the middle of delivery processes and help them work for us [figure 3.12, fourth row]. See Table 3.1 for summary.

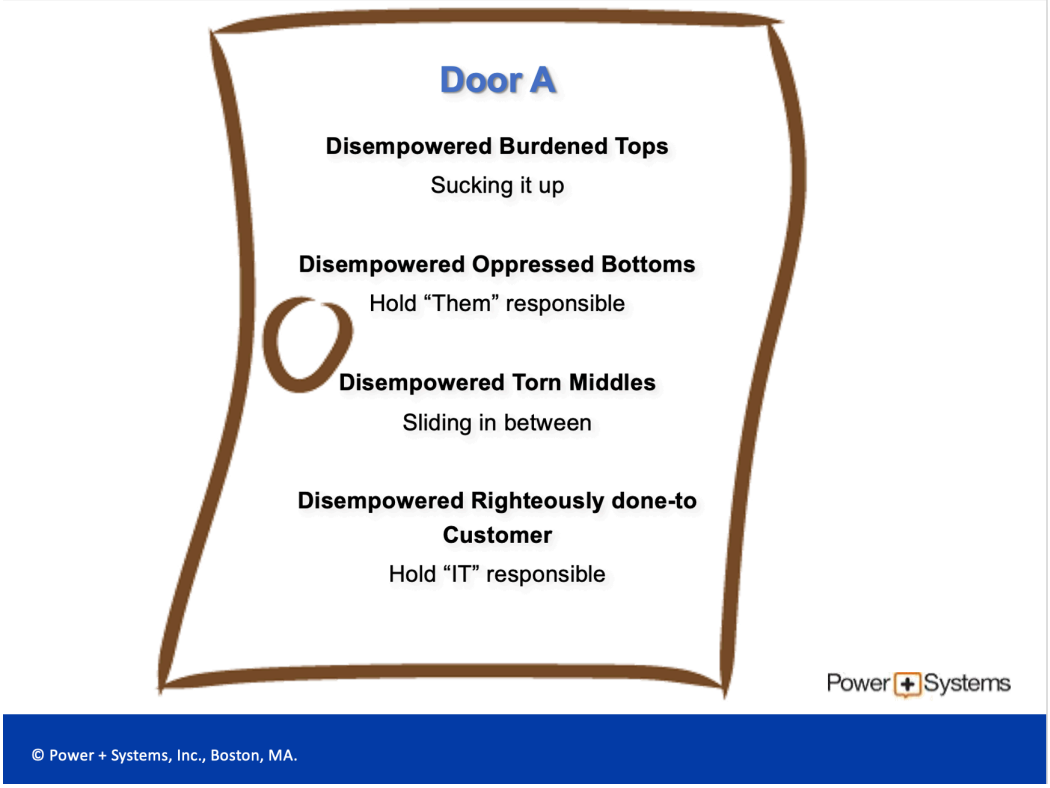


Figure 3.11 Door A Disempowering Reflex Responses (Power and Systems, 2018)

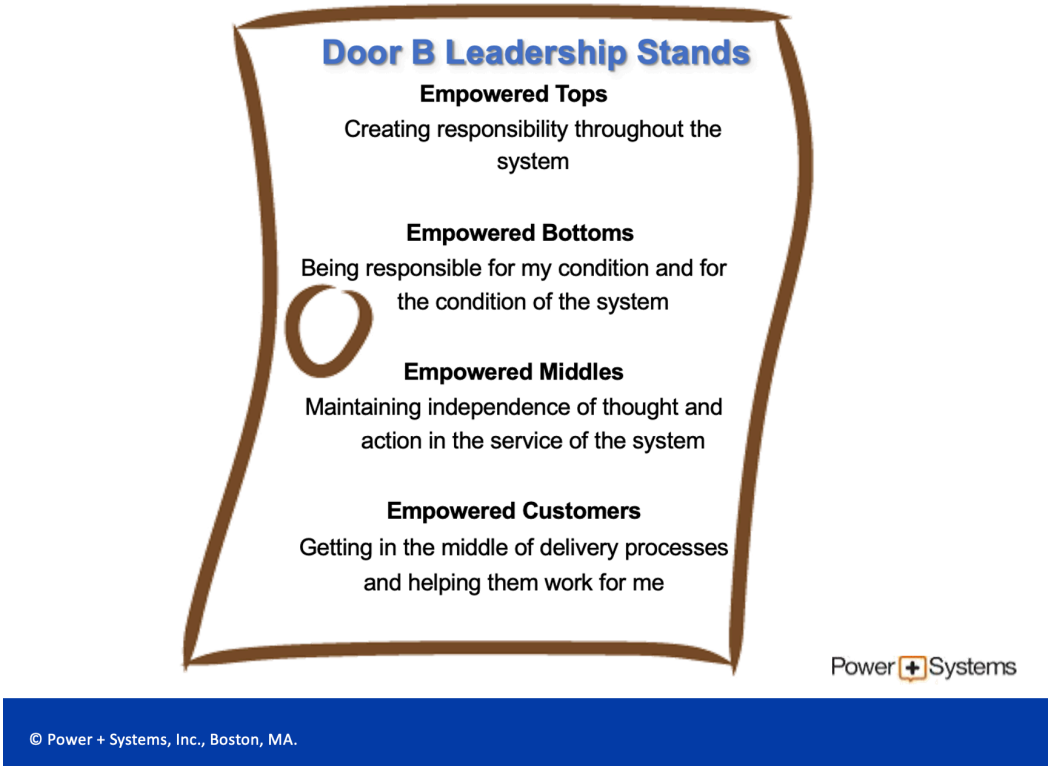


Figure 3.12 Door B Leadership Empowerment Stands (Power and Systems, 2018)

Door A		Door B
Burdened Tops Sucking it up	→	Empowered Tops Creating responsibility throughout the system
Oppressed Bottoms Hold "Them" responsible	→	Empowered Bottoms Being responsible for my condition and for the condition of the system
Torn Middles Sliding in between	→	Empowered Middles Maintaining independence of thought and action in the service of the system
Righteously done-to Customer Hold "IT" responsible	→	Empowered Customers Getting in the middle of delivery processes and helping them work for me

Table 3.1 Moving from Door A Disempowering Reflex Responses to Door B Leadership Empowerment Stands

Oshry (2018) further proposes that this blindness comprises of five dimensions: *relational, spatial, temporal, positional* and *process blindness*. We experience *relational blindness* when we fail to grasp the idea that we are constantly in systemic relationships to one another and that our relative position in organisations, whether that be top, middle or provider, structures our relationships. We suffer from *spatial blindness* when we see only our fragment of the system but fail to see the whole, what is happening in our world but not in others. *Positional blindness* occurs when we see fixed roles clashing with other fixed positions but neglect to realise the uncertainty and ambiguity that underlies these positions, the conditions associated with them and the predictable patterns of behaviour that those conditions summon. *Temporal blindness* shrouds the story of our system and shared history that has brought us to this point. P*rocess blindness* results when we fail to pay attention to what Oshry (2020) refers to as the four fundamental organisational processes: individuation, integration differentiation and homogenisation. *Process blindness* occurs as result of us failing to appreciate the relative balance between these processes, the intensity that they are expressed in different contexts and the part that we enact in strengthening and weakening them. These processes are now discussed in detail.

Whole Systems as Patterns of Systemic Processes

When Oshry (2018) talks about systemic relationships, he is very clear that as members of whole systems we see people and groups of people, we interact with some people and not with others, we have our feelings toward one another and our judgements, we find ourselves in one form of a drama or another, with the good people versus the not so good ones. However, he proposes that what we do not see is these systems as whole organic entities interacting with their immediate environments. Seeing this whole system entity, Oshry (2020, p.17) argues will 'enable us to avoid predictable dysfunctional scenarios that human systems are prone to, and it will reveal a clear pathway for creating healthy, vibrant human systems, ones capable of outstanding individual and collective achievement and contribution.' To achieve this Oshry (2018) provides us with the language of whole system processes; individuation, integration differentiation and homogenisation [figure 3.13]. The patterns of processes that systems fall into will shape how members experience one another, their system and other systems. It is about finding balance among these processes. Whilst each process has its unique potential contribution to the survival of the whole, each process has the potential to diminish system survivability if one predominates while others are suppressed.

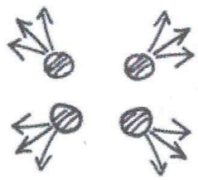
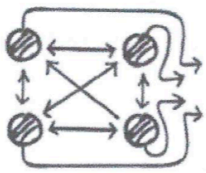
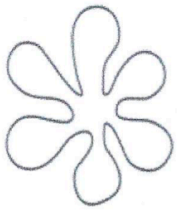
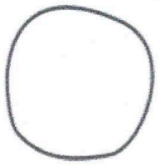
			
Whole systems Individuate	Whole systems Integrate	Whole systems Differentiate	Whole systems Homogenize
The parts operate independently	The parts work collaboratively	The whole develops a variety of structures and processes	The whole maintains commonality across the system

Figure 3.13 Language of Whole System Processes

Individuation is about the parts of the system operating independently. Individuation is about having the freedom to innovate and realise one's personal potential. Integration on the other hand is about the parts of the systems operating collaboratively. Integration concerns system members functioning as parts in the service of common goals and agenda where members nurture and support each other's talents and skills. Differentiation contributes to the system survival by providing the whole with a variety of structures and processes for coping with the dangers and threats that exist within the environment. Differentiation is about harnessing and elaborating diversity. When the system is homogenising, system information, knowledge, values and capacity are distributed throughout the system. Homogenisation is about identifying and focusing on what unites us.

A Whole System Expressing its Power and Love

All of these processes happen within systems with variations in balance, intensity and blind reflex or conscious choice. Early in the development of his theory Oshry (1999, 2007) focused on the tensions that exists between these processes and considered how a system expressed its Power and its Love. Individuation and differentiation working together are how a system expresses its Power processes [figure 3.14]; independence, freedom to pursue individual dreams, to explore and challenge ourselves. These processes are the outward acting system processes and are the parts and the whole becoming all that they can be.

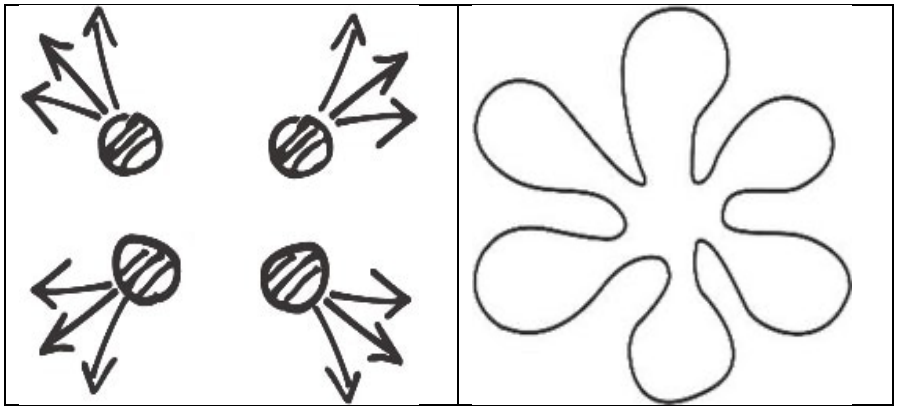


Figure 3.14 A system exerting its Power by individuating and differentiating

Integration and homogenisation working together are how a system expresses its Love processes [figure 3.15]; connectedness and working together in common cause, mutual responsibility and unity. Integration and homogenisation are the inward focusing system processes.

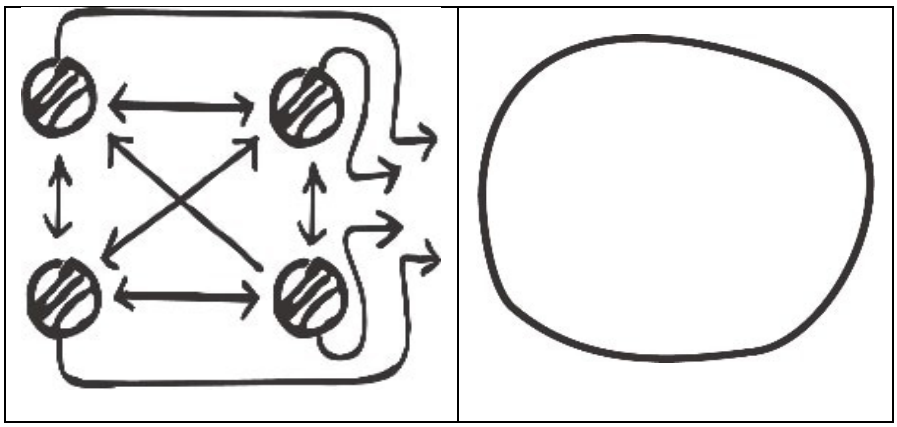


Figure 3.15 A system expressing its Love by integrating and homogenising

System Power processes turn us loose, unleashing competition, heating up the system, allowing us to elaborate our differences and operate independently of one another. System Love processes bring us together supporting cooperation, focusing on our commonalities and allowing us to work interdependently.

Highly individuated systems with little integration lead to chaos with no collective action, whereas highly integrated systems with little individuation results in apathy and reduced creativity. Highly differentiated environments with no homogenisation result in territorial silos with little or no sharing, while highly homogenised systems lead to considerable unity but limited repertoire for engaging with the environment. Connecting this thinking with the healthcare system, McNamara and Teeling (2021) suggest that understanding these processes can help us to appreciate the importance of maintaining a balance between the development and maintenance of our distinctive professional identities and expertise, on the one hand, and the need for interprofessional collaboration, on the other. Returning to examples from practice, systemically, the healthcare system may be characterised as highly differentiated with no homogenisation, where numerous specialities share little and fail to cooperate across boundaries. Moreover, it can be highly individuated with minimal integration,

which results in territorial stances amongst the professions and siloing. This can lead to turf wars, reduced organisational productivity and poor working relationships. Within this environment, the structure has shaped consciousness; no one is stress free, we have become hardened and fail to contribute, our issues have become personal and we assign blame, relationships have broken and we are clueless.

Before I move onto the significance and contribution of GST, SSM and OSF to this study, I should highlight that I do not claim that SSM or OSF produces ultimate and conclusive solutions to problems. I find the SSM and OSF approaches fascinating, as I believe they possess possibilities for resolving complex problem situations within many spheres of nursing and human-activities systems. In the following sections, I provide the rationale for my belief that GST, SSM and OSF are significant for my study. I will show how I have used elements of Checkland's iterative approach to SSM to, among other things, scope my study, examine my setting and select participants. I will show how OSF allowed me to adopt the position of an observer and examine the patterns of systemic relationships and processes with which organic systems interact with their environments.

3.4.3 Significance and Contribution of GST, SSM and OSF for this Study

GST, SSM and OSF are especially valuable when used as a framework to address the many complicated problems and systems issues in health services (Cordon, 2013). According to some authors, social sciences, including nursing, have had some success in identifying and describing complex real-world problems, but have had difficulty in offering a means of resolving those problems (Land, 1994). The stimulus for resolution and change is so often impeded by political, economic and environmental factors. Healthcare is a system with various levels of complexities and, in attempting to reduce it to separate manageable parts, its meaning can be lost. It involves decision makers, policy makers, and groups of people in institutions, organisations and agencies that shape the way in which healthcare is delivered to the public. GST, SSM and OSF acknowledge the importance of these individuals and studies a situation from many points of view so that complex problem situations can be better understood (Gasson, 2015). The aim is to progress from discovering a problem situation to taking action within it. From the literature review, it is evident that

the various epistemological perspectives among and within different health disciplines have created barriers and boundaries between various health professionals, including ANPs.

These silos are a challenge for health professionals, but Cordon (2013) suggests that using systems theory can address these silos and can help in identifying an overarching goal to enhance patient care. To do this, professionals must first be unified as a team and identify as a team an overall purpose and goals. Additionally, they must share their knowledge with each other so that professional boundaries are blurred, and members think more alike. SSM is designed to 'cope with the vagaries of human activity' and acknowledges that the attitudes and views of individuals within a system may present differing perspectives of a problem, and ultimately 'gain varying satisfaction from a particular solution' (Land, 1994, p. 80). McMurtry (2007) suggests that health professionals need to learn to make their values become more apparent to one another. Whilst this may appear simple, Freidman et al. (2007) argue that this may not be the case, as for most health professionals, our focus lies only on one part of the system, the other parts beyond those barriers being largely invisible to us. We have little or no knowledge of what is happening in the rest of the system, being particularly oblivious to our potential role in contributing and helping to sustain the very conditions we deplore. This results in an unintended but very real inability to see the whole system resulting in what Oshry (2007) aptly terms 'system blindness'. This notion is also seen in the work and thinking of Stitger and Cooper (2015) who discuss an outside-in sensing model for seeing, feeling, and thinking strategically, and in the work of Heifetz et al. (2009) who suggests that we 'get on the balcony' to examine the wider systemic environment. Cordon (2013) proposes that an inability to see the whole system is as a result of the hierarchies and power dynamics between various members that are prevalent in the health system. Our reflex responses are conditioned by our status and place in the system yet we do not discern this (Oshry, 2018).

Structural inequalities in the healthcare system create difficulties in forming functional health care teams. Rather than attempting to work as a team, Cordon (2013, p.21) argues that various health disciplines are still 'focusing on highlighting the magnitude of their contribution to healthcare by minimising the expertise of other health professions, in order to remain in power.' Checkland (1981) describe each of these

perspectives as a world view or what he calls *Weltanschauung* – 'one person's freedom fighter is another person's terrorist'. These *'Weltanschauungs'* were very much evident whilst reviewing the literature. They can be a force in coercing or resisting change and must be considered when exploring any system. The major strengths of GST include the ability to facilitate integration within health care systems, engage complex systems, understand change, as well as considering the micro-, meta- and macrolevels of systems. SSM, Lane (1994) argues, offers possibilities when there are no definite objectives or where objectives might vary from person to person and permits the use of dialogue and debate to decide what change is feasible and desirable within a system.

The goal of OSF, according to Oshry (2020), is to demonstrate how, through awareness of the underlying whole system structure and the processes, we can create satisfying and productive partnerships in all the systems of our lives, and how that awareness can support us in creating robust human systems, systems with outstanding capacity to survive, develop and to create and contribute. OSF offers improved solutions to managing issues that occur within systems. Rather than always returning to tested solutions that fail such as, rotating, firing, moving, counselling, and so on, OSF facilitates system members to see and master conditions in the system that are shaping their relationships. Regarding systemic relationships, this could mean shifting the locus of responsibility in the Top/Bottom, End/Middle/End, or Provider/Customer relationships. With regard to systemic processes, this means adjusting the balance or intensity of processes: individuation, integration, differentiation or homogenisation. OSF additionally offers broad avenues for future research. It allows us to stand outside systems, see them as whole, and eventually begin to see them as patterns of systemic processes and relationships. Rather than focusing just on the ANP role, the OSF it allows us to analyse it in its systemic contexts, a key aim of this thesis.

3.4.4 Rationale for using elements of Checkland's seven-stage framework

I now outline how I used elements of Checkland's iterative approach to SSM to, among other things, scope my study, examine my setting and select participants.

3.4.4.1 Define and understand the problem situation

The most critical parts of this step, according to Gasson (2015), are understanding the relationships, elements and main activities involved in the problem situation as well as deciding a boundary within which this situation can be improved. Checkland (1981) suggests that building a rich picture of the problem [figure 3.16] can demonstrate both the structure and the process of the system. The purpose of this diagram was to examine various aspects of the situation, without trying to structure or analyse it. This step within Checkland's framework allowed me to scope the study, examine the context and identify the discourses and language-in-use concerning the ANP role that were prevalent. Within this rich picture, I included as much information as possible so that a 'rich', in the sense of complete and wide-ranging, picture of how and in what environment the system operated was obtained. Just drawing this picture made me think of factors which affected the situation and I deemed it an iterative and cathartic process that stimulated my thinking and generated new ideas.

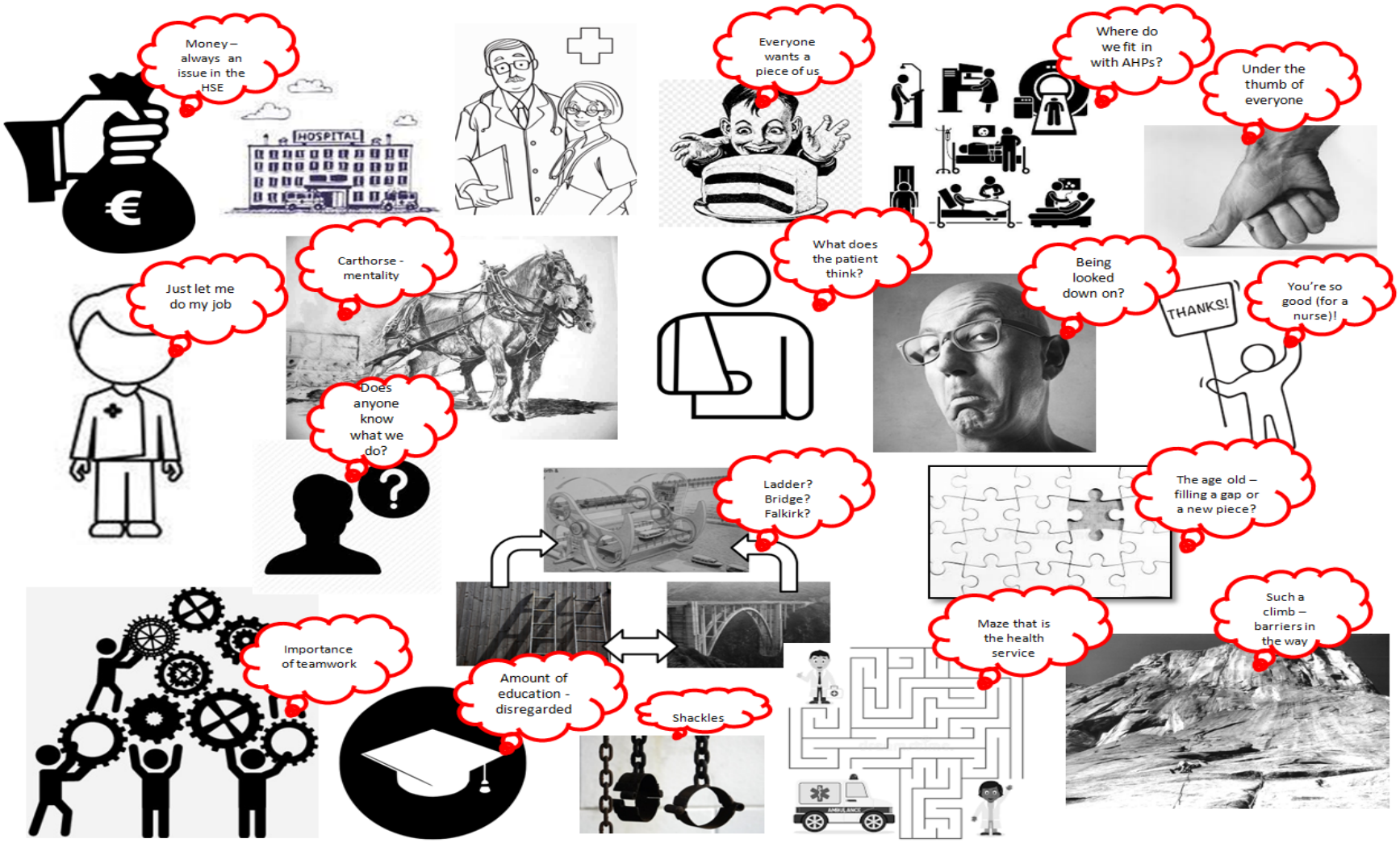


Figure 3.16 Rich Picture

3.4.4.2 Express the problem situation

Returning to the study's aims and objectives, I found this stage of Checkland's framework to be helpful in negotiating the system boundaries as well as helping me identify participants to take part in the study. Within this stage, I needed to define my relevant system of interest and separate out the various subsystems of activity required. By separating out these various purposes of the system, Gasson (2015, p.4) suggests that 'we can model the requisite activities separately, without worrying about trade-offs and conflicts between sub-systems which will come later.' Choosing what to focus on represented my first boundary judgement. For the purpose of this thesis, I decided that my first boundary judgement and primary system of interest would be the Ireland East Hospital Group (IEHG) [figure 3.17]. This is the largest and most complex of Ireland's hospital groups comprising eleven hospitals (6 voluntary and 5 statutory).

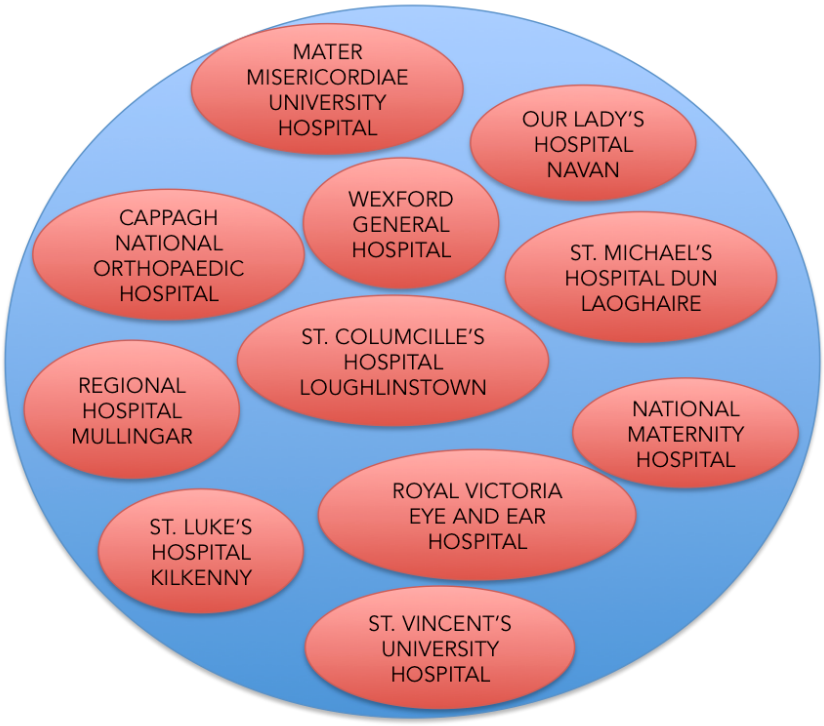


Figure 3.17 Primary System of Interest – IEHG

I could have chosen to focus down a level concentrating on nursing structures alone in the hospital system [figure 3.18].

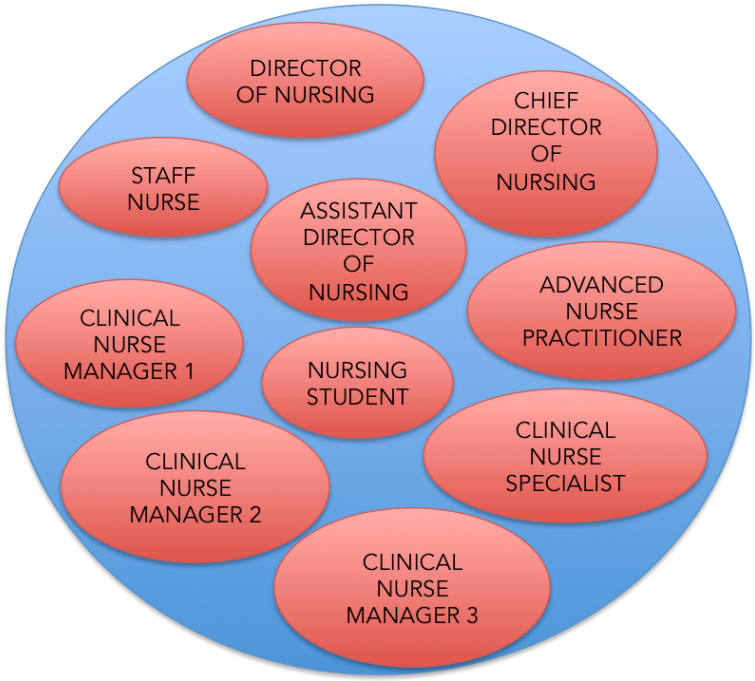


Figure 3.18 Nursing Structures in Hospital System

Alternatively, I could have focused up a level exploring service delivery across all hospital groups in Ireland [figure 3.19].

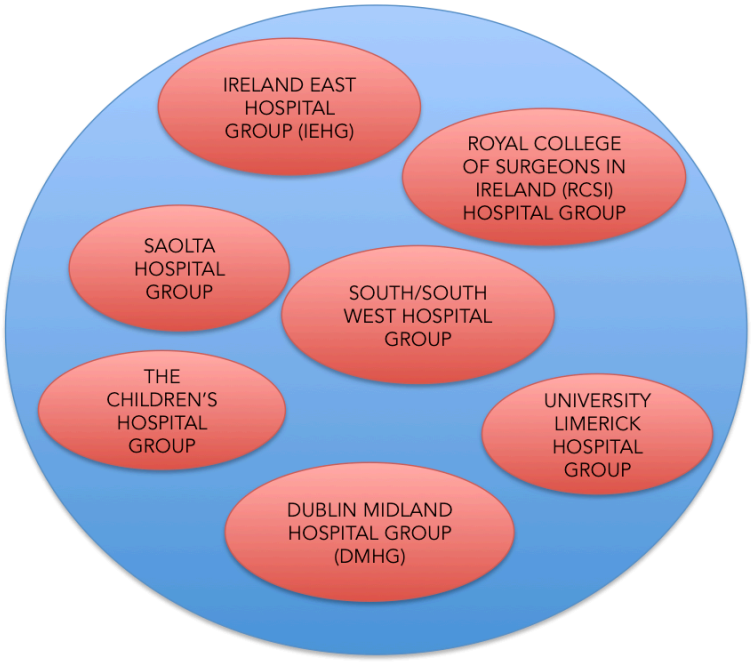


Figure 3.19 Hospital Groups Ireland

This systems mapping is a particularly useful model to make a first pass at systems analysis. There are no right answers to systems mapping. Using this process, I was primarily engaged with the skill of making and defending boundary judgements which helped me justify my sample and setting. Adhering to the principles of GST, it prompted important questions such as which groups of stakeholders are actually involved in the system and which might be relevant but not actually involved in the system and therefore placed in the environment (Katz & Kahn, 1978). Returning to my system of interest, I identified relevant component parts of this system by brainstorming everything that came to mind that I deemed relevant to the system. I placed on Stattys© everything that related to my system of interest, which permitted me to group related factors together and construct subsystems and further subsystems. This resulted in the creation of my subsystem of interest as shown in Figure 3.20.

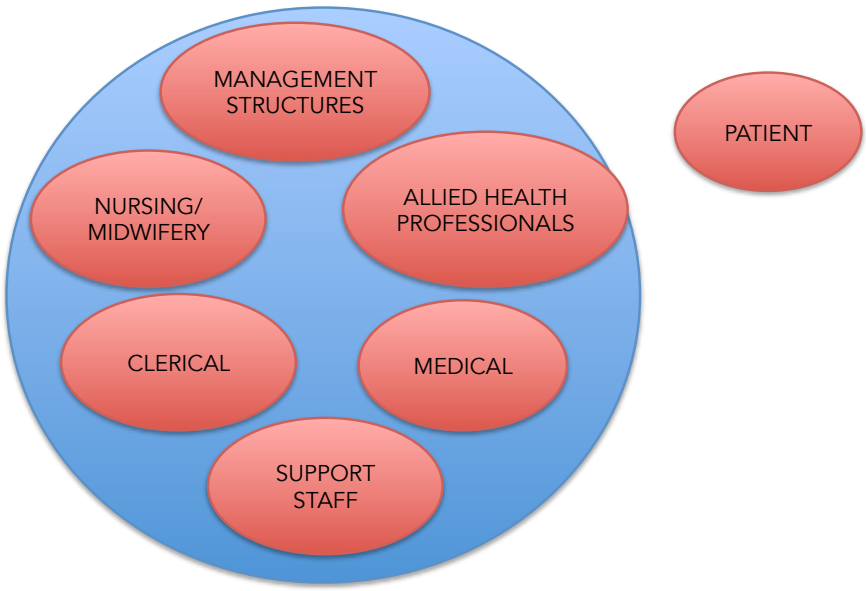


Figure 3.20 Subsystem of Interest

Applying systems theory and mapping allowed me to scope and bound the study. Mapping and brainstorming allowed me to determine who was involved in the system. This brainstorming was an iterative and cyclical process. For example, I had initially placed patients in the environment, as I considered that whilst they have the potential to affect the system, I believed they were outside the system [figure 3.20]. On reflection

and considering the ideologies of OSF, SSM and GST, I could see that patients have a stake in the system and therefore must be part of it. However, as the aim of this thesis is to gain an understanding of how ANPs are discursively positioned within current nursing and health system structures, I believed the inclusion of patients within this study would be of no benefit. Other organisations such as professional regulatory bodies, union representatives and the media were included in the environment as they have the potential to affect the system. Additionally, as this study's focus is on ANPs and not Advanced Midwife Practitioners, midwifery structures were excluded from the system as well as stakeholders that do not necessarily impact on or affect the ANP role such as clerical and support staff [figure 3.21].

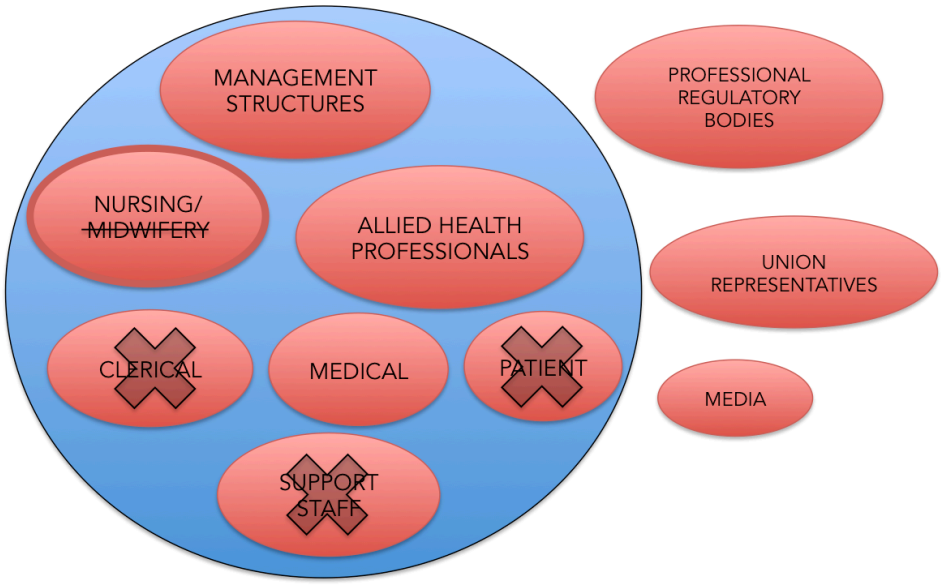


Figure 3.21 Revised Subsystem of Interest

3.4.4.3 Formulate root definitions of relevant systems

This element of Checkland's framework helped me name my system of interest and understand what the focus of my study should be. The purpose of this stage, according to Checkland (1981) is to name the system as he argues that naming a thing is important as you define exactly what you mean by your understanding of it. These definitions are expressed in terms of root definitions. A root definition is a concise description of an activity system which captures a particular view of it (Land, 1994). For example, an ED might be described as a system for patients with life threatening injuries, where expert and specialist multidisciplinary practitioners can provide

appropriate assistance and interventions to save their life. However, Burge (2015) emphasises that root definitions are not once-and-for-all definitions, but rather an attempt to embody a particular image. For my study, I identified and named the mission of the Irish health service as:

> *A health system to support Irish people's health and social care, allowing access to safe, compassionate, and quality care that delivers the best health outcomes in the most efficient and effective ways*

I additionally identified and named the mission of the Irish ANP sub-system as:

> *A sub-system to support Irish people's health and social care, providing safe, timely and evidence-based nurse-led care to patients at an advanced nursing level by undertaking and documenting a complete episode of patient care from assessment, diagnosis, planning, treatment to discharge.*

The naming of these systems enables others to understand, contribute to, or perhaps challenge my provided definitions.

3.5 Chapter Conclusion

This chapter has outlined the epistemological and ontological beliefs that provide the theoretical and methodological underpinnings of my study. The origins and development of the conceptual framework for the thesis have been discussed. Systems Theories, General Systems Theories (GST), Soft Systems Methodology (SSM), Organic Systems Framework (OSF) and how they are relevant to, and significant for, Irish Healthcare Systems and my thesis have also been discussed. The next chapter provides an overview of my chosen methodological approach and discusses how this approach is justified with respect to the philosophical premises of the study, its conceptual framework, the methodological guidelines on how to approach the research domain, and the specific techniques for analysis used.

Chapter 4 Critical Discourse Analysis

4.1 Introduction

In this chapter I provide an overview of Discourse Analysis and Critical Discourse Analysis (CDA) and consider some of the definitions that are in use concerning this methodological approach. Considering the bespoke approach to CDA and Systems Thinking used in this thesis, figure 4.1 shows how CDA and the works of Michel Foucault and Norman Fairclough intersect with the theoretical framework and design. I first examine the CDA element of this framework. The approach to discourse analysis that I propose is justified with respect to first, the philosophical premises; secondly, the conceptual framework; third, methodological guidelines on how to approach the research domain; and fourth, specific techniques for analysis. I examine the key concepts of CDA and discuss the key analytical tools utilised to interrogate the textual and conversational data, which constitute the study's empirical base. I provide an outline of the prominent theorist Michel Foucault and his contribution to discourse analysis, as well as an overview of other theorists that have played significant roles in the development and application of CDA. In particular, I consider the contributions and works of James Paul Gee (1948-) with a focus on his concepts of Building Tasks, specifically tasks related to building identity, relationships, politics (distribution of social goods) and sign systems and knowledge, and Tools of Inquiry. The rationale and justification for choosing this methodological paradigm are provided.

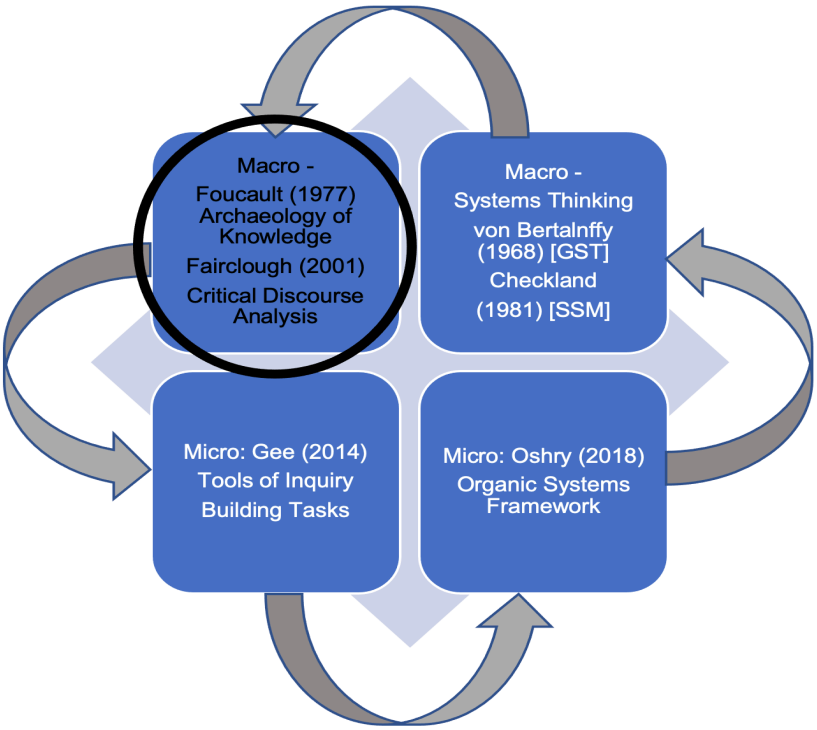


Figure 4.1 A bespoke approach to CDA and Systems Thinking showing key points of intersection with theoretical framework [Adapted from McNamara (2007)]

4.2 What is discourse?

In everyday language, the word discourse usually relates to conversation or discussion concerned with human expressions, often in the form of language. However, for academics, discourse is more nuanced. There are many descriptions of discourse provided by leading theorists with such diverse explanations that within the field of discourse analysis 'it is perfectly possible to have two books on discourse analysis with no overlap in content at all' (Potter and Wetherell, 1987, p. 6). In his book exploring the way language is used within the world of politics, Chilton (2004, p. 16) defines discourse as simply the 'use of language' whereas Fillingham and Süsser (1993, p. 100), suggest that discourse is 'anything written or said or communicated using signs'.

From a social perspective, Potter (1996, p. 105) proposes that discourse is 'talk and texts as parts of social practice' whilst Gee (2010, p. 7) advises that discourse is how language is used 'on site' to enact activities and identities. Gee (2010) elaborates on

this definition highlighting that these activities and identities are rarely ever enacted through language alone but are instead reinforced by what he calls the 'big D' Discourse. It is not just enough to get the words right, but Gee (2010) argues that it is necessary to get the clothes, gestures, actions, interactions, ways with things, symbols, tools, technologies, values, attitudes, beliefs and emotions right and all of this at the right time and place – an element of 'walking the walk' as well as 'talking the talk'. This view of discourse is discussed later in this chapter.

A shared perspective amongst the majority of academics is that the things people say or write draw from a pool of generally accepted knowledge in a society, while simultaneously feeding back into society to shape or reinforce such knowledge. Schneider (2013) proposes that what a society holds to be true changes over time, dependent on the ideas that members of a society exchange, and on the way in which these exchanges happen. From this outlook, one can ascertain that certain individuals in society are in particular influential positions to determine what is true, whilst others in an inferior position may be excluded from the discussion. In turn, Karlberg (2005, p. 1) argues that discourse theory is associated with questions of power either 'competition at best, coercion or domination at worst' and often with questions of institutional hierarchies which sequentially lead to domination and resistance. This position aligns with that of the most famous discourse theorist: the French philosopher, social theorist and literary critic, Michel Foucault (1926-1984).

4.3 Michel Foucault

Along with other social theorists, Foucault believed that knowledge is always a form of power, but unlike other academics of that period, he went a step further and informed us that knowledge can be gained from power; producing it, not preventing it (Mason, 2018). Carryer (2020, p.3577) suggests that there is a 'close nexus between language, knowledge and power, and few nurses fully appreciate how critical language is in asserting and demonstrating power. Foucault believed the world in which we live is structured by this knowledge. He theorised that certain people and social groups create and formulate ideas about our world, which under certain

conditions turn into what he called ‘unquestioned truths’ and in turn appear normal. Foucault’s theory states that knowledge is power:

> ‘…knowledge linked to power not only assumes the authority of the truth but has the power to make itself true. All knowledge, once applied in the real world, has effects, and in that sense at least, becomes true knowledge, once used to regulate the conduct of others, entails constraint, regulation, and the disciplining of practice. Thus, there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations.’
>
> (Foucault, 1977, p. 27)

Foucault (1972) argued that this power is generated by the micro-activities and everyday behaviours and from the bottom up. The focus of Foucault’s studies were the analysis of these ‘truths’ and their history (Potter, 1996). Examples include the development, demise and reoccurrence of statements on subjects like crime and punishment, mental health and sexuality (Foucault, 2001a; Foucault, 1991; Foucault, 1988). Initially, Foucault explored the rules that governed how these statements emerged, as well as how knowledge was historically ordered (Dreyfus and Rabinow, 1982). Foucault applied this approach, which he referred to as an *archaeology of knowledge,* to such areas as the history of medicine, psychology and social sciences (Foucault, 2001b). Utilising this approach, Foucault in essence, was examining the structures of knowledge. As a result, his early studies are often referred to as structuralist in nature. In his subsequent work, Foucault shifted his emphasis from the objects of social interaction to the subjects and as a result became more post-structuralist (Dreyfus and Rabinow, 1982). Throughout his work, Foucault showed how specific opinions came to be formed and preserved in society, what today is commonly referred to as hegemony (MacDonald, 2003).

4.4 What is discourse analysis?

From a historical perspective, the term discourse analysis, was first coined by Zellig Harris in the early 1950s as a method of analysing speech and writing. His main interests included examining language beyond the level of the sentence and investigating the relationships between linguistic and non-linguistic behaviour. As a

methodology, discourse analysis has its foundations in sociological and anthropological disciplines such as ethnomethodology and ethnography of communication (Heap, 1981; Mehan & Wood, 1975). Discourse analysis, broadly speaking, is the analysis and interpretation of the operation of systems of signs as they relate to communicative practices between humans (Traynor, 2004).

Communicative practices may relate to texts, whether written or spoken, or other multimodal approaches (Kress & Van Leeuwen, 2001) such as signs, sounds or visuals, or even tastes and smells dependent on which literature you peruse. Whilst the majority of discourse analysts admit that discourse can play out in these various forms of communication, their focus is overwhelmingly on language. This is seen in the definition of discourse analysis provided by Wetherell et al. (2001), who describe it as:

> '…the study of talk and texts. It is a set of methods and theories for investigating language in use and language in social contexts. Discourse research offers routes into the study of meanings, a way of investigating the back-and-forth dialogues which constitute social action, along with the patterns of signification and representation which constitute culture.'
>
> (Wetherell et al., 2001, p. i)

Included in discourse analysis is the examination of social interaction patterns. This is evident in the definitions provided by Gee and Brian Paltridge. Gee (2011) suggests that discourse analysis is the study of 'language at use in the world, not just to *say* things, but to *do* things.' Expanding on this viewpoint, Paltridge (2012) suggests that discourse analysis focuses on knowledge about language beyond the word and looks at patterns of language across texts and considers the relationships between language and the social and cultural contexts in which it is used. Discourse analysis considers how 'views of the world, and identities, are constructed through the use of discourse.' (Paltridge, 2012, p.2).

Whilst some may argue that this is a very basic outlook on discourse analysis, I feel that this description sums up my own idea of the features of discourse analysis. Whilst many definitions of discourse analysis are tied closely to the study of grammar and linguistics, this definition allows the individual to focus on the 'bigger picture' of ideas,

issues, themes and, most importantly, context. The concern here for me is to show how discursive effects are realised in the technical details of language use.

4.5 When is discourse analysis critical?

Whilst discourse analysis is a broad term to describe a field of linguistics that is concerned with language use and the relationship between text and discourse in the process of human communication, CDA, whilst part of discourse analysis, encompasses an even wider sphere that includes all of the social practices, individuals and institutions that make it possible or legitimate to understand phenomena in a particular way (Hodges et al., 2008).

The origins of CDA lie largely in the works of Norman Fairclough, Ruth Wodak and Teun van Dijk, who remain some of the main exponents of the method (Blommaert & Bulcaen, 2000). The manifold roots of CDA lie in rhetoric, text linguistics, anthropology, philosophy, socio-psychology, cognitive science, literary studies and sociolinguistics, as well as applied linguistics and pragmatics (Wodak & Meyer, 2009a). The theoretical underpinnings of CDA bring together a wide selection of critical social theories, including those of Pierre Bordieu, Jurgen Habermas, Ernesto Laclau and Chantel Mouffe, Anthony Giddens, Antonio Gramsci and the previously discussed Michel Foucault.

Dornan (2014) states that discourse analysis becomes ‘critical’ when it explains how discourse affects social goods like power and status. Protagonists of CDA argue that some strands of discourse analysis are too descriptive (Smith, 2007); however, others contend that using the term ‘critical’ indicates a departure from this stance indicating an analysis that focuses on exploring the ‘ideological underpinnings of discourse that become so naturalised over time that we begin to treat them as common, acceptable and natural features of discourse’ (Gee, 2004; Teo, 2000). Van Dijk (1994) suggests that CDA has become the general label for a special approach to the study of text and talk, emerging from critical linguistics, critical semiotics and, in general, from a socio-politically conscious and oppositional way of investigating language, discourse and communication. He emphasises that CDA should primarily deal with the discourse

dimensions of power abuse and the injustice and inequality that result from it (van Dijk, 1993).

This view is supported by Wodak and Meyer (2009a) who suggest that CDA is not interested in investigating a linguistic unit per se but instead, in studying social phenomena. Similar to van Dijk, Wodak and Meyer (2009a) argue that the concept of power is central to CDA, as it often analyses the language use of those in power, who are responsible for the existence of inequalities. The authors argue that:

> '…CDA researchers are interested in the way discourse (re)produces social domination, that is, the power abuse of one group over others, and how dominated groups may discursively resist such abuse.'
>
> (Wodak and Meyer, 2009, p. 9)

This ties in very much with the research aims and objectives of this study to explore the discourses in circulation around the ANP role. This relation between language and power is also evident in the works of Fairclough (2010), who contends that CDA is neither a theory, nor a method but is preferably 'an analytical framework for studying connections between language, power and ideology' and he argues that what distinguishes CDA from other methods of language investigation is its interest in the relation between language and power. He contends that CDA attempts to examine the processes of power and how these processes use discourse in subtle, yet controlling ways (Fairclough, 2001, p. 229).

For critical discourse analysts, it is important to acknowledge that language is not viewed 'as powerful in and of itself, but is given power as a result of how it is used, who uses it and the context within which this usage takes place' (Wodak, 2001, p. 10). This aspect of context is reaffirmed by Fairclough (2001, p. 234) who states that it is crucial that language is not analysed out of context, but is 'situated within the specific context of social practices of which it is part'. This position correlates with the workings and ideologies of Gee (2010) and his theory of 'big D' Discourse. The following section provides more discussion on the works of Gee and introduces the concepts of what he labels 'Tools of Inquiry' and 'Building Tasks'.

4.6 The Work of Gee

The works of Gee are categorised as critical discourse analysis and together provide an approach that is embedded in a theory of language-in-use in culture and society (Rogers et al., 2005; Gee, 2004). Language-in-use is a tool used to design or build things. Discourse, according to Gee, is ways of combining and integrating language, actions, interactions, ways of thinking, believing, valuing, and using various symbols, tools, and objects to enact a particular sort of socially recognisable identity (Gee, 2010). Gee describes his approach to discourse analysis in the following way:

> '… discourse analysis seeks to balance talk about the mind, talk about the interaction and activities, and talk about society and institutions more than is the case in some other approaches.'
>
> (Gee, 2011, p. 5)

Considering the bespoke approach to CDA and Systems Thinking used within this thesis, figure 4.2 shows where the works of Gee intersect with the theoretical framework and design. I now examine this element of the framework.

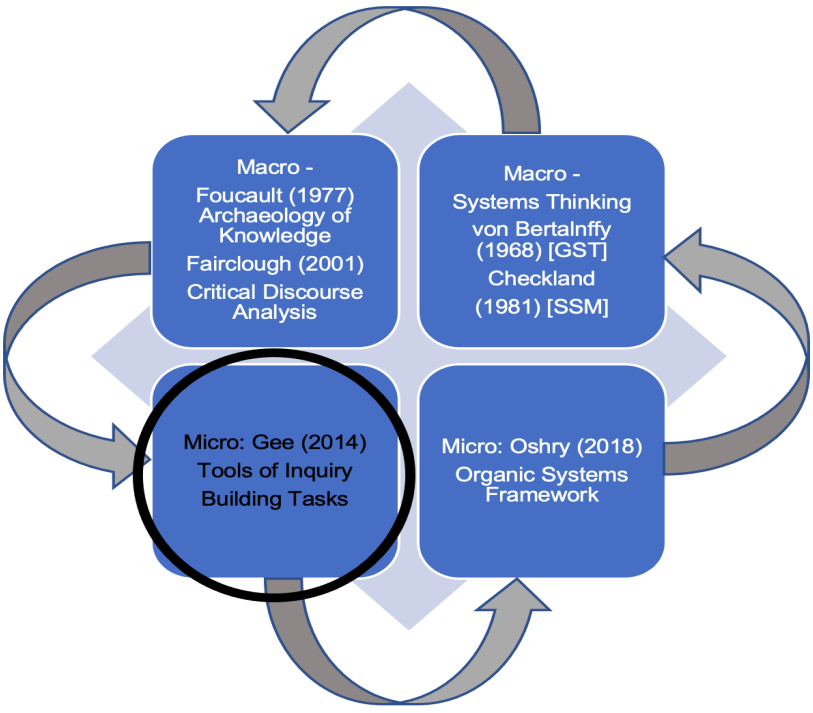


Figure 4.2 A bespoke approach to CDA and Systems Thinking showing key points of intersection with theoretical framework [Adapted from McNamara (2007)]

Gee has developed a two-dimensional framework to facilitate analysis of discourse comprising 'Building Tasks' and 'Tools of Inquiry' [figure 4.3]. These are now discussed in turn.

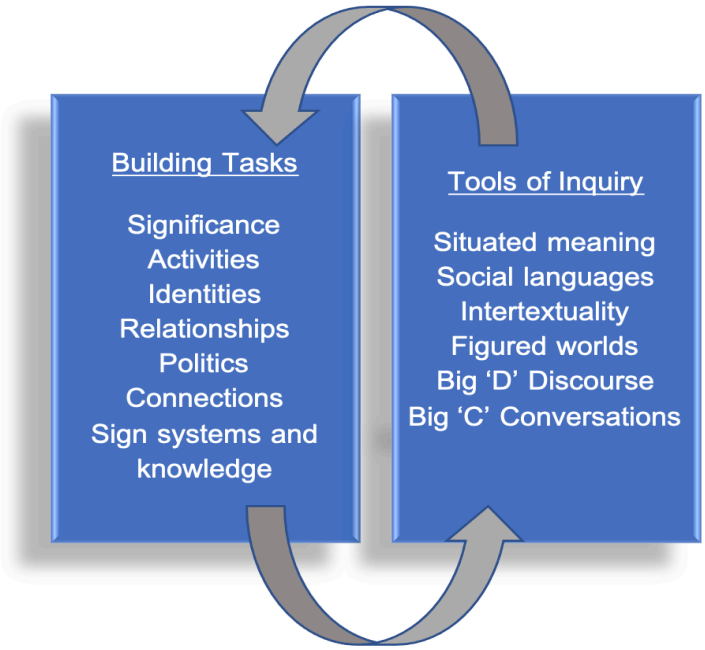


Figure 4.3 Framework to Facilitate Analysis of Discourse

4.6.1 Building Tasks

Gee (2010) proposes that we continually build, destroy and rebuild our worlds, not just using language and words, but through language that is used in tandem with actions, interactions, non-linguistic symbol systems, objects, tools, technologies, and distinctive ways of thinking, valuing, feeling and believing. According to Gee (2011), when speaking or writing we construct seven areas of "reality": significance, activities, identities, relationships, politics (the distribution of social goods), connections and sign systems and knowledge. In turn, Gee (2010) argues that since we use language to construct these seven areas, discourse analysts can ask seven different questions about any piece of language-in-use. Below, I briefly describe each of these areas and list the kinds of questions that may be associated with this area aligned to the research questions, aims and the overall purpose of my study.

Significance

The first task, building significance, involves how and what different elements mean with respect to the many components of any situation (Gee, 2011). Things are not trivial or important all by themselves but instead we use language to make things significant in specific ways. We give things, people, ideas meaning or value in the present situation.

Questions designed to address the building task of significance is: How is this piece of language being used to make certain things significant or not and in what ways? How is language used in health systems to make medicine significant, as we saw from the literature review and how is language used within nursing to make caring a significant part of the nursing identity?

Activities

With the second building task, Gee is focusing on doing and what is being done. The way we use language informs others of what we see ourselves as doing and in turn what is being said helps others to recognise what is going on. By an activity, Gee means:

> '...a socially recognised and institutionally or culturally supported endeavour that usually involves sequencing or combining actions in certain specified ways.'
>
> (Gee, 2011, p. 30)

Utilising the activities building tool, we need to enquire how individuals build socially recognisable activities, what actions this requires, and what actions they manage to accomplish within this activity that realise their own goals and agendas. However, Gee cautions that, as discourse analysts, we must always ask how rigid or not the activity being studied is:

> '…how much freedom are people normally allowed in how they carry out the activity; and how much innovation if any, is occurring in how the activity is being carried out?'
>
> (Gee, 2011, p. 103)

A sample question to facilitate understanding of building activities would be: What activity or activities is this piece of language being used to enact (i.e., to get others to

recognise as going on)? How do ANPs use language to inform others of what we see ourselves as doing (e.g., as advanced, expanded, extended roles and practices)?

Identities

Gee (2010) explained the third building task, building identities, as any situation that involves role or identity as a consequence of an event. We use language to indicate a certain role or identity we have assumed here and now. We each act out different identities in our lives in different contexts. For example, we assume different identities when we act as a parent, a man, an educator, a doctor, a nurse, an ANP etc.

We assemble situated meanings about what identities are relevant to the interaction, with their concomitant attitudes and ways of feeling, ways of knowing and believing, as well as ways of acting and interacting (Carbaugh, 1997; Gee, 2004; Wieder & Pratt, 1990). Since we all have different identities in different contexts, as discourse analysts, we want to focus on how people express their sense of who they are and their multiple other identities through language. Gee argues:

> '…it is important that as researchers, we additionally recognise that individuals do not just enact their own identity but moreover 'position' others in certain ways.'
>
> (Gee, 2011, p. 110)

Through our talk we create an identity 'position' or 'place' for them to take up and to talk within, for this time and place. This tool allows us to study how an individual both builds an identity for themselves and uses identities they attribute to others to further the construction of their own identity.

The following sample questions refer to building identities: What identity or identities is this piece of language being used to enact (i.e., to get others to recognise as operative)? What identity or identities is this piece of language attributing to others, and how does this help the speaker or writer enact his or own identity? How do ANPs build their own identities within the health system and how do they attribute identities to other health professionals to further build this identity?

Relationships

The fourth building task, building relationships, is undoubtedly related to the previous task, building identities, since the identity we build for ourselves in any context is often defined, in part, by how we see and construct our relationships with other people, social groups, cultures or institutions (Gee, 2011). Different kinds of relationships are built and sustained through the use of language. For example, we can construct relatively formal and deferential relationships with others or indeed relatively informal or less deferential relationships by our actions and language we choose to use.

As researchers, Gee (2011) suggests that we must always ask about identity and relationships and how these interact. Whilst identity and relationships go hand in hand, he suggests that one focuses on each separately:

> '…creating or taking an identity and creating and sustaining a relationship of a certain type are not the same, however closely related they are. Even in one identity, for example being a professor, a person can relate to people in many different ways, all without losing his or her identity as professor.'
>
> (Gee, 2011, p. 115)

Gee suggests the following sample question to examine building relationships: What sort of relationship or relationships is this piece of language seeking to enact with others (present or not)? What sort of relationships, through the use of language, do ANPs construct with other members of the healthcare system, such as other ANPs, nursing and medical colleagues, healthcare managers, regulators, policy makers and so on to build relationships and identities?

Politics (the distribution of social goods)

With respect to the fifth building task, building politics (distribution of social goods), Gee (2004) surmises that any situation involves what he terms 'social goods'. By 'social goods' Gee (2011, p. 118) means '…anything a social group or society takes as a good worth having'. By 'politics' he means '…any situation where the distribution of these social goods is at stake.' Looking at these definitions, I can assume that there is an abundance of social goods in society – some being viewed as social goods by everyone in society such as respect for each other and some being viewed as specific to certain sub-groups in society.

How we use our language effects the distribution of social goods, we can add to or take away from reputation, authority, status or power as well as convey perspectives on motives, responsibility and right or wrong. Ultimately, we can build and destroy these social goods. It is important as a discourse analyst to examine this area of discourse as Gee argues that:

> '…the distribution of social goods and claims about them – goods like a person being taken as acceptable, normal, important, respected, an 'insider' or an 'outsider', or as being connected to acceptable, normal, or important things (in the right circumstances) – are ultimately what give people power and status in a society or not.'
>
> (Gee, 2004, p. 31)

Sample questions to address the concept of building politics include: What perspective on social goods is this piece of language communicating (i.e., what is being communicated as to what is taken to be "normal", "right", "good", "correct", "proper", "appropriate", "valuable", "the way things are", "the way things ought to be", "high status or low status", "like me or not like me" and so forth)? What is deemed as a social good in the Irish healthcare system and how are these social goods being communicated in healthcare?

Connections

The sixth building task, building connections, refers to the way situations are connected or disconnected and are relevant or irrelevant to each other (Gee, 2011). Whilst connections can be explicit, there are occasions where connections are not made explicit. The speaker may assume the listener will make the connection and at other times speakers may wish to manipulate how listeners perceive particular connections. Gee (2011) emphasises that all speakers manipulate words and control meanings whenever they speak as this is what language is about. However, he advises that:

> '…people who are good, adept or skilled at manipulating words and controlling meanings are the powerful ones who control other people and reality.'
>
> (Gee, 2011, p. 127)

To facilitate the task of building connections, the following sample question is distinguished: How does this piece of language connect or disconnect things; how does it make one thing relevant or irrelevant to another? How is language used within the health care system to connect or disconnect situations? How does this language make these situations relevant or irrelevant?

Sign systems and knowledge

Finally, Gee (2004) talks about the seventh building task, sign systems and knowledge. Sign systems include languages, language varieties and communicative systems that are not languages. Gee argues that we can use language to make:

> '…certain sign systems and certain forms of knowledge and belief relevant or privileged, or not, in given situations, that is to build privilege or prestige for one sign system or knowledge claim over another.'
>
> (Gee, 2010, p.13)

Different sign systems are important to the people who use them and at least partly define their identities in terms of them. This building task is clearly related to the building politics task, since constructing privilege for a sign system or way of knowing the world is to create and offer a social good (Gee, 2011). Like social goods, we can build up or destroy various sign systems and knowing the world. According to Gee (2004), these sign systems represent different views of knowledge and beliefs and individuals contest the value of different languages and sign systems. We use language to privilege one set of knowledge over another such as the doctor and patient. We thereby accord greater authority to one person than another.

A sample question facilitating understanding of participants' sign systems and knowledge would include: How does this piece of language privilege or disprivilege specific sign systems (e.g., technical language vs. everyday language, words vs. images, words vs. equations) or different ways of knowing and believing or claims to knowledge and belief? Thinking of all the loaded terms identified in the literature review related to ANP such as expanded, specialist, advanced, caring, holistic, non-physician – how do these pieces of language privilege or disprivilege sign systems or ways of knowing?

The building tasks that address this study's research questions are the building identities task, the building relationships task, the building politics (the distribution of social goods) task and the sign systems and knowledge task.

A brief definition of these chosen tasks is provided in table 4.1.

Table 4.1 Definitions of Building Tasks [Adapted from Gee (2017)]

Building Task	Definition
Identities	Using language to enact specific socially situated identities or to project such identities onto others, or to privilege or disprivilege such identities.
Relationships	Using language to create or sustain social relationships or to end or harm them. Any situation whereby the people involved in an event enact and contract with each other.
Politics (the distribution of social goods)	Using language to give or take away social goods or projecting how social goods are or ought to be distributed. Social goods been seen as anything a person or group in society wants and values. Some things (like status, money, love, respect, and friendship) are taken by nearly everyone in society as social goods. Other things are social goods only to small groups.
Sign systems and knowledge	Using language to create, sustain, revise, change, privilege, or disprivilege any language or sign system or characteristic way of knowing the world or making knowledge claims about the world.

4.6.2 Tools of Inquiry

When Gee uses the term 'Tools of Inquiry' he alludes to '…ways of looking at the world of talk and interaction that will help us study how these building tasks are carried out and with what social and political consequences.' (Gee, 2011, p. 12). He further elaborates that these tools are primarily relevant to how we (together with others) build identities and activities and recognise the identities and activities that are being built around us. Each of these tools will now be described briefly so that the reader is familiar with them when their application to data analysis is discussed later. Again, to illustrate the use of the tools, I have formulated questions that speak to the study's research questions, aims and purpose.

Situated meaning

The first tool to be discussed is situated meaning. Meaning, Gee (2011) argues, is an extremely complicated concept. Any word or structure in language has a certain 'meaning potential' that is a range of possible meanings that the word or structure can take on in different contexts of use (Gee, 2011, p. 5). For example, in nursing, the word "tablet" refers to medication however in a computer store the word "tablet" would connote something else entirely. One can see that the context has changed the meaning of the word. Gee (2010) proposes that words do not have general meanings but instead have different and specific meanings in the different contexts in which they are used and in different specialist domains that recruit them. Whilst in many cases, the meanings of words and phrases in context are clear, as discourse analysts, Gee advises that we must:

> '…be on the watch for cases where words and phrases are being given situated meanings that are nuanced and quite specific to the speaker's worldview or values or to the special qualities of the context the speaker is assuming and helping to construe or create.'
>
> (Gee, 2011, p. 154)

Social languages

The second tool Gee discusses is that of social languages. Gee (2011) argues that in order to fully understand what someone is saying or writing, it is necessary to not only know who is speaking, but what identity the person is speaking as. He defines social languages as styles or varieties of a language (or a mixture of languages) that enact specific identities and perform different meaning making activities (Gee, 2011, p. 154). Social languages are what we learn and speak, and examples include the language of literature, science, street gangs and, specific to this study, the language of health systems. Each of these social languages has their own distinctive grammar and to know any specific social language is to know how its characteristic lexical and grammatical resources are combined to enact specific socially situated identities (Gee, 2011). Social languages are used to enact an identity in a specific setting. People use social languages to show membership in groups, to identify the role we assume in a given situation and to show our relationships with other individuals. Gee proposes that:

> '…to know a particular social language is either to be able to "do" a particular identity or to be able to recognise such an identity, when we do not want to or cannot actively participate.'
>
> (Gee, 2004, p. 39)

Intertextuality

The third tool is that of intertextuality. The notion of intertextuality describes how the discourses within a particular text (oral or written) do not exist in a discursive vacuum (Gee, 2011). This refers to the situation where a speaker or writer alludes, quotes, or references what someone else has said or written. Gee (2011, p.55) comments that 'all texts (written and oral) are "infected" with the meanings of all the other texts in which its words have comported'. Marshall observes that:

> '…intertextuality calls attention to prior texts in the sense that it acknowledges that no text can have meaning without those prior texts, it is a space where "meanings" intersect. There is no such thing as the autonomous text (or work)'.
>
> (Marshall, 1992, p. 128)

In order for intertextuality to be successful, the source must be familiar to those listening or reading the work that includes the reference. A classic example of intertextuality provided by Gee (2011) is the adage of David and Goliath, where the mere mention of this is enough to make reference to the biblical story of the young David defeating the giant Goliath. Whilst this adage alludes to or makes an intertextual reference to a biblical text, it is only effective if the source is aware of this tale. Intertextuality also occurs when a piece of writing prepared in one primary style includes a second style of language, which may be associated with a different identity. This juxtaposing of two different social languages is seen by Gee (2011) as an extreme example of intertextuality.

Figured worlds

The fourth tool provided by Gee (2011) focuses on what are seen as pictures or stories of a simplified world that people have stored in their minds that capture what is taken to be typical or normal. What is taken to be typical or normal varies by context and by people's social and cultural group. Gee uses the term 'figured world' for these stories or theories. Figured world has been defined as follows:

> ‘A socially and culturally constructed realm of interpretation in which particular characters and actors are recognised, significance is assigned to certain acts, and particular outcomes are valued over others. Each is a simplified world populated by a set of agents who engage in a limited range of meaningful acts or changes of state as moved by a specific set of forces.’
>
> (Holland et al., 2001, p. 52)

Gee (2011) proposes that we all hold a ‘myriad’ of these figured worlds so that we do not have to consciously think about everything before we speak and act. He argues that we do not use words based only on their definitions but instead we must think more overtly about matters and abandon the typical or normal picture. Similar to the situated meaning tool, context is imperative as what may count as a typical picture for individuals will differ by their social and culture groups. Nonetheless, Gee argues that the sense of typical or normal that is captured in figured worlds has the potential to lapse into a notion of what may be deemed ‘appropriate or good’ (Gee, 2011, p. 173). He further elaborates and suggests this can sometimes become a means to judge and discriminate against people who are taken as untypical or not ‘normal’.

The big ‘D’ Discourse

The fifth tool Gee (2011) presents is big ‘D’ Discourse. Whilst Gee uses ‘discourse’ with a little ‘d’ to mean “language in use” or stretches of oral or written language, big ‘D’ Discourse he suggests is:

> ‘...composed of distinctive ways of speaking/listening and writing/reading coupled with distinctive ways of acting, interacting, valuing, feeling, dressing, thinking and believing. In turn, all of these are coupled with ways of coordinating oneself with other people and various objects, tools and technologies.’
>
> (Gee, 2011, p. 177)

Just as I previously discussed how social languages serve to communicate a particular identity, so too do Discourses. As mentioned, Discourses combine ‘walking the walk’ with ‘talking the talk’. The whole point of talking about Discourses is to focus on the fact that when people mean things to each other, there is always more than language at stake. To mean anything to someone else or even myself, Gee (2004) recommends that one has to communicate who they are in the sense of what socially situated identity they are taking. This is supported by Wieder and Pratt (1990) who contend that what a person says is meaningful only if and when it communicates a ‘who’ and a ‘what’. Gee asserts that:

> '...a 'who' is a socially situated identity, the kind of person one is seeking to be and enact here-and-now...a 'what' is a socially situated activity that the utterance helps to constitute.'
>
> (Gee, 2004, p. 22)

This is important to note as Discourses exist in part to allow individuals carry out certain distinctive activities such as a Garda arresting a criminal or a nurse feeding a patient. Gee (2011) proposes that being in a Discourse is being able to engage in a 'particular sort of dance' and being able to understand a Discourse is 'recognising such dances'. Discourse analysts must note that to study Discourses we must research both language and people's actions, interactions, values, beliefs and uses of objects, tools, and environments within social or institutional settings.

The big 'C' Conversations

Finally, Gee presents the tool of big 'C' Conversations. The use of the word 'conversation' Gee suggests can be misleading as people generally think of conversations as merely words. However, the sort of conversations Gee talks about involves considerably more than just vocabulary. Instead, he argues that it is better to refer to them as 'Conversations' with a big 'C' since they are better viewed as:

> '...(historic) conversations between and among Discourses, not just among individual people...More than people, and more than language, are involved in Conversations.'
>
> (Gee, 2011, p. 34)

Using the concept of Conversation with a big 'C', Gee refers to all the talk and writing that has gone on in a specific social group or in society at large around a major theme, debate or motif, adding later that Conversations are 'the products of historical disputes between and among different Discourses.' (Gee, 2011, p.56). As individuals, we interpret each other's language through what we know about these Conversations. As a society we understand the meaning of 'smoking is associated with health problems' as a consequence of what we know about Conversations regarding smoking.

A brief definition of these tools is provided in table 4.2.

Table 4.2 Definitions of Tools of Inquiry [Adapted from Gee (2017)]

Tool of Inquiry	Definition
Situated meanings	Any word or structure in language has a certain 'meaning potential' that is the range of possible meanings that the word or structure can take on in different contexts of use; e.g., 'nursing' in nursing mother or nursing practice or nursing theory. Words have different and specific meanings in the different contexts in which they are used and in the different specialist domains that recruit them.
Social languages	Styles or varieties of a language (or a mixture of languages) that enact and are associated with a particular social identity; e.g., the language of science, medicine or nursing.
Intertextuality	When one text (in this sense) quotes, refers to, or alludes to another text as in 'When John fought with his boss, it was like David and Goliath!' Here my speech (the 'text) has alluded to (made an intertextual reference to) a Biblical text
Figured Worlds	A picture of a simplified world that captures what is taken to be typical or normal – what is taken to be typical or normal varies by context and by people's social and cultural group.
The Big 'D' Discourses	Distinctive ways of speaking and listening and/or writing/reading are coupled with distinctive ways of acting, interacting, valuing, feeling, dressing, thinking and believing. In turn all these are coupled with ways of coordinating oneself with (getting in synch with) other people and with various objects, tools and technologies.
The Big 'C' Conversations	Debates in society or within specific social groups (over focused issues like smoking, abortion, or school reform) that large numbers of people recognise, both in terms of what "sides" there are to take in such debates and what sorts of people tend to be on each side.

4.7 Chapter Conclusion

This chapter has presented the theoretical underpinnings of CDA as the appropriate basis to address my study's research aims and objectives. I have shown how critical discourse analysts are interested in how language works ideologically to construct, represent and position subjects in particular ways. I have specifically focused on the works of Gee who provides an approach to CDA that is embedded in a theory of

language-in-use in culture and society. I have discussed Building Tasks, specifically tasks related to building identities, relationships, politics (distribution of social goods) and sign systems and knowledge, and Tools of Inquiry, and have aligned these to the study's research aims and purpose. The next chapter presents the study's research design and methods.

Chapter 5 Research Design

5.1 Introduction

The aim of this chapter is to present the research design of this study so that the 'fit' among my research aims and objectives, the theoretical foundations, CDA and my research design is illustrated. The aim of this study is to gain an understanding of how ANPs are discursively positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it. The following research questions are posed:

- What value does the ANP role bring to the healthcare system?
- How is the 'nursing' dimension of the ANP role realised?
- By and through what discourses have ANPs and the wider healthcare system come to know, understand, construct and utilise the ANP role?
- Considering the current discursive positioning of ANPs, what potentially significant issues might extant discourses be minimising or excluding?

In this chapter, I first outline the rationale for undertaking a case study approach. Second, I discuss how the data was elicited and co-constructed. The research setting and sample will then be examined. Next, I discuss how the data was handled, processed and stored before outlining how the data were analysed and interpreted. I then discuss how the works of Gee and Oshry were applied to the analysis. Finally, I show how transparency, rigour and ethical principles for conducting discourse analytic studies were respected throughout the study.

5.2 Making a case for the case study approach

In chapter 3, I delineated my system of interest [figures 3.17 – 3.21]. The system of interest for this case is ANPs working within the Ireland East Hospital Group. I decided to undertake a case study approach as it excels at bringing us to an understanding of complex issues such as the questions that I have posed concerning the ANP role and identity, whilst also extending experience and adding strength to what is already known through previous research. The study triangulated multiple data sources and

data collection methods. Whilst the literature review identified the discourses that are in circulation concerning the ANP role and identity, the interviews and focus groups provided insight into the intentions, feelings, purposes and comprehensions of participants concerning those discourses. The intention of this chapter is to make explicit the decisions and pathways that were taken from the generation of data, through its handling and processing, to its analysis and interpretation. These decisions and pathways are now presented.

Case study approaches to research have grown in reputation in recent years as an effective tool to investigate and understand complex issues in real world settings (Harrison et al., 2017). There are multiple definitions and understandings of the case study, which can create confusion when attempting to understand case study research. The most common and cited definitions are provided by the leading methodologists in the area, Yin (2014), Stake (1995) and Merriam (2009). Yin (2014) focuses on the scope, process and methodological characteristics when defining a case study, accentuating the empirical nature of the inquiry and the significance of context to the case. Alternatively, Stake (1995) is more flexible in his defining, with more focus on what is studied (the case) rather than how it is studied (the method). For Stake (1995, p. 11), case study research is the 'study of the particularity and complexity of a single case, coming to understand its activity within important circumstances'. Merriam (2009, p. 40) includes what is studied and the products of the research when defining case study as '…an in depth description and analysis of a bounded system'. Whilst one can identify the differences within these definitions, Cope (2015, p. 681) suggests that all three methodologists see case study research as:

> '…an approach that focuses on one phenomenon, variable or set of variables, thing, or case occurring in a defined or bounded context of time and place to gain an understanding of the phenomenon of the investigation.'

One challenge to understanding and employing a case study approach relates to the question of whether it is a methodology or a method. Given the proliferation of definitions in circulation it is not surprising that this issue is seen as perplexing, misleading and counterproductive (Harrison et al., 2017). This ambiguity is further compounded by some theorists who advocate that researchers must employ quantitative and qualitative methods within their case study designs (Stewart, 2014).

However, the leading methodologists do emphasise that an overarching methodology shapes a case study design and that multiple sources of data and methods can be employed (Merriam, 2009; Stake, 1995; Yin, 2014). My overarching methodology, discourse analysis, supported by my interpretivist and social constructivist worldview, underpinned by my conceptual framework, systems thinking and, Oshry's OSF, specifically, has facilitated my case study design and the selection of data collection methods [figure 5.1].

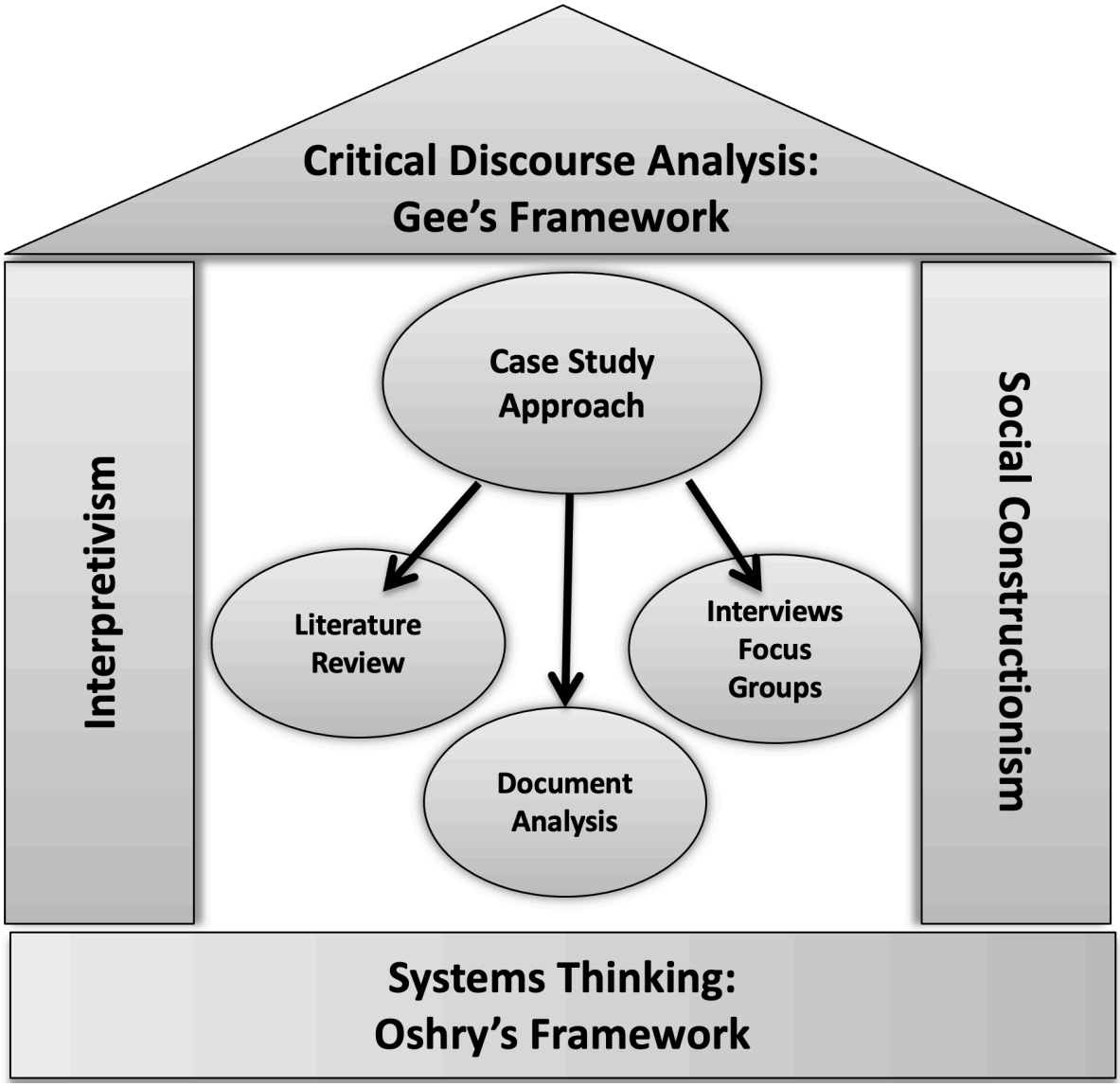


Figure 5.1 Research Design and Collection Methods

Harrison et al. (2017) suggest that one must carefully consider the different case study approaches to determine the design that will best address the aims of the study, and also align with the researcher's worldview. The goal of this alignment is to engender

coherence between my own philosophical position, my research questions, the theoretical underpinnings, CDA, the research design and the methods to be used in this study (Luck et al., 2006; Stewart, 2014). Examining the approaches to case study and considering my own interpretivist philosophy, I felt that I was most aligned to the approach outlined by Stake (1995; 2006). Stake's approach is aligned with a constructivist and interpretivist orientation underpinned by a strong motivation for discovering meaning and understanding experiences in context. Comparable with my own beliefs, Stake (2006) argues that context shapes activity, experience and one's interpretation of the case. This viewpoint aligns very much with the area of systems theory (Oshry, 2018) and critical discourse analysis, more specifically the works of Gee. The empathetic stance of the researcher that is crucial to an interpretivist epistemology is recognised by Stake (2006), who argues that case study researchers attempt to capture their reality of the case, while studying the case situationally, enabling an examination of the integrated system in which the case unfolds. The researcher's perceptions and interpretations become part of the research and, as a result, a subjective and interpretive orientation flows throughout the inquiry (Creswell, 2013). Based on these positions, a case study approach is the most appropriate method consistent with my commitments and the research focus of this thesis.

Stake has characterised three main types of case study: intrinsic, instrumental and collective (Stake, 1995). In an intrinsic case study, researchers examine a case for its own sake to learn about a unique case. In contrast, the instrumental case study uses a small group of subjects to examine a certain pattern of behaviour to gain a broader appreciation of an issue or case. In a collective case study, the researcher coordinates data from several different sources to generate a broader appreciation of a particular issue (Crowe et al., 2011; Zainal, 2007). Returning to my research aims and objectives, I felt that an intrinsic and instrumental case study would not fully achieve them, whereas a collective case study was more suitable, as I wished to use different methods and to examine data from several different sources. Flyvbjerg (2011) encourages the use of multiple methods to collect and analyse data because they are mutually informative in case study research and provide a more synergistic and comprehensive view of the issue being studied. Additionally, Zainal (2007) suggests that collective case studies may allow for the generalisation of findings to a bigger population.

Linking back to chapter 3 and the systems of interest outlined in Figures 3.17 – 3.21, I extracted my case. Whilst a case can be a person, a group, an organisation or an event, in this study the case was ANPs working in the IEHG who met the criteria outlined below under sample and setting. The ultimate goal of employing a case study approach was to examine 'how' or 'why' a case works as opposed to other qualitative research approaches that seek only to define the 'what' of a case (Polit & Beck, 2011). This viewpoint aligns my research questions as I am attempting to understand the 'how' and 'why' of the ANP role and identity. For the purpose of my study and to provide an in-depth analysis of my chosen case, I employed the following data collection methods: literature review and document analysis, focus groups and interviews. Each is now discussed in turn.

5.3 Data Elicitation

Discourse analysis can be performed on everything from professional articles, letters, diaries and interviews to newspaper articles, movies, memes and images. However, Cruickshank (2012) suggests that discourse analysis does not necessarily distinguish between different data sources or alternative methods for collecting and creating data. Considering this, I felt that it was apt to divide my sources of data as follows: literature review and document analysis, focus groups and interviews. The use of multiple sources of data has been advocated as a way of increasing the internal validity of studies (Stake, 1995). An underlying assumption is that this data triangulation should lead to similar conclusions and approaching the same issue from different angles can develop a holistic picture of the case (Crowe et al., 2011).

5.3.1 Literature Review and Document Analysis

One of the most demanding challenges that any researcher faces is determining just where and how to start their research (Zikmund et al., 2010). Since the principle of any research is to contribute to the current body of knowledge, the literature is certainly an excellent starting point especially in discourse analysis where researchers rely heavily on text (Levy & Ellis, 2006; McCloskey, 2008). My ultimate challenge was to select the

countless possible articles and texts that could be used in the study that would provide rich data and enable me to meet the study's aims and objectives. Critically reviewing this literature provided many ideas and perspectives, allowing me to arrive at a contextualised interpretation of what is being conveyed. This enabled me to better understand what studies had been undertaken concerning the ANP role. It additionally provided me with a plethora of ideas on what methods my own study could deploy. It is important to note at this point that discourse analytic research gives great power to the analyst to impose meanings on texts and literature (Cheek, 2004) and 'analysts are not only readers but also producers of discourse' (Parker & Burman, 1993, p. 159). Therefore, the literature can be identified and interpreted in different ways depending on the researcher's background and interests. Thus, interpretations and explanations of discourses are never complete or authoritative; they are always open to new information and contexts (van Dijk, 1997a). Applying CDA and OSF to the literature review captured the debates and discourses in circulation concerning the ANP role and identity that constitute particular social realities at a point in time (see Chapter 6).

5.3.2 Focus Groups and Interviews

Focus groups and interviews are widely used in health research to explore phenomena and are accepted as a legitimate qualitative methodology. Aligning to my own research worldviews, focus groups and interviews emphasise meaning rather than measurement and the process is that of a humanistic interview where the researcher must immerse themselves in other peoples' lives (Doody, Slevin and Taggart, 2013; Redmond and Curtis, 2009). I combined both methods for the purpose of data completeness and confirmation and found that the data obtained by one method corroborated those acquired with the other. Additionally, for pragmatic and practical reasons, I decided to use both methods. For instance, individual interviews were offered to participants that may have been unable or unwilling to attend a focus group such as medics, AHPs and nurse managers. The following account discusses focus groups, then interviews, how both methods aligned with a CDA approach, and, finally, how the interviews and focus groups were undertaken.

Wilkinson (2004, p. 177) defines focus group research as ‘a way of collecting data, which – essentially – involves engaging a small number of people in an informal group discussion (or discussions), “focused” around a particular topic or set of issues.’ Exploring the definitions of focus groups, it is apparent that there is tension between an emphasis on ‘participant-researcher interaction’ and ‘interaction between participants’. This is seen in the definition provided by Hughes and DuMont (1993, p. 776) who argues that focus groups are ‘in-depth group interviews employing relatively homogenous groups to provide information around topics specified by the researchers’. Alternatively, Krueger and Casey (2014, p. 88) define focus groups as ‘carefully planned discussions designed to obtain perceptions on a defined environment’.

Regardless of these disparities, focus groups are an excellent method for gaining insight into the intentions, feelings, purposes and comprehensions of participants. One of the core strengths of focus groups is the ability of participants to compare views with other participants in the groups, rather than simply narrating their own view as would happen in an individual interview. The dynamics of the focus group also permit participants to challenge each other’s views, revealing a more nuanced perspective on a case, an aspect which again may not occur in single interviews. Gaiser (1997) believes that the most fundamental strength of focus groups lies in the efficiency with which they can be used to generate new ideas, and argues that a small number of focus groups may be as informative as a dozen or more individual interviews. However, Wildemuth and Wilkins Jordan (2016) caution that these ideas may not be as fully developed as they might be if explored through individual interviews.

Exploring methods of qualitative research data collection, individual interviews are the most frequently used method; their popularity is related to their being perceived as ‘talking’ and talking is natural (Griffee, 2005, Doody and Noonan, 2013). Considering that the focus of my study is to examine contextual features that produce consistencies, contradictions and disparities in the discourses relating to the ANP, interviews are an excellent method to generate deeply contextual accounts of participants’ experiences and their interpretation of them (Schultze and Avital, 2011). Interactions that occur between the participants and myself afforded them with an opportunity to explore events in their lives and provided rich discursive data.

There were a range of formats from which to choose, including unstructured, structured and semi-structured. The research design determines the approach most likely to generate data that will answer the research questions (Doody and Noonan, 2013). Whilst the strengths of structured interviews are that of efficiency and ease of analysis, Berg (2009) comments that they can be like spoken questionnaires that leave no room for elaboration. Holloway and Wheeler (2010) hold the view that structured interviews should only be used to elicit sociodemographic data. Exploring unstructured approaches, strengths of such interviews are that they do not restrict the questions that may be asked and are useful when little is known about a topic (Ryan et al., 2009). However, participants are more likely to discuss irrelevant issues, which consequently will make analysis and coding difficult (Doody and Noonan, 2013). Whilst not without fault, semi-structured interviews were deemed to be the most suitable to my own research study. They allowed me to use predetermined questions, which were flexible, open-ended, and granted me opportunities to explore issues that arose spontaneously (Berg, 2009; Ryan et al., 2009). I was free to vary the order and wording of the questions (Power et al., 2010), depending on the direction of the interview, and to ask additional questions (Corbetta, 2003).

The more common reasons for performing focus groups and interviews do not apply in discourse analysis. Whereas the aim of focus groups and interviews in many alternate research methodologies is to examine or understand a specific issue and to generate consistency, focus groups and interviewing in discourse analysis allows the researcher to look intently for inconsistencies and contradictions in participant's narratives (van Dijk, 1997b; McCloskey, 2008). This is the concept Gee (2010) alludes to when he discusses language-in-use. This idea is further supported by Bryman (2012) and Doody et al. (2013) who suggest that focus groups and interviews give the researcher an opportunity to study the ways in which participants collectively make sense of the phenomenon and build meaning around it, broadening a focus beyond what people say to how they say it, the language they use and the intensity of their feelings about the phenomenon. The purpose of the focus groups and interviews was to learn more about how participants discursively position and construct the ANP role through their language-in-use, including how the role functions and what it accomplishes. The purpose was to understand rather than infer, to determine the

range rather than generalise, and to gain insight into how people in the groups perceive situations rather than make statements about the population (Krueger and Casey, 2014).

Rather than the focus group and interview being seen as 'machinery for harvesting data from respondents' (Potter, 1997, p. 149), they are instead seen as pieces of interaction in their own right (Speer, 2002). Far from being impartial and unresponsive, researchers assume an active and interventionist stance in data collection. Speer (2002) argues that this bias in data collection need not be regarded as a problem but can be 'turned on its head' and celebrated. As a consequence, analysts believe that one is able to get a wider range of discussion and the traditional distinction between active questioning researcher and passive participant becomes blurred (Potter and Wetherell, 1987; Holstein and Gubrium, 2007). With this is mind, the focus group and interview were made comparable to a conversation and my questions were just as important as the participant's responses. By assuming a less formal conversational identity, I was able to access the sorts of discourses that individuals engage in outside of the focus group and interview setting. The questions I used, and my comments set the functional context for the participant's responses and were included in the study's analysis (Wodak and Meyer, 2009; Potter and Wetherell, 1987). I saw myself, not as a potential 'contaminant', but as much a 'member' as the other participants, and of equal status for the purpose of the analysis (Speer, 2002, p. 513).

Planning the focus group and interview involved reflecting carefully on the research purpose, as Fern (2001) proposes that the purpose frames the task of the focus group and interview and all subsequent decisions made about the study. Considering duration, well-designed focus groups and interviews usually last between one and two hours (Onwuegbuzie *et al.*, 2009; Morgan, 1998). However, the duration is dependent on the complexity of the topic under review. The researcher needed to consider whether the topic is specific or broad and the number of questions to be asked as Plummer-D'Amato (2008) advises that only limited and superficial data will be collected if sufficient time is not provided for discussion. However, Krueger and Casey (2014) remind us that two hours is the general psychological and physical limit for people and, in most cases, focus groups and interviews should not last longer than this. One way of ensuring that focus groups and interviews do not go beyond this time

period was the development and use of an interview guide. This guide acted as a road map that plotted the course of the sessions from start to finish (Vaughn, Schumm and Sinagub, 1996). The authors suggested the following inclusions to the focus groups, with my own suggested length of time for each:

Table 5.1 Focus Group Interview Guide

Item	**Duration (estimate in minutes)**
Introduction/Clarification of terms	5
Warm up/Introduction of participants	5
Easy and non-threatening questions – experiences	20 – 25
Questioning of experiences	30 – 40
Wrap up of session/Member check (providing members with an opportunity to verify their feelings/ideas)	5 – 10
Closing statements/Thanks	5

Wildemuth and Wilkins Jordan (2016) advocate the use of these interview guides as they argue it is very possible for an entire group to get off track and provide the researcher with no usable or useful results. I adapted this guide for use with interviews and this can be seen in Table 5.2 below:

Table 5.2 Individual Interview Guide

Item	**Duration (estimate in minutes)**
Introduction/Clarification of terms	5
Easy and non-threatening questions – experiences	20 – 25
Questioning of experiences	30 – 40
Wrap up of interview/Member check (providing member with an opportunity to verify their feelings/ideas)	5 – 10
Closing statements/Thanks	5

These interview guides are further elaborated on in Appendices I and II.

Applying Gee's (2010) framework of discourse analysis to the literature captured the debates and discourses that are swirling around concerning the ANP role and identity. Several interpretative repertoires from these discourses were identified (see Chapter 6). I intertextually weaved excerpts from these repertoires into the focus group and interview conversations to encourage argumentative and dialogical engagement

(McNamara, 2008). Examples of these repertoires that were used to stimulate conversation include:

- *ANPs have lost their nursing and caring identity and in turn are nurses practicing in doctors' clothes, do you think that is fair?*
- *ANPs will never have the necessary skills to compete with their medical counterparts.*
- *ANPs will always require supervision and medics are the best to oversee this supervision.*
- *ANPs are not cost effective and not a worthwhile investment.*

As I also wanted to access what was spontaneously generated, I used an open approach initially so that I remained sensitive and alert to other discourses that may have emerged.

5.4 Setting and Sample

Research must be motivated by some reason beyond the obvious ones associated with meeting the requirements for doctoral completion – hence the problem motivating the research is my starting point. However, a highly rational factor must also be considered when commencing research; the data sources available to support the research or, more precisely, the researcher's access and ability to collect data (Leedy and Ormrod, 2010).

Having carefully formulated research questions, informed by the extant literature, is important in appropriately and succinctly defining the case (George, Bennett and Belfer Center for Science and International, 2005; Stake, 1995). Whilst Yin (2014) emphasises the importance of a clear definition of the 'case', experts differ as to whether this should be imposed by the researcher or be evolutionary in nature (Bergen and While, 2000). However, Hamel et al. (1993) advise the active selection of the ideal case to grasp the object of the study and that the researcher intervene to produce a definition rather than having it imposed by the field or key informants. This allows the case to have a pre-defined boundary which clarifies the nature and time period covered by the study, the relevant social group, organisation or geographical area of

interest to the investigator, the types of evidence to be collected and the priorities for data collection and interest (Yin, 2014).

The sampling methods should enable the active selection of ideal cases that will serve the research purpose and aims (Hamel et al., 1993). Focus group participants are selected based on the research purpose and because they have knowledge or experiences that are helpful; they are as Patton (2002) states, 'information rich' cases.

Therefore, sampling was purposive and theoretical. Purposive sampling, also known as judgement, selective or subjective sampling, is a sampling technique in which a researcher relies on their own judgement when selecting members of a population to participate in a study (Dudovskiy, 2018). Theoretical sampling is defined as 'the process of data collection for generating theory whereby the analyst jointly collects codes and analyses his data and decides what data to collect next and where to find them in order to develop the theory as it emerges' (Glaser and Strauss, 2017, p. 45). Whilst theoretical sampling is a variation of the purposive method, unlike standard purposive sampling, theoretical sampling attempts to discover categories and their elements in order to detect and explain interrelationships between them, a method quite apt for my own study. Unlike purposive sampling, theoretical sampling cannot be planned in a detailed manner before primary data collection but is instead systematically applied throughout the research process up to the generation of the data (Given, 2008) and beyond as I was analysing and interpreting the data to drive the search for new, contrary or confirming samples. I believe this approach provided structure to my data collection and analysis processes.

Sample size is not a significant issue when using discourse analysis as Boles and Bombard (1998) argue that the interest should be the function and use of language rather than the people using it. To this extent, I was theoretically interested in what anyone talking about ANPs had to say. This concept is supported by McCloskey (2008) who suggests that important patterns can emerge in small samples whereas large samples can create an unmanageable amount of data without adding to the analytic outcome. Yin (2014) suggests that two or three cases would suffice if the theory under investigation is straightforward and five or more if the theory is more subtle. However Crowe et al. (2011) argue that selecting 'cases' in this way is

insufficiently reflexive and ill-suited to the complexities of contemporary healthcare organisations. Therefore, questions around my sampling focused on who and what to include rather than how many. The research questions and the systems of interest directed to me to where the sample should originate (Potter and Wetherell, 1987). The aim was to generate enough data to capture and understand the discourses and discursive practices that are in play concerning the ANP identity and role in the health service.

I was cognisant that sampling is complex when using discourse analysis and additional sampling requirements may not be evident until the initial data is collected and analysed. As DeVault and McCoy (2002) caution, 'researchers know what they want to explain, but only step by step can they discover whom they need to interview and what texts and discourses they need to examine'.

The decision on how to select the cases to study is one that merits reflection. Soy (1997) suggests a useful step in this selection process is to repeatedly refer back to the purpose of the study in order to focus attention on where to look for cases and evidence that will satisfy the purpose of the study and answer the research questions posed. When selecting the cases, I was cognisant that participants must possess the potential to generate useful knowledge (Mason, 2002) in the sense of advancing my study. Access is a central consideration, as I needed to come to know the case study sites well and to work cooperatively with them. Stake (1995) argues that selected cases need to be not only interesting but also hospitable to inquiry if they are to be informative and answer the research questions.

Focus group and interview participants were selected based on the research purpose and because they had knowledge or experiences that were helpful. As Goebert and Rosenthal (2002) note, the 'primary consideration is who will provide the most insightful information' related to the issue, or as Krueger and Casey (2014) put it, I needed to recruit the most 'information-rich' participants. Sample size for focus group research has two dimensions: the size of each group and the number of groups. Variations exist in the literature over the optimum size for focus groups ranging from between four and eight (Cronin, 2001; Bedford and Burgess, 2001), six and ten (Bloor, 2001; Cameron, 2005) and as many as fourteen (Pugsley, 1996). Acknowledging

these variations, I needed to remember that managing larger numbers could be challenging and may require the services of an experienced external moderator which may impact on the dynamics of the group. Conversely, small groups may not have yielded the required data. Krueger and Casey (2014) suggest limiting the number to six to eight participants so that the moderator can control the discussion. An area that all authors agree on concerns the over recruitment of participants, as they may not be available on the day of the focus group. Morgan (1997) has suggested over recruiting by at least 20% of the total number of participants required.

The number of groups and interviews a researcher should undertake is dependent on the study's goals and on the resources that are available. In general, the goal is to do as many sessions as are required to provide a trustworthy answer to the research question (Morgan, 1997). As a theoretical sampling approach is being used, the emphasis was on using theoretical reflection on data as the guide to whether more data were needed. For this study, seven interviews and four focus groups were undertaken. Regardless of the numbers of focus groups and interviews, what is key is the interaction and dynamics between participants. Structuring the group to match carefully selected categories of participants, what Morgan (1997) refers to as 'segmentation', is essential. My main objective concerning the participants was to ensure 'homogeneity in background and not homogeneity in attitudes' (Morgan, 1997, p. 46).

As previously outlined, the setting chosen for my study was the Ireland East Hospital Group (IEHG). The IEHG was selected for numerous reasons. It is the largest and most complex of the hospital groups, comprising eleven hospitals and spanning eight counties. Having a mixture of hospital models and specialities it was identified as a microcosm of the Irish health system. From a practical point of view, I work in this group and the group's academic partner is the University in which I am undertaking my PhD study, University College Dublin. As of July 2021, there are 75 registered ANP/AMPs and 24 candidate ANP/AMP positions, correlating to 2.3% of the nursing and midwifery workforce working within this hospital group (Gallagher, 2021).

Considering my research questions, focus group and interview participants included: ANPs, nursing staff, medical staff, AHPs and nurse managers [table 5.3]. I had initially

excluded individuals who had no experience of 'working with' ANPs; however, on reflection, discourses were circulating among individuals who have never interacted with ANPs, which are of interest for my own research aims, objectives and questions. Both those familiar and unfamiliar with the role are valid for CDA studies. Discourses are not more or less valid depending on the knowledge of those producing or positioned by them. This was reflected in the inclusion and exclusion criteria outlined in table 5.4.

Table 5.3 Definitions of Participants

Definitions of Participants	
Nursing staff	Nurses who do not have a designated managerial position in the IEHG i.e. they are not clinical nurse managers, these will include staff nurses and Clinical Nurse Specialists (CNSs)
Medical staff	Any Hospital Consultant or Non Consultant Hospital Doctor (NCHD) i.e. Interns, Senior House Officers (SHOs), Registrars, Specialist Registrars working in the IEHG
Allied health professions	Any health care profession distinct from nursing and medicine e.g. Physiotherapist, Occupational Therapist working in the IEHG
Nurse managers	Any nurse who has a designated managerial position in the IEHG i.e. Clinical Nurse Manager (CNM) 1,2,3, Assistant Director of Nursing (ADON) and Director of Nursing (DON)

Table 5.4 Inclusion and Exclusion Criteria

Inclusion and Exclusion Criteria	
ANPs	
Inclusion criteria	Exclusion criteria
Registered Advanced Nurse Practitioners working in the IEHG	Registered Advanced Midwife Practitioners working in the IEHG Advanced Nurse Practitioner Candidates working in the IEHG
Nursing Staff	
Inclusion criteria	Exclusion criteria
Nurses working in the IEHG	Midwives working in the IEHG Nurses who are not working in the IEHG Nurses employed by an agency (i.e. agency staff, locum etc.) who have no experience of working with an ANP

Medical Staff	
Inclusion criteria	Exclusion criteria
Medics working in the IEHG	Medics who are not working in the IEHG (i.e. agency staff, locum etc.)
Allied Health Professionals	
Inclusion criteria	Exclusion criteria
Allied health professionals working in the IEHG	Allied health professionals who are not working in the IEHG (i.e. agency staff, locum etc.)
Nurse Management	
Inclusion criteria	Exclusion criteria
Nurses in managerial positions working in the IEHG	Nurses in managerial positions who are not working in the IEHG (i.e. agency staff, locum etc.)

Both interviews and focus groups were used for the purpose of data completeness and confirmation and the data obtained by one method corroborated those acquired with the other. Interaction between group participants is considered a distinct advantage and hallmark of focus group research (Grønkjær et al., 2011), and as discourse analysis, according to Gee (2010), is also about interactions and enacting socially recognisable identities, focus groups permitted these interactions to occur between diverse professions and levels. Additionally, for practical and pragmatic reasons both methods were used. For instance, it was impractical to attempt to create a focus group completely made up of medics or AHPs due to poor response rate on their part, so for these participants, interviews were used.

Requests were made through the Directors of Nursing, Clinical Directors and General Managers (Appendices III-V) of each hospital system to forward the information leaflet and consent forms to relevant practitioners working in their settings. Of these practitioners, 44 responded to the researcher agreeing to participate; fourteen ANPs, six staff nurses, ten clinical nurse managers, two directors of nursing, one nursing project officer working in the Department of Health, six medical practitioners (three consultants and three registrars), three radiographers and two physiotherapists. This number decreased to 29 participants over the period of the research study due to participants not responding to further communication or not showing up on the day of interview or focus groups. These 29 participants were distributed from the eleven different acute hospital systems within the IEHG and included twelve ANPs, two staff

nurses, eight clinical nurse managers, one director of nursing and one nursing project officer working in the Department of Health, three medical practitioners (two consultants and one registrar) and two allied healthcare professionals (one radiographer and one physiotherapist). Each of the focus groups and interviews can be seen in tables 5.5 and 5.6 below:

Table 5.5 Focus Group Participants

Focus Group No.	Participant No.	Participants
1	6	Nursing Staff (mix of nurse managers and staff nurses)
2	4	ANPs (mix of speciality)
3	7	Multidisciplinary team (mix of ANP, nursing staff and allied health professionals)
4	5	ANPs (mix of speciality)

Table 5.6 Interview Participants

Interview No.	Participants
1	ANP (Community)
2	ANP (Emergency)
3	Nursing (Project Officer, Department of Health)
4	Nursing (Director of Nursing)
5	Consultant (Emergency)
6	Registrar (Medical)
7	Consultant (Emergency)

5.5 Data Handling, Processing and Storage

As discourse analysis and case study research generate a large amount of data from multiple sources, systematic organisation of the data was important to prevent me from becoming overwhelmed by the amount of data and additionally to prevent me from losing sight of the original research purpose and questions. Advanced preparation assisted in handling the large amount of data that was generated. All data, including audiotape transcripts from the focus groups and interviews, as well as field notes were examined and coded into emerging analytic categories based on Gee's (2010, 2011) method of language-in-use discourse analysis focused on the four chosen building tasks (identities, relationships, politics [distribution of social goods], and sign systems and knowledge) and the six tools of inquiry (situated meanings, social languages, intertextuality, figured worlds, big D Discourse and big C Conversations). NVivo 12 Pro (QRS International Pty Ltd., 2018) was used to assist with categorising, sorting, storing and retrieving data for analysis. This is further discussed below. A participant key was used throughout the study to aid handling and processing. See table 5.7 below for participant key:

Table 5.7 Participant Key

Initial	Participant
A	Advanced Nurse Practitioner
N	Nurse
NM	Nurse Manager
X	Allied Health Professional
M	Doctor

The letters I and FG refer to Interview and Focus Group and numbers are used to distinguish participants and discrete data collection points; e.g., I3NM1 refers to Interview No. 3 (I3) with a Nurse Manager (NM1), FG4A18 refers to Focus Group No. 4 (FG4) and a particular ANP (A18).

The focus groups and interviews were conducted between April 2019 and January 2020. Focus groups and interviews ranged from 42 to 84 minutes. The conversations were recorded using a digital audio recorder and transcribed verbatim immediately following the sessions.

5.5.1 Level of Transcription

Discourse analysis of spoken interactions such as focus groups and interviews require transcription. The patterns and sequences of the actual conversation must be transcribed so that the data and results are accessible to other analysts and scholars. Because the spoken interactions need to be written down, it is assumed that talk is like writing and the way we transcribe is, inevitably, biased towards writing (Roberts, 2018). However, transcription is both a great deal more and a great deal less than talk written down. It is a great deal more as the transcription will also reveal the particular stance of the transcriber – 'their theoretical home, the purposes of the transcription and their ideological position' (Ochs, 1979, p. 44). Transcription, therefore, cannot be separated off from theory, analysis and interpretation (Roberts, 2018). The amount of detail to include in a transcript is an important question to consider before beginning data collection, and McCloskey (2008) believes its answer lies in the depth and level of analysis the researcher requires. This is particularly challenging in discourse analysis where the process of transcription can be complex and timely as it includes the fine details of the interview, inclusive of pauses, hesitations, emphasis, intonation and so on (Potter & Wetherell, 1987). Some authors suggest that if one is concerned with the big 'D' Discourse of conversations, then the analyst may only transcribe words of talk and indicate who the speaker is and not be so concerned with prosodic features of language (Roberts, 2018). However, I believed that if my transcription was detailed enough, the fine-grained details of interaction and how these feed into identifying the perceived role and identity of the ANP would be exposed. McNamara (2007) argues that discourse analysts consider conversations as action and therefore require transcription systems that display and facilitate this analytical stance. With this in mind, I transcribed not just what was said but also provided some visual indication of *how* things were said (ten Have, 1999). The following excerpt from one focus group provides an example of these visual indicators [clicking fingers] of how things were said:

> 'Nurses speak to patients in layman terms and the whole lot and then you go and speak to the consultant and you have to change it all around and you have to…you know have it all there [*clicks fingers*]...'

However, rather than being too concerned with the linguistic features in narratives, I believe the central tenet of my analysis is the social processes and dynamics contained in the focus groups and interviews. This level of transcription and analysis offers a detailed account of the how the participants describe, understand and respond to the discourses.

5.5.2 Transcription Techniques

I listened repeatedly to each audio-recording and documented as much detail as was practical and feasible concerning how the conversation was spoken. By personally undertaking the transcription role, I gained an in-depth awareness of the data and realised the depth and wealth of information that each focus group and interview provided. Personally conducting the focus groups, interviews and transcriptions also facilitated confidentiality and anonymity.

5.5.3 NVivo 12 Pro

Following transcription of the audio recordings, they were imported into NVivo 12 Pro (QRS International Pty Ltd., 2018). This is a computer-assisted qualitative data analysis software package that is designed for rich text-based data sets where deep levels of analysis are required (Houghton et al., 2017). The software assisted me in data management and eased the burden of clerical work entailed in coding by organising data systematically, which in turn permitted a comprehensive analysis of the data. There are numerous arguments concerning the use of computer-assisted programmes versus manual analysis in qualitative studies with some researchers contending that computer software represents a crossover to the quantitative paradigm (Baugh et al., 2010). Whilst debates will continue, my own study required in-depth analysis and I believed that NVivo 12 facilitated successive rounds of coding and helped prevent ‘premature anchoring’ to initial ideas about the discourses (McNamara, 2007).

5.5.4 Storage

All data was stored in accordance with the Data Protection Act 2018 (Government of Ireland, 2018). Electronic data inclusive of text and audio was stored in an encrypted password protected location on my personal computer. This computer was not accessible to other personnel. Hard data was stored in a locked firebox, within a locked filing cabinet in a locked office. As the principal researcher I had access to the data that was collected. Additionally, Professor Martin McNamara, in his capacity as doctoral research supervisor, had access to this collected data.

5.6 Data Analysis and Interpretation

Discourse analysis does not start after transcription but before it. Indeed, Roberts (2018) suggests that decisions about who and how to record are all part of the interpretive process which culminates in discourse analysis. Considering this, data analysis occurred alongside data collection. This allowed iterative cycles whereby emergent analysis informed the data collection. The analysis concerned itself with variability and consistency regarding the accounts of the descriptions, features and components of the discourse pertaining to the discursive constructions of the role and identity of the ANP. Unlike traditional data analytical approaches in qualitative analysis where the focus is to 'interpret people's talk in everyday life' (Talja, 1999, p. 461), discourse analysis focuses on the 'local and broader discursive system in which the utterance is embedded' (Potter & Wetherell, 1987, p. 169). This ties in with the idea of context (Oshry, 2018) and the concepts presented by Gee (2011) of situated meaning, social language and so on. As a discourse analyst, I examined the contextual features that produced the consistencies, contradictions and disparities that are found in each discourse (McCloskey, 2008) through, inter alia, using Gee's tools of inquiry.

I began the analysis process by immersing myself in the data, coding and grouping the language-in-use. These in turn, were re-examined in a cyclical nature to condense and transform the data by identifying how respondents and participants discursively position and construct the ANP role through the language-in-use pertinent to the research aim and objectives. Whilst the analysis phase was an extremely labour

intensive and time-consuming period, I believed it to be essential in ensuring accurate representations and conceptualisations of the discourses at play.

5.6.1 Grouping and coding

As mentioned, I was in no doubt that analysis was a demanding part of the thesis, but I believed that by employing a coding regime enabled me to 'squeeze an unwieldy body of discourse into manageable chunks' (Potter and Wetherell, 1987, p. 167) and paved the way for data analysis. During the coding process, my attention was always on language-in-use. I was particularly attentive to recurrent and salient phrases, words and expressions regarding the study's dominant discourses, namely the ANP identity and role. As a result, I was able to return to the data, further dissect it by continually moving back and forth between data sources, coding and analysis and identify any unanticipated discourses (Potter and Wetherell, 1987) which in turn prevented anchoring to the initial discourses in the literature.

5.6.2 Application of Gee to the Analysis

Questions related to Gee's (2011) tools of inquiry (situated meaning, social languages, intertextuality, figured worlds, big D Discourse and big C Conversations) and the four selected building tasks (identities, relationships, politics [distribution of social goods)], and sign systems and knowledge) were used to interrogate the data. The principal questions that were posed for each of these tools of inquiry and building tasks can be seen in Appendices VI and VII.

5.7 Transparency and Rigour

Aroni et al. (1999) define rigour as a means to demonstrate integrity, competence and legitimacy of the research process. Without rigour, research is 'worthless, becomes fiction, and loses its utility' (Morse et al., 2002, p. 14). A key issue for any qualitative researcher is convincing the reader of the integrity, import and quality of their research (Golden-Biddle & Locke, 1993). Tobin and Begley (2004) propose that the attributes of rigour span all research approaches. Greckhamer et al. (2014) suggest that key challenges concerning qualitative research include conducting analyses that are

systematic and suitably informed by their particular theoretical and epistemological underpinnings, upholding the transparency of methodological processes, and providing evidence that warrants knowledge claims and represents data and analysis in ways that substantiate the results. Hardy (2001) believes these challenges are particularly salient in the context of projects employing a discourse analytic approach as this approach emphasises the discursive construction of social realities through texts, is highly interpretive in nature and reliant on previous theory.

Considering this, it is apparent that a researcher conducting an empirical discourse analysis will face the challenges of performing an investigation that goes beyond descriptive analysis whilst being transparent and rigorous, as well as representing the process and results of discourse analysis. Whilst I recognise that it is inappropriate to reduce the practice of qualitative research to technical issues that can be resolved by 'cookbook methods' (Anfara et al., 2002, p. 34) and that 'one narrative size does not fit all' (Tierney, 1995, p. 389), I do believe that rigour and transparency was achieved by applying frameworks consistent with and respectful of my own epistemological and theoretical assumptions. Greckhamer et al. (2014, p. 429) propose that such frameworks can capture elements of 'social realities and functions of discourses while allowing for the emergent aspects of data analysis and for researcher's interpretations based on their individual values and interests'. In my own opinion, the framework developed by Gee (2010, 2011) enabled this systematic, rigorous and transparent analysis as it provided structure and guidance to investigate how a view of reality is constructed through discourse.

Greckhamer et al. (2014) advise that systematic and rigorous analysis is essential for enhancing a study's trustworthiness and it is vital that researchers explicitly document and communicate their analysis procedures (Harry et al., 2005). To warrant a study's claims and results, appropriate evidence should be provided that convinces readers of the study's credibility, auditability and trustworthiness. However, Denzin (2009) argues that a key challenge of discourse analysis is deciding what counts as evidence and how to present this evidence to substantiate the claims. Gee (2010) and Fairclough (2010), through their respective works, shed some light on how these challenges may be met. They suggest that an insightful interpretation first involves studying the corpus of text representing a discourse. I achieved this by undertaking

an in-depth literature review of discourses related to the ANP role and identity (see Chapter 2) and also by applying the frameworks of Oshry and Gee to that literature review (see Chapter 6).

Next, they suggest weighing socio-cultural contexts of statements and exploring the intertextual relationships within and between these texts that constitute interfaces between discourses and institutional contexts. The use of Gee's framework for discourse analysis permitted me to explore these relationships and to identify the interfaces between discourses concerning the ANP role and identity and the healthcare system. Finally, they suggest that the researcher explores connections and themes that are saliently absent from texts. I believe that the comparing of my own findings and analysis of the literature, as well as constantly going between the data, facilitated the exploration of these absences.

To demonstrate and enable evaluation of rigour, Constas (1992) suggests that researchers provide a chain of evidence clarifying how they moved from data to results. The auditability of my study will permit others to examine my documentation of data, methods, decisions and end product (Tobin and Begley, 2004). Greckhamer et al. (2014) offer a tool to facilitate auditability which they refer to as *chronicling,* to provide a chain of evidence to clarify how they moved from data to results. I found this framework extremely user friendly as it describes the major analysis processes utilised and macro-level decisions made in analysing and interpreting data. The authors recommend that chronicling is undertaken as follows:

1. Examine Gee's (2010, 2011) discourse analytic framework.
2. Analyse the texts, identify theoretical relevant data units and interpret them in their context, identifying instances of the selected building tasks (identities, relationships, politics [distribution of social goods], and sign systems and knowledge) (see chapter 4).
3. Document relationships and connections between these data units and building tasks [Ryan and Bernard (2003) refer to these connections as concepts].
4. Allow the analysis to be theoretically guided by
    a. Gee's discourse analytic framework – building tasks (identities, relationships, politics (distribution of social goods), and sign systems and knowledge), and tools of inquiry,
    b. Research objectives and aims.

To further facilitate chronicling, Greckhamer et al. (2014) suggests that the discourse analysis process be tabulated. Tabulating the process represents the process of analysis and interpretation by providing anchors connecting data units, concepts and building tasks, which in turn aided rigour and transparency.

I illustrate the use of this tool with an example below which shows the application of Gee's discourse analytical framework to the literature [table 5.8]. The column, data unit in context, represents a segment of raw data from the literature, with the data unit in bold. Transparency is facilitated by showing the textual context of the data and how that informed my interpretation of the data units. The column, data unit, refers to textual elements that I identified as contributing to the construction of the discourse and building task. The concept column represents the data unit's contribution to the function of the discourse and building task. The last column shows the building task that this concept serves to construct. The table permits a 'glimpse of analyses and interpretation processes rather than merely showing data..[and] helps researchers to illustrate the chain of evidence in complex analyses' (Greckhamer et al., 2014, p. 434).

Table 5.8 Tabulation the Discourse Analysis Process

#	Data unit in context (Raw Data)	Data unit	Concept	Building Block
1	In their large scale national study evaluating ANP and CNS roles, Begley et al. (2014b) found that **caring remained a fundamental part of the ANP role with study participants suggesting that whilst medics 'aren't very good at the caring piece', ANPs were lauded for the holistic and educative approach and the resulting impact on patient quality of life**. This holistic approach is consistent with findings from a study by Gould et al. (2007), in which ANP practice was identified to be evidently different than that of medical care. This finding is supported by Li et al. (2013) who found that senior doctors, nurses and ANPs agreed that ANPs embraced	Caring remained a fundamental part of the ANP role with study participants suggesting that whilst medics 'aren't very good at the caring piece', ANPs were lauded for the holistic and educative approach and the resulting impact on patient quality of life	Building identity of ANPs as holistic carers and other professionals identities as not as caring	Identity building

	a more holistic model of patient care.			

As well as tabulating the process as previously illustrated, a further tool Greckhamer et al. (2014) recommend is narrating the process of data interpretation. They argue that doing this will 'explicate the analysis of raw data to concepts and building tasks for specific data units' and address the process-related challenges of discourse analysis (Greckhamer et al., 2014, p. 434). As well as the final interpretation, the narration will also include the intermediary stages of interpretation such as the questions asked, the discussions had and alternative interpretations. Explaining the thought processes, moving from raw data to results in this way enhances transparency; the narrative process provides evidence of rigour by showing depth of analysis and provides a relatively authentic representation of complex analysis processes (Greckhamer et al., 2014).

5.8 Ethical Considerations

Ethical implications were considered at every stage of the research process. The study followed the ethical principles as laid out in The Declaration of Helsinki (World Medical Association, 2004). The nature and purpose of the study was clearly outlined to all potential participants in writing. Within the information leaflet, contact details were provided if there was any further concern about the study or any additional assurances required (Appendix VIII). In keeping with my undertaking to all potential participants, I did not reveal any details that may identify them such as geographical location, employing institution and so on. Approval to undertake the research was obtained from

University College Dublin's Research Ethics Committee – *LS-19-03-Thompson-McNamara* (Appendix IX).

5.8.1 Beneficence – Welfare

The principles of beneficence, autonomy and justice were adhered to throughout the research process. Due to the personal nature of the topic area, I was cognisant that various emotions may surface, and the topic may have the possibility of being emotionally upsetting for some participants. An essential component of the focus groups and interviews was the awareness of sensitivity regarding the topic. If, during any of the focus groups or interviews the participants had become emotional or upset, the session would have been suspended immediately. Following the focus group or interview, participants were given an opportunity to express any issues that may have emerged during the focus group. This debriefing session would have enabled participants to convey any concerns that may have arisen from discussing their experiences of issues related to the research topic. Additionally, lists of support numbers were available if required.

5.8.2 Autonomy – Consent

Prior to commencing the focus groups and interviews, informed consent (Appendix X) was obtained from all participants. The aim of attaining informed consent was to ensure that the potential participants fully comprehended the potential risks and benefits of being involved in the study (Parahoo, 2014). To facilitate these principles of autonomy, an information sheet was given to all participants (Appendix VIII). The information sheet provided a brief synopsis of how the study was to be undertaken in addition to the proposed aim of the study. Participants were fully informed about the nature and importance of the research and were in a position to decide whether or not to participate in the study and to withdraw subsequently. None of the selected participants dropped out of the study.

5.8.3 Justice – Confidentiality

All participants, in accordance with the principle of justice, were treated fairly and had their privacy protected (Polit & Beck, 2011). Participants were treated respectfully and courteously at all times. Participant's anonymity has been maintained throughout the study. No names can be linked to any of the focus groups or interviews and no information obtained from the sessions has been or will be reported in a manner that could possibly identify the partaker. To further assist confidentially and anonymity, the transcribed material obtained from the focus groups and interviews was kept in a locked firebox which was stored in a locked filing cabinet.

These ethical principles were used to guide the research. Adhering to these principles, I believe I achieved the goals of my proposed study, whilst maintaining the rights of the research participants.

5.9 Pilot Study

A pilot study was undertaken prior to commencing any data collection or interpretation. The pilot was a mini version of the full-scale study that pre-tested my research instruments, including the focus group/interview schedule or topic guide as well as the application of Gee's analysis framework. Trying out all the research techniques and methods allowed me to see how they worked in practice and helped identify what needed to be adapted or modified – a 'reassessment without tears' (Blaxter et al., 2010, p. 121).

The value of a pilot study is that it provided advanced warning of where the research project could fail, where research protocols might not be followed, identify practical problems and indeed help indicate where the proposed methods or instruments are inappropriate or too complicated (Vogel & Draper-Rodi, 2017). Two interviews and one focus group took place between February 2019 and March 2019. The interviews and focus group were not included in the main study and individuals were chosen on an opportunistic basis. Goals of the pilot study were to provide information, which I believed contributed to the success of my research project as a whole. The general

goal was to save time, effort and money which could have been lost if a major study, such as my PhD, were to fail because of unforeseen attributes. This view is supported in the literature with numerous academics arguing that pilot studies can 'contribute invaluable information' (Morin, 2013, p. 547) as well as allowing the researcher to 'see if the beast will fly' (de Vos, 2002, p. 410).

5.10 Chapter Conclusion

The purpose of this chapter has been to detail the approach to the research design that I used in my study. This case study's research design demonstrated the fit between my research methodology, my research questions and research design. Participants from my system of interest were purposively and theoretically sampled from the system of interest, the Ireland East Hospital Group. I conducted focus groups and interviews with these participants to explore the extant discourses and language-in-use concerning the research aims. Guided by the frameworks of Gee and the tools provided by Greckhamer and colleagues, the techniques of data collection and analysis facilitated rigorous and transparent research. I used the analytical and conceptual tools to explicate the underlying discourses related to the ANP role and identity in the Irish healthcare system. In chapter 6, I turn to the discourses that have been uncovered by applying these analytic and conceptual tools to the literature review.

Section two: Data Transformation

In each of the four chapters comprising the data transformation section, I shed light on the ANP role by examining what ANPs and others say about it, how and to what effect. I examine how ANPs and others both produce and are positioned by Discourses. Gee's (2014) work concerns how language builds, among other constructs, identities, relationships, politics, and sign systems and knowledge. Employing Gee's Tools of Inquiry and Building Tasks allows me to gain an analytic purchase on participants' language-in-use and what it is doing. Oshry's (2018) Organic System Framework allows me to see the patterns of relationships and processes inherent in human systems and how these are manifest in language. I therefore approach the data from two different angles: with Gee's lens, I can see what language constructs and how; with Oshry's lens, I can look at the patterns of relationships and processes at play in those constructions.

It is important to document how I move from the raw data to the interpretation of my data in CDA (Greckhamer and Cilesiz, 2014). An example of the data transformation process is provided in each chapter of the data transformation section (Chapters 6 to 9) in the form of the journey of a piece of text through the steps of data transformation. These steps allow the data analysis in this study to move from description to interpretive analysis as described by Sandelowski and Barroso (2003) who illustrate how qualitative research findings can move along a continuum from raw data (literature, interviews, focus groups, literature) through description and onwards towards interpretive explanation, moving ever closer to addressing the study's research questions [table 5.9].

Table 5.9 Classification of qualitative findings (Sources: Adapted from Sandelowski and Barroso's (2003, p. 908) Typology of Qualitative Findings

Closest to Data →			Farthest from Data
Thematic Survey	Thematic Description	Interpretive Explanation	
Exploratory	Descriptive	Explanatory	
	Empirical Language of Description	External Language of Description	Internal Language of Description
	Thematic Analysis Gee's (2014) Tools of Inquiry →	Gee's (2014) Building Tasks →	Oshry's (2018) Organic Systems Framework
Data sources: Literature, Interviews, Focus Groups			

Considering this continuum through description towards interpretive explanation, the data has been analysed using a tripartite approach [figure 5.2].

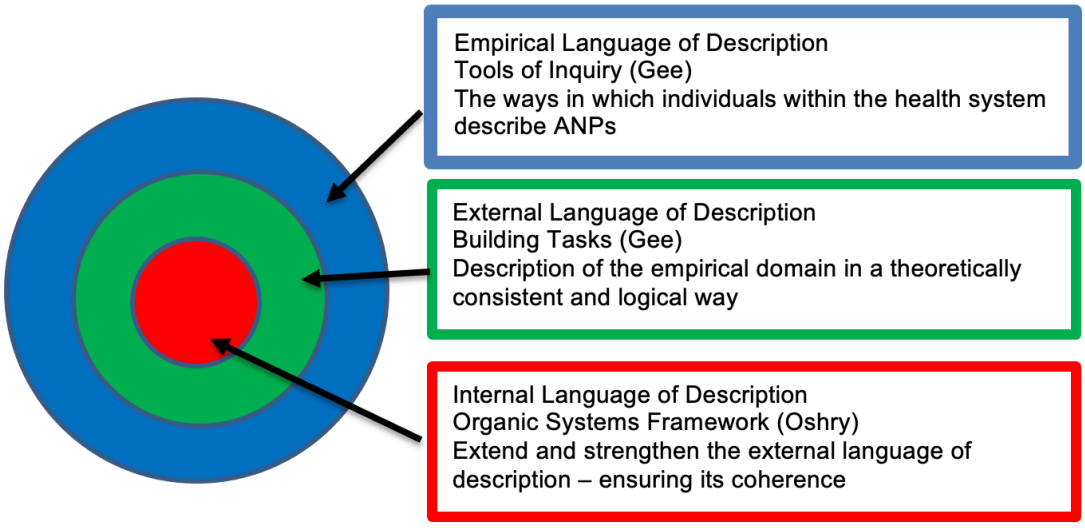


Figure 5.2 Schematic Representation of Analytic Approach

The findings will be presented from the exterior to the interior, starting with the application of the frameworks of Gee and Oshry to the literature, then the empirical language of description (LOD) (blue ring), the external LOD (green ring) and, finally, the internal LOD (red ring).

The blue ring of the circle represents the "real world' empirical language of description. It represents the ways in which the participants *describe* the ANP from their vantage point of their own experience. There is a 'thematic' element to this process and the actual language-in-use will be presented in terms of Gee's (2014) Tools of Inquiry [figure 5.3] (situated meanings, social languages, intertextuality, figured worlds, Big D Discourse and Big C Conversations), setting up what is being constructed in, by and through language.

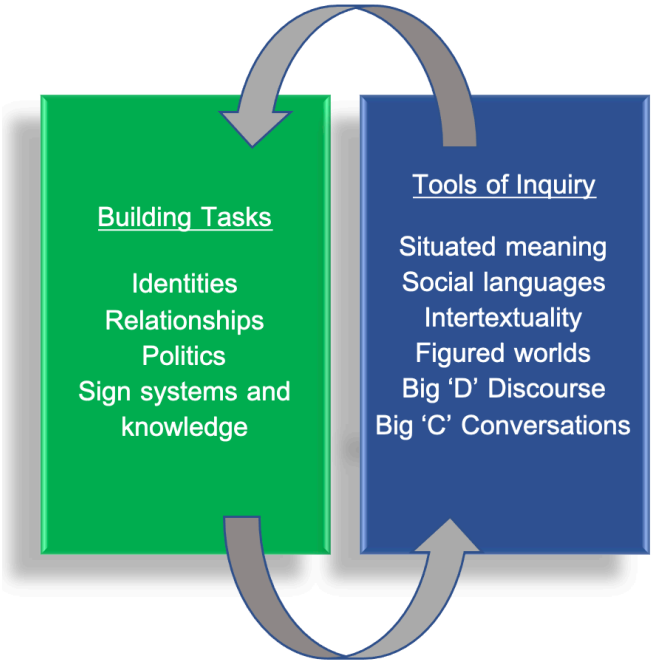


Figure 5.3 Gee's (2014) Discourse Analysis Framework – Tools of Inquiry

Having studied the participants' different understandings of the ANP from their various positions, experiences and actual language-in-use, I will move to investigate the external LOD (green ring) to develop a consistent and systematic understanding of what is being done through the selected Building Tasks (Gee, 2014) [figure 5.3] (identities, relationships, politics, sign systems and knowledge). These four tasks were

selected as they address the study's research questions and aims. This lens of analysis transforms the empirical LOD by allowing me to step back from the subjective experiences and positions. Applying Gee's framework to the analysis, the CDA becomes critical and explore how language works ideologically to construct, represent and position subjects in particular ways.

Finally, I investigate the internal LOD (red ring) to strengthen the external LOD, ensuring the overall coherence of the analysis and setting the ANP role in a wider context within the healthcare system. I use the four systemic processes (integration, individuation, homogenisation and differentiation) and the three systemic relationships (Top/Bottom, End/Middle/End and Provider/Customer) outlined in Oshry's (2018) OSF and explore the relative balance and intensity with which these processes and relationships are expressed in the overall system in which ANPs exist as a (sub-) system [figure 5.4]. I am looking at ANPs as a system or sub-system and identifying the patterns and process that characterise this system. Oshry's (2018) OSF lens of analysis allows me to adopt the position of an observer, getting out on the balcony and standing apart from the whole system, noticing what identities, relationships, politics, sign systems and knowledge the research participants have constructed through their language-in-use and what this reveals about the processes and relationships at work in their system. This helps to identify possible solutions to existing problems in systems, allowing me to articulate, frame and situate recommendations. Oshry's work is anthropological/ethnographic, and his theory builds from observing and theorising exactly the phenomena CDA constructs.

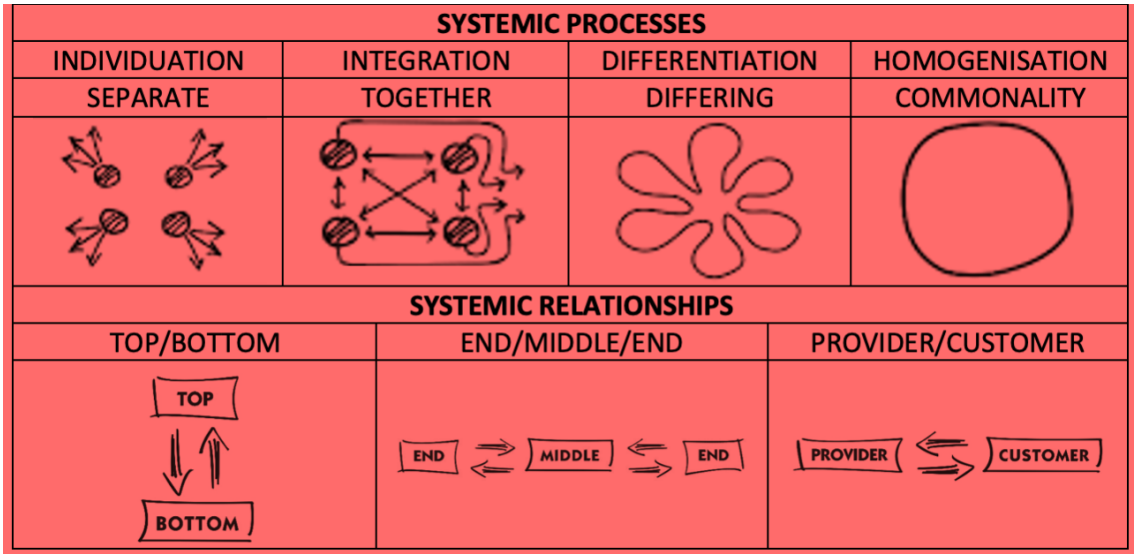


Figure 5.4 Oshry's (2018) Organic System Processes and Relationships

In figure 5.5, I depict the steps of the data transformation process followed in this study. Examples of how raw, extant data (literature review) and researcher-generated data (interviews, focus groups) was transformed through these analytic steps are provided in chapters 6 to 9.

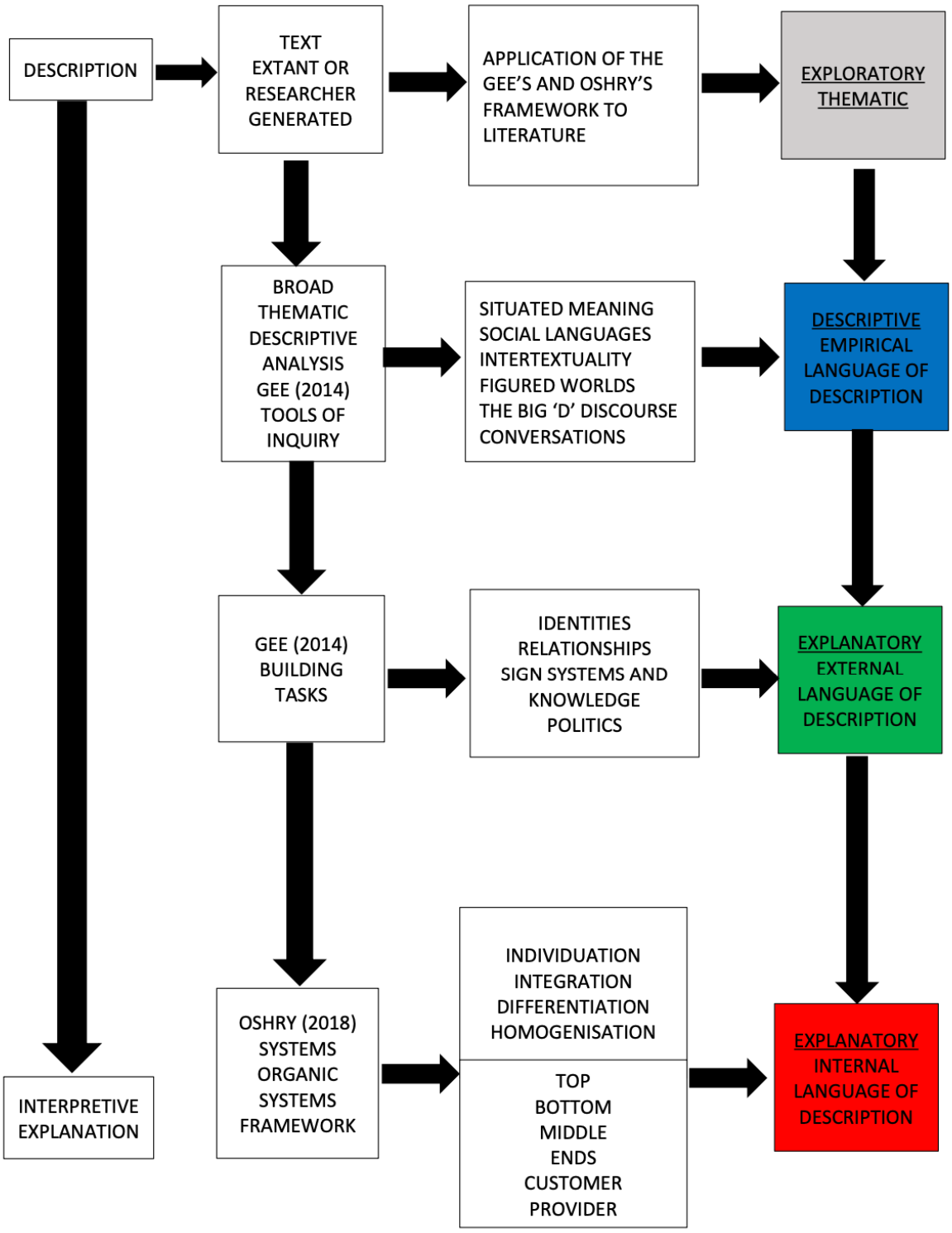


Figure 5.5 Process of data transformation

Chapter 6 Applying the Frameworks of Gee and Oshry to the Literature Review

6.1 Introduction

Discourse analysis as presented by Gee (2010) is particularly suitable for application to the literature review as any given source, be it an article, policy, opinion piece or editorial, that informs the review represents a discourse. Analysing the literature review in this way captures debates and discourses swirling about that constitute a particular social reality at a point in time, recognising that its emerging construction is always in process. Onwuegbuzie and Frels (2014) imply that literature review sources are not meaningful in and of themselves, an opinion supported by Phillips and Hardy (2002) who highlight that it is only through its connections with other sources, the diverse discourses upon which it draws, and the nature of its development, dissemination and utilisation that the literature acquires meaning. In the context of my literature review, discourse analysis will involve examining how sources are made meaningful through these processes and the role they play in constructing particular social realities. By subjecting the literature review to a discourse analysis, I am interested in exploring relationships between discourse and the social realities of the ANP. Applying Oshry's (2018) Organic Systems Framework (OSF) to the literature will provide a further layer of analysis to allow me to investigate how ANPs comprise a system that can be described in terms of the distinctive patterns of relationships and processes that constitute it and then to illuminate the relationships and processes evident in the literature that characterise the ways in which the ANP (sub-) system interacts with the wider healthcare system.

I applied Gee's (2010) discourse analytic approach and Oshry's (2018) OSF to the literature review primarily by examining the findings, opinions, interpretations and feelings that are presented in each empirical article, policy, opinion piece and editorial and considering whether and to what extent Gee's (2011) building tasks and tools of inquiry, and Oshry's (2018) OSF added value through uncovering new meanings. That is, for my given topic, I first examined whether, to what extent and in what ways each of the building tasks of significance, activities, identities, relationships, politics, connections and sign systems and knowledge, as well as the tools of inquiry of situated meaning, social language, intertextuality, figured worlds, Discourse and

Conversations are realised in the extant literature. Secondly, I examined whether, to what extent and in what ways each of the distinctive patterns of systemic relationships and processes are realised in the literature. These patterns of relationships and processes shape how ANPs experience themselves, one another, other members of the system and the system itself.

6.2 Language-in-Use – The ANP Role

The first section identifies the language-in-use that constitutes key circulating discourses concerning the role of the ANP.

Activities are built by language-in-use such as ‘extended’, ‘expanded’ and ‘advanced’ (Laperrière, 2008) which has created confusion and ambiguity around the role and resulted in a failure to adequately convey what an ANP does in the health system. Conversations that are taking place within the health system focus on the issue of whether the foundations of the ANP role are grounded in a nursing paradigm, a medico-nursing world or some other healthcare domain. In turn, ANPs are positioned as disempowered Middles, sliding between these nursing and medical identities and constructing a confusing identity for some. Paying attention to the characters narrating in these Conversations, it is evident that ANPs are emphatic that ‘nursing is the basis for their practice’ (Carryer and Adams, 2017) whereas other health professions use language that recognises a hybrid element to the role which functions with ‘one foot in medicine and one foot in nursing’ (Ulrich, 2010, p. 10). Larger Conversations at play include ANPs preoccupation with medicine when the role is discussed. The presence of this Conversation results in ANP practice being defined with reference to medicine, a position that is seen as antithetical to the essential values of the ANP role (Carryer and Adams, 2021). In this context, differentiation is submerged and the alignment of the ANP role with medicine may limit the distinctive potential contribution of the ANP to the system.

Constructing an identity for ANPs that crosses over into the medical domain attempts to enact an identity that is new and has not existed in the health system. Differentiating, ANPs bring variety to the system and the system becomes richer for the value that

they bring. ANPs employ medical terminology as a social language to create this identity by using language such ‘history-taking’ ‘diagnostic skills’ and ‘referral rights’ (Panigua, 2011). Enacting this medical identity, ANPs attempt to obtain a more socially recognisable identity and higher status. This ‘medicalisation’ of the role is recognised by other professionals who use language suggesting that the ANP role has ‘lost its nursing and caring identity’ (Griffin and Melby, 2006). This is done at a cost, as some nurses resist, and are ‘ambivalent’ about, the ANP role, using language such as ‘‘nurses who practice in doctors' clothing" to connect the role with a perceived medical identity (Li et al., 2013, p. 5). Within this environment, the position of ANPs as disempowered Middles, torn between the conflicting identities of medicine and nursing, is reinforced.

ANPs are endeavouring to construct an identity for themselves that aligns with nursing. They want society to see them first as nurses and then as advanced practitioners (Burgess and Purkis, 2010). This is evident in language-in-use that continually emphasises the ‘nursing’ aspect of the role, such as having ‘allegiance to a nursing philosophy of practice’ and having skills ‘derived from a nursing paradigm’ (Carryer and Adams, 2017; Lowe, 2017). How this is accomplished is shown through the use of the tool of inquiry, intertextuality, when nursing is discussed, commentators allude to texts and sources that refer to previous identities for nurses such as ‘Angel of Mercy’ and ‘Sex Object’ (ten Hoeve et al., 2014). Using this kind of language, nursing knowledge is identified as inexpert and less influential than medicine. These themes and values are products of historical disputes between and among different Discourses. These Conversations go beyond the confines of the text itself and larger Conversations at play in society can be identified. These Conversations include nursing being identified as a female role with an inference that it is inferior and less educated than other traditionally male-dominated health professions. Rather than taking responsibility for themselves and their system, ANPs instead are positioned as oppressed Bottoms, holding others responsible and reinforcing this figured world where nursing is identified as inferior to other professions.

Sign systems and knowledge are being constructed by ANPs using language to privilege their role over other healthcare roles as well as building identities in an attempt to persuade colleagues and service users that the ANP role and identity is

complex, varied and valuable and also to rid themselves of identities traditionally ascribed to nursing that do not serve their purpose. Language-in-use such as ‘better diagnostic skills’, ‘increased awareness...and a greater impact’ (Thompson and Meskell, 2012) and ‘key players…for a more efficient workforce’ (Lowe et al., 2012), mark their identity as one that is most effective and desirable specifically at ‘addressing shortcomings’ (Archibald and Fraser, 2013). A lot of this discussion is ANPs talking among themselves about themselves. In turn, ANPs position themselves as disempowered Tops in the literature, sucking up the responsibility by continuously returning to arguments that are based on comparison and alignment rather than positioning themselves as distinctive practitioners in their own right.

Some authors build connections between nursing and a caring function whilst connecting doctors with a less caring role through language such as ‘caring is a fundamental part of the ANP role…whilst medics ‘aren’t very good at the caring piece’ (Begley et al., 2014, p.4). In turn, this language-in-use makes caring relevant to the ANP role but less relevant for doctors. Nurses themselves have used this language to create a simplified figured world that constructs nurses as being more caring and holistic than other health professionals. This is taken to be normal by society but this discursive monopolising of caring and holism by nurses negates the caring and holistic aspects of other professionals' practice within the system. Within this environment, the literature positions ANPs as burdened Tops sucking up the monopolisation and responsibility of providing a caring service.

This monopolisation of the caring identity relates strongly to the Discourses that exist in Ireland where the image and identity of nursing is interweaved historically with religious and secular orders. This identity does not serve the purpose of the ANP as it contributes to the belief that nurses can be caring and kind but at the expense of an identity as a professional practitioner who is educated and knowledgeable and can lead. In response to this, identities are constructed by ANPs by employing language-in-use that attempts to create an identity that is related to ‘education, research and policy’ (NCNM, 2007). As part of this identity, ANPs position themselves as empowered Middles, for whose role, education, coaching and facilitating are pivotal, and seek to persuade others to recognise and acknowledge that they have an important role to play beyond the direct provision of clinical care and treatment.

Relationships are built with some nurses using language that identifies the ANP role as ‘eroding the traditional role of the caring nurse’ and in turn the relationship between ANPs and some nurses has ‘become strained’ (Griffin and Melby, 2006). This language-in-use has resulted in some ANPs becoming isolated and siloed, and an imbalanced Customer/Provider systemic relationship is built. Some nurses, acting like righteously done to Customers hold the ANP responsible for issues that exist in the system, such as the erosion of the nursing identity and medicalisation of nursing. Conversely, other nurses use language that recognises that the ANP role has brought ‘the profession into the twenty-first century’. They identify the role as ‘experienced’ and ‘skilled’, changing existing relationships in the health service for the better (ten Hoeve et al., 2014). Considering this outlook, ANP systems are identified as exerting Power through individuation and differentiation.

ANPs use language that recognises these experiences and skills by enacting the identity of a leader by positioning themselves at the ‘forefront’ of ‘complex health systems’ (Aleshire et al., 2012). They employ the social languages of leadership and management such as, ‘replace hospital appointments and in turn free up hospital resources to deal with other issues’ to enact an identity that will help solve problems in the health system (Casey et al., 2017c). This social language of leadership is used by ANPs to show ‘membership’ of the health system and to be recognised as competent and efficient leaders as well as practitioners. Here, ANPs are positioned as empowered Bottoms in the healthcare system, accepting responsibility for the system in which they work.

Significance is constructed for independent practice where ANPs give meaning to ‘autonomy’ as they use language such as, ‘fearing collaboration will make their role dependent and challenging’ to make autonomy significant. However, the word ‘autonomy’ creates problems for professionals in other disciplines with language-in-use that indicates that the ‘focus should be on collaboration and not sovereignty’ (Street and Cossman, 2010). Using the tool of inquiry, big ‘D’ Discourse, ANPs use language to insist that their role should be ‘independent and autonomous‘ (Begley et al., 2013), enacting an identity that is self-governing. In this environment, individuation

is to the forefront, where the ANP pursues individual goals and interests to prevent the role from being aligned to medicine.

6.3 Language-in-Use – The Medical Question

The second section identifies the language-in-use that constitutes key circulating discourses concerning medicine and the ANP role.

Significance, connections and identities are built by some medics, with their language-in-use placing certain words and terms to the foreground; for example, indicating that the ANP role is 'lacking' something, provides a 'lower quality of care' and that 'safety issues' arise when independence for the ANP role is discussed. The burdened Top/oppressed Bottom systemic relationship manifests in this context with the medic as the burdened Top, the only professional that can provide the required level of clinical care. ANPs on the other hand are constructed as oppressed Bottoms. This foregrounds significant doubts around advanced nursing practice (Maten-Speksnijder et al., 2014, Hoskins, 2012). Medics construct ANPs as inferior practitioners by using language such as 'lesser or more narrowly trained' than doctors who provide services for patients with 'simple' and 'non-complex' conditions (Power and Philips, 2017). The phrase 'lesser or more narrowly trained' professional provides a situated meaning that any professional that is not a doctor is inadequately educated and trained. A context is construed that enacts an identity for ANPs that cannot be independent and autonomous but instead requires supervision and management.

The building task of identity is accomplished through language, such as suggesting that 'certain tasks are forever to be performed by ANPs and other tasks performed by doctors', a picture is drawn of a simplified and static healthcare world that places each healthcare role in boxes (Wilson et al., 2015). Epithets such as 'physician extenders', midlevel providers' and 'non-physician providers' (Poghosyan et al., 2012) lessen the importance of the ANP role by signifying it as less than medicine and providing a service that is second class. Discursively describing something with reference to lack is problematic, as in 'non-physician'. It constructs an absence or lesser status relative to a dominant referent. Some medics have used this figured world and invited others

to assume that, whilst ANPs are highly competent, they cannot care for ‘complex’ patients and should not be seen as a panacea for healthcare issues (Newhouse et al., 2011). Activities are additionally being built where the use of language such as ‘reluctant to accept’ (Norris and Melby, 2006) and ‘ANPs should be supervised’ (Nardi and Diallo, 2014) informs others that medics see themselves as overseers of the health service and that any decision in the health system requires their approval. Medics are therefore positioned as the burdened Top, donning the ‘gatekeeper’ identity (Irish Medical Organisation, 2017) rather than distributing responsibility throughout the system.

This burdened Top identity is also seen in the language used by ED clinical directors who suggest that ‘ANPs could not match the patient throughput achieved by junior doctors’ (Li et al., 2013) to connect the work of the ANPs with decreased efficiency and conversely connecting the work of the junior doctor with increased efficiency. This viewpoint implicitly considers efficiency in absolute terms where numbers are seen as relevant and quality irrelevant. Phrases and language such as ‘longer consultation times’ and ‘higher incidence of referrals’ (McGlynn et al., 2014) are used in a way, which provides a situated meaning identifying this as a ‘bad thing’. Some doctors use the big ‘D’ Discourse of thinking about a ‘good’ health service in numbers and hard figures (Li et al., 2013) to enact an identity for themselves that is socially recognisable – an element of a ‘get them in and get them out’ philosophy. Some authors believe that scientific medical knowledge is ‘simply the more powerful knowledge’ (Beck and Young, 2005). Employing this sort of language is part of a Discourse that enacts a belief and recognisable identity for medics that is seen as more erudite than other health professionals.

Relationships are being built when some medics use language to maintain their superior relationship within the health system. These systemic relationships are positioned as medics acting like burdened Tops sucking up the responsibility of the ANP system and ANPs positioned as oppressed Bottoms that need to be controlled and supervised. Language-in-use such as, ‘accepting’ that nurses should be allowed to undertake certain advanced skills’ (Norris and Melby, 2006) and identifying physicians as the ‘natural’ leader (Nardi and Diallo, 2014) seeks to enact a relationship with ANPs that is based on concern and control. This relationship is sustained by some

medics who use language such as ‘cannot match’ a medic and ‘increased cost’ of ANP positions (Li et al., 2013). This idea of cost and efficiency is seen in the relationships being constructed in the language-in-use expressed by medics such as ‘ANPs earn as much money as junior doctors and are therefore not a valid alternative’ when discussing ANP services (Markewitz, 2013). The situated meaning that can be attributed to this statement is that even if doctors and ANPs earn the same it is better to choose the doctor. The words ’accept’ and ‘certain’ in the sentence concerning doctor’s reluctance to ‘accept that nurses should be allowed to undertake certain advanced skills’ (Norris and Melby, 2006) are both used to presuppose that doctors have the final say on what advanced skills the ANP role assumes. A system is constructed that is imbalanced where medics are free to pursue their individual goals whereas ANPs are prevented from individuating and being all that they can be.

Further connections are being built with language-in-use such as ‘decision makers…think of medical solutions to health problems’ (Currie et al., 2012) that connects medicine with problem solving and decision making within the health system and therefore creates an identity for medics as authority figures. These connections are evident in the language used by medical representatives who use the word ‘gatekeeper’ to represent GPs in the health system – a term which indicates control and jurisdiction. The intertextuality tool of inquiry shows how this is further accomplished when Irish medical organisations allude to draft policies produced by the Department of Health to argue the case that any expansion of healthcare services should be ‘aligned to General Practitioners’ (Irish Medical Organisation, 2017). By using language such as ‘jumped up’ (Oxtoby, 2016), which positions ANPs as undeserving of enhanced status and less important than they consider themselves to be, medics are creating a socially recognisable identity for themselves of defenders against pretenders to their positions and power.

Sign systems and knowledge are being built by the language-in-use of some doctors, such as ‘only doctors have necessary diagnostic and prescriptive training’ (Oxtoby, 2016) and ‘medical ability as pinnacle of achievement’ (Carryer et al., 2007) which accords great authority to the service they deliver and de-privileges the service that other health professions provide. Again, we see here medics acting like burdened Tops, sucking up all responsibility and believing that no other professional can ‘match

their ability' (Li et al., 2013). This language presents a figured world that invites individuals to assume that medical ability is more important and superior to other health professionals' abilities. Within this figured world, it is taken as typical and normal that doctors would maintain 'professional control over health services' (Street and Cossman, 2010).

Sign systems and knowledge are also being built by some individuals' use of language that de-privileges the ANP role, identifying ANPs as followers and 'not recognised as leaders or independent professionals' (Anderson, 2018). This privileges one form of knowing and knowledge, medicine, over others, such as ANPs' nursing knowledge and practice, and accords greater authority to medicine over nursing. This is shown through the big 'D' Discourse tool of inquiry whereby some ANPs employ language that constructs the medical role as controlling and superior whilst enacting an identity for ANPs that is subaltern, sitting at the bottom of a 'hierarchical medical system'. Within this system, ANPs are positioned as oppressed Bottoms and hold others responsible for the conditions they find themselves in. Taking no responsibility for this positioning results in the ANP becoming disempowered and their activities 'constrained by interdisciplinary relationships, organisational culture and role isolation' (Higgins et al., 2014).

6.4 Language-in-Use – Cost Effectiveness

The next section identifies the language-in-use that constitutes key circulating discourses that focus on cost effectiveness comparisons and the ANP role.

Politics and the social good of money is shown in the language used by nurses that characterises the role as being 'cost neutral' (Begley et al., 2010). ANPs use sign systems and knowledge, the language of economics, to mark themselves as empowered Bottoms who are important members of the health system. This is evident when ANPs use language such as 'cost effective' (Archibald and Fraser, 2013), 'free up hospital resources' (Casey et al., 2017b), 'reduced turnover', 'worthwhile investment' (Weiland et al., 2010) and 'a socially responsive profession' (Archibald and Fraser, 2013) to construct ANPs as dependable and steadfast. The social

language of economics is employed by others to de-privilege the ANP role with language-in-use such as ‘cost saving is offset by other factors’ (Maten-Speksnijder et al., 2014), ‘replacing doctors with a non-physician may even be more costly’ (Markewitz, 2013). Within this environment, differentiation occurs without homogenisation, where commonality and oneness are disregarded and a territorial system is created.

It is significant that value is reduced to monetary aspects, which are foregrounded in the literature, particularly in articles written by medics (Markewitz, 2013, Maten-Speksnijder et al., 2014). Significance is built by doctors’ language-in-use that makes their role more significant, using language such as providing a ‘superior’ and ‘higher quality’ service (Donelan et al., 2013) than their ANP counterparts. ANPs, however, employ language such as ‘raising standards of quality and efficiency’ (Zwijnenberg and Bours, 2012) to build significance for their perceived distinctive contribution or ‘money’s worth’. Again, in this system, doctors act like disempowered Tops sucking up responsibility and constructing barriers that prevent collaborative practices. When discussing the ANP role, certain individuals use the social language of accountancy, employing percentages and numbers to argue that ANPs are ‘good’ for the health system (Bauer, 2010). ANPs also adopt this social language to affirm the role they play, especially when discussing cost savings.

Some medics use language that invites others to accept that ANPs will cost the same as doctors so therefore why alter what currently exists, i.e., employing doctors rather than ANPs. However, ANPs, through language such as ‘ANPs can be substituted for doctors in a significant portion of medical services –with *at least* comparable outcomes’, are inviting listeners to assume a figured world that shows their role will reduce costs and provide a comparable service to doctors (Bauer, 2010). Additionally, ANPs eschew counting value in absolute terms, and instead use language that contributes to the building task of politics, emphasising the social good of access to equitable healthcare through, for example, ‘shorter re-hospitalisations, reduced burden on outpatient clinics’ and ‘free up hospital appointments’ (Moore and McQuestion, 2012, Casey et al., 2017b). This suggests that nurse-led healthcare services have ‘more positive healthcare costs’ in comparison to services provided by

doctors (Albers-Heitner et al., 2012). Thus, ANPs invite others to position ANPs as empowered Bottoms that are integral to and improve the healthcare system.

6.5 Language-in-Use – Collaboration and Relationships

This final section identifies the language-in-use that constitutes key circulating discourses concerning collaboration, relationships and the ANP role.

Connections are built when ANPs employ language that connects their identity to partnership and teamwork, identifying collaboration as the ‘cornerstone’ of the ANP role (Rashotte and Jensen, 2010). With this language-in-use, ANPs make their role and other health professionals' roles valued and relevant in the healthcare system. This collaborative model is explicitly connected with the integration of the ‘diverse knowledge and skills of multiple types of providers’ (Stanik-Hutt et al., 2013) and constructs an ANP identity of an empowered Top that involves others throughout the healthcare system. In this way, ANPs connect their role with desired service changes and improvements through language such as ‘ANPs are in an excellent position to address current (healthcare) shortcomings’ (Archibald and Fraser, 2013). This makes their role salient and relevant to the health system.

Significance is built for collaboration as it is identified as important for health systems to operate effectively. Language-in-use such as ‘critical to establish’ and ‘embrace the gifts’ suggests that health services ignore at their peril the benefits of team-working when compared to the ‘traditional medical hierarchical model of…ineffective teamwork’ (Institute of Medicine, 2011). As Discourses are about being ‘kinds of people’, these organisations want health professionals to be identified as ‘cooperative and interprofessional’, ways of working that are associated with collaboration and enhanced care. This is realised when ANPs use language that constructs an empowered Top identity that supports the principle of equality and equity for all healthcare professions and enables the system to homogenise. Using words like ‘resisting elitist aspects’ and ‘commitment to egalitarian power relations’ signals a social language that is based on fairness and parity (Burgess and Purkis, 2010). When discussing efficiency and effectiveness within the health system, several authors

assign significance to the act of collaboration. A figured world that takes ‘working together’ to be normal and contributing to improvements enables systems to express their love by integrating and homogenising through connectedness and mutual responsibility.

Relationships have been affected by the crossing of role boundaries, which has changed doctor-nurse relationships and provoked resistance. Language-in-use by some medics such as ’invading’ (Lowe et al., 2012) is provocative as it indicates that ANPs are attacking or assaulting the relationship that has existed between doctors and nurses. This is evident in the Discourses wherein some medics employ language such as, ‘losing their professional identity’, their role is being ‘devalued’ and they are struggling to ‘maintain a professional role’ (Harmer, 2010) to create an identity that is under attack and being ‘eroded’ (Street and Cossman, 2010).

6.6 Chapter Conclusion

By applying Gee’s (2010) discourse analytic approach to the literature review, I have explored the discourses that are in circulation concerning the ANP role and how they affect the social realities of the ANP. Oshry’s (2018) OSF provided a further layer of analysis and allowed me, first, to show how ANPs comprise a system that can be described in terms of the distinctive patterns of relationships and processes that constitute it and, second, to illuminate the relationships and processes evident in the literature that characterise the ways in which the ANP (sub-)system interacts with the wider healthcare system.

I now present the rest of the study’s findings from two different angles. First, through Gee’s lens, I show what language constructs and how, employing his Tools of Inquiry and Building Tasks frameworks. I focus specifically on the tasks related to building identities, relationships, politics (distribution of social goods) and sign systems and knowledge. Second, through Oshry’s lens, I explore the patterns of relationships and processes at play in those constructions.

Chapter 7 Empirical Language of Description: Presentation of Outcome of Analysis of Participants' Language-in-Use Using Gee's Tools of Inquiry

7.1 Introduction

The purpose of this chapter is to present the empirical LOD. The findings in this chapter represent the ways in which the participants *describe* the ANP from the vantage point of their own experience [figure 7.1].

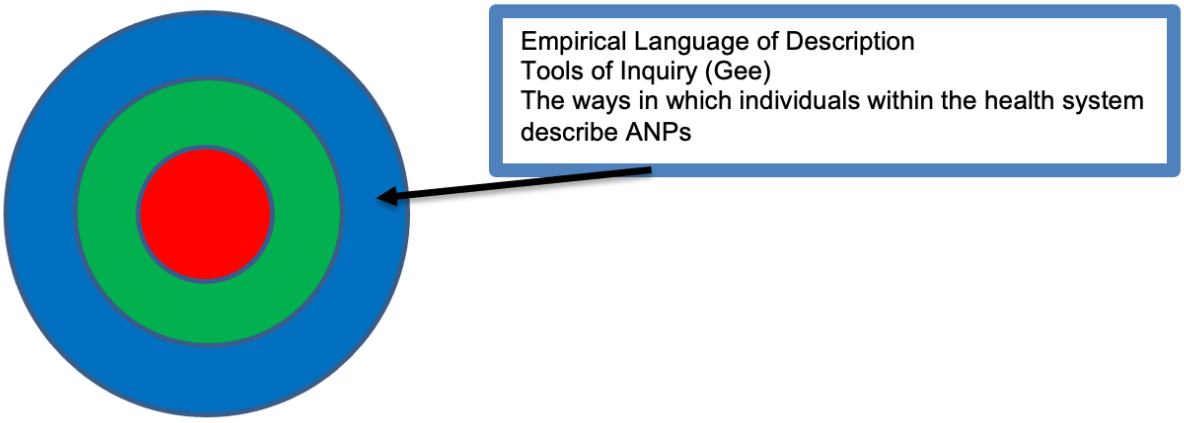


Figure 7.1 Empirical Language of Description

Considering the bespoke approach to CDA and Systems Thinking used within this thesis, figure 7.2 shows where the works of Gee (2014) and his Tools of Inquiry intersect with the theoretical framework and design. This chapter examines this element of the framework.

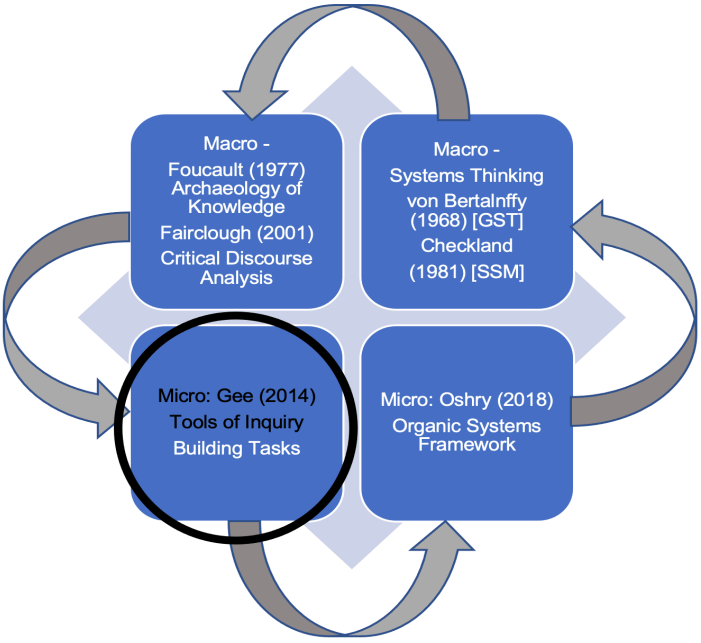


Figure 7.2 A bespoke approach to CDA and Systems Thinking showing key points of intersection with theoretical framework [Adapted from McNamara (2007)]

There is a 'thematic' element to this process and the analysis of participants' language-in-use is presented using Gee's (2014) Tools of Inquiry [figure 7.3] (situated meanings, social languages, intertextuality, figured worlds, Big D Discourse and Big C Conversations), setting up what is being constructed in, by and through language. Further explanation of these tools is provided in table 7.1.

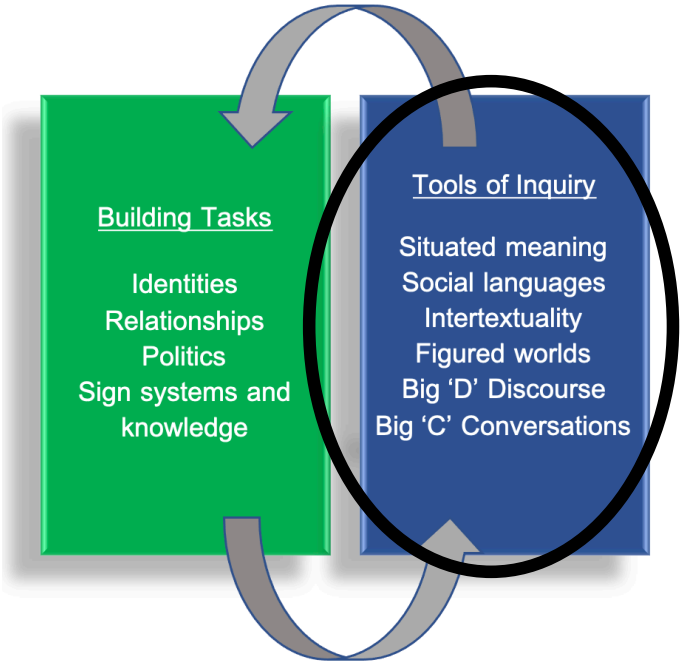


Figure 7.3 Gee's (2014) Discourse Analysis Framework – Tools of Inquiry

Tool of Inquiry	Definition
Situated meanings	Any word or structure in language has a certain 'meaning potential' that is the range of possible meanings that the word or structure can take on in different contexts of use; e.g., 'nursing' in nursing mother or nursing practice or nursing theory. Words have different and specific meanings in the different contexts in which they are used and in the different specialist domains that recruit them.
Social languages	Styles or varieties of a language (or a mixture of languages) that enact and are associated with a particular social identity; e.g., the language of science, medicine or nursing.
Intertextuality	When one text (in this sense) quotes, refers to, or alludes to another text as in 'When John fought with his boss, it was like David and Goliath!' Here my speech (the 'text) has alluded to (made an intertextual reference to) a Biblical text
Figured Worlds	A picture of a simplified world that captures what is taken to be typical or normal – what is taken to be typical or normal varies by context and by people's social and cultural group.
The Big 'D' Discourses	Distinctive ways of speaking and listening and/or writing/reading are coupled with distinctive ways of acting, interacting, valuing, feeling, dressing, thinking and believing. In turn all these are coupled with ways of coordinating oneself with (getting in synch with) other people and with various objects, tools and technologies.
The Big 'C' Conversations	Debates in society or within specific social groups (over focused issues like smoking, abortion, or school reform) that large numbers of people recognise, both in terms of what "sides" there are to take in such debates and what sorts of people tend to be on each side.

Table 7.1 Definitions of Tools of Inquiry [Adapted from Gee (2017)]

In figure 7.4, I depict the steps of the data transformation process presented in this chapter.

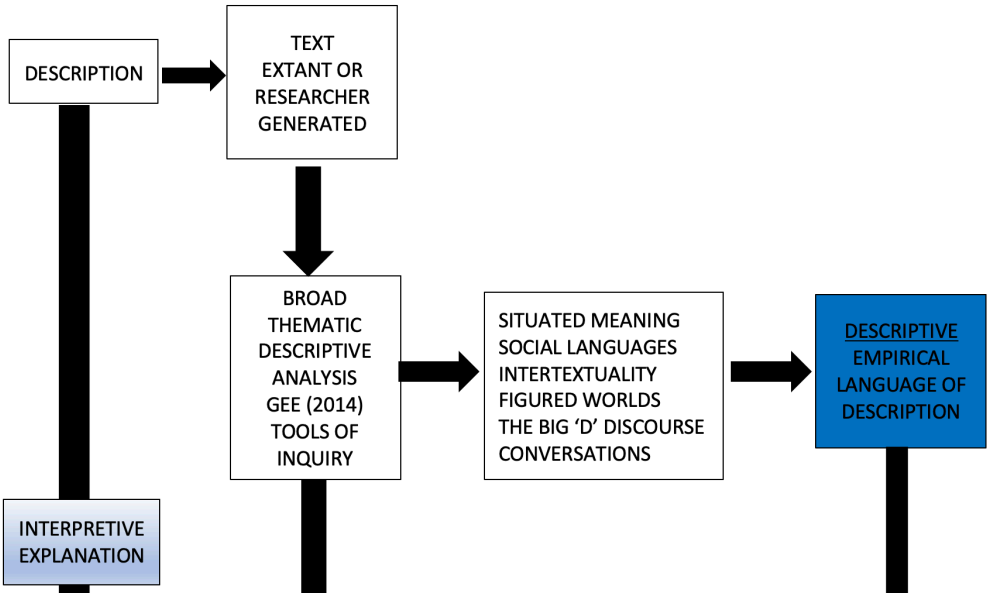


Figure 7.4 Process of Data Transformation – Empirical Language of Description

I now present five broad themes in terms of Gee's (2014) Tools of Inquiry that are constructed in, by and through language that describes the ANP from their vantage point of their own and their colleagues' experience. The following headings have been used:

- The value for money and value adding nurse practitioner
- In search of the nurse
- The skilled and willing doer
- Carving out a place in the healthcare system
- Supervision or control?

Selected direct quotations are used in the headings as they were particularly useful in understanding the saying, being and doing of the participants. I now present each theme in turn.

7.2 'They're worth their money – 100% - The Value for money and Value Adding Nurse Practitioner

A predominant premise evident in the findings relates to value. It is continuously raised by participants when the identity of the ANP is discussed both from a positive and a negative aspect. ANPs employ language that builds up the way they have come to be positioned within the health system and use the social language of a narrow bureaucratic managerial discourse, almost accountant like, to mark themselves as important members of the health system. ANPs are endeavouring to construct their own powerful identity by employing these different styles of social language to establish themselves and argue that ANPs are 'good' for the health system. ANPs adopt this social language to affirm the role they play specifically when discussing financial cost savings. This is evident in the language-in-use such as 'Well ANPs are worth their money – 100%' and 'good value for money' (FG4A4) which creates an identity that is financially worthwhile.

In contrast, the social language of economics is employed by others to de-privilege the ANP identity with language-in-use such as ANPs being positioned as 'cheaper versions' (FG2A9) of doctors. A situated meaning is constructed that the ANP identity is somehow a cheaper and inferior identity when compared to other professions in the healthcare system – some may say a yellow pack healthcare professional, a generic term for cheap products or low-paid jobs in Ireland. This idea is further seen when participants use words such as 'just a' when referring to the ANP identity. Examples include 'seen by a doctor as well or just by you…' (I7M3) and 'they're not just nurses' (I6M1). The term 'just' carries a significant amount of weight and diminishes the importance of the ANP identity by not placing a worth or value on the role, particularly the nursing element.

For some participants, value is related to enhanced patient outcomes while for others the idea of value is reduced to monetary aspects and cost is made significant. Senior nurse managers describe the role as beneficial if it is seen to save money for the healthcare system and improve patient journeys through the system. One Director of Nursing uses language that shows this:

> ‘It’s vital to look at cost because everything ultimately will come down to cost…then you say well what is the benefit of paying a high salary to a nurse if there are no improved outcomes and reduced costs.’
>
> (I4NM3)

This ‘value for money’ Discourse is prevalent in the system, where ANPs are positioned as an expensive commodity and a situated meaning is constructed that if ANPs do not save money they cannot be a ‘valuable’ member of the healthcare system. This idea is also considered by nurse managers who work alongside ANPs, but these managers are more likely to consider value in terms of quality when discussing the ANP identity. One nurse manager observes that ANPs are ‘more expensive to train and hire an ANP than to bring in a junior NCHD but if you want to look at their quality of care, I don’t think you could argue that they’re not cost effective…’ (FG3NM2). This opinion is further supported by medics who argue that whilst ANPs may not be:

> ‘…any more cheaper than a doctor, I just think the quality is so much better. If you pay for quality, you get quality in return and I think that is what the ANPs are all about.’
>
> (I6M1)

Other participants employ language that continues in this vein moving the ANP identity away from counting value as cost to a wider concept of value and value from the service user perspective. Language-in-use such as ‘reduce waiting times’ (I5M2), ‘we don’t waste resources’ (I2A1), ‘avoidance of admission’ (I3NM1) and ‘reduced staff turnover’ (FG3X4), invites others to assume a picture of a simplified world that sees ANPs as integral to the health system. This ‘added value’ figured world connects the work of ANPs with enhancing the system, with improved quality care, improved patient outcomes and better patient experience to the forefront of their identity. A situated meaning is created where doctors can be positioned or constructed as less efficient, wasting resources and admitting unnecessarily:

> ‘We don’t waste resources. I know from my own practice or my colleagues’ practices there’s no unnecessary investigations or you know…compared to a lot of other people, doctors who would order multiple x-rays unnecessarily, multiple blood tests unnecessarily.’
>
> (I2A1)

Countering the previous construction, conflicting findings were shown by some medics' and nurse managers' language that constructed an 'invalid alternative' figured world where ANPs 'pick and choose what they see' (I5M2) and have 'limited scope' (I6M1) and 'longer consultation times' (FG3NM2). By connecting these to the ANP role they attempt to provide a situated meaning that scopes of practice and longer consultation times are 'bad and do not add value' whereas ANPs provide a conflicting situated meaning that these are 'good and do add value':

> I think as nurses we look at the patient as a whole…patients will sit and talk and tell you important things about their life and they really appreciate you giving them time'
>
> (FG2A2)

These discourses do not exist in a discursive vacuum and ANPs are quick to highlight the values and savings that their role and presence within the healthcare service provides. ANPs employing the tool of intertextuality, refer to *The SCAPE Report* (Begley et al., 2013) and recently published *Policy on the Development of Graduate to Advanced Nursing and Midwifery Practice* (Department of Health, 2019) for support. Both of these texts were discussed in the literature review section and their findings emphasise the value that the ANP role brings to the health system from both a cost and quality perspective. Intertextuality is affected only if the source is aware of these texts and whilst the majority of nursing participants were familiar with these documents, other healthcare professionals, including medics, were not. Participants within the study construct the ANP role as one that improves the patient's experience of the healthcare system.

ANP permanency is constructed as a positive aspect of the role adding value to the system when compared with other healthcare professionals. Rather than medical transience, which is seen most commonly in junior medics, participants suggest that ANP permanency has led to significant system improvements including reduced waiting times, reduced hospitalisation and length of stay:

> '…the ANP is in the job on a permanent basis…they're consistent, they are a consistent body, they get to know the run of the place…they become a constant of the hospital whereas you build up a rapport with a doctor and next thing he's gone.'
>
> (FG3X4)

Employing language that emphasise the permanence of the ANP role, such as ‘consistent body’ and a ‘constant of the hospital’ creates a figured world where the ANP identity is built in a narrow sense as continual, regular and a steady continuity in the system and the medical identity contrarily is constructed as temporary and transient. A situated meaning can be constructed where participants, in their own subsystems, connect this permanency to added value and system improvements where ANPs can build a rapport with members of the MDT over time whereas junior medics are less able to do so.

Participants use language that recognises the value of the expertise that the ANP brings with them within their role. They connect these skills and expertise with the experience the ANP has assimilated:

> ‘Like a lot of people who have ended up in an ANP role have been working in that area for long…have experience of that area for a long time you know will get to develop skills that they will be capable any medical doctor.’
>
> (FG1N15)

> ‘An ANP has a lot of experience…they may have huge more experience than a junior doctor that might not be able to take on that complex case in the first off.’
>
> (FG1N2)

Participants not only connected this accumulated expertise and skill to adding value for patient care but also for the system as a whole:

> 'An ANP is gaining experience for the hospital that you’re based in which is a good thing…they’ve become a resource for the hospital.’
>
> (FG3X4)

When discussing the value that ANPs add to the health system, several participants assign significance to collaborative practice. As Discourses are about being ‘kinds of people’, healthcare organisations want healthcare professionals to be identified as ‘cooperative and interprofessional’, which are associated with this value of collaboration and enhanced care. This is realised when ANPs use language that advocates an identity that supports the principle of collaboration and assumes a figured world that takes ‘working together’ to be normal and will lead to improvements:

> ‘ANPs have always been team players do you know, other people kinda tend to work in silos, but ANPs work across disciplines and work across medicine, work across physiotherapy, OT, do you know, they coordinate and link services as well.’
>
> (FG2A9)

Language such as ‘have always been team players’ and ‘other people tend to work in silos’ (FG2A9) builds up a situated meaning of the collaborative aspect of the nursing dimension of the ANP role that adds value to the system through collaboration, and teamwork. The situated meaning constructed for medics, on the other hand, identifies them as ‘lone players’ through language-in-use such as ‘flying solo’ (I5M2) and ‘thinking they can manage everything themselves’ (I5M2).

To summarise, it is evident in the findings that participants’ language-in-use recognises the contributions that the ANP makes to the healthcare system, both from a monetary and non-monetary aspect. For some participants, value was considered from a narrow perspective, with ANPs’ value being positioned as a ‘cheaper alternative’ to more expensive doctors. For other participants, a wider concept of value was considered; the ANP was seen as integral to the health system due to the value of reduced hospitalisations and reduced staff turnover. ANP participants frequently employed the tool of intertextuality by referring to previous reports and policies to emphasise this added value. Furthermore, language-in-use shows that the accumulated skills and expertise that the ANP brings, as well the collaborative elements were seen as the foci of the value added by the ANP.

7.3 “I’m a nurse, I want to be a nurse” – In Search of the Nurse

The distinct role that the ANP provides compared to other health professionals is apparent when the language used in the interviews and focus groups is analysed. Descriptions of the ANP role provided by participants show that ANPs foreground the ‘nursing’ dimension of their identity. They argue that this nursing disposition places them in a more beneficial position than other health professionals and consider themselves perspicacious and astute in relation to patient care:

> ‘ANPs are in a position, a more advantageous position, than a doctor because we have the nursing background, oftentimes I think we see the bigger picture…’

(FG4A18)

Employing language such as ‘seeing the bigger picture’ and ‘take all into account’ (FG3X2) constructs a situated meaning where ANPs see the whole person in their total context and understands more than what is immediately apparent. ANPs’ language positioned medics in a contrary way:

> ‘…they have done a medical degree but have no experience in patient care or assessment or family or social...sometimes they can be socially inept at performing an evaluation or examination, but they know all the medical, all the conditions.’
>
> (FG3A22)

This figured world where ‘nurses care and doctors cure’ is taken to be normal by society but this discursive monopolising of caring and holism by nurses negates the caring and holistic aspects of other professionals' practice within the system. Employing language such as ‘socially inept’ when discussing doctors constructs a situated meaning that they are less adept than nurses and lack skill in patient care.

ANPs are endeavouring to construct an identity for themselves that aligns with nursing:

> ‘I’m a nurse, I want to be a nurse, and I want to practise at the highest level that I can practice at, and I know that I can do an awful lot more…’
>
> (FG2A9)

The language-in-use seen in the interviews and focus groups continually emphasises the nursing aspect of the ANP role, such as ‘we are nurses first and foremost’ (FG3A22) and ‘the fact is we are nurses’ (FG4A4). One way this is accomplished is shown through the use of the tool of inquiry, intertextuality, when the ANP role is discussed, ANPs frequently allude to texts and sources that refer to the development of the role, such as the *Commission on Nursing* (Carroll et al., 1998) and *The SCAPE Report* (Begley et al., 2013).

Even though ANPs constantly align their identity to nursing, they employ language that associates this identity with medicine such as, ‘I don’t think we’ll ever get to the stage where you’d be on par [*with medics*]’ (FG4A18). Employing the social language of medicine, nursing knowledge is constructed as less specialised and less influential than medicine. These themes and values are products of historical disputes between

and among the 'inferior nurse' and 'superior doctor' Discourses that persist. These Conversations go beyond the confines of the text itself and larger Conversations at play in society can be identified. These Conversations include nursing being positioned as a female role with an inference that it is an inferior and less educated position than that of doctors.

Participants' language builds connections between nursing and a caring function whilst connecting doctors with a less caring identity:

> 'ANPs bring something very different to a doctor. I think they are coming from a different angle to a doctor. I believe they are more intuitive, and I think they are detail oriented.'
>
> (I4NM3)

In turn, this language-in-use makes caring relevant to the ANP but irrelevant for doctors. An 'Angel of Mercy' figured world is created that draws on circulating Discourses where ANPs are primarily constructed as passionate, intuitive and caring rather than professional and expert. ANPs themselves have used this language to create a simplified figured world that constructs nurses as being more caring and holistic than other health professionals.

Whilst the majority of ANPs were keen to highlight the caring dimension of the ANP role, others were eager to rid themselves of identities traditionally ascribed to nursing that no longer serve their purpose. How this is accomplished is shown through the use of the tools of inquiry, intertextuality and Conversations, when nursing is discussed, participants allude to texts and sources that refer to the caring, 'angelic' nursing identity and the curative 'scientific' medical identity. Whilst ANPs use language that constructs 'knowledgeable' and 'professional' identities', an 'Angel of Mercy' figured world is also created that draws on circulating Discourses that construct ANPs as passionate, intuitive and 'desperately' caring as well as professional and expert:

> '…because they are passionate about their field they are passionate about caring for their patients with those conditions – that's how they show their nursing, they know those conditions, they've treated those conditions, they explain to the patients, they give them huge amounts of information and they care desperately about their patients.'
>
> (I6M1)

Several ANPs comment that there is considerable confusion amongst health professionals and patients when differentiating between whether they are a nurse or a doctor. One male ANP explains:

> 'it doesn't matter how many times I tell the patient I'm a nurse practitioner they will almost, 90%, 95% of the time when they leave the consultation they will say thanks doctor'
>
> (FG4A18)

This is further supported by another male ANP who suggests that this issue is a cultural one and 'you're not going to change the public in that regard' (FG4A7). Language such as this creates a simplified figured world where men are doctors and women are nurses related to current male/female gendered Discourses and Conversations that even though ANPs highlight to the patient that they are an ANP, they undoubtedly will be referred to as Doctor by the end of the consultation, especially male ANPs.

In summary, language-in-use shows that ANP participants were keen to highlight the nursing dimension of the ANP role. They use language connected with holistic practice to build up this nursing element whilst positioning medics in a contrary position as less adept. However, by emphasising the caring element over other aspects of the ANP role, language-in-use shows that ANPs construct figured worlds that draw on the Discourse of a virtue script (Nelson and Gordon, 2018) where ANPs, whilst passionate and caring, are positioned as less skilled and expert than their medical colleagues. This construction is recognised by the majority of ANP participants who employ language that acknowledges the need to build a more balanced identity that captures the full extent of ANPs' practice.

7.4 "The Jack of all trades" – The Skilled and Willing Doer

Employing language such as 'well qualified', 'well experienced' and 'skilled' constructs a figured world where ANPs are thought of as educated and expert professional practitioners. This professionalism and expertise are tied to the level of the ANPs' education where a situated meaning is created that the more educated an individual is the more professional they are and, equally, less education results in a more

restricted professional practice. Education is therefore seen as a social good and enables nurses to progress:

> '…as the profession developed and became a degree with more opportunity for education it has been a natural progression for us to take on more clinical roles within healthcare.
>
> (I2A1)

Whilst education is identified as a social good, several participants when discussing the ANP role refer to terms associated with tasks and skills rather than education and knowledge. Participants employ language-in-use such as, 'intubating skills' (I4NM3), 'masters at suturing' (I5M2) and 'improved scoping' (FG2A8) to construct an identity that is based around the performance of tasks:

> 'I think they are also much better at reading x-rays… I think there was an audit done and the rate of umm x-rays being read properly was much better with the ANPs.'
>
> (FG1N3)

However, findings also show that these tasks are sometimes identified as the 'simpler tasks' and 'easier tasks' like a 'little bit of simple suturing' (I5M2), which builds an identity for ANPs that is less specialised and less influential than their medical counterparts and centres around the performance of tasks. The term 'Jack of all trades' was also used by one participant when the ANP identity was discussed:

> 'They [*ANPs*] were seen as the Jack of all trades you know…not replacing doctors but at the time it was seen that nurses could do certain tasks that doctors you know could do also like suturing, plastering, x-rays, giving drugs so it filled a gap umm for that.'
>
> (FG2A2)

Here the term 'Jack of all trades' is used in a positive manner; however, the term can have negative connotations, especially when tasks are front and central:

> 'An ANP is probably doing stuff that you would probably associate with a doctor; you know dipping their toe into many of the things you would associate with a doctor…the easier tasks, you know…with the more complicated stuff being managed by senior doctors
>
> (I5M2)

> '…nurses could do certain tasks that doctors you know could do like suturing, plastering, x-rays, giving drugs so it filled a gap.'
>
> (FG2A2)

The situated meaning is that the ANP may be experienced but lacks expertise in focused areas of specialisation or, indeed, may be the 'master of none'. This runs counter to the original purpose and aims of the ANP role. Situated meanings are further constructed for the advanced element of the ANP role that relates mainly to whether and how well an individual can perform certain tasks. The use of 'master' in this context privileges a mastery of tasks rather than mastery of the knowledge required to undertake those tasks and to engage in decision making about treatment and diagnostic options let alone mastery of the scholarship required to produce and evaluate knowledge. A significant amount of talking, writing and Conversations have taken place in nursing circles and in wider society around this Discourse, including the *SCAPE Report* (Begley et al. 2010) whose findings show that advanced practice resides in the degree of decision making and accountability rather than the nature of the tasks carried out.

7.5 "Crossing boundaries isn't always right, boundaries are there for a reason" – Carving out a Place in the Healthcare System.

Participants in the study consistently raised the issue of substitution when discussing the ANP role. One ANP suggests that some people in the healthcare system believe the origin of the role was 'driven by replacing, by answering a medical problem like the waiting list to see dermatology is too long okay so let's get some ANPs in…' (I2A1). A situated meaning is created where difficulties in recruiting medics are seen by some as an opportunity to expand ANP numbers in the system. This in turn constructs an 'ANP substitute' figured world where ANPs fill workforce gaps and consequently ANPs are then thought of as medical substitutes rather than practitioners in their own right. This is evident in the language-in-use of one radiographer:

> 'I suppose if you look at it from a hospital perspective there and this is just my opinion, just say for, you basically mightn't need as many doctors if you have more ANPs in roles, so then your pool of doctors get smaller…You're probably decreasing on the NCHD side when it's probably more of them that you need for all these new services coming on stream...'

(FG3X4)

Further emphasis is given to this idea by the language employed by some medics. The use of phrases such as ANPs are 'losing part of themselves' (I7M3) creates a simplified 'nurses who practice in doctors' clothing' figured world where ANPs need to shed their nursing background to undertake their role which strengthens this medical-replacement identity. Using language such as 'replacing', 'substituting', and 'answering a medical problem' (I2A1) when discussing the ANP role constructs an attenuated medicalised identity for the ANP with medicine to the forefront and nursing to the back, 'a doctor manqué' figured world. Language-in-use shows that Conversations taking place within the health system focus on the issue of whether the foundations of the ANP role are grounded in a nursing paradigm, a medico-nursing worldview or some other healthcare domain. Paying attention to the characters contributing to these Conversations, it is evident that ANPs are emphatic that nursing is the basis for their practice, whereas other healthcare professionals employ language that recognises the hybrid nature of the ANP role that crosses professional boundaries and 'takes on medical roles' (I2A1). The presence of this Conversation results in ANPs' practice always being associated and defined with reference to medicine.

Language-in-use constructs an environment where it is difficult for ANPs to carve out a defined place for themselves in the healthcare system. One ANP highlights the requirement to prove himself before he can further advance his role, having to 'get permission even before I want to expand my practice and jump through hoops to you know…prove myself'(I2A1). Through this language a situated meaning is built that without this 'walking the walk', the ANP role will not be valued by others in the healthcare system, as 'respect is something that you have to earn so the more that the ANP service works in the hospital the better they are going to earn it' (FG4A4). This idea is further reinforced in the language used by medics when they talk about acceptance of the ANP:

> 'What you need to do is get a few ANPs out there and they will realise that the ANPs are doing a fantastic job and it actually makes their life easier.'
>
> (I6M1)

Several participants employ language-in-use that construct ANPs as inferior practitioners, devaluing the nursing element of the ANP role. An example of this language includes:

> I'd say they still look at us as handmaids in a way ummm now I can only talk about my own situation, they definitely think that you're just a nurse.'
>
> (FG2A9)

Use of language such as this constructs a situated meaning that the ANP identity is a relatively inferior role to other professions in the healthcare system by virtue of its basis in nursing. This idea is further enhanced with the use of 'just a' when referring to the ANP identity. Other examples from the interviews and focus groups include 'seen by a doctor as well or just by you…' (I7M3) and 'they're not just nurses' (I6M1), where the use of the term 'just' works to diminish the importance of the ANP identity by not placing a worth or value on it, particularly its nursing element.

Other examples of language-in-use include 'less than' and 'subservient to others' (FG2A9) with participants relating their identity to other professions and being identified as 'handmaidens' by their medical colleagues:

> '…we have a very important role but we don't see ourselves as very important and I think we become subservient to other professions and we allow that to happen.
>
> (FG2A9)

This terminology creates a situated meaning that ANPs are at the beck and call of others and this language arguably constructs a situated meaning that medics have played a significant role in creating barriers to the future advancement and development of the ANP role. A figured world is constructed in which ANPs are positioned as only doing work that is technical in nature and not as cognitive or intellectual as that of other healthcare professionals. This language-in-use is also evident in the findings when medical consultants discuss doctors and ANPs, referring to them as 'their doctors' and 'my ANPs' (I6M1), constructing a situated meaning of ownership on the consultants' part. This 'nurses who practice in doctors clothing' Discourse is prevalent in the system, where ANPs are seen to enact an identity that is connected to and reliant on medicine. This reliance on medics is seen in the language used by one nurse manager:

> ‘I don’t see who can replace that clinical knowledge within an organisation to give you the governance that you would need.’
>
> (I4NM3)

Using language such as ‘you’re getting seen by a nurse but also someone who has experience of medicine that they bring with them...’ (FG3X2), participants underscored the hybrid nature of the ANP role. They create a figured world where it is seen as normal that ANPs cross boundaries to carry out their role. Language in use shows that these boundaries, amongst others, relate predominantly to professional and practice boundaries where ANPs now supervise some of their medical colleagues and manage a cohort of complex cases once managed by medics:

> ‘On a routine basis doctors walk into the ANP office to ask for advice on x-rays – that happens with senior and junior doctors in our department…the ANP’s role is significant you know for teaching, teaching junior doctors.’
>
> (FG1N13)

> ‘When you (*an ANP*) build yourself up to expert you know you can supervise other people, including medics, and we will probably be supervising more and more so going down the line.’
>
> (FG2A9)

> ‘Within our patient cohort there’s lots of complicated cases that we see. Lots of very strange cases that you would not see every day that the Registrars would not have seen either...just because they are seeing the bigger scope and they’re seeing patients in Resus doesn’t mean anything...we’re seeing patients in Resus but they’re within our scope.’
>
> (FG4A7)

One ANP highlights that without this crossing of barriers and pushing of boundaries in an informal way, she would be unable to undertake her role:

> ‘A lot of what we do is a medical role. I think we come at it from a different perspective. We embrace the medical role…with a slightly different view on it…we need to do that to adapt to the changing needs of healthcare…’
>
> (FG3A22)

The use of language such as ‘slightly different view on it’ constructs a situated meaning that whilst ANPs ‘embrace’ the medical role, they do so in a unique way and this ‘really valuable’ (FG4A25) role is needed in the health system. Other AHPs were less appreciative of ANPs crossing boundaries:

> '…it's not their defined profession and crossing boundaries isn't always right…boundaries are there for a reason sometimes you know.'
>
> (FG3X4)

The use of phrases such as 'boundaries are there for a reason' to advise that 'crossing over' into the domain of other healthcare professionals is not always right constructs a situated meaning that boundaries are rigid and not porous, and it is wrong for the ANP to attempt to breach these barriers. This 'professional siloes' Discourse is prevalent in the system and a major theme in Conversations that have taken place, where crossing role boundaries causes difficulties and is seen as troublesome.

When discussing the scope of the ANP, participants frequently employ language such as 'limited', 'defined', and 'distinct', which enacts an identity for the ANP that is restricted, bounded and rigidly demarcated. This is further evident in the language-in-use of some nurse managers:

> '…what I would worry about with ANPs, is all you need is one or two unsuccessful ANPs and then it's really ummm…'
>
> (I3NM1)

> 'I've noticed a nurse practitioner who is actually in a clinic with a consultant but what is she doing like...it doesn't make sense if they are an autonomous practitioner... so I'm asking for external eyes to maybe have a look.'
>
> (I4NM3)

Figured worlds are constructed that speak to an abiding sense of provisionality or precarity: if the ANP errs, it might lead to the demise of the role. Examining the language-in-use showed that there was no evidence of any practice errors, failures or critical incidents. Situated meanings are built where the ANP role is being continually observed, scrutinised and their practice questioned to see what they are 'doing like'. Examining these difficulties, a considerable number of nurses employ language that is somewhat hostile when discussing ANPs crossing barriers. This language is seen in excerpts from the focus groups:

> '…doctors feel threatened because it might take away…what would you say…power to the name doctor or word doctor…they might feel like it's taking away from their title.'
>
> (FG1N8)

> '…doctors feel threatened because a nurse is coming in to do their role and doing it better… someone who can fill their role and fill it to their capability or better at times.'
>
> (FG1N13)

The use of language such as 'threatened' constructs a situated meaning that ANPs are a risk to their medical colleagues and a 'threat to medical identity' figured world is created where medics are vulnerable and exposed to newer roles coming into the health system that should be seen as possibly dangerous. This is seen in language-in-use by one ANP who suggests that medics are:

> '…afraid of their role, their profession becoming threatened by all the other professions that have progressed both in their education and knowledge and now they're not afraid to express those.'
>
> (FG3A22).

Nurse managers use language such as 'fearful of losing their position in the healthcare system…' (I3NM1) and 'it comes back to fear again…of the professions becoming equal within the healthcare system' (FG1N3) when discussing medics' resistance to ANPs' boundary-crossing practices. This constructs a situated meaning that medics view their positioning in the healthcare system as more influential and powerful than other professions. This is a prevalent theme in the 'physician sitting at the top of the hierarchy' Discourses and Conversations when ANPs and others refer to the hierarchical structures that ANPs experience, with the medic in a dominant position and the ANP in a subordinate role.

ANPs employ language when discussing their acceptance in the healthcare system that highlights the necessity to continuously demonstrate their ability before they are accepted by colleagues and peers:

> '…there's always the job of trying to prove yourself but sometimes you're just like whatever.'
>
> (I1A26)

Summing up, whilst attempting to carve out a place for the ANP role, language-in-use constructs a figured world where the role is seen as filling workforce gaps left by medics and consequently, ANPs are identified by participants as medical substitutes rather than practitioners in their own right. Within this environment, ANPs employ

language that emphasises the need for the ANP to constantly prove themselves and 'walk the walk' to be seen as a valuable addition to the healthcare system. Arguably, this is difficult to achieve when language-in-use constructs situated meanings that the ANP role is relatively inferior to other professionals in that system. More positively, other participants use language that underscores the integrative and hybrid nature of the role that allows ANPs to cross barriers and push boundaries, a notion not appreciated by all. Some participants believe that this characteristic of the ANP role may threaten the system and some of those working in it.

7.6 "It's the fox guarding the henhouse" – Supervision or Control?

Emphasis on autonomous practice is seen in the language-in-use employed by ANPs, such as 'responsible for your own practice' (I2A1) and 'we're more autonomous and more strong' (FG2A16). Language-in-use such as '…without autonomy ANPs will not bring to the service what could be brought' (I3NM1) foregrounds this idea and creates a figured world where independent autonomous ANPs are practitioners in their own right and are essential. A situated meaning is constructed by ANPs where they believe they need to be more independent for the role to be beneficial:

> 'There was merit to that (*supervision*) to establish the role and ensure it was well founded, well supervised to give assurance to the public and the regulator that these nurses weren't just going to go mad doing all sorts of things, but I think now is the time we make a start at breaking that connection…it is only then that the role can come into its own.'
>
> (I2A1)

One ANP suggests that the advanced elements comprise autonomy, independence and freedom:

> '…you can manage your own area; you can manage it quite well and manage in a way that you feel to the standard that it should be managed at. You're not under the realms of…because you're so independent, you're not under the realms of a lot of other people, and other influences.'
>
> (FG4A18)

Employing language like 'not under the realms of' (FG4A18) when discussing the autonomous element of the ANP role provides a situated meaning that without autonomy, an ANP could be controlled and directed by others, predominantly doctors:

> ‘There will always be a little cap on it as well I feel; they (*doctors*) will never let you any further than your cohort of patients…’
>
> (FG4A4)

The use of language that insists that their role be ‘independent and autonomous’, enacts an identity that is self-governing and the use of language such as ‘in reality, no consultant supervises my work’ (FG2A8) attempts to disrupt the figured world where ANPs require supervision. Correspondingly, some medics believe that ‘ANPs have demonstrated a degree of autonomy and a degree of professionalism that clearly doesn’t require supervision from a medical point of view…’ (I6M1).

Medical participants employed language such as ‘ANPs have a very defined and limited scope’ (I6M1) and ‘they cannot do everything whereas doctors can’ (I6M1) to deprivilege the ANP identity. These phrases provide a situated meaning that the ANP role requires control and supervision and only medics are competent to provide this supervision. This is evident in the language-in-use where senior medics see themselves as overseers of clinical services and that any clinical decision requires their approval:

> ‘I’m ED consultant and one way or another I suppose I’m responsible for everything that happens.’
>
> (I7M3)

ANPs in turn employ language such as ‘it’s the fox guarding the henhouse’ (I2A1) when discussing this supervisory role of the medic. Consequently, a ‘physician sitting at the top of the hierarchy’ figured world is created where medics are the natural supervisors of the ANP and consequently control the development of nursing roles and doctors being ‘in charge’ of ANPs is constructed as normal and typical.

One medic suggested that whilst ANPs ‘know what they can treat and they know what they can do and what they cannot do whereas doctors will take on everything’ (I6M1), there is obviously a ‘lack of certain capabilities’ (I6M1). Discursively describing something with reference to lack is problematic. It constructs an absence or inferiority relative to a dominant referent. Some medics have used this ‘complex versus simple’ figured world and invited others to assume that whilst ANPs are highly competent they have ‘voiced concerns’ that ANPs cannot care for ‘complex’ patients and should not

be seen as the answer for all healthcare issues. This is evident in the language used by some medics in the study:

> 'ANPs can go so far…the patient they look after are cared for following strict guidelines…the more complex patients will always be looked after by the doctors you know…'
>
> (I5M2)

When the expansion of the ANP role is discussed, participants use terms and phrases such as 'tighter controlled areas' (FG3X4) and 'the reins are very tightly held' (FG2A9). Language such as this constructs a figured world where it is typical that ANPs need to be controlled and preventing from expanding. One ANP:

> '…there would be occasions that we would speak of expanding into something else you know, and no matter how competent, how much we feel that it would be within our scope, the decision will be made at what level they will allow us to get to...'
>
> (FG4A4)

Many participants relate this figured world to trust and the lack of trust that exists between members of the healthcare system:

> 'We have to be careful of how we go about seeing new patients…it's all about having good relations especially with the consultant…it comes down to trust as well if the consultant or the doctor or whoever trusts your judgement…that takes time.'
>
> (FG2A9)

> 'I suppose when you think about it, the role it's highly regulated and it's backed up by a masters and then a large number of hours have to be undertaken – supervise you know…and then you have to earn that trust and prove yourself.'
>
> (FG2A8)

Examining the language used here, it can be seen that ANPs are attempting to emphasise their credibility and reliability, two key facets related to trust as well as accentuating the importance of having good relations with other members of the system. On the other hand, medics use language that is self-orientated in nature connecting trust with having to control:

> '…there are places where ANPs don't work on the same site so you've a lot of trust that is the person when you don't have those contacts, you're not really working side by side regularly you don't have that trust and control, not control

> but trust and belief that the person is able to do what they say they can do and the assessment is what it is.'
>
> (I7M3)

In summary, language-in-use shows that most participants are cognisant of the need for a degree of autonomy for ANPs to fully realise the potential of their role. However, ANP participants employ language that shows they believe their autonomous practice is restricted under the guise of supervision. The use of terms such as 'defined and limited scope' and 'strict guidelines' construct an ANP role that requires control and supervision rather than constructing an independent, autonomous professional identity. Language used connects this to longstanding hierarchical structures that exist in the healthcare system where the doctor is in charge and the ANP is positioned as subservient. Language-in-use shows that ANPs are striving to be credible and reliable professionals; however, this quest is thwarted by medics who continue to have issues with trust and control.

7.7 Chapter Conclusion

In this chapter I have presented the "real world' empirical language of description where participants have *described* the ANP role from their vantage point of their own experience. Language-in-use describes the ANP role from a number of positions: as a valuable and value-adding practitioner; a practitioner torn between a caring and curative identity; a less educated skilled practitioner; a medical substitute; a pioneer disrupting the system and a constrained practitioner striving for more independence. In the next chapter, I present the findings of how Gee's (2014) Building Tasks of building identities, relationships, politics and sign systems and knowledge construct, represent and position the ANP role in the current structures of the healthcare system.

Chapter 8 External Language of Description: Presentation of a Systematic Understanding of 'What is Being Done' in, by and through language using Gee's Building Tasks

8.1 Introduction

The purpose of this chapter is to present the external LODs [figure 8.1] and to provide a description of the empirical domain in a theoretically consistent and logical way.

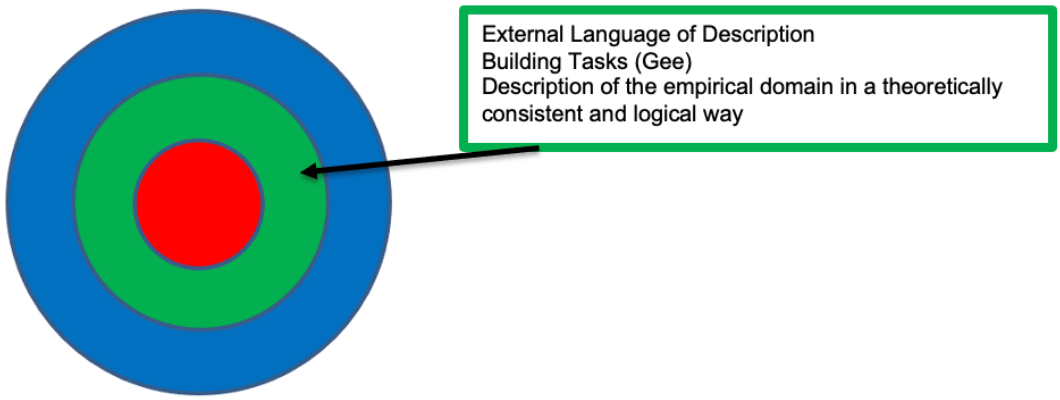


Figure 8.1 External Language of Description

Considering the bespoke approach to CDA and Systems Thinking used within this thesis, figure 8.2 shows where the works of Gee (2014) and his Building Tasks intersect with the theoretical framework and design. This chapter examines this element of the framework.

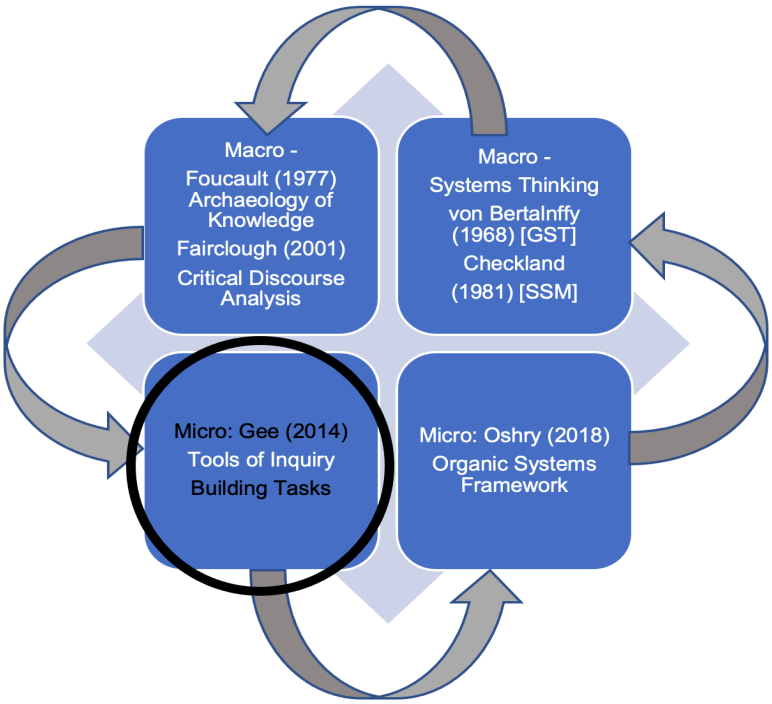


Figure 8.2 A bespoke approach to CDA and Systems Thinking showing key points of intersection with theoretical framework [Adapted from McNamara (2007)]

The previous chapter presented five constructions that emerged from the application of Gee's (2014) Tools of Inquiry to the language used by the study's participants to describe the ANP from their vantage point of their own experience. The findings in this chapter represent what is being done in, by and through language using Gee's (2014) Building Tasks [figure 8.3] (identities, relationships, politics, sign systems and knowledge). These four tasks were selected as they best address the study's research questions and aims. Further explanation of these tasks is provided in table 8.1. This analytic lens develops and deepens the analysis by allowing me to move from the empirical LOD towards a more critical analysis and interpretation of the data. Applying Gee's framework, the CDA reveals how language works ideologically to construct, represent and position subjects in particular ways, adding value through uncovering new meanings. That is, for my given topic, I examined whether, to what extent and in what ways each of the building tasks are realised in the language-in-use of the research participants.

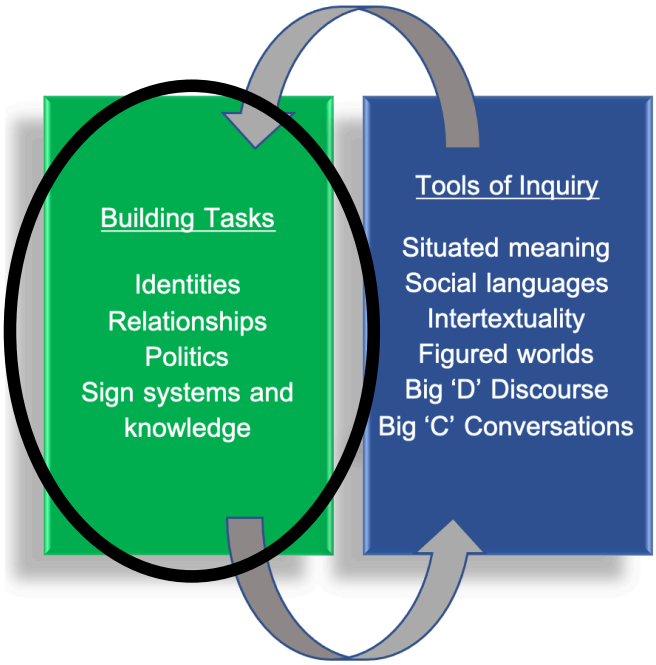


Figure 8.3 Gee's (2014) Discourse Analysis Framework – Building Tasks

Building Task	Definition
Identities	Using language to enact specific socially situated identities or to project such identities onto others, or to privilege or disprivilege such identities.
Relationships	Using language to create or sustain social relationships or to end or harm them. Any situation whereby the people involved in an event enact and contract with each other.
Politics (the distribution of social goods)	Using language to give or take away social goods or projecting how social goods are or ought to be distributed. Social goods been seen as anything a person or group in society wants and values. Some things (like status, money, love, respect, and friendship) are taken by nearly everyone in society as social goods. Other things are social goods only to small groups.
Sign systems and knowledge	Using language to create, sustain, revise, change, privilege, or disprivilege any language or sign system or characteristic way of knowing the world or making knowledge claims about the world.

Table 8.1 Definitions of Building Tasks [Adapted from Gee (2017)]

In figure 8.4, I depict the steps of the data transformation process followed specifically for this chapter.

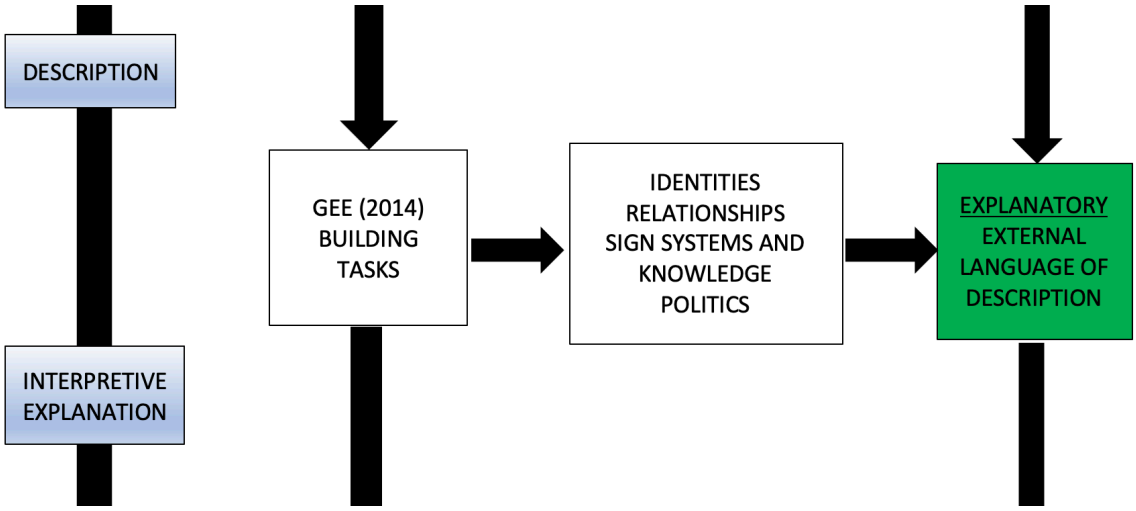


Figure 8.4 Process of Data Transformation – External Language of Description

I now present the findings from the external LOD in terms of the selected Gee's (2014) Building Tasks:

- Building identities,
- Building relationships,
- Building politics (the distribution of social goods) and
- Building sign systems and knowledge).

8.2 Building identities

This first section reveals the key discourses that were identified from applying Gee's Identities Building Tool to the data, focusing on specific instances of participants' language-in-use concerning the ANP identity. Gee (2010) identified the building task, building identities, as the various ways of being that individuals adopt for different reasons and contexts. We use language to indicate a certain identity we have assumed here and now. We each act out different identities in our lives in different environments. For example, we assume different identities when we act as a parent, a man, an educator, a doctor, a nurse or an ANP.

We assemble situated meanings about what identities are relevant to an interaction, with their concomitant attitudes and ways of feeling, ways of knowing and believing, as well as ways of acting and interacting (Carbaugh, 1997, Gee, 2004, Wieder and Pratt, 1990). Since we all have a number of different identities in different contexts, as discourse analysts, we want to focus on how people express their sense of who they are and their multiple other identities through language. Gee argues that '…it is important that as researchers, we additionally recognise that individuals do not just enact their own identity but moreover 'position' others in certain ways.'(Gee, 2011, p. 110).

Through our talk we create an identity 'position' or 'place' to take up and to talk within, for this time and place. This tool allows us to study how an individual both builds an identity for themselves and uses the identities they attribute to others to further the construction of their own identity. Using Gee's (2014) Identities Building Tool, I now present six discourses that are constructed in, by and through language and that describe the ANP rolefrom their vantage point of their own and their colleagues' experience.

The following headings have been used:

- The uniquely holistic identity
- The intuitive identity
- The controlled identity

- The medical(ised) identity
- The independent powerful identity
- The collaborative identity

Selected direct quotations are used in the headings as they were particularly useful in understanding the saying, being and doing of the participants. I now present each discourse in turn.

8.2.1 "They are passionate about caring for their patients" – The Uniquely Holistic Identity

ANPs use language such as 'unique' when discussing their identity and the role that they play within the healthcare system:

> 'I think they contribute something unique because they specialise in certain areas so then they become expert in that area'
>
> (FG31N3)

Language such as this privileges the ANP role above other healthcare professionals and constructs an identity that is distinctive within the healthcare system. ANPs further comment that they are 'much more holistic' (FG3A22) than other professionals, where holistic practices are constructed as social goods. This idea of holism draws on circulating Discourses where 'nurses care and doctors cure'. This is evident in participants' language-in-use:

> '…they (ANPs) took everything into account whereas the doctors are just looking at the medical issues and not taking anything into account...'
>
> (FG3X2)

This is further reinforced by some participants' language which constructs an identity for the ANP that is passionate, intuitive and caring rather than scientific, scholarly, technical and expert:

> '…because they are passionate about their field they are passionate about caring for their patients…they care desperately about their patients.'
>
> (I6M1)

Language such as ‘take everything into account’ and ‘see the patient as a whole’ (FG2A8) privileges the nursing aspect of the identity whilst deprivileging doctors’ approach to patient care. Examples include ‘guilty of just looking at the problem’ (FG4A18) when discussing the medical role to construct an identity for doctors that is almost technician like and neglectful of certain elements of patient care. In turn, this language-in-use makes whole patient care relevant to the ANP identity but irrelevant to doctors.

8.2.2 “Having a sixth sense’ – The Intuitive Identity

Participants use language such as ‘bigger picture’ (FG4A18) when discussing the ANP identity in an attempt to construct a distinct identity for the ANP. Other examples of this language include:

> ‘Our consultants always says that nurses have a sixth sense about things...whether doctors do I don’t know...if you feel it’s not right then you would go with your gut.’
>
> (FG2A2)

> ‘I think ANPs bring something very different to a doctor…I think they can be much more intuitive. I think they are coming from a different angle to a doctor.’
>
> (I4NM3)

This language-in-use constructs an identity for ANPs that is characterised by what feels naturally right or true without necessarily coming from research or scholarship. An identity that considers the entire perspective on situations and issues that arise in practice.

ANPs also use language such as ‘politically astute’ (I2A1) and ‘our roles change as society changes’ (FG3A22) which creates an identity that is socially responsive and adaptive, with the ability to address current healthcare shortcomings and emerging needs:

> ‘…from what experience I’ve had with ANPs, they would have seen an area where they could see an improvements where they could have an effect on patient care umm from experience and working with ANPs, it has been great.’
>
> (FG3X4)

8.2.3 "It comes back to us being nurses" – The Controlled Identity

Some participants employ language that constructs an identity for ANPs that is controlled, predominantly by their medical colleagues. Language-in-use shows that some ANPs connected this controlled element of their identity to their nursing background and the requirement for supervision. Examples of this language include:

> '…it's so frustrating because it stops me from doing my job…supervision helped us in the start but in some ways now it is impeding us…stops us developing…'
> (I2A1)

> '…it comes back to us being nurses...you would get more freedom if you were a doctor... there is definitely an element of control...'
> (FG4A25)

> 'Well I think that the way the legislation is structured around advanced practice we are inseparable and ultimately a consultant has governance over my practice and I can only work where he or she says I can.'
> (FG4A5)

This language-in-use constructs an identity for medics as unwilling to relinquish the control of resources and other healthcare professionals that they believe they are charged with, and an identity for ANPs as unwilling subjects of such control. Examples of this language-in-use include:

> 'I think medics hold power and they don't want to give it up and that's for a multitude of reasons and I can't see them letting go of that very easily'
> (I2A1)

> 'They (*doctors*) think they're at the centre of their clinical universe and if there are things that are going to happen outside their control there are certain people who will not be comfortable.'
> (I4NM3)

This creates a 'hierarchical physician sitting at the top' figured world where doctors being 'in charge' of ANPs is positioned as normal and typical. This is further seen in the language used by one medical consultant:

> '…there are places where ANPs don't work on the same site so you have to have a lot of trust in the person…you're not really working side by side regularly, you don't have that trust and control…'
> (I7M3)

> ‘It (*setting up an ANP service*) may be challenging in the primary care setting because there is going to be a lot of work required to develop that trust when those people don’t really work together.’
>
> (I7M3)

This language-in-use constructs a situated meaning that associates trust with control and conveys a sense of unease when ANPs’ practice cannot be closely monitored, enhancing the construction of this ‘hierarchical physician sitting at the top’ figured world where medics are the natural supervisors of the ANP and consequently control the development of nursing roles. Other examples include the use of language such as ‘walk the walk’ (FG2A2) that constructs for ANPs an identity that is always in progress and whose value needs continuously to be proven, justified and accepted. This language-in-use results in formal hierarchical relationships being constructed in the system and places the ANP in a relatively subordinate position.

8.2.4 “It's driven by replacing…by answering a medical problem” – The Medical(ised) Identity

Using language such as ‘substituting’ and ‘role-reversal’ (FG1N2), some participants construct an identity for the ANP as one that is replacing a doctor:

> ‘The new roles and everything it’s really, it’s driven by replacing…by answering a medical problem like the waiting list to see dermatology is too long okay so let’s get some ANPs in there…’
>
> (I2A1)

> ‘I think now the light is shone more in light of umm recruitment particularly medical staff leaving now they are realising there is the capability in nursing to solve some of the issues.’
>
> (I3NM1)

Doctors employ language such as ‘losing part of themselves’ (I7M3) when discussing the ANP identity, which strengthens this medical-replacement identity for ANPs. This is further evident in the language-in-use of some medical consultants who construct an identity for the ANP that is more medical than nursing:

> ‘I don’t know if nurses should be called nurses anymore…I think they are more than that, they’re not just nurses, their nursing role has become less and less.’
>
> (I6M1)

> '…they (*ANPs*) definitely contribute something to the health service…they can be used to support the medical structures for one thing.'
>
> (I5M2)

Using language such as 'replacing', 'substituting', 'support the medical structures' and 'answering a medical problem' when discussing the ANP identity constructs a medicalised identity for the ANP with medicine to the forefront and nursing relegated to the background. This privileges medicine at the expense of nursing. This is further elaborated through the use of language that disparages the identity. An example of this from the data is where one medic refers to the 'simpler tasks' (I5M2) when discussing the origins of the ANP role:

> '…well you know there were nurses there as well that could do those jobs you know...some of the more simpler tasks could be completed by nursing staff so why not train them up to do those kind of jobs...I suppose like putting on plasters, a little bit of simple suturing you know and things like that...'
>
> (I5M2)

Through this language-in-use, an identity is being constructed for ANPs where they are being granted unwanted, relatively trivial medical tasks, suitable for nurses but not medics. This 'complex versus simple' Discourse is prevalent in the system, where ANPs are seen to embody an identity that is not capable of engaging in complex patient care. This identity is further intensified by language-in-use that connects the ANP identity with medically oriented tasks, 'better at reading x-rays' (FG1N3), 'intubating skills' (I4NM3), 'masters at suturing' (I5M2) and 'improved scoping' (FG2A8). ANPs themselves employ the social languages of medicine such as 'diagnosing', 'treating', and 'discharging rights', in an attempt to obtain a more socially recognisable identity and higher status. Using this language ANPs create an amalgam of existing professions to enact an identity that is new and has not hitherto existed in the system. This is a prevalent theme in the Discourses and Conversations that exist in society that warn of the perils of ANPs working within this 'medical framework' and raise concerns that the ANP could become medicalised and lose the caring focus that is considered to be fundamental to nursing.

8.2.5 'Not under the realms of anyone…' – The Independent Powerful Identity

Using language such as 'identifying, diagnosing and decision making and putting a plan into action independently' constructs an identity for the ANP that is concerned with independent practice and autonomy. One nurse manager when asked what makes the ANP identity separate from other nursing roles was keen to highlight these autonomous aspects:

> 'Well for me it's the decision making – it's that final decision umm that you know that is agreed within certain parameters that can be made independently and autonomously by a nurse practitioner.'
>
> (I4NM3)

ANPs also employ language which emphasises this autonomous identity:

> 'We manage our own caseload…you're not under the realms of anyone because you're so independent, you're not under the realms of a lot of other people, and other influences…'
>
> (FG4A18)

Other uses of language connect this independent and autonomous identity to systems improvements and suggest that autonomous practice may be the key to maximising ANPs' potential:

> 'ANPs are able to make big decisions about patients and that they're kinda getting through waiting lists, they're not waiting to see a consultant necessarily that they can go through quicker, they're not waiting to see a doctor, that they can get through quicker in any of the services that they are involved in.'
>
> (FG3X2)

In turn, participants create a figured world where an autonomous identity equates to a powerful identity. This powerful independent identity is constructed as a social good by ANPs as they correlate it with decision-making:

> 'The only way to get your voice heard is to be at the table, that's where the decisions are made…and ANPs have been there from the beginning making those decisions.'
>
> (FG4A4)

> '…they (*doctors*) have power and they have a role to say what you can and cannot do.'
>
> (FG2A16)

Assuming the powerful identity they attribute to medics, ANPs construct politically aware identities for themselves that show an appreciation of the dynamics underlying behaviours and situations, and they are skilful at using this knowledge to their own advantage:

> 'The two ANP candidates are very politically astute, they are gradually getting their legs under the table…'
>
> (I4NM3)

ANPs use language to further construct an identity for ANPs that is striving to become more powerful and independent:

> '…if there is a strong voice for nurses do you know at the top – it'll give... it will make nurses more autonomous.'
>
> (FG2A9)

8.2.6 "ANPs have always been team players" – The Collaborative Identity

Participants employ language such as 'team players', 'teamwork', 'liaising with others' and 'working in partnership' when discussing the ANP identity in the healthcare system. This language-in-use constructs a collaborative identity for the ANP where all team members are valued for the contributions they make:

> 'ANPs have always been team players do you know, other people kinda tend to work in silos, but ANPs work across disciplines and work across medicine, work across physiotherapy, OT, do you know, they coordinate and link services as well.'
>
> (FG2A9)

Language such as 'have always been team players' and 'other people tend to work in silos' builds up the collaborative aspect of the ANP identity and enacts a collaborative ideology and figured world wherein ANPs are collaborative team players and organisers. Other language-in-use constructs ANPs as individuals who understand that the multidisciplinary team's success is their own success:

> 'That's how you (ANPs) provide a good service for your patients…if you were a lone island it wouldn't work well.'
>
> (FG4A5)

On the other hand, language-in-use employed by some participants creates an identity for medics as practitioners who are 'flying solo' (I5M2), less subject to constraints and who believe they can manage independently:

> 'ANPs are probably more likely to get other members of the multidisciplinary team involve in patient care…I don't know if that goes back to a doctor thinking he can manage everything himself?'
>
> (I5M2)

To summarise, participants use language to build an identity for ANPs that emphasises the nursing dimension of the ANP role. They use language connected with holistic practice to create a unique, socially responsive identity that does not exist elsewhere within the health system whilst positioning medics as being less holistic and more technical practitioners. Language-in-use builds a world in which medics overseeing ANPs is positioned as typical and normal. The ANP identity is in turn built as one that should be controlled by medics. The use of terms such as replacing' and 'substituting' when discussing ANPs constructs a medicalised identity for them, an unbalanced identity with medicine to the forefront and nursing in the background. Language-in-use also builds an identity for ANPs as at once independent practitioners and team players. Both these identities are constructed as important to the advancement of the ANP within the healthcare system. The next section reveals key discourses that were identified from applying Gee's Relationships Building Tool to the data.

8.3 Building relationships

This section reveals key discourses that were identified from applying Gee's Relationships Building Tool to participants' language-in-use. This tool is related to the previous task, building identities, since the identity we build for ourselves in any context is often defined, in part, by how we see and construct our relationships with other people, social groups, cultures or institutions (Gee, 2011). Different kinds of relationships are built and sustained through the use of language. For example, we can construct relatively formal and deferential relationships with others or indeed relatively informal or less deferential relationships by our actions and language we choose to use. As researchers, Gee (2011) suggests we must always ask about identity and relationships and how these interact. Whilst identity and relationships go hand in hand, he suggests that one focuses on each separately:

> '…creating or taking an identity and creating and sustaining a relationship of a certain type are not the same, however closely related they are. Even in one identity, for example being a professor, a person can relate to people in many different ways, all without losing his or her identity as professor.'
>
> (Gee, 2011, p. 115)

I now present four discourses in terms of Gee's (2014) Building Relationships Tool that are constructed in, by and through language that describe the ANP from the vantage point of their own and their colleagues' experience.

These relationships have been discerned as follows:

- The ANP – 'system' relationship
- The ANP – nurse relationship
- The ANP – public relationship
- The ANP – medic relationship
    - The supervisory relationship
    - The threatened relationship
    - The hierarchical relationship
    - The interdependent relationship

Again, selected direct quotations are used in the headings as they were particularly useful in understanding the saying, being and doing of the participants. I now present each discourse in turn.

8.3.1 The ANP - 'system' relationship – 'They know the systems where they are working and use that to their advantage'

Relationships are built by participants when they employ language that associates the ANP role with collaborative practice. Language-in-use constructs relationships where ANPs work as team members, and they connect this teamwork with improvements throughout the system:

> 'That's how you provide the service as well that you can bring in, that you can ask...you get advice and so on. That's how you provide a good service for your patients. If you were a lone island it wouldn't work well.'
>
> (FG4A5)

> 'ANPs are probably more likely to get other members of the multidisciplinary team involved in patient care...'
>
> (FG4A18)

Language used by some participants show that this collaborative relationship is secondary to the 'years of nursing experience' that the ANP brings with them to the role. One nurse manager explains:

> '…they know the systems where they are working and use that to their advantage, that they can liaise to their other colleagues, care is kind of expedited and umm...quicker I would feel.'
>
> (I3NM1)

This collaborative relationship is also constructed in the language used by some medics who recognise that if this collaboration did not exist the system would struggle:

> '…we are all at the coal face together, we are either collaborative or we fail so I think especially in areas like emergency medicine.'
>
> (I6M1)

Relationships are built within the system with some participants using language such as 'hybrid roles' and 'pioneers' that builds the ANP as a system integrator crossing boundaries and working collaboratively:

> 'There is definitely a medical element to the ANP role…in some ways they do a nursing role and in other ways it's definitely more medical you know when it comes to diagnostics like x-rays, CT and blood tests…it's the whole service you

know...you're getting seen by a nurse but also someone who has experience of medicine that they bring with them...'

(I5M2)

However, language-in-use such as 'each profession has their boxes and they stay in them where an ANP crosses those boxes' (FG2A9) constructs an identity for ANPs that extends into other healthcare practitioners' domains as they attempt to enact an identity that is innovative and has not previously existed in the health system. Medics' language constructs more strained relationships; they believe that ANPs should not cross boundaries:

'…the patients that ANPs look after are cared for following umm...like strict guidelines and you can't expect an ANP to be managing something that's a bit extreme.'

(I5M2)

The use of terms like 'strict guidelines' and 'defined profession' constructs strong boundaries around the ANP role that diminishes the advanced element by insisting that some barriers should not be crossed, a sense of "keeping them in their boxes" is constructed. Some participants employed language which connected this notion with the context in which the ANP role was originally established and the actual and potential concerns of various stakeholders that needed to be managed:

'I think that the way the legislation is structured around advanced practice we are inseparable and ultimately a consultant has governance over my practice and I can only work where he or she says I can…I suppose when you think back and think about all that legislation and restrictions...like the majority came from our own colleagues...like the nursing board you know...I think it came about from trying to pre-empt resistance from the medical profession or to provide reassurance to stakeholders, the Department of Health, government bodies, or even the general public, although twenty years later the general public still don't know who we are so I don't think they would be that outraged.'

(I2A1)

Confusion surrounding the ANP identity impacts relationships within the system:

'…there are so much jargon and things, situations like that, that the whole system is actually confusing to many people.'

(I6M1)

'I think they have a vague idea of what you (*ANPs*) do...but not what the actual role is...I think ummm unless they've had experience within, unless they come down and be seen by one of us and you know, know exactly what we do I

> think...even some of them who don't have ANPs within their service they're unsure of even where you stand in the hierarchy of it all...'
>
> (FG4A5)

This confusion has further hampered relationships with other healthcare professionals within the system. An identity for ANPs has been created as one that will take roles from others:

> 'They're taking 700 and those 700 nurses have to be backfilled, so it's swings and roundabouts, that you're robbing Peter to pay Paul, but then you have to balance it all out with patient care so you're employing probably less doctors and employing more ANPs.'
>
> (FG3X4)

> 'I suppose if you look at it from a hospital perspective there and this is just my opinion, just say for, you basically mightn't need as many doctors if you have more ANPS in roles, so then your pool of doctors get smaller.'
>
> (FG3X2)

ANPs in the study recognise this concern and use language to emphasise their 'nursing background' and 'scope of practice' in an attempt to counter the substitution-replacement figured world that others create:

> 'Confusion about the role… I think it's probably to our disadvantage…I think it's (*ANPs*) seen as a bit of a buzzword, bit of a solution to…the panacea of all problems within the health service.'
>
> (I2A1)

8.3.2 The ANP-nurse relationship – '…see the patient…treat the patient and discharge the patient'

Nurses and other AHPs employ language that builds respect for the ANP identity:

> 'ANPs have definitely made a big impact on the system…like working as a physio[therapist] I've learnt a huge amount from ANPs because they made me think of things I wouldn't necessarily have thought of.'
>
> (FG3X2)

> '…like an ANP's quality of care is so much better than what you would get from a doctor.'
>
> (FG3NM2)

Employing language such as 'doing a better job' (I5M2) and 'quality of care is better', this respectful relationship uses other professions, particularly medics, as a point of reference. Nursing participants also used language which constructed a supportive

relationship between ANPs, nurses and other AHPs. This supportive relationship relates to educating nurses and AHPs, the reassurance that the ANP provides and how they 'take pressure' off of them:

> 'One role or one area which is significant in the ANP role is you know teaching, you're educating all the time, be it with families, health promotion with the individual or with other nursing staff…they take pressure off of us.'
>
> (FG1N13)

> 'They (*ANPs*) are like autonomous decision makers, senior decision makers you know, so it does expedite the patient care and kinda benefits patient flow, I suppose especially in our department, we would feel it when there isn't an ANP on duty because the backlog starts then, you know they can see the patient, you know, treat the patient and discharge the patient.'
>
> (FG3N16)

> 'From a radiographer's point of view for patients, it has been great…patients come over quicker, they're not waiting as long…that can only improve patient experience…'
>
> (FG3X4)

However, some ANP participants employ language that constructs an ambivalent relationship with nursing colleagues that may be impacted by jealousy:

> 'I suppose people will always try to cut you down and you have to kinda rise above it...like what are ye at now! The dossers...there is a professional jealousy amongst nurses…'
>
> (FG2A9)

> 'You can see, there would be an aspect of negativity and that negativity can spread and I think that is the one thing I did see…was negativity from certain nursing colleagues about it (*ANP role*) so that even before we started it was a downer straightaway, you know they didn't want to see the positives or what would come from it.'
>
> (FG1N8)

Whilst some participants associate this ambivalent relationship with 'professional jealousy' other participants employ language that links it to a lack of familiarity about the ANP role:

> 'I don't think it comes from jealousy; I think it's from lack of understanding.'
>
> (FG2A16)

Language-in-use such as 'negativity…even before we started' and the use of derogatory terms like 'dossers' reinforces the idea that this ambivalence is secondary

to lack of knowledge about the ANP role. Another example is provided by the language used by one nurse manager who requested outside guidance to ensure the ANP was doing their job:

> 'I've asked as Director of Nursing for some assistance to come to [*name of hospital*] and review the role of all our ANPs, to zone in and make sure that everything is at ANP level.'
>
> (I4NM3)

8.3.3 The ANP-public relationship – 'They don't really care if you're a nurse or a doctor…'

When discussing the ANP relationship with the public, the majority of participants highlighted the fact that for much of the public, the ANP role itself is unknown. However, the language-in-use indicates that this is not necessarily an issue for patients 'as long' as they are seen in a timely fashion by someone who is appropriately qualified and experienced:

> 'The patient comes in and they're there to be sorted, they don't really care that they call you nurse or doctor or whatever. They don't really care if you are a nurse or a doctor, they're here to see you because they have a problem end of and they're going to get that sorted and you're the person to sort it....'
>
> (FG4A18)

> '…once the patient is seen and treated by an ANP, I don't think they actually care too much who sees and treats them as long as it's done by someone who is competent.'
>
> (I6M1)

> 'Once you explain that you are an ANP they do get it and you fully explain it…I think they have a positive response to it umm I only have had one or two cases where patients would want to see a doctor…but when you act confident and know what you're doing they don't have a problem.'
>
> (I2A1)

This outlook references the 'nurses practicing in doctors clothes' discourses and Conversations that are at play within the healthcare system whereby the ANP identity is constructed by some participants as 'taking away the identity of the doctor' (FG1N3). Other participants employ language that constructs a patient-ANP relationship based on holistic nursing care rather than just 'sorting the problem':

> 'I could see where the "nurses who practice in doctors' clothing" could come from…especially from other health professionals more so than the public

> because I've seen the literature where patients' outcomes and patient satisfactions are much happier because they've had the full holistic care. The whole point of the ANP is taking the whole patient into account, it's not just see, sort and move on.'
>
> (I3NM1)

Participants use language to build and sustain ANP-patient relationships that are based on mutuality and trust:

> 'The doctor will often leave the room and they will say 'what did he say', 'what will I do now' where the ANP provides that full service...'
>
> (FG3N16)

> '…they think differently and they can speak differently to the patient in a way that the patient can understand where sometimes when they're with the doctor it is rushed and they see only one problem where the nurse sees all the problems.'
>
> (FG2A9)

8.3.4 The ANP-medic relationship

Four dimensions of the ANP-medic relationship were identified from the findings:

1. The supervisory relationship
2. The threatened relationship
3. The hierarchical relationship
4. The interdependent relationship

Each is now presented in turn.

'There will always be a little cap on it.' – The Supervisory Relationship

Medical participants employ language such as 'demonstrate a degree of autonomy and professionalism' (I6M1) when discussing supervision of the ANP. Using language such as 'a degree of' constructs a situated meaning that medics believe the ANP role is professional and autonomous but only to a certain extent. They focus on these relationships where a figured world is constructed where medics are still required as supervisors of ANP practice:

> '…there would be occasions that we would speak of expanding into something else and as a group we might discuss it and then we would bring it to the table and they'd say, 'no we don't want you seeing hips now' you know, so no matter how competent, how much we feel that it would be within our scope, the

> decision will be made at what level they will allow us to get to…there will always be a little cap on it.'
>
> (FG4A4)

ANPs, on the other hand, use language such that focuses on autonomy as 'in reality, no consultant supervises my work' (FG2A8) in an attempt to disrupt the figured world where ANPs require supervision and instead create a figured world where the identity is independent and autonomous:

> 'We all practice in our own scope of practice and we're educated, intelligent enough to know what we should and shouldn't do and we should take responsibility for that as any nurse would do for any registration they hold and I think ANPs are able to do that and I don't think that there needs to be a consultant supervising (in inverted commas) when in reality no consultant supervises my work but on paper they do.'
>
> (I2A1)

This language-in-use shows that ANPs are attempting to minimise this supervisory relationship where the medic is positioned as overseer of their practice. However continually referring to medics when discussing supervision of the ANP results in medicine being seen as relevant to the ANP and the creation of identities and relationships for ANPs that remain connected to medicine.

'They feel threatened by someone who can fill their role…' – The Threatened Relationship

ANPs' language-in-use builds relationships with medics that are characterised by fear and threat:

> 'They (*medics*) feel threatened by someone who can fill their role and fill it to their capability or better at times.'
>
> (FG1N13)

> 'They're (*medics*) afraid of their role, their profession becoming threatened by all the other professions that have progressed both in their education and knowledge and now they're not afraid to express those.'
>
> (FG3A22)

Language such as this creates a situated meaning that ANPs might harm the medical profession . As a consequence, ANP-medical relationships are compromised:

> '…there was umm an issue with a negative feeling from the medical point of view, from orthopaedics, they felt how could a nurse refer a patient to me.'
>
> (FG1N3)

Similar to the ambivalent relationship that exists between ANPs and some nursing colleagues, participants' language connects this threatened relationship to a lack of understanding about the ANP role:

> 'I think it's secondary to lack of understanding…acceptance of that and I think it's encroaching on their patch umm I think it's that kind of reneging a little bit of control…'
>
> (I3NM1)

> 'I also think at the beginning of our process they were threatened by us because they thought that they would lose Registrars' positions in the hospital…'
>
> (FG2A16)

'They definitely think that you're just a nurse' – The Hierarchical Relationship

The language ANPs use when discussing medical colleagues' views of the ANP role constructs a relationship in which the ANP is subordinate. Examples of this language include 'less than' and 'subservient to others' (FG2A9) when relating their role to other professions, and being positioned as 'handmaidens' or 'lower order' by their medical colleagues:

> 'I'd say they still look at us as handmaids in a way…now I can only talk about my own situation, they definitely think that you're just a nurse.'
>
> (FG2A2)

> 'I wouldn't see the role as a lower order, it's just a different choice within the health service you know.'
>
> (I5M2)

This language and terminology create a situated meaning that ANPs are at the beck and call of others and a figured world is constructed in which ANPs' work is not as important as doctors. This is also evident in the findings when medical consultants discuss doctors and ANPs, referring to them as 'their doctors' and 'my ANPs' (I6M1). Relationships are constructed whereby consultants are positioned as owners or possessors of these roles within the healthcare system, and where ANPs and junior doctors are dominated and controlled by senior doctors:

> '…nothing happens until the consultant surgeon is present and everyone is subservient so there is a hierarchical thing that comes from that, that the consultant has to present and everyone has to work around him.'
>
> (I6M1)

ANPs employ terms that have negative connotations for the ANP-medic relationship such as 'fought so hard as ANPs' (I1A26) and the ANP 'connection with them (medics) angers some people' (I2A1). This language-in-use constructs relationships between ANPs and medics that are based on struggle, conflict and some hostility, and where there are constant attempts to assert control.

'They will always be connected' – The Interdependent Relationship

Here language-in-use constructs an ANP-medic relationship that this is reliant and dependent on each other where the two professions 'will always be connected.' (FG1N13). This is seen predominantly in language employed by senior medics more so than in language used by their junior colleagues:

> 'You know the consultants working with those ANPs are very dependent on them as well because they will know that they know what's exactly what's going on with their patients.'
>
> (FG1N2)

> 'I have seen several cases around Ireland where the consultant would not be without their ANP.'
>
> (I3NM1)

The use of the term 'very dependent on' provides a situated meaning that both medics and ANPs have a mutual reliance on each other. Employing the terms 'knowing exactly what's happening with their patients' and 'not be without their ANP', consultants recognise the importance that ANPs play within the healthcare system. Conversely, the reliance of the ANP on the consultant is also identified in the language used by one participant when discussing the supervisory role of the medic:

> 'I don't see who can replace that clinical knowledge within an organisation to give you the governance that you would need.'
>
> (I4NM3)

This interdependent relationship is further enhanced by the role that ANPs play in educating junior doctors on consultants' teams and by reducing the number of complaints that consultants receive:

> 'I've never had any dealings, requests or complaints about the ANP service whereas I've had lots of complaints about the NCHDs so that's you know if I've had no complaints about the treatment from ANPs it means I don't have to spend my time dealing with these complaints so it frees me up to do other things.'
>
> (I6M1)

> 'On a routine basis doctors walk into the ANP office to ask for advice on x-rays – that happens with senior and junior doctors in our department and I think that kind of point stands alone to show the contribution of ANPs.'
>
> (FG1N13)

In summary, we see that, through their language-in-use, participants build and sustain different sets of relationships. ANPs engage in collaborative practice, teamwork and boundary spanning that helps health system integration. However, at the same time, the system works to constrain the ANP role secondary to persistent confusion about it and concerns about crossing traditional professional boundaries. When ANPs' relationships with their nursing colleagues are discussed, several participants build a deferential and formal relationship that is based upon the respect and prestige the identity is afforded, However, for other nurses, a more ambivalent relationship is constructed due to professional jealousy. Participants' language-in-use positioned the ANP as a relatively unknown entity for the public. Tensions and contradictions are exposed in the four dimensions of the ANP-medic relationship. Language-in-use shows that ANPs are positioned as challenging the identity of the medic as their supervisors. Medics in turn are positioned as under threat by ANPs. While participants' language-in-use reinforces existing hierarchical structures, language also works to construct a more interdependent relationship between the two professions.

8.4 Building politics

This section reveals key discourses that were identified from applying Gee's Politics Building Tool to the data. With respect to this building task, Gee (2004) argues that any situation involves what he terms 'social goods'. By 'social goods' Gee (2011, p. 118) means '…anything a social group or society takes as a good worth having.' and 'politics' as '…any situation where the distribution of these social goods is at stake.' Some social goods may be held by everyone in society to be desirable such as respect for each other while others are specific to certain sub-groups such as independence and autonomy for ANPs. How we use our language effects the distribution of social goods, we can add to or take away from reputation, authority, status or power as well as convey perspectives on motives, responsibility and right or wrong. Ultimately, we can build and destroy these social goods. It is important as a discourse analyst to examine this area of discourse as Gee argues that:

> '…the distribution of social goods and claims about them – goods like a person being taken as acceptable, normal, important, respected, an 'insider' or an 'outsider', or as being connected to acceptable, normal, or important things (in the right circumstances) – are ultimately what give people power and status in a society or not.'
>
> (Gee, 2004, p. 31)

I now present four discourses in terms of Gee's (2014) Building Politics Tool that are constructed in, by and through language that describe the ANP from their vantage point of their own experience and their colleagues' experience of them.

The social goods have been discerned as follows:

- The social good of value for money
- The social good of added value
- The social good of autonomy and power
- The social good of respect and prestige

I now discuss each of these in turn.

8.4.1 The social good of value for money

Politics and the social good of value for money concerning the ANP role are evident in the language used by participants. Several participants employ language that emphasises the social good of money saving that is connected to the role:

> 'I think we're good value for money. We're paid a lot less than our medical colleagues…we don't waste resources.'
>
> (I2A1)

> 'I've been saying this for years you can be penny wise and pound foolish, you can have a doctor who is paid less than an ANP but is going to miss a lot more fractures. I think the money saved with better patient treatment and management plans and…to society in general.'
>
> (I6M1)

The social language of economics is employed by others to deprivilege the value of the ANP role when compared with the value that a doctor brings to the system. This is evident in the language-in-use used by some participants that suggest ANPs 'are cheap doctors' (I2A1) and 'not on par' (FG4A18) with doctors. Other language-in-use constructs an ideology that rather than 'throwing money' at nurses to resolve problems in the healthcare system, it would be wise to consider more thoughtful and practical methods of improvement:

> 'They're *(ANPs)* seen as the panacea to all problems within the health service and we're just going to minimise the waiting lists by throwing money at the nurses to sort it out…that isn't going to work.'
>
> (I7M3)

This 'cost savings' Discourse is prevalent throughout the system, where the ANP role is constructed as beneficial only if they save money. Language-in-use employed by ANP reinforces this idea, continuously returning to the Conversation that the ANP does save money:

> '…we can't from a money point of view equal our work to the savings that we make and if we can do that it would be brilliant…'
>
> (I1A26)

> '…we don't waste resources. I know from my own practice or my colleagues' practices there's no unnecessary investigations or you know…compared to a

lot of other people, doctors who would order multiple x-rays unnecessarily, multiple blood tests unnecessarily.'

(I2A1)

8.4.2 The social good of added value

Other ANPs employ language that moves away from counting cost in absolute terms to the wider concept of the social good of added value, and the creation of new value. Examining the language-in-use it is evident that the vast majority of participants connect the ANP role with the social good of improving the healthcare system. The building task of politics and the social good of access to equitable healthcare is seen in the language-in-use such as 'reduce waiting times' (I5M2), 'avoidance of admission' (I3NM1) and 'reduced staff turnover'(FG3X4):

'…there are a lot of areas where ANP can take care preventing admissions to hospitals, keeping the patient at home and keeping them as independent as possible.'

(FG2A16)

'…access to well qualified ANPs is definitely going to reduce cost of medication, reduced hospitalisation and I would imagine greater patient satisfaction…'

(I4NM3)

'…they definitely contribute something to the health service... they can be used to support the medical structures for one thing...they have shown that they can reduce waiting times which is always a good thing, but they also add their own thing.'

(I5M2)

Other participants' language-in-use connects the social good of added value with the caring dimension of the ANP role. Participants use language that connects the social good of holistic practice with the social good of being in tune with what is occurring in society:

'I think ANPs bring something very different to a doctor. I think they are coming from a different angle to a doctor. I believe they are more intuitive and I think they are detail oriented.'

(I4NM3)

Such language-in-use creates an identity for the ANP that is distinctive and exclusive to the healthcare system. Some participants, whilst using language that constructs ANPs as being intuitive, position other healthcare professionals as lacking the

interpersonal and communicative skills which lend to the social good of intuition through language such as 'lacking that social skill that nurses have' (FG2A2) and 'no experience in social' (FG3A22).

ANPs assert that they are 'much more holistic' (FG3A22) than other professionals, where holistic practice is seen as a valued social good. This notion of holism draws on circulating Discourses:

> 'Nursing is much more holistic, and I think that side of your nursing shines through...in regard to the medical aspect that side will be managed...like the fracture will still be looked after or whatever but you still have that nurse in you to do the nursing part of it all.'
>
> (FG3NM2)

Language-in-use positions medics as less holistic:

> 'Well they (*ANPs*) definitely spend more time with patients and they're probably a bit more thorough and consider things that we (*Doctors*) wouldn't consider... like their home situations...their social background and stuff.'
>
> (I5M2)

Some medics employ language that questions the value of putative social goods such as spending more time with patients. For example:

> 'You can't compare throughput of ANPs and medics really…it's a different service, a different ball game…like you have to ask yourself…is it not better to get the patient sorted as quick as before the line gets longer…they're there to be seen and sorted – don't you think?'
>
> (I6M1)

Other medics' language-in-use shows that the distribution of the social good of improving the system by spending more time with patients can be difficult to achieve:

> 'I would love to spend as much time with my patients as the ANPs do, but I think it is reasonable to say that ANPS have a very specific role and you can't compare doctors and nurses in that situation. I think they are different roles, and they have different workloads, there are different pressures on each.'
>
> (I7M3)

> 'Spending time with patients is essential, but doctors have to be careful as people could be waiting longer for services and to be seen because there just isn't enough doctors to go round…'

(I5M2)

8.4.3 The social good of autonomy and power

Linking with the supervisory and hierarchical relationships discussed in the previous section, participants employ language that emphasises autonomy for ANPs as a social good:

> 'Well for me it's the decision making – it's that final decision umm that you know that is agreed within certain parameters that can be made independently and autonomously by a nurse practitioner.'
>
> (I4NM3)

> '…I think it comes from the grassroots of nursing that we really need to be, articulate...more autonomous and more strong.'
>
> (FG2A9)

The majority of participants connect the social good of autonomy with the social good of power. This is evident in the language used by some participants such as 'if there is a strong voice for nurses…it will make nurses more autonomous.' In turn, participants create a figured world where an autonomous identity equals to a more powerful identity which is more visible and recognised.

> 'I think autonomy gives you power because you know we say we are ANPs, we are at this level so we can make these decisions at local without having to include managers all the time.'
>
> (FG4A4)

Employing language concerning the social good of autonomy, ANPs are attempting to construct an identity as independent professionals. Conversely, some medics employed language that removed the social good of autonomy and independence, and consequently deprivileged the ANP identity:

> 'ANPs have very defined and limited scope so they know what they can treat, and they know what they can do and what they cannot do.'
>
> (I6M1)

The use of language such as 'defined' and 'limited scope' provides a situated meaning that ANPs require some element of control and supervision and only medics are competent to provide this supervision. Language such as 'responsible for your own practice' (I2A1) and 'not under the realms' (FG4A18) emphasises the importance of

the social good of autonomy. Without the social good of independent practice there is a fear that scopes of practice will be used to control the ANP role and in turn the role will contribute little new value to the system:

> '…they've (*ANPs*) defined their area whereas medics have a wider scope.....ANPs are in a tighter controlled area.'
>
> (FG4X3)

> 'The patients that ANPs look after are cared for following strict guidelines and when the patient goes beyond those guidelines...I suppose in a way becomes more difficult the doctor can manage them then and take over their care...'
>
> (I5M2)

Some ANPs use language which attempts to move the conversation away from reliance on medics, emphasising the autonomous aspects:

> 'the actual fact is the patients I see and treat are my full responsibility and we know that from when a problem arises – if there is a misdiagnosis…it is simply me and only me that would take that responsibility and the consultant has no input.'
>
> (FG3A22)

> 'Supervision is a difficult word, we use that word supervised but there's direct supervision and you move on from direct supervision so if I'm for example if I'm scoping I have supervision up "there" but it's not in the room, its available in the hospital if I come across a bleed and I need assistance but yet we call 'overseeing' we say but it could be called supervised even though it's not direct, it's not in the room.'
>
> (FG2A8)

Employing language like 'without autonomy ANPs will not bring to the service what could be brought' (I3NM1) creates a figured world where independent autonomous ANPs are essential. A situated meaning is built where ANPs need to be independent for ANPs to add real value to the health system.

8.4.4 The social good of respect and prestige

Participants employ language that speaks respectfully and admiringly of the ANP role:

> 'I was very impressed, the level of training was incredible, the level of service was incredible…'
>
> (I4NM3)

> 'ANPs are significantly experienced and well capable practitioners…'

(FG1N3)

Speaking in this way, the social good of respect, an attribute that healthcare professionals and society as a whole would see as a good worth having, is granted to the ANP. The quality of service that they provide is seen as worthy of respect:

> 'Well I'd imagine it is more expensive to train and hire an ANP than to bring in a junior NCHD but if you want to look at your quality of care I don't think you could argue that you're not cost effective.'
>
> (FG3NM2)

> 'In financial terms I don't think an ANP is actually anymore cheaper than a doctor but I just think the quality is so much better.'
>
> (I6M1)

The distribution of the social good of respect is also at stake when participants employ language that connects the ANP role to deficiencies in the system, predominantly the expansion of ANP services and the consequent added responsibility for medics:

> '…it is definitely a cost driven thing that some hospitals are hiring ANPs to try and drive down their costs and when mistakes are made they're blaming the doctor who was supervising four ANPs who were seeing 100 patients and the doctor's got the 100 charts to sign off at the end of the day and they're annoyed that that part is coming under their medical role...'
>
> (I7M3)

Summing up, we can see that the participants' language-in-use affects the distribution of social goods within the healthcare system. The social goods of value for money and adding value to improve the healthcare system were salient in the data. Considering the social good of value for money, participants used language that connected the role with cost savings whereas other participants' language worked to position ANPs as 'cheaper doctors'. Turning to the social good of added value, participants' language attributed to the ANP identity the social good of improving the healthcare system due to ANPs' more holistic approach. ANPs' language highlighted the social goods of power and autonomy. With these social goods ANPs can build a more independent identity that does not require close supervision. However, other participants' language stresses the importance of supervision, limited scopes and tight guidelines for ANPs' practice, diminishing their share of the social goods of power and autonomy. The nature and quality of service that the ANP provides to patients is seen as deserving of

the social goods of respect and prestige. However, these same goods are withheld from some medics when participants contrast the quality-of-service ANPs provide to theirs.

8.5 Building sign systems and knowledge

This final section reveals the key discourses that were identified by applying Gee's Sign Systems and Knowledge Building Tool to the data. Gee (2010) identified the building task, building sign systems and knowledge, as the way language is used to create, sustain, revise, change, privilege or deprivilege any language or sign system or characteristic way of knowing the world or making knowledge claims about the world. Sign systems include languages, language varieties and communicative systems that are not languages. Gee argues that we can use language to make:

> '…certain sign systems and certain forms of knowledge and belief relevant or privileged, or not, in given situations, that is to build privilege or prestige for one sign system or knowledge claim over another.'
>
> (Gee, 2010, p.13)

Various sign systems are important to the people who use them and at least partly define their identities. This building task is clearly related to the building politics task, since constructing privilege for a sign system or way of knowing the world is to create and offer a social good (Gee, 2011). Like social goods, we can build up or destroy various sign systems and ways of knowing the world. According to Gee (2004), these sign systems represent different views of knowledge and beliefs and individuals contest the value of different languages and sign systems. We use language to privilege one set of knowledge over another such as that of the doctor or the layperson. We thereby accord greater authority to one person than another in specific contexts.

I now present three discourses in terms of Gee's (2014) Building Sign Systems and Knowledge Tool that are constructed in, by and through language that describes the ANP from their vantage point of their own experience and their colleagues' experience of them.

These sign systems and knowledges have been discerned as follows:

- Knowledge – The Knowing Nurse
- Knowledge – The Knowledgeable Doctor
- Sign Systems
  - The ANP title
  - The doctor title
  - Clothes and artefacts

- Doctorspeak

I now present each of these in turn.

8.5.1 Knowledge – The Knowing Nurse

Participants' language builds up the sign systems and knowledge characterising the distinctive role that education and knowledge play in constructing the ANP role. One nurse manager suggests that without the introduction of tertiary education the advanced role would not exist. One ANP (I2A1) suggests that 'as the profession developed and became a degree with more opportunity for education, it has been a natural progression for us to take on more clinical roles within healthcare'. A figured world is created wherein the more educated one is the more opportunities one has and the more duties and responsibilities one can assume. However, it is important to consider how knowledge is being contextually constructed when participants discuss this element of the ANP role. For example, some participants use language that connects the knowing identity with situational and practical knowledge:

> 'ANPs know the ins and outs of what is needed…they've done it for years and have experience of what they need to do…you know not everything is in a book.'
>
> (I3NM1)

> 'If an ANP has a lot of experience they may have more experience than a junior doctor that might not be able to take on that complex case in the first off.'
>
> (FG1N2)

> '…it comes back to the experience you bring with the role…X number of years of you being a nurse…X numbers of years of you all being managers…and then X number of years of you all practicing the same thing over and over again…'
>
> (I7M3)

For other participants, the ANPs knowing identity is grounded in theoretical underpinnings:

> 'And the same with respiratory. I mean respiratory is a huge thing here…I find a lot of the medical doctors coming don't have that specialist knowledge and do very much depend on the ANP for that because they have done the training…'
>
> (FG1N8)

Whilst for others, the ANP role is distinguished from the roles of other healthcare professions through language that relates to their 'unique' ways of knowing: 'they have a gut feeling' (FG2A9) and 'they just know' (FG1N8). ANPs use language such as 'unique' when discussing their role and the part they play within the healthcare system:

> 'I think they contribute something unique because they specialise in certain areas so then they become expert in that area.'
>
> (FG1N3)

> 'They (*Doctors*) only tend to look at bones whereas ANPs tend to look at the whole thing – the holistic element of it all.'
>
> (FG3NM2)

> 'I think as nurses we look at the patient as a whole'
>
> (FG2A2)

This language-in-use privileges the ANP role above those of other healthcare professionals and constructs a distinctive and specialised identity within the healthcare system that contributes 'something different':

> 'ANP candidates themselves have been incredibly sensitive to their position and they've delivered small projects already that people can see.'
>
> (I4NM3)

> '…we're taking on medical roles but I do think we do it differently and I think the way that I, not only practice and fulfil the medical part of the role, I also bring something different to it from my years of nursing experience.'
>
> (I2A1)

Privilege for ANPs' knowledge is further built up through language such as 'on a routine basis doctors walk into the ANPs office to ask for advice' (FG1N13). Participants use language that emphasises this knowledge, employing adverbs such as 'well', 'thoroughly' and 'significant' creating a professional identity that is experienced, capable and knowledgeable:

> 'ANPs…from the start have developed skills and knowledge that are comparable with any medical doctor.'
>
> (FG1N3)

For other participants however, ANP knowing is constructed as having limits and being bounded and consequently ANP knowledge is deprivileged. This is evident in the language-in-use used by some participants that suggest ANPs 'are cheap doctors'

(I2A1) and ‘not on par’ (FG4A18) with doctors. This outlook is reinforced by language-in-use that constructs the ANP role as being less valuable as a result of their less ‘rigorous training’ rendering them less knowledgeable and skilled than medical counterparts:

> ‘I suppose you have to appreciate they have much more rigorous training, like the point system to get into medicine much higher, there are six years before they get to any level and then they have to do loads of exams ongoing so if they see nurses coming out to do similar, their job with a two year course with no medicine, well nursing medicine you know, I wonder do they see that as being a little unfair, and then they look pay parity and stuff...I don’t know do they get a little bit peeved with that a little bit.’
>
> (FG4A4)

It is noteworthy that the point of reference and gold standard for the ANP role is often the doctor. Using language such as ‘nursing medicine’, the ANP role is constructed as an almost ‘dumbed down’ attenuated medic. This comparison is linked, in part, to the previously discussed social goods of respect and prestige that is awarded to medics’ knowing, which is explored next.

8.5.2 Knowledge – The Knowledgeable Medic

When participants discuss the education of ANPs they employ language such as ‘training’, ‘nursing school’, and ‘vocation’ whereas language such as ‘university’ and ‘education’ are more likely to be employed when discussing medical education. Again, we see patterns in the language used by participants which connects ANP knowledge with practice and application whereas language-in-use connects medics with theoretical and professional knowledge. This in turn creates a distinction between the two knowledges:

> ‘ANPs come at it from a completely different viewpoint in terms of an ANPs background…your *(ANPs)* training is quite different to any medical doctors’ education which allows them to take on a wider scope…’
>
> (FG1N13)

> ‘I think ANPs bring something very different to a doctor…their training allows them to look at things differently…they are coming from a different angle to a doctor.’
>
> (I4NM3)

Medical participants in the study use language which reinforces the differences between the two knowledges and privileges medical knowledge over ANP knowledge by building up the supervisory identity of the medic:

> 'As an ANP you would need an expert to consult with umm you need...you're always going to have a cohort of your own but then there's going to be patients that move outside of that scope.'
>
> (I4NM3)

> 'Looking at the ANP role it's kind of the same thing isn't it...they will always need an expert to discuss things with...to point them in the right direction.'
>
> (I5M2)

Using language such as 'I suppose I'm responsible for everything' (I7M3), consultants inform others that they see themselves as the overseers of clinical care, and in turn ANPs, and that any clinical decision requires their approval. This outlook is also seen in language used by nurse managers who build up the medical knowledge they believe is required in the supervisory relationship:

> '…the consultant in the service is offering that governance...I don't see who can replace that clinical knowledge within an organisation to give you the governance that you would need…an ANP would need an expert to consult with…'
>
> (I4NM3)

Within this figured world, it is the doctors perceived superior knowledge that enables and requires them to maintain professional control over clinical services and that underpins the controlled identity and threatened and hierarchical relationships we have seen earlier in the chapter.

8.5.3 Sign Systems

A number of sign systems were identified from the findings:

- The ANP title
- The doctor title
- Clothes and artefacts
- Doctorspeak

Each is now discussed in turn.

The ANP Title

The ANP title, when we consider the words advanced nurse practitioner, can be seen as a sign system, therefore it is important to explore the language-in-use to identify how this language constructs and deconstructs the ANP identity. Participants used language that built up the new and innovative aspect of the advanced role that moves away from the 'traditional' nursing image:

> 'I suppose they take on new jobs as such as opposed to the traditional nurse…It's a new role as opposed to the old style of nursing.'
>
> (FG1N3)

> 'More autonomous and innovative – making more decisions at a higher level…an extended role of the traditional nurse…that's my understanding of it.'
>
> (FG4A18)

The majority of participants employed language that connected the 'advanced' aspect of the role with diagnosing, treating and discharging:

> '…as an ANP you are diagnosing and treating and managing the whole episode of care.'
>
> (FG2A9)

> 'I suppose I would see them relating to full complete care, so the assessment, the diagnosis, the prescribing, the referral, access to diagnostics, it's the complete episode of care that the ANP can deliver.'
>
> (I3NM1)

Language-in-use such as 'diagnosing and treating' has long standing connections to medicine so therefore it is unsurprising that the majority medical participants employed language that medicalised the ANP sign system:

> '…you expect an ANP probably to be doing stuff that you would probably associate with a doctor...things that you wouldn't expect a nurse to be able to do.'
>
> (I5M2)

> '…we talk about advanced, expanded and extended roles where the nurses are actually seeing, diagnosing and treating patients…doing what a doctor normally does…that's what I think of when those terms are used.'
>
> (I6M1)

ANP participants correlated the 'advanced' aspect of the ANP title with 'experience and education'. By building up the educational aspects of their role, ANPs are attempting to construct knowledgeable identities for themselves:

> 'Well I think it is, since advanced is used in the title, I think this is the most descriptive for ourselves to use…that you are at an advanced level both in experience and in education…you are able to make those advanced decision making so that is usually the word I use to describe my role.'
>
> (I1A26)

The Doctor Title

Emphasis concerning the occupational 'doctor' title is seen in the language used by both medics and ANPs that both privileges and deprivileges the title. Language such as 'power to the name doctor or word doctor' (FG1N8) builds up the ways of knowing the world where doctors have power secondary to their assigned title:

> '…doctors feel threatened because it might take away…what would you say…power to the name doctor or word doctor ummm…they might feel like it's taking away from their title.'
>
> (FG1N8)

Conversely, ANPs employ language that weakens the power attached to the title 'doctor':

> 'I don't think that just having two letters in front of your name means somebody who doesn't have them can't gain the same skills and knowledge as you approaching it from a different angle.'
>
> (I2A1)

This building up and disassembling of the 'doctor' title is evident in Discourses and Conversations circulating in the healthcare system.

Clothes and Artefacts

Language is employed by medical participants that build up and tear down the sign systems associated with dress and uniform in the healthcare system. Using phrases and terms they deconstruct the ways people know the healthcare world:

> '…there is so much jargon and things, situations like that, that the whole system is actually confusing to many people…doctors used to wear a white coat and

> the nurse a white dress but that doesn't happen anymore either…no wonder everyone is confused.'
>
> (I6M1)

Language such as this creates a figured world related to current male/female gendered Discourses and Conversations where the doctor is male and nurse female.

Further language-in-use related to artefacts used in the system, constructing a figured world where these artefacts are the property of medics, they are the only ones capable of using them and no one else. This privileges medicine over other healthcare professionals. A classic example from the findings is a stethoscope:

> 'I don't understand what some of the jobs are in the hospital. The same with doctors and nurses, with everyone wearing the same uniform like scrubs, it's hard to distinguish…even stethoscopes don't mean it's a doctor.'
>
> (I7M3)

Doctorspeak

Language-in-use makes the language used by doctors more relevant and privileged than language used by other healthcare professionals. For example, one nursing participant highlighted issues that they had encountered when they used language that they perceived was just for medics:

> '…you have to be political, very political in the language you use. There can't be a threat...what language...that needs to be used...proper language that is service driven you know outcomes, looking at data, hospital avoidance, so it's trying to use language that is more service driven. I used the words that they should have admission and discharge rights and someone said to me immediately, and it was really good advice, do not use those words, that means that you are taking someone's rights you know like you're taking something away from the consultants so don't...just don't use that language, just be careful…that definitely would have probably put a red flag, raised a red flag I would say to my consultant colleagues because it's too medical.'
>
> (I4NM3)

The use of the word 'rights' in this situation construct a situated meaning that doctors have entitlements and claims that are not authorised for use by any other healthcare professional and in turn constructing privilege for this sign system.

Other nursing participants recognise the importance that language plays when speaking with healthcare professionals as well as members of the public:

> 'I think that if you are articulate and if you...you do have to use their language though...and this is the thing with nurses and they're not comfortable with. Nurses speak to patients in layman terms and the whole lot and then you go and speak to the consultant and you have to change it all around and you have to do you know have it all there (*clicks fingers*)...'
>
> (FG2A9)

Summarising, the data shows that participants use language to privilege and deprivilege sign systems and knowledge, and in turn accord greater authority to certain individuals over others. Participants' language builds up the sign systems and knowledge characterising the distinctive role that education and knowledge play in constructing the ANP identity. There is some divergence in participants understanding for the epistemological basis of the ANPs knowledge. Some participants use language that constructs ANPs knowledge as situational or practical, for others it is grounded in theoretical underpinnings, whilst others consider an ANPs knowledge to be tacit. Medics knowledge, on the other hand, is constructed through language-in-use as learned and scholarly. Privileging medical knowledge over ANP knowledge enables medics to build up their supervisory identity reinforcing the controlled ANP identity and upholding the hierarchical relationships that exist in the system. Some participants to counteract this, employ language to weaken the power that is attached to this aspect of the medical identity. Participant's language-in-use endeavours to dismantle and remove power from the doctor title as well as attempting to tear down sign systems associated with dress and uniforms and artefacts that have been long associated with medics. In doing so participants are attempting to deconstruct the way people know the world.

8.6 Chapter Conclusion

Within this chapter, I have provided a critical analysis and interpretation of the findings. Applying Gee's (2014) theoretical framework and building tasks of building identities, building relationships, building politics and building sign systems and knowledge to the data, I have shown how language-in-use has worked ideologically to construct, represent and position ANPs in the current healthcare structures. ANPs are positioned

as unique practitioners; for some, intuitive holistic team players; for others, a ‘médecin manqué’, contrasting identities operating within controlling and restrictive settings. A diverse range of relationships are constructed through language-in-use and exist in these environments, some relationships constrain the development of the ANP identity while others facilitate its advancement. Within these contexts, language-in-use effects the distribution of the social goods of value for money, added value, autonomy and respect, and language is also used to privilege and deprivilege nursing and medical knowledge, as well as building up and dismantling sign systems that exist in the system. In the next chapter, I will present the Internal Language of Description, findings of how ANPs experience themselves, one another, other members of the system and the system itself by using Oshry’s (2018) Organic Systems Framework (OSF) to describe and analyse the dynamics of organic systems in terms of distinctive patterns of systemic relationships and processes.

Chapter 9 Internal Language of Description: Presentation of Relative Balance and Intensity of the Systemic Processes in terms of Oshry's (2018) Organic Systems Framework

9.1 Introduction

The purpose of this chapter is to present the internal LOD (figure 9.1). The internal LOD is used to extend and strengthen the external LOD and to locate, describe and analyse ANPs in a wider systems context.

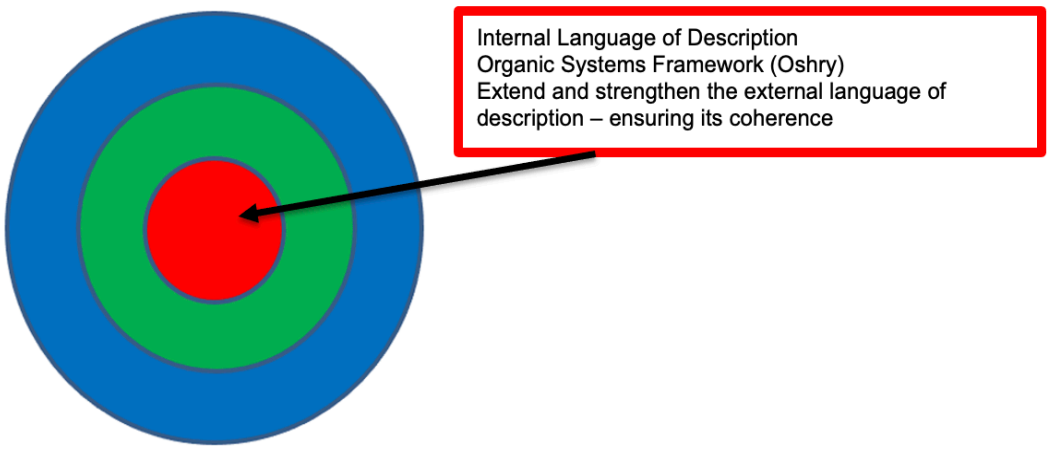


Figure 9.1 Internal Language of Description

Considering the bespoke approach to CDA and Systems Thinking used within this thesis, figure 9.2 shows where Oshry's (2018) Organic Systems Framework intersects with the theoretical framework and design. This section examines the systems element of this framework.

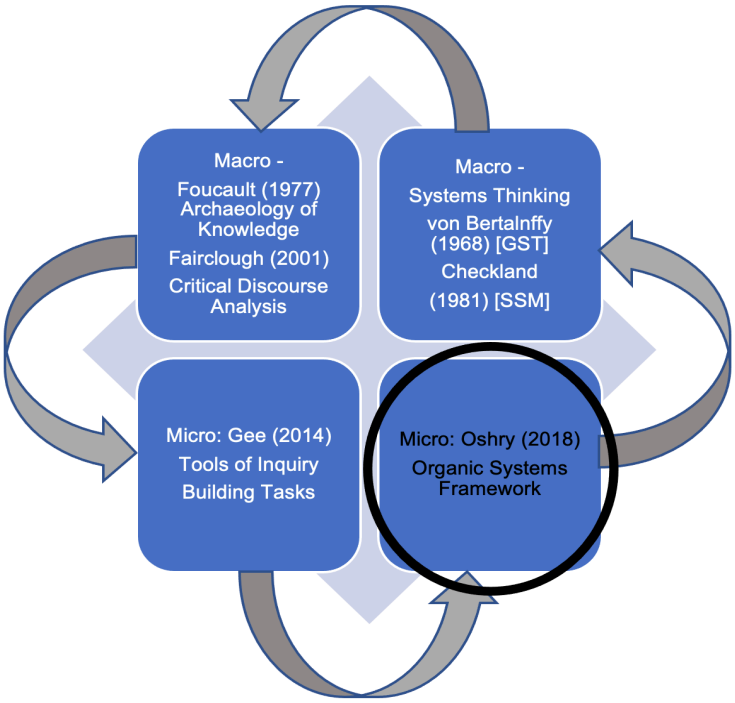


Figure 9.2 A bespoke approach to CDA and Systems Thinking showing key points of intersection with theoretical framework [Adapted from McNamara (2007)]

The findings in this chapter are structured according to Oshry's (2018) Organic Systems Framework (OSF). The OSF has been applied to the outputs of the prior analysis presented in Chapters 7 and 8 and provides a way to describe and analyse the dynamics of organic systems in terms of distinctive patterns of systemic relationships and processes [figure 9.3]. These patterns of relationships and processes shape how ANPs experience themselves, one another, other members of the system and the system itself.

The purpose of using OSF as a lens of analysis is to show, first, how ANPs comprise a system that can be described in terms of the distinctive patterns of relationships and processes that constitute it and, second, to illuminate the relationships and processes that characterise the ways in which the ANP (sub-)system interacts with the wider healthcare system. OSF is concerned with transforming our 'system blindness' with all of its costs, into 'system sight' with all of its productive possibilities. It allows us to notice how the structures, relationships and processes of the whole system affect our consciousness, that is, how we experience ourselves, others, and other systems. OSF allows us to see the system spaces we fall into and out of, and the typical responses that these spaces evoke.

System blindness results in familiar disempowering scenarios with costs in terms of personal stress, broken relationships, missed opportunities, diminished effectiveness and contribution, and destructive behaviours within and across systems. Oshry's (2007, 2018, 2019, 2020) concepts provide a way of describing and analysing the relative balance and intensity with which distinctive relationships and processes are expressed in systems. I am looking at ANPs as a collective, a bounded system, rather than as individuals, so as to explore the patterns of relationships and processes that characterise ANPs as a system that is shaped by – and shapes – the wider system of which it is a part.

The value of employing the Building Task Framework, as discussed in the previous chapter, has been to systematise some of the randomness that can arise from the empirical circle by overlaying a logical analytic framework. This framework helped describe and analyse the language-in-use in culture and society and how relationships and identities or 'views of the world' are constructed in and through discourse. CDA complements and dovetails with OSF. In the same way as CDA, OSF allows the researcher to adopt the position of an observer – standing apart from the whole system and noticing what is going on through the language in use – like observing the movement of bees as they dance around the hive (Oshry, 2017) or getting on the balcony to observe the dancefloor (Heifetz et al., 2009).

SYSTEMIC RELATIONSHIPS		
TOP/BOTTOM	END/MIDDLE/END	PROVIDER/CUSTOMER
		

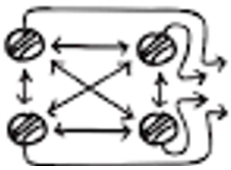
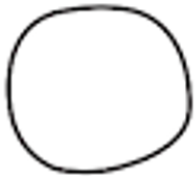
SYSTEMIC PROCESSES			
INDIVIDUATION	INTEGRATION	DIFFERENTIATION	HOMOGENISATION
SEPARATE	TOGETHER	DIFFERING	COMMONALITY
			

Figure 9.3 Organic System Relationships and Processes (Oshry, 2019)

In figure 9.4, I depict the steps of the data transformation process followed specifically for this chapter.

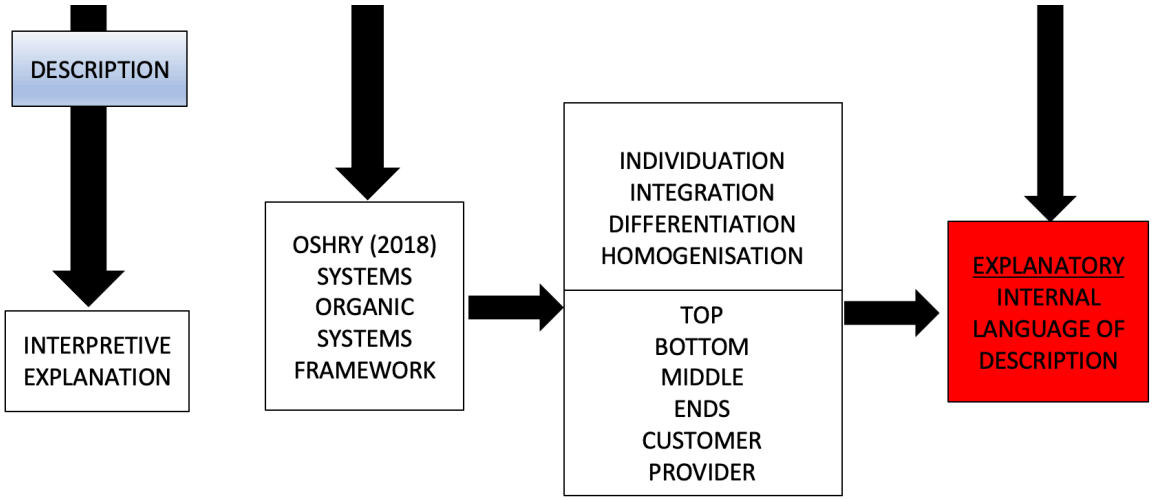


Figure 9.4 Process of Data Transformation – Internal Language of Description

I now present the internal LOD, the findings arising from the application of the OSF to the outputs of the previous analysis presented in Chapters 7 and 8. The chapter has been broken into two sections, the first focusing on the three key systemic relationships that determine the essential properties of the ANP system and the second focusing on the four fundamental whole organisational system processes with which the ANP system interacts with its environment [figure 9.5].

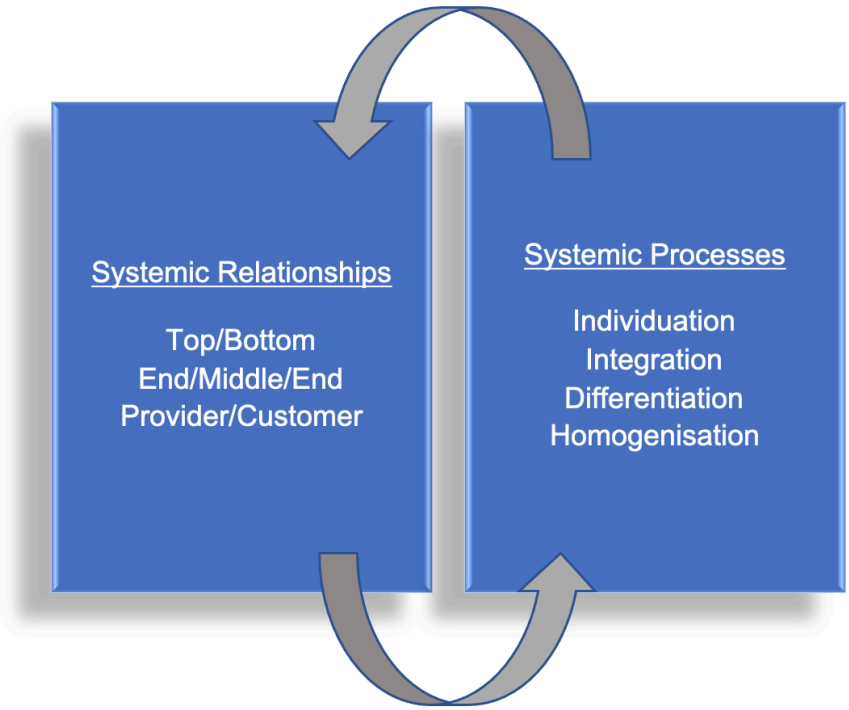


Figure 9.5 Oshry's (2019) Systemic Relationships and Processes

9.2 Whole Systems as Patterns of Systemic Relationships

Oshry (2020) shows how, as we go about our lives, we move in and out of systemic relationships. He refers to these relationships as Top/Bottom, End/Middle/End and Provider/Customer [figure 9.6].

SYSTEMIC RELATIONSHIPS		
TOP/BOTTOM	END/MIDDLE/END	PROVIDER/CUSTOMER
		

Figure 9.6 Organic System Relationships (Oshry, 2019)

These patterns exist at all levels and in all types of social systems, existing in hierarchical and non-hierarchical systems. Regardless of our role and position in these social systems, we are continuously moving in and out of these relationships, sometimes on one side and sometimes on the other. Within this section, I will examine the spaces of Top/Bottom, End/Middle/End and Provider/Customers, showing how within each of these spaces some ANPs, blind to the space they occupy, feel burdened, oppressed, torn and righteously done to and show how this systemic blindness constrains the role. Conversely, I will also show how other ANPs working in these environs are aware of the spaces they are in, choose to eschew oppression, dependence and blame and instead exercise system sight to enable and advance their role. I do this by applying OSF to the outputs of the previous analysis presented in Chapters 7 and 8.

9.2.1 The Top/Bottom Relationship

When we consider the Top/Bottom relationship we discern that those at the top of organisations are responsible for shaping the overall system, creating the right conditions for the organisation to flourish, to cope with threat and to recognise and

seek out opportunities. In this environment, Tops have designated responsibility for the system, project or process whereas the Bottoms are members of this system, project or process. The Top World is a world of complexity and accountability, and the Bottom World is a world of vulnerability and disregard. In these worlds, Tops feel responsible for success and can become overburdened, 'sucking it up', whereas Bottoms may feel little responsibility and become oppressed by what they perceive to be remote, disengaged and indifferent managers at the top and middle of their organisations [figures 9.7 and 9.8].



Figure 9.7 Top World (Power and Systems, 2018)

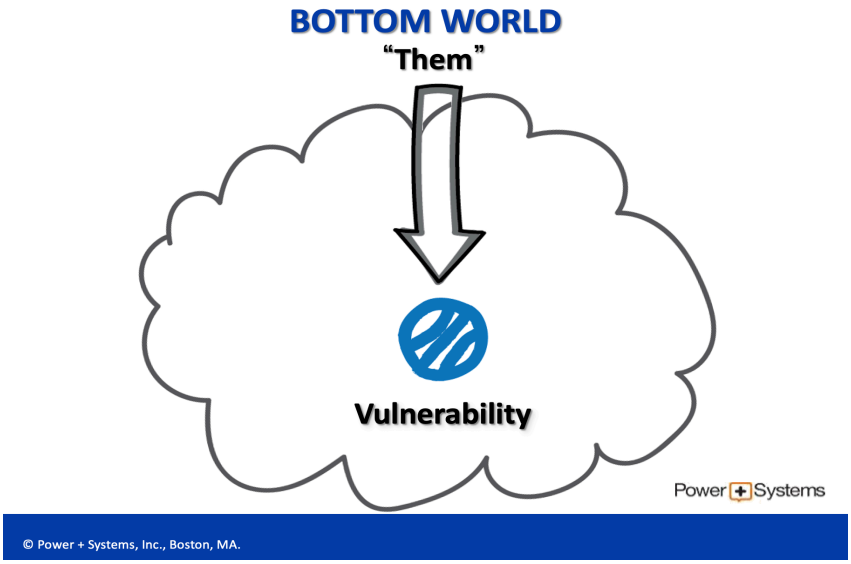


Figure 9.8 Bottom World (Power and Systems, 2018)

One consequence of this imbalanced relationship is that Tops' attention can become too focused on coping with immediate issues to the extent that important longer-term issues are neglected, issues that Bottoms may not even be aware of. Tops become increasingly burdened, alone in their responsibility and concerned that they are not doing all that they should be doing. As a consequence, Bottoms are absolved of responsibility for the overall condition of the system of which they are a part.

Returning to the analogy of the Doors provided by Oshry (2018), as Tops move readily through Door A, blind to the system they are in, they continue to suck up responsibility to themselves and away from others. However, with a dawning system sight, Tops can choose to pass through Door B, overcoming system blindness and creating responsibility throughout their system. Drawn inexorably through Door A, Bottoms, also blind to the system they are in, continue to hold Tops responsible for their condition and for the condition of the system, contributing to feelings of powerlessness and even oppression. But other possibilities exist and, with system sight, Bottoms can choose Door B and assume responsibility for their condition and for the condition of the system [figure 9.9].

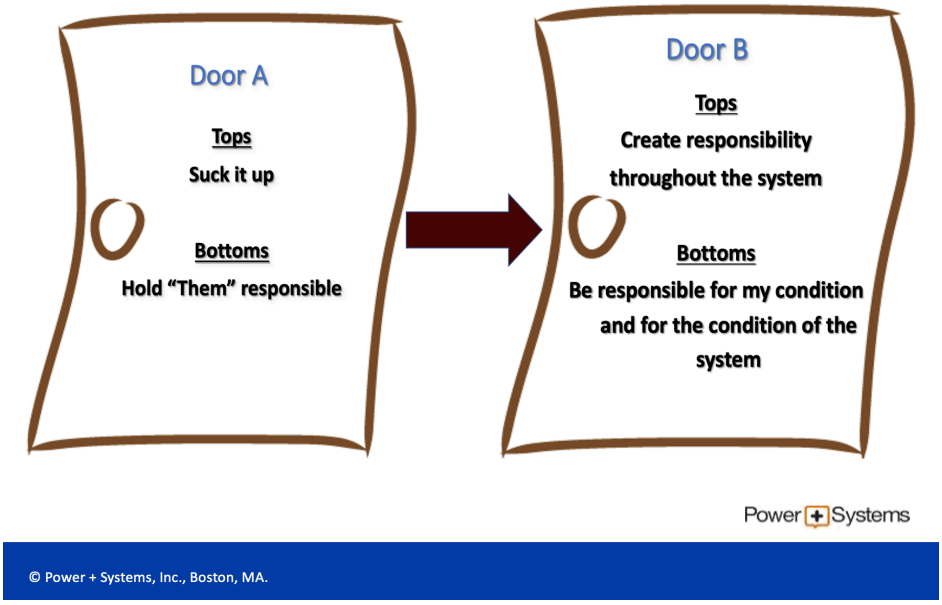


Figure 9.9 Moving from Door A to Door B – Tops/Bottoms (Power and Systems, 2018)

9.2.1.1 Blind and sighted responses within the Top space

Corresponding with the independent powerful identity that was built in the external LOD, findings show that participants position ANPs as drawn to Door A, building an identity for the ANP that is burdened with the responsibility for the success or failure of the entire system. In turn, ANPs are positioned as overloaded Tops with increased expectation from all members of the healthcare system, including themselves [figure 9.10].

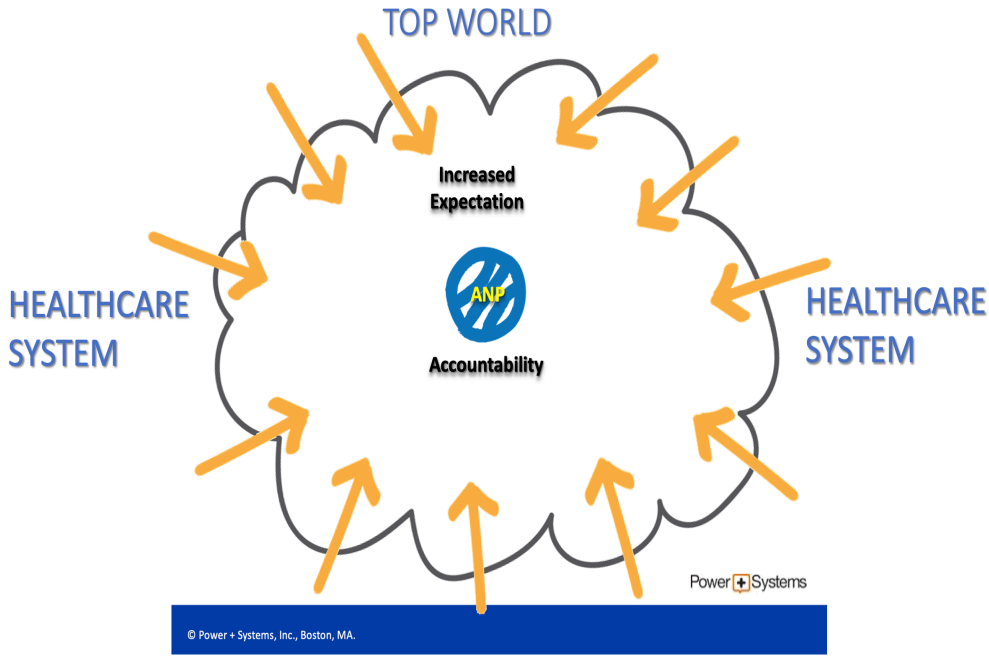


Figure 9.10 ANPs as oppressed Tops(Power and Systems, 2018)

Placing ANPs in a Top position, participants construct an identity that sucks up responsibility for ensuring patients have access to the social goods of equitable and efficient healthcare. ANPs are constructed as the answer to many of the problems that beset the healthcare system such as increasing waiting times, lack of interdisciplinary and innovative approaches to patient care, and increasing hospital admissions:

> 'ANP – I think it's seen as a bit of a buzzword, bit of a solution to…the panacea of all problems within the health service and we're just going to minimise the waiting lists by throwing money at the nurses to sort it out.'
>
> (I2A1)

This figured world where ANPs are constructed as the answer to many of the enduring challenges facing the healthcare system has resulted in the building of relationships

characterised by overreliance on the ANP role. This has led to the ANP becoming overloaded and burdened with increased responsibilities, and situations have arisen where ANPs cannot now be 'done without' (FG1N15) with problems arising when they are not on duty:

> 'I suppose working in triage you really do see the benefits you know especially for the waiting times for the patients coming in – waiting times go out the window when there isn't an ANP on duty.'
>
> (FG1N14)

> 'I'd like to see ANPs probably stay on a bit longer… when the ANPs go off patients wait longer, and the waiting times increase so obviously there is probably a need for the ANP to be there longer.'
>
> (FG3X4)

However, participants also use language such as 'reduce waiting times' (I5M2) and 'preventing hospital admissions' (FG2A16) to construct a figured world where ANPs are positioned as empowered Tops, moving through Door B, creating responsibility throughout the wider healthcare system and recognising the personal power they play in achieving these outcomes. As was seen in the previous chapters, the social language of economics and value is used by participants to both privilege and deprivilege the role. In certain contexts, this results in ANPs being constructed as oppressed Bottoms and identified as 'cheap doctors' (I2A1). In other contexts, it has led to ANPs being constructed as empowered practitioners, and there is evidence of system sight when ANPs move through Door B, articulating clearly how they are responsible for cost savings and '…worth their money – 100%' (FG4A4).

ANPs are further positioned as empowered Tops who create responsibility throughout the entire system by building respect for the role and being a source inspiration for other members of the system. This was key for the building of the interdependent relationships and collaborative identity discussed in the previous section where language-in-use emphasised the building of respect and rapport between members of the multidisciplinary team. Use of language such as 'working in partnership' (FG1N15) and 'team players' (FG2A2) shows evidence of system sight responses that enable ANPs to move through Door B and behave like empowered Tops where they involve and inform others as well as distribute responsibility throughout the system:

> ‘That’s how you provide the service…you provide a good service for your patients. If you were a lone island, it wouldn’t work well.’
>
> (FG4A5)

Other participants, predominantly medics, use language that creates a figured world where ANPs are not seen as the answer to the many problems in the healthcare system but instead are seen as inferior practitioners requiring medical supervision to practise. Medical colleagues regularly feel responsible for dealing with every issue that arises, to the extent that ANPs ‘wings are clipped’ (FG4A4), restricting their practice. This is particularly salient amongst consultants who act as burdened and siloed Tops, sucking up all responsibility rather than distributing this responsibility throughout the wider healthcare system:

> ‘I’m ED consultant and pretty much all complaints end up coming to me one way or another, so I suppose I’m responsible for everything that happens but I’m happy the way that it is developing.‘
>
> (I7M3)

> ‘…there would be occasions that we would speak of expanding into something else and as a group we might discuss it and then we would bring it to the table and they’d say ‘no we don’t want you seeing hips now’ you know, so no matter how competent, how much we feel that it would be within our scope, the decision will be made at what level they will allow us to get to.
>
> (FG4A4)

9.2.1.2 Blind and sighted responses within the Bottom space

As we have seen in the building relationships task, language-in-use such as ‘strict guidelines’ and ‘defined profession’ identify certain regulations and policies as contributing to an oppressed Bottom identity for the ANP. The controlled ANP identity becomes the oppressed Bottom in a Top/Bottom relationship where policy makers and regulators are Tops [figure 9.11]. The data shows that language-in-use constructs ANPs as disempowered Bottoms within the healthcare system, holding ‘them’ responsible for the Bottom position they see themselves in: ‘’…they’re unsure of even where we stand in the hierarchy of it all…’ (FG4A5).

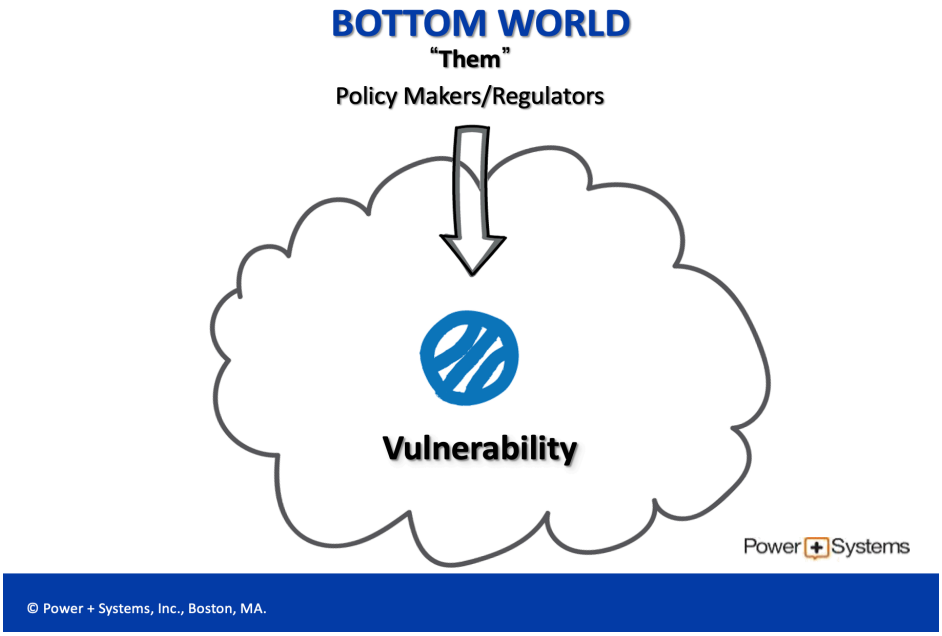


Figure 9.11 ANPs as oppressed Bottoms (Power and Systems, 2018)

In this Bottom position, consistent with the four dimensions of the ANP-medic relationship uncovered in the previous chapter, ANPs are on the receiving end of policies and regulations that restrict their practice, are unable to perform to their full potential and feel disregarded:

> 'When you think back and think about all that legislation and restrictions…like the majority came from our own colleagues…like the nursing board you know… supervision helped us in the start but in some ways now it is impeding us…stops us developing…it's so frustrating because it stops me from doing my job.'
>
> (I2A1)

In this figured world, where it is taken for granted that the ANP role must be controlled and restricted, ANPs are constructed as disempowered and oppressed Bottoms. Rather than taking responsibility for themselves and their own system, ANPs are positioned as holding medics responsible, reinforcing a figured world where medics are needed to supervise the role. Findings from the critical discourse analysis show that the inability to realise the full potential of the ANP role is discursively constructed as arising from hierarchical relationships, and indifferent nursing management and medical colleagues:

> ‘ANPs may have had problems with x-ray themselves like, you know the consultants in x-ray felt that it should be an NCHD or a senior doctor ordering x-ray and not ANPs.’
>
> (FG1N2)

This highlights the vulnerability that is experienced by ANPs and the impact on their practice and relationships with colleagues in the wider healthcare system. Drawn through Door A, ANPs, feel oppressed by managers and colleagues at the top of healthcare organisations who they position as remote and disengaged, failing to call upon their contributions, experiences and perspectives:

> ‘They don’t know what the actual role is, which is a shame...I don’t know if it’s inexperience or they just don’t want to know what we do…’
>
> (FG4A5)

However, some ANPs with system sight choose Door B, disrupting this figured world where ANPs require supervision, and become empowered Bottoms. They take responsibility for themselves and their system as evident in language that emphasises their skills, expertise and knowledge base. A figured world is constructed where independent, autonomous ANPs are essential practitioners in their own right. Applying the OSF to the outputs of Chapters 7 and 8 demonstrates that other participants’ language positions ANPs as more empowered Bottoms. Selecting Door B, ANPs create responsibility through the system, accepting a degree of responsibility for the condition of their system by invoking the independent powerful identity that was presented in the building identities task and inspire others by ‘contributing something unique’ (FG1N3) to the healthcare system. These ANPs argue that ANPs need to become active players in resolving issues, continually referring to the ‘voice of the ANP’:

> ‘…if there is a strong voice for nurses, do you know at the top – it’ll give... it will make nurses more autonomous, more able…’
>
> (FG2A9)

> ‘I think it comes from the grassroots of nursing that ANPs really need to be, articulate to become more autonomous and more strong.’ (A16)
>
> (FG2A16)

To summarise, ANPs are positioned by some participants’ language-in-use as overburdened Tops sucking up the responsibility for ensuring that patients have

access to equitable and efficient healthcare and for promoting interdisciplinary approaches to care. Other participants use language that builds an identity for the ANP as an oppressed Bottom subjected to Tops in the wider system such as managers and medics whose habitual response of sucking up responsibility disempowers others. Being on the receiving end of regulations, attitudes and behaviours that restrict their practice, ANPs are constructed as disregarded.

However, findings also show that there is evidence of sighted responses, a discernible movement from system blindness to system sight; from predictable reflex responses to empowerment stands as participants opt for Door B responses. Correlating with the construction of the independent powerful identity discussed in the previous chapter, ANPs are positioned as empowered Bottoms taking responsibility for their own system and recognising the personal power they have within that system as essential, independent autonomous practitioners who reduce waiting times, hospitalisations and lengths of stay and improve the patient experience. Participants also position ANPs as empowered Tops, creating responsibility throughout the wider healthcare system through their collaborative practice and interdependent relationships.

9.2.2 The End/Middle/End Relationship

At times we can see ourselves moving in and out of End/Middle/End relationships. In the middle, we can become torn between the conflicting agendas, needs, desires or priorities of our managers or tops, on the one hand, and those who report to them, such as workers, on the other. The more burdened Tops become, the more they will look to Middles for support and the more unhappy Workers are, the more they will look to Middles to fix things. In this End/Middle/End relationship responsibility for success flows from both Ends to Middle with Middle feeling responsibility for resolving Ends' issues, with both Ends feeling no responsibility for success [figure 9.12].

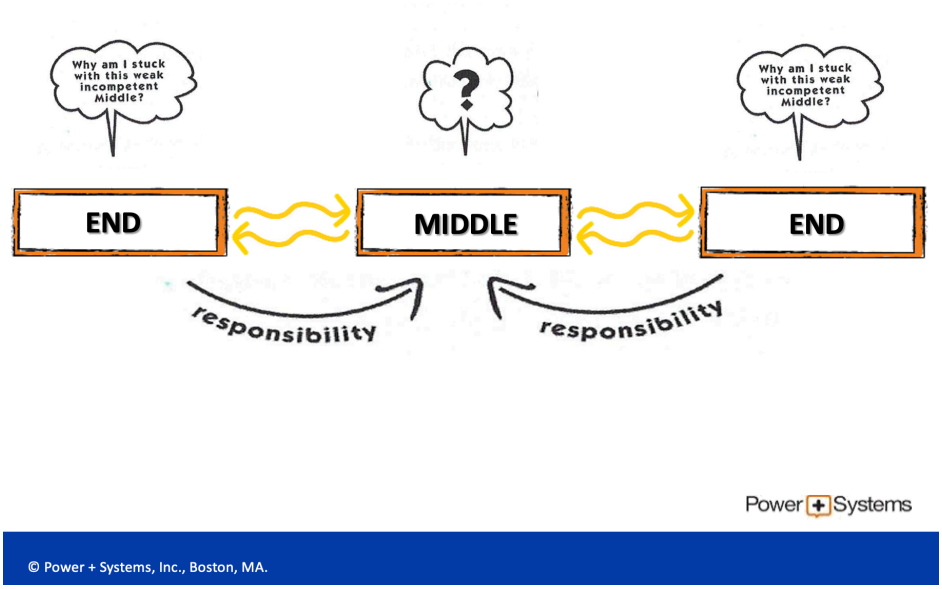


Figure 9.12 End/Middle/End Relationship (Power and Systems, 2018)

In this relationship in which the responsible Middle is continually stretched and torn between the demands of both Ends, it is not uncommon for Middles to become overwhelmed and burnt out, never fully pleasing either End and in turn dropping out of the relationship in anger and futility. Ends, on the other hand, who find it easier dealing with Middles, find it more difficult when the Middle is gone and are unable to work with each other. Returning to the analogy of the Doors provided by Oshry (2018), Middles, rather than passing through Door A are blind to the spaces they fall in and out of. They slide into the middle of other peoples' issues and become torn. But they can instead pass through Door B to become Middles who see the productive possibilities of the system when they maintain independence of thought and action [figure 9.13].

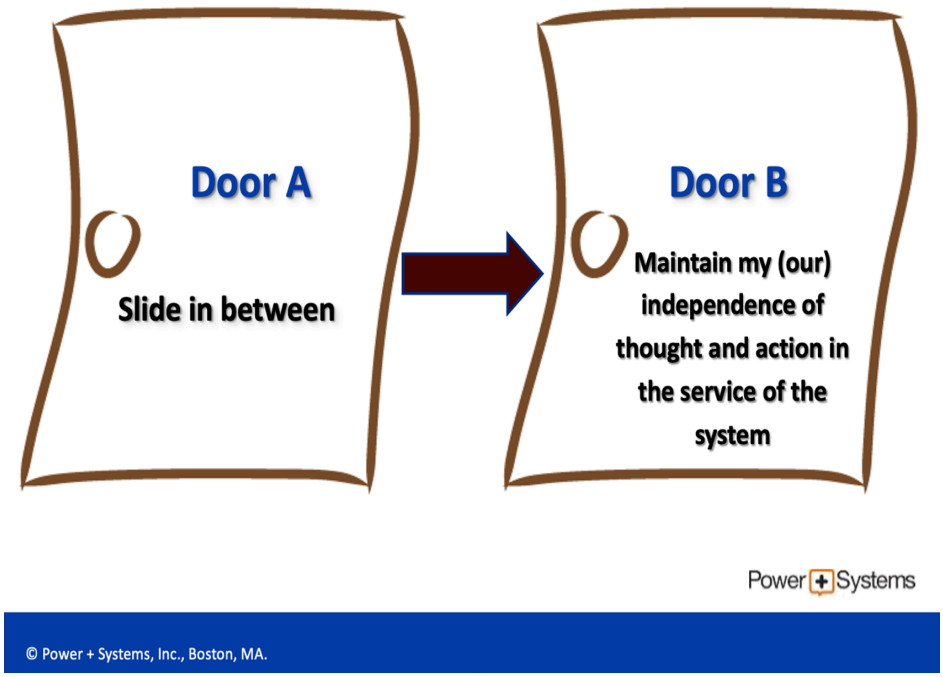


Figure 9.13 Moving from Door A to Door B – Middles/Ends (Power and Systems, 2018)

9.2.2.1 Blind responses within the Middle space

When we consider the End/Middle/End relationship, several participants position the ANP role as a Middle, an identity that is frequently torn between the conflicting demands and priorities of their nursing and medical managers. This is evident in the outputs of the previous analysis seen in Chapters 7 and 8 when nurse managers and medics differ on the scope of the ANP role. For some nurse managers, ANPs are not working at the level they should be whereas for some medics, ANPs are working at levels that they believe to be beyond their capabilities:

> I've asked as Director of Nursing for some assistance to come to my hospital and review the role of all our ANPs, to zone in and make sure that everything is at ANP level.'
>
> (I4NM3)

> '…it depends on what you mean by complex...like you can't expect an ANP to be managing something like an MI or PE or something like that when the patient is completely unstable…'
>
> (I5M2)

Evidence shows that some ANPs adopt blind responses, moving through Door A to a tearing environment, where ANPs slide in between both parties and there is the real possibility that ANPs will never really satisfy either End [figure 9.14]:

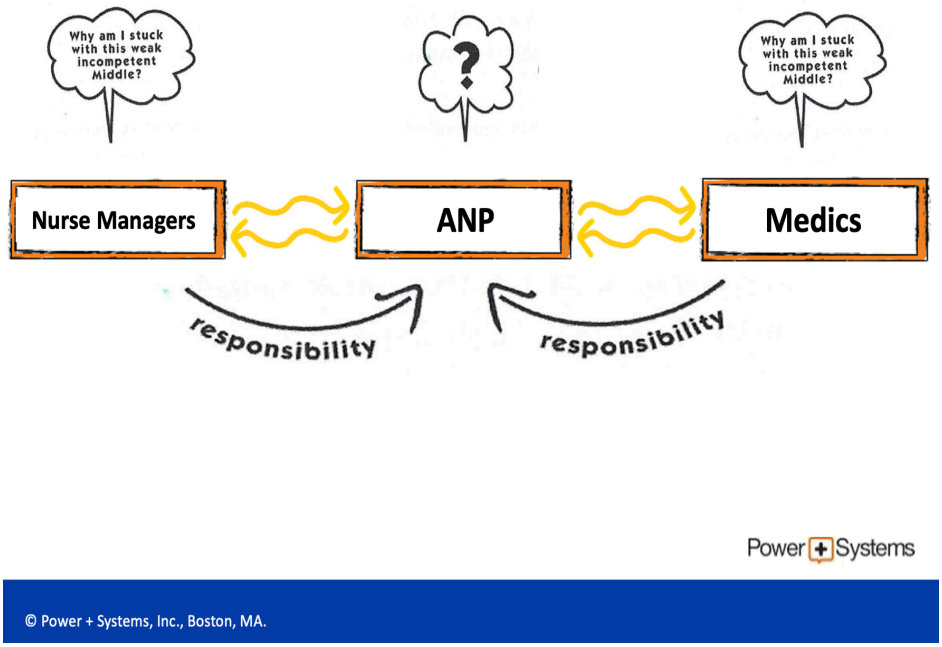


Figure 9.14 ANPs as oppressed Middles (Power and Systems, 2018)

The application of Gee's Tools of Inquiry to the language-in-use in the empirical LOD section showed that ANPs believe that their identity is weakened and unappreciated and that their role continuously needs to be proven and justified, stressing the importance of having to 'prove that you're able to do the job' (FG2A2):

> '…there's always the job of trying to prove yourself but sometimes you're just like whatever.'
>
> (I1A26)

ANPs are further torn with the conflicting identities that are attributed to the ANP role. On one hand, a medical identity and, on the other, a nursing one. The 'integrative' nature of the role and ANPs being the 'answer to a medical problem' (I2A1), discussed in the previous chapter, is a discourse that is prevalent in the wider system and a major theme in Conversations that have taken place in the Irish healthcare system, and globally. For some Ends, such as other healthcare professionals, these conflicting identities result in the ANP role not being appreciated in its own right; rather, it is constructed as a medical substitute:

> '…some argue they're not nurses but they're not doctors...it's a new role really isn't it…so not everyone knows what all of them is doing.'
>
> (I5M2)

Without system sight, ANPs, attempting to please everyone, are at risk of pleasing no one, including themselves. ANPs have an impossible task. Both Ends, one who believes the ANP should be medicalised and the other who believes that the ANP should not, are never satisfied. ANPs in turn feel unappreciated:

> '…there would be an aspect of negativity and that negativity can spread…negativity from certain colleagues, so that even before we started the job it was a downer straightaway, you know they didn't want to see the positives or what would come from it.'
>
> (FG1N8)

> 'I suppose people will always try to cut you down and you have to kinda rise above it...like what are ye at now! The dossers...there is a professional jealousy amongst nurses...'
>
> (FG2A9)

In this disempowering environment, where the ANP role is frequently compared to that of a medic, the ANP is much less able to exercise independent thought and action and is instead identified as a substandard substitute for medics. Consequently, medicine is further privileged at the expense of ANPs. This vulnerability limits the ANP role and its potential contribution to the wider healthcare system.

9.2.2.2 Sighted responses within the Middle space

However, for other participants this Middle position, so often identified in the Discourse and Conversations, is constructed as positive and full of potential. ANPs' language shows that, adopting a sighted Door B response, they can embrace the medicalised element of the role and integrate it into a hybrid, boundary-spanning construct:

> '…[*ANPs*] take on more clinical roles within healthcare…you can't deny we take on medical roles, I don't care what anyone says you know…'
>
> (I2A1)

Acknowledging and recognising their advanced nursing element as well as elements that were historically associated with medical practice enables the ANP to maintain independent thought and action to improve the system and be seen as credible

practitioners in their own right. This is further achieved through the innovative and integrative aspects of the role.

Acting like empowered Middles in their own system, ANPs build interdependent relationships that are based on coaching and mentoring:

> '…it's a matter of working together…I know the ANP acts as kind of a mentor to other staff in the department.'
>
> (I5M2)

> 'I've seen the ANPs say it to the doctors as well about shoulder dislocations, the junior ones and show them how to do it. They provide education to the staff…'
>
> (FG1N14)

This movement from Door A reactions, where the ANP is sliding between other people's issues in the healthcare system, to the more confident and agentic Middle ANP identity arising from recognising and seizing Door B possibilities, is further strengthened and sustained through regular integration with colleagues. This stance reinforces the figured world wherein ANPs are collaborative team players and organisers. This identity was noted in the construction of the collaborative identity seen in Chapter 8 and is an identity that empowers ANPs and enriches the wider healthcare system.

In summary, some participants use language that builds an identity for ANPs as disempowered Middles walking blindly through Door A, unaware of what is happening in their own system and frequently torn between the conflicting needs and priorities of their nursing managers and medical colleagues. Conversely, nursing management employ language that questions whether ANPs are working at an 'advanced enough' level whereas the language-in-use of some medics questions whether ANPs are working at 'too advanced' a level. A tearing environment is created where ANPs never truly satisfy either End. This is further complicated with ANPs themselves being torn between their own conflicting identities of nursing and medicine, as seen in the findings presented in both the empirical LOD and external LOD chapters.

However, for some participants this hybridity is seen as a positive, permitting ANPs to become empowered Middles. Findings also show that ANPs move from the

predictable reflex responses of Door A to the empowerment stands of coaching and facilitating found behind Door B. System blindness is transformed into system sight and the productive possibilities of the ANP role are realised in practitioners who engage in independent thought and actions while maintaining collaborative relationships.

9.2.3 The Provider/Customer Relationship

We are in a Provider/Customer systemic relationship, moving in and out of each of these roles, sometimes as the Customer looking to the Provider for services or products, and sometimes as the Provider of these services and products. In this relationship, responsibility for delivering quality services flows from the service user to the provider where the provider feels responsible for delivery and the customer is absolved of responsibility. Problems occur when Providers no longer continue to provide satisfactory services to the Customer. Customers, the ultimate validators of our systems, feel righteously done-to, neglected and short-changed, and complain about the inability of the system to respond appropriately to their needs. Providers in this environment of responsibility feel unfairly judged [figure 9.15].

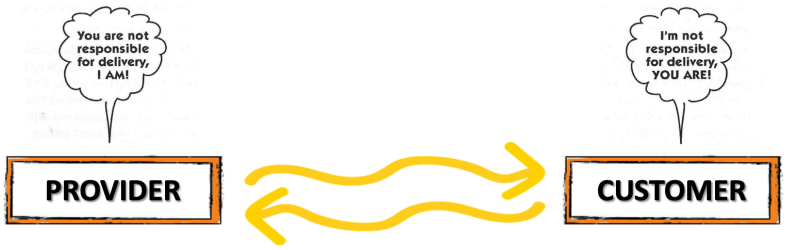


Figure 9.15 Provider/Customer Relationship (Power and Systems, 2018)

Returning to the analogy of the Doors provided by Oshry (2018), Customers who are blind to the system are drawn through Door A and stay aloof from the delivery system, holding it responsible for delivery, and become the righteously done-to Customer. By choosing Door B, Customers can achieve 'system sight' with all of its productive possibilities, including getting involved in service delivery processes and helping them to work in their interests [figure 9.16]

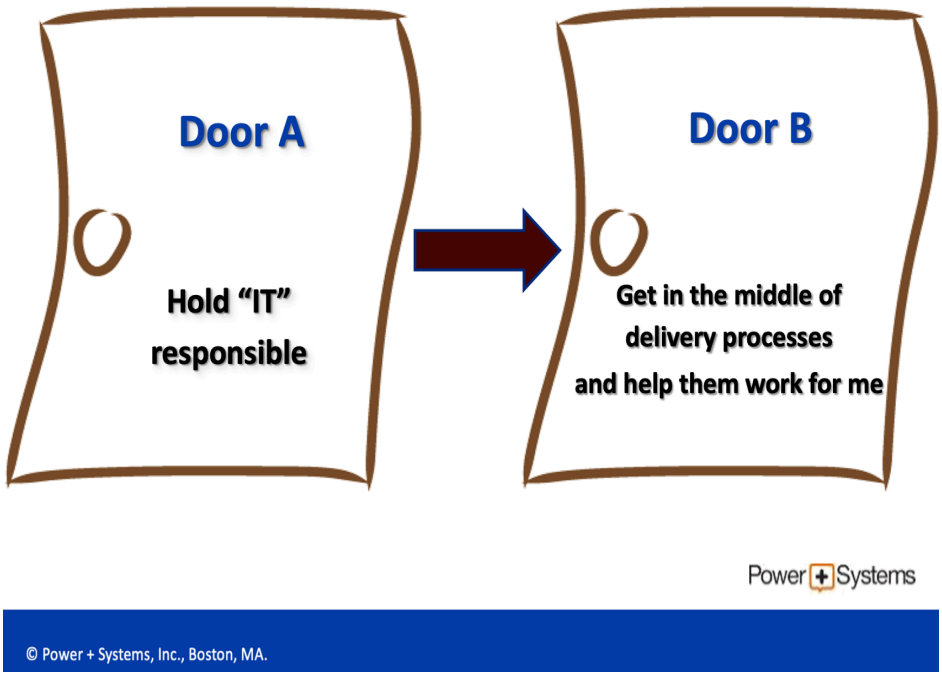


Figure 9.16 Moving from Door A to Door B – Provider/Customer (Power and Systems, 2018)

9.2.3.1 Blind and sighted responses within the Provider space

The Provider/Customer relationship is very much evident in participants' language-in-use that shows that ANPs feel responsible for delivering a quality service, not only to service users, but also to other healthcare professionals. For a few participants this service is identified as a 'yellow pack service', a generic term for cheap products in Ireland and ANPs adopt a disempowered Provider persona where the role is positioned as falling short [figure 9.17].

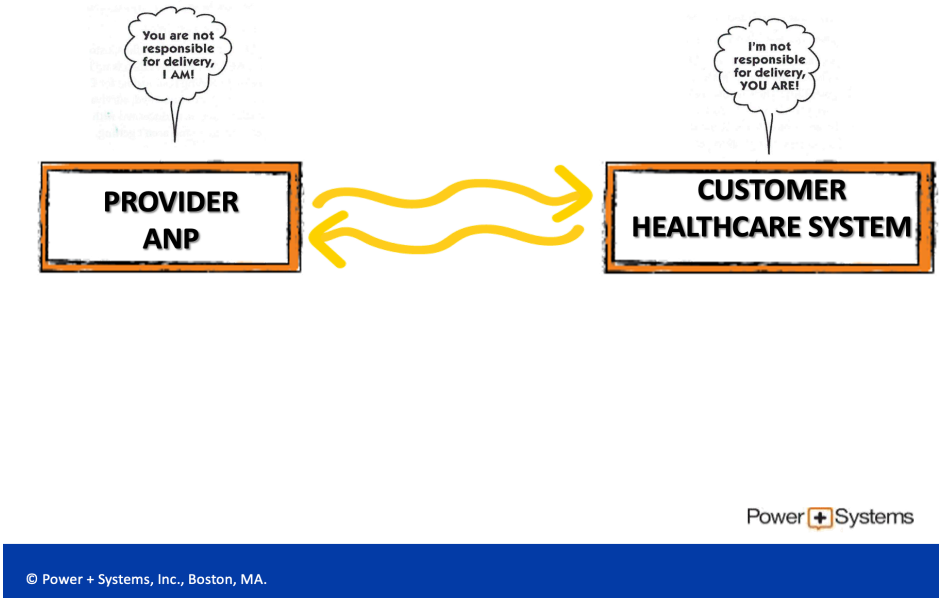


Figure 9.17 ANPs as oppressed Providers (Power and Systems, 2018)

Whilst ANPs believe they have responsibility for the delivery of the service, issues outside of their control prevent them from fulfilling it. These include limited ANP numbers, perceived constraints on ANPs' roles, working in 'tightly controlled' (FG3X4) areas, controlling supervisory relationships with medics as well as restrictive guidelines and policies:

> 'We're always told to pull back even though we take our own responsibility, the consultant will say no pull back on what you're seeing and discharging…I know they don't want us to make mistakes, but they have to trust we won't but that's a long way off yet…'
>
> (FG3A22)

These constraints on ANPs as Providers are not just built by ANPs themselves but by other healthcare professionals too:

> 'I'd say why is there a push to have consultants working nights in hospital when we won't have ANPs – oh no, no we'd never recruit people to do that so that just doesn't gel with me then if you're looking to create loads and loads of services that only work 9 to 5 Monday to Friday. That's not collaborative in a health service that needs to work 24/7 particularly in an acute service.'
>
> (I7M3)

> 'I think people need to sit back and remember that there are only so many ANPs you know…we don't have enough ANPs, we don't have enough capacity…the

> service is being judged on such small numbers and even with that small number amazing things are happening but right now they can't get to everything.'
>
> (I3NM1)

However, as seen in the Top/Bottom relationships, other participants continually refer to the 'added value figured world' to connect the work of the ANP with enhancing the wider system. In turn, participants position ANPs as empowered Providers and an integral component in the healthcare system:

> 'ANPs are like autonomous decision makers, senior decision makers you know, so it does expedite the patient care and kinda benefits patient flow…'
>
> (FG3N16)

> 'If I can see them and prevent them from going into the acute sector…I can prevent somebody going into hospital and we know over 85s…they don't stay two days they stay twelve days…how much does that cost the health service, one hundred thousand easily on that one person not taking up that bed.'
>
> (I1A26)

9.2.3.2 Blind and sighted responses within the Customer space

When we consider the Customer element in the Customer/Provider relationship, several participants position the ANP as an empowered Customer moving through Door B in the sense that the ANP is, unsurprisingly, very aware of how the ANP system works. ANPs are positioned as 'knowing what they can do and what they cannot do…' (I6M1) and as 'educated and intelligent enough' (I2A1) to know what an ANP is capable of. Knowing how 'it' (i.e., the system) works is further facilitated through the construction of the intuitive identity discussed in the previous chapter where language-in-use positions ANPs as 'politically astute' (I2A1), socially responsive professionals.

Whilst ANPs are positioned as empowered Customers and central to service delivery, other professionals, predominantly medics and nurse managers, are positioned by participants as disempowered Customers, not knowing how the ANP system works and not taking the time to find out [figure 9.18]. This is evident in language-in-use through which ANPs are characterised as 'picking and choosing what they see' (I5M2), an aspect of the role that is constructed as negative. As was seen in the ANP-system relationship and in the threatened relationship discussed in the previous chapter, this confusion negatively impacts relationships in the ANP system, medic system as well

as the wider healthcare system. ANPs, drawn through Door A, behave like disempowered Tops, failing to inform and involve others. Therefore, it is foreseeable that others in the healthcare system would behave like disempowered Customers and hold the ANP responsible.

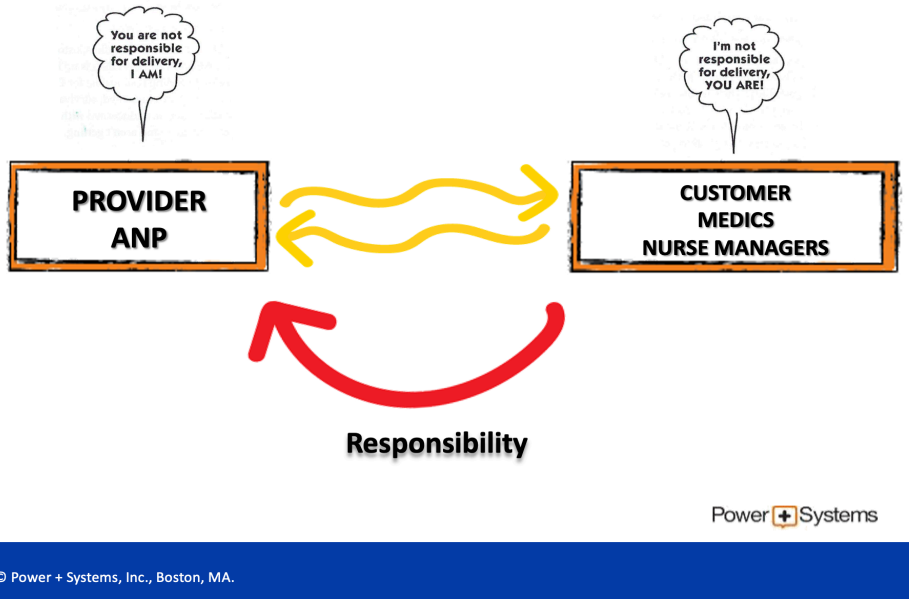


Figure 9.18 Nurse managers and medics as oppressed Customers (Power and Systems, 2018)

By engaging from the outset, ANPs have helped to construct for themselves the identity of the empowered Customer who gets involved and takes responsibility. This empowered Customer identity was revealed through the analyses discussed in the previous two chapters to be at once collaborative and independent, engaging in enabling relationships such as the interdependent relationship. The identity of the ANP as an empowered Customer is further enhanced when regulation of the role is considered:

> '…the role it's highly regulated and it's backed up by a masters and then a large number of hours have to be undertaken – supervised...'
>
> (FG2A8)

Clearly articulated and high standards facilitate the ANP to move away from disempowered Door A responses towards more empowered Door B patterns of thought and action that add significant value to the system. Examining the outputs of

the previous analysis presented in Chapters 7 and 8, we can see that ANPs are constructed as pioneers and as key players in the development of the ANP role:

> '…ANPs have been there from the beginning making those decisions.'
>
> (FG4A4)

Summing up, some participants construct an identity for ANPs as disempowered Providers who fall short in the delivery of their service. Some ANPs, whilst feeling responsible for the service, also feel unfairly judged because many factors that limit their contribution are outside their control. However, findings show that there is also a shift from these predictable reflex responses to a more empowered Provider stance from which ANPs recognise the value they create for the healthcare system. ANPs are also seen as empowered Customers, choosing Door B, and getting into middle of processes. Nonetheless, findings show that system blindness still exists in some parts of the system with several nurse managers and medics being identified as disempowered Customers due to their ignorance of the ANP role. However, findings also show that some ANPs may themselves contribute to ANPs' disempowerment by acting like disempowered Tops and failing to inform and involve others.

In the following section, I move to examining the outputs of the previous analysis presented in Chapters 7 and 8 through the lens of Oshry's (2017) theory of whole systems as patterns of systemic processes. I will describe and explore how these processes manifest as ANPs navigate and negotiate the health system.

9.3 Whole Systems as Patterns of Systemic Processes

Oshry (2020) pays particular attention to four fundamental systemic processes: individuation, integration, differentiation and homogenisation [figure 9.19].

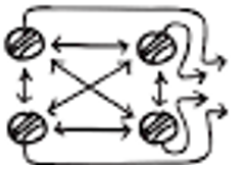
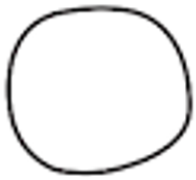
SYSTEMIC PROCESSES			
INDIVIDUATION	INTEGRATION	DIFFERENTIATION	HOMOGENISATION
SEPARATE	TOGETHER	DIFFERING	COMMONALITY
			

Figure 9.19 Organic System Processes (Oshry, 2019)

As we saw in Chapter 3, the relative intensity with which each of these four processes is expressed in any system can vary, affecting the relative balance among them. Another source of variation is whether they arise as a result of habitual reflex responses or intentionally. Using these processes, Oshry (2019) proposes that we can identify how whole systems express their power and love. When Oshry talks about Love, he proposes that a whole system expresses its Love through integration and homogenisation, so when members are working together around a common goal and working on our commonality with one another, differences are submerged and commonality reigns. A system expresses its Power through individuation setting individuals free to pursue independence and through differentiation as the system is allowed to realise more and more of its possibilities. All systems have the prospect of being systems of Power and Love, where the potential of all members is acknowledged, leading to more positive and productive relationships, and more creative approaches to the business of the system. However, in our blindness to system processes, Power and Love systems are a possibility too rarely achieved, none more so than in complex healthcare systems.

In the following section, I will show how the ANP system manifests individuation and differentiation to create a system of Power and how it manifests integration and homogenisation to create a system of Love. I will also show how this is enabled and constrained within the ANP system by the wider system or by other systems such as the medical system, nurse management system and by individuals within those systems. I do this by applying the OSF to the outputs of the previous analysis presented in Chapters 7 and 8. As noted in Chapter 3, for the purpose of this study, and to meet the study's aims and objectives, the system of interest is shown below:

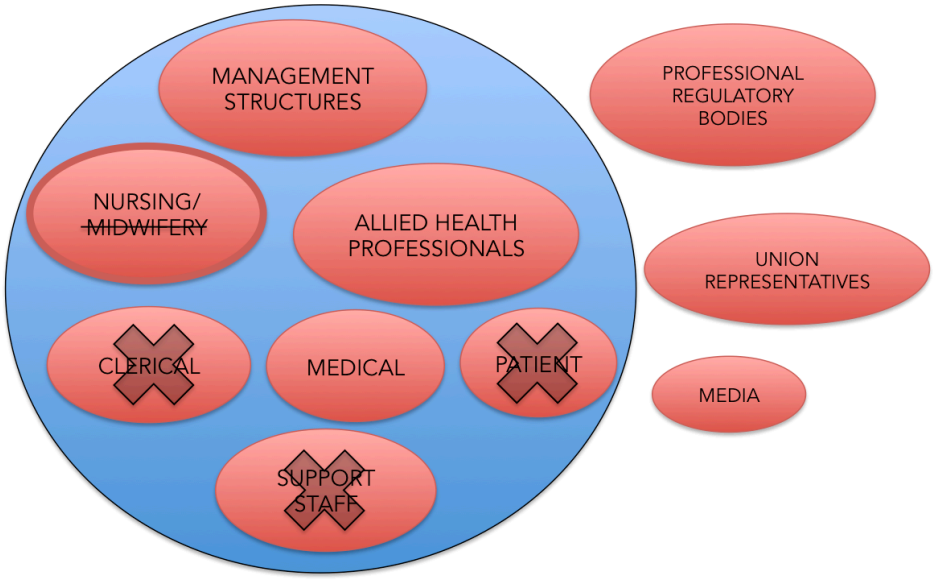


Figure 9.20 System of Interest

9.3.1 The ANP system and Power – Individuating and Differentiating

This first section reveals key discourses that were identified from applying Oshry's (2017) concept of individuation and differentiation to the outputs of the analysis presented in Chapters 7 and 8 [figure 9.21].

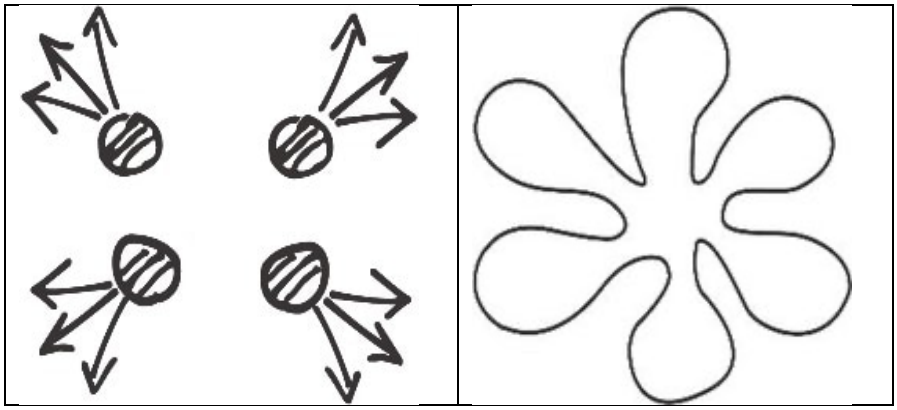


Figure 9.21 A system exerting its Power by individuating and differentiating

This application provides an analytic lens through which to consider three important questions. First, how a system develops variety in form and function as it interacts with its environment. Second, whether, to what extent and how individuals in the healthcare system function independently of one another. Third, and related to this, the extent to which notions of freedom, independence, and self-responsibility in the pursuit of individual goals, interests and agendas are manifest in the system. Oshry (2020) suggests that individuation strengthens the whole because individuals and groups are free to pursue their dreams, to compete, and to contribute. However, he warns that individuation without integration can create systems that are vulnerable, chaotic and unfair, with damaging effects on individuals and the system as a whole. Differentiating contributes to system survival by affording it a repertoire of structures and processes for coping with 'the dangers in the system's environments and prospecting among its opportunities' (Oshry, 2020, p.18). Within this environment, variety and change is inevitable resulting in rich and adaptive systems. Yet, Oshry (2019) points out that differentiation without homogenisation leads to territorialism, impermeable boundaries, and professional conflict.

9.3.1.1 'Definitely an element of control…' – Constraining the Individuation

Individuation is to do with independence and separateness and was consistently raised by participants as seen in the discursive constructions already presented. ANPs express the need for freedom and personal autonomy to undertake their role. However, language-in-use such as 'work within strict guidelines' (I5M2) and 'tightly controlled areas' (FG3X4) when discussing the ANP role, indicate factors that prevent

ANPs from individuating, functioning independently and having the freedom to innovate:

> ‘It comes back to us being nurses...you would get more freedom if you were a doctor... there is definitely an element of control...’
>
> (FG4A25)

> ‘There will always be a little cap on it as well I feel; they [*doctors*] will never let you any further than your cohort of patients...’
>
> (FG4A4)

This thwarting of the ANP role and ANPs’ limited freedom to practise independently is also seen in the language used by consultants who see themselves as ‘responsible for everything’ and ‘when they are not really working side by side…[*doctors*] don’t have that trust and control’ (I7M3). Participants offer several reasons for why there is a reluctance in the healthcare system to allow ANPs to practise more independently and to innovate to a greater extent. These include the supposed threat to the medical identity from the ANP as seen in the figured world that constructs medics as vulnerable and exposed to newer roles coming into the health system. It was also evident in the Building Relationships Task that revealed the perceived threatened relationship that language-in-use constructed between medics and ANPs:

> ‘Well doctors have voiced concerns that the ANP role umm you know they’re concerned about the ANP role because they’re fearful of losing their position in the healthcare system.’
>
> (I3NM1)

> ‘They [*doctors*] feel that ANPs are taking their role, that’s where...I think that’s where the issue is and that definitely goes on…’
>
> (FG4A4)

ANPs themselves believed that lack of trust and restrictive scopes of practice and guidelines were two of the main reasons why the role was constrained from individuating by medic and nurse management systems:

> ‘…it comes down to trust as well if the consultant or the doctor or whoever trusts your judgement...it takes time.’
>
> (FG2A9)

> ‘I remember having a discussion with someone in this hospital at senior level about nurse prescribing and getting rid of CPAs [*guidelines and regulations*] and her response to that was ‘well that can never happen in this hospital’ – so there you go again – nurses again trying to bring nurses back…’

(FG4A7)

In this environment, the ANP system is prevented from being all that it can be, the wider system is prevented from being all that it can be and the role itself is prevented from advancing.

ANPs considered whether they had sufficient belief in themselves with some positioning themselves as less important and less competent:

> ‘We have a very important role but we don’t see ourselves as very important and I think we become subservient to other professions and we allow that to happen.’
>
> (FG2A9)

This lack of confidence and subservient self-positioning is associated with the removal of the social good of respect and may prevent ANPs from recognising and harnessing their unique potential in the service of the healthcare system.

In contrast, some participants highlight that some ANPs have individuated and forged their own path, pursuing their own professional goals and interests. They believe that ANPs are making their own way in the healthcare system and creating an identity that is distinctive from that of other healthcare professionals. This was evident in the ‘uniquely holistic identity’ revealed by the Building Identities Task:

> ‘ANPs can manage their own area; they can manage it quite well and manage in a way that they feel to the standard that it should be managed at. They’re not under the realms of anyone…because they’re so independent…’
>
> (FG4A18)

Other participants suggest that the level of experience and education the role entails promote individuation. A situated meaning is created that the more a role is educated and experienced the more freedom and independence it is granted:

> ‘ANPs were trained to a certain level so you could manage a cohort of patients umm on your own you know within a multidisciplinary team setting’
>
> (I1A26)

> ‘I think there are lots of areas within healthcare, not just nursing, where people with their areas of expertise should be expanding their own body of knowledge for the betterment of patient care. I think that’s what we’ve done and everyone else should be doing the same...’

(FG3A22)

As a result of enabling ANPs to pursue their individual goals, ANPs recognise and realise their power which in turn increases power within the ANP and wider healthcare systems.

9.3.1.2 'It is simply me and only me…' – Individuating to Realise their Potential

Whilst education and independent practice are constructed as key to the ability to individuate, considerable emphasis is also placed on power as a social good. ANPs need to be 'politically astute' (I4NM3), to find their voice and become more vocal; this, it is thought, will lead to further individuation and independence:

> '…if there is a strong voice for nurses do you know at the top it will make nurses more autonomous.'
>
> (FG2A9)

> '…to stop us from being so connected to and reliant on the medical profession we need to be articulate…more autonomous and strong.'
>
> (FG2A16)

ANPs are also keen to stress the importance of accountability and 'self-responsibility' (FG4A7) in enabling the ANP system to individuate and in allowing the ANP role to be all that it can be. Excerpts from the focus groups show that ANP participants use language that emphasises individuation rather than integration when discussing responsibility in the system:

> '…the actual fact is my patients I see and treat are my full responsibility and we know that from when a problem arises – if there is a misdiagnosis…it is simply me and only me that would take that responsibility and the consultant has no input.'
>
> (FG3A22)

> 'We take our own responsibility from day one whereas I wonder if I had a consultant always to fall back on, I wonder how much I would have progressed because I would always have somebody to assume the responsibility which is what we face in medicine at the moment.'
>
> (FG2A8)

Other participants connect individuation to the power inherent in the ANP role:

> ‘I suppose the pay level as an ANP you are on a par with an ADON [Assistant Director of Nursing] level, so it gives you the power in a way to manage your own caseload so you don’t have to take direction as much. I think it gives you power because you know we say we are ANPs, we are at this level so we can make these decisions at local without having to include managers all the time.’
> (FG4A4)

The significance of power here relates to the value for money it is claimed that the ANP brings to the entire healthcare system. This was evident in the value adding nurse practitioner identity encountered earlier in the study. However, this individuation and wish to function independently is thwarted by certain individuals in the system, especially medic and nurse manager systems:

> ‘I think every nurse on the floor, including ANPs, they [*nurse management*] won’t allow them to develop, they have to have, management have to have total control on how fast they progress.’
> (FG4A4)

> ‘I don’t think you’ll ever get to the stage where you’d be on par [*with medics*]…’
> (FG4A18)

Within this ANP system, where individuation is restricted or even prevented, reduced creativity, detachment and apathy occurs, as one ANP highlights:

> ‘Some days it does feel like an uphill battle…they’ll [*consultants*] allow junior doctors who are still training to make decisions about patient care, but they sometimes won’t allow ANPs, who wouldn’t be afraid, to make these decisions or take the responsibility…that can be disheartening.’
> (FG3A22)

9.3.1.3 ‘Nursing has always been…the radar system. A good nurse can foresee the issues.’ – Prospecting Amongst the Opportunities

The findings show that participants are aware of the need to have variety and diversity within the healthcare system. However, some participants employ language-in-use that constructs the ANP role as a medical replacement or substitute, and not novel:

> ‘They also do X-ray and determine what’s wrong with the patient and give them treatment…they can bring them back to make sure everything is going okay so their role as such is very much an independent role from staff nurse or a doctor.’
> (FG1N2)

> '…it's hard to say we're not taking on a medical role when the driver for most of the role developing is the lack of medical resources…'
>
> (I2A1)

As a result, the ANP role is not built as varied and diverse but is instead positioned as more of the same, reinforcing the medicalised identity revealed though application of the Building Identities Task. Others counteract this construction, emphasising the holistic element of the ANP role and how it promotes diversity in the whole system:

> '…our medical colleagues might be guilty of just looking at the problem, sorting of the problem, and they send them off but it doesn't come into account whether they can be at home, be safe at home, have they anyone to come give them a hand.'
>
> (FG4A18)

> '…with the advancement of other healthcare professions they will start to look at the fact that they have done a medical degree but have no experience in patient care or assessment or family or social.'
>
> (FG3A22)

ANPs are positioned as prospecting among the entire healthcare systems opportunities to carve out a place for themselves. Whilst several participants noted that the role was initially established to 'fill a gap', others constructed it as a distinctively nursing role:

> 'I think personally it was actually professionals…it was driven from the nurses upwards…I don't think it was 'oh we can fill the gap in because we don't have a doctor to do a job' I don't think that that was the issue.'
>
> (I6M1)

> '…initially they were there to maybe to fill a gap but within that they have created their own…'
>
> (FG1N8)

Regardless of the initial conception of the role, findings show that participants agree that the ANP role has adapted to the changing needs of the healthcare system and that this adaptability creates distinctive value related to the role's basis in nursing:

> '…they contribute something unique because they specialise in certain areas so then they become expert in that area.'
>
> (FG1N3)

> 'I think it was about maximising nursing, I personally feel that nursing has always been the gatekeepers and the radar system. A good nurse can foresee

> the issues and they're identifying that. They are the radar picking up the…umm like a warning system.'
>
> (I3NM1)

> 'I think you know people would be waiting longer for services because there just wouldn't be enough doctors to go round... that they can reduce waiting times which is always a good thing.'
>
> (I5M2)

Summarising, ANPs employed language that emphasises the need for the role to have freedom and personal autonomy. However, the language-in-use of other participants, predominantly within medical systems, centres on control and restriction and indicates factors that prevent ANP systems from exerting Power, individuating and functioning more independently. Within this environment, where the ANP system is constrained and ANPs are prevented from being all they can, the wider healthcare system is prevented from being all it can be and the ANP role is prevented from advancing and adding value to the system.

In contrast, some participants highlight that some ANPs have individuated and forged their own path, pursuing their own professional goals and interests in an effort to exert Power. Attempting to manoeuvre in this wider system, participants build on the 'unique holistic' ANP identity as well as the added value the ANP role brings to the healthcare system to carve out a distinctive and legitimate place within it [figure 9.22]. Other participants, use language that is more cognisant of the need for the role to become more vocal and self-responsible, emphasising individuation, independence and, ultimately, power. Without this individuation, language-in-use shows that participants believe ANPs will become apathetic and uncreative. Language-in-use further shows that participants are aware of the need for variety and diversity in healthcare to enable the system to be all that it can be [figure 9.23].

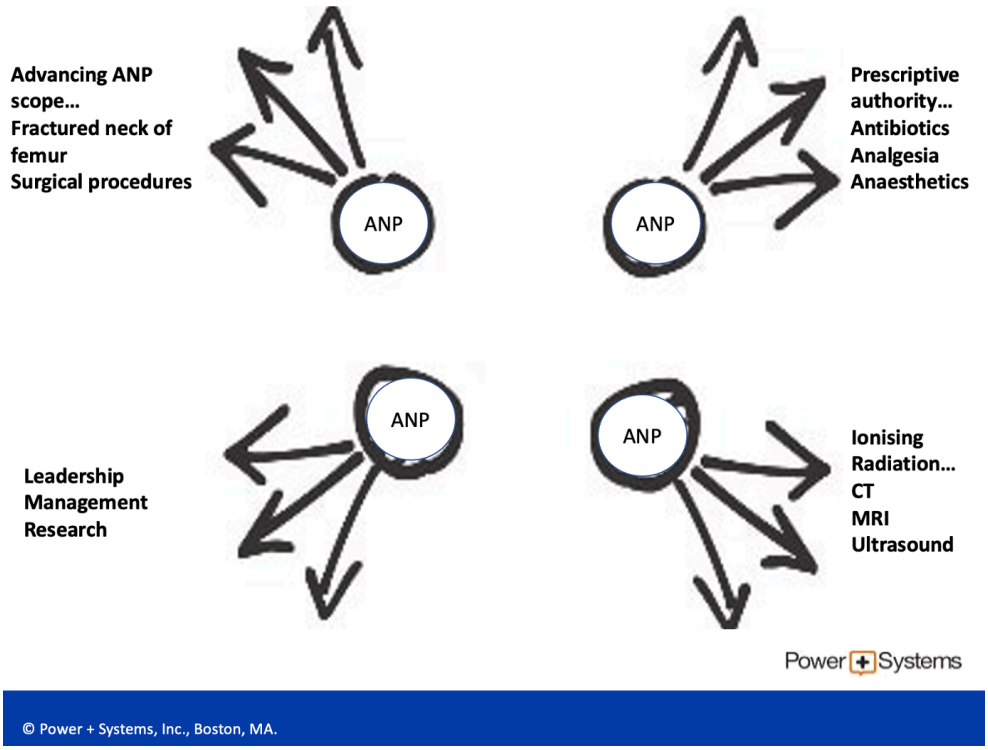


Figure 9.22 Example of the ANP system exerting its Power by individuating (Power and Systems, 2018)

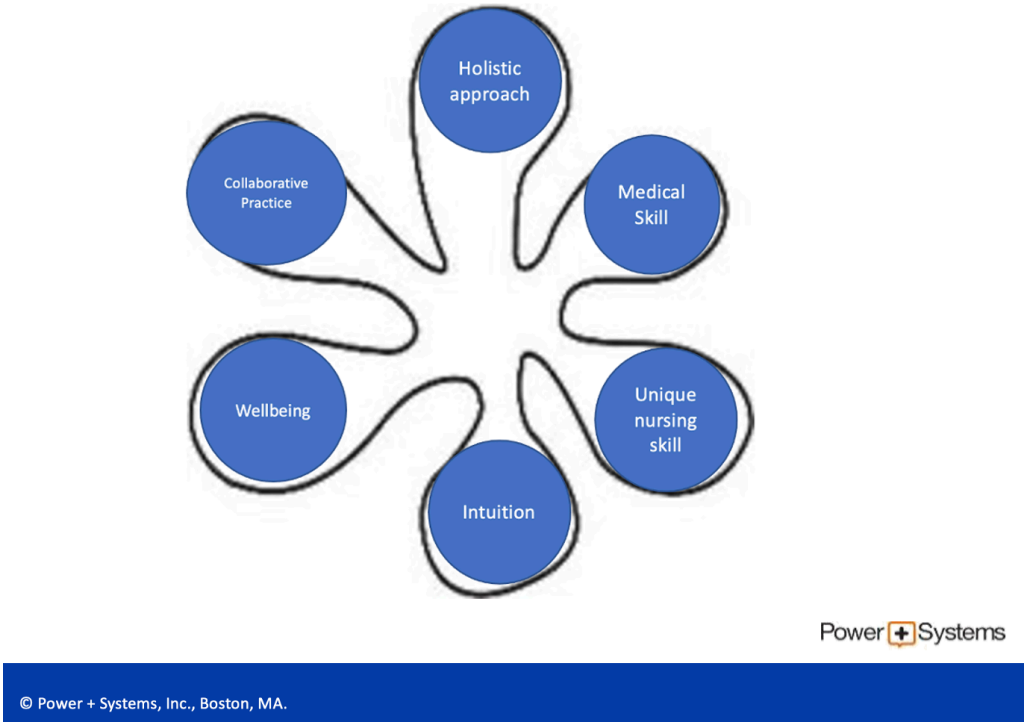


Figure 9.23 Example of the ANP system exerting its Power by differentiating (Power and Systems, 2018)

However, a small number of participants do not believe that the ANP role adds variety to the system. Instead, the role is constructed as a medicalised substitute, an identity evident throughout the findings, negating differentiation and constraining the ANP system from exerting Power. Within the next section, I will show how ANP systems manifest integration and homogenisation to create systems of Love and show how this is enabled and constrained within the ANP system by the wider system or other systems such as the medical system, nurse management system and by individuals within those systems.

9.3.2 The ANP system and Love – Integrating and Homogenising

This section reveals key discourses that were identified by applying Oshry's (2017) concept of integration and homogenisation to the outputs of the previous analysis presented in Chapters 7 and 8 [figure 9.24].

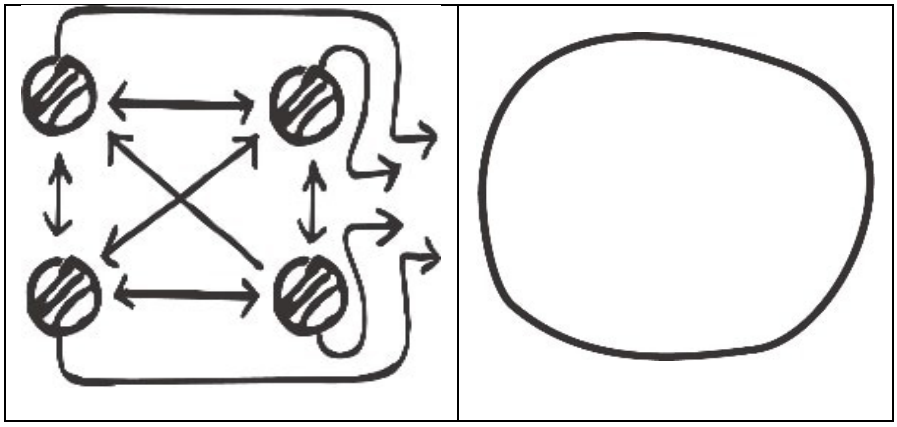


Figure 9.24 A system expressing its Love by integrating and homogenising

The focus is on how individuals within the healthcare system function as parts, operating as components in service of the whole and how information and capacity are distributed across the system. At its core, these processes concern commonality and oneness, where information is shared in a common language that is understood by all. For Oshry (2020), integration concerns individuals who are mutually connected and supportive of each other and emphasises team work to achieve collective interests, goals and agendas. However, he cautions that integration without individuation will crush individual spirit and initiative resulting in poor system

outcomes. Homogenisation is about identifying and articulating the shared values that exist in a system, focusing on what unites us, and thereby reducing the vulnerability of the system to loss or incapacity. However, as with all the processes, balance is key. Homogenisation without differentiation will limit the capacity of the system to cope with dangers and to prospect among opportunities in its environment (Oshry, 2019).

9.3.2.1 'We are team players…' – Pursuing the Collective Goal

Participants use language that emphasises the integrative nature of the ANP role, building a collaborative identity and placing teamwork and collaboration to the fore. ANPs are positioned as mobilisers of individuals and groups, as system integrators, working together to provide a better service:

> 'Sometimes we think things are rocket science but it's actually not if we all work together, that's the way I would work and I think all ANPs work like this – we are team players whereas different professions like to keep their boundaries.'
>
> (FG2A9)

> 'ANPs are probably more likely to get other members of the multidisciplinary team involved in patient care…'
>
> (I5M2)

> '…without doubt ANPs have a more collaborative approach to working than other healthcare workers…'
>
> (I6M1)

This ability to integrate and work interdependently strengthens the ANPs' collaborative identity and demonstrates how they can mobilise individuals and groups to work together in their collective interests. Mutually respectful, supportive and interdependent relationships enable ANPs to realise the full potential of their roles:

> 'I knew what I wanted my role to do and I had a very supportive team of geriatricians here and the community geriatrician came on board in 2012 and she was very supportive…without that support you'd really have to question could I do my job, you know…'
>
> (I1A26)

9.3.2.2 'I would have no problem in going to an ANP…' – The Mutual Interdependence

Considering these mutually dependent relationships that exist in the wider healthcare system, the outputs of the previous analyses presented in Chapters 7 and 8 show that participants recognise how members of the ANP system nurture and support all healthcare professionals as well as each other's talents and skills. In certain situations, this mutual support came from working alongside an ANP and recognising the benefits that the role added to the wider healthcare system:

> '…looking at the positives, that you can up skill them [*doctors*], they can come work with you, side by side and learn from you and that's how they will get experience and a better knowledge from working by themselves...'
>
> (FG3NM2)

> 'I think all the doctors working in ED would have a good understanding of what they do because they work with them every day…I would have no problem in going to an ANP or nurse even and asking them for advice...you know from my own experience an ANP has done a better job doing some things than a doctor would have you know.'
>
> (I5M2)

Participants are mindful of how medics depend on their ANP colleagues. This mutual dependence disrupts the figured world wherein ANPs need supervision and instead creates one where ANPs integrate, functioning as parts and operating as components in service of the whole:

> 'I have seen several cases around Ireland where the consultant would not be without their ANP, so I do feel there is light there. Awareness of the role is coming…it is changing…'
>
> (I3NM1)

9.3.2.3 'Working at the coal face together…' – The Common Purpose

Examining the outputs of the previous analysis presented in Chapters 7 and 8, it is apparent that participants build as significant for the ANP system, commonality and oneness with other members of the healthcare system. This reinforces the collaborative identity constructed in the Building Identities Task. Findings shows that many participants, when discussing the ANP and medical roles, stressed that both

roles had more in common than that which divided them. Focusing on what united the roles, participants gave examples such as 'working at the coal face together' (I6M1) and the 'bridging of roles' (FG1N13), creating a figured world where it is seen as normal that ANPs cross boundaries to carry out their role. Homogenisation is evident in the system. Commonality and oneness are constructed as social goods that add value, reflected in discussions about shared values and practices:

> 'You would have ANP teams and team with a consultant. It was always consultant level cover but there was actually, the ANP or the consultants were totally interchangeable so that's actually the level that the ANPs were functioning at.'
>
> (I4NM3)

> '…it's a role that falls between two stones…They're extended as in they have that nursing background but also medical experience you know like that, they bring with them too…'
>
> (I5M2)

Findings shows that, amongst the participants, mutual understanding exists about the benefits of the ANP role. These advantages relate to the career benefits of the role for nurses as well as the social goods of added value and value for money, such as cost saving, reduced hospital admissions and service user benefits:

> '…as the profession developed and became a degree with more opportunity for education it has been a natural progression for us to take on more clinical roles within, within healthcare.'
>
> (I2A1)

> '…access to well qualified ANPs is definitely going to reduce cost of medication, reduced hospitalisation and I would imagine greater patient satisfaction…'
>
> (I4NM3)

To summarise, applying Oshry's (2017) OSF framework to the outputs of the previous analyses seen in Chapters 7 and 8 has emphasised the role that homogenisation and integration plays in the ANP role and affirmed what was seen in the previous empirical and external LOD sections [figures 9.25 and 9.26]. Participants associate the ANP role with commonality and oneness with other members of the healthcare system, a finding that reinforces the collaborative identity that we saw constructed in the Building Identities Task. When discussing ANP and medical roles, participants used language that underlined the fact that both roles had more in common than that which divided them. The commonality, interchangeability and oneness of the ANP role and their

medical counterparts was to the forefront of the language-in-use and facilitates the ANP role crossing boundaries and barriers to carry out their role. Participants employ language that highlights the interdependent relationships that exist in the healthcare system as exemplified by ANPs' and medics' mutual reliance. This interdependency disrupts figured worlds where ANPs need supervision and instead creates a figured world where ANPs integrate, functioning as parts and operating as components of the service of the whole. Having this ability to integrate and work interdependently, mutual respect and support is further enhanced, and the system is further helped to be all that it can be.

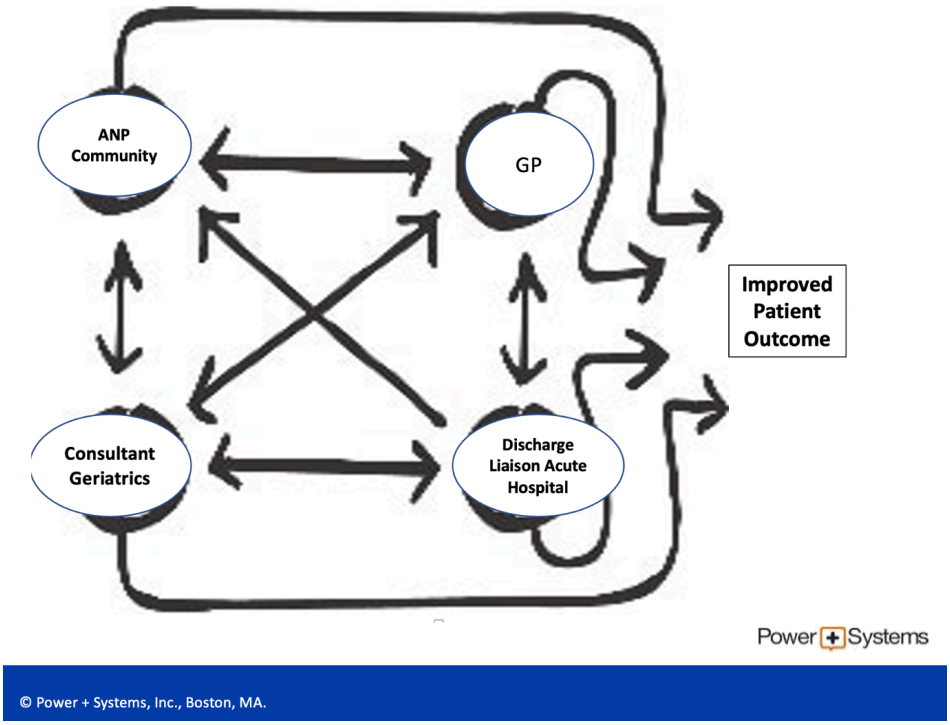


Figure 9.25 Example of the ANP system expressing its Love by integrating (Power and Systems, 2018)

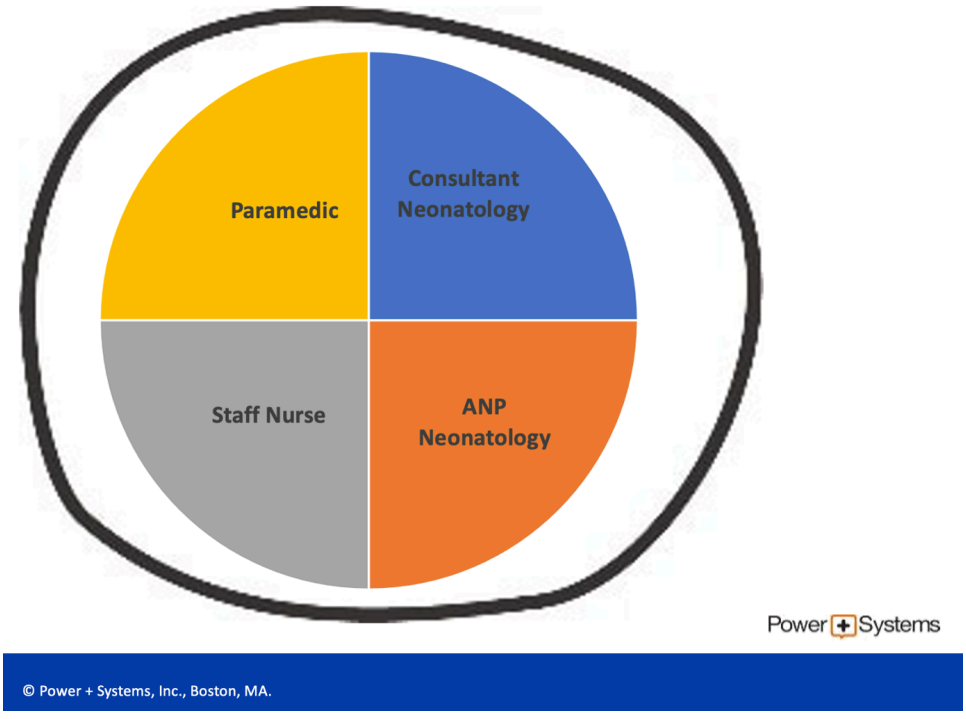


Figure 9.26 Example of the ANP system expressing its Love by homogenising (Power and Systems, 2018)

9.4 Chapter Conclusion

Within this chapter I have provided a description and analysis of the dynamics of the ANP system in terms of distinctive patterns of systemic relationships and processes. I have shown how these patterns of relationships and processes have shaped how ANPs experience themselves, each other, other members of the wider system and the ANP system itself.

Examining the systemic relationships, there is evidence of ANPs adopting both blind and sighted responses to the spaces they find themselves in. Language-in-use positions ANPs as burdened Tops sucking up responsibility for ensuring equitable and efficient healthcare access and fronting interdisciplinary approaches to care. It also positions them as oppressed Bottoms stymied in achieving their full potential. ANPs are situated as torn Middles, torn between conflicting identities related to nursing and medical paradigms, whose ability and practice is continuously questioned and judged. The role is further questioned, when they are constructed as unfairly judged Providers, for parts of a service they have no control over.

However, findings also show that there is evidence of ANPs adopting sighted responses within the spaces they occupy, a discernible shift from system blindness to system sight; from predictable reflex responses to empowerment stands as participants opt for Door B responses. ANPs are positioned as empowered Bottoms who take responsibility for their own system as well as adding value to the wider healthcare system. Recognising the value they create for the healthcare system, ANPs adopt a more empowered Provider stance. There is evidence of ANPs adopting an empowered Top stance, creating responsibility throughout the wider healthcare system through their collaborative practice and interdependent relationships. Instead of being torn between the conflicting medical and nursing identities, for some participants this hybridity is seen as a positive, permitting ANPs to become empowered Middles. System blindness is transformed into system sight and the productive possibilities of the ANP role are realised.

Considering the systemic processes, freedom and personal autonomy are seen as key elements of the ANP system, however this individuation is constrained by other

systems such as the medical and nurse management systems, where the focus is more on control and restriction. Within this environment the wider healthcare system is prevented from being all it can be and the ANP role is prevented from advancing and adding value to the system. ANPs, attempting to manoeuvre within this wider system and exert Power, emphasise how their role provides variety and diversity to carve out a distinctive and legitimate place within the system. ANP systems express their Love by using language that connects the ANP role with commonality and oneness with the wider healthcare system and other systems such as medical systems. Findings show that working interdependently between the ANP and medical system, mutual respect and reliance is enhanced, and the wider system is further helped to be all that it can be.

In the final chapter, I present a discussion of these findings and critique their relationship to previous research and extant published literature.

Section three: Discussion, limitations, recommendations and concluding remarks

In this section, I show how the study's findings address the study's central aim: to gain an understanding of how ANPs are discursively positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it.

Chapter 10 is structured by the four research questions that the study sought to address:

- What value does the ANP role bring to the healthcare system?
- How is the 'nursing' dimension of the ANP role realised?
- By and through what discourses have ANPs and the wider healthcare system come to know, understand, construct and utilise the ANP role?
- Considering the current discursive positioning of ANPs, what potentially significant issues might extant discourses be minimising or excluding?

I then discuss the limitations and delimitations of the study, make recommendations, including opportunities for further research and scholarship.

Chapter 10 Discussion

10.1 Introduction

This chapter discusses the findings of the study and situates them in the context of previous research and the extant literature. The aim of this study is to understand how ANPs are positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it. The discourse analysis of the interviews and focus groups entailed the application of Gee's (2014) tools of inquiry and building tasks as well as Oshry's (2017) organic systems framework to the data. This proved productive, generating detailed and rich answers to my research questions.

The chapter is structured according to the four research questions:

- What value does the ANP role bring to the healthcare system?
- How is the 'nursing' dimension of the ANP role realised?
- By and through what discourses have ANPs and the wider health care system come to know, understand, construct and utilise the ANP role?
- Considering the current discursive positioning of ANPs, what potentially significant issues might extant discourses be minimising or excluding?

Discourse constructs subjects, objects, practices and abstract ideas. It shapes and is shaped by the context in which it is enacted. This thesis presents an analysis of how nursing, medical and other healthcare professionals discursively position ANPs from their vantage point of their own experience and how their language-in-use works to both enable and constrain the role. Applying Gee's Building Tasks and Tools of Inquiry, analysis has revealed how language works ideologically to construct, represent and position ANPs in particular ways, adding value through uncovering new meanings. Applying Oshry's Organic Systems Framework has revealed the patterns of relationships and processes inherent in human systems and how these relationships and processes manifest in language. Discussing the findings, utilising the lens of Oshry and Gee, allows the reader to see what language constructs and how, as well as looking at the patterns of relationships and processes at play in those discursive constructions.

10.2 What value does the ANP role bring to the healthcare system?

The findings show that a key preoccupation of a range of stakeholders relates to the value that the ANP contributes to the healthcare system. What constitutes value in a healthcare system is the stuff of policy deliberation and much debate in the Irish setting, so any attempt to define or itemise it is open to contestation on many grounds. Moore (1995) argues that public value describes the value that an organisation or individual contributes to society. He proposes that it begins with a simple idea: public managers should pursue public goals that are valuable, legitimate and doable. These public goals are valued because they personally benefit the individual citizen, but in many cases, citizens also value things for reasons that go beyond their self-interest. Considering the ANP role and the language-in-use identified in the findings, participants were keen to highlight the monetary and non-monetary value that the ANP role brought to the healthcare system. The value created includes financial cost savings, reduced hospitalisation and expedited patient discharge, the relative permanence and stability of the ANP role, increased holistic and collaborative approaches to care, an educated and skilled resource for other staff and an additional career pathway for nurses.

ANP participants are confident that creating such value is both legitimate and doable; however, they express difficulties in substantiating these benefits, suggesting that they can't from a 'money point of view equal their work to the savings' they make. This finding is supported by Carryer and Adams (2017) and Casey et al. (2017b) who observe that the cost benefits of the ANP role are challenging to make as they are influenced by a combination of important long-term outcomes some of which are relatively difficult to measure compared to others. Measuring one's contribution to a system is further complicated when we consider how the ANP is positioned in the Provider/Customer relationship. Findings show that ANPs feel responsibility for delivering quality services not only to the public but to other healthcare professionals working in the system. However, tensions have developed where issues outside the control of the ANP have resulted in the role being unfairly judged. These include finite ANP numbers, the ANPs perceived controlled identity as well as restrictive guidelines and policies.

Given that the costs of healthcare are expected to continually rise, it is only right that healthcare institutions should consider economics and look elsewhere for high quality practitioners at a lower cost than medical-based health care. ANPs use language that sustains this positioning within the health system and deploy the social language of a narrow bureaucratic managerial discourse, almost accountant like, to mark themselves as important members of the health system. ANPs are endeavouring to construct their own powerful identity by employing this social language to legitimate themselves and argue that they are 'good' for the health system. Examples include ANPs providing longer consultations that give patients the opportunity and time to communicate their issues. Whilst disparaged by medical colleagues (Oxtoby, 2010), these longer consultation times have repeatedly been identified by researchers as valuable to patients (Htay and Whitehead, 2021). ANP permanency is another positive aspect of the role, adding value to the system when compared with other healthcare professionals. Language-in-use constructs an ANP identity that is viewed as a continual and steady presence and connects this stability and permanency to improved patient outcomes and experiences. Unlike junior doctors who are by nature transitory, ANPs provide consistency, a finding supported by the work of Adams and Carryer (2021) who investigated the experiences of ANPs delivering services in areas of high need in New Zealand. Similarly, McDonnell et al. (2015) found that the ANP's constant presence meant that problems were identified and actioned promptly and that the role fostered collaboration and teamwork.

From a monetary perspective, ANPs are arguably 'worth their money'. This is supported by research that demonstrates that the care provided by ANPs is cost neutral (Begley et al., 2010, Kilpatrick et al., 2014, Swan et al., 2015, Kostas-Polston et al., 2015). In contrast, the findings show the social language of economics is employed by others to de-privilege the ANP role with language-in-use that constructs ANPs as 'cheaper versions' when compared with doctors. Hain and Fleck (2014) found that most physicians believed that ANPs should not receive equal pay for providing similar services to those of doctors, whilst Markewitz (2013) advocates that ANPs should not be seen as valid alternatives to doctors as they do not reduce costs, arguing that ANPs in the majority of European countries earn as much money as junior doctors. This represents a clash of values which is undoubtedly exacerbated in the context of the resource-constrained healthcare systems that are now commonplace.

The value associated with collaboration is another discourse evident in the findings. Language-in-use has built up the collaborative aspect of the ANP role and enacted a collaborative ideology that ANPs are consummate team players, co-ordinators and organisers. Participants correlate the ANP role with commonality and oneness with other members of the healthcare system, a finding that reinforces the collaborative identity that we saw constructed in the Building Identities Task. At a time when healthcare reform is rapidly evolving, this collaborative identity has never been as important. The World Health Organisation (2010) contends that ANPs should collaborate with other health professionals in interprofessional teams to achieve best practice.

ANP participants in this study use language that supports the principle of collaboration and assumes a figured world that takes 'working together' to be normal and leading to improvements in care. This finding is supported by many of the medical participants who argued that without collaboration the system would struggle. However, other participants note the tensions that can arise when ANPs act as Providers of collaborative care and attempt to achieve a more collective approach to patient care. Reluctance on the parts of some healthcare professionals to accept responsibility for delivering collaborative initiatives and processes has resulted in ANPs feeling that they are not improving quality and providing an efficient service. The data suggests that the reasons for this include reliance on traditional medical models to deliver services, figured worlds where it is taken for granted that the ANP role needs to be controlled and prevented from expanding.

Findings also show that the reluctance of some healthcare professionals to practise as components of an integrated whole and to work together in a common venture are secondary to lack of confidence and trust in the ANP role, confusion about the role and the longstanding hierarchical structures that persist in the system. Medical participants use language that builds situated meanings that the ANP role must be subject to their close control, and they convey a sense of unease when ANPs' practice cannot be closely observed. This, in turn, contributes to the construction of a 'hierarchical physician sitting at the top' figured world where medics are the natural supervisors of ANPs and consequently control the development of nursing roles. This

finding is noted in the extant literature (MacLellan et al., 2017; Maylone et al., 2011; Crowe et al., 2017).

10.3 How is the nursing dimension of the ANP role realised?

A discourse prevalent throughout the study relates to the origins and underpinnings of the ANP role. Conversations that are taking place within the wider healthcare system are concerned with whether the ANP role is grounded in a nursing paradigm, a medico-nursing world or some other healthcare domain. Paying attention to the agents contributing to these Conversations, it is evident that the vast majority of ANPs are emphatic that their identity aligns significantly with nursing. Furthermore, these alignments construct a relatively superior role compared to other health professionals in the sense that ANPs approach patient care more holistically and intuitively. Participants link this aspect of the role to improved patient outcomes and more responsive patient care. Eriksson et al. (2018) argue that this distinctive emphasis on holistic approaches to healthcare delivery is the reason that ANPs are the preferred healthcare providers for millions of people worldwide.

It is unsurprising that language-in-use connects the ANP identity with the caring element that is so often assigned to the traditional nursing role. In their large-scale national study evaluating ANP and Clinical Nurse Specialist (CNS) roles, Begley et al. (2014, p.4) found that caring remained a fundamental part of the ANP role. Study participants suggested that, whilst medics ‘aren’t very good at the caring piece’, ANPs are to be lauded for the holistic and educative approach and the resulting impact on patients’ quality of life. This holistic approach is consistent with findings from a study by Boeijen et al. (2020), in which ANPs’ practice was found to be evidently different than that of medics. This study shows that participants use language connected with holistic practice to build up this nursing element whilst positioning medics in a contrary position as less adept. However, there is a danger that this discursive monopolising of caring and holism by ANPs negates the caring and holistic aspects of other professionals' practice, running the of alienating them.

By emphasising the caring element over other aspects of the ANP identity, language-in-use shows that ANPs construct figured worlds that draw on the Discourse of a virtue script (Nelson and Gordon, 2018) where ANPs, whilst passionate and caring, are positioned as less skilled and expert than their medical colleagues. There is a risk that by over emphasising this aspect of their identity, comparative figured worlds are created where 'nurses care and doctors cure', a simplified world that is taken to be normal by society. It is also noteworthy that medicine and doctors are continually being used as the reference points when participants attempt to build up the nursing element of the role. This persistent comparison to medicine as the 'gold standard' further contributes to the construction of the ANP role as a medical substitute. Lowe (2017) argues that ANPs continually emphasise the 'nursing' in the ANP role despite their expanded and extended scope of practice, perhaps because they are afraid of being seen as 'nurses who practise in doctors' clothing' (Li et al., 2013, p. 5). This defensiveness may arise because ANPs are positioned by, and are positioning themselves with reference to, the extant discourses in circulation. These are often implicit and elusive, however, and do need to be made explicit and then critiqued and countered. This construction is recognised by the ANP participants who employ language that acknowledges the need to build a more balanced and cohesive identity that captures the full extent of their practice.

10.4 By and through what discourses have ANPs and the wider healthcare system come to know, understand, construct and utilise the ANP role?

The findings revealed the following discourses concerning how ANPs and the wider healthcare system have come to know, understand, construct and utilise the ANP role:

- The independent and autonomous practitioner
- The controlled practitioner
- The collaborative practitioner
- The inferior practitioner
- The disruptive innovator

10.4.1 The independent and autonomous practitioner

Although relative to each individual practitioner, autonomy or independence has always been central to the concept of the ANP role. Analysis of the language-in-use of participants in this study confirms that independence is considered a vital component of the role. This finding is supported by other research that identifies autonomy as a key theme with several authors arguing that a higher degree of autonomy, authority and accountability distinguishes the ANP role from other nursing roles (Slevin et al., 2013, Melby et al., 2011). Maylone et al. (2011) stress that increased autonomy is essential for the advanced role of ANPs. They argue that it is a vital component of clinical practice and is necessary for ANPs to practise to the full extent of their skills and knowledge.

However, the findings suggest that there is ambiguity about what autonomy means in practice. Several participants emphasise self-governing and independence when discussing autonomy, whilst, for others, predominantly doctors, autonomous practice is seen as practicing within a limited and defined scope. These ambiguities are also evident in the literature. Cashin et al. (2015) report that the use of the word autonomy is problematic, particularly for professionals in other disciplines who believe that nursing should be part of a collaborative arrangement of patient care. Whilst Begley et al. (2013) recognise that the advanced role requires autonomous clinical decision-making, they stress that the ANP plays a pivotal role within the multidisciplinary team, improving case management and processing patients through the system more efficiently.

Regardless, ANP participants connect the social good of independence with the social good of power. Language-in-use builds a figured world where increased autonomy equates to a more powerful role that is more visible and recognised. However, this autonomy is diminished by medics who use language that deprivileges this aspect of the role. Language such as ‘defined’ and ‘limited scope’ creates a situated meaning that ANPs provide a distinct and narrow service requiring medical supervision. Analysis of participants’ language-in-use reveals that some ANPs report this supervision as stifling their practice believing themselves to be restricted under the guise of medical supervision. They then attempt to minimise this supervisory

relationship where the medic is positioned as overseer of their practice. This finding aligns with those of Laperrière (2008), who found that ANPs often feel frustrated about unnecessary constraints in their capacity to utilise their training and experience, and Corbally and Lees-Deutsch (2019), who found that, although ANPs are at the peak of their careers, they are clearly frustrated and restricted by constraints placed on their practice. Consequently, some ANPs are fearful that constraints such as regulations and restrictive scopes of practice will be used by others to control their role and curb advancement, limiting their ability to create new value for the system.

Language-in-use shows that, rather than being bystanders, ANPs are attempting to shift the conversation away from reliance on medics towards one that emphasises their relative autonomy and accountability for the success, or indeed shortcomings, of the system. ANPs' language highlighted the connection between the social goods of power and autonomy. Accepting some accountability for their current relatively restricted practice, and thereby acting like empowered Tops, ANPs recognise the need to become active players in resolving issues that constrain their autonomy. Bolstered by these social goods, ANPs can build a more independent role that does not require close supervision. Continually referring to the 'voice of the ANP' and the need to be 'politically astute', ANPs acknowledge that as a collective they need to find their voice and become more vocal, believing that this will lead to further individuation and independence to pursue their goals and agendas to better serve their own and the system's interest.

10.4.2 The controlled practitioner

The study identifies language-in-use that constructs an identity for ANPs that is controlled, predominantly by their medical colleagues. ANP participants connect this control to their nursing backgrounds, existing hierarchical structures that are prevalent in the healthcare system, regulations that hinder rather than help, and reporting relationships and supervision for their clinical practice with their medical consultant. Language-in-use constructs a situated meaning that associates trust with control and conveys a sense of unease when ANPs' practice cannot be closely observed. This strengthens the 'hierarchical physician sitting at the top' figured world where medics

are the natural supervisors of the role and consequently control the development of nursing roles. MacLellan et al. (2017) argue that this hierarchical positioning means that the medical model and physician dominance are still very much ‘alive and well’ within contemporary health systems. In their study of ANPs' transitional experiences, they found that ANPs felt controlled by more senior members of the team who exerted positional power over them with the result that ANPs felt that they were at the bottom of a hierarchy. Carryer et al. (2007) attribute this to ANPs believing that the ANP role extends nursing along a continuum towards medicine. The authors argue that this interpretation ‘presupposes that the knowledge continuum is hierarchical with medical ability as a pinnacle of achievement and secured at the expense of nursing ability' (Carryer et al., 2007, p.1824). Corbally and Lee-Deutsch (2019) note that, whilst nurses who have successfully completed their undergraduate training can practise nursing globally, ANPs in Ireland are not able to provide cover for an ANP colleague in another nearby hospital because of place-based restrictions on their practice. The authors refer to this phenomenon as ‘restriction by advancement’ and as a paradoxical feature of advanced nursing practice in Ireland.

The use of terms like ‘strict guidelines’ and ‘defined profession’ constructs strong boundaries and diminishes the advanced element of the ANP role by insisting that some barriers should not be crossed; a sense of ‘keeping them in their boxes’ is constructed. There is evidence of significant discursive binaries being constructed where there are lots of either/or rather than both/and dichotomies. Medical colleagues regularly feel responsible for dealing with every issue that arises, to the extent that ANPs’ wings are clipped, boundaries constructed, and ANPs restricted in their advancement. This boundary construction fixes power and limits its circulation so that individuation and differentiation dominate. It is important to reflect on who is constructing these barriers and boundaries. Although the literature would imply that it is predominantly medics, this study provides evidence of horizontal oppression where nurses, nurse managers and even ANPs themselves are culpable of constructing boundaries and impeding practice. Carryer (2020, p.3578) argue that advanced nursing practice is frequently hindered and oppressed by managers who ‘rarely take kindly to challenge or queries from nurses even when they are themselves nurses by origin’. This highlights the vulnerability that is experienced by ANPs and how they can feel oppressed by those whom they perceive to be remote, disengaged and lofty

leaders, managers and colleagues at the top of healthcare organisations. By acting as oppressors, these individuals fail to call upon the contributions, experiences and perspectives that the ANP could bring.

10.4.3 The collaborative practitioner

Nurses are often referred to as the 'glue' or 'connective tissue' which holds the healthcare system together and binds disparate elements in the interest of facilitating the patient's journey through the system (Allen, 2002; McNamara et al., 2011). In this study, ANPs emerge as mobilisers of individuals and groups; however, reluctance on the part of some healthcare professionals, predominantly medics, to integrate, makes this difficult. DiCicco-Bloom and Cunningham (2015) in their qualitative study exploring the perceptions of primary care ANPs and primary care physicians found that most of the interactions between both professions were obstructive rather than collaborative. A finding that correlates with this study, where several participants associate integration and teamwork with loss of power and the disruption of traditional hierarchical structures. They are, therefore, reluctant to integrate, reinforcing figured worlds where hierarchical relationships and structures dominate. This finding is supported by the work of Bauer (2010) and Harmer (2010) who argue that medical reluctance to collaborate may be related to changes in health services which have resulted in many doctors feeling threatened by a loss of professional identity and autonomy and struggling to maintain a professional role. Street and Crossman (2010) further suggest that one plausible explanation for doctors' opposition to autonomous ANP practice is their determination to maintain professional control over health services. However, we may underestimate doctors' capacity to reinvent themselves to the extent that other health professionals have. Interestingly, the findings from this study indicate that doctors are not being afforded that agency.

Participants in this study note that familiarity with the ANP role diminishes reluctance in working with ANPs and consequently improves collaborative practices. This finding concurs with those of researchers who have attempted to account for this resistance, arguing that lack of knowledge regarding ANPs' scope of practice and negative beliefs about their competence can be seen as an obstruction to collaboration (Schadewaldt

et al., 2016, Schadewaldt et al., 2013, Street and Crossman, 2010). Nonetheless, this study's participants associate the ANP role with commonality and oneness with other members of the healthcare system. This highlights the interdependent relationships that exist in the healthcare system, exemplified by ANPs' and medics' mutual and collaborative reliance, a finding that highlights the collaborative aspect of the ANP role. The Institute of Medicine (2011) emphasises that it is critical to establish collaborative models of care that embrace the talents of all members of the healthcare team as the traditional medical hierarchical model of practice contributes to ineffective teamwork. A collaborative system can integrate the diverse knowledge and skills of diverse providers who communicate with the patient and each other and are accountable for delivering coordinated care to the patient and society (Stanik-Hutt et al., 2013). Integration and interdependent working further enhance mutual respect and support, enabling the system to be all that it can be.

When discussing ANP and medical roles, participants underlined the fact that both roles had more in common than that which divided them. This commonality, interchangeability and oneness of the ANP and medical roles was to the forefront of the discourses. Participants believe this homogenisation facilitates the ANP crossing boundaries and overcoming barriers to carry out their role. Lowe et al. (2012) believe that it is inevitable that some functions historically completed by one healthcare group will ultimately be assumed by another, redefining professional boundaries in the process. For other participants, congruous relationships are hazardous for the ANP because using medicine as the sole or principal reference point risks the ANP role becoming medicalised and positioned as an inferior alternative. Several authors have warned of the perils of ANPs working within a 'medical framework', concerned that the ANP could become medicalised and lose the caring focus that is fundamental to nursing (Kerr and Macaskill, 2020, Street and Cossman, 2010). For others, this adverse comparison to medicine can lead to a feeling of professional inferiority and nurse practitioners not being recognised as leaders or independent healthcare professionals in their own right (Anderson, 2018; Chulach and Gagnon, 2016). This may constrain the ANP role and its possible influence in the healthcare system.

10.4.4 The inferior practitioner

Analysis of language-in-use shows a discrepancy among participants concerning the educational aspect of the ANP role. For some participants, ANPs were seen as skilled and knowledgeable practitioners, whereas other participants believed ANPs were not necessarily highly educated. Whilst education is seen very much as a social good, the ANP role is one that is based around the performance of a task that is mastered by experience rather than erudition. This finding is supported by Carryer (2020, p.3577) who suggests that nursing is viewed by many as an 'essentially noncognitive endeavour' where 'hands on nursing practice supported by experience rather than scholarship' is considered the only truly reliable source of knowledge. An outlook shared by the past president of the Royal College of Nursing, Anne Marie Rafferty who believes that in most professions it is taken for granted that better education improves performance, but for some strange reason it is a hard battle to prove this for nurses (Rafferty, 2014). Language-in-use describing ANPs as 'not on par' with doctors and as practitioners that carry out 'simpler tasks' for patients, constructs situated meanings that any professional that is not a doctor is constructed as less educated and trained. This positions nurses, including ANPs, as somehow inferior to other professions in the healthcare system. This trivialisation of nursing is seen in the United Kingdom's General Medical Council (2018) annual *State of Medical Education and Practice Report* where language is employed that refers to doctors 'acting down' when they carry out tasks normally completed by nursing staff. This language-in-use reinforces the 'hierarchical physician sitting at the top' figured world that invites others to assume medical ability is more important and superior than other health professionals' abilities. Within this figured world, it is taken as typical and normal that doctors would maintain professional control over health services.

Many healthcare professionals employ language that constructs a medicalised identity for the ANP that is seen as a cheaper and inferior alternative to the doctor. These issues have been debated since the introduction of the ANP role. Mishler (1984) talks of two life worlds: that of the patient and that of medicine. However, Paniagua (2011) proposes that there is a further medico-nursing world, and interestingly not a healthcare-nursing world, in which ANPs have to act and achieve their goals. Chulach and Gagnon (2016) concur that ANPs occupy a space between the cultures of nursing

and medicine; however, they propose that this positioning creates instability and uncertainty for the ANP and may increase threats to identity. Laperrière (2008) contends that professional identity is fluid and constantly changing and argues that it is imperative that nurses find their voice and move away from the ingrained 'handmaiden' identity and instead establish a professional identity and role clarity to ensure effective utilisation of ANPs (Burgess and Purkis, 2010a, Harvey, 2011). Leary (2021) believes the lack of a nursing voice is secondary to what she refers to as 'whitecoat washing', where the media speak to medics about nursing issues rather than speaking directly to nurses about nursing. Ng (2021) argues that this has become much more obvious during the Covid-19 pandemic and highlights the prominence of medics on television and radio panels when discussing largely nursing issues.

10.4.5 The disruptive innovator

Participants are aware of the need to have variety and diversity in the healthcare system to enable it to become all that it can be. However, participants do not believe that the ANP role currently adds as much variety and value to the system as it could, instead identifying the role as a medicalised substitute. This aligns with one of the earliest discourses surrounding the ANP role; the question of role substitution and filling a 'gap' left by the scarcity of doctors. Because of the medical dominance within the healthcare system (Currie et al., 2012), decision makers at most of its tiers tend to think of medical solutions to health problems. Corbally and Lees-Deutsch (2019, p.497) highlight that in some settings '…it was almost impossible for managers to make a "business case" for an ANP as this would mean losing a medical staff member. With this outlook, Carryer and Adams (2017) argue that is it no surprise that ANPs are thought of as medical substitutes. This belief system has resulted in many comparative studies that have confirmed the quality and safety of ANPs when compared with medical practitioners (Stanik-Hutt et al., 2013, Swan et al., 2015, Thompson and Meskell, 2012). However, these studies detract from the focus on the distinctive added value ANPs can potentially bring to the system.

Other healthcare professionals employ language that recognises the hybrid nature of an ANP role that crosses professional boundaries and espouses elements of medical

practice. This Conversation constructs ANP practice as being perpetually associated and defined with reference to medicine. Language-in-use such as ‘replacing’, ‘substituting’, and ‘answering a medical problem’ when discussing the ANP role constructs an attenuated medicalised identity for the ANP with medicine to the forefront and nursing in the background, a doctor manqué figured world. Janssen (2016) argues that newer healthcare roles should not be seen as substituting but instead be considered a disruptive innovation or what he terms ‘situated novelty’. He emphasises that we need to consider new professionals ‘carving’ out their ‘place’ in the healthcare system rather than replacing another. However, this study shows that strong boundary delineation between healthcare professions is pervasive and enduring. Of course, the very nurse/doctor boundary is itself a socially and historically contingent construction that is reinforced as and each profession struggles, discursively and otherwise, to delimit and defend their respective spheres of practice. Frenk et al. (2010, p.9) argue that the ‘division of labour at any specific time and in any specific society is much more the result of […] social forces than of any inherent attribute of health-related work.’ This makes us consider that if we were designing healthcare systems today, we might not start from where we are, with nursing and medicine as separate spheres, a separation that may no longer be fit for purpose.

Although the comparison of the practices for ANPs and doctors will continue to be the cornerstone of any discourse relating to ANP practice, research such as that carried out by Scanlon et al. (2018) and Harvey et al. (2015) recognises the significant role that ANPs play in any health system. Discourses identified in this study support this outlook with most participants keen to emphasise the positive contribution that the role brings to the healthcare system, including the integrative and hybrid nature of the ANP role. However, ANPs need to be careful that by integrating they are not usurped into extant models of reductionist medical care but instead are seen and treated as autonomous professionals in their own right rather than as incumbents of roles who must ‘fit in’ instead of challenging or disrupting the status quo (Delvin et al., 2018; Carryer 2021). This can be achieved by ANPs questioning, challenging and disrupting current healthcare system ideologies by adopting a systems perspective, ‘getting on the balcony’ (Heifetz et al., 2009) and ‘observing the movement of bees as they dance around the hive’ (Oshry, 2017). This would enable us to better appreciate the system

as a whole and transform ‘system blindness’ with all of its costs, into ‘system sight’ with all of its productive possibilities.

10.5 Considering the current discursive positioning of ANPs, what potentially significant issues might extant discourses be minimising or excluding?

Even though ANPs are expected to contribute to nursing research and professional scholarship that shapes and advances nursing practice, education and health care policy at local, national and international levels (HSE, 2020), discourses related to research and scholarship were not prevalent in this study. As discussed, the ANP role although identified as skilled and knowledgeable, was frequently referred to as a practice-based profession supported by experience rather than scholarship or research. This is unsurprising when we consider that nursing research priorities identified from an Irish perspective have not been updated in the last 15 to 20 years (Drennan et al., 2007; Department of Health and Children, 2003) and that, while the World Health Organisation’s nursing strategy mentions competence in ‘evidence generation’, it deems it relevant only to nursing leaders (WHO, 2016). Despite nursing being the largest health workforce across the world and the remarkable developments in the nursing profession in recent years, Ryder et al. (2022) suggest that nursing scholarship and research remains undervalued. This study offers some explanations as to why this is the case.

The clinical aspect of the ANP identity and the impact that this clinical element has on patient care and quality is continually emphasised by the study’s participants. However, very little of the language used relates to research or scholarship. ANPs themselves appear to be torn between the demands of their clinical roles and other aspects of the role such as leadership, education, research and scholarship. This is supported by previous studies which suggest that the research element of the ANP role was the least developed (Royal College of Surgeons, 2010) and only a small minority of ANPs themselves believe that independent research was an important element of their role (Casey et al., 2015). Discourses concerning research in this study predominantly related to audit in practice rather than scholarly research, with nurse managers emphatic that this type of research was the only way for ANPs to prove

themselves. Whilst Twycross and Shorten (2014) would argue that this is not the case, contending that audits do not facilitate nursing's contribution to healthcare knowledge, they are still preferred by management as they provide valuable results quickly, measuring performance against benchmarks (Ryder et al., 2019).

Whilst research and scholarship are identified by experts as key to ANP role actualisation (Casey and O'Connor, 2021), the ANP identity is seen within this study as one that is based around the performance of a task that is mastered by experience rather than erudition. Research has come to be designed and conducted by research experts such as academics who no longer understand the "real' world of nursing (Carryer, 2020), rather than by nurses who 'work the floor'. This undermines the evidence base necessary to realise the value that ANPs can create in the health system and limits their contribution to research and scholarship. This is unfortunate when we consider that nurse-led research projects and programmes have the potential to equip future nurses with the skills necessary to drive improvements that are grounded in evidence of what works for whom, why and in what contexts (Finnegan and Aitkenhead, 2020). However, it is unsurprising that engagement in research is not seen as an important aspect of the ANP role when research is 'undervalued and under-resourced in nursing' (Gibson, 2019, p.1817). ANPs, with their healthcare professional and academic colleagues, need to recognise the role they can potentially play in contributing to the healthcare research agenda.

10.6 Limitations and Delimitations

- Employing a discourse analytic approach that emphasises the discursive construction of social realities through texts, interview and focus group data is highly interpretive in nature and reliant on previous theory. However, rigour and transparency were achieved by systematically applying frameworks developed and elaborated by Gee (2010, 2011) and Oshry (2018) that are consistent with and respectful of my own epistemological and theoretical assumptions. Furthermore, illustrating how I moved along a continuum from raw extant data (the literature) and researcher-generated data (from interviews and focus groups) through description and onwards towards interpretive explanation (Sandelowski and Barroso, 2003),

together with the process of chronicling (Greckhamer et al., 2014), enhances transparency and provides an authentic representation of the complex analysis processes used to arrive at the study's findings.

- This qualitative study was conducted in a specific place and time which cannot be considered, nor was intended, to be generalisable in a quantitative sense. However, the findings are transferable in that they can be used by researchers and practitioners to recognise and interrogate Discourses, Conversations and practices related to the ANP role in other settings to gain a better understanding of the issues that both enable and constrain the role. The insight gained from such in-depth analysis may help inform policy planning at the systems, organisational or local workplace level and help support ANPs at an individual level in negotiating their roles in practice.

- The sample size was relatively small; however, this is not a significant issue when using discourse analysis as Boles and Bombard (1998) argue that the interest should be the function and use of language rather than the people using it.

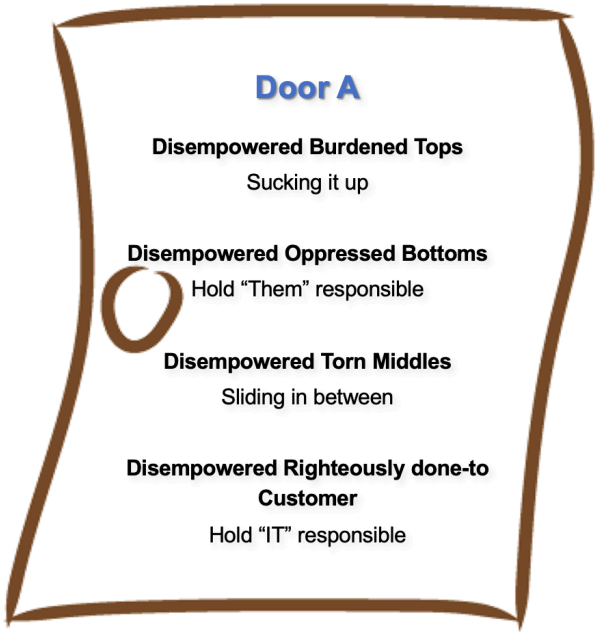
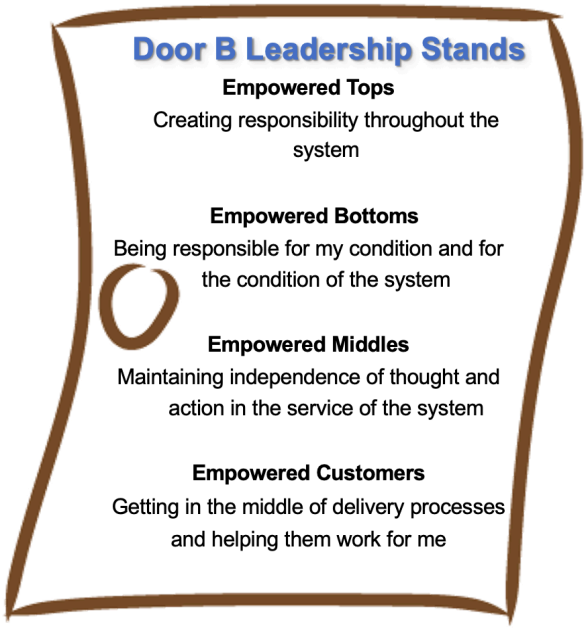
- The study aimed to gain an understanding of how ANPs are positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it. Consequently, the direct involvement of service users was a feature of this study. This can be seen as a limitation but also points to the direct exploration of the language-in-use of service users as a crucial area for future research so as to better understand the positioning, and utilisation, of ANPs in the healthcare system.

- Whilst this study explored advanced nursing practice, it may also inform advanced midwifery practice, which is also distinctly positioned in current healthcare systems and hierarchies. The study may also contribute to debates around the planning of new professional roles within the healthcare system such as physician associates who have yet to establish themselves within the Irish healthcare system. Furthermore, the role of the Healthcare Assistant within the Irish system is

changing (HSE, 2018), and the findings from this study may inform policies concerning the integration, enactment and development of these roles.

10.7 Recommendations

The recommendations for this study are structured according to the empowerment stands described by Oshry (2018) and are presented in table 10.1.

		
Top	Sucking It Up Burdened	Create responsibility through system • Inform others • Involve others • Develop others • Structure • Inspire
Bottom	Holding 'Them' Responsible Oppressed	Be responsible for me and the system

Middle	Sliding In Between Torn	Maintain my independent thought and action to improve system • Be Top when you can • Be Bottom when you should • Coach • Facilitate • Integrate regularly with peers
Customer	Holding 'It' Responsible Righteously done-to	Get in the middle of delivery processes and help them work for me • Contract with supplier • Know how 'it' works • Set clear demands and standards • Stay close to the producer • Get into the process early as partner – not late as a judge

Table 10.1 Empowerment Stands

1. **Support and allow the ANP role to advance**

To meet the demands of ever-changing, dynamic healthcare systems, it is vital that ANPs are supported and allowed to 'advance'. This advancement should include ANPs leading healthcare systems and engaging in research activity and scholarship. Opportunities to achieve this should include a range of level 10 academic modules that can lead to academic qualifications at doctoral level, a comprehensive set of strategies for broader types of engagement in nursing research that contributes to the nursing research agenda, and more public visibility of ANPs' leadership roles in both clinical and organisational contexts. Until this occurs, Conversations that trivialise the role will continue and hierarchies in the system will persist.

2. **Emphasise and strengthen the innovative and integrative elements of the ANP role**

Overemphasis on the caring element of the ANP identity is problematic as there is a risk that the role could be aligned with the 'Angel of Mercy' image that nurses have fought so hard to cast off, rather than being viewed as skilled and educated practitioners. It is crucial that the ANP role is positioned as an essential component within the healthcare system. Positively promoting the visibility of the ANP will help shift away from the ingrained 'handmaiden' and 'angelic' identities which serve the role

no purpose. ANPs need to emphasise the innovative and integrative aspects of their identity and integrate the so-called ‘medical’ elements into a more coherent narrative. Otherwise, there is a risk that the ANP role is regarded as nebulous and incoherent, with ANPs’ roles threatened and controlled, and their voices disregarded.

3. **Recognise the ANPs’ distinctive role and the value they add to the healthcare system**

Healthcare professionals, including ANPs, need to move on from Conversations that continually compare the ANP role with medicine. ANPs should be seen as distinctive practitioners in their own right, rather than as medical substitutes, who offer a model of care that extends traditional medical approaches by embracing collaborative nursing paradigms that focus on health and wellness. We need to move away from positioning ANPs as a marginal and contested presence in the healthcare system and instead see the role as an important and necessary addition, not just from a cost perspective but also for the distinctive value it creates and its impact on patient outcomes and the patient experience.

4. **Embrace the hybrid identity**

As professionals, ANPs need to reframe their identity as one that acknowledges and recognises its advanced nursing element as well as elements that were historically associated with medical practice. Sensitivity to the real-world effects of how language is used can help in achieving a shared understanding of the role and how it can align with and complement other healthcare professionals.

5. **Balance Power and Love in the ANP System**

It is important for ANPs to function independently in a system of Power, where they are seen as practitioners in their own right rather than medical substitutes. The commonality of the role with other healthcare counterparts needs to be recognised and acknowledged as this will undoubtedly create a system of Love that supports cooperation and focuses on our commonalities, and in turn enables ANPs to cross boundaries and barriers to undertake their role. Longstanding traditional hierarchical structures that reify power relationships and reward the pursuit of narrow professional self-interest result in an unbalanced system where integration and homogenisation are submerged. This study shows that familiarity with the ANP role can help, and the

health system can be a robust system of Power and Love. ANPs need to become more visible and vocal, to sit at the policy table and to recognise the tremendous strength and rich diversity that is represented by their collective voice. This is key to maximising ANPs' potential and strengthening the unique position they hold in the healthcare system. Until they do this, a balanced system of Power and Love will continue to be a possibility too rarely achieved.

6. **Identify and challenge negative constructions**

It is essential that healthcare professionals identify and counter disparaging Discourses and Conversations concerning the ANP role, and counter instances in the system where language builds ANP's ways of knowing and knowledge as inferior, so that the role can develop and be utilised to its full potential to enhance healthcare provision. Hierarchical structures that place ANPs in a subservient role must be challenged and instead the ANP should be promoted as a skilled, knowledgeable, independent, and collaborative practitioner. This is key to maximising ANPs' potential and strengthening the unique position they hold in the healthcare system. Until they do this, there is a risk that ANPs will continue to be controlled, their advancement restricted and their potential contribution to the health system unrealised.

10.8 Concluding remarks

This study set out to understand how ANPs are positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it. This study alerts healthcare professionals to the ways in which discourses influence opinion and frame the ANPs' identity. Whilst language-in-use established that ANPs are innovative additions to the healthcare system that add value, language-in-use also confirms the existence of tensions that impact and impede on the ANP roles advancement. To support and allow ANPs to advance, we need to move away from positioning ANPs as a marginal and contested presence in the health system and instead see the role as an important and necessary addition. ANPs need to clearly articulate their role, the value that it adds to the healthcare system and demonstrate how it aligns with and complements other healthcare professionals' roles. ANPs need to become more visible, vocal and sit at

the policy table and recognise the tremendous strength and rich diversity that is represented by their collective voice. This is key to maximising the ANPs potential and strengthening the unique position they hold in the healthcare system.

This study would not have been possible without the invaluable insight and framing that the works of both James Paul Gee and Barry Oshry provided. By applying Gee's (2010) discourse analytic approach to the data, I was able to identify and analyse the discourses that are in circulation concerning the ANP role and how they affect the social realities of the ANP. Oshry's (2018) OSF provided a further layer of analysis and allowed me, first, to show how ANPs comprise a system that can be described in terms of the distinctive patterns of relationships and processes that constitute it and, second, to illuminate the relationships and processes that characterise the ways in which the ANP (sub-)system interacts with the wider healthcare system.

For the data, thanks are due to all those healthcare professionals who have written and spoken so eloquently, honestly and provocatively about the ANP role. A particular debt of gratitude is owed to my healthcare colleagues within the Ireland East Hospital Group with whom I had so many frank and edifying conversations. It was their contribution, above all, that gave the theory so much to listen to and, I hope, this thesis something new and interesting to say.

References

Adam, T. and de Savigny, D. (2012) 'Systems thinking for strengthening health systems in LMICs: need for a paradigm shift', *Health Policy and Planning*, 27, 4, 1-3. https://doi.org/10.1093/heapol/czs084

Adams, S. & Carryer, J. (2021). How the institutional and policy context shapes the establishment of nurse practitioner roles and practice in New Zealand's primary health care sector. *Policy, Policies & Nursing Practice*, 22, 1, 17-27. https://doi.org/10.1177/1527154420965534

Albers-Heitner, C. P., Joore, M. A., Winkens, R. A. G., Lagro-Janssen, A. L. M., Severens, J. L. & Berghmans, L. C. M. (2012). Cost-effectiveness of involving nurse specialists for adult patients with urinary incontinence in primary care compared to care-as-usual: an economic evaluation alongside a pragmatic randomized controlled trial. *Neurourology and Urodynamics*, 31, 526-534. https://doi.org/10.1002/nau.21204

Aleshire, M. E., Wheeler, K. & Prevost, S. S. (2012). The future of nurse practitioner practice: a world of opportunity. *The Nursing Clinics of North America*, 47, 2, 181-91, v. https://doi.org/10.1016/j.cnur.2012.04.002

Allen, D. (2002). The Changing Shape of Nursing Practice. The Role of Nurses in the Hospital Division of Labour. London: Routledge.

Anderson, C. (2018). Exploring the role of advanced nurse practitioners in leadership. *Nursing Standard*. May 2, 33, 2, p.29-33. https://doi.org/10.7748/ns.2018.e11044

Anderson, H., Birks, Y. & Adamson, J. (2020). Exploring the relationship between nursing identity and advanced nursing practice: An ethnographic study. *Journal of Clinical Nursing*, 29, 7-8, 1195-1208. https://doi.org/10.1111/jocn.15155

Andregård, A. C. & Jangland, E. (2015). The tortuous journey of introducing the Nurse Practitioner as a new member of the healthcare team: a meta-synthesis. *Scandinavian Journal of Caring Sciences*, 29, 1, 3-14. https://doi.org/10.1111/scs.12120

Andrews, T. (2012). What is Social Constructionism? Grounded Theory Review: An International Journal, 11, 1. https://doi.org/10.4135/9780857020147.n125

Andrist, L. C., Nicholas, P. K. & Wolf, K. A. (2006). *History of Nursing Ideas*, London; Sudbury, Mass.

Anfara, V. A., Brown, K. M. & Mangione, T. L. (2002). Qualitative Analysis on Stage: Making the Research Process More Public. *Educational Researcher*, 31, 28-38. http://dx.doi.org/10.3102/0013189X031007028

Archer, M. S. (1998). *Critical realism: Essential readings*. London: Routledge.

Archibald, M. M. & Fraser, K. (2013). The potential for nurse practitioners in health care reform. *Journal of Professional Nursing*, 29, 270, 5. https://doi.org/10.1016/j.profnurs.2012.10.002

Austin, S., Powers, K., Florea, S. & Gaston, T. (2020). Evaluation of a nurse practitioner-led project to improve communication and collaboration in the acute care setting. *Journal of the American Association of Nurse Practitioners*, 9, 746-753. https://doi.org/10.1097/jxx.0000000000000402

Australian Medical Association. (2019). *AMA calls for nurse practitioner proposals to be rejected*. [Online]. Available: https://www.ama.com.au/gp-network-news/ama-calls-nurse-practitioner-proposals-be-rejected [Accessed 16th October 2021].

Barry, M. (2007). No need to rush nurse prescribing. *The Irish Times*, Feb 20, 2007.

Bauer, J. C. (2010). Nurse practitioners as an underutilized resource for health reform: evidence-based demonstrations of cost-effectiveness. *Journal of the American Academy of Nurse Practitioners*, 22, 228-231. https://doi.org/10.1111/j.1745-7599.2010.00498.x

Baugh, J., Hallcom, A. & Harris, M. (2010). *Computer assisted qualitative data analysis software: a practical perspective for applied research* [Online]. Available: http://www.revistaiic.org/articulos/num6/articulo4_esp.pdf [Accessed 6th June 2018].

Beck, J. & Young, M. F. D. (2005). The assault on the professions and the restructuring of academic and professional identities: a Bernsteinian analysis. *British Journal of Sociology of Education*, 26, 183-197. https://doi.org/10.1080/0142569042000294165

Bedford, T. & Burgess, J. (2001). The focus group experience. In: Limb, M. & Dwyer, C. (eds.) *Qualitative Methodologies for Geographers: Issues and Debates*. New York: Arnold.

Begley, C., Elliott, N., Lalor, J., Coyne, I., Higgins, A. & Comiskey, C. M. (2013). Differences between clinical specialist and advanced practitioner clinical practice, leadership, and research roles, responsibilities, and perceived outcomes (the SCAPE study). *Journal of Advanced Nursing*, 69, 1323-1337. https://doi.org/10.1111/j.1365-2648.2012.06124.x

Begley, C., Murphy, K., Higgins, A. & Cooney, A. (2014). Policy makers' views on impact of specialist and advanced practitioner roles in Ireland: the SCAPE study. *Journal of Nursing Management*, 22, 410-422. https://doi.org/10.1111/jonm.12018

Begley, C. M., Murphy, K., Higgins, A. & Elliott, N. (2010). *Evaluation of clinical nurse and midwife specialist and advanced nurse and midwife practitioner roles in Ireland (SCAPE): Final report,* Dublin: National Council for the Professional Development of Nursing and Midwifery.

Bergen, A. & While, A. (2000). A case for case studies: exploring the use of case study design in community nursing research. *Journal of Advanced Nursing*, 31, 926-934. https://doi.org/10.1046/j.1365-2648.2000.01356.x

Berger, P. L. & Luckmann, T. (1966). *The Social Construction of Reality*, London, Penguin.

Bertalanffy, L. V. (1968). *General system theory: foundations, development, applications*, New York, Braziller Ltd.

Blaxter, L., Hughes, C. & Tight, M. (2010). *How to research*, Buckingham, Open University Press.

Blommaert, J. & Bulcaen, C. (2000). Critical Discourse Analysis. *Annual Review of Anthropology*, 29, 447-466. https://doi.org/10.1146/annurev.anthro.29.1.447

Bloor, M. (2001*). Focus Groups in Social Research*, London, SAGE.

Blumer, H. (1954). What Is Wrong with Social Theory? *American Sociological Review*, 19, 3-10. https://doi.org/10.2307/2088165

Boeijen, E.R.K., Peters, J.W.B., & van Vught, A.J.A.H. (2020) Nurse practitioners leading the way: An exploratory study on the added value of nurse practitioners in outpatient care in the Netherlands. *Journal of the American Association of Nurse Practitioners*. 32, 12, p.800-808. https://doi.org/10.1097/jxx.0000000000000307

Boles, L. & Bombard, T. (1998). Conversational discourse analysis: Appropriate and useful sample sizes. *Aphasiology*, 12, 547-560. https://doi.org/10.1080/02687039808249557

Boniol, M., McIsaac, M., Xu, L., Wuliji, T., Diallo, K. & Campbell, J. (2019). *Gender equity in the health workforce: Analysis of 104 countries.* Available at: https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf?sequence=1&isAllowed=y (Accessed: 16 January 2021).

Bridges, J. M. (1990). Literature review on the images of the nurse and nursing in the media. *Journal of Advanced Nursing*, 15, 850-4. https://doi.org/10.1111/j.1365-2648.1990.tb01917.x

Brook, S. & Rushforth, H. (2011). Why is the regulation of advanced practice essential? *British Journal of Nursing*, 20, 996-1000. https://doi.org/10.12968/bjon.2011.20.16.996

Brown, M. A. & Draye, M. A. (2003). Experiences of Pioneer Nurse Practitioners in Establishing Advanced Practice Roles. *Journal of Nursing Scholarship*, 35, 391-397. https://doi.org/10.1111/j.1547-5069.2003.00391.x

Bryman, A. (2012). *Social research methods*, Oxford, Oxford University Press.

Burge, S. (2015). *Systems Thinking: Approaches and Methodologies* [Online]. Available: https://www.burgehugheswalsh.co.uk/systems-thinking/process.aspx [Accessed 4th May 2018].

Burgess, J. & Purkis, M. E. (2010). The power and politics of collaboration in nurse practitioner role development. *Nursing Inquiry*, 17, 297-308. https://doi.org/10.1111/j.1440-1800.2010.00505.x

Burns, S. (2019) Nurses are 'underdog of healthcare', says union leader. *The Irish Times.* [Online] Available: https://www.irishtimes.com/opinion/i-am-a-nurse-this-is-why-i-m-striking-1.3751506 (Accessed: 16 January 2021).

Burr, V. (1995). *Introduction to social constructionism*, London, Routledge.

Callaghan, L. (2008). Advanced nursing practice: An idea whose time has come. *Journal of Clinical Nursing*, 205-13. https://doi.org/10.1111/j.1365-2702.2006.01881.x

Cameron, J. (2005). Focussing on the focus groups. In: Hay, I. (ed.) *Qualitative Research Methods in Human Geography*. New York: Oxford University Press.

Canadian Health Services Research Foundation. (2011). Myth: Seeing a nurse practitioner instead of a doctor is second-class care. *Journal of Health Service and Research Policy*, 16, 124-5. https://doi.org/10.1258/jhsrp.2010.211110

Carbaugh, D. (1997). Situating Selves: The Communication of Social Identities in American Scenes. *College Composition and Communication*, 48, 3, 431-432. https://www.jstor.org/stable/358411

Carroll, M. (1998). *Report of the Commission on Nursing: a blueprint for the future.* Dublin: Stationery Office.

Carryer, J. (2020). Letting go of our past to claim our future. *Journal of Clinical Nursing*, 29, 87-289. https://doi.org/10.1111/jocn.15016

Carryer, J. (2020). Pride, power and professional trust in each other are essential if we are to move forward in this year of the nurse. *Journal of Clinical Nursing*, 29, 3577-3579. http://dx.doi.org/10.1111/jocn.15377

Carryer, J. & Adams, S. (2021) Valuing the paradigm of nursing: Can nurse practitioners resist medicalization to transform healthcare?. *Journal of Advanced Nursing,* https://doi.org/10.1111/jan.15082

Carryer, J. & Adams, S. (2017). Nurse practitioners as a solution to transformative and sustainable health services in primary health care: A qualitative exploratory study, *Collegian*, 24, 6, 525-531. https://doi.org/10.1016/j.colegn.2016.12.001

Carryer, J., Gardner, G., Dunn, S. & Gardner, A. (2007). The core role of the nurse practitioner: practice, professionalism and clinical leadership. *Journal of Clinical Nursing*, 16, 1818-25. https://doi.org/10.1111/j.1365-2702.2007.01823.x

Carter, M. [@DrMLJCarter]. (2018. January 25). *This excerpt features in @gmcuk's State of Medical Education and Practice report 2018. "Acting down" Good to know our place as nurses is beneath doctors, not alongside them as degree educated professionals fulfilling our own unique role... Are we not past this yet? [Tweet].* Twitter. https://twitter.com/DrMLJCarter/status/1071784151093792768

Casey, M. & O 'Connor, L. (2021) Advanced practice nursing: Should research be the icing on the cake? *Nursing Open*, 00, 1-3. https://doi.org/10.1002/nop2.1122

Casey, M., Cooney, A., O' Connell, R., Hegarty, J. M., Brady, A. M., O' Reilly, P., Kennedy, C., Heffernan, E., Fealy, G., McNamara, M. & O' Connor, L. (2017a). Nurses', midwives' and key stakeholders' experiences and perceptions on requirements to demonstrate the maintenance of professional competence. *Journal of Advanced Nursing*, 73, 653-664. https://doi.org/10.1111/jan.13171

Casey, M., O' Connor, L., Cashin, A., Smith, R., O' Brien, D., Nicholson, E., O' Leary, D., Fealy, G., McNamara, M., Glasgow, M. E., Stokes, D. & Egan, C. (2017b). An overview of the outcomes and impact of specialist and advanced nursing and midwifery practice, on quality of care, cost and access to services: A narrative review. *Nurse Education Today*, 56, 35-40. https://doi.org/10.1016/j.nedt.2017.06.004

Casey, M., O' Connor, L., Nicholson, E., Smith, R., O'Brien, D., O'Leary, D., Fealy, G. M., McNamara, M. S., Stokes, D. & Egan, C. (2017c). The perceptions of key stakeholders of the roles of specialist and advanced nursing and midwifery practitioners. *Journal Of Advanced Nursing*, 73, 12, 3007-3016. https://doi.org/10.1111/jan.13359

Casey, M., Fealy, G., Kennedy, C., Hegarty, J., Prizeman, G., McNamara, M., O'reilly, P., Brady, A. M. & Rohde, D. (2015). Nurses', midwives' and key stakeholders' experiences and perceptions of a scope of nursing and midwifery practice framework. *Journal of Advanced Nursing*, 71, 1227-1237. https://doi.org/10.1111/jan.12603

Cashin, A., Buckley, T., Donoghue, J., Heartfield, M., Bryce, J., Cox, D., Waters, D., Gosby, H., Kelly, J. & Dunn, S. V. (2015). Development of the Nurse Practitioner Standards for Practice Australia. *Policy, Politics, & Nursing Practice*, 16, 27-37. https://doi.org/10.1177/1527154415584233

Central Statistics Office. (2016). *Census 2016 Reports. Retrieved from Central Statistics Office*. Available: https://www.cso.ie/en/census/census2016reports/

Chakravarthy, A. A. (2008). Core competencies for a trauma subspecialty nurse practitioner. *Journal of Trauma Nursing*, 15, 145-8. https://doi.org/10.1097/01.jtn.0000337159.46582.5a

Chapman, J. (2004). *System Failure*, Hendy Banks, London, Demos.

Checkland, P. (1981). *Systems thinking, systems practice*, Chichester, Wiley.

Checkland, P. & Scholes, J. (1990). *Soft systems methodology in action*, Chichester, Wiley.

Cheek, J. (2004). At the Margins? Discourse Analysis and Qualitative Research. *Qualitative Health Research*, 14, 1140-1150. https://doi.org/10.1177/1049732304266820

Chiarella, M., Hardford, E., & Lau, C. (2007*). Report on the evaluation of nurse/midwife practitioner and clinical nurse/midwife consultant roles*. North Sydney, NSW Department of Health.

Chilton, P. A. (2004). *Analysing Political Discourse: Theory and Practice*, London, Routledge.

Christensen, C. M., Bohmer, R. & Kenagy, J. (2000). Will disruptive innovations cure health care? *Harvard Business Review*. United States: Harvard Business School Press.

Chulach, T. & Gagnon, M. (2016). Working in a 'third space': a closer look at the hybridity, identity and agency of nurse practitioners. *Nursing Inquiry*, 23, 1. http://dx.doi.org/10.1111/nin.12105

Cingel, M. & Brouwer, J. (2021). What makes a nurse today? A debate on the nursing professional identity and its need for change. *Nursing Philosophy*, 22, 2, https://doi.org/10.1111/nup.12343

Clarin, O. A. (2007). Strategies to Overcome Barriers to Effective Nurse Practitioner and Physician Collaboration. *The Journal for Nurse Practitioners*, 3, 538-548. http://dx.doi.org/10.1016/j.nurpra.2007.05.019

Coeling, H. & Cukr, P. (2000). Communication Styles that Promote Perceptions of Collaboration, Quality, and Nurse Satisfaction. *Journal of Nursing Care Quality*, 14, 2, 63-74. https://doi.org/10.1097/00001786-200001000-00009

Connor, D. (2021). *Nurses warn of 'unsafe' conditions due to staff shortages*. *Raidió Teilifís Éireann* [Online]. Available: https://www.rte.ie/news/business/2021/1011/1253065-nurses-warn-conditions-unsafe-due-to-staff-shortages/ [Accessed 16th October 2021].

Constas, M. A. (1992). Qualitative Analysis as a Public Event: The Documentation of Category Development Procedures. *American Educational Research Journal*, 29, 253-266. https://doi.org/10.3102%2F00028312029002253

Cope, D. G. (2015). Case Study Research Methodology in Nursing Research. *Oncology Nursing Forum*, 42, 681-682. https://doi.org/10.1188/15.onf.681-682

Corbally, M. A. And Lees-Deutsch, L. (2019). 'Restriction by advancement - The irony of advanced nursing practice in Ireland'. *Journal of Advanced Nursing*. 75, p.497-498. https://doi.org/10.1111/jan.13861

Cordon, C. (2013). System Theories: An Overview of Various System Theories and Its Application in Healthcare. *American Journal of Systems Science*, 2, 1, 13-22. http://dx.doi.org/10.5923/j.ajss.20130201.03

Coyne, I., Comiskey, C. M., Lalor, J. G., Higgins, A., Elliott, N. & Begley, C. (2016). An exploration of clinical practice in sites with and without clinical nurse or midwife specialists or advanced nurse practitioners, in Ireland. *BMC Health Services Research Journal,* 16, 151. https://doi.org/10.1186/s12913-016-1412-8

Credland, N. [@credland_nicki]. (2021. February 18). *It's not a course it is a degree! You would not say a doctors course or a lawyers course. Semantics matter [Tweet].* Twitter. https://twitter.com/credland_nicki/status/1362411505711513600?lang=cs

Creswell, J. W. (2013). *Qualitative inquiry and research design: choosing among five approaches*, London, SAGE.

Cronenwett, L., Dracup, K., Grey, M., McCauley, L., Meleis, A. & Salmon, M. (2011). The Doctor of Nursing Practice: A national workforce perspective. *Nursing Outlook*, 59, 9-17. https://doi.org/10.1016/j.outlook.2010.11.003

Cronin, A. (2001). Focus groups. In: Gilbert, N. (ed.) *Researching Social Life*. London: Sage.

Crotty, M. (1998*). The foundations of social research: meaning and perspective in the research process,* London, SAGE.

Crowe, S., Clarke, N. & Brugha, R. (2017). You do not cross them': Hierarchy and emotion in doctors' narratives of power relations in specialist training. *Social Science & Medicine,* 186, 70-77. https://doi.org/10.1016/j.socscimed.2017.05.048

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A. J. & Sheikh, A. (2011). The case study approach. *BMC Medical Research Methodology*, 11, 100-100. http://dx.doi.org/10.1186/1471-2288-11-100

Cruickshank, J. (2012). The role of qualitative interviews in discourse theory. *Critical Approaches to Discourse Analysis across Disciplines*, 6, 38-52.

Cummings, G. G., Fraser, K. & Tarlier, D. S. (2003). Implementing Advanced Nurse Practitioner Roles in Acute Care: An Evaluation of Organizational Change. *The Journal of Nursing Administration*, 33, 139-145. https://doi.org/10.1097/00005110-200303000-00004

Currie, G., Lockett, A., Finn, R., Martin, G. & Waring, J. (2012). Institutional Work to Maintain Professional Power: Recreating the Model of Medical Professionalism. *Organization Studies*, 33, 937-962. https://doi.org/10.1177%2F0170840612445116

Currie, J. & Crouch, R. (2008). How far is too far? Exploring the perceptions of the professions on their current and future roles in emergency care. *Emergency Medicine Journal*, 25, 335-9. https://doi.org/10.1136/emj.2007.047332

Dahlborg-Lyckhage, E., Pilhammar-Anderson, E., Institutionen För Omvårdnad, H. O. K., Avd För, S. & Högskolan, V. (2009). Predominant Discourses in Swedish Nursing. *Policy, Politics, & Nursing Practice*, 10, 163-171. https://doi.org/10.1177/1527154409338493

De Meis, C., De Almeida Souza, C. & Da Silva Filho, J. F. (2007). House and Street: Narratives of Professional Identity Among Nurses. *Journal of Professional Nursing*, 23, 325-328. https://doi.org/10.1016/j.profnurs.2007.06.004

De Vos, A. S. (2002). Combined quantitative and qualitative approach. In: De Vos, A. S., Strydom, H., Fouché, C. B. & Delport, C. S. L. (eds.) *Research at grass roots for the social sciences and human service professions*. 2nd ed. Pretoria: Van Schaik Publishers

Dean, E. (2013). Proving the value of advanced roles. *Nursing Standard*, 27, 25, 18-20. https://doi.org/10.7748/ns2013.02.27.25.18.s8

Delamaire, M. L. & Lafortune, G. (2010). *Nurses in Advanced Roles: A Description and Evaluation of Experiences in 12 Developed Countries, Organisation for Economic Co-operation and Development*. https://doi.org/10.1787/18152015

Delvin, M.E., Braithwaite, S. & Plazas, P.C. (2018). Canadian nurse practitioner's quest for identity: A philosophical perspective, *International Journal of Nursing Sciences,* 5, 2, 110-114. https://doi.org/10.1016/j.ijnss.2018.03.001

Denzin, N. K. (2009). The elephant in the living room: or extending the conversation about the politics of evidence. *Qualitative Research,* 9, 139-160. https://doi.org/10.1177/1468794108098034

Denzin, N. K. & Lincoln, Y. S. (2011). *The SAGE handbook of qualitative research*, Los Angeles, SAGE.

Department of Health and Children. (2003). *A research strategy for nursing and midwifery in Ireland* [Online]. Available: https://www.lenus.ie/bitstream/handle/10147/46742/1799.pdf?sequence=1 [Accessed 28th December 2019].

Department of Health (2017). *Developing a Community Nursing and Midwifery Response to an Integrated Model of Care: Consultation Document.* Dublin: Department of Health

Department of Health (2019) *A Policy on the Development of Graduate to Advanced Nursing & Midwifery Practice*. Dublin: Department of Health.

Devault, M. & McCoy, L. (2002). Institutional ethnography: using interviews to investigate ruling relations. In: Gubrium, J. & Holstein, J. (eds.) *Handbook of Interview Research: Context and Method*. Thousand Oaks, California: Sage.

Dicicco-Bloom, B. & Cunningham, R. S. (2015). Complex patients and interprofessional relationships: Perceptions of primary care nurse practitioners and primary care physicians: Complex patients and interprofessional relationships. *Journal of the American Association of Nurse Practitioners*, 27, 646-652. https://doi.org/10.1002/2327-6924.12241

Dillard-Wright, J. & Shields-Haas, V. (2021). Nursing With the People: Reimagining Futures for Nursing, *Advances in Nursing Science*, 44, 3, 195-209. https://doi.org/10.1097/ans.0000000000000361

Donelan, K., Desroches, C. M., Dittus, R. S. & Buerhaus, P. (2013). Perspectives of physicians and nurse practitioners on primary care practice. *The New England Journal of Medicine*, 368, 1898-906. https://doi.org/10.1056/nejmsa1212938

Doody, O., Slevin, E. & Taggart, L. (2013). Focus group interviews in nursing research: part 1. *British Journal of Nursing*, 22, 16-19. https://doi.org/10.12968/bjon.2013.22.1.16

Dornan, T. (2014). When I say…discourse analysis. *Medical Education*, 48, 466-467. https://doi.org/10.1111/medu.12291

Drennan,J., Meehan, T., Kemple, M., Johnson, M. & Butler, M. (2007). Nursing research prioroties for Ireland. *Journal of Nursing Scholarship*, 39, 4, 298-305. https://doi.org/10.1111/j.1547-5069.2007.00184.x

Dreyfus, H. L. & Rabinow, P. (1982). *Michel Foucault: beyond structuralism and hermeneutics,* Brighton, Harvester.

Dudovskiy, J. (2018). *Research Methodology: Purposive Sampling* [Online]. Available: https://research-methodology.net/sampling-in-primary-data-collection/purposive-sampling/ [Accessed 16th July 2018].

Elliott, N. (2017). Building leadership capacity in advanced nurse practitioners - the role of organisational management. *Journal of Nurse Management*, 25, 1, 77-81. https://doi.org/10.1111/jonm.12444

Erikkson, I., Lindblad, M., Möller, U. & Gillsjö, C. (2018). Holistic health care: Patients' experiences of health care provided by an Advanced Practice Nurse. *International Journal of Nursing Practice*. 24, 1. https://doi.org/10.1111/ijn.12603

Evans, A. M., Traynor M. & Glass, N. (2014). An exploration of jealousy in nursing: a Kleinian analysis. *Nursing Inquiry*, 21, 2, 171-178. https://doi.org/10.1111/nin.12036

Evans, C., Pearce, R., Greaves, S. & Blake, H. (2020). Advanced Clinical Practitioners in Primary Care in the UK. *International Journal of Environmental Research and Public Health*. 17, 4500. https://doi.org/10.3390/ijerph17124500

Fain, J. A. (2003). *Reading, understanding, and applying nursing research: a text and workbook*, Philadelphia Pa, F.A. Davis.

Fairclough, N. (2001). *Language and power*, Harlow, Longman.

Fairclough, N. (2010). *Critical discourse analysis: the critical study of language*, Harlow, Longman.

Fealy, G. M. (2004). 'The good nurse': visions and values in images of the nurse. *Journal of Advanced Nursing*, 46, 649-56. https://doi.org/10.1111/j.1365-2648.2004.03056.x

Fealy, G. M. (2005). *Care to remember: Nursing and Midwifery in Ireland*, Cork, Mercier Press.

Fern, E. F. (2001). *Advanced Focus Group Research*, London, Sage.

Fillingham, L. A. & Süsser, M. (1993). *Foucault for beginners*, London, Writers and Readers.

Finnegan, A. & Aitkenhead, S. (2020). A Research Portfolio: Transformational change by nursing, midwifery and care staff across health and care. *Journal of Advanced Nursing.* 76, 1, 7-8. https://doi.org/10.1111/jan.14228

Fitzpatrick, J. J. & Wallace, M. (2009). *The Doctor of Nursing Practice and Clinical Nurse Leader: Essentials of Program Development and Implementation for Clinical Practice,* New York, Bang Printing.

Flyvbjerg, B. (2011). Case study. In: Denzin, N. K. & Lincoln, Y. S. (eds.) The Sage *Handbook of Qualitative Research*. 4th ed. Thousand Oaks, CA: Sage.

Foucault, M. (1972). *The archaeology of knowledge and the discourse on language*. New York, Vintage Books.

Foucault, M. (1977). *Discipline and punish: the birth of the prison*, London, Allen Lane.

Foucault, M. (1988). *The history of sexuality*, London, Allen Lane.

Foucault, M. (1991). *Discipline and punish: the birth of the prison*, London, Penguin.

Foucault, M. (2001a). *Madness and civilization: a history of insanity in the Age of Reason*, London, Routledge.

Foucault, M. (2001b). *The order of things: an archaeology of the human sciences,* London, Routledge.

Fraze, T. K., Briggs, A. D. M., Whitcomb, E. K., Peck, K. A. & Meara, E. (2020). Role of Nurse Practitioners in Caring for Patients with Complex Health Needs. *Medical Care*, 58, 10, 853-860. https://doi.org/10.1097/mlr.0000000000001364

Frenk, J., Chen, L., Bhutta, Z. A., Cohen, J., Crisp, N., Evans, T., Fineberg, H., Garcia, P., Ke, Y., Kelley, P., Kistnasamy, B., Meleis, A., Naylor, D., Pablos-Mendez, A., Reddy, S., Scrimshaw, S., Sepulveda, J., Serwadda, D. & Zurayk, H. (2010). Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *The Lancet,* 376, 1923-1958. https://doi.org/10.1016/s0140-6736(10)61854-5

Friedman, B. D. & Allen, K. N. (2014). Systems Theory. In: BRANDELL, J. R. (ed.) *Essentials of Clinical Social Work*. Thousand Oaks, California.

Friedman, L. H., King, J. B. & Bella, D. (2007). Seeing systems in health care organizations. *Physician Executive,* 33, 20.

Frost, J., Currie, M. J., Cruickshank, M. & Northam, H. (2018). Using the lens of enablement to explore patients' experiences of Nurse Practitioner care in the Primary Health Care setting. *Collegian*, 25, 2, 193-199. http://dx.doi.org/10.1016/j.colegn.2017.06.002

Gaiser, T. J. (1997). Conducting online focus groups: a methodological discussion. Social *Science Computer Review*, 15, 135-144. https://doi.org/10.1177%2F089443939701500202

Gallagher, P. (2021). *Shared Vision for Slaintecare*. 2nd National HEI ANP/AMP Education Consortium Webinar. March 26 2021.

Gantly, D. (2017). Grave concerns over nurse led model. *Irish Medical Times*.

Gardenier, D. (2015). Are Nurse Practitioners Becoming More Like Physicians? *The Journal for Nurse Practitioners*, 11, 608-609.

Gasson, S. (1994*). The use of soft systems methodology (SSM) as a tool for investigation*, Warwick, Warwick Business School.

Gasson, S. (2015*). Soft Systems Methodology. Improvising Design* [Online]. Available from: http://blog.improv-design.com/soft-systems-methodology/. [Accessed 4th May 2018].

Gee, J. P. (2011). *How to do Discourse Analysis: A Toolkit*, Oxon, Routledge.

Gee, J. P. (2010). *An introduction to discourse analysis: theory and method*, New York, Routledge.

Gee, J. P. (2004). Discourse analysis: What makes it critical? In: ROGERS, R. (ed.) *An introduction to critical discourse analysis in education*. London: Lawrence Erlbaum.

Gee, J. P. (2000). Identity as an Analytic Lens for Research in Education. *Review of Research in Education*, 25, 99-125. https://doi.org/10.2307/1167322

General Medical Council. (2018*). The State of Medical Education and Practice in the United Kingdom*, London, General Medical Council.

George, A. L., & Bennett, A. (2005). *Case studies and theory development in the social sciences*, London, MIT.

Gergen, K. J. (2009). The social constructionist movement in modern psychology. *INTERthesis*, 6, 299-325. https://psycnet.apa.org/doi/10.1037/0003-066X.40.3.266

Gerrish, K., Nolan, M., McDonnell, A., Tod, A., Kirshbaum, M. & Guillaume, L. (2012). Factors Influencing Advanced Practice Nurses' Ability to Promote Evidence-Based Practice among Frontline Nurses. *Worldviews on Evidence Based Nursing*, 9, 30-39. https://doi.org/10.1111/j.1741-6787.2011.00230.x

Gibson, J. E. (2019). Shouldn't we all be clinical academics? *Journal of Advanced Nursing*, 75, 9, 1817-1818. https://doi.org/10.1111/jan.14026

Gielen, S. C., Dekker, J., Francke, A. L., Mistiaen, P. & Kroezen, M. (2014). The effects of nurse prescribing: A systematic review. *International Journal of Nursing Studies*, 51, 7, 1048-1061. https://doi.org/10.1016/j.ijnurstu.2013.12.003

Gill, J., Johnson, P. & Clark, M. (2010*). Research methods for managers*, London, SAGE.

Given, L. (2008). *The Sage encyclopaedia of qualitative research methods*, Los Angeles, Calif, Sage Publications.

Glaser, B. G. & Strauss, A. L. (2017). *The Discovery of Grounded Theory: Strategies for Qualitative Research,* New York, Routledge.

Goebert, B. & Rosenthal, G. (2002). *Beyond Listening: Learning the Secret Language of Focus Groups,* New York, John Wiley.

Golden-Biddle, K. & Locke, K. (1993). Appealing Work: An Investigation of How Ethnographic Texts Convince. *Organization Science*, 4, 595-616. https://doi.org/10.1287/orsc.4.4.595

Gordon, S. & Nelson, S. (2018). Moving beyond the Virtue Script in *Nursing: Creating a Knowledge-Based Identity for Nurses*, in Nelson, S. & Gordon, S. (eds.). Ithaca, NY: Cornell University Press, pp. 13-29.

Gordon, S. & Nelson, S. (2005). An End to Angels. *The American Journal of Nursing*, 105, 62-69. https://doi.org/10.1097/00000446-200505000-00031

Gould, O. N., Johnstone, D. & Wasylkiw, L. (2007). Nurse practitioners in Canada: Beginnings, benefits, and barriers. *Journal of the American Academy of Nurse Practitioners*, 19, 165-171. https://doi.org/10.1111/j.1745-7599.2007.00210.x

Government of Ireland (2018). *Data Protection Act*. Dublin: House of the Oireachtas.

Gray, D. E. (2004). *Doing research in the real world*, Thousand Oaks, SAGE.

Greckhamer, T., William, W., Catherine, M. R. & Cilesiz, S. (2014). Rigor, Transparency, Evidence, and Representation in Discourse Analysis: Challenges and Recommendations. *International Journal of Qualitative Methods*, 13, 422-443. https://doi.org/10.1177%2F160940691401300123

Green, H. E. (2014). Use of theoretical and conceptual frameworks in qualitative research. *Nurse Researcher*, 21, 34. https://doi.org/10.7748/nr.21.6.34.e1252

Griffin, M. & Melby, V. (2006). Developing an advanced nurse practitioner service in emergency care: attitudes of nurses and doctors. *Journal of Advanced Nursing*, 56, 292-301. https://doi.org/10.1111/j.1365-2648.2006.04025.x

Grønkjær, M., Curtis, T., Champion De Crespigny, C.F., & Delmar, C. (2011). Analysing group interaction in focus group research: impact on contecnt and the role of the moderator. *Qualitative Studies*. 2, 1, p.16-30. https://doi.org/10.7146/qs.v2i1.4273

Grumbach, K., Hart, L. G., Mertz, E., Coffman, J. & Palazzo, L. (2003). Who is caring for the underserved? A comparison of primary care physicians and nonphysician clinicians in California and Washington. *Annals of Family Medicine*, 1, 97-104. https://doi.org/10.1370/afm.49

Guarino, N. & Musen, M. A. (2015). Ten years of Applied Ontology. *Applied Ontology*, 10, 169-170. http://dx.doi.org/10.3233/AO-150160

Hain, D. & Fleck, L. M. (2014). Barriers to NP Practice that Impact Healthcare Redesign. *Online Journal of Issues in Nursing*, 19, 23.

Hallam, J. (1998). From angels to handmaidens: changing constructions of nursing's public image in post-war Britain. *Nursing inquiry*, 5, 32. http://dx.doi.org/10.1108/09534810210417366

Hallam, J. (2000). *Nursing the image: media, culture and professional identity,* London, Routledge.

Hamel, J., Dufour, S. & Fortin, D. (1993). *Case Study Methods. Qualitative Research Methods* Series No. 32, Newbury Park, CA, Sage.

Hammersley, M. (1992). *What's wrong with ethnography?: methodological explorations,* London, Routledge.

Hardy, C. (2001). Researching Organizational Discourse. *International Studies of Management & Organization,* 31, 25-47. https://doi.org/10.1080/00208825.2001.11656819

Harmer, V. (2010). Are nurses blurring their identity by extending or delegating roles? *British Journal of Nursing*, 19, 295-9. https://doi.org/10.12968/bjon.2010.19.5.47062

Harrison, H., Birks, M., Franklin, R. & Mills, J. (2017). Case Study Research: Foundations and Methodological Orientations. *Forum: Qualitative Social Research*, 18, 1. https://doi.org/10.17169/fqs-18.1.2655

Harry, B., Sturges, K. M. & Klingner, J. K. (2005). Mapping the Process: An Exemplar of Process and Challenge in Grounded Theory Analysis. *Educational Researcher*, 34, 3-13. https://doi.org/10.3102%2F0013189X034002003

Harvey, C. (2011). Legislative hegemony and nurse practitioner practice in rural and remote Australia. *Health Sociology Review*, 20, 269-280. https://doi.org/10.5172/hesr.2011.20.3.269

Harvey, C., Papps, E. & Roberts, J. (2015). Obstacles that prevent nurse practitioners in New Zealand fulfilling their roles. *Primary Health Care*. 25, 5, 24-29. http://dx.doi.org/10.7748/phc.25.5.24.e935

Heale, R. & Rieck Buckley, C. (2015). An international perspective of advanced practice nursing regulation. International *Nursing Review*, 62, 421-429. https://doi.org/10.1111/inr.12193

Health Service Executive. (2020) *National Guideline for the Development of Advanced Nursing or Midwifery Practitioner Services.* Dublin: Office of the Nursing and Midwifery Services Director (ONMSD) and Health Service Executive (HSE).

Health Service Executive. (2018) *Review of Role and Function of Healthcare Assistants.* Health Service Executive: Dublin. https://www.hse.ie/eng/staff/resources/hrstrategiesreports/health-care-assistant-review-final-report-2018.pdf

Heap, J. L. (1981). Hugh Mehan, Learning lessons: Social organization in the classroom, Cambridge, Mass.: Harvard University Press, 1979. Pp. 227.1. *Language in Society*, 10, 279-282.

Heifetz, R., Grashow, A. and Linksy, M. (2009). *The Practice of Adaptive Leadership*. Harvard Business Review Press: Boston, MA.

Higgins, A., Begley, C., Lalor, J., Coyne, I., Murphy, K. & Elliott, N. (2014). Factors influencing advanced practitioners' ability to enact leadership: a case study within Irish healthcare. *Journal of Nursing Management*, 22, 894-905. https://doi.org/10.1111/jonm.12057

Hodges, B. D., Kuper, A. & Reeves, S. (2008). Qualitative Research: Discourse Analysis. *British Medical Journal*, 337, 570-572. https://doi.org/10.1136/bmj.a879

Holland, D., Skinner, D., Lachiotte, W. & Cain, C. (2001). *Identity and Agency in Cultural Worlds,* Cambridge, MA, Harvard University Press.

Hollinghurst, S., Horrocks, S., Anderson, E. & Salisbury, C. (2006). Comparing the cost of nurse practitioners and GPs in primary care: modelling economic data from randomised trials. *British Journal of General Practice*, 56, 530-535.

Holm, S. (2011). Final responsibility for treatment choice: the proper role of medical doctors? *Health Expectations*, 14, 2, 201-209. https://doi.org/10.1111/j.1369-7625.2011.00673.x

Holstein, J. A. & Gubrium, J. F. (2007). Active interviewing. In: Silverman, D. (ed.) *Qualitative Research: Theory, Method and Practice.* London: Sage.

Hoff, T., Carabetta, S. & Collinson, G.E. (2019). Satisfaction, burnout, and turnover among nurse practitioners and physician assistants: A review of the empirical literature. *Medical Care Research and Review*. 76, 1, 3-31. https://doi.org/10.1177%2F1077558717730157

Hooker, R., Nicholson, J. & Le, T. (2009). Does the Employment of Physician Assistants and Nurse Practitioners Increase Liability? *Journal of Medical Licensure and Discipline,* 95,2, 6-16. http://dx.doi.org/10.30770/2572-1852-95.2.6

Hoskins, R. (2012). Interprofessional working or role substitution? A discussion of the emerging roles in emergency care: Interprofessional working in emergency care. *Journal of Advanced Nursing*, 68, 1894-1903. https://doi.org/10.1111/j.1365-2648.2011.05867.x

Houghton, C., Murphy, K., Meehan, B., Thomas, J., Brooker, D. & Casey, D. (2017). From screening to synthesis: using nvivo to enhance transparency in qualitative evidence synthesis. *Journal of Clinical Nursing*, 26, 873-881. https://doi.org/10.1111/jocn.13443

Htay, M. & Whitehead, D. (2021). The effectiveness of the role of advanced nurse practitioners compared to physician-led or usual care: A systematic review. International *Journal of Nursing Studies Advances*, 3, 100034. https://doi.org/10.1016/j.ijnsa.2021.100034

Hughes, D. & Dumont, K. (1993). Using Focus Groups to Facilitate Culturally Anchored Research. *American Journal of Community Psychology*, 21, 775-806. https://psycnet.apa.org/doi/10.1007/BF00942247

Ingersoll, G. L., McIntosh, E. & Williams, M. (2000). Nurse-sensitive outcomes of advanced practice. *Journal of Advanced Nursing*, 32, 1272-1281. https://doi.org/10.1046/j.1365-2648.2000.01598.x

Institute of Medicine. (2011). T*he future of nursing: Leading change, advancing health*, Washington D.C., The National Academies Press.

International Council of Nurses (2002). *International Council of Nurses: Definition and characteristics for nurse practitioners/advanced practice roles* [official position paper]. Switzerland, International Council of Nurses.

International Council of Nurses. (2017). *International Council of Nursing* [Online]. Available: http://www.icn.ch. [Accessed 17 September 2017].

Irish Medical Organisation (2017). *Submission to the Department of Health on Draft Policies to Enhance Roles for Nurses and Midwives*. Dublin, Irish Medical Organisation.

Irish Nursing and Midwives Organisation. (2021). *Psychological Impact of COVID-19 on Nurses and Midwives in Ireland 2021*. Irish Nursing and Midwives Organisation.

Jakimowicz, M., Williams, D. & Stankiewicz, G. (2017). A systematic review of experiences of advanced practice nursing in general practice. *BMC nursing*, 16, 6, 1-13. 10.1186/s12912-016-0198-7

Janssen M. (2016) *Situated Novelty: A study on healthcare innovation and its governance,* Erasmus University Rotterdam.

Jauhar, S. (2014) Nurses are not doctors. [Online]. Available: https://www.nytimes.com/2014/04/30/opinion/nurses-are-not-doctors.html *The New York Times.*

Jennings, N., Clifford, S., Fox, A. R., O'Connell, J. & Gardner, G. (2015) The impact of nurse practitioner services on cost, quality of care, satisfaction and waiting times in the emergency department: A systematic review. *International Journal of Nursing Studies*, 52, 1, 421-435. https://doi.org/10.1016/j.ijnurstu.2014.07.006

Jennings, N., O' Reilly, G., Lee, G., Cameron, P., Free, B. & Bailey, M. (2008). Evaluating outcomes of the emergency nurse practitioner role in a major urban emergency department, Melbourne, Australia. *Journal of Clinical Nursing*, 17, 1044-1050. https://doi.org/10.1111/j.1365-2702.2007.02038.x

Joel, L. A. (2009). *Advanced practice nursing: essentials for role development,* Philadelphia, F.A. Davis.

Jokiniemi, K., Pietilä, A.-M., Kylmä, J. & Haatainen, K. (2012). Advanced nursing roles: A systematic review. *Nursing & Health Sciences*, 14, 421-431. https://doi.org/10.1111/j.1442-2018.2012.00704.x

Jones, A., Powell, T., Watkins, D. & Kelly, D. (2015). Realising their potential? Exploring interprofessional perceptions and potential of the advanced practitioner role: a qualitative analysis. *British Medical Journal Open*, 9, 5, 12. https://doi.org/10.1136/bmjopen-2015-009740

Jones, M. L. (2005). Role development and effective practice in specialist and advanced practice roles in acute hospital settings: systematic review and meta-synthesis. *Journal of Advanced Nursing*, 49, 191-209. https://doi.org/10.1111/j.1365-2648.2004.03279.x

Jŗgensen, M. & Phillips, L. (2010). *Discourse analysis as theory and method*, London, SAGE.

Kalim, K., Carson, E. & G. Cramp, D. (2004). The role of soft systems methodology in healthcare policy provision and decision support. *2004 IEEE International Conference on Systems, Man and Cybernetics* (IEEE Cat No. 04CH37583), 2004, 5025-30, 6. https://doi.org/10.1109/ICSMC.2004.1400989

Karlberg, M. (2005). The Power Of Discourse And The Discourse Of Power: Pursuing Peace Through Discourse Intervention. *International Journal of Peace Studies*, 10, 1-25. https://www.jstor.org/stable/41852070

Katz, D. & Kahn, R. L. (1978). *The social psychology of organisations*, New York, Wiley.

Kelly, J., Fealy, G. M. & Watson, R. (2012). The image of you: constructing nursing identities in YouTube. *Journal of Advanced Nursing*, 68, 1804-1813. https://doi.org/10.1111/j.1365-2648.2011.05872.x

Kenny, C. (2015). Why has Ireland lost so many doctors and nurses? *The Irish Times* [Online]. Available: https://www.irishtimes.com/news/health/why-has-ireland-lost-so-many-doctors-and-nurses-1.2343477 [Accessed 20th September 2017].

Kerr, L. & Macaskill, A. (2020). Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity: A narrative inquiry. *Journal of Advanced Nursing.* 76, p.1201-1210. https://doi.org/10.1111/jan.14314

Kerrigan, J. (2007). Hospital unveils new A&E. [Online]. Available: https://www.irishexaminer.com/search/?cosearch=Hospital+unveils+new+A *Irish Examiner.*

Kilpatrick, K., Kaasalainen, S., Donald, F., Reid, K., Carter, N., Bryant-Lukosius, D., Martin-Misener, R., Harbman, P., Marshall, D. A., Charbonneau-Smith, R. & Dicenso, A. (2014). The effectiveness and cost-effectiveness of clinical nurse specialists in outpatient roles: a systematic review: Cost-effectiveness of outpatient CNSs. *Journal of Evaluation in Clinical Practice*, 20, 1106-1123. https://doi.org/10.1111/jep.12219

Kostas-Polston, E. A., Thanavaro, J., Arvidson, C. & Taub, L. (2015). Advanced practice nursing: Shaping health through policy. *Journal of the American Association of Nurse Practitioners*, 27, 11-20. https://doi.org/10.1002/2327-6924.12192

Kress, G. & Van Leeuwen, T. 2001. *Multimodal Discourse: The Modes and Media of Contemporary Communication,* London, Hodder Education.

Krueger, R. A. (1998). *Analyzing & reporting focus group results*, London, SAGE.

Krueger, R. A. & Casey, M. A. (2014). *Focus groups: a practical guide for applied research*, (5th ed.), London, SAGE.

Land, L. (1994). Problem solving using soft systems methodology. *British Journal of Nursing*, 3, 79-83. https://doi.org/10.12968/bjon.1994.3.2.79

Laperrière, H. (2008). Developing professional autonomy in advanced nursing practice: The critical analysis of socio-political variables. *International Journal of Nursing Practice*, 14, 391-397. https://doi.org/10.1111/j.1440-172x.2008.00700.x

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R. & Sibbald, B. (2005). Substitution of doctors by nurses in primary care. *The Cochrane Database of Systematic Reviews*, CD001271.

Laurant, M., van der Biezen, M., Wijers, N., Watananirun, K., Kontopantelis, E. & van Vught, A. J. (2019). Nurses as substitutes for doctors in primary care. *Cochrane database of systematic reviews.* 2019, 2. https://doi.org/10.1002/14651858.CD001271.pub3

Leary, A. [@alisonleary1]. (2021, January 25). *This is called #whitecoatwashing It's a form of #everydaysexism Medical colleagues can offer allyship by refusing to do this and telling the media to speak directly to nurses about nursing If we don't value expert #Nursing we will lose it. [Tweet].* Twitter. https://twitter.com/alisonleary1/status/1353629133444681729

Leary, A. [@alisonleary1]. (2020, August 15) *It is not illegal for anyone in the UK to call themselves a nurse or variants of such as advanced nurse practitioner, even with no nursing qualifications (registerable or otherwise). It is in other countries. [Tweet].* Twitter. https://twitter.com/alisonleary1/status/1294543103483936768

Leary, A. [@alisonleary1]. (2016, September 30) "*specialist nurse & further up the chain advanced nurse practitioner" how disappointing to see this portrayal [Tweet].* Twitter. https://twitter.com/alisonleary1/status/781820585026396161

Leedy, P. D. & Ormrod, J. E. (2010). *Practical research: Planning and design*, New Jersey, Prentice Hall.

Levy, Y. & Ellis, T. J. (2006). A systems approach to conduct an effective literature review in support of information systems research. Informing Science: the International *Journal of an Emerging Transdiscipline*, 9, 181-212. http://dx.doi.org/10.28945/479

Lewy, L. (2010). The complexities of interprofessional learning/working: Has the agenda lost its way? *The Health Education Journal*, 69, 4. http://dx.doi.org/10.1177/0017896910363299

Li, J., Westbrook, J., Callen, J., Georgiou, A. & Braithwaite, J. (2013). The impact of nurse practitioners on care delivery in the emergency department: a multiple perspectives qualitative study. *BMC Health Services Research*, 13, 356-356. https://doi.org/10.1186/1472-6963-13-356

Lincoln, Y. S. & Denzin, N. K. (2005). *The SAGE handbook of qualitative research*, Thousand Oaks, SAGE Publications.

Ljungbeck, B. & Sjögren Forss, K. (2017). Advanced nurse practitioners in municipal healthcare as a way to meet the growing healthcare needs of the frail elderly: a qualitative interview study with managers, doctors and specialist nurses. *BMC Nursing.* 16, 63. https://doi.org/10.1186/s12912-017-0258-7

Lobiondo-Wood, G. & Haber, J. (2006*). Nursing research: methods and critical appraisal for evidence-based practice,* St. Louis, Mosby Elsevier.

Lovink, M.H., Persoon, A., Finnema, E., Francke, A.L., Schoonhoven, L., Holle, D., Palm, R. & Backhaus, R. (2021) Who is that nurse?: Transferring knowledge requires clarity about professional titles, International *Journal of Nursing Studies*, 113. https://doi.org/10.1016/j.ijnurstu.2020.103805

Lowe, G. (2017). Nurse Practitioners: Framing their professional identity. *Journal for Nurse Practitioners,* 13, 175. https://doi.org/10.1016/j.nurpra.2016.12.021

Lowe, G., Plummer, V., O' Brien, A. P. & Boyd, L. (2012). Time to clarify – the value of advanced practice nursing roles in health care*. Journal of Advanced Nursing*, 68, 677-685. https://doi.org/10.1111/j.1365-2648.2011.05790.x

Luck, L., Jackson, D. & Usher, K. (2006). Case study: a bridge across the paradigms. *Nursing Inquiry*, 13, 103-109. https://doi.org/10.1111/j.1440-1800.2006.00309.x

Maartje G.H. Niezen, M.G.H. & Mathijssen, J.J.P. (2014). Reframing professional boundaries in healthcare: A systematic review of facilitators and barriers to task reallocation from the domain of medicine to the nursing domain, *Health Policy*, 117, 2, 151-169. https://doi.org/10.1016/j.healthpol.2014.04.016

Maben, J. & Griffiths, P. (2008). *Nurses in Society: Starting the Debate*, London, National Nursing Research Unit.

MacDonald, M. (2003). *Exploring Media Discourse*, New York, Bloomsbury Academic.

Maclellan, L., Levett-Jones, T. & Higgins, I. (2017). The enemy within: Power and politics in the transition to nurse practitioner. *Nursing Plus Open*, 2, 1-7. https://doi.org/10.1016/j.npls.2016.01.003

MacLellan, L., Levett-Jones, T. & Higgins, I. (2017). The enemy within: Power and politics in the transition to nurse practitioner. *Nursing Plus Open.* 2**,** p.1-7. https://doi.org/10.1016/j.npls.2016.01.003

MacNamee, G. (2017). Sick and tired: Why Irelands' nurses are leaving in their droves [Online]. Available: https://www.thejournal.ie/irish-nurses-sick-and-tired-3181227-Jan2017/ *The Journal.* [Accessed 19th September 2017].

Maher, F. A. & Tetreault, M. K. T. (1994). *The feminist classroom*, New York, NY, Basic Books.

Markewitz, A. (2013). Nurse practitioners replacing young doctors: it works, but does it make sense? *European Journal of Cardio-Thoracic Surgery*, 43, 23. https://doi.org/10.1093/ejcts/ezs422

Marmot, M., Friel, S., Bell, R., Houweling, T. A. J. & Taylor, S. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet*, 372, 1661-1669. https://doi.org/10.1016/s0140-6736(08)61690-6

Marshall, B. K. (1992). *Teaching the postmodern: fiction and theory*, London, Routledge.

Martin-Misener, R., Harbman, P., Donald, F., Reid, K., Kilpatrick, K., Carter, N., Bryant-Lukosius, D., Kaasalainen, S., Marshall, D. A., Charbonneau-Smith, R. & DiCenso, A. (2015). Cost-effectiveness of nurse practitioners in primary and specialised ambulatory care: systematic review. *BMJ Open*, 5, 6. http://dx.doi.org/10.1136/bmjopen-2014-007167

Mason, J. (2002). *Qualitative researching*, London, SAGE.

Mason, M. K. (2018). *Foucault and his Panopticon* [Online]. Available: http://www.moyak.com/papers/michel-foucault-power.html [Accessed January 2nd 2018].

Maten-Speksnijder, A., Grypdonck, M., Pool, A., Meurs, P. & Staa, A. L. (2014). A literature review of the Dutch debate on the nurse practitioner role: efficiency vs. professional development. *International Nursing Review*, 61, 44-54. https://doi.org/10.1111/inr.12071

Maylone, M. M., Ranieri, L., Griffin, M. T. Q., McNulty, R. & Fitzpatrick, J. J. (2011). Collaboration and autonomy: Perceptions among nurse practitioners. *Journal of the American Academy of Nurse Practitioners*, 23, 51-57. https://doi.org/10.1111/j.1745-7599.2010.00576.x

McCarthy, M. (2020). Time to give nurses a greater share of responsibility. [Online]. Available: https://www.irishtimes.com/life-and-style/health-family/time-to-give-nurses-a-greater-share-of-responsibility-1.4240085?mode=sample&auth-failed=1&pw-origin=https%3A%2F%2Fwww.irishtimes.com%2Flife-and-style%2Fhealth-family%2Ftime-to-give-nurses-a-greater-share-of-responsibility-1.4240085 *The Irish Times.*

McCleery, E., Christensen, V., Peterson, K., Humphrey, L. & Helfand, M. (2011). *VA Evidence-based Synthesis Program Reports Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses. VA Evidence-based Synthesis Program Evidence Briefs.* Washington (DC): Department of Veterans Affairs (US).

McCloskey, R. (2008). A guide to discourse analysis. *Nurse Researcher*, 16, 24. https://doi.org/10.7748/nr2008.10.16.1.24.c6751

McDonnell A., Goodwin E., Kennedy F., Hawley K., Gerrish K. & Smith C. (2015). An evaluation of the implementation of Advanced Nurse Practitioner (ANP) roles in an acute hospital setting. *Journal of Advanced Nursing*. 71, 4, 789–799. https://doi.org/10.1111/jan.12558

McGlynn, B., White, L., Smith, K., Hollins, G., Gurun, M., Little, B., Clark, R., Nair, B., Glen, H., Ansari, J., Mahmood, R., Nairn, R., Balsitis, M., Chanock, D., Mclaughlin, G. & Meddings, R. (2014). A service evaluation describing a nurse-led prostate cancer service in NHS, Ayrshire and Arran. *International Journal of Urological Nursing*, 8, 166-180. http://dx.doi.org/10.1111/ijun.12049

McMurtry, A. (2007). Reinterpreting interdisciplinary health teams from a complexity science perspective. *University of Alberta Health Sciences Journal*, 4, 33-42.

McNamara, M. & Teeling, S.P. (2021). Introducing healthcare professionals to systems thinking through an integrated curriculum for leading in health systems. *Journal of Nursing Management*. 04/2021. https://doi.org/10.1111/jonm.13342

McNamara, M., Fealy, G.M., Casey, M., Geraghty, R., Johnson, M., Halligan, P., Treacy, P. & Butler, M. (2011) Boundary matters: clinical leadership and the distinctive disciplinary contributions of nursing to multidisciplinary care. *Journal of Clinical Nursing*. 20, 23-24, 3502-3512. https://doi.org/10.1111/j.1365-2702.2011.03719.x

McNamara, M. (2008). Of bedpans and ivory towers? Nurse academics' identities and the sacred and profane: A Bernsteinian analysis and discussion paper. International *Journal of Nursing Studies*, 45(3), 458–470. https://doi.org/10.1016/j.ijnurstu.2006.07.012

Mehan, H. & Wood, H. (1975). *The Reality of Ethnomethodology*, New Jersey, Wiley & sons.

Melby, V., Gillespie, M. & Martin, S. (2011). Emergency nurse practitioners: the views of patients and hospital staff at a major acute trust in the UK. *Journal of Clinical Nursing*, 20, 236-246. https://doi.org/10.1111/j.1365-2702.2010.03333.x

Merriam, S. (1998). *Qualitative Research and Case Study Applications in Education*, New Jersey, Wiley & sons.

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation,* San Francisco, CA, Jossey-Bass.

Millward, L. J. (2012). Focus groups. In: Breakwell, G. M., Hammond, S. & Fife-Schaw, C. (eds.) *Research Methods in Psychology*. 4th ed. London: Sage.

Mishler, E. (1984). *The Discourse of Medicine: Dialectics of Medical Interviews*, Norwood, New Jersey, Ablex.

Moore, A. (2008). Historic day as nurse prescribers graduate. *World of Irish Nursing*. Ireland.

Moore, J. & McQuestion, M. (2012). The Clinical Nurse Specialist in Chronic Diseases. *Clinical Nurse Specialist,* 26, 149-163. https://doi.org/10.1097/nur.0b013e3182503fa7

Morgan, D. L. (1997). *Focus groups as qualitative research,* London, SAGE.

Morgan, D. L. (1998). *The focus group guidebook,* London, SAGE.

Morin, K. H. (2013). Value of a Pilot Study. *Journal of Nursing Education*, 52, 547-548. https://doi.org/10.3928/01484834-20130920-10

Morse, J. M., Barrett, M., Mayan, M., Olson, K. & Spiers, J. (2002). Verification Strategies for Establishing Reliability and Validity in Qualitative Research. International *Journal of Qualitative Methods*, 1, 13-22. http://dx.doi.org/10.1177/160940690200100202

Mudiwa, L. (2016). Serious shortage of doctors [Online} Available: https://www.imt.ie/news/serious-shortage-of-doctors-imo-25-08-2016/ *Irish Medical Times*. [Accessed January 2nd 2018].

Mundinger, M. O., Kane, R. L., Lenz, E. R., Totten, A. M., Tsai, W.-Y., Cleary, P. D., Friedewald, W. T., Siu, A. L. & Shelanski, M. L. (2000). Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial. *Journal of the American Medical Association* 283, 59-68. https://doi.org/10.1001/jama.283.1.59

Mustafa, M., Adams, S., Bareham, C. & Carryer, J. (2021). Employing nurse practitioners in general practice: an exploratory survey of the perspectives of managers. *Journal of Primary Health Care,* 13, 3, 274-282. https://doi.org/10.1071/hc21036

Nardi, D. A. & Diallo, R. (2014). Global trends and issues in APN practice: engage in the change. *Journal of Professional Nursing*, 30, 228-232. https://doi.org/10.1016/j.profnurs.2013.09.010

National Council for the Professional Development of Nursing and Midwifery (2007). *Framework for the Establishment of Advanced Nurse Practitioner and Advanced Midwife Practitioner Posts*. Dublin.

Nelson, S. & Gordon, S. (2004). The rhetoric of rupture: Nursing as a practice with a history? *Nursing Outlook*, 52, 255-261. https://doi.org/10.1016/j.outlook.2004.08.001

Newhouse, R. P., Stanik-Hutt, J., White, K. M., Johantgen, M., Bass, E. B., Zangaro, G., Wilson, R. F., Fountain, L., Steinwachs, D. M., Heindel, L. & Weiner, J. P. (2011). Advanced practice nurse outcomes 1990-2008: a systematic review. *Nursing Economic*, 29, 230-50.

Ng, K.[@kenrickng1] (2021, February 10). *Reminds me of that panel a couple of weeks ago which discussed nursing, but composed mainly of doctors (shocking!)...im sure my GSTT colleagues would agree on importance of CNS involvement in research (esp in these areas)...hope we can work together cross-site at some point :)).* [Tweet]. Twitter. https://twitter.com/Kenrickng1/status/1359429545435217927

Ng, H., & Cockburn, H. (2020). 'They're not even counting the nurses': Health chief challenges Matt Hancock on coronavirus impact as more NHS staff die. Independent [Online]. Available: https:// www.independent.co.uk/news/uk/home-news/coronavirus-matt- hancock-question-time-bbc-video-nurses-deaths-a9446076.html [Accessed16th April 2020].

Nightingale, F. (1860). *Notes on nursing: what it is, and what it is not,* London, Harrison.

Norris, T. & Melby, V. (2006). The Acute Care Nurse Practitioner: challenging existing boundaries of emergency nurses in the United Kingdom. *Journal of Clinical Nursing*, 15, 253-263. https://doi.org/10.1111/j.1365-2702.2006.01306.x

Nursing Midwifery Board of Ireland (2017). *Advanced Practice (Nursing) Standards and Requirements.* Dublin: Nursing Midwifery Board of Ireland.

Ní Sheaghdha, P. (2019). *Over 1,300 nursing and midwifery posts left vacant*. [Online]. Available: https://inmo.ie/Home/Index/217/13517#:~:text=1%2C317%20funded%20nursing%20and%20midwifery,vacancies%20out%20of%2017%2C623%20posts. [Accessed 12th December 2019].

O' Connor, L., Casey, M., Smith, R., Fealy, G. M., Brien, D. O., O' Leary, D., Stokes, D., McNamara, M. S., Glasgow, M. E. & Cashin, A. (2018). The universal, collaborative and dynamic model of specialist and advanced nursing and midwifery practice: A way forward? *Journal of Clinical Nursing,* 27, 5-6. https://doi.org/10.1111/jocn.13964

O' Shea Y. 2008. *Nursing and midwifery in Ireland: A strategy for professional development in a changing health service*, Dublin, Blackhall.

O' Regan, H. (2010) 'Rapid Injury Clinic to reduce patient waiting time', *Irish Independent* (Accessed: 16 Feb 2021).

Ochs, E. (1979) Transcription as theory in Ochs, E. & Schieffelin, B. (eds) *Developmental Pragmatics*. New York, Academic Press.

Office of the Nursing and Midwifery Services Director. (2022). *E-mail to Wayne Thompson*, 23 February 2022

Organisation for Economic Co-operation and Development (2015). *Health at a Glance* [Online]. Available: https://www.oecd.org/ireland/Health-at-a-Glance-2015-Key-Findings-IRELAND.pdf [Accessed 4th March 2018].

Onwuegbuzie, A. & Frels, R. (2014). A Framework for Using Discourse Analysis for the Review of the Literature in Counselling Research. *Counselling Outcome Research and Evaluation*, 5, 1. http://dx.doi.org/10.1177/2150137813515905

Onwuegbuzie, A. J., Dickinson, W. B., Leech, N. L. & Zoran, A. G. (2009). A Qualitative Framework for Collecting and Analyzing Data in Focus Group Research. International *Journal of Qualitative Methods*, 8, 1-21. http://dx.doi.org/10.1177/160940690900800301

Oshry, B. (2020). What lies beneath. *Organisation Development Journal.* Autumn. 38, 3, p.11-32.

Oshry, B. (2019). *The Organic Systems Framework: A new paradigm for understanding and intervening in organisational life*. Axminster: Triarchy Press.

Oshry, B. (2018). *Context Context Contex*t, Axminster, Triarchy Press.

Oshry, B. (1999). *Leading Systems: Lessons from the Power Lab*. San Francisco: Berrett-Koehler Publishers Limited.

Oshry, B. (2007). *Seeing systems: unlocking the mysteries of organizational life,* San Francisco, Calif, Berrett-Koehler Publishers.

Oxtoby, K. (2016). Nurse prescribing: 10 years on. *Nurse Prescribing*, 14, 448-449. https://doi.org/10.12968/npre.2016.14.9.448

Oxtoby, K. (2010). Consultation times. *British Medical Journal*. 340, 2554. https://doi.org/10.1136/bmj.c2554

Paina, L. & Peters, D. H. (2012). Understanding pathways for scaling up health services through the lens of complex adaptive systems. *Health Policy And Planning*, 27, 365-373. https://doi.org/10.1093/heapol/czr054

Paltridge, B. 2012. *Discourse analysis: an introduction*, London, Bloomsbury.

Pangbourne, K. (2013). *The Research Journey: Introduction to Inquiry*, New York, The Guilford Press.

Paniagua, H. (2011). Advanced nurse practitioners and GPs: what is the difference? *Practice Nursing*, 22, 383-388. https://doi.org/10.12968/pnur.2011.22.7.383

Parahoo, K. (2014). *Nursing research: principles, process and issues*, Basingstoke, Palgrave Macmillan.

Parker, I. & Burman, E. (1993). Against discursive imperialism, empiricism and constructionism: Thirty-two problems with discourse analysis. In: Burman, E. (ed.) *Discourse analytic researcher: Repertoires and readings of texts in action*. London: Routledge.

Patton, M. Q. (2002). *Qualitative research & evaluation methods*, Thousand Oaks, Sage.

Pawson, R. & Tilley, N. (1997). *Realistic evaluation*, London, SAGE.

Perraud, S., Delaney, K. R., Carlson-Sabelli, L., Johnson, M. E., Shephard, R. & Paun, O. (2006). Advanced Practice Psychiatric Mental Health Nursing, Finding Our Core: The Therapeutic Relationship in 21st Century. *Perspectives in Psychiatric Care*, 42, 215-226. https://doi.org/10.1111/j.1744-6163.2006.00097.x

Peters, D. H. (2014). The application of systems thinking in health: why use systems thinking? *Health research policy and systems / BioMed Central*, 12, 51. https://doi.org/10.1186/1478-4505-12-51

Phillips, N. & Hardy, C. (2002). *Discourse analysis: investigating processes of social construction*, Thousand Oaks, CA, Sage.

Phillips, R. L., Jr., Harper, D. C., Wakefield, M., Green, L. A. & Fryer, G. E., Jr. (2002). Can nurse practitioners and physicians beat parochialism into plowshares? *Health Affairs*, 21, 133-142. https://doi.org/10.1377/hlthaff.21.5.133

Phillips, S. (2007). NPs Face Challenges in the U.S. and the UK. *The Nurse Practitioner,* 32, 25-29. https://doi.org/10.1097/01.npr.0000279568.08819.05

Pierson, J. (2004). *Producing Welfare. A Modern Agenda. Community Care*. Sutton: Reed Business Information UK.

Plummer-D'Amato, P. (2008). Focus group methodology Part 1: Considerations for design. *International Journal of Therapy and Rehabilitation*, 15, 69-73. http://dx.doi.org/10.12968/ijtr.2008.15.2.28189

Poghosyan, L., Lucero, R., Rauch, L. & Berkowitz, B. (2012). Nurse practitioner workforce: a substantial supply of primary care providers. *Nursing Economic*, 30, 268.

Polit, D. F. & Beck, C. T. (2011). *Nursing research: generating and assessing evidence for nursing practice*, London, Lippincott Williams & Wilkins.

Potter, J. (1996). *Representing reality: discourse, rhetoric and social construction*, London, SAGE.

Potter, J. (1997). Discourse Analysis as a Way of Analysing Naturally Occurring Talk. In: Silverman, D. (ed.) *Qualitative Research: Theory, Method and Practice*. London: Sage.

Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: beyond attitudes and behaviour,* London, Sage.

Power and Systems. (2018). *Maximise your people power* [Online]. Available: https://www.powerandsystems.com/ [Accessed September 19, 2020].

Power, R. & Phillips, K. (2017). *Not so Minor Injuries.* ANP Regional Conference, 2017 University Hospital Waterford.

Pugsley, L. (1996). Focus groups, young people and sex education. In: Pilcher, J. & Coffey, A. (eds.) *Gender and Qualitative Research*. Avebury: Aldershot.

Pulcini, J., Jelic, M., Gul, R. & Loke, A. Y. (2010). An international survey on advanced practice nursing education, practice, and regulation. *Journal of Nursing Scholarship*, 42, 31-39. https://doi.org/10.1111/j.1547-5069.2009.01322.x

QRS International Pty Ltd. (2018). *NVivo (Version 12)*. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Rafferty, A.M. (2014). Good to meet you…Anne Marie Rafferty. The Guardian [Online]. Available: https://www.theguardian.com/theguardian/2014/jul/04/good-to-meet-you-anne-marie-rafferty [Accessed September 17 2017].

Rashotte, J. & Jensen, L. (2010). The Transformational Journey of Nurse Practitioners in Acute-Care Settings. *Canadian Journal of Nursing Research*, 42, 2, 70-91.

Rashotte, J. (2005). Knowing the nurse practitioner: dominant discourses shaping our horizons. *Nursing Philosophy*, 6, 51-62. https://doi.org/10.1111/j.1466-769x.2004.00199.x

Razavi, M., O'Reilly-Jacob, M., Perloff, J. and Buerhaus, P. (2021) Drivers of Cost Differences Between Nurse Practitioner and Physician Attributed Medicare Beneficiaries. *Medical Care*, 59, 2, 177-184. https://doi.org/10.1097/mlr.0000000000001477

Redmond, R. & Curtis, E. (2009). Focus groups: principles and process. *Nurse Researcher,* 16, 57. https://doi.org/10.7748/nr2009.04.16.3.57.c6946

Roberts, C. (2018). *Qualitative Research Methods*, London, Kings College London.

Rocco, T. S. & Plakhotnik, M. S. (2009). Literature Reviews, Conceptual Frameworks, and Theoretical Frameworks: Terms, Functions, and Distinctions. *Human Resource Development Review*, 8, 120-130. http://dx.doi.org/10.1177/1534484309332617

Roche, T. E., Gardner, G. & Jack, L. (2017). The effectiveness of emergency nurse practitioner service in the management of patients presenting to rural hospitals with chest pain: a multisite prospective longitudinal nested cohort study. *BMC Health Services Research*, 17, 1, 445-445. https://doi.org/10.1186/s12913-017-2395-9

Rogers, R., Malancharuvil-Berkes, E. & Mosley, M. (2005). Critical discourse analysis in education: A review of the literature. *Review of Educational Research*, 75, 365-416. https://doi.org/10.3102%2F00346543075003365

Royal College of Surgeons Ireland. (2010). *Evaluation of the role of the clinical nurse specialist in cancer care report*. Royal College of Surgeons Ireland.

Running, A., Hoffman, L. & Mercer, V. (2008). Physician perceptions of nurse practitioners: A replication study. *Journal of the American Academy of Nurse Practitioners*, 20, 429-433. https://doi.org/10.1111/j.1745-7599.2008.00339.x

Running, A., Kipp, C. & Mercer, V. (2006). Prescriptive patterns of nurse practitioners and physicians. *Journal of the American Academy of Nurse Practitioners*, 18, 228-233. https://doi.org/10.1111/j.1745-7599.2006.00120.x

Ryan, G. W. & Bernard, H. R. (2003). Techniques to Identify Themes. *Field Methods*, 15, 85-109. https://doi.org/10.1177%2F1525822X02239569

Ryder, M., Connolly, M., Kitson, A.L., Thompson, D.R. & Timmins, F. (2022) A critical discussion regarding the scholarly development of the nursing profession – a call to action. *Nurse Education Today*. 110. http://dx.doi.org/10.1016/j.nedt.2021.105249

Ryder, M. & Jacob, E. (2021) A translational research framework for nurse practitioners. *Journal of Nursing Management*, 1-27. https://doi.org/10.1111/jonm.13496

Ryder, M., Jacob, E. & Hendricks, J. (2020). An integrative review to identify evidence of nurse practitioner-led changes to health-care delivery and the outcomes of such changes. *International Journal of Nursing Practice*, 26, 6. https://doi.org/10.1111/ijn.12901

Ryder, M., Jacob, E. & Hendricks, J. (2019). An inductive qualitative approach to explore Nurse Practitioners views on leadership and research: An international perspective. *Journal of Clinical Nursing*, 28, 13-14, 2644-2658. https://doi.org/10.1111/jocn.14853

Safriet, B. J. (2002). Closing the gap between can and may in health-care providers' scopes of practice: a primer for policymakers. *Yale Journal on Regulation*, 19, 301.

Sandelowski, M., & Barroso, J. (2003). Classifying the findings in qualitative studies. *Qualitative Health Research*. 13, p.905–923. https://doi.org/10.1177/1049732303253488

Saunders, M., Lewis, P. & Thornhill, A. (2016). *Research methods for business students*, Harlow, Pearson Education Limited.

Savigny, D. & Adam, T. (2009). *Systems thinking for health systems strengthening*. World Health Organisation: Geneva.

Scanlon, A., Cashin, A., Bryce, J., Kelly, J. G. & Buckely, T. (2016). The complexities of defining nurse practitioner scope of practice in the Australian context. *Collegian*, 23, 1, 129-142. https://doi.org/10.1016/j.colegn.2014.09.009

Scanlon, A., Murphy, M., Tori, K. & Poghosyan, L. (2018). A national study of Australian nurse practitioners' organisational practice environment. *The Journal for Nurse Practitioners.* 14, 5, 414-418. https://doi.org/10.1016/j.nurpra.2018.01.003

Schadewaldt, V., McInnes, E., Hiller, J.E. & Gardner, A. (2013) Experiences of nurse practitioners and medical practitioners working in collaborative practice models in primary healthcare in Australia – a multiple case study using mixed methods. *BMC Family Practice*. 17, 99. https://doi.org/10.1186/s12875-016-0503-2

Schadewaldt, V., McInnes, E., Hiller, J.E. & Gardner, A. (2013) Views and experiences of nurse practitioners and medical practitioners with collaborative practice in primary health care – an integrative review. *BMC Family Practice*. 14, 132. http://dx.doi.org/10.1186/1471-2296-14-132

Schneider, F. (2013). *How to do a Discourse Analysis* [Online]. Available: http://www.politicseastasia.com/studying/how-to-do-a-discourse-analysis/ [Accessed 12th December 2017].

Schober, M. M. (2013*). Factors influencing the development of advanced practice nursing in Singapore*. PhD, Sheffield Hallam University.

Schram, T. H. (2006). *Conceptualising and proposing qualitative research*, Upper Saddle River, NJ, Pearson Merrill Prentice Hall.

Sibbald, B. (2008). Should primary care be nurse led? Yes. *British Medical Journal*, 4,337. https://doi.org/10.1136/bmj.39661.707083.59

Skinner, H., Skoyles, J., Redfearn, S., Jutley, R., Mitchell, I. & Richens, D. (2013). Advanced care nurse practitioners can safely provide sole resident cover for level three patients: impact on outcomes, cost and work patterns in a cardiac surgery programme. *European Journal of Cardio-Thoracic Surgery*, 43, 19-22. https://doi.org/10.1093/ejcts/ezs353

Slevin, O. D., McConnell, D. & McIlfatrick, S. J. (2013). Emergency nurse practitioners' perceptions of their role and scope of practice: Is it advanced practice? *International Emergency Nursing*, 21, 76. https://doi.org/10.1016/j.ienj.2012.03.004

Smith, J. L. (2007). Critical discourse analysis for nursing research. *Nursing Inquiry*, 14, 60-70. https://doi.org/10.1111/j.1440-1800.2007.00355.x

Soy, S. K. (1997). *The Case Study as a Research Method.* Unpublished paper: University of Texas at Austin.

Speer, S. A. (2002). 'Natural' and 'contrived' data: a sustainable distinction? *Discourse Studies*, 4, 511-525. https://doi.org/10.1177%2F14614456020040040601

Stake, R. E. (1995). *The art of case study research*. London, Sage.

Stake, R. E. (2006). *Multiple Case Study Analysis*, New York, Guilford.

Stanik-Hutt, J., Newhouse, R. P., White, K. M., Johantgen, M., Bass, E. B., Zangaro, G., Wilson, R., Fountain, L., Steinwachs, D. M., Heindel, L. & Weiner, J. P. (2013). The Quality and Effectiveness of Care Provided by Nurse Practitioners. *The Journal for Nurse Practitioners*, 9, 492-500. http://dx.doi.org/10.1016/j.nurpra.2013.07.004

Stanley, J. M. (2005). *Advanced practice nursing: emphasizing common roles*, Philadelphia, F.A. Davis.

Stasa, H., Cashin, A., Buckley, T. & Donoghue, J. (2014). Advancing advanced practice - clarifying the conceptual confusion. *Nurse Education Today*, 34, 356-361. https://doi.org/10.1016/j.nedt.2013.07.012

Stewart, A. (2014). Case study. In: MILLS, J. & BIRKS, M. (eds.) *Qualitative methodology: A practical guide*. Thousand Oaks, CA: Sage.

Street, D. & Cossman, J. S. (2010). Does familiarity breed respect? Physician attitudes toward nurse practitioners in a medically underserved state. *Journal of the American Academy of Nurse Practitioners*, 22, 431. https://doi.org/10.1111/j.1745-7599.2010.00531.x

Swan, M., Ferguson, S., Chang, A., Larson, E. & Smaldone, A. (2015). Quality of primary care by advanced practice nurses: a systematic review. *International Journal for Quality in Health Care*, 27, 396-404. https://doi.org/10.1093/intqhc/mzv054

Takase, M., Maude, P. & Manias, E. (2006). Impact of the perceived public image of nursing on nurses' work behaviour. *Journal of Advanced Nursing*, 53, 333-343. http://dx.doi.org/10.1111/j.1365-2648.2006.03729.x

Talja, S. (1999). Analyzing Qualitative Interview Data: The Discourse Analytic Method. *Library and Information Science Research*, 21, 459-477. https://doi.org/10.1016/S0740-8188(99)00024-9

Ten Have, P. (1999). *Doing conversation analysis: a practical guide*, London, SAGE.

Ten Hoeve, Y., Jansen, G. & Roodbol, P. (2014). The nursing profession: public image, self-concept and professional identity. A discussion paper. *Journal of Advanced Nursing*, 70, 295-309. https://doi.org/10.1111/jan.12177

Teo, P. (2000). Racism in the news: a Critical Discourse Analysis of news reporting in two Australian newspapers. *Discourse & Society*, 11, 7-49. https://doi.org/10.1177%2F0957926500011001002

Thompson, W. & Meskell, P. (2012). Evaluation of an Advanced Nurse Practitioner (Emergency Care)—An Irish Perspective. *The Journal for Nurse Practitioners*, 8, 200-205. http://dx.doi.org/10.1016/j.nurpra.2011.09.002

Tierney, W. G. (1995). (Re)presentation and voice. *Qualitative Inquiry*, 1, 379-390. https://doi.org/10.1177%2F107780049500100401

Tobin, G. & Begley, C. (2004). Methodological rigor within a qualitative framework. *Journal of Advanced Nursing*, 48, 388-96. https://doi.org/10.1111/j.1365-2648.2004.03207.x

Traynor, M. (2004). Discourse analysis. *Nurse Researcher*, 12, 2, 4-6. https://doi.org/10.7748/nr.12.2.4.s2

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. Primary Health Care*, 17, 31-31. https://doi.org/10.1111/j.1365-2648.2007.04275.x

Twycross, A., & Shorten, A. (2014). Service evaluation, audit and re- search: What is the difference? *Evidence-Based Nursing*. 17(3), 65–66. https://doi.org/10.1136/eb-2014-101871

Tye, C. C. & Ross, F. M. (2000). Blurring boundaries: professional perspectives of the emergency nurse practitioner role in a major accident and emergency department. *Journal of Advanced Nursing*, 31, 1089-1096. https://doi.org/10.1046/j.1365-2648.2000.01380.x

Ulrich, C. 2010. Who Defines Advanced Nursing Practice in an Era of Health Care Reform? *Clinical Scholars Review*, 3, 5-7. http://dx.doi.org/10.1891/1939-2095.3.1.5

Van Dijk, T. (1993). Principles of Critical Discourse Analysis. *Discourse & Society*, 4, 249-283. https://doi.org/10.1177%2F0957926593004002006

Van Dijk, T. (1994). Aims of Critical Discourse Analysis. *Discourse & Society*, 1, 17-27. https://doi.org/10.1177%2F0957926593004002006

Van Dijk, T. (1997a). *Discourse as Social Interaction*. Thousand Oaks, CA.

Van Dijk, T. (1997b). *Discourse as Structure and Process*, Thousand Oaks, CA, Sage.

Vaughn, S., Schumm, J. S. & Sinagub, J. (1996). *Focus Group Interviews in Education and Psychology*, Thousand Oaks, CA, Sage.

Vogel, S. & Draper-Rodi, J. (2017). The importance of pilot studies, how to write them and what they mean. *International Journal of Osteopathic Medicine*, 23, 2-3. https://doi.org/10.1016/j.ijosm.2017.02.001

Wall, M. (2016). *Government plans 'more attractive' career pathways for nurses* [Online]. Available: https://www.irishtimes.com/business/financial-services/government-plans-more-attractive-career-pathways-for-nurses-1.2906451 [Accessed 13th July 2018].

Wall, M. (2017). *Doctors oppose tackling GP shortage with nurse led clinics* [Online]. Available: https://www.irishtimes.com/news/health/doctors-oppose-tackling-gp-shortage-with-nurse-led-clinics-1.3216083 [Accessed September 17 2017].

Walsh, M. (1999). Nurses and nurse practitioners part 2: perspectives on care. *Nursing Standard,* 13, 36-40. https://doi.org/10.7748/ns.13.25.36.s62

Weiland, S. A. (2008). Reflections on independence in nurse practitioner practice. *Journal of the American Academy of Nurse Practitioners*, 20, 345-352. https://doi.org/10.1111/j.1745-7599.2008.00330.x

Weiland, T. J., Mackinlay, C. & Jelinek, G. A. (2010). Perceptions of nurse practitioners by emergency department doctors in Australia. *International Journal of Emergency Medicine*, 3, 271-278. https://doi.org/10.1007/s12245-010-0214-8

Wetherell, M., Taylor, S. & Yates, S. J. (2001). *Discourse theory and practice: a reader,* London, Sage in association with The Open University.

Wood, S. K. (2020). Keeping the Nurse in the Nurse Practitioner: Returning to Our Disciplinary Roots of Knowing in Nursing. *Advances in Nursing Science*, 43,1, 50-61. https://doi.org/10.1097/ans.0000000000000301

World Health Organisation (2010). *World Health Organisation Interim report on social determinants of health and the health divide in the European Region*. Geneva, World Health Organisation.

Wieder, D. L. & Pratt, S. (1990). On being a recognisable Indian among Indians In: Carbaugh, D. (ed.) *Cultural communication and intercultural contact*. Hillsdale, N.J.: Lawrence Erlbaum.

Wildemuth, B. M. & Wilkins Jordan, M. (2016). Focus groups. In: Wildemuth, B. M. (ed.) *Applications of Social Research Methods to Questions in Information and Library Science.* London: Pearson Education.

Wilkinson, J. (2007). *The New Zealand nurse practitioner polemic: A discourse analysis*. PhD, Massey University, Wellington.

Wilkinson, S. (2004). Focus groups research. In: Silverman, D. (ed.) *Qualitative Research: Theory, Method and Practice*. Thousand Oaks, CA: Sage.

Willetts, G. & Clarke, D. (2014). Constructing nurses' professional identity through social identity theory. *International Journal of Nursing Practice,* 20, 164-169. https://doi.org/10.1111/ijn.12108

Wilson, A. & Shifaza, F. (2008). An evaluation of the effectiveness and acceptability of nurse practitioners in an adult emergency department. *International Journal of Nursing Practice*, 14, 149-156. https://doi.org/10.1111/j.1440-172x.2008.00678.x

Wodak, R. (2001). The discourse-historical approach. In: Wodak, R. & Meyer, M. (eds.) *Methods of critical discourse analysis*. London: Sage.

Wodak, R. & Meyer, M. (2009a). Critical Discourse Analysis: History, Agenda, Theory, and Methodology 1. In: Wodak, R. & Meyer, M. (eds.) *Methods for Critical Discourse Analysis.* London: Sage.

Wodak, R. & Meyer, M. (2009b). *Methods of critical discourse analysis*, London, SAGE.

World Health Organisation. (2016). *Global strategic directions for strengthening nursing and midwifery 2016-2020.* World Health Organisation.

Yin, R. K. (2014). *Case study research: design and methods*, London, SAGE.

Yong, C. S. (2006). Task substitution: the view of the Australian Medical Association. *The Medical Journal of Australia*, 185, 27-8. https://doi.org/10.5694/j.1326-5377.2006.tb00446.x

Zainal, Z. (2007). Case study as a research method. *Journal of Jurnal Kemanusiaan*, 9, 1-6.

Zeeman, L. & Simons, L. (2011). An analysis of discourses shaping mental health practitioners. *Journal of Psychiatric and Mental Health Nursing*, 18, 712-720. https://doi.org/10.1111/j.1365-2850.2011.01721.x

Zikmund, W. G., Babin, B. J., Carr, J. C. & Griffin, M. (2010). *Business Research Methods,* Mason, Cengage Learning.

Zwijnenberg, N. C. & Bours, G. J. J. W. (2012). Nurse practitioners and physician assistants in Dutch hospitals: their role, extent of substitution and facilitators and barriers experienced in the reallocation of tasks. *Journal of Advanced Nursing,* 68, 1235-1246. https://doi.org/10.1111/j.1365-2648.2011.05823.x

Appendices

Appendix I Interview Schedule

INTERVIEW ON THE DISCOURSES IN CIRCULATION AROUND THE ANP ROLE

Interviewer's Guidelines

The main purpose of the interview is to understand the discourses in circulation around the role of the ANP and how these discourses discursively position and construct the professional identity of the ANP. The aim of the interview is to understand how ANPs are positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it. In order to do this I will be asking participants for open-ended descriptions of experiences they have had either working as an ANP, working with an ANP or interacting with an ANP.

Number of Interviews

Interview No.	Participants
1	ANP (Community)
2	ANP (Emergency)
3	Nursing (Project Officer, Department of Health)
4	Nursing (Director of Nursing)
5	Consultant (Emergency)
6	Registrar (Medical)
7	Consultant (Emergency)

The Interview Agenda

Item	Duration (estimate in minutes)
Introduction/Clarification of terms	5
Easy and non-threatening questions – experiences	20 – 25
Questioning of experiences	30 – 40
Wrap up of interview/Member check (providing member with an opportunity to verify their feelings/ideas)	5 – 10
Closing statements/Thanks	5

1. I will start off by introducing myself, and explaining why the interview is occurring. I will give a brief outline of how the interview will run. The explanation will read as follows:

   I am meeting you here today to discuss the role of the ANP in the Irish healthcare setting and how this role is being enabled and also constrained within the current healthcare structures. What we discuss here will remain confidential. I will start by asking you to describe very briefly an experience you have had working as/working with or interacting with an ANP. We will then go on to discuss some of these experiences in more detail. The entire interview will probably take about 1 and half hours. I have provided refreshments if you need something to drink or eat. I will tape the sessions but nothing you say on tape will be linked to you. I am taping the sessions because I need to have an accurate record of the discussions.

2. I will then invite the participant to introduce themselves and say a short word on:
   a. Who they are
   b. What is their own background

3. I will then start the discussion with the following opening sentence:

   Could you please describe your experience, good or bad, of working as/working with or interacting with an ANP?

4. After completion of the story, I will prompt the participant for more information using the following questions, if necessary and not covered by the participant:

   a. *What did you believe to be 'advanced' about the ANP role from your experience of working as/working with or interacting with an ANP?*
   b. *How do you believe the nursing aspect of the ANP role was realised/not realised?*
   c. *In your opinion, how do you think the ANP role came about? What was the key driver in introducing this role to the Irish health service?*
   d. *From your experience of working as/working with or interacting with ANPs, how do you think the health service understands and uses the ANP?*
   e. *From your experience of working as/working with or interacting with ANPs, how do you think the public and wider society understands the ANP role?*
   f. *Going forward, how do you think the ANP role can be better utilised in the Irish health service?*

5. I plan to intertextually weave excerpts from these repertoires into the focus group and interview conversations to encourage argumentative and dialogical engagement. Examples of these repertoires that will be used to stimulate conversation include:

- *ANPs have lost their nursing and caring identity and in turn are nurses practicing in doctors clothes, do you think that is fair?*
- *ANPs will never have the necessary skills to compete with their medical counterparts.*
- *ANPs will always require supervision and medics are the best to oversee this supervision.*
- *ANPs are not cost effective not a worthwhile investment.*

As I will also want to access what is spontaneously generated, I will need an open approach initially so that I can potentially generate other discourses. The focus will hopefully sharpen as the interaction progresses.

I will then provide a wrap up of the session and provide participants with an opportunity to verify their feelings/ideas.

7. I will finish the interview by thanking the participant

   Your stories have been very insightful and interesting. I would like to thank you for participation.

The 1 and a half hour time limit should be not followed strictly. If I see that the participant is enjoying the discussion, I will let it run for longer. In closing, I will ask if the participant was satisfied with the way the discussion ran and if they felt that they were able to say what they had wanted, bearing in mind that they could not keep going for much longer than an hour and a half.

Appendix II Focus Group Schedule

FOCUS GROUP ON THE DISCOURSES IN CIRCULATION AROUND THE ANP ROLE

Moderator's Guidelines

The main purpose of the focus group is to understand the discourses in circulation around the role of the ANP and how these discourses discursively position and construct the professional identity of the ANP. The aim of the focus group is to understand how ANPs are positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it. In order to do this I will be asking participants for open-ended descriptions of experiences they have had either working as an ANP, working with an ANP or interacting with an ANP.

Number of Focus Groups

Focus Group No.	Participant No.	Participants
1	6	Nursing Staff (mix of nurse managers and staff nurses)
2	4	ANPs (mix of speciality)
3	7	Multidisciplinary team (mix of ANP, nursing staff and allied health professionals)
4	5	ANPs (mix of speciality)

The Focus Group Agenda

Item	Duration (estimate in minutes)
Introduction/Clarification of terms	5
Warm up/Introduction of participants	5
Easy and non-threatening questions – experiences	20 – 25
Questioning of experiences	30 – 40
Wrap up of session/Member check (providing members with an opportunity to verify their feelings/ideas)	5 – 10
Closing statements/Thanks	5

1. I will start off by introducing myself and explaining why the focus group has been gathered. I will give a brief outline of how the focus group will be run. The explanation will read as follows:

We are meeting here today to discuss the role of the ANP in the Irish healthcare setting and how this role is being enabled and also constrained within the current healthcare structures. What we discuss here will remain confidential. I will start by asking you to describe very briefly an experience you have had working as/working with or interacting with an ANP. We will then go on to discuss some of these experiences in more detail. The entire session will probably take about 1 and half hours. I have provided refreshments if you need something to drink or eat. I will tape the sessions but nothing you say on tape will be linked to you. I am taping the sessions because I need to have an accurate record of the discussions.

2. I will then invite the members of the focus group to introduce themselves and say a short word on:
    a. Who they are
    b. What is their own background

3. I will then start the discussion with the following opening sentence:

    Now, very briefly, would each of you please describe your experience, good or bad, of working as/working with or interacting with an ANP? Who would like to start?

    I will make short notes on each story as they go through, to help me decide who will be selected for the more detailed story telling.

4. After everyone has completed their stories, I will indicate that I would like to focus on a few more stories in more detail. The selection of stories will be made according to the following principles: the stories should be diverse with respect to the different experiences of working with an ANP and how good or bad these experiences were.

    The stories that you have told are very interesting. I would now like us to focus on the details of a few of these stories. I would like start with X's story. X, could you please describe your experience again in a little more detail. While X is describing the experience, I would like everyone else in the group to think about what happened to X and how they would have felt in X's situation. After X has retold the story, I will ask some questions for clarification. I would then like to open up the discussion for the whole group to ask questions and make any comments on their reaction to X's experience. Once we have finished discussing X's experience, we will go on to discuss another story.

    Now, X, would you please start.

5. After completion of the first story, I will prompt the participant for more information using the following questions, if necessary and not covered by the participant:

a. *What did you believe to be 'advanced' about the ANP role from your experience of working as/working with or interacting with an ANP?*
b. *How do you believe the nursing aspect of the ANP role was realised/not realised?*
c. *In your opinion, how do you think the ANP role came about? What was the key driver in introducing this role to the Irish health service?*
d. *From your experience of working as/working with or interacting with ANPs, how do you think the health service understands and uses the ANP?*
e. *From your experience of working as/working with or interacting with ANPs, how do you think the public and wider society understands the ANP role?*
f. *Going forward, how do you think the ANP role can be better utilised in the Irish health service?*

6. I will then open the discussion to the rest of the group:

   Now, please would the rest of the group like to discuss their reaction to X's story.

   Once no more comments are forthcoming from the group, I will then move on to the next story and again prompt the participant for more information as above.

   I plan to intertextually weave excerpts from these repertoires into the focus group and interview conversations to encourage argumentative and dialogical engagement. Examples of these repertoires that will be used to stimulate conversation include:
   - *ANPs have lost their nursing and caring identity and in turn are nurses practicing in doctors clothes, do you think that is fair?*
   - *ANPs will never have the necessary skills to compete with their medical counterparts.*
   - *ANPs will always require supervision and medics are the best to oversee this supervision.*
   - *ANPs are not cost effective not a worthwhile investment.*

   As I will also want to access what is spontaneously generated, I will need an open approach initially so that I can potentially generate other discourses. The focus will hopefully sharpen as the interaction progresses.

   I will then provide a wrap up of the session and provide participants with an opportunity to verify their feelings/ideas.

7. I will close the session by thanking everyone for their participation in the focus group:

   Your stories have been very insightful and interesting. I would like to thank you all for participation.

The 1 and a half hour time limit should be not followed strictly. If I see that participants are enjoying the discussion, I will let it run for longer. In closing, I will ask if the group were satisfied with the way the discussion ran and if everyone felt that they were able to say what they had wanted, bearing in mind that they could not keep going for much longer than an hour and a half.

Appendix III Letter to Director of Nursing requesting permission to access the staff/site





Emergency Department
Wexford General Hospital
Newtown Road
Wexford

Director of Nursing Name
Address

Date

Dear [Name],

I would like to request permission to undertake a research study with nursing, medical and allied health professionals within your hospital. I have applied for Research Ethics Approval from the HSE [Name] Area and I am awaiting their decision.

I am undertaking research as part of a Doctor of Philosophy programme that I am undertaking at University College Dublin. My supervisor is Professor Martin McNamara (https://people.ucd.ie/martin.mcnamara). Working as an Advanced Nurse Practitioner (ANP) for the past ten years, I have always been intrigued as to how the role is perceived by my ANP, nursing and medical colleagues, and its positioning within the Irish health service. I would like to present a short synopsis of the proposed research study for your consideration.

The **working title** of the study is Discursive Positioning of the Advanced Nurse Practitioner in the Irish Healthcare System.

The main **aim** of my study is to understand how ANPs are positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it.

Employing a Critical Discourse Analytical (CDA) approach, the **key research questions** of my study are:

- What value does the ANP role bring to the healthcare system?
- How is the 'nursing' dimension of the ANP role realised?
- By and through what discourses have ANPs and the wider healthcare system come to know, understand, construct and utilise the ANP role?
- Considering the current discursive positioning of ANPs, what potentially significant issues might extant discourses be minimising or excluding?

Critically **reviewing the literature,** it is apparent that confusion concerning the role is still apparent and the professional identity of the ANP remains ambiguous. This

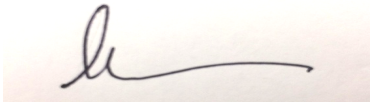
confusion has resulted in issues related to autonomy and professional practice boundaries in addition to resistance from medical and nursing colleagues. From an Irish perspective, there is a dearth of national literature concerning the positioning of ANPs in Irish health system structures as well as a scarcity of studies, nationally and internationally, that have adopted a discourse analytical approach to explore this area.

The **setting** chosen for my study is the Ireland East Hospital Group (IEHG) and the **sample** has been selected based on the research purpose and because they have knowledge or experiences that are helpful. Participants will include: Registered ANPs, nursing staff, medical staff, allied health professionals and nursing managers. I hope to undertake between three and five **focus groups** and six to eight **interviews** across the IEHG. Questions related to James Paul Gee's data analysis building tools will be used to interrogate the data.

I enclose the consent form and information leaflet for your perusal. If you require any additional information please do not hesitate to contact me, I can be contacted via telephone on 087-XXXXXX or email wayne.thompson@hse.ie.

I look forward to hearing from you at your convenience.

Yours sincerely,



Wayne Thompson
Registered Advanced Nurse Practitioner

Appendix IV Letter to the Clinical Director requesting permission to access the staff/site





Emergency Department
Wexford General Hospital
Newtown Road
Wexford

Clinical Director Name
Address

Date

Dear [Name],

I would like to request permission to undertake a research study with nursing, medical and allied health professionals within your hospital. I have applied for Research Ethics Approval from the HSE [Name] Area and I am awaiting their decision.

I am undertaking research as part of a Doctor of Philosophy programme that I am undertaking at University College Dublin. My supervisor is Professor Martin McNamara (https://people.ucd.ie/martin.mcnamara). Working as an Advanced Nurse Practitioner (ANP) for the past ten years, I have always been intrigued as to how the role is perceived by my ANP, nursing and medical colleagues, and its positioning within the Irish health service. I would like to present a short synopsis of the proposed research study for your consideration.

The **working title** of the study is Discursive Positioning of the Advanced Nurse Practitioner in the Irish Healthcare System.

The main **aim** of my study is to understand how ANPs are positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it.

Employing a Critical Discourse Analytical (CDA) approach, the **key research questions** of my study are:

- What value does the ANP role bring to the healthcare system?
- How is the 'nursing' dimension of the ANP role realised?
- By and through what discourses have ANPs and the wider healthcare system come to know, understand, construct and utilise the ANP role?
- Considering the current discursive positioning of ANPs, what potentially significant issues might extant discourses be minimising or excluding?

Critically **reviewing the literature,** it is apparent that confusion concerning the role is still apparent and the professional identity of the ANP remains ambiguous. This

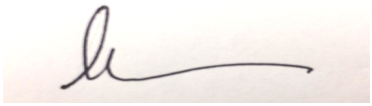
confusion has resulted in issues related to autonomy and professional practice boundaries in addition to resistance from medical and nursing colleagues. From an Irish perspective, there is a dearth of national literature concerning the positioning of ANPs in Irish health system structures as well as a scarcity of studies, nationally and internationally, that have adopted a discourse analytical approach to explore this area.

The **setting** chosen for my study is the Ireland East Hospital Group (IEHG) and the **sample** has been selected based on the research purpose and because they have knowledge or experiences that are helpful. Participants will include: Registered ANPs, nursing staff, medical staff, allied health professionals and nursing managers. I hope to undertake between three and five **focus groups** and six to eight **interviews** across the IEHG. Questions related to James Paul Gee's data analysis building tools will be used to interrogate the data.

I enclose the consent form and information leaflet for your perusal. If you require any additional information please do not hesitate to contact me, I can be contacted via telephone on 087-XXXXXX or email wayne.thompson@hse.ie.

I look forward to hearing from you at your convenience.

Yours sincerely,



Wayne Thompson
Registered Advanced Nurse Practitioner

Appendix V Letter to the General Manager requesting permission to access the staff/site





Emergency Department
Wexford General Hospital
Newtown Road
Wexford

General Manager Name
Address

Date

Dear [Name],

I would like to request permission to undertake a research study with nursing, medical and allied health professionals within your hospital. I have applied for Research Ethics Approval from the HSE [Name] Area and I am awaiting their decision.

I am undertaking research as part of a Doctor of Philosophy programme that I am undertaking at University College Dublin. My supervisor is Professor Martin McNamara (https://people.ucd.ie/martin.mcnamara). Working as an Advanced Nurse Practitioner (ANP) for the past ten years, I have always been intrigued as to how the role is perceived by my ANP, nursing and medical colleagues, and its positioning within the Irish health service. I would like to present a short synopsis of the proposed research study for your consideration.

The **working title** of the study is Discursive Positioning of the Advanced Nurse Practitioner in the Irish Healthcare System.

The main **aim** of my study is to understand how ANPs are positioned within current nursing and health system structures by making explicit the discourses that construct the ANP role and how they both enable and constrain it.

Employing a Critical Discourse Analytical (CDA) approach, the **key research questions** of my study are:

- What value does the ANP role bring to the healthcare system?
- How is the 'nursing' dimension of the ANP role realised?
- By and through what discourses have ANPs and the wider healthcare system come to know, understand, construct and utilise the ANP role?
- Considering the current discursive positioning of ANPs, what potentially significant issues might extant discourses be minimising or excluding?

Critically **reviewing the literature,** it is apparent that confusion concerning the role is still apparent and the professional identity of the ANP remains ambiguous. This

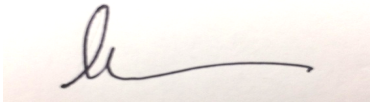
confusion has resulted in issues related to autonomy and professional practice boundaries in addition to resistance from medical and nursing colleagues. From an Irish perspective, there is a dearth of national literature concerning the positioning of ANPs in Irish health system structures as well as a scarcity of studies, nationally and internationally, that have adopted a discourse analytical approach to explore this area.

The **setting** chosen for my study is the Ireland East Hospital Group (IEHG) and the **sample** has been selected based on the research purpose and because they have knowledge or experiences that are helpful. Participants will include: Registered ANPs, nursing staff, medical staff, allied health professionals and nursing managers. I hope to undertake between three and five **focus groups** and six to eight **interviews** across the IEHG. Questions related to James Paul Gee's data analysis building tools will be used to interrogate the data.

I enclose the consent form and information leaflet for your perusal. If you require any additional information please do not hesitate to contact me, I can be contacted via telephone on 087-XXXXXX or email wayne.thompson@hse.ie.

I look forward to hearing from you at your convenience.

Yours sincerely,



Wayne Thompson
Registered Advanced Nurse Practitioner

Appendix VI Questions to use when working with Gee's (2014a) Tools of Inquiry

The Situated Meaning Tool

'For any communication, ask of words and phrases what situated meanings they have. That is, what specific meanings do listeners have to attribute to these words and phrases given the context and how the context is construed' (Gee, 2014a, p. 159)

The Social Language Tool

'For any communication, ask how it uses words and grammatical structures (types of phrases, clauses and sentences) to signal and enact a given social language. The communication may mix two or more social languages or switch between two or more' (Gee, 2014a, p. 167).

The Intertextuality Tool

'For any communication, ask how words and grammatical structures (e.g., direct or indirect quotation) are used to quote, refer to, or allude to other "texts" (that is, what others have said or written) or other styles of language (social languages)' (Gee, 2014a, p. 172).

The Figured World Tool

'For any communication, ask what typical stories or figured worlds the words and phrases of the communication are assuming and inviting listeners to assume. What participants, activities, ways of interacting, forms of language, people, objects, environments and institutions, as well as values, are in these figured worlds?' (Gee, 2014a, p. 177).

The Big 'D' Discourse Tool

'For any communication, ask how the person is using language, as well as ways of acting, interacting, believing, valuing, dressing, and using various objects, tools and technologies in certain sorts of environments to enact a specifically recognizable identity and engage in one or more socially recognizable activities. Even if all you have for data is language, ask what Discourse is this writer seeking to enact or get recognized. What sort of actions, interactions, values, beliefs and objects, tools, technologies, and environments are associated with this sort of language within a particular Discourse?' (Gee, 2014a, p. 186)

Conversation Tool

'For any communication, ask what issues, sides, debates and claims the communication assumes hearers or readers know or what issues, sides, debates and claims they need to know to understand the communication in terms of wider historical and social issues and debates' (Gee, 2014a, p. 204).

Appendix VII Questions to use when working with Gee's (2014a) Building Tasks

The Identities Building Tool

'For any communication, ask what socially recognizable identity or identities, the speaker is trying to enact or to get to others to recognize. Ask also how the speaker's language treats other people's identities, what sorts of identities the speaker recognizes for others in relationships to his or her own. Ask, too, how the speaker is positioning others, what identities the speaker is "inviting" them to take up' (Gee, 2014a, p. 116).

The Relationships Building Tool

'For any communication, ask how words and various grammatical devices are being used to build and sustain or change relationships of various sorts among the speaker, other people, social groups, culture, and / or institutions' (Gee, 2014a, p. 121).

The Politics (the distribution of social goods) Building Tool

'For any communication, ask how the words and grammatical devices are being used to construct what counts as a social good and to distribute this good to, or withhold it from, others' (Gee, 2014a, p. 128).

Sign Systems and Knowledge Building Tool

'For any communication, ask how the words and grammar being used privilege or de-privilege, specific sign systems (e.g., Spanish vs. English, technical language vs. everyday language, words vs images, etc.) or different ways of knowing or claims to knowledge and belief?' (Gee, 2014a, p. 142).

Please do not hesitate to contact me should you require any further information about my study or assurances additional to those given on the consent form. I would greatly appreciate your consent to be involved. I do hope that you will be able to take part, as your participation would add greatly to my research. I look forward to hearing from you.

I additionally enclose a consent form in which I ask you to indicate your willingness to participate in the study and a stamped addressed envelope for the purpose of returning the form to me.

The Advanced Nurse Practitioner Role in the Healthcare System: Your Thoughts?

Contact details:
Wayne Thompson RANP, RNP, RGN, MSc, MA, PGDip, DipHE.

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053 9153264

Wayne Thompson

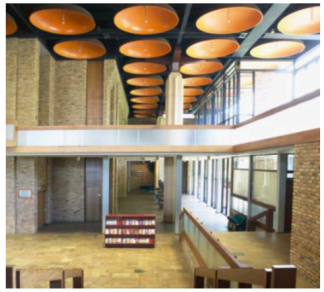
School of Nursing, Midwifery and Health Systems University College Dublin

Ireland East HOSPITAL GROUP

UCD DUBLIN



Appendix VIII Information Leaflet



The ANP role functions with 'one foot in medicine and one foot in nursing'

I am an Advanced Nurse Practitioner (ANP) working in the Emergency Department of Wexford General Hospital and I am currently a second-year PhD student with the School of Nursing, Midwifery and Health Systems, UCD Dublin. My supervisor is Professor Martin McNamara (https://people.ucd.ie/martin.mcnamara)

What is the research about? The working title of my study is: **Discursive Positioning of the Advanced Nurse Practitioner in the Irish Healthcare System**. The aim of this study is to gain an understanding of how ANPs are positioned within current nursing and health system structures by making clear the conversations and discussions that construct the ANP role and how they both facilitate and restrict it.

Why am I doing this research? I believe that by identifying the conversations and discussions that construct the ANP role, my research will contribute to the more effective utilisation of ANPs.

Why have you been invited to take part? I am keen to obtain the views of as wide a group of stakeholders as possible on the role of the ANP, therefore I have asked you to take part in this study as I believe your views can generate useful knowledge about ANPs.

How will your data be used? I propose, over the next number of months, to undertake focus groups/interviews involving representatives from nursing, medical, allied health and management backgrounds. The data obtained from these interviews will be used as part of my PhD project as well as being used in conference papers and posters and published journal articles.

How will your privacy be protected? I will ensure that no clues to your identity, e.g., name, occupation, grade, geographical location and employing institution will appear in this research study or any published material. Prior to commencing the focus group or interview, I will obtain informed consent from each participant. No names will be linked to any of the focus groups or interviews and no information obtained from the sessions will be reported in a manner that could possibly identify the partaker. To further protect your privacy, the transcribed material from the focus group or interview will be safely stored on an encrypted computer that will be password protected and only accessed by the researcher. On completion of this study, all transcribed data will be retained for a further five years and then destroyed.

In compliance with the requirements of **General Data Protections Regulations (GDPR)** all participants personal information will be; processed lawfully, fairly and in a transparent manner; collected for specified, explicit and legitimate purposes; adequate, relevant and limited to what is necessary; accurate and where necessary, kept up-to-date; retained only for as long as necessary; processed in an appropriate manner to maintain security. Further information can be found via the Data Protection Offices websites of either the Ireland East Hospital Group or UCD on https://www.hse.ie/eng/gdpr/data-protection/ or http://www.ucd.ie/gdpr/.

What will happen if you decide to take part in this study? I will contact you with provisional dates for focus groups or interviews. A date will be mutually confirmed and you will then take part in a focus group or interview. These focus groups or interviews will be digitally audio-recorded, take place in a mutually agreed location and last approximately 45 minutes to one hour.

What are the risks of taking part in this study? I do not envisage any negative consequences for you in taking part in this study. It is possible that talking about your experiences may cause some upset. At the end of the focus group or interview, I will discuss with you how you found the experience and how you are feeling. If you subsequently feel upset, I will provide contact details for further advice such as Occupational Health Services which can provide support for employees with both personal and work-related concerns.

What are the benefits of taking part in this study? I believe that by taking part you will provide an invaluable contribution to the advancement of research within this area.

Can you change your mind at any stage and withdraw from the study? Yes, you can change your mind and withdraw from the study at any stage prior to publication or PhD submission.

How will you find out what happens with this project?

If you agree to take part in the study, if desired, you will be provided with a short synopsis of the study's findings and conclusions.

The ANP role enables the health service to address emerging and future service needs (Department of Health, 2017)

Appendix IX Ethics Letter of Approval

UCD Office of Research Ethics

Roebuck Castle
University College Dublin
Belfield, Dublin 4, Ireland

T +353 1 716 8767

An Oifig Eitic Thaighde UCD

Caisleán an Ruabhoic
An Coláiste Ollscoile, Baile Átha Cliath
Belfield, Baile Átha Cliath 4, Éire

hrec@ucd.ie
www.ucd.ie/researchethics

February 12th, 2019

Mr Wayne Thompson
c/o Professor Martin McNamara
UCD School of Nursing, Midwifery & Health Systems
Belfield
Dublin 4

Re: **LS-19-03-Thompson-McNamara:** *Discursive Positioning of the Advanced Nurse Practitioner in the Irish Healthcare System*

Dear Mr Thompson

Thank you for your response to the Human Research Ethics Committee – Sciences (07/02/19). The Decision of the Committee is that **approval is granted** for this application which is subject to the conditions set out below.

Please note that **public liability insurance for this study has been confirmed** in accordance with our guidelines.[i]

Please note that approval is for the work and the time period specified in the above protocol and is subject to the following:

- Any amendments or requests to extend the original approved study will need to be approved by the Committee. Therefore you will need to submit by email the *Request to Amend/Extend Form*;
- Any unexpected adverse events that occur during the conduct of your research should be notified to the Committee. Therefore you will need to Submit, by email, an *Unexpected Adverse Events Report*;
- You or your supervisor (if applicable) are required to submit a signed *End of Study Report Form* to the Committee upon the completion of your study;
- This approval is granted on condition that you ensure that, in compliance with the Data Protection Acts 1988 and 2003, all data will be managed in accordance with your application and that you will confirm this in your *End of Study Report*;
- Please note that further **new** submissions from you may not be reviewed until any **End of Study Reports due** have been submitted to the Office of Research Ethics. That is, any earlier study that you received ethical approval for from the UCD HRECs;
- You may require copies of submitted documentation relating to this approved application and therefore we advise that you retain copies for your own records;

.../.

- Please note that the granting of this ethical approval is premised on the assumption that the research will be carried out within the limits of the law;
- Please also note that approved applications and any subsequent amendments are subject to a Research Ethics Compliance Review.

The Committee wishes you well with your research and look forward to receiving your End of Study Report. All forms are available on the website www.ucd.ie/researchethics please ensure that you submit the latest version of the relevant form. If you have any queries regarding the above please contact the Office of Research Ethics and please quote your reference in all correspondence.

Yours sincerely



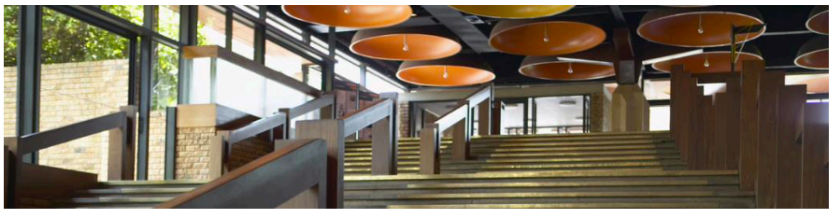
Mr T. John O'Dowd
Chairman, Human Research Ethics Committee - Sciences

[i] http://www.ucd.ie/researchethics/information_for_researchers/insurance/

Appendix X Consent Form

The Advanced Nurse Practitioner Role in the Healthcare System: Your Thoughts?

Wayne Thompson
School of Nursing, Midwifery and Health Systems
University College Dublin



Consent to Participate in Research Study

I have read the information leaflet and have had time to consider whether to take part in this study.

By ticking **yes** in the box below I agree to participate in a digitally audio-recorded focus group/interview with Wayne Thompson, a registered PhD student at the School of Nursing, Midwifery and Health Systems, UCD Dublin for his doctoral study provisionally entitled Discursive Positioning of the Advanced Nurse Practitioner in the Irish Healthcare System, in my capacity as a key informant selected through purposive sampling.

Yes ☐ No ☐

Please confirm your agreement with the following: (please tick appropriate box)

I agree that the data can be used in the publication of higher degrees, scientific publications, conference presentations, and for teaching purposes

Yes ☐ No ☐

I agree that the data collected may be used in future research projects in the same general field of research as the current one and to cases where the research ethics committee or another one competent to do so has approved the use of the data in such a further study :

Yes ☐ No ☐

Contact Details

Name of Participant (in block letters): _____

Phone Number: _____

Email address: _____

Signature: _____ Date:_____

Contact details:
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Newtown Road
Wexford
wayne.thompson@hse.ie
053 9153264