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# Constructing the advanced nurse practitioner identity in the healthcare system: A discourse analysis

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## Abstract

**Aims:** To explore how Advanced Nurse Practitioners (ANP) are positioned within current nursing and health system structures in Ireland by making explicit the discourses that construct ANPs' identities and how they both enable and constrain their roles.

**Background:** Ambiguity and confusion characterize debates about the ANP role having a profound impact on ANP identity and how they realize their roles. Without clear definitions, boundaries are difficult to ascertain, the full potential of the ANP is not realized and, consequently, ANPs are underutilized. Although this study is relevant outside Ireland's borders, it is of particular concern in the Irish setting as current policy aims to increase ANP numbers.

**Design:** A qualitative discourse analysis using Gee's Tools of Inquiry.

**Method:** Data were collected between April 2019 and January 2020 through seven in-depth interviews and four focus groups and analysed using Gee's Tools of Inquiry. Participants included ANPs, nurses, doctors and allied healthcare professionals.

**Findings:** Five key discourses emerged. Language-in-use established, first, that ANPs add value to the healthcare system and, second, highlighted the centrality of nursing to ANPs' identity. The third discourse builds an educated and skilled identity for ANPs, one that, however, lacked the expertise and influence of their medical colleagues. The fourth discourse constructs an identity for ANPs as medical substitutes, lesser roles, yet innovative additions to the system and a threat to existing structures. The final discourse constructs tensions between independence and autonomy, on the one hand, and control, on the other.

**Conclusion:** This study alerts healthcare professionals to ways in which discourses influence opinion and frame ANPs' identity. Healthcare professionals should challenge Conversations and Discourses that disparage the ANP role. 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.

**Impact:** By identifying and critiquing extant Discourses and Conversations, healthcare professionals, and health system leaders and managers will gain a better understanding of the issues that both enable and constrain the ANP role.

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## KEYWORDS

advanced nursing practice, advanced practice nursing, ANP, discourse analysis, nurse practitioner, tools of inquiry

## 1 | INTRODUCTION

Although relatively new to the Irish health system, the role of the Advanced Nurse Practitioner (ANP) has undergone significant transformation since its inception, transcending both nursing and medical domains. The literature shows that there is 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 identity of the ANP. Without definitional clarity, boundaries are difficult to ascertain, the full potential of the ANP role is not realized and, consequently, the ANP is underutilized. In addition to role confusion, marked resistance to the role from some quarters contributes to an identity crisis for the ANP that further limits the realization of their full potential in the health system.

### 1.1 | Background

The Irish Health Service Executive (HSE), 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 environment, hospitals have been facing difficulties staffing their departments with medical and nursing staff due to the shortage of junior doctors (Mudiwa, 2016) and moratoriums on the recruitment and promotion of nurses. The number of nurses and midwives registered with the Nursing Midwifery Board of Ireland (NMBI) stands at just over 78,000 with less than 0.5% ( $n = 421$ ) registered as an ANP or Advanced Midwife Practitioner (AMP). The Department of Health (2019) proposes that advanced nursing and midwifery practice will expand significantly within the next 5 years to 2% ( $n = 700$ ) of the nursing and midwifery workforce. Within the Ireland East Hospital Group (IEHG), of 4500 nursing and midwifery staff, there are 75 ANP/AMP positions and 24 candidate ANP/AMP positions, equating to 2.3% of the nursing and midwifery workforce (Gallagher, 2021).

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 quality and integrated patient care. Advanced nursing practice in Ireland is regulated by the Nursing and Midwifery Board of Ireland (NMBI) with a structured framework for advanced nurse practitioners. The framework is presented under the NMBI's six domains for advanced practice nursing; professional values and conduct; clinical decision-making; knowledge

#### Why is this research needed?

- Healthcare professionals need to be aware of how identities are socially constructed through Discourses and Conversations.
- Healthcare professionals need to be able to identify and counter Discourses and Conversations concerning the ANP role so that the role can develop and be used to its full potential to enhance healthcare provision.
- Ambiguity and confusion around the role and identity of the ANP role can limit ANPs' contribution to the health system. Sensitivity to the real-world effects language-in-use can help in achieving a shared understanding of the role and how it can align with and complement the roles of other healthcare professionals.

#### What were the main findings?

- Five key discourses revealed themselves in the discourse analysis: first, ANPs added considerable value to the healthcare system from both a monetary and non-monetary viewpoint; second, the centrality of nursing to ANPs' identity; next, the educated and skilled identity of the ANP; fourth, the ANP as a medical substitute – a lesser role, yet a disruptive innovation in the system and a threat to existing structures; and, finally, a discourse that constructs a tension between independence and autonomy, on the one hand, and control, on the other.

#### Where and on whom will the research have an impact?

- The research will have an impact on ANPs themselves, facilitating them to move from being regarded as a marginal and contested presence in the health system to an important and necessary innovation. By identifying and critiquing extant Discourses and Conversations, healthcare professionals, and health system leaders and managers will gain a better understanding of the issues that both enable and constrain the ANP role. This understanding enables Discourses and Conversations to be countered so that the ANP role can develop and be used to its full potential. Awareness of circulating Discourses and Conversations will enable educators, policymakers and regulators to develop strategies and programmes that recognize the real-world effects of the way language is used and will help in achieving a shared understanding of the role and how it can align with and complement other healthcare professionals.

and cognitive; communication and interpersonal; management and team; and leadership and professional scholarship (NMBI, 2017). The title of Advanced Nurse Practitioner is a protected title and is used for nurses practicing at an advanced level. In Ireland, the core concepts of the ANP are autonomy, expert practice, professional and clinical leadership, and research (Health Service Executive, 2020). ANPs are expert practitioners who function in a variety of roles. They can initiate an investigation and management plan and complete an episode of care leading to discharge or referral to an appropriate service as agreed in their scope of practice (the range of roles, functions, responsibilities and activities, which a registered nurse or registered midwife is educated, competent and has authority to perform; NMBI, 2015). Although ANPs work autonomously, they require medical consultants to supervise clinical practice and provide clinical support.

The roles have received strong multi-disciplinary and management support, which were seen as essential in their successful development and implementation. ANPs have found that they are located, 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 are themselves bounded (Lowe & Tori, 2017). This tenuous position can affect relationships and the interplay of nurses with other nurses, and with other health professionals within the healthcare system (Willets & Clarke, 2014).

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 an opportunity as it creates more room for manoeuvrability and creativity. It is timely, therefore, to examine how discourses position ANPs, the diverse influences that shape their role and how they integrate and negotiate them to construct meaningful and purposeful professional identities in a range of contexts.

## 2 | THE STUDY

### 2.1 | Aims

The aims were to explore how ANPs are positioned within current nursing and health system structures by making explicit the discourses that construct their role and how they both enable and constrain it. The research questions are as follows:

By analysing what is being constructed in, by and through language,

1. How do nursing, medical and other healthcare professionals describe the ANP from their vantage point of their own experience?
2. How does the language-in-use concerning ANPs enable and constrain their roles?

### 2.2 | Design

A discourse analysis using in-depth interviews and focus groups was undertaken to explore 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 work of James Paul Gee is categorized as critical discourse analysis and provides an approach that is embedded in a theory of language in-use in culture and society (Gee, 2004; Rogers et al., 2005). 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 recognizable identity (Gee, 2010). We use language to indicate a certain role or identity we have assumed here and now. Identity is defined as being recognized as a certain 'kind of person' in a given context (Gee, 2000, p. 100). The concept of role may similarly be defined as a particular image and 'contrived sense of self' that an individual wishes to convey to the world (Kivisto & Pittman, 2013, p. 299). 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)

When Gee uses the term 'Tools of Inquiry' he is referring to '...ways of looking at the world of talk and interaction' (Gee, 2011, p. 12). These tools are relevant to how we, together with others, build identities and activities and recognize the identities and activities that are being built around us. They are tools of inquiry in the sense that they lead us as discourse analysts to ask specific sorts of questions about our data. The tools are situated meanings, social languages, intertextuality, figured worlds, the big 'D' Discourse and big 'C' Conversations (Table 1).

### 2.3 | Participants

Theoretical purposive sampling was used to recruit healthcare professionals who could 'provide the most insightful information' related to the issue (Goebert & Rosenthal, 2002). The acute hospitals in Ireland are organized into seven hospital groups. The setting for this study is the Ireland East Hospital Group (IEHG), the largest of these groups. Participants were selected based on the premise that they will have worked with or were familiar with the ANP role and because they have knowledge or experiences that are helpful. Requests were made through the Directors of Nursing, Clinical Directors and General Managers 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 researchers agreeing to participate; fourteen ANPs, six staff

TABLE 1 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; for example, '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; for example, 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 recognize, 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 2 Participant key

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

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 11 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). ANPs and healthcare professionals not working in the IEHG were excluded from the study. See Table 2 for participant key:

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

## 2.4 | Data collection

All data were collected between April 2019 and January 2020. Data were collected through semi-structured, audio-recorded interviews

TABLE 3 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)

and focus groups that ranged from 42 to 84 min in duration. Seven interviews and four focus groups were undertaken. Interview participants and focus group composition are shown in Tables 3 and 4, respectively.

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 (Grønkvær et al., 2011), and as discourse analysis, according to Gee (2010), is also about interactions and enacting socially recognizable 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 allied health professionals due to poor response rate on their part, so for these participants, interviews were used. Examples of questions that were asked are:

- When people talk about the role of the ANP, they mention the extended or expanded role – what do you think people mean when they use these expressions?
- From your experience of working as/working with or interacting

TABLE 4 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 Classification of qualitative findings (Sources: Adapted from Sandelowski and Barroso's (2003, p. 908)

Closest to data	Thematic description		Farthest from data
Thematic survey	Thematic description		Interpretive explanation
Initial coding of texts into potentially theoretically relevant data units	Identification of patterns, relationships and connections among data units	Examination for instances of Gee's tools of inquiry	Theoretical account of patterns, relationships and connections in participants' language in use using Gee's Tools of Inquiry

➡Chronicling➡

Data sources: literature review, interviews and focus groups

with ANPs, how do you think the public and wider society understands the ANP role?

Debates and discourses that were identified from the extant literature pertaining to the ANP role were also intertextually weaved into the focus groups and interview conversations to encourage argumentative and dialogical engagement (McNamara, 2008).

Examples of these repertoires that were used to stimulate conversation included:

- ANPs have lost their nursing and caring identity and, in turn, are nurses practicing in doctor's clothes. How would you respond to this statement?
- ANPs will always require supervision and medics are the best to oversee this supervision. What is your view?

## 2.5 | Ethical considerations

The research ethics committee of the researchers' university approved the study. Ethical approval was also sought and granted from each of the hospital's research ethics committees. Informed consent was obtained from all participants. Names of organizations and individuals were removed from both the interview and the focus group transcripts prior to analysis.

## 2.6 | Data analysis

It is important to detail how the analytic process transformed raw data to arrive at an interpretation informed by the concepts and methods of CDA (Greckhamer et al., 2014). Interviews and focus groups were transcribed verbatim and checked by the researchers for accuracy against the original recordings. Interviews and focus

groups were analysed together. To aid with coding and tracking quotations, NVivo Version 12, a computer-assisted qualitative data analysis software package was used. There is a 'thematic' element to data analysis where the actual language-in-use was interrogated using the Tools of Inquiry (Table 1) setting up what was being constructed in, by and through language. During the coding process, the researchers' attention was always on language-in-use, with particular consideration awarded to recurrent and salient phrases, words and expressions that contributed to distinct Discourses concerning the study's key focus: the ANP identity. These steps allow data analysis to proceed from naïve description towards an interpretive explanation as described by Sandelowski and Barroso (2003). Sandelowski and Barroso (2003) illustrate how qualitative research findings can move along a continuum from raw data (verbatim extracts from interviews, focus groups, the literature) through description and onwards towards interpretive explanation, moving ever closer to addressing the study's aims (Table 5):

Greckhamer et al. (2014) offer a tool to facilitate this movement from descriptive to interpretive analysis which they refer to as *chronicling*. Chronicling provides a chain of evidence to clarify how researchers move from data to results. Chronicling was undertaken as follows:

1. Examine Gee's (2011) discourse analytic framework.
2. Analyse data, identify theoretically relevant data units and interpret them in their context, identifying instances of Gee's tools of inquiry.
3. Document relationships and connections between these data units and tools of inquiry.
4. Allow the analysis to be theoretically guided by:
  - a. Gee's tools of inquiry.
  - b. Research aims and question.

The researchers regularly returned to the data, dissected it, continually moving back and forth between data sources, coding and

analysing to identify any unanticipated discourses (Potter & Wetherell, 1987) which, in turn, prevented anchoring to initial discourses.

## 2.7 | Rigour

Hardy (2001) believes challenges concerning rigour are particularly salient in the context of projects employing a discourse analytic approach as this approach emphasizes the discursive construction of social realities through texts, and 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 while being transparent and rigorous, as well as representing the process and results of discourse analysis. In these circumstances, rigour is achieved by applying frameworks consistent with and respectful of the researcher's theoretical assumptions. The framework developed by Gee (2010) enables this systematic, rigorous and transparent analysis as it provides structure and guidance to investigate how a view of reality is constructed through discourse. Furthermore, chronicling (Greckhamer et al., 2014) facilitates auditability, clarifying how we moved from data to results.

## 3 | FINDINGS

### 3.1 | Participant descriptors

In all, 29 participants took part in the study. Twelve ANPs working in five speciality areas (emergency, geriatric, community care, surgical and diagnostics) participated. Eleven hospital-based nursing staff (two staff nurses, eight clinical nurse managers and one director of nursing) participated. One nursing project office working in the Irish Department of Health participated. Three doctors (two consultants and one medical registrar) and two allied health professionals (radiographer and physiotherapist) participated. The majority ( $n = 22$ ) were female and were between 23 and 56 years of age (mean = 40) and had 3–32 years of experience working in the healthcare system.

### 3.2 | Discourses

The discourse analysis revealed five main discourses: the value adding nurse practitioner, in search of the nurse, the educated taskmaster, negotiating a place in the healthcare system and supervision or control. Each will be discussed in turn.

#### 3.2.1 | 'They're worth their money, 100%' – The Value Adding Nurse Practitioner

The language-in-use relates value to improve patient outcomes and to monetary aspects that make cost significant. 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:

It's vital to look at cost because everything ultimately will come down to cost... 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 throughout the data, where ANPs are seen to be 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. One nurse manager observes that ANPs are 'more expensive to train and hire than a junior doctor 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 while ANPs may not be:

anymore cheaper than a doctor, I just think the quality is so much better. If you pay for quality, you get quality in return...that is what the ANPs are all about

(I6M1)

Other participants employ language that continues in this vein moving the ANP identity away from framing value solely in terms of 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), constructs a world in which ANPs are embedded in and add value throughout the system, improving the patient journey and patient outcomes.

ANPs' relative permanency in their clinical settings is seen as a positive aspect of the role adding value to the system. Rather than medical transience, which is seen most commonly in junior medics, participants suggest that ANPs' permanency has led to significant system improvements and improvements in patient outcomes including reduced waiting times, reduced hospitalization and reduced lengths of stay:

ANPs 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)

Language-in-use that emphasizes the constancy of the ANP role, such as 'consistent body' and a 'constant of the hospital' creates a figured world where the ANP identity is viewed as a continual, enduring and steady presence in the system while the medical identity, by contrast, is seen as temporary and transient. A situated meaning is 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 doctors are less able to do so.

### 3.2.2 | 'I'm a nurse, I want to be a nurse' – In Search of the Nurse

ANPs were keen to highlight the nursing dimension of their role. As nurses first and foremost, they argue that they are in a better position than other health professionals to deliver responsive patient care:

ANPs are in a more advantageous position than a doctor because we have the nursing background...we see the bigger picture...

(FG4A18)

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 practice at the highest level that I can practice at, and I know that I can do an awful lot more...

(FG2A9)

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, understand more than what is immediately apparent and in turn improve the patient journey through the system. Conversely, ANPs employed language that positions some medics in diametric opposition:

...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.

(FG3A22)

Although ANPs constantly emphasize the nursing dimension, language-in-use also associates the role 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 identified as less specialized 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 endure still. 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 male-dominated health professions.

Language-in-use builds connections between nursing and a caring function while connecting doctors with a less caring role:

ANPs bring something very different to a doctor. I think they are coming from a different angle to a doctor...they are more intuitive...detail oriented.

(I4NM3)

In turn, this language-in-use makes caring relevant to the ANP role but irrelevant for doctors. An 'Angel of Mercy' figured world is created that draws on circulating Discourses that construct ANPs 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.

### 3.2.3 | 'The Jack of all trades' – The Educated Taskmaster

Language-in-use such as 'well qualified', 'well experienced' and 'skilled' constructs a figured world where ANPs are thought of as erudite and expert practitioners. This professionalism is tied to the ANPs' education such that a situated meaning is created that equates level of education with professional status. Education is therefore seen as a social good, improving the patient's experience and enabling nurses to progress:

I think that as nursing has advanced...the willingness to undertake change and accept change and progress from a nursing role to a more diagnostic and treating role has been profound.

(I6M1)

This opinion is also expressed by nursing participants with one nurse manager suggesting 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...it has been a natural progression for us to take on more clinical roles within health-care'. A figured world is created whereby the more educated one is the more opportunity and recognition is received.

When participants discuss the educational pathways of ANPs they employ language such as 'training', 'nursing school' and 'vocation', whereas language such as 'university' and 'education' is more likely to be employed when discussing medical pathways. This language-in-use has a situated meaning that results in medical education being seen as superior to nursing education and consequently medicine privileged over nursing. This is further seen when participants discuss the ANP role in terms of tasks and skills rather than education and knowledge:

...they are much better at reading x-rays...there was an audit done and the rate of x-rays being read properly was much better with the ANPs.

(FG1N3)

Employing language-in-use, such as 'better at reading x-rays', 'intubating skills' (I4NM3), 'masters at suturing' (I5M2) and 'improved scoping' (FG2A8) when discussing the role, creates an identity that is focused on tasks:

They (ANPs) were seen as the Jack of all trades...not replacing doctors but at the time it was seen that nurses could do certain tasks

(FG2A2)

The term 'Jack of all trades' could be used in a negative or positive manner. Here it constructs a situated meaning that while the ANP may be experienced, they may not have expertise in a focused area, or indeed may be 'master of none' which is contradictory to the initial aims of the role. A significant amount of talking, writing and Conversations have taken place in nursing and wider society around this Discourse.

### 3.2.4 | 'Crossing boundaries isn't always right, boundaries are there for a reason' – Negotiating a Place in the Healthcare System

Participants consistently raised the issue of substitution when discussing the ANP role. One ANP suggests that some people in the system believe the origins of the role were 'driven by replacing, by answering a medical problem like waiting lists...' (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:

...if you look at it from a hospital perspective there and this is just my opinion, you basically mightn't need as many doctors if you have more ANPs in roles, so then your pool of doctors get smaller...

(FG3X4)

In language-in-use such as 'you're getting seen by a nurse but also someone who has experience of medicine...' (FG3X2), participants underscored the hybrid nature of the 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, among 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...the ANPs role is significant you know for teaching, teaching junior doctors.

(FG1N13)

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...we come at it from a different perspective embracing the medical role...with a slightly different view on it...we adapt to the changing needs of healthcare...

(FG3A22)

Language-in-use such as 'slightly different view on it' constructs a situated meaning that while 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 allied health professionals 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...

(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 boxes' 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.

Examining these difficulties, a considerable number of nurses employ language that is somewhat hostile when discussing ANPs crossing barriers. This language is seen in an excerpt from the focus groups:

...doctors feel threatened because a nurse is coming in to do their role and doing it better... filling their role and filling it to their capability or better at times.

(FG1N13)

Language-in-use such as 'threatened' constructs a situated meaning that ANPs are a risk to their medical colleagues and a 'medical identity threat' figured world is created where medics are vulnerable and exposed to newer roles coming into the health system that should be seen as a possible danger. 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.

(FG3A22)

Nurse managers use language such as 'fearful of losing their position...' (I3NM1) and 'it comes back to fear of the professions becoming equal within the system' (FG1N3) when discussing medics' resistance to ANPs crossing boundaries. This constructs a situated meaning that medics consider their position in the healthcare system as more influential and powerful than that of other professions. This is a prevalent

theme in the 'hierarchical physician sitting at the top' Discourses and Conversations resulting from ANPs' experience of bureaucratic health system structures, with the medic in a dominant position and the ANP in a subordinate role.

### 3.2.5 | 'It's the fox guarding the henhouse' – Supervision or Control?

An emphasis on autonomous practice pervades ANPs' language. Language-in-use such as '...without autonomy ANPs will not bring to the service what could be brought' (I3NM1) 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 [*medical consultant supervision*] to establish the role and ensure it was well founded...give assurance to the public and the regulator...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)

Language-in-use 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 medical supervision and instead creates a figured world where the role is independent and autonomous. Correspondingly, some medics believe that 'ANPs have demonstrated a degree of autonomy and professionalism that clearly doesn't require supervision from a medical perspective...' (I6M1).

Other medical participants deprivilege the ANP role through language such as 'ANPs have a very defined and limited scope... they cannot do everything whereas doctors can' (I6M1). These phrases provide a situated meaning that the ANP role requires control and supervision and that medics should provide this supervision. This is evident in the language-in-use where senior medics see themselves as overseers of the health service and that any decision in the healthcare service requires their approval:

I'm an ED consultant...one way or another 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 the supervisory role of the medic. Consequently, a 'hierarchical physician sitting at the top' figured world is created where medics are the natural supervisors of the role and consequently control the development of nursing roles. Doctors being 'in charge' of ANPs is seen as normal and typical. Participants' use of

terms and phrases such as 'tighter controlled areas' (FG3X4) and 'the reins are very tightly held' (FG2A9) constructs a figured world where it is taken as right and proper that ANPs need to be controlled and prevented from expanding their roles. One ANP:

...there would be occasions that we would speak of expanding into something else you know, and no matter how competent we feel we are, the decision will be made as to what level they will allow us to get to...

(FG4A4)

## 4 | DISCUSSION

Discourse has constitutive powers, constructing subjects, objects, practices or abstract ideas. It shapes and is shaped by the context in which it is enacted. This paper presents an analysis of how nursing, medical and other healthcare professionals describe the ANP from their vantage point of their own experience. It examines how these discourses construct the ANP role and how they both enable and constrain it. Participants' language-in-use constructs the ANP identity as one that is characterized as valuable to the healthcare system, an identity that is caring and intuitive as well as skilled but not necessarily highly educated. Language-in-use continues to identify the ANP role as one that is a medical substitute and is restricted from advancement by limiting autonomous practice within boundaries related to medical supervision and control.

This study identifies language-in-use that positions ANPs as beneficial to the healthcare system to the extent that they contribute to cost savings. This cost-effectiveness discourse is prevalent in the extant literature. 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 and 'worth their money'. This identity is supported by research that has demonstrated that the care provided by ANPs is cost neutral (Begley et al., 2013; Kilpatrick et al., 2014; Kostas-Polston et al., 2015; Swan 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 the majority of physicians believe that ANPs should not receive equal pay for providing similar services to those of doctors. In their Cochrane review, Laurant et al. (2019) found that nurse practitioners tend to have longer consultation times and higher numbers of patient return attendances than doctors, which may impact on any cost savings.

An analysis of language-in-use reveals Conversations that are taking place within the health system concerned with whether the foundations of the ANP role are 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 ANPs are emphatic that nursing is the basis of their practice. This study shows that language-in-use by participants constructs situated meanings that the ANP identity aligns significantly with nursing. Furthermore, these alignments construct a superior role in the sense that ANPs approach patient care holistically and more intuitively when compared with other healthcare professionals. Participants connect this aspect of the role with improved patient outcomes and responsive patient care. Eriksson et al. (2018) attribute this unique emphasis on holistic approaches to healthcare delivery as the reason that ANPs when compared with other professionals are the preferred healthcare providers for millions of people worldwide. As a result of these comparisons with other healthcare professionals, predominantly medics, comparative figured worlds are created where 'nurses care and doctors cure', a simplified world that is taken to be normal by society. This discursive monopolizing of caring and holism by nurses negates the caring and holistic aspects of other professionals' practice within the system.

Other healthcare professionals employ language that recognizes 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 medicalized identity for the ANP with medicine to the forefront and nursing in the background, a doctor manqué figured world. Janssen (2016) argues newer healthcare roles should not be seen as substituting but instead seen as a disruptive innovation or what he terms a 'situated novelty'. He emphasizes that we need to consider new professionals 'carving' out their 'place' in the healthcare system rather than replacing. While 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) recognize the significant role ANPs play in any health system. Discourses identified in this study support this outlook with the majority of participants keen to emphasize the positives that the role brings to the healthcare system. 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. McDonnell et al. (2015) found that the ANP's constant presence meant that problems were picked up and actioned promptly and that the role fosters collaboration and teamwork.

Analysis of language-in-use shows a discrepancy between participants concerning the educational aspect of the role. For some participants, ANPs were seen as skilled and educated practitioners, whereas other participants believed ANPs were not necessarily highly educated. For some participants, language-in-use identified the ANP role as positively improving the healthcare system through

the teaching and supervision they provided to junior medical staff. McDonnell et al. (2015) report similar findings where junior doctors valued the ANPs' clinical expertise and their in-depth knowledge of clinical policies and how hospital systems worked, learning by example from them. Conversely, other language-in-use that describes 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 identified as less educated and trained. This positions nurses, including ANPs, as somehow inferior to other professions in the healthcare system. This trivialization 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 builds a 'hierarchical physician sitting at the top' 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.

Autonomy is a key discourse in the study. ANP participants stress that increased autonomy is an essential component of clinical practice and necessary for their ability to practice to the full extent of their skills and knowledge. The language-in-use shows that there appears to be ambiguity about what autonomy means in practice. A number of participants employ language that emphasizes self-governing and independence when discussing autonomy, while for others, predominantly doctors, autonomous practice is seen as practicing within a limited and defined scope. MacLellan et al. (2017) and Hoff et al. (2019) found that ANPs often feel frustrated about unnecessary constraints in their capacity to use their training and experience, an idea also identified by Corbally and Lees-Deutsch (2019) who found that, although ANPs are at the peak of their careers, they were clearly frustrated and restricted by constraints placed on their roles.

#### 4.1 | Limitations

A limitation of our study is that it was conducted in a specific place and time and may not be generalizable to other populations. However, the findings are transferable in that they can be used by researchers and practitioners to 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 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. Another limitation of the study is that it only included specific healthcare professionals and excluded others such as midwives. An area for future research could include exploring the discourses that construct ANPs' identities from the perspectives of service users, the general population and healthcare professionals not included in this study.

## 5 | CONCLUSION

This study presents a discourse analysis of how ANPs are positioned within current nursing and health system structures by making explicit the discourses that construct their role and how they both enable and constrain it. We hope that the discourses revealed provide another perspective on the challenges that ANPs encounter. 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, not just from a cost perspective but also for the distinctive value it adds to patient outcomes and the patient experience. It is essential that healthcare professionals identify and counter Discourses and Conversations concerning the ANP role so that the role can develop and be used to its full potential to enhance healthcare provision. To meet the demands of ever-changing, dynamic healthcare systems, it is vital that ANPs are supported and allowed to 'advance'. Until this occurs, Conversations that trivialize the role will continue and hierarchies in the system will persist. Healthcare professionals, including ANPs, need to move on from Conversations that continually compare the ANP role with medicine. They should be seen as practitioners in their own right rather than as medical substitutes. As professionals, they need to reframe their identity as one that acknowledges and recognizes 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.

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### CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

### AUTHORS' CONTRIBUTIONS

Criteria	Author initials
Made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data;	WT, MM
Involved in drafting the manuscript or revising it critically for important intellectual content;	WT, MM
Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content;	WT, MM
Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.	WT

### PEER REVIEW

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