Role Perceptions of Experienced Nurse practitioners: A Configuration of Individual and Institutional Roles

by

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Dedication

This dissertation is dedicated with love to the memory of my mother Grace Renwanz R.N. and to my husband Robert, in grateful appreciation for all they have given me.

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Abstract

Approximately 25,000 nurse practitioners currently work in the United States in multiple locations and areas of specialization. The nurse practitioner role has been intensively studied from its mid-1960s inception to the present day and is considered by many as the prototype clinical nursing role. Defining this role has been problematic, however, for nurse practitioners, consumers, and others in the health care professions.

Disparate role perceptions can be explained by shifting role boundaries, overlapping health worker functions, differing role autonomy perceptions, and methodologic limitations of nurse practitioner research that has been focused on students and novice clinicians rather than experienced nurse practitioners.

The study purpose was to explore and describe the role definitions and perceptions of experienced nurse practitioners. Questions were addressed concerning role descriptions, problems in role delineation, and the identification of factors influencing role definitions.

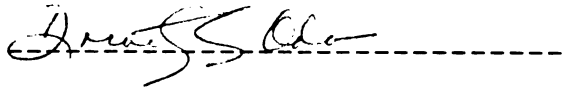
The study design was exploratory and descriptive. Field and grounded theory methodologies were employed in data collection and analysis. Twenty-three nurse practitioners with two or more years of nurse practitioner experience were informally interviewed. The study participants were employed in three organizational settings and were specialized in the areas of medicine, obstetrics, or gynecology.

Two disparate roles were identified by the study participants. The individually desired role, delineated by professional nurse identity, professional autonomy, and activity integration was the ideal role. In contrast, the institutionally expected role, characterized by medical associated identity, decreased professional autonomy, and diminished activity integration, was the requisite nurse practitioner role.

Role disparity was influenced by a number of contextual factors that included: temporal factors, role comprehension, role ambiguity, interactional mode, and interprofessional control. The study participants utilized strategies to reduce or accommodate to role disparity that included: role negotiation, role optioning, role compromising, role re-routing, and role exiting.

All study participants engaged in the central process of role blending, a continual process of individually desired and institutionally expected role amalgamation. The configuration of blended roles varied according to the contextual factors that influenced role disparity and individual strategy utilization.

Study implications for nurse practitioners, nursing administrators and educators were identified and discussed.



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CHAPTER ONE--INTRODUCTION

Introduction

There are approximately 25,000 nurse practitioners (NPs) currently working in the United States (Mezey, 1987). According to the American Nurses' Association (1985), the nurse practitioner title is granted to registered nurses who are educated in formal practitioner programs that are organized to adhere to guidelines established by the nursing profession.

The educational preparation for NP roles has historically been varied. Practitioner programs have ranged in length from several weeks to several years and in location from classes held in medical offices and work sites to formal academic settings.

The educational format of NP programs has also been widely varied. Continuing education programs were designed to provide NPs with the skills necessary to perform specific tasks, including physical examinations and treatment of selected diseases. In contrast to the continuing education programs, academic programs were developed to provide NPs with graduate education as well as to prepare NPs as nursing specialists or experts (American Nurses' Association, 1985).

Nurse practitioner work has been described as the performance of traditional nursing functions such as teaching and counseling in combination with selected tasks once performed exclusively by physicians such as disease diagnosis. The guidelines for NP training programs,

published in 1977, described NP activities as the following:

1. Assess the health status of individuals and families through health and medical history taking, physical examination, and defining of health and developmental problems;
2. Institute and provide continuity of health care to clients (patients), work with the client to insure understanding of and compliance with the therapeutic regimen within established protocols, and recognize when to refer the client to a physician or other health care provider;
3. Provide instruction and counseling to individuals, families, and groups in the areas of health promotion and maintenance, including involving such persons in planning for their health care; and
4. Work in collaboration with other health care providers and agencies to provide and where appropriate, coordinate services to individuals and families (Guidelines, 1977, p.3).

Nurse practitioner work has been conducted in a number of locations. Practitioners have traditionally functioned in the ambulatory clinics and outpatient departments of university teaching hospitals and public health departments because initial NP programs were developed in these settings. The growth and development of the NP role expanded the location of NP work settings to include

government agencies, health maintenance organizations, community health centers, rural clinics, and private and group practice offices (Kitzman, 1983).

Nurse practitioner work is currently performed in schools, correctional settings, and occupational health settings. Practitioners are also developing work settings in a number of hospitals, hospital emergency rooms, patient homes, skilled nursing facilities, and short-term rehabilitation centers (American Nurses' Association, 1985; Mezey, 1986).

Historically, NPs have functioned in multiple, specialized areas of nursing practice. Early NP roles were created within pediatric and adult medical specialty areas. Practitioners then moved into the areas of obstetrics, gynecology, surgery, family health care, and school health as NP roles were extended into these work settings. Practitioners have continued to expand their roles into new specialty areas by branching into the fields of geriatrics and occupational health (Kitzman, 1983).

Nature Of The Problem

Defining the NP role has been problematic not only for many members of the nursing profession but also for NPs themselves from the beginnings of the practitioner role to the present day. There are multiple causes for this difficulty including shifting nursing role boundaries, the overlap of NP roles with those of other health care workers, differing perceptions of NP role autonomy, and methodologic

limitations of prior NP research.

Shifting Role Boundaries

Nursing is generally a profession with changing and shifting role boundaries. In 1980, the American Nurses' Association issued a nursing policy statement which described the boundaries of nursing practice as expanding "outward in response to changing needs, demands, and capacities of society" (p. 13). Nursing was described as a profession which converged with other health care professions.

The intersections between nursing and other health professions were characterized not as hard and fast separations but as fluid and shifting, constantly changing in response to changes in societal demands for health services (American Nurses' Association, 1980). Nursing boundaries additionally evolved in response to forces generated within the nursing profession as well as to the external forces of other health professions and of society at large.

In 1985, the American Nurses' Association Council of Primary Health Care Nurse Practitioners further delineated the boundaries and intersections of NP work. "Nurse practitioners have expanded the boundary of nursing practice, first through extension of traditional medical services and then through definition of these and other services as nursing care" (p. 5). Thus, NPs were noted to

expand the parameters of professional nursing practice.

The nurse practitioner role is defined and delimited in part by nursing practice acts, i.e. legal statutes enacted by all state legislatures. Each nursing practice act is composed of laws which regulate nursing education, licensure, and practice. Nurse practitioner roles are extended by amendments and additions to these laws governing NP work. At the present time, 37 states have changed laws regulating nursing practice, permitting NPs to legally practice within expanded role boundaries (Bullough, 1986).

The California Nurse Practice Act, for example, defines NP practice as similar in scope to the practice of all registered nurses (Board of Registered Nursing, 1983). California NPs are able to expand their roles through the utilization of standardized procedures. "Standardized procedures are the legal means by which registered nurses may amplify their practice into areas traditionally considered to be within the realm of medicine" (California Nurses' Association, 1986, p. 22).

The California Nurse Practice Act describes standardized procedures as either policies or protocols "developed through collaboration among administrators and health professionals, including physicians and nurses ..." (Board of Registered Nursing, 1983, p. 86). Nurse practitioners are able to expand and extend their roles by developing and implementing specific policies and protocols.

The fluid and changing nature of nurse practitioner role

boundaries creates difficulties in precisely defining these roles. These problems are additionally compounded by variation in state nursing practice acts, as NP roles are defined differently in each state.

Role Overlap

Role overlap between NPs, physicians, physician assistants, and clinical nurse specialists contributes in part to the difficulty in defining NP roles.

The work of NPs is similiar in many respects to the work of physicians. Physicians are specialists in the diagnosis and treatment of illness. Educated in four year medical school programs, physicians perform a number of tasks centering around the diagnosis and treatment of diseases. Nurse practitioners now routinely perform many of these same physical assessment and treatment activities.

Physician assistants are a second group of health care workers executing tasks similiar to those completed by NPs. Physician assistants practice under the direct supervision of physicians to provide medical services such as obtaining medical histories, performing physical examinations, and ordering and evaluating diagnostic laboratory tests. Physician assistants also treat a number of medical emergencies, evaluate medical illnesses and educate patients on many health issues (Golden Gate Nurses'Association, 1987).

In contrast to NP educational programs, the educational

preparation for the physician assistant role involves participation in a two year college or university program which has been accredited by the Committee on Allied Health Education and Accreditation (Golden Gate Nurses' Association, 1987). Graduates of these training programs are awarded associate college degrees or certification for practice.

Clinical nurse specialists are a third group of health workers who function similarly to NPs. The American Nurses' Association (1980) defines a nurse specialist as an individual who has become an expert in a defined area of clinical nursing practice and knowledge. This is accomplished through nursing study at the graduate level and through supervised nursing practice.

Clinical nurse specialists serve as a resource to patients, physicians, students, and other groups of nurses. Additionally, clinical nurse specialists complete a number of nursing functions including educating and counseling patients and utilize many of the physical assessment skills employed by NPs.

The roles of NPs overlap then in many areas with those of physicians, physician assistants, and clinical nurse specialists. This creates difficulties for NPs as they attempt to differentiate their roles from those of other health care providers.

Differing Perceptions Of NP Role Autonomy

Differing perceptions of NP role autonomy also create

problems in the definition of NP roles. The NP role is viewed as an autonomous and independent role by nursing profession members. The American Nurses' Association (1985) describes NPs as primary health care providers who are "responsible for managing all health problems encountered by the client, and are accountable for health and cost outcomes" (p. 6).

In contrast to nursing perceptions of NP role automomy, many physicians view NP roles as subordinate to medical roles. In 1970, the American Medical Association issued a position statement on the status of nursing roles. While recognizing the importance of expanding the roles of nurses, the American Medical Association stated, "professional nurses are equipped to assume greater medical service responsibility under the supervision of physicians" ("Medicine and Nursing", 1970, p. 1881).

The American Medical Association position statement additionally commented on the ability of physicians to provide leadership for other groups of health workers. Physicians were noted to "possess the degree of competence required to assume authoritative direction of the medical team " ("Medicine and Nursing", 1970, p. 1883). The NP role was perceived to be subordinate to physician roles and thus viewed as less independent and autonomous than physician roles.

Methodologic Limitations Of Prior NP Research

A number of methodologic limitations present in prior NP research have contributed to the difficulties encountered by individuals defining NP roles. A number of researchers investigating NP roles have utilized survey methodologies. The absence of data on the reliability and validity of survey instruments has limited the utility of many study results (Edmunds, 1978).

Some comparison studies of practitioners and physicians relied primarily on data gathered from patient chart audits, an unreliable source of data about actual clinical practice for both groups of clinicians (Diers & Molde, 1979). Other researchers compared NPs and physician assistants together under multiple titles such as new health workers, or para-professionals. By not conceptually differentiating the two roles, researchers generated data revealing the similarities but not the differences between NP and physician assistant roles. Distinctions between the roles were blurred, increasing the difficulty in defining NP roles.

The conceptualization of NPs as physician substitutes has been problematic for those delineating NP roles. When NPs have been viewed solely as physician substitutes, other aspects of NP roles, such as nursing functions, have not been examined (Freund, 1986). As Diers and Molde (1979) have stated, many NP studies have been evaluations of a NP's ability to safely and effectively provide traditional medical services. By not evaluating the nursing components

of NP roles, the definitions of NP roles have become restricted primarily to the performance of medical functions.

A number of NP studies have been single case studies or evaluations of one or two NPs working within one work setting. The small sample size of these studies has limited the generalizability of this research.

Nurse practitioner research has frequently been focused on areas of inquiry relevant to members of professions other than nursing, primarily the medical profession. Nurse practitioner research has been limited in scope because medical norms have guided the problems identified and the phenomena explored by physician investigators. Many potentially important areas of inquiry for NPs have never been investigated by these researchers.

Prior researchers have focused their attention on populations of student or novice NPs. Student and novice practitioners have limited experience in NP roles. Research conducted exclusively within these two groups provides information about NP role acquisition but limits the data on role expertise. Because populations of experienced or expert NPs have been infrequently investigated, very little is known about these clinicians and their role perceptions.

Statement Of Purpose

The purpose of this study was to explore and describe the role definitions of experienced NPs in order to obtain

information about the role perceptions held by experienced rather than novice NPs. More specifically, the study addressed the following questions:

1. How do experienced practitioners describe their roles and the contexts in which they practice?
2. What individual and contextual factors are identified by practitioners as influencing their role definitions?
3. What problems do these practitioners experience in defining their roles?
4. How do practitioners define their roles in relation to other complementary roles?

CHAPTER TWO--REVIEW OF THE LITERATURE

The purpose of this chapter is to review literature relevant to the study in question. Role theory and symbolic interactionism form the conceptual framework for this research and are described here. A discussion of relevant nurse practitioner research concludes the literature review.

Background

Introduction

Nurses have been functioning independently in a number of roles for many years. De Maio (1979) wrote that the basic constructs of the practitioner role were incorporated into the nursing roles and education of public health nurses early in the twentieth century. Others cited the work of nurses employed in the Kentucky Frontier Nursing Service who had incorporated medical functions into their nursing roles since 1926 (Kalish, 1986; Rogers, 1975).

The beginnings of the nurse practitioner role are generally traced back to the early 1960s. Noonan (1972) described her work in the Medical Nurse Clinic of the Massachusetts General Hospital. Siegal and Bryson (1963) reported a project redefining the role of public health nurses in Berkeley, California.

Ford and Silver (1965) are credited with the initiation of the first formal NP educational program at the University of Colorado. Their intent was to prepare pediatric nurses to give comprehensive care to populations of well children.

At the University of Kansas, Lewis and Resnik (1967)

investigated the provision of comprehensive services to adults with chronic diseases by ambulatory care medical nurses.

Evolution And Development Of The Nurse Practitioner Role

The 1960s were a time ripe for social innovation as people demanded a variety of rights and social institutions were pressured to respond to these demands. Humanistic rather than materialistic values were in vogue at this time, generating demands for increased services to the disenfranchised; demands that were not then met by members of the health care system (Ford, 1982).

Factors Influencing Role Evolution

Factors both within society and the nursing profession contributed to the evolution of NP roles. Social factors included the civil rights and women's rights movements, both of which were prominent in the mid 1960s. An economic factor contributing to the creation of NP roles was the formation of a national medicare program in the 1960s.

Health care delivery in the United States was also being examined in the 1960s by many health professionals concerned about the geographical maldistribution of physicians. The movement of physicians toward areas of medical specialization and away from areas of general medical practice was additionally viewed with alarm by many in the health professions. These trends were viewed as precursors of physician shortages, particularly of physicians able to provide general medical services to all segments of the

United States population (Weston, 1975).

The physician assistant movement originated at this time to provide, in part, a solution to perceived physician shortages. The first physician assistant program began at Duke University in 1965, and was followed by a number of programs that were established throughout the country. Physician assistants were trained to provide a number of traditional medical services such as the performance of routine physical examinations to healthy individuals, and the treatment of minor medical illnesses including colds and sore throats. Physician assistants were viewed as providers of general medical services to underserved populations, especially those in rural areas (Weston, 1975).

Sadler, Sadler, and Bliss (1975) noted the impetus for the creation of this "non-nurse" physician assistant role was the American Nurses' Association rejection of American Medical Association suggestions for the movement of nurses into physician assistant roles. The intent of physicians was to increase the delivery of traditional medical services to populations of underserved individuals.

Multiple factors can be identified within the nursing profession that contributed to NP role development. Prior to the 1950s, nursing was essentially a generalist occupation with few areas of specialization (Bullough & Bullough, 1983). There were attempts within the nursing profession to refocus attention on clinical nursing and direct patient care services through nursing specialization. This was in

response to concerns that many nurses were moving away from the provision of patient oriented services toward administrative positions, leaving less skilled workers to provide the majority of direct patient services.

Educational trends influenced the evolution and development of NP roles. The Nurse Training Act of 1964 facilitated the expansion of graduate nursing education. The legislation provided money for facility construction, loans, traineeships, and expanded student programs (Bullough & Bullough, 1983; Sadler, Sadler, & Bliss, 1975). Additionally, the Nurse Training Act advanced the expansion of NP educational programs as well as strengthening nursing education at all levels of preparation.

A position paper published by the American Nurses' Association in 1965 was a factor in advancing NP roles. The position paper stated that all nursing education should transpire in formal academic learning institutions. Nurses were categorized into two educational groups: the professional nurse who would enter practice with a baccalaureate degree in nursing and the technical nurse who would have an associate degree in nursing as a requirement for entry into practice (American Nurses' Association, 1965). Nursing educators were provided with an added incentive to create and expand collegiate nursing programs for all nurses.

From the mid 1960s through the 1970s, NP educational

programs were developed in a number of settings. Rapid expansion of NP roles was primarily a consequence of readily available federal funding for these programs, designed to teach primary health care skills to registered nurses (Billingsley & Harper, 1982). Program sites ranged from private physician offices and health agencies to university schools of medicine and nursing. Programs varied in duration from 6 weeks to 2 years and in administration by nurses, physicians, or nurse-physician teams. Entry requirements were also widely varied; students were accepted from all levels of nursing preparation. Credentials after program completion ranged from none to certification or bachelor's or master's degree (Garland & Marchione, 1982).

Bullough (1986) noted that many of the initial NP programs were sponsored by service agencies. Programs were additionally developed by diverse providers and agencies in this beginning phase of NP education.

Another factor in the growth of NP roles was the Nurse Training Act of 1971. This legislation created the impetus for continued expansion of the NP movement through the allocation of funds for specific NP training programs such as pediatric NP programs (Kalish & Kalish,1986). The allocation of funding for specialized NP programs provided a specific strategy for increasing the total number of working NPs. Additionally, the 1971 Nurse Training Act increased the Divisions of Nursing's activities within the NP field and marked the move of NP education into the mainstream of

higher education (Bullough, 1979).

Role Development

The emergence of a beginning dialogue between nurses and physicians regarding NP roles accompanied the initial development of NP roles. The American Nurses' Association-American Medical Association Joint Practice Commission was formed in January, 1972. The goal of the commission was to establish optimal working relationships between registered nurses and physicians. The commission provided an opportunity for both professional groups to discuss the roles of NPs and physicians as quality health care providers within the health care system (Sadler, Sadler, & Bliss, 1975).

The development of the NP movement was accompanied by expanded definitions of the NP role and by delineation of the functions NPs were to perform. By 1975, the American Nurses' Association had drafted guidelines for NP educational preparation. Within the guidelines, the functions to be performed by NPs were delineated as follows:

> Performs a basic physical assessment using techniques of observation, inspection, ascultation, percussion, palpation, and oto/ophthalmoscopic examinations.
>
> Performs or requests special screening or developmental tests and other laboratory tests and interprets the results.
>
> Identifies and manages specific minor illnesses and

emergencies under broad medical supervision.

Obtains a comprehensive health history.

Again by 1975, the American Association of Colleges of Nursing had differentiated the responsibilites of the NP from those of general registered nurses. NP roles were separated from other nursing roles by the following tasks:

For the purpose of diagnoses: conducting comprehensive physical examinations in a systematic manner using appropriate techniques and tools; and ordering laboratory and screening tests necessary for the determination of health status.

Upon determination of health needs: prescribing care where appropriate; consulting other health professionals where indicated; or referring those clients needing further evaluation to appropriate resources.

Initiating and modifying therapies, including drug therapies, and managing the medical care regimens for acute and chronically ill patients within established protocols.

The American Nurses' Association Congress for Nursing Practice (1976) described the NP as a nurse who "... assesses the physical and psychosocial status of clients by means of interview, health history, physical examination, and diagnostic tests ... interprets the data, develops and implements therapeutic plans, and follows through on the continuum of care of the client ..."

As the NP movement grew in the 1970's, so did a variety

of NP organizations. In 1975, the Nurse Practitioner: The American Journal of Primary Health Care was initially published. The journal was designed to communicate information of interest to NPs through articles and research reports.

The growth of the NP role was readily viewed by examination of established NP organizations. The Nurse Practitioner: The American Journal of Primary Health Care published a directory in 1984 that listed 21 national NP organizations, 10 international NP organizations and a large number of regional and state practitioner groups.

Initial Role Perceptions

The development of the NP role was accompanied by disparate NP role perceptions. Early leaders of the NP movement viewed the role as primarily a nursing role. Ford (1985) noted that her intent in developing the first educational program for pediatric NPs was to test a program that expanded clinical nursing into areas of wellness and health care. Nurse practitioners were, however, to retain a nursing rather than a medical identity.

Resnik (1981) stated that her goal was the enhancement of ambulatory nursing roles so that medical patients would benefit from nursing as well as medical skills. She envisioned NPs and physicians working collaboratively to provide comprehensive patient care.

Others within the nursing profesion however, had difficulty with the NP title. Ozimek and Yara (1975) wrote that the NP title was redundant because, by definition, all nurses were nursing practitioners. The authors further noted that a review of nursing literature demonstrated usage of the NP title within the nursing profession for many years. Practitioners in nursing had been described throughout the nursing literature of the 1950s and 1960s prior to the inception of NP roles.

Some nursing leaders perceived NP roles as synonymous with physician assistant roles. Nurse practitioners were described as having succumbed to the "blatent perfidy spawned by such terms as NP...and [were] designed to provide succor and profit for the nation's shamans" (Rogers, 1975, p. 1839). Many considered NPs to be nurses who had in fact abandoned the nursing profession and were accordingly no longer entitled to a professional nursing identity (Keller, 1973; Rogers, 1972).

Many physicians viewed NPs primarily as physician assistants, capable of providing direct services to patients while remaining under physician control (Sadler, Sadler, & Bliss, 1975). The utilization of NPs was noted to contribute significantly to the quality of the medical rather than nursing services offered to the public ("Medicine & Nursing", 1970).

These disparate perceptions of the NP role had significant consequences for future development of NP roles.

Dissension among nursing leaders as to the definition and location of NPs within professional nursing resulted in the development of NP programs at varied educational levels. This directly contrasted with the visions of early NP role proponents who viewed graduate educational preparation for all practitioners (Ford, 1975).

Another consequence of the disagreement among nursing leaders about NP role definitions has been the creation of confusion about the NP role that has been especially prevalent among consumers and other professionals (Garland & Marchione, 1982). This confusion has been compounded by physician assumptions that NPs can be perceived interchangeably with other physician assistants.

Current Role Status

The scope of the NP role has been delineated. In 1985, the American Nurses' Association Council of Primary Health Care Nurse Practitioners dimensionalized NP roles into two components: direct roles and indirect roles.

Direct NP roles included the following functions: assessment of the health status, health risks, and illness conditions of individuals, families, and groups; diagnosis of actual or potential health problems; planning of therapeutic interventions;intervening to increase the client's participation in her/his health care; evaluation of the intervention with the client.

Indirect NP roles were identified as: the educator role

(involves teaching NP students or other NPs); the administrator role (providing leadership to teams of NPs or other nurses delivering primary health care); the researcher role (investigating clinical phenomena); and the consultant role (or problem solver with clients who may be individuals, families, groups, colleagues, agencies, or communities).

Current NP educational programs now prepare NPs at the graduate level rather than through certification or continuing education programs. In 1984, the American Nurses' Association House of Delegates adopted a resolution establishing 1990 as a target date for all NP educational programs to be located at the graduate preparation level (American Nurses' Association, 1985). The resolution reflects the current conceptualization of the NP role as an advanced nursing practice role and mirrors the general trend toward graduate education as minimal preparation for advanced nursing practice that is now prevalent within the nursing profession.

Current Factors Influencing The NP Role

Factors that currently influence the NP role are primarily economic in origin. At the present time, federal funding for graduate education and nursing education has been reduced significantly from funding levels established in the early 1970s. The costs of health care in the United States have escalated dramatically in the past 20 years and concern is now focused on mechanisms to reduce health care expenditures.

Competition between NPs and physicians for the opportunity to provide direct patient services is another issue currently faced by NPs. In 1980, the Graduate Medical Education Advisory Committee released a report to the United States Congress projecting a surplus of physicians in the United States by 1990. One recommendation of this committee was to limit training of NPs and physicians to projected 1990 levels of 50,000 providers. The limits were proposed as one strategy to control the projected physician surplus (Ginsberg & Ostrow, 1984). Many perceive the projected physician surplus as a major contributing factor in the competition between NPs and physicians for service delivery to populations of patients (Beason, 1978; Edmunds, 1981; Spitzer, 1984).

There are several other current issues of relevance for NP role occupants. Direct reimbursement for NP services by insurance companies and other third party payers is an issue of concern for NPs. The majority of these agents are opposed to payment for NP services. Questions have been raised to what services should be reimbursed, how much these services should cost, and what conditions should exist for reimbursement such as physician supervision, practice settings, and certification of NP providers (La Bar, 1986; Spitzer, 1984).

Legitimation of prescribing privileges is another issue faced by NPs. The capacity to directly order or prescribe

medications would increase independent NP functioning because NPs would no longer be dependent on physicians for signatures on medication orders. In 1983, Oregon and Washington were the only two states to authorize NPs to independently order or prescribe medications (Kalish & Kalish, 1986). At present, several states including California, have developed legislation allowing NPs to provide this service to patients.

An additional issue that NPs must currently address is singular titling for both NPs and clinical nurse specialists. Many nursing profession members are discussing the possibility of adopting one title to represent both groups of nurse clinicians. NPs define themselves primarily as direct patient service providers. Clinical nurse specialists delineate their roles primarily in terms of consulting or educating patients, families, and nurse colleagues. While NPs usually work in ambulatory clinics and clinical nurse specialists are usually located in acute care hospital settings, the distinctions between these nursing roles are frequently blurred. Both groups of nurses perform similar functions including physical assessment and treatment of patient problems, and patient and family teaching (Bullough & Bullough, 1983).

Current Role Perceptions

Current perceptions of the NP role remain disparate among nursing groups. For some, the NP role is considered to be innovative, occupied by a select group of individuals

who utilize new nursing skills and behaviors. This role is considered complementary to physician roles (Ford, 1985; Mauksch, 1978).

Many nurses perceive the NP role as a model for all future nursing roles. NPs are viewed as having influenced changes in current nursing practice. This is evidenced by the incorporation of NP role skills such as physical assessment into baccalaureate nursing programs (Lewis, 1979; Mundinger, 1980).

Others within both the nursing and medical professions continue to view NP roles as subordinate to physician roles. This is documented in many studies of physician attitudes toward NPs (Bliss & Cohen, 1977; Moloney, 1986; Spitzer, 1984).

Differing perceptions of the NP role continue to create problems for those defining NP roles. A number of nursing writers note that NP roles should be further defined and clarified. Mezey (1986) for example, notes that the roles of NPs should be further analyzed for clarity. Moloney (1986) writes that the controversy over the NP role continues in present role discussions.

Conceptual Framework

The role of the nurse practitioner will be viewed from a conceptual framework that incorporates elements of role theory and symbolic interactionism.

Role Theory

The study domain of role theory is the behavior of humans as it is displayed in real-life social situations (Thomas & Biddle, 1966). Integrating the work of anthropologists, sociologists, and social philosophers, role theorists use the concept of role to explain human functioning within groups or societies. The perspective of role theorists assumes that an individual's behavior results from the social prescriptions and behaviors of others as well as from the positions occupied by the individual and her/his understanding and reactions to these factors (Thomas & Biddle, 1966).

A role is a metaphor in which human actions adhere to certain parts rather than to the players reading or reciting them (Sarbin & Allen, 1968). Roles are collections of characteristic or organized sets of behaviors, beliefs, and values that are associated with specific positions occupied by individuals. Positions occur within larger social structures. Individual actions or role enactments are influenced by role expectations (the rights and obligations associated with a role), role location (selecting roles appropriate to the situation), role skills

(the ability to perform roles), and self-role congruence (the degree of congruence between the individual's self and requirements of the role being enacted) (Sarbin & Allen, 1968).

Roles, which are both continuous and cumulative, are learned through the interrelated processes of role acquisition, training, and practice. Human actors must learn the roles for the positions they occupy as well as the role expectations for all complementary roles (Sarbin & Allen, 1968). Professional roles are acquired as a result of lengthy training periods. Professional roles tend to be performed in private and are governed by explicit codes of conduct that are determined and enforced by other profession members (Biddle, 1979).

Roles are interactional in nature. Role enactment always occurs within a social context of complementary roles. An individual's behavior while in a position takes into account the role behaviors of those in complementary positions. Role set refers to the total number of complementary roles related to any given role (Sarbin & Allen, 1968).

From a symbolic interactional perspective, a role describes the processes of cooperative behavior and communication. Role-taking involves devising a performance on the basis of imputed other-roles (Lindesmith & Strauss, 1968; Mead, 1934; Turner, 1978). An assumption is made in this perspective that roles are learned through social interactions (Hurley, 1978). This stresses the reciprocal

interrelationships between roles as actors must constantly adjust their responses to what they think others are going to do (Lindesmith & Strauss, 1968).

Role theory has been selected to view the NP concept for several reasons. Role theory is ecclectic, incorporating elements of various theoretical traditions and perspectives, and thus has potential utility for members of a number of disciplines, including nursing.

Role theory is relevant for the investigation of micro-level phenomena such as the actions of individuals. The theory is equally applicable to the study of macro-level phenomena such as group or organizational conduct (Turner, 1978). This study of experienced NPs working within organizational settings is best viewed from a role theory perspective. Role concepts then, have great utility for the study of the phenomenon in question, the work roles of experienced NPs within institutional settings.

A number of researchers investigating the NP role have either implicitly or explicitly utilized role theory in their research (Garland & Marchione, 1982). Research on NP roles, including analysis of NP role functions, role relationships between NPs and physicians, and expectations of NPs about their roles will be examined further in the research review.

Symbolic Interactionism

Symbolic interactionism is not a unified theory but

rather a social psychological perspective that is focused on the nature of the interactions or social activities occurring among individuals (Charon, 1979). Human activity is characterized as a changing and dynamic process rather than something static or fixed. The process of human activity involves the ability of each person to interpret situations, to define the actions of others within situations, and to indicate then to others how they are to act (Blumer, 1966). Interactions involve mutual social action, as individuals act in relation to each other by taking each other into account, interpreting actions, and then acting again (Charon, 1979; Turner, 1978).

There are basic assumptions which underlie symbolic interactionism. First, that humans have the capacity to create and use symbols for complex thinking, and for communication that is accomplished through gestures (vocal and nonvocal). Humans, then, live in symbolic environments. A second assumption is that humans have a capacity for self-reflection because they have the ability to view themselves as objects. A third assumption is that humans are unique because of the existence of self conception and of generalized, as well as particular, others that result from the interactional process (Mead, 1934; Rose, 1962; Turner, 1978). For Mead (1934), the self is primarily a social process developed in a series of stages through social experiences. The preparatory stage is the first and earliest step in the development of the presymbolic self and

interactions here are primarily imitations of others. In the second or play stage, the acquisition of language allows children to define and label objects with words that have shared meanings for others. The final or game stage allows children to assume additional perspectives which are assembled into a generalized other. It is this generalized other arising from experiences in the game stage that provides children with a self.

As a social process, the self is also structured into an "I" and a "me". The "I" represents the individual as subject, impulsive, spontaneous, never fully socialized or controlled. The "me" constitutes the individual as object, a social self which results from interactions with others (Charon, 1979; Mead, 1934).

The concept of self has significance because it is basic to an understanding of the concept of mind. Mind is a social process, a symbolic interaction with the self and an integration of self and symbols. Thinkng then involves the capacity to communicate with one's self (Charon, 1979; Mead, 1934).

Mead's concept of self also serves to explain communication and human activity. The process of communicating through symbol use is possible only when the symbols arouse in one's self what is aroused in other individuals (Mead, 1934). The generalized other, an indicator of a mature self, is an incorporation of the

attitudes of significant others. This internalization of society allows individuals to act in consistent, organized ways. The mechanism of self interaction also allows individuals to develop an active rather than a passive relationship to their environment (Blumer, 1966; Charon, 1979).

The interactional perspective is one that views human behavior as a response to the interpretation of the symbolic actions of others. Reality is constructed by each actor who defines and interprets situations and then acts on these perceptions (Hardy & Conway, 1978). Reality is a social construction that is stable or changing according to one's interactions with others.

Symbolic interactionism was selected to view the NP role because it represents human activity as a dynamic and changing process rather than as a fixed response to the environment. This approach to human activity is congruent with the researcher's understanding of human functioning as an active process rather than as a response to external forces.

Symbolic interactionism is also congruent with role theory. Symbolic interactionism represents one major perspective from which roles and role performances have been studied within the behavioral sciences (Conway, 1978). The role definitions of experienced NPs are best understood from this interactional perspective.

A number of researchers investigating NP roles have

utilized the perspective of symbolic interactionism. Studies of the developing perceptions student NPs hold about their roles as well as the perceptions that groups of patients, physicians, and registered nurses hold about NP roles will be examined in the review of relevant NP research.

Review of Nurse Practitioner Research

Prior research on NPs has been extensive, incorporating hundreds of studies conducted over a 20 year time period. The NP research reviewed here has been grouped into four categories: role descriptions, role comparisons, role perceptions, and role adjustment. Each category will be discussed further.

Role Descriptions

Early NP research was primarily descriptive in design. The components of NP roles and the settings in which roles were practiced were depicted by numerous researchers.

Ford and Silver (1967) discussed the work of pediatric NPs in community-based health stations. The NPs provided services to ill children, participated in conferences for well children, and held immunization clinics. From this, Ford and Silver determined that pediatric NPs were capable of functioning both independently and interdependently with pediatricians.

Mauksch, a NP, and Young, a physician (1974), described their roles and work experiences in a family medical care center. The NP role was focused on the provision of services to chronically ill individuals and on health maintenance services. The physician role centered around the care of acutely ill individuals. Both viewed the NP and physician roles as complementary rather than competitive in nature.

As the NP role became more widespread in the United States, descriptive studies were conducted to determine the

types of activities NPs performed, the settings in which they practiced, and the types of problems NPs encountered within practice settings. Wirth, Storm, and Kahn (1978) surveyed 50 graduates of a pediatric NP program and noted that the NPs were younger, less likely to be married and more likely to have a baccalaureate degree than nurses in general. The researchers also found that the NPs were more likely to work in ambulatory care settings than were other groups of nurses.

In 1973, the Division of Nursing of the Department of Health and Human Services initiated a longitudinal study of NPs (Sultz, Henry, and Sullivan, 1979). The study was designed to evaluate NP educational programs and to provide information about NPs. A cohort of NP program graduates were evaluated and 1,099 NP graduates were surveyed. The NPs were graduated from 76 certificate and 40 master's programs. Research findings indicated: the NP movement was flourishing across the United States; many NPs were working in rural and disadvantaged urban areas; NPs were satisfied with their roles; and that NPs were well accepted by employers, physicians, and patients.

Several researchers investigated the relationship between NP roles and NP work settings. Zammuto, et.al. (1979) surveyed 191 pediatric and medical NPs working in institutional settings such as hospital outpatient departments, state, county, and municipal health

departments, free-standing health centers, Veterans hospitals, and visiting nurse associations. The researchers also investigated NPs working in noninstitutional settings such as solo and group medical practices. Study findings indicated that the institutional settings formalized the NP role at a more rapid rate than noninstitutional settings. Physician intensive settings utilized NPs less effectively than other settings with fewer physicians.

The researchers further noted that NP roles could be implemented in typical health delivery settings. The rate of role implementation would be influenced by agency characteristics such as size, leadership philosophy, resource availability, and public or private ownership of the work site.

In an exploratory study, Bower (1979) collected data from 45 health workers in five settings: a joint practice setting, a health maintenance organization, a consumer owned clinic, a government run emergency room, and a rural health department. Bower found that NP influence within settings was greater in small practice locations with fewer health care workers than in the larger agencies. The researcher also noted that the amount of time the NPs worked in a setting as well as the sophistication of the activities they performed determined the independence of NP functioning within individual practice settings.

Feldman, Ventura, and Crosby (1987) scrutinized 248 documents related to NP care delivery, NP utilization, and

the health outcomes associated with the care provided by NPs. The authors determined relevance, flaw, and clarity scores for each study. Of the 248 documents, 56 were determined to be the most valid and relevant studies of NP effectiveness.

Role Comparisons

Early NP research was also focused on comparisons of NPs and physicians. The outcomes of NP and physician care were compared by researchers as were the roles of NPs, physicians, physician assistants, and other registered nurse groups.

In 1974, Spitzer and his colleagues conducted a randomized, controlled trial of 1598 families (families were defined as a person or group sharing a common health insurance number). Each family was assigned to receive services from either two family physicians or two NPs in a large suburban practice. Data were obtained over a one year time period by the following methods: administration of questionnaires to an interview cohort, defined as a randomly selected single member from a family participating in the study; performance of time and motion studies of physician and conventional nursing activity performance; and completion of a daily journal for all clinical activities completed by both nursing and medical practitioners.

The researchers found no significant differences in the physical functional, social, or emotional capacities of

those families treated in both experimental and control groups. The researchers also noted that study results demonstrated the capacity of NPs to provide primary clinical care as effectively and safely and with as much patient satisfaction as the care provided provided by physicians.

The ability of NPs to provide patient care comparable to that delivered by physicians was also documented by other researchers (Charney & Kitzman, 1971; Sox, 1979).

Differences in the outcomes of care provided by NPs and physicians were identified by Lewis, Resnik, Schmidt, and Waxman (1969). Two hundred and four patients were randomly allocated into the experimental NP clinics or the control or physician run medical clinics. Patient records were then reviewed after the patients had been in the clinics for a one year time period. Researchers found a statistically significant increase ($p < .05$) in the number of patients seen in the nurse clinics who had returned to part-time or full-time employment as compared to those patients seen by physicians in the control clinics.

The researchers also noted a reduction in the frequency of symptoms reported by the NP patients. No change in symptom frequency was noted for the physician patients. The changes in patient symptoms were postulated to be due to differences in the roles of the two provider groups, with the NPs engaging in supportive role functions as opposed to the diagnostic, technical, and theraputic role functions of physicians.

Ramsay, McKenzie, and Fish (1982) found differences in care outcomes for hypertensive patients attending either nurse or physician managed hypertension clinics. Forty patients were evaluated in each of the two clinics over a fifteen month period of time. Patients were not randomly allocated to either clinic but were reported to be similar in terms of initial blood pressure reading, weight, gender, and employment status. Significant differences in weight reduction were demonstrated for patients in the NP clinic and blood pressures were significantly lower ($p < .05$) for NP patients after twelve months of care in comparison to those patients in physician clinics. The researchers suggested that these outcomes may have been the result of an increased NP motivation to succeed in a new health care role status.

Comparison studies were conducted between NPs, physicians, and physician assistants. Levine et. al. (1976) collected data from NPs and physician assistants (grouped together under the label of health associates) and from physicians over a two week time period. All providers worked in the ambulatory medical and pediatric clinics of a pre-paid group practice. Questionnaires were completed by provider respondents for a random sample of 50% of their patient encounters. Data were collected on the amount of time spent in patient encounters, the types of tasks performed by providers, and the types of patient referrals

completed by providers. The researchers found that the NPs and physician assistants delivered approximately 75% of well-person care and 56% of problem oriented care in the medical clinics and 29% of problem care in the pediatric clinics. Researchers also found that the NPs and physician assistants provided patient care of comparable quality to physician delivered care.

Lewis and Linn (1977) collected data on NP and patient encounters at two, four, and twelve month intervals. The NPs studied were recent graduates of the University of California, Los Angeles family NP program and were employed in health maintenance organizations, public health clinics, and hospital-based ambulatory care programs. Data generated from this study were compared to data generated by the National Ambulatory Care Survey of Physicians from 1983 to 1984. Comparisons revealed that the NPs spent more time with patients, utilized more lab procedures, and employed more traditional nursing functions such as theraputic listening than did physicians.

Scherger et.al. (1977) utilized a review of four hundred and twenty eight patient records to compare the practices of family practice resident teams with teams of family practice residents and NPs. All practice teams worked in a university medical center family practice unit. The researchers measured the frequency of continuity breaks in patient encounters, defined as a visit recorded in the chart by providers other than a family practice resident or NP (both

designated as primary providers). The researchers found a significant difference between these two groups with fewer continuity breaks reported by the NP and resident teams than by the resident teams. The NPs and residents provided greater continuity of care to patients than did groups of family practice residents.

Simborg, Starfield and Horn (1978) studied physicians and non-physician practitioners (defined as NPs and others receiving training to practice primary care under the general supervision of physicians) working in general medical and general pediatric clinics. The researchers reviewed records of 109 physicians and 35 non-physician providers and examined 1,369 patient and provider encounters, finding that the non-physician providers identified more signs and symptoms of disease in patients and prescribed more non-drug therapies than physicians did. The researchers also found that physicians were more likely to follow up on recommendations for non-drug therapies made by physicians than by non-physician providers. Physicians responded more positively to information generated by physicians than by the non-physician providers. Non-physician providers responded positively to information generated by all providers. Researchers noted one possible explanation for these findings was incomplete communication between practitioner groups.

Mendenhall, Repicky, and Neville (1980) surveyed 455

primary care practices (defined as a physician and the one or more NPs or physician assistants working most often with the physician) across the United States to determine the utilization and productivity of both NPs and physician assistants. The researchers found that the physician assistants had a greater number of patient encounters, spent more time in direct patient contact, and generated more income than the NPs did. NPs however, spent more time with each patient encounter than did the physician assistants. NPs also provided more complex counseling services to patients and functioned with less direct physician supervision that did the physician assistants studied.

Celentano (1978) surveyed 143 graduates of a university NP and physician assistant programs and noted that both groups had high employment rates with low job turnover. Celentano also found similarities in the activities performed by both groups of clinicians but noted that the physician assistants had larger caseloads of patients and saw larger numbers of patients per day than did the NPs. The physician assistants were often employed in private practice settings as opposed to the NPs who were most often employed in hospital clinic settings.

Researchers compared the roles of individual NPs. Lewis and Cheyovich (1976) examined the work of two NPs working in the medical department of a Veterans Administration clinic. Observations were made over a one year period of time. The researchers found that the two NPs provided very different

care despite similar occupational histories and practice in similar settings. The researchers also noted that after patients participated in the NP managed clinics they ranked the NPs as an important source of information about health.

Researchers also compared the roles of NPs and other groups of registered nurses. Vacek and Ashikaga (1980) compared the graduates of a university family NP program with a sample of "nonpractitioner nurses" (registered nurses) working in ambulatory, home health, and office settings to determine the differences in their roles. Fifty of the NPs (who were 6 months post graduation) and 244 of the "nonpractitioner nurses" were surveyed as to the frequency with which they performed health care activities. The researchers found substantial differences between the two groups with the NPs more frequently performing activities such as physical assessment, medication prescription, patient education and counseling while the "nonpractitioner nurses" performed more clerical tasks than the NPs did. The researchers additionally noted that the NPs perceived themselves as having a greater impact in the area of patient education than the "nonpractitioner nurses". NPs tended to express more satisfaction about their work in general while the "nonpractitioner nurses" tended to be more satisfied with the responsibility and authority afforded by their positions.

Role Perceptions

Researchers were also interested in investigating the perceptions that physicians, consumers, and nurses held about the NP role. Physician perceptions of the NP role were investigated by Little (1978) who surveyed 140 Northern California physicians to determine physician attitudes toward NP employment. The researcher found that 49% of respondents (N=88) did not plan to employ NPs, 24% had made no decision about NP employment, and 27% of respondents viewed NP employment favorably. Using multiple regression analysis, Little noted that: larger communities were more closed to NPs than were rural communities ($p < .01$), the longer a physician practiced medicine the less likely the physician was to employ a NP ($p < .05$), physician practices composed of a higher proportion of female patients were more open to NP employment than practices with more even patient sex distributions ($p < .04$).

Kahn and Wirth (1978) surveyed 35 physician supervisors each of whom had worked with a NP graduate of a pediatric NP program. The supervisors worked with a NP for an average of 2.1 years. Twenty six of the physicians worked in private practice settings and 74% worked in institutional or agency settings. The physicians felt that well child care and the management of minor illnesses should be shared by pediatric NPs and physicians rather than be performed independently by the NPs. The physicians also felt that the NPs provided necessary services and noted an increase in the range,

volume, and quality of patient care which they attributed to the presence of the NPs. The physicians were unwilling however to grant the NPs independence to manage problems without physician input. In addition, 75% of the study physicians felt that nursing should be controlled by medicine.

In a study of 40 interns and residents working in a Veterans hospital primary medical care clinic, Connelly and Connelly (1979) found that the physicians had positive attitudes toward NPs but actually infrequently referred patients to NPs. Two of the physicians referred more than 50% of their chronically ill patients to NPs, while 34 physicians referred less than 30% of their patients to NPs. This supported the researchers hypothesis of a significant discrepancy between the physician's theoretical acceptance of NPs and physician utilization of NP services.

Fottler (1979) surveyed 735 members of the Western New York Medical Society (41% of eligible respondents) on their attitudes toward NP employment. He noted that 71% of the physicians were unwilling to employ NPs citing reasons such as concern for legal liability, a perceived inability of NPs to perform expanded roles, a lack of economic incentives and a perceived lack of NP applicability to a particular medical speciality.

Fottler also found a positive correlation between favorable attitudes toward NP employment and physicians who

worked in group practices or institutions and a negative correlation between NP employment attitudes and physicians working in solo practices. There was a positive relationship between physician experience with NPs and a willingness to employ NPs. Younger physicians and primary care specialists and psychiatrists were also more likely to have positive attitudes toward NP employment than were older physicians in other specialty areas.

Researchers also compared physician and NP perceptions of the NP role. Burkett et.al. (1978) surveyed 1,000 registered nurses and 1,018 physicians in southeastern Pennsylvania to determine their conceptions of the NP role. Respondents (72% of the nurses and 60% of the physicians) were asked to chose which of 86 listed tasks they felt were appropriate for NPs to perform. The researchers found that the majority of respondents (73% of the nurses and 92% of physicians) felt that NPs should practice with physicians. Only 2.3% of the nurses and 1.5% of physicians indicated that NPs should practice independently. The nurses and physicians disagreed on tasks appropriate for NPs to perform. Disagreements centered primarily around traditional medical procedures such as disease diagnosis, lab test interpretations and initiation of a theraputic regimen with medication. Physician variation in task selection was influenced by specialization. General practitioners were least likely to check most tasks as appropriate for NPs to perform, while obstetricians were

most likely to view tasks such as lab interpretations or drug prescribing as appropriate for NPs to perform.

Levine and associates (1978) investigated the role activities of NPs, physician utilization of NP services, and patient acceptance of NPs. The reseachers interviewed 58 NPs working in a total of 35 Virginia and Philadelphia practice settings. Respondents were asked to report the frequency with which tasks associated with the NP role were performed. All respondents regularly performed routine physical examinations, obtained historical information from patients, counseled patients about diets, and explained the NP role to patients. The respondent NPs frequently ordered lab procedures but seldom were permitted to independently analyze the test results. For example, 66% of the NPs routinely ordered x-rays but only 7% reported that they sometimes analyzed the x-ray findings.

The researchers also interviewed 46 physicians who supervised NPs. The physicians worked in institutional settings (54%) or private or group practices and were specialized in pediatrics (48%) or other medical and specialty practice areas. The respondents cited several reasons for adding NPs to their staff including physician substitution, interest in the NP concept, and help in the reduction of patient case loads.

The researchers also surveyed 1,500 NP patients (with a 46% response rate) and noted that most of the patients were

satisfied with services provided by NPs. The majority of respondents (94%) felt comfortable with the NP, felt that NPs were easy to understand, and noted that NPs were able to answer patient questions.

Davidson and Lauver (1984) investigated the perceptions held by practicing NPs and physicians about the NP role. The researchers chose 15 NPs and 15 physicians working in a variety of ambulatory care settings to respond to a series of patient care vignettes. The vignettes were classified into three categories, those appropriate for NP management, those appropriate for physician management, and those appropriate for management by either provider. Study participants confirmed that the NPs and physicians perceived separate and complementary roles for themselves. The NPs chose vignettes with strong psychosocial and educational components in connection with low-risk physical conditions as appropriate for the NP role. The physicians chose vignettes representing high-risk physical situations as appropriate for physician roles. The participants disagreed on 2 of the 9 vignettes, implying a difference of opinion and some overlap between the NP and physician roles. The researchers recommended further research to assess role overlap where role boundaries are unclear.

Consumer perceptions of the NP role were investigated by many researchers. Storms and Fox (1979) telephone surveyed 2,583 Baltimore residents on their attitudes toward NPs and physician assistants. The researchers interviewed adults in

homes with listed phone numbers and reported that their sample over represented females, the elderly, and the college educated, but was representative of medical services utilization within this urban population. The majority of respondents (95%) had heard of registered nurses. While 52% of the respondents had prior knowledge of physician assistants, only 42% of respondents had prior knowledge of NPs. These numbers were in sharp contrast to the 4.1% of respondents who stated they had actually received services from either physician assistants or NPs. Respondents felt that NPs and physician assistants could perform a variety of medical care functions while under physician supervision. Respondents also felt that NPs could perform more tasks than could physician assistants, although the differences cited were minimal.

Zikmund and Miller (1979) measured the attitudes of 205 rural health care consumers toward NPs. Prior to each interview, each participant was given a definition of the NP role. The NP was defined as "a medically trained person who has passed the state licensing examination for registered nurse and has one additional year of special studies in medicine" (p. 85). The researchers then measured 15 attitudinal variables and found that there was strong agreement among consumers that NPs would be qualified to provide care for minor health problems, and would be expected to provide health counseling to consumers. There

was moderate agreement that NPs would spend more time with patients and their patients would save on medical bills. Respondents were uncertain as the whether NPs would correctly diagnose illnesses or provide more personal service to patients than that provided by physicians.

Other researchers investigating consumer perceptions of NPs found that in general, consumers accepted the NP concept. Consumers were additionally satisfied with the care provided by NPs (Kviz, et. al., 1983).

The perceptions held by registered nurses about the NP role were measured by Wright (1976) who surveyed 237 Texas nurses. Participants were asked to indicate the level of responsibility NPs should assume for a number of activities. Participants were also asked to identify potential implications of the NP role for nursing. The researcher found that there was strong support for NPs assuming responsibility for data collection and dissemination, and for activities such as completing patient health histories, performing triage functions, and managing chronic stable illnesses. Potential implications for the nursing profession were the development of group of professionals who would (a) facilitate communication among physicians, registered nurses, health workers, patients, patient families, and (b) inform patients and patient families about patient condititons. Respondents also felt that NPs would enhance the status of nursing as a profession.

Prior research was conducted on perceptions of the NP

role held by NPs. Linn (1975) described the role perceptions of a cohort of 11 University of California, Los Angeles NP students. Perceptions were measured on the initial class day, and at 6 and 12 months following completion of the 4.5 month NP training program. All of the NP students were employed in ambulatory health settings and had provided primary care prior to entry in the training program. All students returned to their original work settings at the conclusion of their NP training program.

Linn noted that the activities most frequently performed by the NPs involved patient communication through data gathering, teaching or counseling. The researcher noted that the NPs found their work to be interesting, creative, and varied. The NPs felt that they provided better, more comprehensive patient care and that they were in better positions to educate and advise patients following completion of the NP training program. The NPs also felt that their new NP roles were more stressful and less secure than prior nursing roles within the same ambulatory settings.

Knafl (1978) observed and interviewed the 7 students enrolled in a master's family NP program over a 16 month period of time. In this longitudinal field study, the researcher studied student views of the NP role and observed that during the initial phase of the program the NP students focused on learning new information. During this initial

phase, the NP students de-emphasized the incorporation of medical skills into their nursing roles, assuming they would be able to later integrate the skills into their roles. As the NP students became involved in providing care to patients, there was a redefinition of the NP role. Less emphasis was placed on mastery or medical skills and greater emphasis was placed on the nursing component of the NP role. By the time the NP students graduated from the training program, the NP role was equated with nursing interventions rather than exclusively with medical skill employment.

Lurie (1981) investigated the relationship of professional socialization to changes in the role behaviors and attitudes, role content, and working relationships of adult health NP training program graduates. The NP role was defined as the addition of medical skills to a nursing base, allowing NPs greater responsibility in clinical decision-making. Behaviors, attitudes, and commitment to the NP role were compared between 46 NP students (in 5 cohorts or classes) and a comparison group of 12 registered nurses. The researcher utilized 12 scales to measure the NP students at program entry, program midpoint, program graduation, and one year post graduation. The comparison group was measured at 12 month intervals.

Additionally, the researcher conducted observations and interviews with NPs, registered nurses, NP nursing supervisors, and NP physician preceptors. Observations of NPs were made at 6 and 12 months post graduation. The

comparison group of registered nurses were observed one year following initial study contact. Observations of both nursing groups involved nurse-patient interactions. Interviews were conducted with the NPs, 22 nursing supervisors, and 39 physician preceptors were interviewed 6 months following NP program completion. NPs were then re-interviewed one year post graduation to determine the degree of NP role autonomy, the scope of the NP role and the problems NPs experienced within health settings.

Study findings revealed significant shifts in attitudes and behaviors relating to the NP role. Attitudes toward patient care and work with physicians changed positively for the NP students as did nursing self-perceptions and coping skills. Positive changes in nursing care functions and nursing leadership were present for the NP students but were of lesser magnitude. These findings did not support the expectations of the NP program directors that NPs would change relationships with other staff members in practice settings.

Observations of NPs and the comparison registered nurses revealed that the NPs spent more time doing physical examinations educating patients and consulting with physicians than did the comparison nurses. The NPs did not do more psychosocial counseling that the comparison nurse group, suggesting that aspects of NP program socialization were not reinforced within work settings.

The NPs were noted to be functioning autonomously in terms of patient-focused activities at both 6 and 12 month intervals post graduation. The content of the NP role was well understood by NPs, NP role partners, physicians, and NP supervisors. NPs felt support for their roles from physicians with whom the NPs worked, other NPs, and nursing supervisors. NPs also reported little support for the NP role from other registered nurses and from organizational administrators suggesting that effective constraints could be placed on NP work by more powerful members of organizational hierarchies.

The researcher found that socialization for the NP role occurred initially through training and was the most important determinant of role content. Socialization within the work setting was a more powerful determinant of socialization than was the training socialization because the work setting offered the opportunity for professional employment. Professional socialization into the NP role was then viewed by Lurie as a two-step process.

Ward (1979) surveyed 327 family NPs to determine perceived competence in providing health services and alleviating patient problems. All study NPs worked within the United States in a variety of settings including community health centers, physician offices, nurse clinics, health departments, hospital outpatient clinics, visiting nurse associations, schools and other settings. All NPs had been working for an average of two years or more.

Ward found that the NPs judged themselves competent to obtain histories, perform physical examinations, and teach about health and illnesses. The researcher also noted that the NPs practicing in physician office sites and the NPs working in small cities judged themselves to be less competent in general health care delivery, consultations, and referrals to other providers than did the NPs working in large cities or other practice settings. The reseacher found it difficult to draw a singular well-defined picture of family NP activities, and stated that the family NP role may always be characterized by wide diversity. As the NP role matures within the nursing profession, it may potentially be more clearly defined.

Role Adjustment

Role adjustment from student to practicing clinician roles was investigated by Lukacs (1982) in a survey of 135 NPs practicing in obstetrics, gynecology, family, adult, and other specialty areas. The NPs worked in a variety of settings including health departments, family planning agencies, outpatient clinics, physician offices, and emergency rooms. The majority of respondents (86,7%) experienced a distinct adjustment period from student to clinician roles. The adjustment time was around six months in length and was extended for NPs who were the initial NP role occupants within a practice setting (mean= 7.4 months; S.D= 6.9 months). Adjustment times were correspondingly

shorter for NPs preceding other NP role occupants within a setting (mean= 4.9 months; S.D= 3.3 months;p <.01).

The researcher found that the respondents cited a fear of "missing something" and uncertainties regarding the diagnosis and treatment of illness as descriptive of feelings during the role adjustment period. NPs also noted they consulted with physicians more frequently, and rechecked charts more frequently during the role adjustment period.

CHAPTER THREE--RESEARCH METHODOLOGY

Research Design

The purpose of this study was to explore and describe how experienced NPs working in organizational settings defined their roles. The research design selected to investigate the phenomenon of nurse practitioner role definitions was descriptive or factor-searching. A factor-searching design is utilized by researchers to describe, categorize, and conceptualize events or situations through an inductive thinking process (Diers, 1979).

A factor-searching research scheme enables researchers to view situations openly rather than with preconceived ideas of significance. An investigator's understanding of situations is enhanced when both conceptions and methods guide data collection as opposed to data collection that is structured by previously determined concepts and methodology (Brink & Wood, 1983; Diers, 1979).

Factor-searching research methods were selected for this research because the emphasis of factor-searching studies is on the discovery and identification of phenomena. This study focuses on experienced NPs, a nurse clinician group for whom there is very limited information currently available. Few researchers have investigated NPs working for extended time periods and there is minimal data available on the role perceptions of experienced practitioners. The utilization of a more structured relation-searching or association-testing design would not

have been feasible without prior identification and description of the phenomenon in question.

Additionally, a flexible research design provides the researcher with the opportunity to utilize a variety of data collection and analytic strategies. Variation, in turn, promotes the development of a rich and broad data base (Wilson, 1987). Quantitative methods that are structured, control for variance and minimize bias and error. A quantitative methodology would then limit the researcher's ability to investigate potentially relevant data sources, thus potentially limiting the entire study.

The grounded theory methods developed by Glaser and Strauss (1967) were utilized in the analysis of data generated in this study. Strauss (1987), viewed the grounded theory analysis of data as an analytic style or approach rather than a specific methodology. Corbin (1986) noted that analyzing data by utilization of grounded theory methods may be thought of as a process of direct interaction between the analyst and the data. This process occurs over time and moves through a number of distinct phases.

The purpose of grounded theory data analysis is the development of a theory that is derived from or "grounded" in the data itself. Through the identification of variables or processes that describe characteristics of particular social worlds, grounded theory provides a new way to understand the world from which the theory emerges (Brink &

Wood, 1983; Diers, 1979; Hutchinson, 1986).

The researcher employing grounded theory methods identifies patterns of similarities and differences in various incidents. Incident patterns are then organized or coded into concepts and propositions and are, in effect, elevated to higher levels of abstraction. This is an inductive approach to theory development, moving from the specific to the general or utilizing observed behaviors or interactions to derive theory "from the ground up" (Hutchinson, 1986). The process of analyzing ideas developed from collected data and abstracting them to higher conceptual levels leads to a theory that is integrated, consistent, plausible, and close to the original data (Glaser, & Strauss, 1967).

Research Settings

Rationale For Setting Selection

Institutional settings for this study were chosen for a variety of reasons. First, NPs worked within a number of clinics in each institutional setting. This was important because the study was designed to examine NPs in medical, obstetric, and gynecology specialty areas.

Secondly, there were a number of NPs working within each organizational setting. This was important for the researcher in obtaining study participation. Study sites with few working NPs would have potentially increased the difficulty in acquiring experienced NPs for inclusion in the study. The decision to conduct research in

organizational settings was underscored by the knowledge of NP work patterns. The majority of NPs working in the United States are located within clinics or ambulatory offices of large organizational settings (Sultz, et. al., 1979).

Finally, all organizational settings were located within the San Francisco Bay Area. This provided the researcher with increased access to both study sites and potential study participants.

Entry Into Research Settings

Entry into research settings began after approval to conduct the study was granted by the University of California, San Francisco Human Subjects Committee. Initial entry into the study settings was made through each nursing administration department. Appointments were scheduled with the ambulatory nursing directors at one of the health maintenance organizations and the university clinics. Telephone contact was established with the nursing supervisor at the health maintenance organization that was the third study site. The telephone contact was made because the supervisor was known to the researcher.

The research proposal was presented and discussed with each nurse administrator. Questions posed by the administrators were then addressed by the researcher. A major concern of the administrators was the length of time required for completion of the interviews. The administrators were assured that each NP participating in

the study would determine both the time and the place of the the interviews. The reseacher assured the nurse administrators that the interviews would be rescheduled if the NPs requested changes in interview times. Permission to conduct the study within each institutional setting was then obtained from each administrator.

The researcher was provided with a list of NPs working within each institution and the names of NP contacts by each of the nurse administrators. Contacts with the NPs were advised by the nurse administrators as a strategy to facilitate NP participation in the study. The nurse administrators also suggested that the researcher discuss the research proposal with the NPs prior to requesting NP participation in the project. In the university setting, the NP contact was the chairperson of the NP educational program committee. The NP contacts in both health maintenance organizations also functioned as NP supervisors.

Initial contact was made by the researcher in a telephone call to each of the NP contacts. The study was briefly explained to each NP and the researcher then scheduled a meeting with all of the NPs working in each organization. In the university setting, the researcher attended an 8 A.M. practitioner meeting and briefly presented the research proposal. Questions about the project were then addressed by the researcher.

The researcher attended a noontime NP business meeting at one health maintenance setting and presented the research

proposal to a group of NPs and their physician consultant. At the second health maintenance setting, the research proposal was informally discussed with each of the NPs. This was done informally because the NPs were known to the researcher. Individual NPs were then contacted and asked to participate in the research project. This was accomplished by either a telephone call or personal visit with the NP.

Description Of Research Settings

The experienced NPs who participated in this research were all employed in one of three formal organizational settings. A brief description of each setting follows.

The NPs employed within the university setting worked in a large, modern, glass and concrete building located within a university campus. To reach the NPs working in the university setting, one enters the building and takes the elevator to one of seven floors where a number of offices and clinics are located according to medical specialization. After walking down a long hallway, one reaches a large reception desk where a receptionist provides directions to each NP's office.

Each NP worked in a small, windowless room located along a long, inner corridor. For all but the administrative NPs, this room was both office and examination space, and contained a desk, phone, several chairs, sink, and examination table. The table was in actuality a small vinyl covered bed which was covered with a strip of thin, white

paper. Light colored cloth curtains were suspended from the ceiling around the examination table and could be opened or closed as needed. Each of the NPs had placed posters or art prints on the beige office walls for decoration.

In contrast to the university setting, the two health maintenance settings were located within a complex of hospital, office, and administrative structures. Each of the clinic buildings was modern in design, and was surrounded by landscaped flowers and shrubs. One enters the clinic buildings into a modern lobby which contained a directory listing the names and office locations of all physicians and NPs.

To reach the practitioner offices, one takes the elevator from the lobby to the designated clinic location and walks down a carpeted corridor to a small waiting room decorated with soft lighting, carpeting, and bright colored art work. There was a reception area adjacent to most waiting rooms. In many of the clinic settings, this area was glass enclosed. One can speak to the clinic staff only by speaking through a small opening in the glass.

In the health maintenance settings, the NP offices and examination rooms were located along the sides of a long and narrow corridor which formed a ring around the clinic building. Each of the NP offices contained two desks, chairs, and bookcases. The examination rooms were separate spaces, and each contained an examination table that was surrounded by a curtain suspended from the ceiling. There

was also a small stool, sink, light, and a small desk in each room. Each of the study NPs in the health maintenance settings shared office space with another NP and had the use of one or two of the patient examination rooms. As one of the NPs noted, "actually, we've got 8 exam rooms and we've got 5 people." In situations where there were more providers than available examination spaces, the NPs frequently moved to other clinics to utilize available examination rooms.

Sample

Rationale For Sample Selection

A convenience sample of 23 working NPs were included in the study. Nurse practitioners with a minimum of two years of prior NP role experience were selected for study inclusion for several reasons. First, the majority of researchers investigating NP roles have focused on either students learning the NP role or on neophyte clinicians. Few researchers have investigated experienced NPs. Secondly, research that has been focused on experienced NPs has primarily addressed NPs with one or two years of NP work. The role perceptions of NPs with two or more years of experience have not been widely investigated to date.

Each of the NPs selected for inclusion in the study was employed in one of nine different ambulatory clinics. Each clinic was located in one of the three study sites and included medical, obstetrics, gynecology, screening, and

specialty practice areas. These fields were selected by the researcher because many experienced NPs were educated in NP programs that focused NP training in these specialties.

Additionally, NPs working within institutional settings such as those selected for this research are more likely to be working within medical or obstetric and gynecology clinics. This is a consequence of organizational hiring practices and the current structure of health care institutions.

The NPs who participated in the study came from diverse educational and experiential backgrounds and were varied in age and gender. This diversity provided "richness" to the data collected. Richness, a sampling principle utilized in grounded theory analysis, allows for sample adequacy on the basis of diversity and the researcher's ability to fully develop and explain or saturate categories derived from data collection and analysis (Diers, 1979).

Protection Of Human Rights

Participation in this study was strictly voluntary. Each participant was advised of that prior to signing the written consent form. Participants were also advised that they had the right to refuse to answer any questions and could terminate the interview at any time.

Permission was obtained to tape record interviews and participants were informed that they could request to have the taping stopped at any point during the interview process. The participants were further informed that all

interview data would be confidential, and all interview materials reported in a format that would protect individual identities.

Data Collection Methods

The field methods utilized to colloct data for this study were informal interviewing, direct observations, and document analysis. The interviews were "guided conversations", designed to elicit an informant's experiences of particular topics or situations. The information obtained from these encounters was then qualitatively analyzed (Lofland & Lofland, 1984).

Direct observations of the clinic settings were made by the researcher both before and after the interviews were conducted. A record of observations was made in a series of field notes that were later reviewed and analyzed. The observations were employed to describe and understand NP actions and the organizational settings in which the NPs functioned.

A number of documents were reviewed and analyzed by the researcher. The documents included organizational memos, procedure and protocol manuals, NP journals, newspaper and magazine articles, and minutes from NP meetings. These materials provided additional data for study analysis.

Data Collection Procedure

Data were collected during informal interviews that were scheduled at the convenience of each study participant. The

interviewing took place in the work settings, usually in NP offices or clinic conference rooms. Interviews were usually scheduled early in the morning or during NP lunch breaks, or in the late afternoon at the conclusion of NP work hours. All interviews were tape recorded and notes were taken by the researcher before, during, and at the conclusion of each interview.

Each of the interviews began with a series of general questions. Information was obtained about each participant's age, registered nurse and NP educational preparation, prior registered nurse and NP work experiences, and the number of years of both registered nurse and NP experiences. The participants were then asked to describe current NP work and their general perceptions of NP roles. The interview questions and interview content were determined during the course of each interview. The interviews were varied in duration, with the majority of interviews approximately one to one-half hours in time.

At the conclusion of the interviews each study participant was then asked if she/he would consent to a future follow up telephone call by the researcher. The NPs were advised that the telephone follow up would be designated for data clarification. Each NP was advised that she/he was under no obligation to agree to any future telephone contacts.

Direct observations were made by the researcher before, during, and at the conclusion of each interview. The

researcher arranged to arrive at each clinic setting prior to scheduled interview times. Time was spent sitting in clinic waiting rooms, hallways, and NP offices. This provided the researcher with an opportunity to observe the study participants interacting with patients and other clinic staff members.

Relevant documents were reviewed and analyzed by the researcher as data were being collected. The documents reviewed included minutes from the Golden Gate Nurses' Association Primary Care Interest Group meetings, a monthly NP journal, and position papers on the roles of NPs in San Francisco. Articles discussing NP issues in state and national nursing newspapers, correspondence from the California Board of Registered Nursing relating to prescribing information for NPs, and a number of medical and nursing journals were additionally reviewed by the researcher.

All study participants were informed that the researcher would provide the study findings to them at the completion of the study. Participants who requested this information were informed that they would be given the option of receiving either a written report or an informal oral presentation of the research findings.

Data Analysis

Data analysis for this research project proceeded in phases and was done concurrently with both data collection

and data processing. In the initial phase of analysis, data obtained through observations of study participants and informal interviewing were collected and recorded. Tape recorded interviews were transcribed and scrutinized as were the researcher's field notes. Initial evaluation of the data was done by investigating each sentence of the tape transcripts and notes for ideas and themes about role definitions.

For example, scrutiny of early tape transcripts and field notes sentence by sentence revealed ideas about the types of role activities performed by the study participants. Activities included descriptions of work settings, and descriptions of activities the NPs routinely performed.

The line by line investigation of interviews and field notes corresponds to initial coding in grounded theory data analysis. Initial or open coding is done in the beginning of data analysis of field notes and interviews. The aim of this line by line or word by word scrutiny is the production of concepts that match the data (Strauss, 1987). Category discovery occurs here as the data is broken down into bits and pieces and attempts are made to view abstractions of phenomena in the data. This is the major unit of analysis in grounded theory (Corbin, 1986).

The initial interviews with the study participants were then compared by the researcher in an attempt to identify patterns of similarities and differences in the data. For

example, descriptions of the types of activities routinely performed by the study practitioners were compared and similarities were noted in activity performance. Differences were noted in the number of activities performed, and in activity selection, or what tasks were performed at any given time.

The comparison of early interviews corresponds to the first stage of constant comparative analysis. Comparison making is utilized as a strategy to discover and to build on initial concepts and categories. Comparisons are made by examining the similarities and differences between incidents or cases (Corbin, 1986).

As categories were being developed by the researcher, questions were additionally being raised as part of the category development process. For example, questions about the types of activities the NPs performed were addressed and the category of activities was expanded to include specific activity types. Two sub-categories of nursing and medical activities were identified through review and re-review of the data. Questions were then raised about each sub-category. Some of the questions were: What is a medical activity as compared to a nursing activity? When were specific activities performed? Why and how did the NPs choose tasks to be performed?

Questioning occurs throughout the entire data analysis process. This level of questioning, however,is designed to

build and to densify categories that have been previously identified (Corbin, 1986).

Information about developing categories was then organized into written memos or short notes written by the researcher to herself. The memos included category descriptions and ideas about the developing categories. For example, a memo was written by the researcher about the types and subtypes of NP activities. Ideas about the sub-categories of nursing and medical activities were also included in this short note. Memos are an analysts written record of the analytic process. In memo writing the analyst is able to record hypotheses and then compare, verify, and modify or change the hypotheses with the addition of additional data (Corbin, 1986).

The interviewing of study participants continued at the same time. Ongoing interviews were still focused on the role perceptions of the study NPs, but were now directed toward identified and emerging categories. This was done to allow the researcher to answer questions derived from the analysis of prior interviews. For example, as the category of nursing activities was being developed, it was noted by the researcher that discussions of activities in early interviews clearly identified types of medical activities performed by the study NPs. Nursing tasks, although frequently discussed, were not clearly identified. Thus, in subsequent interviews, study participants were asked to identify, define and discuss specific examples of nursing

activities.

This process corresponds to theoretical sampling, an analytic strategy employed to build and densify categories. In theoretical sampling, the analyst moves to additional sites or populations to gather data based on the evolving theory. Sampling theoretically is continued until all of the major variables are explored and the categories fully developed (Corbin, 1986).

In quantitative research methods, the sample group is predetermined prior to the onset of data collection and analysis. In grounded theory research methods, sampling decisions are made theoretically at all points in the research process (Hutchinson, 1986). The researcher makes decisions about sampling based on the need for information required to develop, delimit and to complete all theoretical coding (Corbin,1986; Hutchinson, 1986).

As new interviews were conducted, the constant comparisons between newly obtained data and previously collected data continued. The researcher returned to the data for information to answer questions being generated about the developing categories. For example, questions about NP activities resulted in the identification of sub-types of nursing and medical work such as clinical, communication, and health focusing tasks.

The goal of this process was theoretical saturation. Theoretical saturation can be defined as the development of

all theoretical codes to a point where "no new conceptual information is available to indicate new codes or the expansion of existing ones" (Hutchinson, 1976, p. 125). Saturation suggests that any missed data will have minimal effect on the developed theory (Glaser & Strauss, 1967; Hutchinson, 1986).

As categories began to take form, the researcher then linked them together. Linking of categories to form a theory required a great deal of trial and error. Categories were arranged and then rearranged together in differing patterns to explain how the study participants defined their roles. Analytic diagrams were utilized to enable the researcher to visualize the structural formations of linked categories. Categories were also subsumed under larger units, or higher level categories. For example, NP activities were subsumed under a larger category of NP role definitions. The category of role definitions was in turn linked to higher levels of categorical abstractions to explain the process of role delineating utilized by the study participants.

Developing and forming linkages among categories is a process of conceptually ordering a large data mass (Corbin, 1986). The theory is then built around a central or core category, the main theme or pattern recurring throughout the data. The core category explains the major action in the data (Corbin, 1986).

Development of a core category was central to the

integration of the data analysis. Identification of the core variable or category in this research project was achieved after much review of the data, development of analytic memos, and after many discussions with other researchers about categories and proposed linkages. The categories were conceptually reorganized many times before the final linkages were accomplished.

In the final analytic phase, the theory was written with the use of memos and analytic schemes. The categories, their linkages, and the core category were written in narrative form. The theory developed from this process was continually refined by the researcher during the writing process.

The grounded theory analysis did not occur in the discrete and circumscribed phases previously described. The phases of category identification, development, and linkage were frequently overlapping. The refining process continued throughout all stages of the research project.

In final form, the sub-categories, categories, and linkages are developed into a coherent theoretical presentation of the core category. A conceptual model depicting the core operational process further explains the relationship of category components and dimensions.

CHAPTER FOUR--RESEARCH FINDINGS

The research findings from this study are presented in this chapter. The initial section of the chapter deals with information about the study participants, the context of practitioner roles, and the content of practitioner roles.

The second section of this chapter provides information about NP role definitions. The role definitions of the experienced NPs are identified and the contextual factors and the strategies which influence NP role definitions are presented for discussion.

The research findings are relevant for all of the experienced NPs in the three research settings and in all areas of specialization.

Nurse Practitioner Role Information

Biographic and Demographic Role Information

The NP role is initially described through biographic and demographic data obtained from the study participants.

Biographic Information

The ages of the NPs who participated in this study ranged from 28 to 44 years. The majority of the NPs (65%) were between ages 35 and 40. Twenty one (91%) of the NPs were female, two NPs were male.

Educational Preparation

The educational programs attended by the study participants varied in content, but could be classified as either continuing education, baccalaureate, or master's

degree.

Thirty percent of the 23 NPs in the study attended continuing education programs. These programs ranged from 6 months to 1 year in length and were designed as post graduate programs for individuals who had previously completed basic registered nursing study. The continuing education courses were primarily associated with university schools of nursing. One participant did attend a program developed by a western health maintenance organization. Individuals completing continuing education programs received certification as nurse practitioners.

Thirty percent of the NP participants received their NP training in conjunction with college or university baccalaureate nursing programs. The programs varied in length from 1 to 5 years. The majority of these participants had registered nurse training prior to entering these courses. Two of the NPs however, recieved basic registered nurse training in conjunction with their NP training. Individuals completing these programs received NP certification in addition to a baccalureate degree in nursing.

Forty percent of the participants completed graduate nursing programs at the master's degree level. Graduate NP programs were two years in length and all of the participants had completed registered nursing training before entering into graduate work. Individuals completing these educational programs were awarded NP certificates as

well as master's degrees in nursing.

Each of the educational programs prepared the NP in several areas of specialization including family health care, women's health care, adult medicine, and obstetrics and gynecology. Program specialization was not dependent on the type of educational program or upon the certificate or degree awarded upon program completion.

Occupational History

The number of years of experience in registered nurse roles prior to entry into NP roles varied considerably among the study NPs. Only one of the NPs reported entering into NP work without any prior nursing experiences. Two of the NPs (9%) had experience levels ranging from 3 to 6 months in length. Eleven of the NPs (48%) had a range of 1 to 5 years of registered nurse experience prior to beginning their NP roles while 7 of the study NPs (30%) experienced 6 to 10 years in registered nurse roles. Two of the NPs (9%) worked for a total of 11 years within registered nursing roles.

Wide variation existed in the total number of years of NP experience held by each of the NP participants. Each NP had a minimum of 2 years within a NP role as a prerequisite for inclusion into the study. Seven of the NPs (30%) had a range of 3 to 5 years of NP experience. Eight of the NPs (35%) had worked in practitioner roles for a total of 6 to 10 years, while 8 of the NPs (35%) had a range of 11 to 15 years of NP role experience.

Each NP discussed work experiences following completion of the educational programs. Three of the NPs were currently employed in their initial job sites. The remaining study NPs had been employed in one or more NP positions within a range of locations.

Four of the study NPs (17%) had prior experiences in migrant farm clinics or rural community clinics. Three of the study participants had prior work experiences in medical group or physician-owned practices. These were usually family based, requiring the NPs to provide a wide range of services to both children and adults.

The majority of the NPs noted prior work experiences in one of several organizational settings. Eight of the NPs worked in ambulatory clinics of health maintenance organizations. Seven of the NPs (30%) had been employed in hospital based ambulatory clinics. Four NPs (17%) worked in a variety of Planned Parenthood clinics and 4 NPs (17%) taught practitioner students in one of several university based nursing programs. In addition to these settings, one of the NPs worked for a state public health department, while another NP worked as a camp nurse and a third NP participated in an osteoporosis drug testing study.

Motivation For Entry Into NP Roles

Participants in this research project discussed their motivations for entry into practitioner roles. While each individual had a different reason for NP role selection, most choices originated from either a dissatisfaction with

other nursing roles or a desire for change to a new nursing role.

Dissatisfaction With Prior Nursing Roles

Many of the study participants chose entry into NP roles because of dissatisfaction with prior nursing roles. As one of the NPs noted the following:

> After spending about 5 years in a critical care setting, either ER (emergency room) or ICU (intensive care unit), I found that I was empathizing less with patients and was becoming more and more involved with machinery ... So I looked around in nursing for something else that I might do ... I opted for the NP curriculum as a way of perhaps establishing some higher career goals for myself. A place in the profession where I felt that my continued growth, my career advancement and my job advancement could all be addressed.

Another of the NPs commented:

> I was very burned out in nursing ... I found myself traveling and got to Asia ... the kind of work there was for me in Nepal was to go up to the hills and help the people, diagnose them, treat them, deliver the babies. Well I realized I had none of those skills. I didn't know anything ... except how to be a nurse in a hospital around a lot of equipment. I knew nothing about common illnesses at all.

Desire For Change

Many of the study participants made decisions to enter NP roles because of a desire for change. Some of the study participants wanted to "do more", to add to skills they had attained as nurses, or to augment future nursing work. " The NP role seemed like a good idea, to go back into the community and work with well people...to have those extra assessment skills." Another individual stated, "When I was working in the ER, there was a NP ... And it struck me that was an ideal situation, that a NP could really be useful in an ER seeing patients who didn't really have emergent problems but who had some urgent problems."

The NP role was also perceived by the study participants as a mechanism for increasing professional independence and autonomy. One of the NPs noted that NP work "appealed to me ... I think because you get more responsibility ... you get closer interaction with patients. I think you can work more independently. Others stated, "I was looking for more. More responsibility. More respect." "I didn't perceive myself as being a staff nurse the rest of my life. It's not that I didn't like it, I didn't feel challenged. The role of the NP came about because I felt I'd be making a bigger impact on the patient's life."

The NP role was also perceived by several of the participants as "representing everything good about nursing." NPs were viewed as "functioning at a very high, complex level of practice...the wave of the future."

The Context of NP Roles

The context of NP roles is discussed in terms of complementary roles and the patient appointment process.

Complementary Roles

The study participants worked with a variety of individuals in roles complementary to practitioner roles. In the university setting, there were between 1 and 4 NPs in many of the clinics. Additionally, the clinic staff included: a receptionist; licensed vocational nurses, and nursing assistants; and a number of physicians, including medical students, interns, residents, and attendings. During the hours when patients were being seen in the clinic, there were between 2 and 10 physicians working in each clinic along with the NPs.

There were between 1 and 4 NPs in each of the health maintenance clinics. The NPs worked with several medical assistants or licensed vocational nurses and a number of staff physicians. There were no students in these clinics. In one of the clinics, the NPs were placed together. The NPs worked with only one physician, in contrast to the other clinic settings where the NPs worked with a number of attending physicians. The NPs who were grouped together were in effect "geographically isolated" from all other physicians within the health maintenance organization.

Interactions with physicians were identified as important by the study participants There were

administrative expectations in all institutional settings that all NPs would engage in consultative interactions with one or more physicians.

In the university setting, the practitioners were expected to to consult with the residents or attending physicians assigned on a rotating basis to the clinic in which the NPs worked. The practitioners were able to discuss patients or problems with any of the medical students or interns working in the clinic or with physicians in other university departments.

In the health maintenance settings, the NPs were expected to consult with the physician or physicians working in their clinics. While the NPs were able to consult with physicians working in other organizational areas, administrators expected the NPs would consult primarily with assigned physician consultants.

The Patient Appointment Process

In both the university and health maintenance settings, there were a number of channels designated to assign patients to each NP schedule. Patient appointments, or prearranged time allocations for those individuals visiting the NPs, were the primary mechanisms for patient channeling or scheduling.

Patients primarily obtained NP appointments by calling a specific appointment service telephone number or by walking into a setting and going to an appointment window or office. Clerks with minimal formal medical training but with

organizational experience scheduled these appointments.

Appointments with the NPs were scheduled for the same day or for several weeks or months in advance. Appointment timing was dependent upon several factors such as the number of scheduled appointments the NPs had available for any given day or the amount of time patients were willing to wait for NP appointments.

Patients utilized other mechanisms to obtain appointments with NPs. In one of the university clinics, a patient could walk directly into the clinic to be seen the same day. The patient would talk briefly with a triage nurse who obtained a medical history and the patient would then be asked to wait until the NP is available to examine him or her.

Patients were also directly referred to the NP by other professional staff members including physician consultants. Other practitioners and registered nurses initiated patient visits as well. Patients in the health maintenance settings were frequently referred to the NP by triage nurses. Triage nurses were registered nurses who talked with patients about their problems and then assigned patients to the NPs or to other providers within the organization. In several of the health maintenance clinics, the NPs had developed guidelines for the triage nurses. The guidelines specified both the assignment of patient problems that the NPs wished to evaluate as well as those problems

which the NPs felt should be assigned directly to physicians.

The Content of NP Roles

The content of NP roles is discussed in terms of the activities NPs perform and the daily structure of NP work. Role content is further delineated by a description of a typical NP work day.

Role Activities

The experienced NPs identified a number of activities that they associated with the performance of NP roles. While some specific tasks were associated with the specialization of particular NP roles, either medical, obstetrical, or gynecological, the majority of the activities were performed by NPs working in all three specialty areas. Activities were grouped into clinical, educational, and administrative categories.

Clinical activities. Nursing and medical activities were described by the study NPs as the major clinical tasks performed in association with practitioner roles. The nursing activities described were similar to those performed by registered nurses in other nursing roles. The medical activities described were similar to those performed by the occupants of physician roles.

The study NPs identified a number of of nursing tasks. Physiologic activities encompassed nursing tasks such as obtaining and monitoring patient vital signs or measuring blood pressures, pulse rates, and temperatures. Performance of immunizations, provision of oral and injected medications

to patients, and skin testing for infections such as tuberculosis were additionally described as nursing activities.

Communicating nursing activities encompassed patient teaching and counseling on a wide range of subjects such as weight loss diets, guidelines for adequate nutrition in pregnancy, recommendations for exercise programs, and self breast examinations. Communicating activities involved "giving specific guidelines on how the person can accomplish it [specific goal] rather than just saying you need to [change a problem]."

Listening to patients was described as an important communicating activity. As one of the study NPs commented, "NPs use a variety of conversational skills to listen to what the person has to tell you."

Translating and interpreting were other communicating activities described by the study NPs. The NPs were frequently involved in "translating the medical terminology so that a patient can understand." For example, the NPs frequently explained the meaning of specific laboratory tests to patients in language which the patients were able to comprehend.

Clinical networking was another nursing activity identified by the study participants. Clinical networking encompassed patient referrals to organizational and community agencies, "getting people in to see the

coordinated home care person ... or get the riders service to take them here and there." One of the NPs noted, " I think that NPs have a better handle on community resources than the physicians do."

Clinical networking involved "making more use of ancillary personnel" in treating patients than physicians or other providers. The practitioners stated that they utilized the services of social workers, dieticians, and clinical nurse specialists more frequently than did their physician co-workers.

Focusing on holism was another nursing activity identified by the study practitioners as important to NP role performance. This was described as a focus on the "total patient." The study NPs focused on multiple aspects of an individual's life or looked "at the patient holistically" , rather than dealing only with the patient's diseases or medical problems.

> For the NPs, viewing patients holistically involved: a lot of assessment going on at different levels. It's not just related to the physical problem but what's going on in this person's head that makes this a problem ... It's assessing the individual's level of being able to work with them on their level.

Additionally, the NPs stated, "we are indeed trained to manage and inclined to manage the human response to illness rather than the illness itself."

Focusing on health was a final nursing activity

identified by the study NPs. One NP noted, "I do a lot of well adult physicals and health care maintenance. Health care maintenance for me means keeping people healthy, in looking for the healthy part of people." For the study participants, focusing on health involved activities designed to prevent disease and promote wellness. This was described as "preventive types of care."

In contrast to nursing activities, the study NPs identified physiologic medical activities as a group of specific procedures which included performing pap smears, culposcopy, prescribing drugs, performing surgery, and diagnosing and treating diseases. Physiologic medical activities were defined as "a lot of readily measurable activity ... more definitive and easier to evaluate."

The study NPs noted that performing medical activities involved a "clinical medical knowledge base ... knowing biochemistry, physiology to a detailed degree ... all the pathophysiology of diseases." This medical knowledge base was differentiated from nursing knowledge by the amount of information available on disease pathology and also by the medical focus.

A medical focus was defined by the study NPs as a "pathology focus", a "focus on the disease process, pathology, and curing the disease ... looking more at the illness side of the continuum." In contrast to nursing, this illness focusing was one in which the emphasis was

placed on "curing the problem so it won't come back but not taking care of the whole person ..."

Educational activities. Many of the study NPs identified several types of educational activites additionally performed in conjunction with NP roles. These tasks were performed in all study settings and all areas of specialization. Educational functions were performed by registered nurses and some physicians as well as by the study NPs.

Group teaching was defined by the study practitioners as an educational activity that involved the development and teaching of classes for groups of patients and family members. Examples of classes included those on breast feeding, natural childbirth, menopause, hypertension, and the treatment and prevention of colds and respiratory infections.

Program developing was another educational activity described by the study NPs. Program developing involved the creation of programs designed to teach patients about specific topics such as normal pregnancy or wellness. Program development involved the formation of a series of classes as well as the writing of pamphlets or informational materials for patients and their families.

Precepting NP students was described by only those NPs working within the university setting. As one of the study NPs noted, "I'm a clinical faculty member and I precept NP students going through the ... adult, geriatric, and

occupational health [programs]."

Precepting students involved monitoring and evaluating student interactions with patients as well as evaluation of student treatment of patient problems.

Administrative activities. Administrative activities were associated with the roles of a selected number of the study NPs in both the university and the health maintenance settings. These NPs performed administrative tasks in addition to a variety of clinical and educational tasks.

In the university setting, selected NPs were organizationally allocated several hours per day for administrative activities. In the health maintenance settings, selected NPs were organizationally allocated several hours per week for administrative tasks. The administrative activities described by the NPs were similar to those performed by other organizational administrators.

Time scheduling was an important activity delineated by the study NPs. This involved the organization of NP work hours and the scheduling of NPs to work in specific clinic locations.

Supervising and evaluating NPs and other clinic staff were described by the study NPs as important administrative activities. Supervising involved the "hiring and firing of the clinic staff" as well as the interviewing of potential NP staff and the orientation of "new hire NPs" to the clinics. In association with supervising, evaluating

involved the completion of yearly performance reports on NP staff, licensed vocational nurses, nursing assistants, and other clinic staff members.

Clinic managing was another administrative activity described by the study NPs. Clinic managing involved the tasks associated with the daily operation of the clinics including "ordering supplies and the equipment and the maintenance of the physical plant ... managing all the medications."

Administrative networking was a final area of administrative activity identified by the study NPs. Networking was described as "work with other administrative nurses" and work with "clinic administration closely on many issues, some cost, budget issues ... patient related complaints, committee work ... going to lots of meetings."

The Daily Structure of NP Work

For the majority of the study participants, the appointment schedule formed a structure for the daily work routine. The NPs received a printed schedule listing the names of the patients to be seen that day as well as the time allocation for each patient. In the university setting, the NPs were usually allocated 30 minutes for patient visits. Patients initially entering the organizational system or visiting the NP for the purpose of a complete physical examination were allocated 60 minutes of NP time. A one hour lunch break was included in practitioner work schedules. One day per week the NPs were

allocated a four hour block of time without scheduled patient visits. The NPs utilized this time to attend meetings, complete paperwork, and follow up on any unfinished work they had accumulated.

There were several exceptions to prearranged scheduling in the university setting. The NP working in the "drop in" clinic did not work with a fixed appointment schedule. "In this clinic we don't have blocked time off. The clinic never closes...the clinic doesn't close for lunch and so you just have to find the time that's best and just sneak out." The patients entering this clinic were seen the same day and were usually evaluated sequentially as they came into the clinic. The NP working in this clinic was expected to examine two patients per hour although this requirment was flexible, depending on the numbers of patients entering the clinic at any given in time. The NP was expected to remain in the clinic until all patients had been treated.

In the health maintenance settings, all NPs worked within the boundaries of pre-determined appointment schedules. The NPs stated, "our schedules are set up in advance so that we are scheduled a patient every 15 minutes. If we have physicals [complete physical examinations] on the schedule we're given a half hour for the physical." The work day was divided into these 15 and 30 minute appointment slots. Two of the 15 minute time slots per day were labeled as phone time. This time was allocated for calls to

patients at home. Usually the NPs provided patients with test results or answered specific patient questions. The NPs noted that telephone time was fequently filled with patient appointments. This occurred when there were more patient requests for service than there were available appointment times.

All of the NPs working in the health maintenance settings were allocated one hour for lunch on their daily appointment schedule. This was expanded to an hour and a half one day per week when the NPs attended prearranged educational or business meetings with physicians or other practitioner groups.

Description of a Typical Work Day

A typical work day for the study participants was centered primarily around patient work. Each of the experienced NPs usually arrived at her/his office between 8 and 9 in the morning. The practitioners completed paperwork or had coffee with colleagues before beginning the initial patient appointments. As previously noted, patient work encompassed a number of activities. The patient appointment schedule structured the work day for the majority of the study participants and was similar to physician work schedules.

Following a lunch break, the study NPs began their afternoon clinic sessions which were similar in format to morning appointment sessions. Many of the clinics operated until 4:30 or 5:00 in the afternoon and patients were not

given scheduled appointments with the NPs after these times. The study NPs however, frequently remained late in the evening to finish paperwork, complete entries in patient charts, or telephone patients with test results.

Definitions Of The Nurse Practitioner Role

Two distinctive and disparate nurse practitioner roles have been identified by the study participants. These two roles, the individually desired role and the institutionally expected role will be first discussed. The disparity existing between the two roles will then be delineated. Contextual factors influencing the amount of disparity between roles will be examined as well as the strategies employed by the study NPs to reduce or accommodate to disparity. Consequences of this process will then be presented and analyzed further.

Few analytic distinctions were noted between the three organizational settings and the areas of NP specialization. The discussion of the study findings reflects these similarities.

Individually Desired Role

The first of the two roles identified by study practitioners was the individually desired role. This was the role that every NP wanted to perform. It represented the ideal role for the study NPs, one in which all study NPs had been educated to enact. The individually desired role was delineated by the following: professional nurse identity, professional autonomy, and activity integration. Each of these elements will be discussed further.

Professional Nurse Identity. As the initial component of the individually desired NP role, professional nurse identity was defined by the study NPs as a strong

association with other members of the nursing profession. The study NPs compared themselves to other professional registered nurses. This comparison revealed both similarities and differences between the NPs and others in professional nursing roles.

Similarites between the experienced NPs roles and other professional nursing roles were described by the study NPs. "I'm a nurse and I take care of normal problems." "I'm a registered nurse with basic registered nurse skills and background."

Differences between practitioner and other professional nursing roles were delineated by the study NPs who stated that they were nurses who "have gone on for more advanced training" or had a "special training and health promotion focus." The study NPs identified their roles as "an extension of the nursing role", or "an extension of the nursing role in more specified areas doing health maintenance." Practitioner roles were viewed then as "nursing roles which require additional skills in treating the human condition."

Professional Autonomy. Another component of the ideal or individually desired NP role was professional autonomy. When describing autonomy, the study NPs referred to professional independence. This was described as independent decision making or "... being able to do whatever I want to do in a room ... Independence in terms of my own independent

judgement and assessment ... I am told who to see but nobody tells me how to see them ... I make that decision." The study participants also defined independence as the capacity of NPs to "think for ourselves."

Professional autonomy denoted the responsibility and accountability the NPs felt towards their patients. The study NPs noted that this occurred "when you make an assessment on a patient's state of health and make a plan of action." As one of the study participants commented, "When I see a patient, that patient is my responsibility. Their problem then becomes by problem and we [the NP and the patient] have to find a solution for the problem." For the study NPs, autonomy meant being "ultimately ... responsible to people."

Controlling all aspects of the professional role was another characteristic of professional autonomy identified by the study NPs. "For me, having ... control over my schedule would be critical." Controlling scheduling was felt to be important by all of the NPs because they worked within organizational settings where, as previously described, most daily work was structured around patient appointment schedules. The study NPs noted that the ability to control the daily work schedules allowed the NPs to moderate the numbers of patients they would be required to assume responsibility for at any given day. Control of the scheduling would also permit the NPs to more effectively regulate the severity of the patient problems scheduled for

NP intervention.

The ability to control other aspects of the professional role such as pay scale and weekly work hours was associated with professional autonomy. Decision making within organizational settings were additionally cited as a significant aspect of controlling or professional autonomy by the study NPs.

Activity Integrating. Activity integrating was a third important characteristic of the indiviudally desired NP role. The study participants employed strategies to integrate the clinical, educational, and administrative activities identified in the section on role description. Meshing was one strategy utilized by many of the study NPs to integrate activities. Meshing involved the combination of different activities. As one of the NPs stated, "I carry that nursing orientation with a very strong dose of medical training." Another practitioner commented, "the NP role is not just well physicals and counseling but should be a variety of roles built into one practitioner." NP work involved "doing some just educational things, not have all of my time tied up with doing appointments be they physicals or be they episodic care ... doing some administrative work along with seeing patients. Have a combination of the two things."

The study participants also discussed balancing as a second activity integrating strategy. For one of the NPs this

involved, "applying the principles of preventive health care intervention that I learned as a NP into an acute care setting." Another NP commented:

> the NP role requires a balance of nursing and medicine. It requires a solid grounding in medicine and it requires an expectation and acceptance on the part of the health care team and the patient that counseling and education will be the central part of the care process.

Balancing the elements of nursing and medicine was accomplished differently by individual practitioners. As one of the experienced NPs stated, "my hands are working like a physician but my brain is working like a nurse." Another of the NPs was able to balance the nursing and medical components of the desired role by "carrying a lot more knowledge of medicine than the average registered nurse and [carrying] a lot more knowledge of the nursing process, [the] humanistic side of health care than the average physician."

Institutionally Expected Role

The institutionally expected role was the second of two roles identified by the study participants. In contrast to the individually desired role, this was the role that the study participants primarily occupied within each of the organizational setting. Institutionally expected roles were distinguished by the following: medical associated identity, diminished professional autonomy, and non-integration of clinical activities. Each of these characteristics is

discussed further.

Medical Associated Identity. The study NPs identified a medical associated or a physician comparing identity as one characteristic of the institutionally expected role. Here, the NP role was compared and associated primarily with physician rather than with professional nursing roles. The NPs described titles which reflected this association such as "mini-doc" or "junior physician." As one study participant commented, "I trained to function as a health educator, as a preventive health specialist. I'm not utilized in that fashion in this system. I'm utilized as a mini-doc." These titles reflected the expectations of many institutional physicians and administrators that the study NPs were to "be like a medical student and to function like a MD."

Medical associated identity was derived primarily from physician and administrator perceptions of the similarities between the work of NPs and physicians. The concept of medical identity was also closely associated with the NP's work environment. As one NP stated, "We work on a medical model here and that's a big problem. We do a lot of the same things that the physicians do and that's all they see. There's no way to measure what we do that is not medical."

Another of the study participants commented on the similarities between the work of physicians and NPs. "I

feel much more aligned with the physician role model than with the nursing role model ... because of the kind of work that I'm doing. It dictates that I know much more about medicine than I know about nursing."

Diminished Professional Autonomy. Institutionally expected roles were also characterized by diminished or absent professional autonomy. This was described by the study NPs as physician dependence. The study NPs noted that they were dependent on physicians to validate a number of of specific activities which the practitioners stated they were capable of performing without physician intervention.

For example, the study NPs cited a dependence on physicians for signatures on any drug prescriptions given by the NPs to patients. All of the NPs routinely recommended specific drug treatments to patients as part of their assessment and treatment of various patient problems. The study NPs were prohibited by California law from signing drug prescriptions, the forms required by pharmacists for drug dispensing. As one of the study NPs stated, "we don't have our own prescribing right and we need a prescribing right. Otherwise we're always going to be tied onto the shirttail of a physician somewhere. No independence. No autonomy."

Each of the individual physicians signing prescriptions for the NPs had the option of making alterations in the NP's recommended drug therapy. When this occured, the study NPs had either to accept the physician's decisions, or to alter

the physician's decisions through discussion or argument. At times the NPs stated they then approached another physician in an effort to obtain the desired drug prescription.

The study practitioners were also dependent on physicians for validation of their assessment and treatment of many patient problems. This occurred because all of the study NPs were required to work under institutionally designated protocols. The protocols were institutional guidelines developed for the assessment and treatment of medical problems. Each of the protocols outlined a proscribed course of action which included an assessment, treatment, and follow up for each identified problem.

Protocols were written primarily by the NPs working within each of the medical, obstetrics, and gynecology specialty areas. Each protocol was subjected to review and revision by the physicians who worked with the study NPs and also by those physicians who worked as organizational administrators. As one of the NPs commented, "protocols just are guidelines...but they're not functional most of the time because most of the time you've only got 50 or 60 protocols (but you see many more problems)."

Diminished control over aspects of daily work was a second component of diminished professional autonomy. The study practitioners noted that physicians controlled many aspects of NP patient scheduling. "Medical administrators

are the ones who go ahead and set our schedules." Physician administrators in effect decided on the number of patients each of the NPs were to evaluate within each regular work day, the time allocated for each patient appointment, and the types of patient problems each of the NPs was expected to deal with. Many of the NPs frequently stated, "I feel as though I have no control over my own schedule." The study NPs then experienced physician control of their work within institutionally expected roles.

A consequence of physician control of NP work was articulated by study participants who noted, "there's really no chance for advancement in any way as a NP." The physicians controlled career advancement for NPs within institutionally expected roles.

Diminished Activity Integrating. Diminished activity integrating was described by the study participants as an additional component of institutionally expected roles. Diminished activity integrating was characterized primarily by a non-integration of the clinical activities described earlier in the section on role description. The study NPs reported an emphasis on the performance and completion of medical tasks as opposed to the integration of nursing and medical activities associated with individually desired roles.

The emphasis on medical activity performance within the institutionally expected role was noted by several of the NPs. "I'd like to do more, to do good patient education

and preventive health teaching rather than always being bombarded with acute care."

Several study participants also remarked on the non-integration of activities within the institutionally expected role. "You do what a general practitioner does." "What we're doing is the practice of medicine here on a day to day basis." "We are required to practice medicine."

Role Disparity

As previously discussed, there were two roles identified by the study participants. The individually desired role was the role that the NPs wanted to perform, while the institutionally expected role was the role that the NPs were required to perform within organizational settings.

For the study NPs, the amount of disparity between the two NP roles was determined by a number of contextual factors. The study NPs then utilized one or more strategies to decrease or accommodate to role disparity. The consequences of this process were combined or blended practitioner roles. Contextual factors, strategies to decrease or accommodate to disparity, and role blending will be discussed further.

Contextual Factors

The amount of disparity between the individually desired NP role and the institutionally required NP role was determined by a number of contextual factors. Contextual factors were present within all study settings and study areas of NP specialization. The factors that influenced role disparity included: temporal factors, role comprehension, role ambiguity, interactive mode, and interprofessional control.

Temporal Factors

Time allocation and pace were the temporal factors that influenced the disparity between the individually desired and institutionally expected NP roles.

Time allocation. Time allocation referred to the amount of time available for task performance and completion. In each organizational setting, administrators determined the number of minutes required for completion of specific patient activities. For example, in the university setting, the NPs were given 60 minutes to perform physical examination activities for patients and 30 minutes to examine patients for complaints, problems, or for ongoing evaluations. In the health maintenance settings, the study NPs were allocated 30 minutes for physical examination activities and 15 minutes for the investigation of any other patient problems.

Additionally,the NPs had perceptions of the time required to initiate patient interactions. The NPs

commented that although they could not precisely indicate the actual number of minutes needed for every patient interaction, they could determine time ranges for completion of specific tasks, particularly nursing tasks. The NPs noted that "to function effectively as a NP requires a certain amount of time." The NPs also commented, that time allocation or "the amount of time affects the quality of your care."

In a discussion on the time needed by NPs to perform activities, one of the NPs remarked, "often times 10 minutes or 15 minutes is enough, all you need for a quick, brief problem or a quick, brief follow up ... Five minutes is rarely often enough to deal with a patient's problems ..."

The NPs experienced few problems when there was congruence between institutional time allocations and their clinical time perceptions. The NPs who worked within the university setting commented that there was "time allocated in our schedule for education. The organization gives more time for teaching."

Problems developed however, when the NPs perceived time constraints, a common occurrence for NPs working in all of the study settings. As one of the experienced NPs observed, "I can't do what I need to do in 10 minutes. I need 20 or 25 minutes ... I can do a physical for an ob [obstetrical patient] with a normal pregnancy in less than 5 minutes. That doesn't give me enough time to tell the patient why I

came to this conclusion." Another of the NPs stated, "in 10 minutes I couldn't establish needs, design an intervention plan and then implement it. That's too quick. If I had 30 minutes, I can."

Time constraints developed for a variety of reasons. The acuity of patient problems created time restrictions because the study NPs required additional time to evaluate complex problems. As one the the NPs commented:

> We see some very frail elderly patients. When they come in and we've got 5 minutes it's usually never enough ... many of our patients could not be dealt with well in 10 or 15 minutes. Some of them can be. It depends on their disease. Or when a new patient comes to the clinic and doesn't speak any English and brings a translator ... depending on the complaints of the patient it can double the time.

Time constraints additionally developed for other reasons. On occasion, individual patients requested additional time for interactions with NPs. "With some people you need more time ... they would like to talk more." Many of the NPs were interrupted during patient interactions to answer staff questions, talk to patients who called in from home for information, or to consult with physicians about patient problems. These interruptions frequently precipitated time constraints as noted by one study participant. "Personally I don't see any reason why a NP can't see a patient in 15 to 20 minutes ... if you're not

interrupted. If you don't have these other things to take care of."

One important consequence of time constraints as perceived by the NPs was that the NPs began to view their roles as similar to physician roles. This resemblance was discussed by several of the study participants who noted:

> Especially when you don't have enough time, I don't see very much difference in what the two of us [NP and physician] are doing for regular routine patients ... If you have the extra time you get to do the stuff you were also trained to do as far as the counseling, and education and preventive stuff.

Another of the NPs stated, "I find the longer I work here the more likely I an to resemble a physician if I am short of time."

The amount of time allocated for NP work influenced the amount of role disparity between individually desired and institutionally expected NP roles. If the amount of time available for NPs to perform tasks and interact with patients was not perceived by the NPs to be adequate, then time constraints developed. One consequence of time constraints was a NP perception that the NP role was very similar to physician roles.

In individually desired roles, the NPs perceived themselves as professional nurses, integrated both medical and nursing activities and stressed the significance of

professional autonomy. Viewing the NP role as similar to physician roles corresponded to a conceptualization of an institutionally expected role, with an emphasis on medical associated identity. The disparity then between these two roles was enhanced by time constraints.

Pace. Pace was the second temporal factor that influenced role disparity and was defined as work rate, the ability of the study NPs to perform patient activities within given time intervals. Each organizational setting had an expected pace or NP work rate, reflected in the NP work schedules utilized by the majority of the study participants. As noted earlier, patient interactions were given specific time allocations ranging from 15 to 60 minutes in length and each of the NPs were expected to perform their patient work within these time allocations.

One of the NPs working within a health maintenance setting remarked on the institutional expectations to maintain a certain work pace by stating:

> There's a fair amount of stress to be on time, to make the right diagnosis, to give the appropriate treatment, to have the appropriate follow up and always know that there's people behind waiting to be seen. And once it starts at 9 in the morning and once it starts at 1:30 or 2 in the afternoon, you know you're not going to finish until the end.

Other study practitioners remarked on the work pace in the health maintenance settings. "There's no mechanism to

shut off the flow of people. The time constraints were so inflexible. You will see the patient in 15 minutes and if you don't then you're behind the whole rest of the day."

The study participants experienced problems if they did not adhere to the expected daily work pace. Problems were created with other clinic staff members when the NPs were unable to move at the expected pace. One NP commented that "if you start getting backed up other people get upset." Patients frequently complained if NPs kept them waiting for scheduled appointments as the result of a decreased work pace.

Another problem NPs in all the institutional settings experienced when they were unable to work as rapidly as expected was a concern for the quality of patient service they were providing. One of the NPs commented, "I'm more apprehensive now about the pace. I'm seeing so much in such a short period of time that my concern is that because of time constraints ... that I'm not going to do something that I should have done." Another study NP remarked, "because there is no down time and because you're constantly going and seeing patients ... there's probably a high level of burnout ... dissatisfaction and frustration with the role and the setting."

While slowing down the work rate created problems with other staff and patients, it also was viewed by the NPs to be beneficial at times. As one of the NPs remarked, "my

pace is a little slower, I think that my patients don't feel as rushed ... I can spend more time explaining ..." With a slower pace, several NPs noted "we have the time for education ...the patients are not rushed out the door."

The area of disparity between the individually desired and the institutionally expected roles was greatly influenced by pace. When the work pace was rapid, the study NPs frequently felt constrained. They did not experience the professional autonomy which was a component of individually desired roles and often felt pressured, apprehensive or dissatisfied with their roles.

Role Comprehension

Nursing administration comprehension of NP work was a second condition influencing the amount of role disparity between individually desired and institutionally expected roles. Comprehension of the practitioner role was viewed on a continuum from greater to lesser role understanding.

Greater role understanding. Nursing administrators with a greater understanding of practitioner roles made decisions about the scheduling of patients, the timing of patient visits, and the types of patient problems that the NPs would encounter. Additionally, these nursing administrators directly evaluated NP work performance. As one of the experienced NPs noted, "many of the administrative people here are NPs ... [This] is a real plus because they know exactly where we're coming from. And what the issues are. So they're not just speculating on what they might be. They've

been there."

Nursing administrators with a greater understanding of NP work decreased the disparity between the individually desired and the institutionally expected roles. The decrease in disparity occurred because the nursing administrators fostered the professional identity, professional autonomy, and integrated activities that the study participants identified as components of the individually desired role.

Lesser role understanding. Nursing administrators with a lesser understanding of NP roles interacted infrequently with the study NPs and made few decisions regarding the daily activities the NPs performed. This was most clearly demonstrated to those NPs in the health maintenance settings when they receive yearly performance evaluations.

In contrast to the university setting where the NPs were evaluated by head nurses, many of whom were NPs, the NPs working in the health maintenance organizations received work evaluations from physicians. As one of the NPs noted, "It's always interesting when you get your evaluation. The physician does it and then it gets to the nursing administraton and it goes through nursing but the physician has done the evaluation." Another of the NPs commented that although the outpatient nursing administrator was the person who discussed performance evaluations with NPs, "I think essentially it's a medical evaluation."

Nursing administrators with lesser understanding of NP roles increased the amount of disparity between individually desired and institutionally expected roles. This occurred because other groups, primarily physicians, made decisions which influenced NP work.

One example of this was the evaluation of NP work performance by physicians rather than by registered nurses. Physicians judged the study NPs on their ability to perform medical activities rather than on the ability of NPs to integrate medical and nursing tasks. This emphasis on the performance of medical tasks was congruent with institutionally expected NP roles. As one of the study NPs commented, "I never considered that I had a nursing supervisor. I always thought that my supervisor was the physician because that's who I deal with all the time."

Role Ambiguity

Role ambiguity was the third contextual factor that influenced the amount of disparity between the two roles identified by the study participants. The amount of role ambiguity experienced by the NPs was determined by the types of work activities which the NPs routinely performed. Role ambiguity was viewed on a continuum of minimal to maximal ambiguity.

Minimal ambiguity. Minimal role ambiguity was experienced by the study NPs who performed a specific number of well defined activities. This group of NPs were able to identify, with reasonable clarity, both the number and the

type of activities they routinely performed. The activities included performing routine physical examinations, teaching and counseling patients on a number of topics, and treating specific medical problems such as colds, sore throats, hypertension, and diabetes.

In minimally ambiguous roles, the NPs were also able to clearly state activities performed by physicians as opposed to NPs. For example, the NPs working in obstetric and gynecologic clinics in both the university and the health maintenance settings discussed activities which physicians rather than NPs routinely performed. Such activities included conducting surgery and delivering babies. One of the NPs noted, "in gynecology so much of it is surgery, the territory between physicians and NPs is pretty defined."

Minimal role ambiguity was thus accompanied by clearly articulated and well defined role boundaries. While the NPs and physicians were engaged in some of the same functions, the study NPs were able to distinguish their roles from physician roles. " There are [sic] a lot of overlapping in the functions of the job of NP and physician. But I also like to think there are distinct differences too."

Nurse practitioners in all of the study settings stated that the differences between NP and physician work centered primarily around communication activities. The NPs noted a preference for patient education and counseling activities. The study participants also discussed an interest in

focusing on individuals rather than focusing on the treatment of specific disease processes.

When the experienced NPs perceived minimal role ambiguity, they experienced a decrease in the amount of disparity between individually desired and institutionally expected roles. The NPs with clearly established role boundaries were able to differentiate activities performed by NPs from those that physicians executed. This enabled the practitioners to develop the independence and control they required for professional autonomy.

Maximal ambiguity. Maximal role ambiguity, by comparison, was experienced by the study NPs who encountered difficulty in distinguishing their work from physician work. While the NPs were capable of defining tasks that practitioners routinely perform, they were unable to differentiate their work from that of physicians. These difficulties were most pronounced for the study participants in medical specialties within all three of the study settings. As one of the NPs commented, "I think NPs and physicians have a lot more overlap and there is a lot more gray area as to what is NP responsibility and what is physician responsibility."

The nurse practitioners described working with maximal role ambiguity as "operating in a gray zone." Another NP stated, "the more that I think that I have the answer to what a NP is, the more I realize I don't really know. I think that there is a lot of overlap between what the

physicians are doing and what the NPs are doing."

Study nurse practitioners additionally noted that maximal role ambiguity created confusion for administrators, physicians, patients, and others. Unclear role boundaries were especially problematic for NP patients who experienced difficulties in distinguishing the NPs from physicians working in the study sites. One of the NPs commented that "a lot of patients look at us as their physician and so they don't think of us as a registered nurse. When we tell them we're nurses...they consider us their physician." Another of the NPs noted that "for all practical purposes there is no difference between the NP and the physician. Often the patients think we're physicians. They don't really understand the differences."

Many of the study practitioners also stated, "there are still an awful lot of people who have no idea what a NP is. I would say that the vast majority of people I run into have no idea ..." Other NPs commented on a "lack of understanding on the physician's part of what NPs are and what their role is", and also noted, " I work with internists who have no idea what I do ... and I've worked with these internists for seven years."

The overlapping of activities and the unclear role boundaries characteristic of maximal role ambiguity contributed to an increased disparity between individually desired and institutionally required roles. The study NPs

encountered difficulty in demonstrating a strong professional nursing identity to others, including patients and physicians, when they performed activities which were not differentiated from physician activities or when they occupied roles with uncertain and poorly defined boundaries. The NPs also encountered difficulty in maintaining professional autonomy when they they were unable to demonstrate clear differences between NP work and physician work.

Maximal role ambiguity contributed to the disparity between the two identified NP roles because it promoted a medical associated identity characteristic of institutionally expected roles. The absence of clear role boundaries strengthened thoughts of NPs as similar in function to physicians. This contributed to a subsequent decrease in NP professional autonomy.

Interactional Mode

Interactional mode was the fourth condition influencing NP role disparity. Interactional mode referred to the types of interactions NPs held with other individuals. The interactions held by the study NPs with two groups of individuals, physicians and patients, were of special importance to the experienced NPs.

NP and physician interactions. The interactions between the study NPs and physicians were directed primarily toward clinical information exchange. The NPs noted that physician interactions were either bidirectional or unidirectional in

focus. Bidirectional interactions were characterized by requests for information originating from NPs and physician staff members in all of the organizational settings. The NPs approached physicians for information and advice and in turn, physicians approached the NPs for information and advice. The study NPs noted that bidirectional information exchange was not limited to those physicians in consulting relationships with NPs (as was discussed in the section on role information) but included many physicians in the organizational settings.

Bidirectional interactions were focused on the exchange of specific information. The NPs noted that they asked physicians for medical information. As one of the study NPs noted, "I depend on him [the physician] heavily to give us accurate advice and concrete suggestions." Other study participants stated that they initiated physician interactions when they encountered "abnormalities on physical examination" , or "for expertise, for an opinion..."

Physicians frequently asked the NPs for non-medical information and advice. As the NPs in the university setting remarked, "the medical students and the residents are coming to consult with the NP ... on policy and procedures ..." Many NPs in all study settings noted that "physicians ask for social kinds of things ... family problems, what kind of resources we have here." The

study NPs preferred bidirectional information exhange in their physician interactions. Bidirectional exhanges decreased the amount of disparity between individually desired and institutionally expected roles because they promoted professional autonomy for NPs, an important characteristic of individually desired NP roles.

Nurse practitioner and physician interactions characterized by unidirectional information exchange were described by the experienced NPs as interactions with limited information flow. The NPs initiated requests for medical information from physician consultants but did not receive similar requests from physicians. As one NP remarked, "I am very rarely consulted on a patient. And if I am it's usually something that's not necessarily my opinion but simply, do I have data, do I have the results of a pap available for him or her, do I have some lab work available?"

Unidirectional information exchanges had varied origins. For some of the experienced NPs, these interactions resulted from a lack of physician understanding of NP roles. "The new residents don't know what a NP is ... they sometimes are threatened by us. I think that's where most of the conflict comes."

For study participants in all study settings, unidirectional information interactions originated from situations in which the frequency of all NP and physician interactions were limited. This was problematic for the NPs

who worked with few physician consultants. The NPs discussed the consequences of limited physician interactions. "The NPs here don't have a good relationship with many of the physicians ... We don't feel that the political acceptance of NPs is terribly high ..."

Unidirectional information exchange increased the amount of disparity between the two identified NP roles. This occurred when the medical associated identity of the institutionally expected roles was fostered, rather than the professional nurse identity of the individually desired role.

NP and patient interactions. The interactions between NPs and patients were described as important by all of the study participants. Interactions were described as either initial or ongoing in origin and focus. Initial interactions were the first contact between the study NPs and patients. The practitioners noted that initial interactions required "you to start from the bottom up and get to know them and treat them ... you know very little about these people." One consequence of primary or initial NP and patient interactions for the study participants was an increase in the amount of time that the NPs spent in the interactions.

Initial patient interactions were more likely then to increase the amount of disparity between the individually desired and the institutionally expected NP roles because they required additional time expenditures. The study NPs

noted that when constrained for time they freqently were unable to integrate clinical activities. Non integration of activities was characteristic of institutionally expected roles.

Ongoing interactions were described by the study NPs as interactions established with patients over extended time periods. Ongoing interactions were characterized by patients returning to visit with the NP at regular intervals. Many of the NPs observed an "emotional bond" which developed with many patients who visited with the NPs on an ongoing basis.

Ongoing NP and patient interactions were more likely to decrease disparity between the two identified NP roles. The NPs noted that many nursing activities were easier to perform when an ongoing relationship was established with patients.

Interprofessional Control

Interprofessional control was the final contextual factor identified that influenced the amount of role disparity experienced by the NPs. There were several groups of professionals controlling NP work, including administrators and physicians.

Administrator control. Organizational administrators exerted control on the roles of the study NPs by making decisions about the structure of NP work, through control of the practitioner work schedules. As many of the NPs stated, "medical administrators are the ones who go ahead and set

our schedule." The organizational administrators in effect made determinations about the amount of time allocated for patient interactions and the pace at which the NPs were expected to maintain during the work day.

One of the NPs discussed the control exerted by administrators on NP schedules. "I think that organizationally, administration dictates how we practice [and] they dictate our schedules completely. We have absolutely no control over our own schedule." Other NPs remarked, "I have no control over my own schedule." "I don't feel like I have very much control."

Organizational administrators not only determined the parameters of NP work schedules, they also monitored the ability of the study NPs to adhere to daily work schedules. The practitioners were expected to follow guidelines for patient scheduling. One of the NPs stated:

> It seems like we get mixed messages from the administrators saying that if you're not productive, then what are you doing? ... The administrators forget that in addition to seeing the patients that we do a lot of other things ... holding the clinic so to speak together ... They say, why aren't you seeing 15 patients a day?

Physician control

Physicians were the second group of professionals exerting control over NP roles. Physicians made decisions

about the content of NP work. One of the NPs noted, "we're working for a giant organization and the powers that be are medical doctors and they're the ones that make the final decisions."

Interprofessional control of the NP role increased the amount of disparity between the individually desired and institutionally expected roles. When administrators and physicians made decisions directly effecting NP work, the study NPs were unable to fully develop the professional autonomy that characterized individually desired roles. When administrators and physicians determined the structure of NP work, they indirectly influenced the types of activities the study NPs performed. The disparity between the individually desired and the institutionally expected practitioner roles was increased because the study NPs were frequently unable to integrate activities, an important component of desired roles.

Reduction And Accommodation Strategies

All study participants identified disparity between the two NP roles. Each of the experienced NPs utilized a variety of actions or strategies to reduce the amount of disparity between individually desired and institutionally expected NP roles. Strategies for reduction or accomodation to role disparity were employed on an ongoing basis by the NPs. Decisions to utilize strategic methods were made on the basis of prior experiences with the utilization of specific methods, both sucessful and unsucessful. Individual work styles influenced strategy choices as did the presence or absence of specific contextual factors and each NP's perception of the amount of disparity between individually desired and institutionally expected roles.

Specific strategies for reduction or accomodation to role disparity were utilized by the experienced NPs in all of the study settings and in all areas of NP specialization. The strategies included: role negotiation, role optioning, role compromising, role re-routing, and role exiting. Each strategy will be discussed further.

Role Negotiation

Role negotiating was a bargaining strategy employed by many of the NPs to reduce role disparity. The practitioners negotiated with organizational administrators and physicians to change their role activities. Role negotiating involved either bargaining to do more, to add new activities to those already performed by the NPs, or bargaining to do less, to

delete activities the NPs were expected to perform.

Negotiating to do more. Nurse practitioners negotiated changes in activities by agreeing to perform additional activities in exchange for the opportunity to perform desired activities. For example, one of the NPs was interested in teaching patients about illness prevention and health promotion. The NP was working in a clinic where the patients were primarily being evaluated for acute medical problems and there was little opportunity for the NP to do any health teaching. The NP noted a significant disparity between what was desired (teaching patients about health) and what was organizationally required (treating acute illness problems). To reduce the disparity, the NP negotiated with one of the clinic administrators. The NP agreed to assume responsibility for administrative tasks such as scheduling NP clinic work time. In exchange, the NP was given the opportunity to become the coordinator of a "preventive health services program."

Coordinating the program enabled the NP to become involved in health teaching. As the NP stated, "I saw it as perhaps a way to wean myself out of the system and into an area that I think I have some expertise in and that I have interest in."

Negotiating for change by increasing the number of activities performed was illustrated by another of the NPs interested in teaching pregnant women about childbirth. The

NP noted that this teaching was an important aspect of her NP role but was difficult to accomplish within her work schedule. The NP negotiated with the clinic chief and the nursing supervisor to begin childbirth classes. "When I first came here I negotiated to have Lamaze classes ... It takes time and procedures and policies and some headaches but it's not something I find insurmountable."

This NP noted that she was able to negotiate for extra classes because she was "very willing to do this on my own and in my own time or within my patient load ... Things I've done have not created any additional time or money by administration." In this example, the NP developed a teaching program without institutional financial support in exchange for the opportunity to teach pregnant women.

This experienced NP had additionally negotiated with administrators to assume responsibility for teaching and counseling pregnant teenagers along with regularly scheduled practitioner activities. As the NP noted:

> I see all the pregnant teens ... and that's because I said I was interested and I set up a protocol and a procedure ... It wasn't being done and I felt that it should be done and so that was one of the negotiating things.

Negotiating to do more, or to add activities to preexisting work schedules was employed sucessfully by several of the study NPs. These NPs reduced disparity between individually desired and institutionally expected

roles because they were able to bargain for the addition of nursing activities to their roles.

Negotiating to do less. Many of the study NPs negotiated with administrators to reduce role disparity by decreasing the number of activities they performed. This was bargaining to do less, or activity reduction. As one of the NPs stated, " we're always hitting on this system for the kinds of changes that we want ... we're saying we're already doing too much." Discussions with administrators about activity reduction were frequently unsuccessful as one of the study NPs noted. "I've talked to people who are in charge of things to try and see if we can change the schedules a bit but I haven't been successful in doing that."

Organizational administrators were frequently unwilling to make reductions in the number of activities that the study NPs performed. Negotiations to do less then were frequently unsucessful in reducing disparity between the two NP roles.

Role Optioning

Optioning was a second strategy that many of the experienced NPs employed to decrese role disparity. The NPs examined a number of choices or alternative actions available to them when they perceived role disparity and then selected the actions which best worked for them.

Time altering. Optioning for time altering was

frequently employed by the NPs when time or scheduling constraints prevented the NPs from completing activities they considered important to perform. For example, the integration of activities was described as important by all of the study NPs. It was difficult for the NPs to integrate activities when they had time constraints. Some of the practitioners optioned to work additional hours so they could then integrate activities. As one of the NPs noted, "I have more overtime on my paychecks now. I rarely have lunch breaks and I never go to the john."

Another of the NPs remarked, "lunch time is often used for some work ... to do charting, sometimes make phone calls, review some lab work. There's no time for that in the day." One NP commented:

> I spend a lot of my lunch hours doing my charts and or doing phone calls. I almost always leave here late, I would say I average an hour overtime everyday at the end of my day...I usually try and get here about 8:45 in the morning just to do a few phone calls before I start seeing patients. I come in at 8:30 every day and work for a half hour before I start work and I usually am here until 6 or 8 at night and that's the price you pay for trying to do what you do.

Some of the NPs chose to increase the amount of time spent with patients despite the presence of time constraints. "Often times 10 minutes is not enough so I will see them [patients] and I'll get backed up." While

this strategy decreased role disparity for the NPs because it provided the NPs with the time to integrate activities, problems were created for those patients who encountered extended delays for practitioner appointments.

Nurse practitioners employed scheduling options to reduce role disparity. For example, one study participant noted that time constraints precluded her from performing many nursing activities for patients. The NP chose to "solve the problem of not having enough time [for nursing activities] by bringing people back for additional visits."

Another of the NPs commented that when faced with time constraints "you end up bringing the patient in more often." The NP commented however that this had the potential to create additional problems. "I'm not so sure the end result is cost effectiveness which is what NPs are known for."

Defining. Optioning to delineate roles was frequently utilized by the study NPs. Role disparity was decreased when both the NP and the physician roles were clearly defined. As one study NP stated, "I think that the primary role of the NP was [sic] wellness and anyone with diseases got referred to physicians. And technically that's what we're still doing. Diabetics get referred [to the physician], abnormal pap smears go to the physician for culposcopy." Another NP remarked, "I do what I want to do and I screen out what I don't want to do but I'm in a real nice situation that way. When it gets to be something

that's too medical and too clinical then I say this is not what I do ..."

A third NP commented, "when I feel like it's outside my role ... problems that I can't deal with ... then I refer them to a physician."

Personalizing. Optioning to decrease role disparity by personalizing all patient visits was exercised by the experienced NPs. For example, one NP noted that with "every patient I see I try and learn something about them as individuals ... it makes my job more enjoyable to know who they are as people."

Role Compromising

Compromising was a third strategy which the NPs utilized to diminish disparity between the individually desired and the institutionally expected roles.

Disparity accepting. In disparity accepting, the study NPs chose to accept or accommodate to the disparity existing between the two practitioner roles rather than attempting role difference reductions. This was illustrated in the following NP statements:

> You can't change things that much so what you do, you end up going along with it. This is my job, this is my role here. It's already been laid out for me based on how other NPs have functioned.
>
> I'm just not making any waves and I'm just kind of going with the flow right now and that has a lot to do with feeling that I don't have much control. And just to

> keep everything the way it is, is good enough for me right now ... I put my hours in and then I go home ... It's not totally boring, still it's not overly challenging ...

Selective glossing. Many of the NPs reduced role disparity by selective glossing that involved compromising on the activities they chose to perform. For some of the NPs this was accomplished by eliminating nursing tasks such as counseling or teaching. One NP noted that "sometimes what was compromised in the visit was the educational portion of it ..." Another NP stated that patient education activities were not completely abandoned. "I give information, a little bit at each visit, but it's fragmented." The patients then received information that the NP considered important to give to the patient. In this example, the NP compromised on the delivery of patient information.

For other study NPs, selective glossing involved a primary focus on medical activities.

> I worked in a setting where I had a resident's schedule ... 40 patients a day to see. What you do in that situation is you go in, you sort of run down a list of questions and hope the patient says no to all of them because you don't have time to talk about it if they say yes and do a physical exam and shake their hand and that's it. It's very focused, primarily on physical

things.

Many of the other NPs accommodated to role disparity by performing nursing activities only when they had available time to spend with patients as noted by one study participant:

> When you don't feel like you have that time, you're pressed to move from one patient to the next patient, you're just going to address those one or two really pertinent issues that the patient focuses on. And then you say, the rest we'll have to take care of later.

Another of the NPs commented:

> I take care of the basic task first. I update the history and do the things that'll help me to solve or resolve what the patient's there for. And then if other things have popped up that are sort of peripheral to their main complaint, then I deal with those issues.

Decreased physical and professional functioning. The NPs described compromises in physical and professional functioning as another group of strategies to resolve role disparity. The practitioners frequently compromised their physical functioning by working additional hours or by forgoing any lunch or relaxation breaks during the course of a work day. These compromises resulted in "an inordinately high degree of burnout." One of the experienced NPs commented on decreased physical functioning:

> What I see as a physical deterioration in regards to the ability to fight off colds, chest infections ... getting

> physically ill ... We're noses to the grindstone and we've got to get through with what we've got to get through with and that's about it.

Professional compromises were described by the NPs as a strategy to reduce role disparity. The study participants noted that they expended time and energy to work with and educate physicians about NP roles rather than working with other nursing groups or consumers. The consequences of these professional compromises were described by one of the experienced NPs. "In the process of attempting to prove to the medical community that we can function in the [NP] role we have alienated ourselves from the general population of nursing."

Role Re-routing

Re-routing was a fourth strategy that experienced nurse practitioners utilized to relieve role disparity. The practitioners who employed this strategy chose to relocate in order to decrease the differences between individually desired and institutionally expected roles. For some of the NPs, this involved organizational movement. The NPs made decisions to work in different institutional settings. As one of the practitioners remarked, "I know that if the opportunity arose I would be gone in two weeks and would be practicing preventive health care in some setting." Another of the NPs noted, "Believe me, if I thought I found a job and they were going to pay me $2.00 less an hour I would

satisfaction."

The ability of the study NPs to move into new institutional settings was determined by a number of factors. The availability of NP positions and the ability of individual NPs to make the changes required for job transitions influenced the utilization of re-routing strategies.

Several other NPs spoke of relocating by moving out of NP roles and into student roles. The NPs spoke of going back to school as a mechanism to relieve role disparity. Practitioners discussed plans to attend graduate nursing programs or other graduate programs in related fields, including public health.

Role Exiting

Exiting was a final strategy discussed by the NPs as a mechanism to relieve their role disparity. Exiting referred to the movement of the NP from the nursing profession into other professional roles. One of the NPs spoke of exiting as a strategy to resolve role disparity that had not been resolved by the use of other strategies. Because the use of other strategies was unsuccessful for this individual, exiting was viewed as the next strategy of choice. The NP noted, "I'm making preparation to move out of this field. I'm going to move into another endeavor, out of nursing ... I see my job opportunities [as a NP] diminishing ... I see increasing resistance against the concept ..." Exiting then

was viewed as a final strategy to cope with role disparity by at least one of the study participants.

Role Blending

The major finding of this study was the identification of the central category of role blending. All of the experienced NPs were interested in performing individually desired roles. However, the NPs worked in institutional settings that required the performance of institutionally expected roles. This disparity was related to a number of contextual factors and to NP strategy deployment as each NP utilized strategies to reduce or accommodate to the distance between the two roles. The end result of this process was a work role that combined elements of both individually desired and institutionally expected roles, a blended NP role (see Figure 1).

The process of blending or combining the individually desired and institutionally expected roles was not static, but was ongoing and changing. As contextual factors influenced the amount of disparity between roles, the strategies that these experienced NPs utilized to diminish disparity changed. As the amount of disparity between the two roles changed, the configuration of the blended role changed. There were a number of configurations of blended roles for these experienced NPs (see Figure 2). Configuration of the blended role was dependent upon the individual NP, the contextual factors which influenced the amount of perceived role disparity, the individual NP's utilization of strategies to decrease or accommodate to role disparity, and the success or failure of this strategy

utilization. Thus, some of the blended roles contained multiple elements of the individually desired role and few elements of the institutionally expected role. This configuration of the blended role may have been the result of successful strategy utilization by the NPs, or it may have indicated that there were few contextual factors that increased the amount of disparity between roles. It may also have indicated a minimal amount of disparity between the roles that the NP must reduce.

Conversely, blended roles with configurations containing many institutionally expected elements and few individually desired elements may have been the result of unsuccessful stategy employment by the NPs, or may have indicated changes in multiple contextual factors increasing the amount of disparity between roles.

It is important to note that all of these experienced NPs had blended roles. None of the practitioners engaged in strictly individually desired or institutionally expected roles. All of the experienced NPs performed role blending within their work situations.

Figure 1

The Blended Nurse Practitioner Role

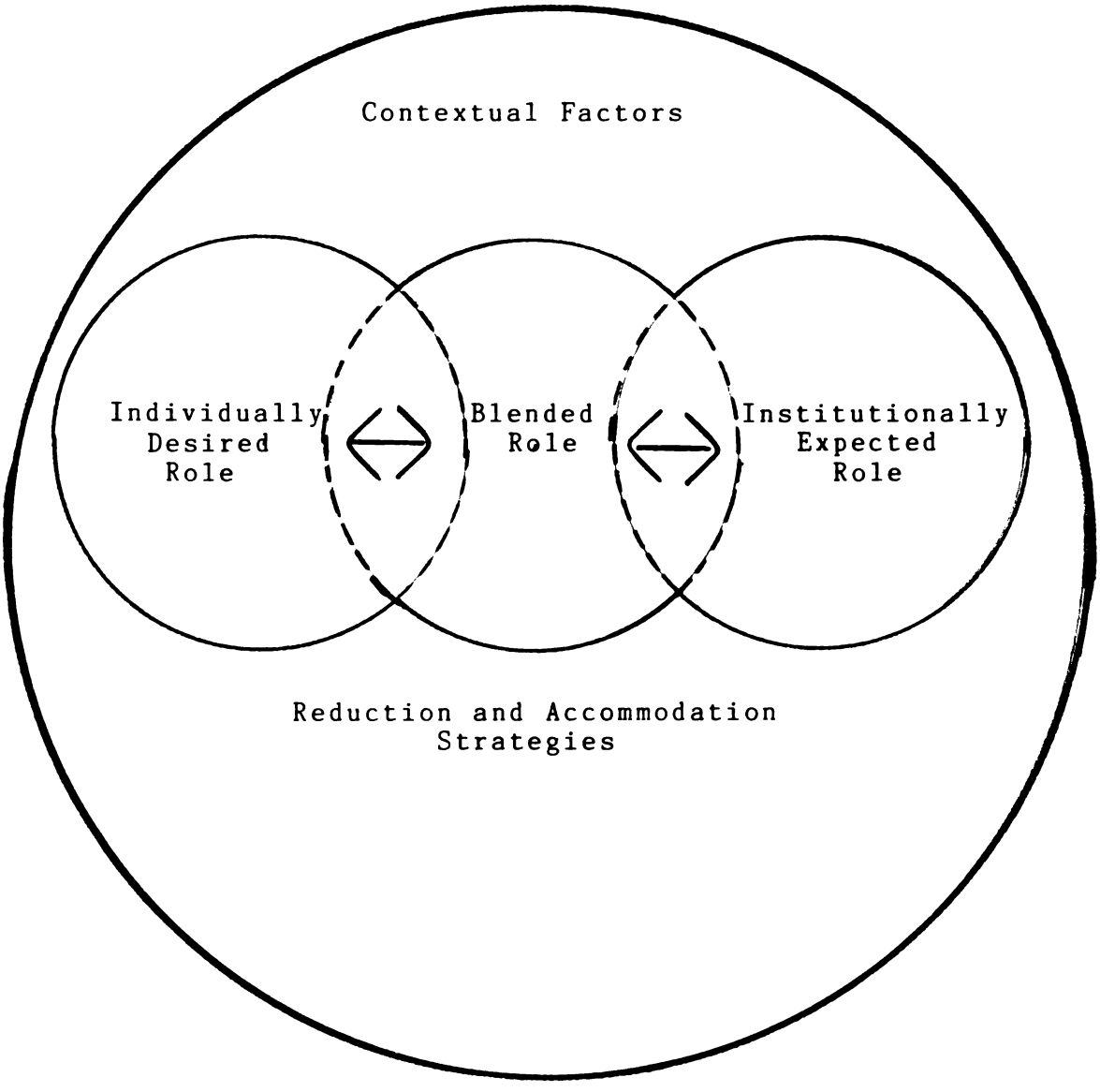
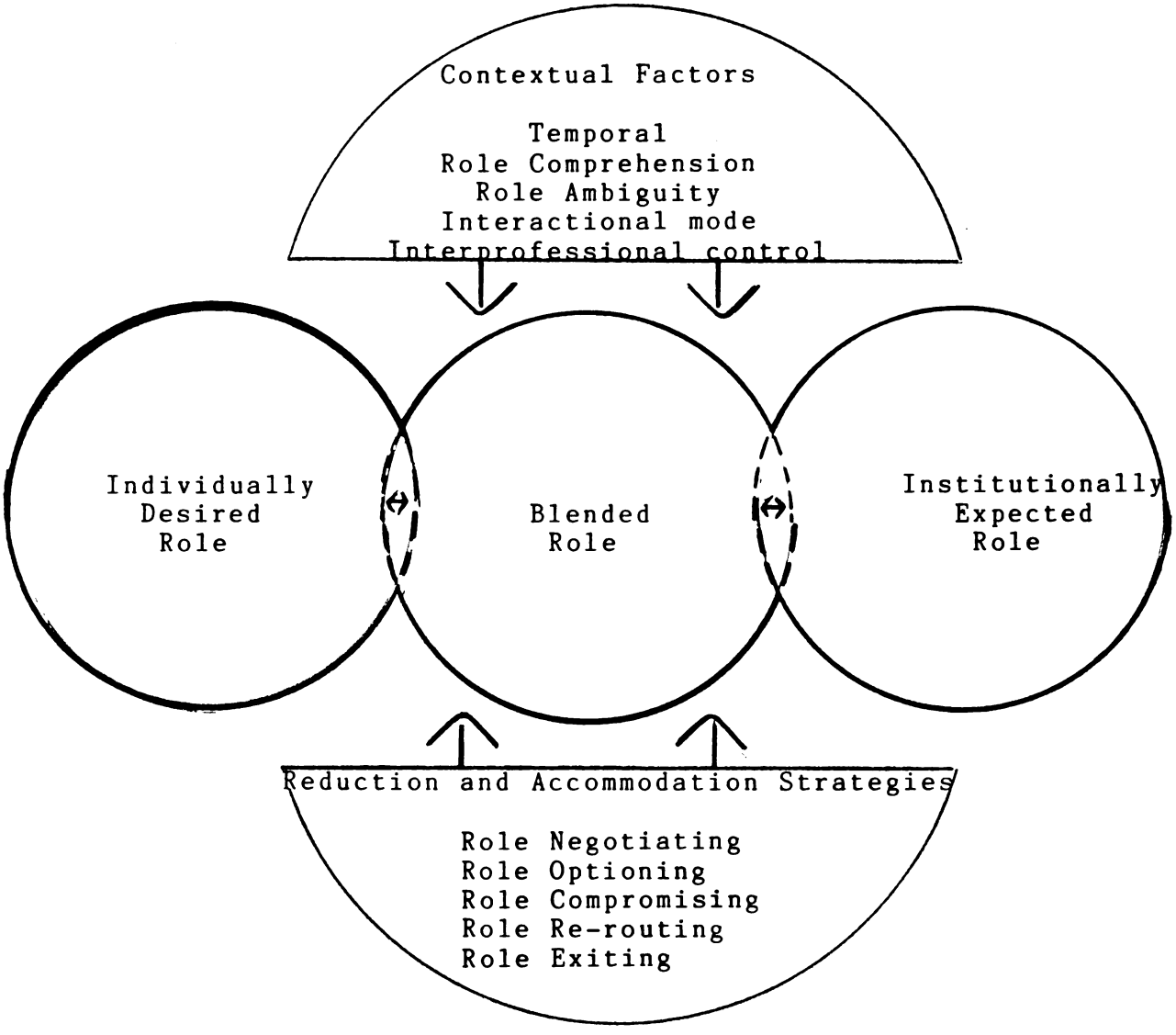


Figure 2

The Process of Nurse Practitioner Role Blending



CHAPTER FIVE--CONCLUSION

The study conclusions are presented in this final chapter. Additionally, implications of the research findings for the nursing profession are discussed as are future research recommendations.

Conclusions

The role perceptions of the twenty-three experienced NPs who participated in this study were remarkably similar despite considerable variation in the age, type of NP educational preparation, and number of years of NP work experience of the study participants. There were few differences in the NP role perceptions of the experienced practitioners in the three study settings and within each area of study specialization. While the biographical and occupational histories of the individual practitioner and the location of current work roles differed, definitions of NP roles and the identification of contextual factors and disparity reduction or accommodation strategies remained constant among the study participants.

The majority of the study practitioners entered into NP roles for two reasons: dissatisfaction with prior nursing roles, or a desire to change nursing roles and perform additional activities in an advanced nursing role.

Each of the experienced NPs who participated in the study defined two NP roles: the individually desired role, and the institutionally expected role. The individually desired NP role was described as the ideal role and included

the components of a very strong professional nurse identity, a sense of professional autonomy, and an integration of nursing and medical activities. The institutionally expected role was defined as the role the NPs were expected to perform and included a medical associated identity, diminished professional autonomy, and decreased activity integration.

Contrary to the assertions of individuals both within and outside of the nursing profession, the study NPs viewed themselves as professional nurses. The emphasis on professional nursing identity, the performance of nursing activities, and the desire for autonomy identified by the study participants was congruent with the contentions of many nursing leaders that the NP role is a nursing rather than a physician assistant or quasi-medical role (Ford, 1985; Mauksch, 1974).

All study participants experienced a discrepancy between individually desired and institutionally expected roles This disparity originated from conflicting expectations between the role that the NPs wanted to perform, the individually desired role, and the role they were expected to perform, the institutionally expected role.

The amount of disparity between the roles was rather extensive for the majority of the study NPs and was due in part to a number of contextual factors. The temporal factors of time allocation and pace contributed to distancing the

two roles. The study NPs noted an inability to perform many desired nursing functions when they perceived time constraints and an enforced work pace. Each study participant required a discrete amount of time to perform and complete her/his work. Practitioners experienced time constraints when their time requirements differed from institutionally mandated time. Additionally, an acceleration in work pace caused NP concern for decreased quality patient care, diminished professional autonomy, and increased dissatisfaction with NP work. Many of these NPs experienced a shift toward institutionally expected roles as a consequence of time constraints and enforced work rates.

Nurse practitioner role comprehension by nursing administrators influenced the amount of disparity between the two NP roles. The NPs in the university setting worked with nursing administrators who displayed a greater understanding of NP roles. These NPs experienced less role disparity than did their counterparts in the health maintenance settings. Interactions with nurse administrators who demonstrated a lesser understanding of NP roles resulted in increased role disparity for the NPs. This occurred as a consequence of physician decisions about the structure of NP work that fostered institutionally expected roles.

The amount of role disparity experienced by the study participants was influenced in part by their perceptions of role ambiguity. Role ambiguity has been defined as a

vagueness, uncertainty, or lack of agreement among actors on the expectations for particular roles (Hardy, 1978). As noted by Sarbin and Allen (1968), when role ambiguity or decreased clarity of role expectations occurs, the effectiveness and productivity of role occupants are diminished. Further, ambiguity of occupational roles is significantly related to many outcomes for role occupants including tension and job dissatisfaction.

Practitioners with minimal role ambiguity encounterd less disparity between the two two NP roles. The NPs were clearly able to delineate their role boundaries and thus were capable of increased professional autonomy. Clearly able to delineate their role boundaries, these NPs were capable of increased professional autonomy. For NPs with maximal role ambiguity, an increase in the amount of disparity between their roles was experienced consequent to indistinct role boundaries.

Interactions with physicians and patients were important contextual factors determining the amount of disparity between NP roles. From a symbolic interactional perspective, reality is defined by actors in situations. The actors then respond according to their perceptions of a given situation (Hardy & Conway, 1978). The meanings humans ascribe to objects or things are derived then from social interactions (Blumer, 1969).

When the NPs were able to interact bidirectionally with

physicians who positively viewed their roles, they experienced a decreased amount of role disparity. Unidirectional interactions between the NPs and physicians increased role disparity.

Interprofessional control influenced the disparity between the two defined NP roles. When administrators and physicians controlled daily work schedules, the NPs were unable to determine time allocation or work pace. This frequently resulted in the performance of institutionally expected roles with decreased integration of medical and nursing activities, medical associated identity, and diminished professional autonomy.

All study participants utilized strategies to reduce or accommodate to the amount of disparity they experienced between desired and organizational roles. While some of the NPs were more successful with their strategy employment than others, strategy utilization was ongoing.

Role negotiation strategies were utilized to bargain with administrators and were successful when the study practitioners added activities to busy work schedules. Attempts to negotiate with administrators to decrease the number of activities performed were frequently unsuccessful.

Role optioning and role compromising were widely utilized strategies. The NPs freqeuently optioned to decrease the nursing activities they performed. Compromising strategies were employed by the practitioners frequently with negative consequences for the study

participants. Compromising in physical functioning, for example, resulted in increased illness and burnout for the practitioners, while professional compromises alienated many NPs from their nursing colleagues.

While many study participants were planning to continue in their present positions, several of the NPs talked of role re-routing, the strategy of moving to new NP positions or enrolling in academic programs for additional education. One of the NPs planned to exit, a strategy of movement from the nursing professsion into other professions.

A majority of the study NPs viewed the future of the NP movement with concern. Some described the future of NP roles as "dismal" and wondered whether the practitioner movement would survive the next twenty years. While the NPs did not articulate their reasons for these views of the NP role, some of their concerns may have been derived from blended roles with more organizationally expected than individually desired role components.

Significance

This study was significant for several reasons. First, it examined experienced rather than novice practitioners, a population that has not been fully investigated in prior research. The importance of understanding how these experienced NPs defined their roles was underscored by the assertions of many nurses that the practitioner role will become the "generic" nursing role of the future (Ford, 1982;

Mauksch, 1978; Moloney, 1986; Mundinger, 1980).

Secondly, this study provided information about the NP role from the perspective of an experienced nurse practitioner. Prior NP research has been focused on the interests of non-nurse researchers. Thus, many NP role definitions have been limited to the norms, behaviors, and concepts of medical rather than nursing practice (Billingsley & Harper, 1982; Ford, 1982; Freund, 1986; Lukacs, 1984; Lynaugh, 1986).

The data gathered from this study provided information of interest to nurse practitioners and to other members of the nursing profession. The data also contributed to the knowledge base of the nursing profession by providing an understanding of the role perceptions of experienced, working nurse practitioners.

Implications For Nursing

These research findings have implications for nurse practitioners in current practice, novice practitioners, practitioner students and educators, and for nurse administrators.

All study participants identified two roles that they then combined through a process of role blending. It may be helpful for students, educators, and novice clinicians to know that this role blending process consistently occurred for the study NPs. It may also be of assistance to these groups to know that a disparity existed between individually desired and institutionally expected roles.

Role disparity, as indicated by the study participants, may influence the role definitions of student or novice NPs selecting work in similar institutional settings.

It is important for NP students, educators, and novice clinicians to realize that this group of experienced practitioners did not find their NP roles to be ideal. The study participants identified multiple problems associated with the blended NP roles they practiced in all three organizational settings. Students and novice clinicians should be aware of the realities of NP roles, especially if they are planning to enter into practitioner roles to change activities, increase professional autonomy or relieve dissatisfaction with other types of nursing work. Nurse practitioner educators should provide NP students with a realistic view of NP roles as practiced by experienced NPs.

Nursing administrators should be cognizant of their importance to the NP role blending process. In this study, the nursing administrators with a greater comprehension of NP roles promoted the professional nursing identity, professional autonomy, and integration of activities characteristic of individually desired NP roles. Conversely, those nursing administrators with a lesser understanding of NP roles increased the role disparity experienced by the NPs. Nursing administrators should be aware of this and provide NPs with as much nursing support as possible to foster individually desired NP role

development and staff retention.

All of the study practitioners identified specific activities that were associated with NP roles. The study NPs did not, however, identify activities which were unique to NP roles. This finding increases the importance of clear and comprehensive role boundary development and concise activity defining for all practitioners who require increased professional autonomy.

Nurse practitioners additionally should recognize the importance of their interactions with physicians. Nurse practitioner educators need to teach students the importance of these interpersonal relationships within organizational settings. Students and practitioners who are in institutional work settings ought to develop the skills that will enable them to successfully interact with physicians.

Nurse practitioners would benefit from a focus on strategies that decrease role disparity such as role negotiating. Skills in bargaining need to be developed by all practitioners, whether as students in NP educational programs, or as practicing clinicians. The addition of negotiating skills may decrease or prevent the utilization of strategies such as role re-routing or role exiting. If disparity between the two roles increases or remains the same, and NPs working in organizational settings are unable to decrease or accommodate to disparity, then re-routing and exiting strategy utilization may drain the nursing

profession of a group of well trained and well educated nurse clinicians.

As noted by Fagin (1987), "it is becoming clear that we are headed for a period of severe nursing shortage ..." (p. 125). In times of nursing shortage, the potential loss of well qualified nurse clinicians is of very critical importance to all members of the nursing profession and ultimately to all health care recipients. Steps need to be taken to modify the effects of negative contextual factors for those NPs working in institutional settings. Additionally, an increased focus on health service financing changes such as third party reimbursement for NP services and legislative changes such as providing NPs with prescription prescribing capability may enable NPs to decrease role disparity by strengthening individually desired roles or by movement into alternative practice settings.

Study Limitations And Recommendations For Future Research

The research project was limited to experienced NPs who worked in one of three institutional settings. Future research could be focused on experienced NPs working in a number of different locations such as private office practices, independent practice settings, rural clinics, or state or government agencies. Research in additional institutional and non institutional settings, would provide further information on the significance of work location to

the role definitions of NPs.

The study of NPs practicing in varied occupational settings could provide information on the significance of potential contextual factors such as setting location and size, organizational funding sources, as well as the potential influence of other complementary role occupants such as other nursing groups.

The study was limited to NPs who worked in medical, obstetrical, or gynecological areas of specialization. Future research on NPs working in other specialized areas such as pediatrics, occupational health or geriatrics would also contribute to the information base on NP role definitions. The study of such practitioners could provide information on potential differences in role definitions due to variations in patient populations.

Future research might also be conducted on the role definitions of other groups of experienced registered nurses such as clinical nurse specialists. As noted by Rickard (1986), the clinical nurse specialist roles is still characterized as experimental and lacks uniformity between work settings. Research on the role definitions of the clinical nurse specialist could determine whether role blending is a phenomena associated only with NPs or whether it is noted by other groups of nursing professionals. This is especially significant in view of the current single title dilemma being faced by NPs and clinical nurse specialists (Pearson, & Stallmeyer, 1987; Sparacino, &

Durand, 1986).

The findings of this study are a beginning attempt to systematically analyze the role perceptions of one group of advanced nurse clinicians. Additional research is indicated in this area.

References

American Nurses' Association Position Paper. (1965). Educational preparation for nurse practitioners and assistants to nurses. Kansas City, MO: Author.

American Nurses' Association. (1975). Drafts of guidelines for preparing nurse practitioners both specialized and generalized. Through continuing education. Kansas City, MO: Author.

American Nurses' Association. (1980). Nursing. A social policy statement. Kansas City, MO: Author.

American Nurses' Association Congress for Nursing Practice. (1976). The scope of nursing practice: Description of practice, nurse practitioner, clinician, clinical nurse specialist. Kansas City, MO: Author.

American Nurses' Association. (1985). The scope of practice of the primary health care nurse practitioner. Kansas City, MO: Author.

Andrews, P. M., & Yankauer, A. (1971). The pediatric nurse practitioner. American Journal of Nursing,71(3), 504-508.

Beason, C. (1978). Nurse practitioners: The flak from doctors is getting heavier. R.N,41(10), 27-37.

Biddle, B. J. (1979). Role theory. Expectations, identities, and behaviors. New York: Academic Press.

Billingsley, M. C., & Harper, D. C. (1982). The extinction of the nurse practitioner: threat or reality? Nurse Practitioner,30, 22-23.

Bliss, A., & Cohen, E. (Eds.). (1977). The new health professionals. Germantown, MD: Aspen Systems.

Blumer, H. (1969). Symbolic interactionism. New Jersey: Prentice-Hall.

Board of Registered Nursing. (1983). Laws relating to nursing education licensure practice. With rules and regulations.. Sacramento, CA: Author.

Bower, F. (1979). Relationship of practice setting variables to nurse practitioners' performance Unpublished doctoral dissertation, University of California, San Francisco.

Brink, P. J., & Wood, M. J. (1983). Basic steps in planning nursing research, from question to proposal. (2nd ed.). Monterey, CA: Wadsworth Health Sciences.

Bullough, B. (1986). The state nurse practice acts. In M. D. Mezey & D. O. McGivern (Eds.). Nurses, nurse practitioners. The evolution of primary care, (pp. 350-367). Boston: Little, Brown & Co.

Bullough, V. L., & Bullough, B. (1978). The care of the sick : The emergence of modern nursing. New York: Prodist.

Bullough, B., Bullough, V. L., & Soukup, M. C. (1983). Nursing issues and nursing strategies for the eighties. New York: Springer Publishing Co.

Burkett, G. L., Parken-Harris, M., Kuhn, J. C., & Escovitz, G. H. (1978). A comparative study of

physicians' and nurses' conceptions of the role of the nurse practitioner. American Journal of Public Health, 68(11), 1090-1096.

California Nurses Association. (1986). Regulation of nursing practice in California. San Francisco, CA: Author.

Celentano, D. D. (1978). New health professional practice patterns. Medical Care,XVI(10), 837-849.

Charney, E., & Kitzman, H. (1971). The child health nurse (pediatric nurse practitioner) in private practice: A controlled trial. New England Journal of Medicine,285, 1353-1358.

Charon, J. M. (1979). Symbolic interactionism. An introduction, an interpretation, an integration. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Chaska, N. L. (1978). The nursing profession. Views through the mist. New York: Mc Graw-Hill.

Connelly, S. V., & Connelly, P. A. (1979). Physicians' patient referrals to a nurse practitioner in a primary care medical clinic. American Journal of Public Health, 69(1), 73-75.

Connelly, J. P., Stoeckle, J. D., Lepper, E. S., & Farrisey, E. M. Physician and nurse-their interprofessional work in office and hospital ambulatory settings. New England Journal of Medicine,275, 765-769.

Conway, M. E. (1978). Theoretical approaches to the study of roles. In M. E. Hardy, & M. E. Conway (Eds.),

Role theory: Perspectives for health professionals. New York: Appleton-Century-Crofts.

Corbin, J. (1986). Qualitative data analysis for grounded theory. In W. C. Chenitz, & J. M. Swanson (Eds.), From practice to grounded theory. Qualitative research in nursing, (pp. 91-101). Menlo Park, California: Addison Wesley.

Davidson, R. A., & Lauver, D. (1984). Nurse practitioner and physician roles: Delineation and complementarity of practice. Research in Nursing and Health, 7, 3-9.

Del Bueno, D. J. (1986). Issues in continuing education related to primary care. In M. D. Mezey, & D. O. McGivern (Eds.), Nurses, nurse practitioners. The evolution of primary care (pp. 72-77). Boston: Little, Brown & Co.

De Maio, D. (1979). The born-again nurse. Nursing Outlook, 272-273.

Diers, D. (1979). Research in nursing practice. New York: J. B. Lippincott.

Diers, D. (1982). Nursing reclaims its role. Nursing Outlook, 459-463.

Diers, D., & Molde, S. (1979). Some conceptual and methodologic issues in nurse practitioner research. Research in Nursing and Health, 2, 73-84.

Edmunds, M. W. (1979). "Junior doctoring." Nurse Practitioner, 4(5), 38-46.

Edmunds, M. (1981). Nurse practitioner-physician

competition. Nurse Practitioner, March-April, 47-54.

Edmunds, M. W. (1978). Evaluations of nurse practitioner effectiveness: An overview of the literature. Evaluation and the Health Professions,1(1), 69-81.

Ellis, B. (1978). Future evolution of nursing role contingent on legislation. Hospitals,52, 81-82.

Fagin, C. M. (1987). The visible problems of an "invisible" profession: The crisis and challenge for nursing. Inquiry,24, 119-126.

Feldman, M. J., Ventura, M. R., & Crosby, F. (1987). Studies of nurse practitioner effectiveness. Nursing Research, 36(5), 303-308.

Ford, L. C. (1982). Nurse practitioners: History of a new idea and predictions for the future. In L. H. Aiken (Ed), Nursing in the 1980s: Crises, opportunities, challenges. Philadelphia: J.B. Lippincott.

Ford, L. (1985). Perspectives 20 years later. Nurse Practitioner, 15-18.

Ford, L. C., & Silver, H. K. (1967). The expanded role of the nurse in child care. Nursing Outlook,15, 43-45.

Fottler, M. D. (1979). Physician attitudes toward physician extenders: A comparison of nurse practitioners and physician assistants. Medical Care,17(5), 536-549.

Freund, C. M. Nurse practitioners in primary care. In M. D. Mezey, & D. O. McGivern (Eds.), Nurses, nurse practitioners The evolution of primary care (pp. 305-334). (1986). Boston: Little, Brown Co.

Garland, N., & Marchione, A. (1982). A framework for analyzing the role of the nurse practitioner. Advances in Nursing Science, 19-29.

Ginsberg, E., & Ostrow, M. (Eds.). (1984). The coming physician surplus. In search of a policy. New Jersey: Rowman & Allanheld.

Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory: Strategies for qualitative research. New York: Aldine.

Golden Gate Nurses' Association. (1987). Position statement on nurse practitioners and physician assistants. San Francisco: Author.

Hamric, A. B., & Spross, J. (Eds.). (1983). The clinical nurse specialist in theory and practice. New York: Grune & Stratton, Inc.

Hardy, M. E. (1978). Perspectives on knowledge and role theory. In M. E. Hardy, & M. E. Conway (Eds.), Role theory. Perspectives for health professionals (pp. 1-15). New York: Appleton-Century-Crofts.

Hardy, M. E., & Conway, M. E. (1978). Role theory. Perspectives for health professionals. New York: Appleton-Century-Crofts.

Hurley, B. A. (1978). Socialization for roles. In M. E. Hardy, & M. E. Conway (Eds.), Role theory. Perspectives for health professionals (pp. 29-72). New York: Appleton-Century-Crofts.

Hutchinson, S. (1986). Grounded theory: The method. In P. L. Munhall, & C. J. Oiler (Eds.), Nursing research. A qualitative perspective (pp. 111-130). Norwalk, CT: Appleton-Century-Croft.

Kahn, L., & Worth, P. (1978). Perceptions and expectations of physician supervisors. Nurse Practitioner. January-February, 27-31.

Kalisch, P. A., & Kalisch, B. J. (1986). The advance of american nursing. (2nd ed.). Boston: Little, Brown & Co.

Kitzman, H. (1983). The clinical nurse specialist and the nurse practitioner. In A. B. Hamric, & J. Spross (Eds.). The clinical nurse specialist in theory and practice. (pp. 275-290). New York: Grune & Stratton, Inc.

Knafl, K. A. (1978). How nurse practitioner students construct their role. Nursing Outlook, October, 650-653.

Kvis, F. J., Misener, T. R., & Vinson, N. (1983). Rural health care consumers' perceptions of the nurse practitioner role. Journal of Community Health, 8(4), 248-262.

La Bar, C. (1983). The regulation of advanced nursing practice as provided for in nursing practice acts and administrative rules. Kansas City, MO: American Nurses' Association.

Levine, E. (1977). What do we know about nurse practitioners? American Journal of Nursing, 1799-1803.

Levine, D. M., Morlock, L. L., Mushlin, A. I., Shapiro, S., & Malitz, F. E. (1976). The role of new

health practitioners in a prepaid group practice: provider differences in process and outcomes of medical care. Medical Care,xiv, 4, 326-347.

Levine, J. I. , Orr, S. T., Sheatsley, D. W., Lohr, J. A., & Brodie, B. M. (1978). The nurse practitioner: Role, physician utilization, patient acceptance. Nursing Research,27(4), 245-254.

Lewis, E. (1975). Nurse practitioner: The way to go? Nursing Outlook,23, 3.

Lewis, C. E., & Cheyovich, T. K. (1976). Who is a nurse practitioner? Processes of care and patients' and physicians' perceptions. Medical Care,XIV(4), 365-371.

Lewis, C. E., & Linn, L. S. (1977). The content of care provided by family nurse practitioners. Journal of Community Health,2(4), 259-267.

Lewis, C. E., & Resnik, B. A. (1967). Nurse clinics and progressive ambulatory patient care. New England Journal of Medicine,277, 765-769.

Lewis, C. E., Resnik, B. A., Schmidt, G., & Waxman, D. (1969). Activities, events and outcomes in ambulatory patient care. New England Journal of Medicine,280, 645-649.

Lindesmith, A., & Strauss, A. (1968). Social psychology. New York: Holt, Rinehart & Winston.

Linn, L. (1975). Expectation vs realization in the nurse

practitioner role. Nursing Outlook,23,3, 166-171.

Little, M. (1978). Physicians' attitudes toward employment of nurse practitioners. (Part 1). Nurse Practitioner, July-August, 27-30.

Little, M. (1978). Physicians' attitudes toward employment of nurse practitioners. (Part 2). Nurse Practitioner, November-December, 26-29.

Lofland, J., & Lofland, L. H. (1971). Analyzing social Settings. A guide to qualitative observation and analysis. Belmont, Ca: Wadsworth, Inc.

Lukacs, J. L. (1982). Factors in nurse practitioner role adjustment. Nurse Practitioner, March, 21-23.

Lukacs, J. L. (1984). Developing a practice definition. Nurse Practitioner, April, 59-62.

Lurie, E. E. (1981). Nurse practitioners: issues in professional socialization. Journal of Health and Social Behavior,22, 31-48.

Lynaugh, J. E. (1986). The nurse practitioner: Issues in practice. In M. D. Mezey, & D.O. McGivern (Eds.), Nurses nurse practitioners. The evolution of primary care (pp. 137-145). Boston: Little, Brown & Co.

Mauksch, I. G. (1978). The nurse practitioner movement where does it go from here? American Journal of Health, 68(11), 1074-1075.

Mauksch, I. G., & Young, P. R. (1974). Nurse-physician interaction in a family medical care center. Nursing Outlook,22(2), 113-119.

Mead, G. H. (1934). Mind, self, and society. Chicago: University of Chicago Press.

Medicine and nursing in the 1970s. A position statement. (1970). Journal of the American Medical Association, 213(11), 1881-1883.

Mendenhall, R. C., Repicky, P. A., & Neville, R. E. (1980). Assessing the utilization and productivity of nurse practitioners and physicians assistants: methodology and findings on productivity. Medical Care,XVIII(6), 609-623.

Mezey, M. D. (1986). The future of primary care and nurse practitioners. In M. D. Mezey, & D. O. McGivern (Eds.), Nurses, nurse practitioners. The evolution of primary care (pp. 101-119). Boston: Little, Brown & Co.

Molde, S., & Diers, D. (1985). Nurse practitioner research: selected literature review and research agenda. Nursing Research,34(6), 362-367.

Moloney, M. M. (1986). Professionalization of nursing Current issues and trends. Philadelphia: J.B.Lippincott.

Mundinger, M. O. (1980). Autonomy in nursing. Maryland: Aspen.

Noonan, B. R. (1972). Eight years in a medical clinic. American Journal of Nursing,72(6), 1128-1130.

Ozimek, D., & Yura, H. (1975). Who is the nurse practitioner? (Pub. No. 15-1555). New York: National League For Nursing.

Pearson, L. J., & Stallmeyer, J. (1987). Opposition to title change overwhelming. Nurse Practitioner, 12(5), pp. 10, 15.

Pender, N. J., & Pender, A. R. (1980). Illness prevention and health promotion services by nurse practitioners: predicting potential customers. American Journal of Public Health,70(8), 798-803.

Ramsay, J. A., McKenzie, J. K., & Fish, D. G. (1982). Physicians and nurse practitioners: Do they provide equivalent equivalent health care? American Journal of Public Health,72(1), 55-57.

Randall, C. S., & Williams, J. K. (1985). The role of the nurse practitioner: Distributive or episodic care? In J. C. McCloskey, & H. K. Grace (Eds.), Current Issues in Nursing. (2nd ed.). Boston: Blackwell Scientific Publications.

Resnik, B. (1981). Personal correspondence.

Rickard, L. D. (1986). Role ambiguity and job satisfaction of clinical nurse specialists in a cost-conscious environment. Nursing Administration Quarterly,11(1). 65-70.

Rogers, M. E. (1972). Nursing: To be or not to be? Nursing Outlook,20(1), 42-46.

Rogers, M. E. (1975). Nursing is coming of age through the practitioner movement-con. American Journal of Nursing, 75(10). 1834-1843.

Rose, A. M. (1962). A systematic summary of symbolic

interaction theory. In A. Rose (Ed.), Human behavior and social processes: An interactionist approach (pp. 3-19). Boston: Houghton Mifflin.

Sadler, A. M., Sadler, B. L., & Bliss, A. A. (1975). The physician's assistant -today and tomorrow. Cambridge, MA: Ballinger Co.

Sarbin, T. R., & Allen, V. L. (1968). Role theory. In L. Gardner, & E. Aronson (Eds.), Handbook of social psychology (Vol.I). (pp. 488-567). Reading: Addison-Wesley.

Scherger, J. E., Eaton, M. H., Flaherty, S., & Gordon, M. J. (1977). A nurse practitioner in a family practice residency: Role description and impact on continuity of the practitioner-patient relationship. Journal of Family Practice,5(5), 791-794.

Siegel, E., & Bryson, S. C. (1963). A redefinition of the role of the public health nurse in child health supervision. American Journal of Public Health,53, 1015-1024.

Simborg, D. W., Starfield, B. H., & Horn, S. D. (1978). Physicians and non-physician health practitioners: The characteristics of their practices and their relationships. American Journal of Public Health,68(1), 44-48.

Sox, H. C. (1979). Quality of patient care by nurse practitioners and physician's assistants: A ten-year

perspective. Annals of Internal Medicine,91, 459-468.

Sparacino, P., & Durand, B. (1986). Editorial on specialization in advanced nursing practice. Momentum.

Spitzer, W. O. (1984). The nurse practitioner revisited. Slow death of a good idea. New England Journal of Medicine, 310(16), 1049-1051.

Spitzer, W. O., Sackett, D. L., Sibley, J. C., Roberts, R. S., Gent, M., Kergin, D. L., Hackett, B. C., & Olnyich, A. (1974). The burlington randomized trial of the nurse practitioner. New England Journal of Medicine,290, 251-156.

Storms, D. M., & Fox, J. G. (1979). The public's view of physicians' assistants and nurse practitioners. Medical Care,XVII(5), 526-535.

Strauss, A. (1987). Qualitative analysis for social scientists. Cambridge: Cambridge University Press.

Sultz, H., Henry, O. M., & Sullivan, J. A. (1979). Nurse practitioners: U.S.A. Lexington, MA: Lexington Books.

Thomas, E., & Biddle, B. (1966). Basic concepts for classifying the phenomena of role. In B. Biddle, & E. Thomas (Eds.), Role theory concepts and research. (pp. 3-19). New York: Wiley.

Turner, J. H. (1978). The structure of sociological theory. Homewood, IL: Dorsey Press.

Vacek, P., & Ashikaga, T. (1980). Quantification of the expanded role of the nurse practitioner: a discriminate

analysis approach. Health Services Research,15, 105-125.

Ward, M. J. (1979). Family nurse practitioners: perceived competencies and recommendations. Nursing Research, 28(6), 343-347.

Weston, J. L. (1975). Whither the 'nurse' in nurse practitioner? Nursing Outlook,23(3), 148-152.

Wilson, H. S. (1987). Introducing research in nursing. Menlo Park, CA: Addison-Wesley.

Wirth, P., Storm, E., & Kahn, L. (1975). An analysis of the fifty graduates of the washington university pediatric nurse practitioner program Part 1: Scope of practice and professional responsibility. Nurse Practitioner, 18-23.

Wright, E. (1976). Registered nurses' opinions on an extended role concept. Nursing Research,25(2), 112-114.

Zammuto, R. F., Turner, I. R., Miller, S., Shannon, I. & Christian, J. (1979). Effect of clinical settings on the the utilization of nurse practitioners. Nursing Research, 28(2), 98-102.

Zikmund, W. G., & Miller, S. J. (1979). A factor analysis of attitudes of rural health care consumers toward nurse practitioners. Research in Nursing and Health,2, 85-90.