Finding Florence

Shedding Light on Nurse Practitioners' Professional Responsibility

Ada ter Maten-Speksnijder

FINDING FLORENCE: SHEDDING LIGHT ON NURSE PRACTITIONERS' PROFESSIONAL RESPONSIBILITY

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GENERAL INTRODUCTION

PRELUDE

I am glad that she's laughing, that she takes me from my bed to my chair as if she is leading me onto the dance floor, that I can place my fingers in hers and put my feet in the spot where she has put hers.
She lowers me carefully into my chair.
She asks whether it is close enough to the window.
She lays my feet on the pouf.
She wraps my feet in an extra blanket.
Am I sitting comfortably?
Don't I need an extra cushion behind my hips?
"I've poured the tea in the thermos, Mrs Helena. Would you like the paper first?"
When I shake my head she lays the board on my lap and says that there is enough ink in the pens.
Although she asks whether I'm feeling cold, as she asks she has already knelt down beside me. She rubs my fingers warm until they tingle. I'm glad she understands, understands so much, that she doesn't overwhelm me with favours for which I first have to beg and that her gestures and grimaces do not spell out to me the thousands of connotations of the word parasite.
As you get older you automatically calculate in nanograms and micrometres. You weigh friendship like gold dust on tiny scales and the merest grain of sand embodies the grossest humiliation.
She gets up. Looks down at me with satisfaction.
"They and the Spirit ascend to Him, on a Day whose length is 50,000 years."
"What was that, Mrs Helena?"
"Nothing, child. Something about your angels…"

(Mortier, 2015, p. 20)

In the novel 'While the Gods were Sleeping' [in Dutch: *Godenslaap*], the main character, Mrs Helena, describes how it feels to be dependent on others and what it means to her that someone understands what she needs. This reflects what Toombs (1993, p. 110) called: 'the voice of the lifeworld'. The cited passage shows what I believe is the essence of good care: to support people to live well in spite of illness and disability, and to maintain human dignity. Providing good care is the ultimate goal of nursing. The narrative also reveals that Mrs Helena is not only passively receiving care. By citing the Quran she connects with her nurse Rachida's cultural background. This indicates that a nurse-patient relationship has been established. As Bishop & Scudder (2003) have it in their philosophical work on

the sense of nursing, a nurse-patient relationship should be at the heart of nursing. In this view, good care depends on the relationship between a unique nurse and a unique patient in which both are actively involved. Many nurses would embrace Mortier's narrative as an exemplar of their ideals of good care too. However, these ideals vary from care being effective, well managed or tailored to someone's needs (Pols, 2004). In the constantly changing healthcare sector nurses need to continuously review their responsibility to provide good care. For example, the new nurse practitioner [NP] role comes with more responsibility for patients. This trend provided the rationale for selecting NPs' professional responsibility as the topic of the thesis. Below, I will first explain why a new role in healthcare was needed, present the aim of the thesis, introduce the NP role and describe the responsibility implied.

THE NEED FOR A NEW ROLE

In the past few decades we have seen the sprouting of new professional roles, such as the NP role, worldwide. In the Netherlands, the NP role has emerged in response to several human resource problems: a shortage of physicians, the need for continuity and coordination between patients and healthcare workers, and the lack of career possibility for nurses (Roodbol, 2005). At the same time, being confronted with an ethnically more diverse and ageing population that strained healthcare resources, nurses needed to create flexibility in working practices and service organizations (Nancarrow & Borthwick, 2005). Moreover, more nurses with a higher education were needed to deal with the new patient populations and new sets of varied health problems with a high degree of unpredictability. Nowadays, hospitals cater primarily for highly physiologically unstable patients and started to deliver medical therapies in ambulatory care facilities, including patient homes. More than ever before, nurses are expected to be able to accurately assess changes in a patient's physical condition so as to ensure the patient's safety and well-being. In all healthcare settings, nurses see people who live longer but then often may have multiple complicated health conditions that require increasingly complex care. Another major challenge of nursing is to intertwine instrumental, technical-scientific work with effective communication and relational skills. As Benner, Tanner, & Chesla (2009) put it: technology has changed healthcare, increasing the need for higher levels of skills necessary to communicate with patients and families. In summary, human resource problems, changing patient populations, and increasing high tech care were instrumental in the sprouting of new roles.

The new NP role came with high expectations, in terms of formal transfer of tasks from physicians to NPs – the so-called task substitution – and of providing high-quality nursing care. NPs are expected to blend the medical management of patients into the

nursing role. This enrichment can be captured in a care model – called Advanced Practice Nursing [APN] – that encourages exploring both the disease and illness experience, understanding the whole person and incorporating prevention and health promotion (Bryant-Lukosius DiCenso, Browne & Pinelli, 2004). APN is distinct from basic nursing in that it involves specialization and requires expansion of knowledge, skills and role autonomy to achieve innovation and improved nursing care (Spross, 2014). Still, APN involves more than just acquiring knowledge and skills needed for the medical discipline. It also implies more than providing continuity of care during the absence of other professionals or by virtue of increased demand (Daly & Carnwell, 2003). Also specialty nursing, which requires detailed knowledge of a specialized area, does not reflect the scope and depth of knowledge that characterize APN. In the end, APN is best characterized by nursing interventions for which nurses are responsible and accountable, and which emerge from a broader and deeper understanding of human responses to health and illness. Thus, NPs are presumed to possess comprehensive insight in the complexity of healthcare situations (Grypdonck, 1995); to be able to reflect on their own practices and those of others; to create new knowledge; and improve the quality of nursing and of healthcare services in general (Bryant-Lukosius et al., 2004). Expansion of the NP role into medical practice might be a by-product of these requirements (Rolfe & Fulbrook, 1998; Elsom, Happell, & Manias, 2005; Meurs interviewed by Adriaansen, 2006).

THE AIM OF THE THESIS

Scant research has attempted to describe the value of NP practice for healthcare organizations in the Netherlands (Bloemendaal, Albers, de Kroon & Dekker, 2009; Tempelman, 2005, Wallenburg, Janssen & de Bont, 2015), the impact on organizational structures (Knip, 2006; Van Offenbeek, 2007), and the division of jurisdictional control over prescribing (Kroezen, Mistiaen, Van Dijk, Groenewegen & Francke, 2014). Other studies mostly focused on patient satisfaction with the NP role in comparison with physicians (Balk, van Bergeijk & Rabeling-Keus, 2009; Laurant et al., 2008; Goessens, Visseren, Sol, de Man-van Ginkel & van der Graaf, 2006; Schuttelaar , Vermeulen, Drukker & Coenraad, 2010; Van Veldhuisen, Koopmans & Jaarsma, 2006; Zwinkels et al., 2008), on coordination of care (Bredero-Boelhouwer, Treharne & Mathijssen 2009; Broers et al., 2006; Van der Sluis, Datema, Saan, Stant & Dijkstra, 2009), costs (Dierick-van Daele, Steuten, Romeijn, Derckx & Vrijhoef, 2011), clinical outcomes such as weight gain (Ter Bogt et al., 2011), eczema severity (Schuttelaar et al., 2010), length of hospital stay (Broers et al., 2006), and adequacy of medical treatment (Van der Linden, Reijnen & de Vos, 2010). While Dutch policymakers opted for task substitution from more expensive doctors to cheaper nurses mainly for efficiency's sake, the economic arguments for

substitution were all but robust (Dierick-van Daele et al., 2011). The above-mentioned studies provided some evidence that the NP role is appreciated in the Netherlands; it was shown that the NPs could manage condition-specific cases and achieve the same level of patient-related outcomes as obtained with medical management by physicians. Similarly, Tsiachristas et al.'s systematic literature review (2015) of international studies on the NP role found evidence for improvements in patient satisfaction, patient information, and clinical outcomes.

However, the NP role development in the Dutch healthcare context has not yet been dealt with at length, and neither has the question whether NPs share a vision on their professional responsibility. The NP role can be seen as a product of how the NPs see themselves as members of the profession and what they see as society's expectations of the role (Meleis, 2010). But what is more, environmental support and barriers to NPs are relevant, too. Also knowledge is lacking on NPs' actual practice-related actions and the extent to which these flow from nursing knowledge and are anchored in nursing goals. Because the NP role comes with more responsibility for patients, various stakeholders apart from NPs themselves need insight in its scope. To guide NP students, nurse educators need to know how NPs enact this new responsibility. Healthcare organizations will want to know how to position NP students and new graduates in a multidisciplinary context. Lastly, the society must feel assured that the new care providers can be trusted. This implies that knowledge is needed about NPs' actual role enactment, the way in which they recognize and address healthcare problems, and what they see as good nursing care. Therefore, the aim of this thesis is: *To explore how the Dutch nurse practitioners perceive, develop and enact their professional responsibility*.

NURSE PRACTITIONERS' PROFESSIONAL ROLE

In this section the professional role will be explored with regard to 1) the nursing profession's transformation, 2) a new position, and 3) professional responsibility.

Transformation of a Profession

The evolution from the basic nursing role to the NP role reflects Mok's (1990) concept of *differentiation* in the job structure: specific workers take on more specific tasks and functions, which creates variety and specialization. The differentiation of the NP role in the Netherlands started in 2000 with a group of fifteen nurses, supported by the University Medical Centre in Groningen. The then Minister of Health, late Dr. E. Borst-Eilers was open to the idea of adding tasks from the medical domain to the nursing practice as had been done in the United States in the 1960s (Roodbol, 2005).

Occupational groups acquire a professional status by *institutionalization,* which implies that specific solutions for certain problems form new patterns of action that become the standards of the profession. These standards regulate professional behaviour and professional relationships by showing what professionals do, or can do in their professional practices. Van der Arend (2009) calls this process 'the formation of practices'. Institutionalization of the NP profession in the Netherlands was realised through Master of Advanced Nursing Practice programs offered in eight universities of applied sciences. A new competency framework defined the NPs' level and scope of expertise (VBOC, 2008).

Then, it is important to explain how the profession contributes to society. After all, it is imperative that society eventually recognizes the profession (Mok, 1990). The professional NP standards were designed to guarantee that the new graduates are qualified to examine patients physically, initiate investigations, and diagnose health problems. Furthermore, they are able to decide about treatment and care, prescribe medications or refer patients to other sources of help, and evaluate and alter treatment and care as appropriate (VBOC, 2008). Finally, when the society is convinced of the exceptional value of the professional services, *legitimation* follows by which the position of the profession is protected (Freidson, 2001). In 2011, Dutch NPs were legally authorised to work in a specific area of expertise, regulated by the experimental article 36A of the Individual Healthcare Professions Act (in Dutch: *Wet Beroepen in de Individuele Gezondheidszorg).* The NPs were permitted for an experimental period of five years to perform the so-called 'reserved procedures' that until then were restricted to practitioners with direct authorisation (e.g. physicians), including the prescribing of medicines. The Minister of Health, Welfare and Sports recognized the title 'Nurse Specialist', which was legally protected since then (Van Meersbergen, 2011). Most NPs have begun to use this title as their job name. In this thesis, the term 'nurse practitioner' will be used, in congruence with international research. Fifteen years after the start of the NP development, some 1,900 NPs work in hospitals, in nursing homes and in general practices. Still, they constitute only 0.75% of all nurses in the Netherlands (CBS, 2011).

A New Professional Position

NPs will gain their position in healthcare in congruence with the professional standards of responsible behaviour, which is summarized as 'acting skilfully on behalf of patients' wellbeing' (VBOC, 2008). However, this position is not a fixed fact. Professions are constantly in motion; even the classic medical profession is subject to on-going negotiation, for example about the authority over certain therapies and procedures. Abbott (2014) noticed that professions acquire authority and prestige by their expertise, on the basis of which they legitimize their monopoly. By joining professional organizations and through formal and informal education and training, professionals are socialized into the norms and values of the profession. Gaining authority in society is based on the voluntary

acceptance of the suggestions, ideas, and guidelines that professionals propose to find solutions to people's problems. This is what Abbott (2014, p. 40) considers the concept of 'jurisdiction', "being that what is under control by the professional". Abbott argued that a profession is successful if its members can offer unique selling points, and if they can maintain professional relationships with other professional groups. This is also the case with the nursing profession, striving to expand certain nursing roles. Competition between professions (e.g. between the medical and the nursing professions) is based on the use of abstract knowledge to diagnose a problem, to identify the cause and to come up with a solution (Abbott, 2014). In the case of nursing, many authors see professional knowledge mirrored in the identification of nursing diagnoses, to be understood as patients' problems as defined by the nurse, which are amenable to nursing interventions (Hyde, Lohan & McDonnell, 2004). Nursing diagnoses and nursing interventions are perceived as representations of the identification of a knowledge base, which only nurses – by virtue of their training and registration- have control over. Although having rational knowledge is important, the situation, the context of the problem and the question itself define the right knowledge (Abbott, 2014).

Professional Responsibility

Before characterizing NPs' professional responsibility, it must be made clear what the concept of 'responsibility' implies (Rodgers, 1989). Responsibility is defined by Komter (2004, p. 36) as: "Being liable for your actions, to justify your actions for a forum of 'others' who represent 'the conscience' and who judge morally over a person's actions". As if there is always someone present asking the question: 'why did you do it this way?' This definition is in congruence with a passive form of responsibility (or responsibility-as-accountability) to which Bovens (1998) added 'active responsibility'. Bovens sees active responsibility as a virtue, the virtue of taking responsibility when something needs to be done to deal with a problem or put things right. The question here is: 'what is to be done?' Active responsibility can even be in the form of claiming, like a football player claiming a penalty or a politician asking: 'who stands up for this issue?' Bovens sees someone's task as the connecting piece between passive and active responsibility. In this thesis the concept of 'responsibility' encompasses both responsibility-as-a-virtue and responsibility-as-accountability, and is defined as: *to take actions, which I can and want to vouch for, even if I will never be held accountable*. NPs have the responsibility to act skilfully on behalf of patients' wellbeing in congruence with the professional standards of responsible behaviour (VBOC, 2008). They are asked, therefore, with supporting people to live well in spite of illness and disability, while the human dignity is protected, even if they would never be held accountable for it.

Apart from being based on technical competences, the NP practice is guided by moral, legal and social norms. Moral norms review behaviour in terms of good and bad. While

legal norms serve to examine whether behaviour is legally permitted or not, social norms review appropriate or inappropriate interactions with others (WRR, 2004). Professionals need to make choices that will engender trust and confidence in the people they serve. Meurs (1997) described a professional's technical knowledge and expertise as the first layer of professional behaviour. The second layer concerns internalization: the ability to connect acquired knowledge with one's possibilities, impossibilities, and ideals. Lastly, the third layer constitutes the way in which professional knowledge and doings connect with the social context. The latter is the most difficult to put into practice because it requires thinking about the question: 'what is appropriate in this situation and why?' Meurs (1997) argued that professionals will be able of coming up with an answer to this question by keeping their own knowledge and skills at a high level and putting their encounters with patients at the centre. It is not the official standard that is leading in these encounters, but rather the unique characteristics of the situation and the persons involved. Freidson (2001) also emphasized that, next to a unique body of knowledge and skills, professional ethics determines the professional role content and legitimizes a profession's jurisdiction and independence. The core of the professional ethics in healthcare is commitment to serve the patients by focusing of what patients *need* and rather not on what patients *want*. This commitment serves a higher purpose, such as health and welfare (Freidson, 2001).

In her study of ethical issues arising from the daily work of advanced practice nurses, Grace (2013) sees nursing ethics and professional responsibility as equivalent concepts. She noticed that a healthcare professional's ethics have to do with understanding of what is required for good professional action. In the hypothetical example of one available heart for four people who urgently need it a nursing ethics' question might be: "What is my professional responsibility toward my patient irrespective of whether he receives the heart or not? And what is needed for good care?" This is in contrast of the bioethical perspective: "How to decide who of the four gets the heart?" (Grace, 2013, p. 7). The Dutch Code of Ethics for Nurses and Carers provides ethical principles and rules that may guide nurses in the Netherlands (CGMV et al., 2015). The code defines that in a relationship with a patient the nurse should be the patient's advocate, in a relation with another health professional a colleague, in relation with the nursing profession a contributor and with society a representative of health care for all. Justification of nursing practice has largely relied on medical ethical principles derived from Beauchamp and Childress's bioethical theory (2001), such as autonomy, beneficence, and justice. In addition to the emphasis on meeting moral rules, various nurse professionals – for example Gadow, 1985; Watson, 1988, and Griffin, 1983 (in: Frye, 1989) – identified caring as the fundamental value in nursing next to advocacy, as well as engagement with a patient in a situation of vulnerability, stress or distress, and knowing a patient within his or her social context (Grace, 2013). Frye (1989) argued that caring ought to be central to a theory of nursing ethics in the form of respect-for-persons, and that caring will benefit from being linked to the practice of medical ethics with its focus

on the healthcare provider's behaviour on behalf of patient good, and vice versa. Grace (2013) noticed that the principles that are used by nurses are driven by the goals of nursing rather than the other way around. The principle of beneficence (which is: producing the good) urges nurses to provide a good (which is: care), but the goals of nursing describe what good is (promotion of health or relief of suffering). Nurses make their decisions based on the good that nursing practice set as a goal, which becomes concrete through the relation between the nurse and the patient (Gastmans, 2002).

Kunneman (1996) also emphasizes that professionals must be able to relate to patients, and to the content of their profession from an ethical stance, or: 'normative professional behaviour', characterized by reflection on one's professional behaviour and values, which should prompt the question: 'how can I do it better in this situation?' He argued that professionals should be able to let go of their safe role as experts who judge from an obvious moral authority and have a technical answer for all problems. Indeed, professionals are also accountable for the use of other qualities, such as commitment, a caring attitude and emotional sensibility (Kunneman, 1996). Van der Cingel (2012) showed in her doctoral thesis that nurses are familiar with these qualities that she connected to the overarching concept 'compassion', which means 'a moral answer to a person's suffering'. Compassionate nurses wish to take care of somebody and keep life going also when it is failing, and when it loses quality and autonomy (Baart & Grypdonck, 2008). These nurses want to know if they made a difference to patients. Especially, professionals starting a new role may, as Savater (2015, p. 96) argued, find that professional responsibility can be described as: "Knowing that each of my actions forms me, and defines me. I will change gradually by the choices I make. All my decisions leave a trace in myself before they do in the world around me. And of course, after I used my freedom to give myself a face, I cannot complain or be scared when I look at myself in the mirror. When I am doing well, it will be increasingly difficult to act badly; this is also reversed unfortunately".

NURSE PRACTITIONERS' PROFESSIONAL RESPONSIBILITY

As described in the previous section, professional responsibility implies serving the welfare of patients, and reflecting whether one's actions were performed using high-level expertise grounded on technical, moral, social, and legal norms. Professional responsibility could be studied by investigating the central aspect of the NP role: the provision of direct patient care. In the Netherlands, the NPs have to distinguish themselves from registered nurses by three criteria: independency, expertise, and an active attitude to role development (Meurs & van Rooyen, 2006). In this section these criteria will be explained in relation to the concept of professional responsibility (Figure 1).

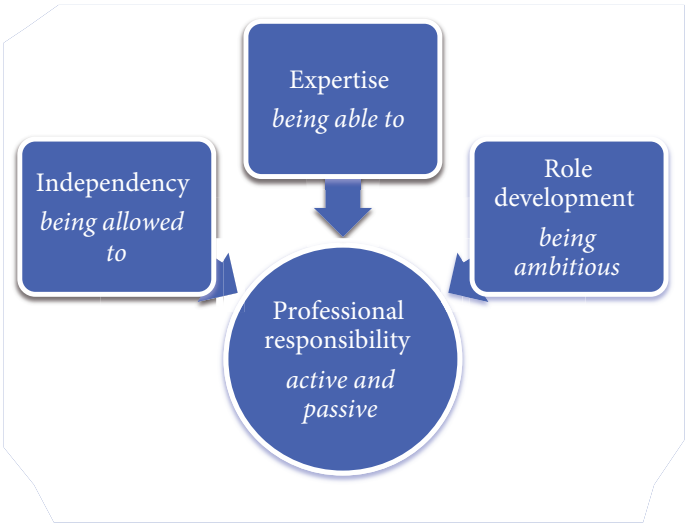

Figure 1: Nurse practitioner's professional responsibility

Independency

The independency criterion implies that NPs *are allowed to* provide care in an independent capacity. Thus they are permitted to act as the first point of contact for patients and to enter into treatment relationships with patients independently of physicians, so they can make responsible decisions about patients' needs (VBOC, 2008). Decisions about diagnoses and interventions must fit with professional standards of quality care. In the Netherlands, two laws govern quality care. The Quality, Complaints, and Disputes Act stipulates that care must be provided in a timely, safe and effective manner (VWS, 2015). The Individual Healthcare Professions Act fosters and monitors the standards of professional practice in order to protect patients against professional incompetence (VWS, 1996). By virtue of the latter, NPs are authorized to practice independently without direct physician oversight, which includes the prescription of medications. The College of Nursing Specialties of the National Professional Organization of Nurses [in Dutch: *V&VN*] has set specific requirements for NPs' expertise, skills, and attitudes, which are subject to accountability procedures (vsregister.venvn.nl). Furthermore, in line with Abbott's concept of jurisdiction (2014), NPs are authorized to have control over their work because the NP role has been accepted by society and NPs adhere to guidelines on solving certain healthcare problems. It marks them as being liable for their actions. Therefore, NPs must be prepared to take full responsibility for their decisions and actions. NPs are legitimized to practise independently if they show virtuous professional behaviour. Such behaviour is understood to imply: meeting patients as persons with rights and duties; performing one's tasks to the highest standards; working as a team member, and thinking along with other stakeholders on what should and what can we expect from healthcare

in the future (WRR, 2014). This requirement links the 'independency' criterion with the 'expertise' criterion described next.

Expertise

This criterion requires that the NPs *are able to* distinguish themselves from nurses educated at the Bachelor level, by being an expert in one of the five specialties: acute care, chronic care, intensive care, preventive care, and mental healthcare. The NPs are expected to complement their nursing knowledge base with expertise on diseases and the clinical implications for patients through a graduate (Master-level) education (Meurs & van Rooyen, 2006). The NP profession adapted the CanMeds 7-Role Framework for Medical Specialists (2011) to describe the areas of NP competence: clinical care, communication, collaboration, health promotion, organization, science, and professional behaviour (Schuurmans et al., 2012). The required competences fit with Hamric's model for advanced nursing practice (2014), which is based on international research. The clinical care competency includes the following elements (Hamric, 2014):

- Use of holistic perspective, considering the impact of a new diagnosis, the medical plan of action, the patient's story, and other life circumstances that contribute to the situation;
- Formation of therapeutic partnerships with patients, encouraging patients to actively participate in decision-making, advocating patient's perspective to others;
- Expert clinical reasoning and skilful performance, activating quickly one or several lines of reasoning about changes in a situation regarding what might be going on;
- Use of evidence as a guide to practice, bringing research findings to practice, seeking out research-based guidelines, and integrating with clinical expertise and patient values;
- Use of reflective practice, exploring experiences to clarify meaning, critically analysing, synthesizing and learn to improve practice and ethical decision-making;
- Use of diverse approaches to health and illness management, acquiring proficiency in new ways of treating and helping patients to maintain health and capitalize on their strengths and resources.

Expertise implies using abstract knowledge to diagnose a problem, to identify the cause and to come up with a solution – although what should be considered the right knowledge depends on the situation, the context of the problem and the question itself (Abbott, 2014). NPs need extensive, varied, and complex knowledge networks to help them understand clinical situations and events. Benner, Tanner & Chesla (2009) emphasized that expertise is a function of a nurse's experience, coupled with greater capacity to navigate complex clinical situations. This allows making fine distinctions among features of a particular condition, which would not be possible during beginning practice (Tracy, 2014). Still, NPs'

expertise is not only based on experience. Tanner's literature review (2006) showed that three types of knowledge are required:

- Personal knowledge (know yourself, know your patient) based on an interpersonal connection;
- Experiential knowledge (know from your own experience what has happened in many cases to fill in gaps and assist the prompt identification of clinical issues);
- Propositional knowledge (know from research what might happen in similar cases, and know from research what might happen in the general case).

Next to knowledge and expert clinical reasoning, skilful performance is also an important element of NPs' professional responsibility. In the Netherlands, the NP profession attaches great value to a reflective attitude enabling to make careful decisions based on a moral framework of good care (VBOC, 2008). This was emphasized by Freidson (2001), Grace (2013), Kunneman (1996) and Meurs (1997) as well; they all coupled expertise with ethics. In addition, Benner (1989) pointed out that apart from a purely technical approach something else is needed as well, i.e. providing comfort and preserving human dignity in the face of pain and extreme breakdown, and being there for the patient (Van der Cingel, 2012, Baart & Grypdonck 2008).

Role Development

The 'role development' criterion implies that the NPs *are ambitious to* enter the domain of physicians and move to higher levels of nursing practice at the same time. This requires much effort, which Brykczynski (2014, p. 86) worded as follows: "it is more than socializing and taking on a new role, it involves transforming one's professional identity". Meeting this criterion 'active attitude to role development' requires as well the fulfilment of the 'independency' and 'expertise' criteria. First, because NPs are expected to provide their care in an independent capacity, they have to be clinical scholars with a higher level of thinking and working. At the same time they must have a broad scope of practice, not only providing direct patient care but being able to engage in education and in research too. Such role development is a process of continuous refinement of knowledge and skills, including leadership skills. In the NP competency framework this is described as follows: "NPs promote the development and implementation of knowledge and skills within their own specialty and their own field of expertise by executing research or through participation in research, which is integrated in patient care" (Schuurmans et al., 2012, p. 23). Only then, NPs will be able to provide patient care of the highest quality in collaboration with other professionals, while challenging traditional values and transform clinical care for the better, which is a crucial aspect of their new role and professional responsibility.

THIS THESIS

Scott (1995) suggested that looking at healthcare practice purely in terms of roles with duties and rights, and at skills necessary for competent practice might not fully capture what the healthcare practitioner needs to know, to do, or to be. It is also the quality of role enactment, and moral strategy that will bear on the quality of patient care. Many factors need to be considered, including ethics, job and task analysis, training, and the needs of individual NPs to understand how NPs see their professional responsibility. In other words: in what way do they perceive, develop and enact their *task to take actions which they can and want to vouch for, even if they will never be held accountable*. Three major objectives were formulated for the five studies included in this thesis, related to the above-mentioned criteria defining the Dutch NP role. These objectives and the related questions are introduced in this section.

Part I. Independency

NPs need some freedom to take decisions at their own discretion in the interest of patients. The criterion related to independency is rooted in the clinical act of patient care. Its fulfilment relies on the collaboration with other healthcare providers, which can be impeded, however, by a number of reasons. For one thing, the NP profession is still young, and despite the legal framework in which NPs operate, they are vulnerable because they are still dependent on the medical professionals who must facilitate their training and supervise them in their clinical work. The NPs also depend on the willingness of administrators to develop policies aimed at task substitution.

Since the introduction of the NP role in the Netherlands a debate is on going of which the outcome may either hinder or facilitate recognition of the NPs' professional work by the stakeholders. The outcome of the debate is particularly crucial for NPs' professional development and society's legitimation of what professionals do. A profession can only be acknowledged if the professionals' knowledge and competence rest on rational, scientific grounds, and judgment and advice are based on substantive values, validated by peers (Freidson, 2001). Professionals may claim their work as legitimate when it produces valued results, such as health, in a culturally approved manner – e.g. efficient (Abbott, 1988). Because the debate on the NP role in other countries was quite complicated (Rashotte, 2005; Brykczynski, 2012), it was found useful to unravel all aspects of the debate in the Netherlands so as to assess its impact on NPs' independency. The following objective and research question were formulated:

- **To explore the debate on the development of the NP profession in the Netherlands**
- *How did the public debate influence the development of the NP profession in the Netherlands and how did this shape NPs' professional responsibility*?

Part II. Expertise

The transition from being a novice in the complex, unfamiliar domain of the NP practice to a competent professional is challenging for students. Master programs aim to equip students with a fundamental body of knowledge about nursing and medical care. The next step, moving from competence to expertise demands high engagement in learning over a long time. Experts need not only possess a broad and deep knowledge base, but are expected to continuously add to this by research. NPs bear professional responsibility for patient's problems for which existing knowledge is not always sufficient. NP students have to learn how to apply their knowledge and skills within a broader context in new or unfamiliar environments. Thus they will be able to handle complexity and to formulate judgments on the basis of incomplete or limited information, while reflecting on their responsibilities. A reflective attitude is needed to challenge rigorous application of formal nursing theory and to integrate different perspectives into an evolving personal theory (Kunneman, 1996).

Dewey (1997) established the grounds for the notion that reflection is the basic mechanism for learning and improvement of practice. In the course of this PhD research we therefore developed an educational tool named: 'the reflective case study'. The reflective case study entails a narrative about a patient encounter and the student's reflection on it. Narratives are stories of people's lives or situations told with rich detail and often from different perspectives. After having described a situation, the student closely examines and questions her or his own decision-making process to uncover what knowledge was applied in the encounter. In two meetings with small groups of students and a teacher, the students peer-review each other's narratives on clarity and completeness. Lastly, the students consider if and how the situation could have been handled differently and what other knowledge could have been brought to bear on the situation. Reflection can indeed lead to better clinical performance in troublesome situations (Mamede, Rikers & Schmid, 2012). It is crucial, therefore, to being an advanced practice nurse whose mind is set not only at learning from the situation and striving to do better next time, but at instantly improving the current situation (Rolfe, Jaspers & Freshwater, 2011). It is not known what the reflective case study adds to the development of a reflective attitude and how NP students reflect on their professional responsibility in the reflective case studies. The following objective and research questions were formulated:

- **To identify the learning opportunities of reflective case studies and how NP students reflect on their professional responsibility for patient care in these case studies**
- *What learning opportunities do reflective case studies as educational tools reveal?*
- *How do Dutch NP students, practicing in hospitals, perceive their responsibility in the new NP role?*

Part III. Role Development

Nurses may not always find it easy to develop a new role. According to Meleis (2010), a transition like this does not simply equal a change, but is rather a process to incorporate changes in or disruptions of one's life. Several studies showed that NPs experienced their role transition as an identity crisis accompanied by regression and anxiety (Brykczynski, 2014). Insight into this process could help NP students and new graduates in taking on new responsibilities. However, little is known about the way in which in the Netherlands newly trained NPs perceive the complex problems of patients and how they provide their NP care. When NPs just provide medical care, they develop more towards a physician assistant role. In contrast, when NPs are not allowed to perform certain medical tasks and focus only on complex care issues and/or coordination of complex medical care, they cannot be distinguished from specialized registered nurses. Van Offenbeek & Knip (2004) showed that NPs sometimes were employed in care situations where recourse to experts in the field of coordination or specialized nurses would have been more appropriate. Recent research by Wallenburg, Janssen and de Bont (2015) showed that while NPs have positioned themselves firmly in medical teams, local regulations often prevent them from practicing to the full scope of their education.

Ultimately, NPs are supposed to expand their nursing competences on behalf of a better healthcare. A nice example is supporting patients with chronic conditions in self-management and coping with the consequences of the disease in their daily lives combined with attention to the diseases themselves. In the Netherlands, many NPs work in outpatient clinics for patients with chronic conditions. No research has addressed how they enact this type of care and how they develop their new role. The following objective and research questions were formulated:

- **To study the role transition from nurse to nurse practitioner, and to examine how NPs develop their role in outpatient clinics**
- *What characterizes the NPs' role transition to an advanced nursing role and how do the NPs experience their transition?*
- *How do NPs enact their roles in outpatient clinics and how does this compare to the perception of their responsibility to patients with chronic conditions?*

RESEARCH APPROACH

The aim of the thesis is to explore how the Dutch NPs perceive, develop and enact their professional responsibility. In line with this aim, a naturalistic inquiry was designed to study the meanings and experiences of NPs' professional responsibility in real-world situations with openness to whatever emerges (Patton, 2002). Since each research question required a particular approach of data collection and analysis, a mix of different qualitative research designs was used. A review of literature (opinion papers, policy documents and

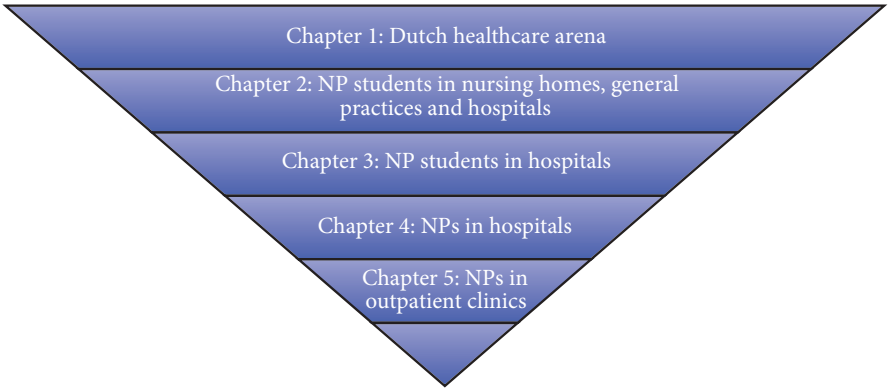

Figure 2: Study populations

research articles) was performed (Chapter 1); two qualitative interpretative studies of students' work were conducted (Chapter 2, 3); and a descriptive qualitative study (Chapter 4) as well as a qualitative ethnographic study (Chapter 5) of NPs' experiences, perceptions and role enactment. The study populations per research project are presented in Figure 2.

Three kinds of data were collected: 1. Written documents (Chapters 1, 2, 3); 2. In-depth and open-ended interviews, focus group discussions (Chapter 4, 5); and 3. Direct observations (Chapter 5). The study in Chapter 1 provided a rich source of information about expectations to the new role comparing official statements with private opinions. Reflective case studies gave access to particular experiences of NP students including the context of the nurse-patient encounters. These also gave insight in how the situation evolved over time, and in the student' concerns and actions throughout the episode. The concerns could be explicated by the students' reflections and interpretations of the type of care that was appropriate in the situations (Chapter 2, 3). Through interviews and focus group discussions we could explore the perspectives and opinions of those who experiences the phenomenon of interest (Patton, 2002), which is NPs' professional responsibility (Chapter 4). The observations offered behaviour descriptions that completed the in-depth picture of nurse practitioner's responsibility (Creswell, 2013) (Chapter 5).

The Guide for Qualitative Data Analysis [QUAGOL] (Dierckx de Casterlé, Gastmans, Bryon, & Denier, 2011) facilitated the process of the qualitative data analysis. The first step was thorough reading of the data (for example case studies or field notes) to apprehend their essential features. This resulted in a holistic understanding of the patient encounters and NPs' reasoning on appropriate care. In the study on role transition (Chapter 4), a Directed Content Analysis approach was chosen rather than conventional analysis because existing theory is available on this phenomenon (Hsieh & Shannon, 2005). After having developed a conceptual view of the data, we started to code inductively and then categorized the codes in a predetermined matrix. This method helped predict what would the variables of interest and how they would be related.

THESIS OUTLINE (TABLE 1)

Part I. Independency. Chapter 1 offers an overview of the debate on the development of the NP profession in the Netherlands, and how this could influence the development of the NP profession. *Part II. Expertise.* This part focuses on the writing of reflective case studies as a means to develop expertise. Chapter 2 identifies the learning opportunities of reflective case studies and chapter 3 describes how NP students practicing in hospitals reflected on their professional responsibility for patient care in these case studies. The chapter provide insight into what NPs students perceive as their responsibility in the new NP role. *Part III. Role Development* describes the role transition from nurse to nurse practitioner, and examines how NPs develop their role in outpatient clinics. Chapter 4 defines what characterizes the NPs' role transition to an advanced nursing role and how the NPs experience this transition. Chapter 5 describes the way NPs enact their roles in outpatient clinics and how they perceive their responsibility to patients with chronic conditions. *The Conclusion section* reviews the results of the studies in this thesis and discusses the implications for clinical practice, education, and further research in relation to the developing role of the nurse practitioner.

Table 1: Schematic overview of the thesis

INTRODUCTION		
PART I: INDEPENDENCY	Chapter 1: A literature review of the Dutch debate on the NP role	Policy documents (n=14), opinion papers from nurses (n=35), opinion articles from physicians (n=363), Dutch research papers (n=24)
PART II: EXPERTISE	Chapter 2: Learning opportunities in case studies to become a reflective NP, a qualitative interpretative study	Reflective case studies (n=46) written by NP students
	Chapter 3: Learning to attain an advanced level of professional responsibility, a qualitative interpretative study	Reflective case studies (n=77) written by NP students
PART III: ROLE DEVELOPMENT	Chapter 4: Driven by ambitions: The NP's role transition in Dutch hospital care, a descriptive qualitative study	Individual interviews with NPs (n=9), two focus group discussions with NPs (n=12)
	Chapter 5: Rhetoric or reality? What nurse practitioners do to provide self-management support in outpatient clinics: an ethnographic study	Individual interviews with NPs (n=5), episodic participant observations and informal interviews in outpatient clinics (n=5)
CONCLUSION: GENERAL DISCUSSION AND FUTURE DIRECTIONS		

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PART I

INDEPENCY

CHAPTER 1

DUTCH DEBATE ON THE NP ROLE: EFFICIENCY VERSUS PROFESSIONAL DEVELOPMENT

The text of this chapter has been published as: Ter Maten-Speksnijder A., Grypdonck M., Pool A., Meurs P., and van Staa AL. (2014). Dutch debate on the NP role: efficiency versus professional development. *International nursing review*, 61, 41-54

ABSTRACT

Aim: To explore the debate on the development of the nurse practitioner profession in the Netherlands. **Background:** In the Netherlands, the positives and negatives of nurse practitioners working in the medical domain have been debated since the role was introduced in 1997. The outcome of the debate is crucial for nurse practitioners' professional development and society's justification of their tasks. **Method:** Review of 14 policy documents, 35 opinion papers from nurses, 363 opinion articles from physicians, and 24 Dutch research papers concerning nurse practitioners from 1995-2012. **Results:** Two discourses were revealed: one related to efficiency and one to the development of the profession. In both, the nurse practitioner role was presented as a solution for healthcare and workforce problems, while arguments differed. The efficiency discourse seemed most influential. Opinions of nurse practitioners themselves were underrepresented; taking up new responsibilities was driven by the wish to improve patient care. While most physicians were willing to delegate tasks to nurse practitioners, they still wished to retain final responsibility for medical care. **Limitations:** All available publications were extensively studied, which could not include unpublished policy documents from the government or influential parties. This may have led to some selectivity. **Conclusion:** The case of the Netherlands shows that nurses in developing their advanced role are facing barriers, similar to those in other countries. The dominance of efficiency arguments, combined with the protection of medical autonomy undermines the development towards nursing care that really benefits patients. **Implications for nursing and health policy:** Nurse practitioners should strive to obtain positions in which they are allowed to make their own decisions and wise use of healthcare resources for the good of patients and society. Nurse practitioners should aim to become members of influential healthcare Boards in their countries, in which they can raise their voices and be involved in policy making.

INTRODUCTION

Governments in many countries worldwide have created opportunities to develop new nursing roles. In particular, the nurse practitioner [NP] role was considered to contribute to cost effective solutions for the increased demand for more intensive patient care (Pulcini et al., 2010). However, it is not yet unambiguously clear what is expected of NPs. The International Council of Nurses (2002) defined NPs as advanced practice nurses with expert knowledge, complex decision-making skills and clinical competence required for expanded nursing practice. Many nurse theorists pleaded that the new knowledge and skills of the NP associated with the medical domain be used to enrich the holistic quality of nursing practice (McGee, 2009). In the USA and Canada, the nursing sector feared the loss of nursing core when NPs were trained according to the medical model instead of the nursing model (Bryant-Lukosius et al., 2004). According to Rashotte (2005), in the USA NPs became to be seen as efficient and effective 'tools' within the healthcare system, instead of individuals dedicated to meeting a patient's need. Brykczynski (2011) also argued that the dominant discourse in the USA has focused on economics with little attention to care and humanistic aspects. The UK has seen an ongoing debate on the meaning, value, and regulation of advanced nursing for over two decades (Barton & Mashlan, 2011). In Australia, NPs were unable to realize autonomy because there was a gap between policy rhetoric and the implementation of NP positions (Harvey et al., 2011; Lowe et al., 2013; Turner et al., 2007). In essence, the longstanding controversy in all countries entails the risk that the NP role may result in a more narrow focus on performing delegated medical tasks instead of an enlarged professional scope (Turner et al., 2007; Bryckzynski, 2012; Rashotte, 2005).

The Dutch Background

The Dutch health ministry in 1997 was positive about nurses performing certain medical activities, such as small surgical procedures, seeing that informal transfer of medical procedures from physicians to nurses had been a practice for many years already (Roodbol, 2005). Thereupon, the positives and negatives of NPs working in the medical domain began to be discussed in medical and nursing journals. Although suggestions were made to restrict the definition and the occupational boundaries of the NP, the running process could not been stopped. In 2000, the government started to subsidize the master programs especially designed for NPs. The national professional nursing organization formalized the distinction between NPs and registered nurses (RNs) on 'independence, expertise, and role development' (CSV, 2008). The legal framework for healthcare professions was adapted in 2011. Only NPs with professional master degrees can use the protected title 'Nurse Specialist', based on expertise in acute care, chronic care, preventive care, intensive care, or mental health care. In 2011, 1400 NPs were working in hospitals, in nursing homes and some in general practices in the Netherlands (http://www.verpleegkundigspecialisme.nl). Still, NPs

constitute only 0.75% of all RNs (Capacity Group, 2011). The latest milestone was granting direct legal authority to NPs for medical health checks and certain medical procedures within selected fields for selected patients. This new policy is being piloted from 2012 to 2016 (van Meersbergen, 2011) and signifies a shift from a bottom-up strategy to a top-down approach. The government obliged physicians and NPs to realize the formal transfer of tasks (KNMG et al., 2012). Therefore, the NPs have arrived at a crucial point in the development of their profession. Like in other countries, the Netherlands NP role and scope of practice might be influenced by public debate.

The Dutch NP profession is developing along the line of Mok's (1994) theory of professional development: work differentiation, institutionalization and legitimation. NPs indeed have differentiated their work activities from those of RNs; institutionalization has been prepared, and they are on their way to legitimation (Figure 1). Institutionalization is defined as the creation of ethical, practical, and cognitive standards, and routines (van der Arend, 2009). The Dutch national professional organization of nurses devised a new competency framework based on the Canadian Medical Education Directions for Specialists (CanMeds) (Lambregts & Grotendorst, 2011). However, as the framework outlines only the contours of the new profession, NPs must still define the practical and theoretical knowledge needed to master complex clinical situations. A profession can only be acknowledged if the professionals' knowledge and competence rest on rational, scientific grounds, and judgment and advice are based on substantive values, validated by peers (Freidson, 2001). And then, these professionals must produce valued results, such as health, in a culturally approved manner, for example, efficient (Abbott, 1988). Thus, it is society that eventually determines what professionals can do and how they do it. A profession's growth is intertwined with the development of the professional responsibility of its members (Abbott, 1988). In line with Bovens (1990), we define

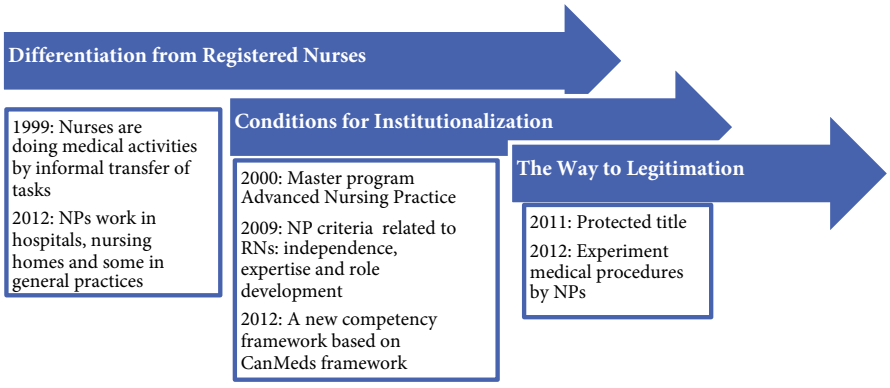

Figure 1: Development of the NP profession in the Netherlands

professional responsibility as current or future virtuous professional behaviour, combined with the motivation and ability to vouch for one's own actions, even if one is never held accountable. The public debate on the NP role may hinder or facilitate the NPs' efforts to have their professional work recognized by the stakeholders. Different perceptions of the roles, their place in healthcare settings and the scope of practice in the healthcare team could impede the expansion and sustainability of these roles (Lowe et al., 2013). The research question for this study is: *How did the public debate influence the development of the NP profession in the Netherlands and how did this shape NPs' professional responsibility*?

THE STUDY

Aim

The aim is to explore the debate in the Netherlands as an exemplar of the development of the nursing profession evolving worldwide and the changing responsibility of NPs in patient care.

Design

A review of published documents were performed to examine the arguments of the various actors in the debate on NPs. Documents need to be interpreted; after all, they cannot be seen as containers of direct representations of social reality (Miller & Alvarado, 2005).

Sample/Data Collection

Our data were textual publications in the public domain about the NP profession in the Netherlands written by physicians and nurses, and the policy-documents issued by the Ministry of Health in the period 1995 through 2012. The year 1995 was a convenient starting point because the first master program was launched 2 years later. Search terms used were: '(advanced practice nurse OR nurse practitioner OR nurse practitioner role) AND Netherlands'. The term 'advanced practice nurse' was included because the term 'nurse practitioner' is not consistently used in the Netherlands (Dierick-van Daele et al., 2011). Picarta, Invert and the Dutch Online Library for Healthcare were searched for professional journals; the website of the Dutch Ministry of Health was searched for published policy documents; the Cochrane Library, CINAHL, and Medline databases were searched for research articles. Secondary sources and newspaper articles written by journalists were excluded. Four retrieved research articles of which it was not clear whether they addressed the NP or another nursing role were excluded also. Eventually we analysed 24 research articles, 14 policy documents, 35 opinion articles from nurses and 363 opinion articles from physicians. In line with our objective, the research articles were also analysed on their content without critical appraisal of the research quality.

Data Analysis

A range of qualitative analytic strategies are available to perform content analysis (Patton 2002, p. 453). We opted for 'the spiral of analysis' model, described by Boeije (2010). This model implies systematic data ordering through a constant comparison method, applying open codes to the relevant fragments and searching for common themes in the codes. Identified themes were discussed within the research team until consensus was reached. Analysis was aided by the software program Atlas.ti, version 7.0 (Atlas.ti Scientific Software Development GmbH, Berlin, Germany), for qualitative analysis.

RESULTS

Analysis showed that the actors approached the themes identified in different ways. The actors were nurse leaders, physicians, researchers and policymakers. The following sections present: (a) the positions of the various actors in the debate, (b) the two dominant discourses; and (c) The Dutch research related to the discourses.

Actors in the Debate

The debate since 1997 sees an overrepresentation of physicians (Table 2). Nurse leaders mostly emphasized the value of NPs in relation to patient care. The new professionals themselves hardly raised their voices. Policy documents had been prepared by the nursing and medical professional organizations, and by working groups commissioned by the Ministry of Health from the year 1999. These addressed workforce issues; medical education was made shorter and more efficient than before, and therefore the need of task substitution, renewal of the nursing profession, and quality-of-care improvement. In contrast, researchers acted only indirectly in the debate. They sought evidence that care delivered by NPs is at least as good and as safe as care delivered by doctors and that patients are satisfied with it. Interestingly, researchers were representatives of both medicine and nursing. Other stakeholders, such as health insurers were virtually absent from the debate.

Two Discourses and the Major Themes

Two discourses proved to be influential in the debate: one addressing efficiency and the other one addressing professional concerns (Table 1). Hajer (2006, p. 67) defines a discourse as 'a set of ideas and concepts that structure the contribution of participants to a discussion. It frames certain problems, distinguishing some aspects of a situation rather than others'. Several discourses on a certain matter may exist at the same time, although with different grades of influence.

Table 1: Major themes in the debate

	Formal transfer of medical tasks	Quality in healthcare
1. Efficiency discourse	1.a. Expected shortage of caregivers 1.b. Growth in healthcare spending	1.c. Need for coordinated care
2. Professional discourse	2.a. Supervised or final responsibility	2.b. Combining nursing and medical care

The prevailing themes in both discourses were: 'Formal transfer of tasks', and 'Quality in healthcare'. Formal transfer of tasks, or: task substitution, is understood as taking over activities traditionally considered to be outside the scope of the professionals' practice and also taking over responsibility for these tasks. A related concept is task delegation, in which physicians remain responsible for the correct performance of the tasks delegated to nurses (Raas & de Lint, 2002). Quality in healthcare is understood, as the extent to which health services improve desired health outcomes of individuals and patient populations (Institute of Medicine, 2001). Arguments with which the actors underpinned their opinions on both themes differed between the discourses.

The efficiency discourse

The efficiency discourse basically addressed the extent to which time, effort, or costs improve patient satisfaction or health (Donker, 2009). The three arguments brought forward are discussed in some detail below: the expected shortages of caregivers, the growth in healthcare spending, and the need for coordinated care.

Expected shortages of caregivers

The oldest argument to legitimize task substitution to nurses is the expected shortage of physicians. In 2002, the European Working Time Directive stipulated a maximum working week of 56 h, as a result of which the clinical productivity of junior doctors dropped (LeGrand-van den Bogaard & van Rooijen, 2003). However, in 2010 the Dutch Capacity Group predicted a physician's shortage in the nursing homes only. A more recent argument is the expected shortage of nurses (Van der Windt et al., 2009). Nurses were expected to be in greater demand due to ageing of the population, a larger range of treatable conditions and greater consumer activism. At the same time, it was thought that the nurse workforce might decrease due to ageing and the greater availability of professional opportunities for young people (Harmsen et al., 2006). The Netherlands Association of Universities of Applied Sciences argued (2011) that a broader professional responsibility might boost the intake of new nursing students. In particular, the NP role could help retain nurses in the profession as it offers good career perspectives in clinical patient care.

Growth in healthcare spending

In the Netherlands, the soaring healthcare costs resulted in a call for efficiency (RVZ, 2002). Task substitution by NPs was one of the solutions presented. Higher efficiency was expected from NPs carrying out the low complex medical care (Dutch Health Council, 2008). However, in the Dutch health insurance system NPs cannot claim reimbursements for the medical treatment given. This is the exclusive right of medical specialists and general practitioners (GPs) who receive fixed remuneration through the system of diagnosis-treatment combinations (Debets & Schroten, 2005). In reality, healthcare volumes and costs have increased, as doctors started to hire NPs to perform tasks that are reimbursed at the standard rate. Nevertheless, the national professional organization for nurses, V&VN called upon the political parties to invest in NPs (V&VN, 2010). One of the major arguments was that task substitution could lower healthcare costs. The proposed renewal of healthcare reimbursement system in 2015 intends her policy to take into account of this by removing the financial obstacles (MoH, 2011).

The need for coordinated care

The Dutch Health Care Inspectorate (IGZ, 2009) was critical of situations in which multiple caregivers were involved. Such situations, it was argued, might lead to fragmented care, patients losing overview, and confusion about who is responsible for the patient's care. The Inspectorate therefore instigated development of a guideline to improve collaborative care. NPs were given the opportunity to assume a role as care coordinator (KNMG et al., 2010). The main goal of coordinated care was to maximize efficiency by reducing the number of hospital readmissions, length of hospital stay and volume of resource utilization. NPs were expected to possess strong clinical, communicative, and managerial skills. These characteristics could also help lower the threshold for patients to contact care providers (Van Offenbeek, 2007).

The professional discourse

The professional discourse relates to the issue of combining comprehensive nursing care with medical care, on the one hand, and the issue of transferring final responsibility to NPs on the other hand.

Combining comprehensive nursing care with medical care

Many physicians heartily welcomed NPs: 'Let them in, together we go for the best care and they give us the opportunity to explore our discipline more in-depth' (Elders & Jungbauer, 2010). Policymakers and healthcare professionals expected better health outcomes and higher patient satisfaction through an effective skills mix (RVZ, 2002) – and especially by deploying NPs (Dutch Health Council, 2008). Grypdonck (2000) argued that the expansion of the nursing role with medical tasks requires that NPs should employ a

broader perspective and pay more attention to experiences of patients and their families. As patient educators, they can stimulate patients to be more active in their own care. Grypdonck also emphasized that the expanded role may benefit patients with complex problems, such as patients with a non-Dutch background who might not be familiar with the Dutch healthcare system, NPs could also help the chronically ill to manage their diseases or their daily lives (Grypdonck, 2000).

An extensive round of discussions about role expectations (Lambregts & Grotendorst, 2011) made clear that NPs in 2020 expected to work as independent, comprehensive care providers; to substitute 80% of the standardized medical care, in partnership with patients; to be using information and communications technology in direct clinical care; and to be supervising fellow nurses. They also saw themselves as case managers triaging patients either to a physician or the NP, and as innovative professionals in nurse-led practices, lifestyle clinics and multidisciplinary practices, on an equal level with physicians. Still, the director of the Society for Boards of Governors in Healthcare (Buiting, 2012) felt that for the time being Dutch NPs tended to assume a doctor's assistant role, leaving nursing care to less educated colleagues and informal caregivers.

Supervised or final responsibility

Although the Royal Dutch Medical Association (RDMA) stated that task substitution may contribute to quality of care, they raised serious concerns about new legislation allowing NPs to perform specific medical health checks and procedures. In a survey, 61% (n = 1082) of RDMA members were especially reluctant to grant NPs the responsibility for medication prescription and for procedures so far exclusively reserved for physicians. Task substitution was seen useful only in the domain of coordination of care. Overall, the members agreed that the physician should bear final responsibility for medical care (Van Rooijen, 2003). In a letter to the Dutch parliament, the RDMA made a plea to clarify the scope of authorization, and pointed out that protocols and guidelines were not yet available (KNMG, 2011). Physicians claimed final responsibility for diagnosis and planning of medical treatment in nursing homes as well, with a supportive role for the NP. Physicians were to supervise autonomous NP practices in nursing homes, even though this did not seem feasible in view of the physician shortage (Bloemendaal et al., 2009). GPs also had reservations about allocating specific tasks to NPs, as this could lead to fragmentation of care (LHV, 2011). Moreover, they argued that care delivered by NPs is in contradiction with their understanding of providing primary care. In the Netherlands, NPs are educated as specialists, whereas GPs provide generalized, community-based care. Most GPs objected to direct accessibility of the NP because 'you need to know much in order to do little', implying that NPs do not possess this ability. NPs were seen as useful innovators in quality improvement and in integrated care projects, and as coaches for the practice nurses who are allowed to diagnose and treat the less complex, common

complaints. Therefore, the professional organization of GPs' official standpoint was that NPs should be allowed to work in the medical domain on the basis of task delegation and not on the basis of task substitution (LHV, 2011).

Research Related to the NP Role

The Dutch research studies could be related to the themes identified in both discourses (Table 2). One study showed that substituting tasks to a NP saved costs (a). Another study showed that employing NPs in a general practice was seldom economically viable (b). Care coordination by NPs improved the logistics in outpatient clinics. Triage to a NP

Table 2: The actors and the opinions, policy and facts

Opinions (398)		Written by nurses (n = 35): Tijdschrift voor Verpleegkundigen (nursing journal); Medisch Contact (medical journal) Written by physicians (n = 363): Medisch Contact; Huisarts en Wetenschap; Nederlands Tijdschrift voor Geneeskunde (medical journals)
Policy (14)		Ministry of Health, Welfare and Sport; Committees providing policy advice to the government Council for Public Health and Health Care; Health Council of the Netherlands Professional nursing and medical organizations Healthcare Inspectorate Association of Universities of Applied Sciences
Research papers (n = 22). Short descriptions are given below; full references are supplied in additional file.		
Efficiency Discourse, costs		
a.	Schuttelaar et al., 2011	A NP replacing dermatologist was cost-saving and cost-effective with a higher patient satisfaction.
b.	Dierick-van Daele et al., 2011	Three of 17 GPs earned employed NP. Only three out of 17 general practices were able to earn fully the cost of NP employment. GP freed-up time was not used towards practice growth, NPs' consultations took more time, they had more follow-up appointments. Costs of NPs' consultations were lower due to lower salary.
Efficiency Discourse, care coordination		
c.	Bredero et al., 2009	Triage was implemented for patients with craniosynostosis to a NP clinic. The correct clinical pathway was entered earlier than before.
d.	Van der Sluis et al., 2008	NPs gathered information from patients with RA (n=148), measured mobility/grip of hands, contacted patients after consultation by phone, coordinated postoperative treatment, improved logistics clinical pathway and information material. Patients equally satisfied before and after.
Professional Discourse, combining nursing and medical care		
e.	Scholten et al., 1999	Task substitution from physicians to nurses was acceptable for patients, and was appreciated. Primary concern was the care provider's knowledge of the disease.
f.	Laurant et al., 2008	Patients with acute (n=235) and chronic conditions (n=20) preferred GP for medical aspects. They were more satisfied with NPs for support and time available for consultation. 50% preferred NPs for health education and routine procedures; 50% no preference.

g.	Balk et al., 2009	Patients with colorectal cancer (n=118) liked to discuss such as fatigue, nutritional intake, and changing defecation. Patients with longer follow-up: preferred physicians; short follow-up: NPs.
h.	Van Hezewijk et al., 2011	Patients with breast cancer (n=189) appreciated discussing fatigue, pain, genetic factors, prevention, arm function. Valued NP communication and time taken higher after start NP unit.
i.	Schuttelaar et al., 2010	Level of NP care to children with eczema was comparable with that by a dermatologist: improved severity and quality of life (n= 160). Parents were more satisfied with NP care.
j.	Van Veldhuisen et al., 2006	NPs working with a protocol, supervised by a cardiologist were well equipped to care for patients with a myocardial infarction. Clinical outcomes didn't differ; patients were more satisfied with NPs' information provision than were those under the care of residents.
k.	Broers et al., 2009	Length of stay of patients (n = 500) with a myocardial infarction was reduced by 30% compared with the care of residents.
l.	Zwinkels et al., 2008	NP-led clinic was safe for patients with brain tumours treated with temozolomide. Physician explained treatment to patients, NP informed about side effects, monitors potential toxicity of temozolomide. NP was easy accessible, patients' questions were answered sooner.
m.	Van der Linden et al., 2010	In an ER, NPs diagnostic accuracy did not differ from that of physicians'; 97.3% of patients with minor injuries were adequately treated. Waiting times did not differ. Treatment was initiated faster by NPs.
n.	Goessens et al., 2006	In a cardiovascular prevention program, NPs descreased scores on risk factors compared to care as usual. NPs reserved more time and informed patients better.
o.	Ter Bogt et al., 2011	11 general practices with 457 patients with hypertension, dyslipidemia or both, lifestyle counselling by NPs prevented weight gain as effectively as that of GP.
p.	Dierick-van Daele et al., 2009/2010	Patients with common complaints (n=1501) from 15 general practices, equally appreciated care from NP and GP. No difference in health outcomes, medical supplies, guideline adherence.
Professional Discourse, supervised or final responsibility		
q.	Van den Hoed-Heerschop, 2005	Early discharge of children with cancer shifted the care from hospital care to home care. NP's filled the gap to support parents in the outpatient clinic.
r.	Zwijnenburg & Bours, 2011	Of 24 NPs in six hospitals. 17 performed substituted tasks, 20 delegation of tasks for which NPs were not responsible, and 13 did both. Many met with resistance from physicians, insecure about position/ job content, management had no long-term planning. Problems: prescribing medication, funding of NP by physicians, no office or computer of their own.
s.	Bloemendaal et al., 2009	NPs had varying roles in nursing homes (n=38). Some ran departments with physicians or independently with physicians as backup. Some performed specific medical tasks in support of physicians. Some NPs were working with jobs that could be done by nurses.
t.	Van Offenbeek & Knip, 2004; Van Offenbeek et al., 2009	In a hospital, the best NP role combined routine- and cure-oriented care with more difficult care aspects (physical care, information, coaching of patients). Most appropriate in easy analysable situations where medical problems are clear.
u.	Knip, 2005;	Some NPs in hospitals were working with jobs that could be done by nurse case managers, practice nurses and specialized nurses.
v.	Laurant et al., 2004	Twenty- three per cent of the NP tasks in general practices were complementary, considered essential to improve quality of care.

ER, emergency room; GP, general practitioner; NP, nurse practitioner

clinic was improved by the implementation of a clinical pathway (c). Patient satisfaction after the implementation of the NP's coordinating role in a multidisciplinary team did not differ from that before implementation (d). Most studies focused on NPs compared with physicians. Patients accepted the transfer of medical tasks; their primary concern was the care provider's knowledge of the disease (e). In general practices, patients preferred the GP for medical aspects (f). But patients in general practices (f) and in outpatient clinics valued the communication and the time taken by NPs. Because NPs were easily accessible, patients' questions could be answered sooner (g, h). Several studies on patient outcomes showed similar level of care provided by NPs and physicians, for example, to children with eczema (i) and to patients with a myocardial infarction (j, k). NPs as well as residents were working within the limits of a protocol and under the supervision of a staff cardiologist. Standardized medical care provided by a NP reduced length of stay in hospital (k). NPs' monitoring of medication was safe for patients with brain tumours (l). In an emergency room study, the NP's diagnostic accuracy did not differ from that of the physicians; patients with minor injuries were adequately treated (m). In two prevention program studies, patients coached by NPs had lower scores on risk factors than patients receiving usual care (n, o). In a general practice, NP care was similar to GP care for patients with common complaints with regard to health outcomes, medical supplies and guideline adherence (p). Three studies have shown that task substitution and level of transfer of responsibilities varied in hospitals and nursing homes (r, s, t). A study of 24 NPs in six hospitals revealed that 17 NPs performed substituted tasks, 20 delegated tasks, and that 13 combined substituted and delegated tasks (r). Many respondents who met resistance from physicians were insecure about their positions or job content, and accused management of having no long-term planning and vision. Legal (authority to prescribe medication), financial (funding of the NP role by physicians) or facility problems (not having an office or computer of their own) were also reported (r). In general practices, 23% of the NP tasks were complementary to those of the GP and considered essential to improving quality of care (v). In contrast, in hospitals and in nursing homes, many NPs performed tasks that could have been done by nurse case managers, practice nurses and specialized nurses (q, s, u).

DISCUSSION

The efficiency discourse, and especially the argument that transferring certain tasks from more expensive doctors to less expensive NPs can reduce health spending, dominated over the professional discourse. However, cost reduction is not supported by sound evidence, neither in the Netherlands nor in other countries. Delamaire & Lafortune (2010) reviewed studies done in Australia, UK, USA, Canada, Japan and eight European countries. They found that task substitution was cost neutral because saving on nurses'

salaries (compared with physicians' salaries) is offset partly or entirely by other factors, such as longer consultation times, more referrals to other physicians or higher recall rates, and in some cases more tests ordered. But supplementary tasks performed by NPs could result in higher costs (DiCenso et al., 2010). Both discourses emphasized the importance of quality improvement, in line with the quality improvement efforts in European nations and the USA (Legido-Quigley et al., 2008). All actors in the debate emphasized that continuity of patient care would be helpful in this regard. This approach, however, tends to position NPs solely as managers of integrated pathways. McGee (2009) stated that teams in a multidisciplinary context should acknowledge that NPs contribute to direct care, as they ensure that each caregiver is involved in the patient's overall treatment and care at the appropriate moment. Dutch NPs themselves wish to expand their activities in the future (Lambregts & Grotendorst 2011). They expect more autonomy, for example, greater freedom, to make decisions and clinical judgments within their scope of practice (Oermann, 1997). However, our data did not support that the NPs' aspirations to provide a substantial part of medical care will be fulfilled. Physicians may be reluctant to give final responsibility to NPs, like in other countries. In this light, it is worth recalling that the World Medical Association, as well as the Standing Committee of European Doctors, warned that task substitution by NPs may carry the risk of lower quality of patient care (van Meersbergen, 2011). Delamaire & Lafortune (2010) identified opposition of the medical profession as one of the main barriers to the development of advanced nursing roles internationally. Consequently, NPs could be forced in the dependent role of physician extender, secondary to the physician provider. This debate is in line with Abbott's (1988) theory on how competitive forces internally and externally work to change professionals' jurisdictions and tasks. This theory has it that professions are powerful and vulnerable in their subjective qualities, that is, diagnosis, inference and treatment. That is why the most convincing argument for the role development of the NP is the statement of the Dutch Council for Public Health and Healthcare (RVZ, 2002, p. 3): 'knowledge and competencies are crucial for the decision which care provider is most capable to help the patient'. Only when the time comes that NPs successfully provide some part of the medical care, added to their nursing care, the NP profession may claim jurisdiction over these tasks.

The absence of the healthcare insurers in the debate is remarkable as they are important decision makers in reimbursement issues in the Dutch healthcare system. In the past 20 years,

the Dutch Government aimed to strengthen the role of market elements in health care. Regulations were issued to promote price and quality competition, and on the other hand to safeguard equity and solidarity (Helderman et al., 2012). This ambiguous task within a semi-competitive context may explain why insurance companies might have been reluctant to mingle into the debate on NPs. Even more remarkable, the NPs themselves

were nearly absent in the debate. They probably left involvement in health policy development to the professional nursing organizations, as seen by Ketefian et al. (2001) in a study in Brazil, Thailand, the UK and the USA. History has shown that dominant individuals or organizations are needed to direct the process of forming a new profession, and this was Florence Nightingale in the case of the nursing profession (Abbott, 1988). Abbott (1988) presented the creation of the nursing profession as a classical example of seizing a potential area of work from the military (and later civil) authorities. He stated that modern nursing began only when it started to expand out of the hospitals into primary health care, invading the doctors' heartland jurisdiction. NPs need to challenge nurses and leaders to raise the standards of care. Furthermore, they should be advocates for a health system that better serves all people. The discussion rounds organized by Lambregts & Grotendorst (2011), in which NPs envisaged the future of NP care, mark a new beginning. This study's strength is that we extensively studied all available publications, which regrettably could not include unpublished policy documents from the government or influential parties. The incomplete collection of the documents may have led to some selectivity, as described by Yin (1994).

IMPLICATIONS FOR PRACTICE/RESEARCH

The global NP workforce should strive to obtain positions in which they are allowed to make their own decisions and wise use of healthcare resources for the good of patients and society. On the macro level, NPs should aim to become members of influential healthcare Boards and Committees in their countries, in which they can raise their voices. NPs themselves should put great effort into their role development. Cooperating intensively with physicians, and taking responsibilities based on high competency levels and shared concerns in patient care, offers a chance to withstand opposition from the medical profession. The Dutch research studies provide some evidence that NPs can effectively manage condition-specific cases and achieve outcomes similar to those in medical management. But on the whole, the evidence base remains too small. Neither is there evidence for greater efficiency, and cost-effectiveness is also scarcely researched. In future research, NPs particularly need to focus on patients' benefits, for example, in terms of outcomes related to costs.

CONCLUSION

The present dominance of efficiency arguments combined with the protection of the medical jurisdiction seems to stand in the way of proper development of the NP role as

an advance practice nurse. Like elsewhere, Dutch NPs are caught between conflicting expectations about improvement of quality of care – the main target of the nursing and medical professions. This target, however, requires complementary tasks that may affect costeffectiveness. There is a risk that NPs' responsibility for qualitative aspects, such as establishing good relationships with patients, will be assessed in terms of financial costs and benefits. Then, controversies about the NP's autonomy may undermine the development towards nursing care that really benefits patients.

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PART II

EXPERTISE

CHAPTER 2

LEARNING OPPORTUNITIES IN CASE STUDIES FOR BECOMING A REFLECTIVE NURSE PRACTITIONER

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ABSTRACT

The transition from registered nurse to nurse practitioner presents challenges. Because nurse practitioners require deeper critical decision making abilities to provide safe and quality health care, the Master in Advanced Nursing Practice curriculum implemented reflective case studies to facilitate active and reflective learning. To identify the learning opportunities, we performed a qualitative interpretative study of 77 reflective case studies written by students enrolled in the program. Analysis revealed two categories of learning opportunities — (a) Direct care, with subcategories on focusing on patients' needs, exploring one's own values, and providing comprehensive care; and (b) Increased Performance Demands, with the subcategories of handling independence and dependence, and, dealing with emotions. The reflective case study is a powerful educational tool to create and guide a new professional with increased responsibilities for a comprehensive and compassionate response to patients' needs.

INTRODUCTION

In the Netherlands, advanced nursing practice educational programs that focus on the role of the nurse practitioner (NP) are sprouting up in all areas of primary, secondary and tertiary care (Knip, 2006). The Dutch Universities of Applied Science currently offer nine Master in Advance Nursing Practice (MANP) programs, with an emphasis on training-on-the job. The MANP students are supervised by a medical doctor and a nurse leader. The transition from RN to NP presents challenges because the nurses enter the domain of physicians and also move to higher levels of nursing practice. According to the Dutch Nurses' Association (V&VN), the NPs' care goal is to improve access to effective, integrated, and coordinated healthcare and to contribute to nursing knowledge, in addition to developing and advancing the profession (Meurs &Van Rooijen, 2006). In the Netherlands, these criteria show that the NP is seen as an advanced practice nurse [APN] who is expected to provide complex patient care that is grounded in research-based knowledge and clinical expertise.

Combining practice and study, the MANP programs in the Netherlands are designed to train and educate nursing professionals to become academic nurse clinicians while working in direct patient care. NP students are trained to provide evidence based care, and to search for scientific rationales for their practices. To this aim, the curricula emphasize students' self-directed learning to achieve so-called 'lifelong learning competencies'. Self-directed learning assumes that students want to learn and possess the attributes and motivations to take responsibility for their own learning (Knapper & Cropley, 2000). However, Knowles (1990) suggested that adults do not learn for the sake of learning but rather to know how to master a task or solve a problem effectively. The primary underlying theory base to the Dutch MANP curricula is formed by Piaget's cognitive constructivism and Vygotsky's perspective on social constructivism, which state that knowledge is constructed, not given, and is not solely in the mind of the individual but by acquired by interacting within the social context (Powers, 2007).

The social context of the NP student entails nurse-patient encounters within a network of families and other health care providers. The workplace offers great opportunity for interacting within this social context, but gaining experience alone is not sufficient for learning. Investigating the clinical encounters between the NP student and the patient may generate knowledge about many aspects of nursing care.

As NPs must have critical decision-making abilities to provide safe and appropriate health care, the MANP implemented the case study method to facilitate active and reflective learning. This means that students have to identify and use opportunities for learning from practice and experience. They do so by exploring their own nursing care in a detailed case study based on the narrative of a demanding experience. After all, actual situations give better access to practice and practical knowledge than do questions about

beliefs, ideology, theory or what the students typically do in practice (Benner, Tanner & Chesla, 2009).

The aim of this article is to describe learning opportunities in the reflective case study, which is used as an educational tool to inform future curriculum development. A qualitative study was designed to gain insight into the problems that NP students face in their practices and how they reflect on such problems in their case studies. We first reviewed the literature to explore reflection as a concept and to summarize the body of knowledge about the use of reflection as an educational tool.

Literature Review

Boud, Keogh, and Walker (1985) suggested that structured reflection is the key to learn from experience. Daudelin (1996) provided a definition of reflection that explicitly captures its relation to learning: "Reflection is the process of stepping back from an experience to ponder, carefully and persistently, its meaning to the self through the development of inferences; learning is the creation of meaning from past or current events that serves as a guide for future behaviour" (p. 39). According to Dewey (1933, p. 494), reflection begins with a 'perplexed troubled or confused situation', and then entails four further steps:

- Conjectural anticipation and tentative interpretation of given elements or meanings of the situation and their possible consequences;
- Examination, inspection, exploration, analysis of all attainable considerations, which may define and clarify a problem with which one is confronted;
- Elaboration of the tentative hypothesis suggestions;
- Deciding on a plan of action or doing something about a desired result.

Daudelin's definition resembled Schön's (1983) concept of reflection-on-action. Schön developed an approach whereby professional learning is facilitated by reflection. He argued that professionals face unfamiliar, unique, and complex situations in their everyday practice that require theoretical and technical, but these skills alone are not sufficient.

For the novice practitioner with little previous experience who is nursing a new patient, the option might be to base practice solely on research-based knowledge (Benner, 1984), but we can never be certain that what theory tells us *should* happen, *will* happen. Also, we can never be certain that actions based on theory alone will result in the best nursing intervention for a particular patient in a particular setting. Nursing is complex, context-dependent, and not amenable to simple research-based prescriptions. In a given situation, nurses will need both personal and experiential knowledge. Personal knowledge is gained from therapeutic relationships with individual patients; experiential knowledge is gained from reflecting on one's own past practice. The experiential knowledge is useful in determining how a particular case might differ from a theoretical one (Rolfe, 2002).

Knowledge gained from reflection-on-action helps to manage the uncertain, instable, unique, and value conflicts of practice (Schön, 1983). Reflection-on-action results in new insights, knowledge, and theories of practice (Rolfe, 2001). Ultimately, nurses have to reach this level of so-called 'reflexive practice', in which they constantly formulate theories about the specific clinical situation in which they find themselves (Rolfe, 2002). Reflexive practitioners build on a situational repertoire, which is forever being expanded and modified to meet new situations (Schön, 1983). For Schön (1983), this is the essence of 'reflection-in-action' or 'on-the-spot-experimenting'. It brings thinking and doing together in a single act, to which Schön sometimes refers to as 'knowing-in-action' and to which Rolfe (1993) refers to as 'nursing praxis'. Integration of theory, practice, and art is crucial for NP students to develop into advanced practitioners. The students' learning needs are based on the capability to recognize and value different types of knowledge by reflection (Kilpatrick, 2008).

Eyler, Giles and Schmiede (1996) administered semi-structured interviews to examine technical students' experiences of reflection. These students viewed reflection as an ongoing project - focusing on the meaning of the experience, integrating old knowledge and new information, and formulating a future course of action. The students said that faculty can help them develop conceptual frameworks, which will guide them in applying concepts and theories to their work. Furthermore, challenging reflection pushed the students to think in new ways, to develop new questions, to produce new understanding, and to find new ways of problem solving.

The reviews of Kuiper and Pesut (2004) and Ruth-Sahd (2003) showed that most publications focus on the stages of knowledge development and the differences in students' levels of reflectivity. Powell (1989) and Richardson and Maltby (1995) concluded that nurses mainly reflect at lower levels, also called 'single-loop learning' (Argyris & Schön, 1974). However, a master's student's aim should be 'double-loop learning', which goes beyond simple problem solving. It involves questioning the roles of the learning systems that underlie actual goals and strategies, and it involves consideration of notions of the good (Argyris & Schön, 1987). Teekman (2000) found little indication that nurses in practice would reflect at the level of double-loop learning. These findings suggest that nurses do not challenge their practices and gain little insight into the ideological constraints that bind them.

Wellard and Bethune (1996) encouraged nursing students to reflect, but these students seemed to resist encouragement. The authors consequently questioned the value of reflective journal writing in nursing education. The term *journal* incorporates diaries or logs, and the purpose of reflective writing is to record things that are significant for the keeper of the journal. Trying to develop reflective skills was rather a negative experience for students undertaking a graduate diploma in the nursing programs. Chirema (2007) showed that some students appeared to benefit more from journal writing than others. As

evidence suggests that journaling is a useful tool for promoting reflection and learning, Chirema's finding indicates that student writing can be used as evidence for the presence or absence of reflective thinking. Langley and Brown (2010) found positive outcomes of reflective journaling in online education in terms of, for example, the connection between theory and practice and the integration of new ideas and concepts. Holmström and Rosenqvist (2004) showed that the mentor-supervisor can facilitate reflection and learning by discussing with other care providers the videotapes of their regular meetings with patients.

For NP students, it is important to keep a nursing focus to their practice, rather than being subsumed by the medical model and turning into technological experts (Glaze, 1999). At the level of ANP, the students must question the ideologies that shape their daily practice to become independent autonomous practitioners. In a qualitative research study on NP students' perceptions on the impact of reflection the students described themselves as being more confident and assertive after they had taken a reflective module in the MANP program (Glaze, 2001). The students felt that they could combine their own nursing knowledge and skill base with pushing forward the boundaries of practice into the medical domain. Glaze (2002) found that developing reflective abilities is a complex transitional process for ANP students. Receiving challenges helped students to explore their practice in depth and identify factors that were shaping their practice. This enabled them to think in new ways, ensuring effective practices. However, not all students found it easy to shrug off their early nursing socialization where obedience, rather than questioning, was the order of the day.

No literature exists on the opportunities for learning within reflective case studies written by NP students. In our study, we addressed the research question: *What learning opportunities do the reflective case studies reveal?*

METHOD

A qualitative interpretative study was designed to identify NP students' learning opportunities emerging from their reflective case studies. We defined *learning opportunity* as the likelihood of a learning process occurring in a particular job situation, aimed at analysing and optimizing work practices on an individual, team, or organizational level (Van Woerkom, 2006). The research approach will help discover what is happening in the patient-NP student context to name it as a learning opportunity and to grasp the meaning of it (Munhall, 2012). To this end, we collected and analysed reflective case studies.

Reflective Case Study

In the second semester of the 2-year program, NP students perform a reflective case study. This entails both a narrative about a nurse-patient encounter and the student's reflection on this experience. First, students describe a situation from their practice in which they felt confused or uncertain. Second, they closely examine and thoroughly question their own decision-making process to uncover the knowledge could have been applied to the situation. Students consider how the situation could have been handled differently and what other knowledge could have been brought to bear on the situation. The reflective mindset needed to complete this assignment consists of mindfulness (concentrated awareness of one's thoughts, actions or motivations), open-mindedness (being receptive to new ideas or information), responsibility, and wholeheartedness (the quality of being open and truthful) (Dewey, 1933). The narratives are discussed in two meetings with small groups of students and a teacher, during which the students peer-review each other's narratives for clearness and completeness. Mantesso, Petrucka and Bassendowski (2008) stated that a discussion between colleagues (i.e., peer feedback) will increase nurses' ability to reflect on their practice. This shared reflection promotes professional partnership and is invaluable to nurses because it emphasizes dialogue and development.

Faculty coached students to use Borton's reflexive framework (as cited in Rolfe, Freshwater & Jasper, 2001), as an ordered set of cues through which they might structure their reflective thoughts. The cues are: (a) What happened? (b) What do I make of this? And (c) What can I do to make the situation better? The last question is crucial to being an advanced reflective practitioner whose mind is set not only at learning from the situation and striving to do better next time, but at instantly improving the current situation (Rolfe et al., 2001).

Sample and Data Collection

We collected all 77 case studies written by the MANP students in 2006 (20 studies), 2007 (21 studies), and 2008 (36 studies). These students were practicing in, emergency care departments, hospitals, university medical centers, nursing homes, psychiatric hospitals, outpatient clinics, and general practices. The patient population served were children, adults, families and elderly people. All participants were informed about the study both orally and in writing and were assured of complete confidentiality, and informed that neither the name of the organization nor their identity would be disclosed in any published material. The participants gave written consent. The study protocol was approved by the university's research board.

Both for ethical reasons and to ensure good validity of the research, teachers' roles and researchers' roles were kept separate. Therefore, the researchers did not teach in the program.

Students' data were not collected until they had completed the course in which the reflective case study was to be written. The teachers' feedback on the reflective case studies was not included in the research data.

Data Analysis

The research team (A.t.M.-S., A.P., M.H.F.G.) reviewed, interpreted, and identified the learning opportunities in the reflective case studies by methods derived from Boeije's (2010) description of the Spiral of Analysis. First, the researchers immersed themselves in the narrative text, and then reconstructed the situation, described from the perspective of learning opportunities. Next, the student' reflections were studied to uncover his or her interpretation of the event and the learning opportunities identified. For the analysis, the following questions were used:

- What was the context of the situation?
- To what demands from the patient is the NP student expected to respond in this situation?
- What demands did the student attend to in this situation and what was left unattended?
- Which arguments gave the student for his or her decision?
- Which unexplained factors were involved?

Researchers' triangulation was used to increase the credibility of the findings (Polit & Beck, 2012). The three researchers (A.t.M.-S., A.P., M.H.F.G.) analyzed 10 case studies thoroughly and independently by answering the above questions. The reasons, feelings, and actions of the students were identified and recorded. The three researchers subsequently discussed the interpretation of the event and the learning opportunities identified. The primary investigator (A.t.M.-S.) analysed the remaining 67 case studies, and the two other researchers independently analysed a sample of 16 case studies drawn from those 67 case studies, representing the major healthcare fields (i.e., acute care, chronic care, intensive care, and mental healthcare). The complete research team discussed the results. The researchers categorized the learning opportunities by subcategories. Agreement was reached on the resulting categories and subcategories. Then, exemplars of each subcategory were selected from the case studies. The relevant passages of these case studies were transformed into vignettes to illustrate each subcategory. A *vignette* is a focused description of a series of events taken to be representative, typical, or emblematic "rich pockets of especially representative data [or] meaningful data" (Miles & Huberman, 1994, p. 81).

RESULTS

The study question was: 'What learning opportunities do the reflective case studies reveal?' The results showed that students questioned difficulties within the nurse-patient encounter and the NP's role. We organized these learning opportunities into two categories: (a) Direct care, with the subcategories - focusing on patients' needs, exploring one's own values, and providing comprehensive care; and (b) Increased performance demands, with the subcategories - handling independence and dependence and dealing with emotions.

Three of 77 NP students did not question their actions or decisions but presented success stories instead. These students did not use learning opportunities; therefore, their case studies were excluded from the data analysis.

Category Direct care

This category focuses on the central competency of the NP to provide medical and nursing care, referring to the activities NP students perform within the nurse-patient interface.

Focusing on patients' needs

In general, the students took a health care provider's perspective instead of focusing on the patients' needs. They translated the reason for seeking medical attention into a manageable problem to assure the diagnosis matched with the interventions they were planning to undertake. In most situations, the interventions entailed stimulating the patient to comply with medical recommendations or lifestyle modifications the professionals considered favorable to the patient's health. The following vignette reflects one case study:

> *A young couple visits a HIV outpatient clinic. The woman is pregnant and medication must be started to prevent a mother-to-child transmission of HIV. The situation is complex due to a history of violence in the relationship; the young woman stabbed her friend with a knife 6 months ago. She was kept in prison for 1 day. The woman is seriously afraid to lose her pregnancy because of the medication. The NP student aims to improve adherence to antiretroviral therapy on behalf of the baby's health. Therefore she focuses on nursing education as an intervention.*
>
> ***Student reflection***
>
> *I discuss with her the side effects, give her the medication card and ask how it goes with her and her boyfriend; she answers: most of the time it's OK, but sometimes not.*

NP students must learn to pay attention to life's complexities, which many of their patients have to manage. By acknowledging the young woman's fear of losing her pregnancy and acknowledging the relationship in which to raise a child as being unstable, the student in this vignette enriches herself with the learning opportunity of how to develop patient-centered interventions. Understanding the patient's perspective is necessary to meet the patients' needs and to encourage the patients to participate in decisions regarding disease management.

Exploring one's own values

In the same vein, the students tended to work towards goals they did not share with their patients; they were hardly aware that a patient might not understand the rationale of these goals. In the case studies, the values underlying actual behaviour were not made explicit.

> *A nursing home resident is suffering from Korsakoff's syndrome. The Dutch legal system has developed a number of methods by which the state or private parties may intervene to protect such people, including those with dementia, who do not have sufficient cognitive or emotional capacities to make and express autonomous choices about various aspects of their lives. These interventions may be planned and voluntary, or unplanned and involuntary. For this patient there is no judicial involvement, but his parents want him to stay in the nursing home. However, the patient keeps asking the NP student to help him find a house of his own. The student thinks it is better for the patient to stay in the nursing home. To influence the situation, the student develops a care plan aimed to achieve the patient's conformity to this policy.*
>
> ***Student reflection***
>
> *I want to achieve the following goals: 1. the patient understands his situation; 2. he has insight into his disease; and 3. he knows that he has to stay and why.*

NP students must learn to recognize a moral problem and seek to clarify it, especially in situations in which regulations may influence ethical decision-making. The student in this vignette resorts to paternalistic measures to influence the patient's wishes because they are at odds with medical treatment. The reflective case study offers the opportunity to consider the contextual characteristics of the case and to explore one's own values to justify affecting a patient's life. The student will then be able to realize a nurse-patient partnership that is in the best interest of a patient.

Providing comprehensive care

The NP students tended to limit their care to one single aspect of a greater problem and neglected the other aspects. They often overlooked questions about physiological causes, mental states of the patient, or the context in which the problems occurred.

> *The NP student visits one of his patients in a nursing home, who is suffering from Lewy Body Dementia. The patient is very upset and cries because the nurses on the ward have ordered him to stay in bed because he fell and hit his head on a home trainer on his way to the bathroom in the night. The nurses then took him to the emergency room for stitching.*
>
> ***Student reflection***
>
> *I am worried about the nurses on the ward, because I have noticed they are not competent enough to give good wound care.*

The role of the NP requires specialized and expanded knowledge and skills that blend nursing and medical orientations. The student in the vignette had to take care of a serious head wound. However, other problems were neglected. Indeed, a patient with dementia at a high risk for falls needs more than wound care. The reflective case studies offered the opportunity to become aware of the need to combine various types of interventions to alleviate, prevent, or manage specific physical problems and to be attentive toward the effect of accidents on patients and their families. In the case studies, the NP students can reflect critically on how they handle complex situations that require coordination with other care providers and guiding of the family.

Category Increased Performance Demands

This category focuses on role development in advanced practice nursing, which is a process that evolves over time. It reveals the threat for the NP students to become frustrated and tensed in response to increased performance demands.

Handling independence and dependence

Usually, NP students work considerably independently with medical protocols but can defer to their medical supervisor if complex problems arise. This combination of apparent independence and actual dependence was quite stressful for the students.

> *On Friday, an elderly man visits the outpatient clinic with his wife and daughter. He is a regular visitor because of his chronic heart failure. He hadn't felt well over the past few days. The blood tests and the ECG [electrocardiogram] confirm the student's expectation that the man's heart*

is functioning poorly. The student would like to admit him to hospital to monitor the necessary pharmacological therapy, which is the usual procedure. However, his [the student] own medical supervisor is on holiday, and his substitute supervisor refuses to go ahead with the student's proposal. The patient is then sent home with medication. On Monday, the patient returns in a terminal stage of disease, is admitted, and dies.

Student reflection

I was angry because I was not taken seriously; in my opinion the patient was in a bad condition and now he had to wake up himself to take his medicine during the night, it was too heavy for such an old man.

NP students are allowed to make a medical diagnosis under supervision but are not formally permitted to admit a patient to a hospital. For a profession undergoing change, it can be expected that physicians react in different ways, and the student in the above vignette had to cope with limited authority. Reflective case studies offer learning opportunities to analyze the context in which the NP student has to work and to reflect on patient welfare-enhancing strategies in situations in which their authority is limited. They may consider how to cope with their dependence on individuals with more authority, as well as organizational restrictions, and, at the same time, act in the best interest of the patient. Increased confidence in the ability to soundly contribute to patient care will stimulate students to develop firstly toward independency, and secondly toward a renewed appreciation of the interdependence of nursing and medicine.

Coping with emotions

Nursing care is associated with many emotions. Emotional skills are needed to cope with the suffering of patients and their families.

The NP student works in a nursing home. Two daughters are really involved in the care for their mother with dementia but are not satisfied with the quality of care given by the nurses. The patient is given medication to counteract agitation (anxiety, restlessness, hallucinations) on which her mental state improves. After a few days, the physician decides to stop the medication, and the condition of the patient again deteriorates. The daughters react furiously; no one told them about the doctor's decision. The student is shocked by the lack of communication toward the family; she wants to start the medication again. The student also fears that the nurses may feel threatened by her and does not want to risk a fight with the physician. She wants to develop her role as a nurse practitioner and wants a good relationship with the nurses.

Student reflection

I feel very uncomfortable because the daughters take good care of their mother and they are not rewarded for that.

When NP students reflect on their emotions in the case studies, they can learn to see the emotions from another (more positive) perspective. This reflection will help them to open up to their own feelings of unhappiness and to search for their own sources of power.

DISCUSSION

This study explored the learning opportunities provided by reflective case studies assigned to enhance the reflective skills of NP students. Analysis showed that the students most often narrated situations related to Direct care and Increased performance demands.

Direct care could be subcategorized into focusing on patient's needs, exploring one's own values, and providing comprehensive care. The Dutch Code of Professional Conduct for Nurses states that the nurse must be able to "identify, respect, and care about patients' differences, values, preferences and expressed needs" (NU'91 & V&VN, 2007, p.1). This definition resembles the concept of patient-centered care, which has gained wide acceptance in western countries. This concept changes perceptions of the relationship between patients and health care providers in terms of the balance of power between provider and patient, empowerment of patients, shared decisions, understanding others' perspective, and common goals (Rubenfeld & Scheffer, 2006). Holmström and Rosenqvist (2004) found that only 11% of the professionals in diabetes care focused on the patients' individual understanding of the situation. The MANP program requires students to focus on patients' individual needs and collaborate with them in addressing health issues. With the case studies, NP students have the opportunity to reflect on how they can adapt to patient needs and work from a perspective shared between patients and nurses. In-depth analysis of what patients need is like a voyage of discovery because patients live in unique situations and have unique life histories (Grypdonck, 1986).

In the reflective case study, the students can ask themselves what should be done and why it should be done. The identified learning opportunities concerned several issues requiring ethical decision-making skills. Working on the APN level implicates active involvement with the patient, family, and health care team in understanding and seeking ethical resolutions to complex problems. This involvement is to extend beyond the technical demands of clinical practice, thereby entering the patient's world (Benner et al., 2009). The program teaches the students to identify and critically examine ethical dilemmas. In the reflective case studies, the students are expected to analyze these dilemmas and to explore their own beliefs and value systems.

NPs use a variety of interventions to affect change in a person's health status or quality of life, and they tailor their recommendations, approaches, and treatment to this individual person and his or her family (Hughes, 2002). Good clinical decision-making skills are needed to correctly interpret a patient's needs, concerns, or health problems, and to decide on action (or not), decide on standard or modified approaches, or improvise new approaches as deemed appropriate in light of the patient's response (Tanner, 2006). What is good for a patient can only be discovered in a context. The NP therefore should be a capable observer of the patient's entire context. Husted and Husted (2004) defined two contextual elements that should always guide objective awareness and action:

- 'The context of the situation': the interwoven aspects of a situation that are fundamental to understanding the situation and to acting effectively in it;
- 'The context of knowledge': the agent's awareness and understanding of the aspects of the situation that are necessary to an understanding of the situation and to acting effectively in it).

The second category, Increased Performance Demands, could be categorized into handling independence and dependence and coping with emotions. The latter two subcategories covered the struggles related to the students' new role as NP. The reflective case studies created learning opportunities to reflect on experiences related to role transition. Several factors influence role transitions: (a) personal meaning of the transition, which relates to the degree of identity crisis experienced; (b) degree of planning, which involves the time and energy devoted to anticipating change; (c) environmental barriers and supports from family, peers, school and others; 4. Level of knowledge and skill, which relates to prior experience and school experiences; and (d) expectations, related to role models (Schumacher & Meleis, 1994). The role strain (i.e., subjective feelings of frustration in response to increased role performance demands) can be minimized by individualized assessment of these five essential factors, development of strategies to cope with them, and rehearsal of situations designed for application of these strategies (Brykczynski, 2009).

In evaluating both Increased Performance Demands and Direct Care categories, Direct Care resulted in the least amount of student questioning. The NP students were able to identify a medical problem but seemed not so much inclined to consider holistic (physical and psychosocial) assessment and intervention options. On the other hand, reflexivity seemed stronger in the context of the student's new role. Only by strengthening all role components, including Direct Care as the central competency of NPs, can one become self-confident and assured in the new role (Hamric & Taylor, 1989). Students must cope with both categories of learning opportunities in their reflective case studies before they can take the next step in role development. A central element of nursing practice is to engage with the patient as a person with biological, psychological, social and spiritual dimensions. Direct care is founded by a detailed, systematic collection of relevant

information about the patients' problems and health status. Shifting attention away from the patient to the diagnosis and treatment plan would be detrimental for the quality of nursing care. Reflection is a useful strategy to gain awareness of this design.

Our study showed that students tend to draw premature conclusions from insufficient data. The reflective case studies create an opportunity to be aware of this flaw and to discuss it with a teacher, which was also proposed by Eyler et al. (1996). Reflective case studies offer faculty the opportunity to respond to student performance and pay more attention to double-loop learning, if necessary. Another major advantage of reflective case studies is that faculty have the opportunity to think and rethink about students' interaction with patients, as well as their reflections on the decision making process used in the case studies. Faculty can then step back from students' experiences to ponder and create a meaning from past events that may serve as a guide for future nursing behavior, which is in accordance with Daudelin's (1996) definition of learning.

CONCLUSION

The reflective case studies offered learning opportunities about the nurse-patient interface and about role development as an NP student. They also gave the NP students the opportunity to consider how a situation in which obscurity, doubt, conflict, or disturbance of some sort was experienced could have been handled differently. Because advanced practitioners have to manage the unknown, they cannot rely on a single approach. By writing case studies, NP students are able to build a broad repertoire of strategies and interventions for patient care. Ultimately, the reflective case study is a powerful educational tool in master's programs to create and guide a new professional with greater responsibilities for a comprehensive and compassionate response to patients' needs.

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CHAPTER 3

LEARNING TO ATTAIN AN ADVANCED LEVEL OF PROFESSIONAL RESPONSIBILITY

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ABSTRACT

Background. After graduation, nurse practitioner students are expected to be capable of providing complex, evidence-based nursing care independently, combined with standardized medical care. The students who follow work-study programs have to develop their competencies in a healthcare environment dominated by efficiency policies. **Objective.** To explore nurse practitioner students' perceptions of their professional responsibility for patient care. **Method.** This qualitative interpretative study entails a content analysis of 46 reflective case studies written by nurse practitioner students. **Findings.** The students felt responsible for the monitoring of patients' health status, attending to psychosocial problems, emphasizing compliance, and optimizing the family's role as informal caregivers. At the same time, students struggled to understand the complexities of their patients' needs, and they had difficulty applying their knowledge and skills to complex medical, psychological, and social problems. **Conclusion.** The students' perceptions of their new responsibility were characterized by a strong focus on curative care, while psychosocial components of health and illness concerns were often overlooked. The students experienced difficulties in meeting the criteria of advanced practice nursing described in the Dutch competency framework.

INTRODUCTION

In high- and middle-income countries, healthcare is becoming more complex and costly, which places additional demands on health workers. Patients are now sicker and frailer than some decades ago – partly because there are more elderly, and because some patients have multiple chronic conditions accompanied by psychosocial challenges (World Health Organization, 2006). In the Netherlands, policymakers presented the deployment of nurse practitioners (NPs) as a solution for the shortages of medical staff and the explosive growth of healthcare expenditure. The nursing profession emphasized the opportunities to enhance quality of care through this new role (Ter Maten-Speksnijder et al., 2014). Universities of Applied Sciences designed two-year full-time Master programs for NPs, of 120 European credits (EC) in total. One EC equals of 28 hours of study. In contrast to other countries, the Master programs in the Netherlands are organized as work-study programs and subsidized by the government. The students are in training as NPs for 32 hours a week in general practices, hospitals, and nursing homes (80 EC). They attend university one day per week (40 EC) and the government reimburses their salaries for that day to the employers (VBOC, 2008).

The roles of the Dutch NPs are based on the CanMEDs model for medical specialists, developed by the Royal College of Physicians and Surgeons of Canada (2011). The roles described in this model have been adapted to advanced practice nursing competencies (VBOC, 2008). The central competency of Dutch NPs is defined as: *NPs contribute to patient care by providing complex, evidence based nursing care independently, combined with protocolized medical care* (Box 1). In Europe, the qualifications that typify the educational levels were defined with the so-called Dublin descriptors (www.ec.europe.eu). According to these descriptors, Master students have to learn how to apply their knowledge and problem solving abilities in new or unfamiliar environments within broader (or multidisciplinary) contexts related to their area of expertise. They must integrate their knowledge in order to handle complexity and to formulate judgments with incomplete or limited information, using reflective skills on their social and ethical responsibilities. Therefore, the NP role is not only based upon a breadth of abilities and skills but also on in-depth and focused clinical application of specialty knowledge and skills.

Box 1 Summary of Dutch NPs' competencies. VBOC 2008

NPs contribute to patient care by providing complex, evidence-based nursing care combined with protocolized medical care. To address the health care needs of their patients, NPs promote both the continuity and quality of nursing care and medical treatment, and they support patients' capacities for self-management and preserving quality of life.

NPs form individual therapeutic relationships with patients and their families that facilitate the gathering and sharing of information essential for exemplary health care.

NPs work effectively with other health care providers to provide safe, high-quality patient care.

NPs demonstrate a lifelong commitment to excellence in practice through continuous learning, the teaching of others, the evaluation of evidence and other resources, and contributions to scholarship.

NPs develop, in collaboration with other health care leaders, a vision of a high-quality healthcare system and take responsibility for effecting change to move the system toward the achievement of that vision.

NPs are committed to the health and well-being of individual patients and society through ethical practice, high personal standards of behavior, commitment to the profession, profession-led regulation, and maintaining personal health.

The NP curriculum at Rotterdam University of Applied Sciences encompasses courses related to Medicine, Nursing and Research. In medical courses the students are trained in physical examination, medical diagnosis and treatment planning. In relation to advanced nursing, courses are offered on leadership, patient education, coordinating clinical pathways, guidance and coaching. These courses provide the tools to deepen their understanding of clinical, professional and policy issues in order to encourage the NP students to move beyond their present Bachelor's degree level and to cope with the demands of complex patient care. Research courses enable students to read and understand scientific research, and to design and conduct practice-oriented research themselves. The final project in the program consists of completing a Master's thesis on a clinical topic related to NP practice (18 EC).

The transition from RN to NP is a challenging one (Lloyd-Jones, 2005). NP students have to deal with a conflict of priorities between what individual patients need, what is permitted by medical protocols, and what other stakeholders, such as physicians, see as good care. Structured reflection can be helpful to learn how to manage uncertainty and value conflicts of practice (Schön, 1983). By stepping back from an experience to ponder, carefully and persistently, the learner is able to create meaning from past or current events that may serve as a guide for future behavior (Daudelin, 1996). Rotterdam University of Applied Sciences implemented a reflective case study assignment in the Master program to support reflective learning (Box 2). Students were asked to write a narrative about a demanding student-patient encounter and to reflect on this experience. Data generated

from case studies allow for a more in-depth exploration of phenomena in the real life context of NP students (Rolfe, Freshwater & Jasper, 2001). Therefore, the case studies could help gain insight into the students' perceptions of the new role and their responsibility in patient care, making them an important educational tool for the training of advanced professionals. The results of this study help inform the education community about the NP students' development of advanced nursing competencies.

In this study, responsibility is defined as the current or future virtuous professional behaviour, based on the motivation and ability to vouch for one's own actions, even if one is never held accountable (Bovens, 1998). Based on the above, we formulated the following research question: *How do Dutch NP students, practicing in hospitals, perceive their responsibility in the new nurse practitioner role?*

Box 2 The reflective case study

The 'reflective case study' is an educational tool that offers learning opportunities to critically reflect on one's own practices and to make changes to aspects of patient care. A reflective case study entails a narrative about a demanding student-patient encounter and the student's reflection on it.

The assignment consists of three phases and is based on Borton's reflexive framework (as cited in Rolfe, Freshwater & Jasper, 2001). Each phase follows an ordered set of cues through which students might structure their reflective thoughts. In phase 1, the central cue is: **What** happened? In phase 2, **So What** do I make of this? And in phase 3, **Now What** can I do to improve the situation? After having described a situation, the student closely examines and questions her or his own decision-making process to uncover what knowledge was applied in the encounter.

In two meetings with small groups of students and a teacher, the students peer-review each other's narratives for clearness and completeness. In the last phase the students are expected to consider how the situation could have been handled differently and what other knowledge could have been brought to bear on the situation. This last question is crucial to being an advanced reflective practitioner whose mind is set not only at learning from the situation and striving to do better next time, but at instantly improving the current situation (Rolfe et al., 2001).

DESIGN

This study used a qualitative interpretative design. Reflective case studies on patient care work were analysed, written by NP students during the first year of their Master program.

Sample and Data Collection

In the Netherlands, 75% of NPs are working in a hospital setting (Nuijen et al., 2008), so we sampled NP students working in hospitals. The study sample consisted of all 46 students working in emergency care departments, inpatient and outpatient clinics, and

educated at the same university of applied sciences between 2008 and 2012. We collected the case studies written by each student in the sample.

Ethical Considerations

All students were informed about the study both orally and in writing and were assured of complete confidentiality and informed that neither the name of the organization nor their identity or that of their patients would be disclosed in any published material. The students guaranteed the anonymity of their patients in the case studies, and patients gave written consent. The study protocol was reviewed and approved by a committee of the University's Doctoral Research Board, in compliance with the Dutch ethical research regulations.

Data Analysis

The research team interpreted the data inductively, inspired by the Grounded Theory Approach. This implied systematic data ordering and interpretation through a constant comparison method, applying open codes to the relevant fragments and searching for higher-level themes to order the codes (Boeije, 2010). The software used for qualitative data analysis was Atlas.ti, version 7.0.

First, we selected three case studies that three researchers (AtM, MG, AP) each read several times, thoroughly and independently. Then, the researchers analyzed thirteen studies (including the first three) thoroughly and independently with the use of the analytic questions, such as: what does the participant see (or not see) as his/her responsibility with regard to the patient in this situation? (Box 3), and discussed the interpretation of the data. This resulted in memos about the essence of the demanding clinical situations in the case study, the student's reasoning, as well as his/her response to it. This first stage was an intensive and time-consuming process, but was important to understand the complexity of the students' narratives and their reflections in order to know what to look for in the data (Dierckx de Casterlé et al., 2011). In the second stage – the actual coding process – the primary researcher (AtM) divided the narratives and the reflections of the same thirteen case studies into fragments and attached one or more codes to the fragments. The research team discussed the coding until agreement was reached, and subsequently, the team categorized the codes into higher order themes. The primary investigator (AtM) also analyzed the remaining 33 case studies. The entire research team discussed the interpretations of the data until agreement was reached on the APN students' view on their role.

Box 3 Analytic Questions

What does the student see (or not see) as his/her responsibility with regard to this patient?

What decisions did he/she take (or not take) to fulfill this responsibility?

What were the justifications for taking these decisions?

What other strategies could have been considered?

Rigour

We used several procedures to warrant reliability and validity. Firstly, the analysis of the data was regularly discussed within the research team. The preliminary code-structure was co-checked in order to reduce bias from the first author (Boeije, 2010). Secondly, the credibility of the study is established through the richness of our data. Writing about actual situations gives better access to applied practical knowledge than do questions about beliefs, ideology, theory, or whatever students typically do in practice (Benner, Tanner & Chesla, 2009). Both for ethical reasons and in order to ensure good validity of the research, the researchers were neither involved in the course for which the case study was prepared, nor in the grading of the case studies. Data were analyzed after the students had completed the course for which the case study was written.

FINDINGS

Most participating NP students had been practicing for many years as senior nurses prior to their entrance into the master program (Table 1). The students felt responsible for 1. Monitoring patients' health status. 2. Attending to psychosocial problems. 3. Emphasizing compliance, and 4. Optimizing the family's role as informal caregivers. The results presented below (summarized in Table 2) are illustrated with quotations from the case studies (CS), written by a participant working in outpatient or inpatient departments (OPD or IPD).

Monitoring Patients' Health Status

The essence of this theme was feeling responsible for the identification of changes in a patient's physical condition and for taking action based on these changes. All students used medical protocols, and physicians supervised their clinical decisions. *I work with patients with very specific chronic diseases. I can handle an exacerbation completely. I am able to provide proper treatment at short notice (CS12, OPD).* The students felt responsible

Table 1: The sample of APN students (n=46)

Characteristics		N
Year of study	2007	10
	2008	14
	2009	8
	2010	14
Specialty	Acute care	7
	Chronic care	26
	Intensive care	13
Patient category	Children	10
	Adults and elderly	36
Age group	25-35 years	10
	35-45 years	31
	45-55 years	5
Gender	Men	6
	Women	40
Years of experience as a nurse	5 –10 years	6
	10-20 years	20
	20-30 years	20
Work setting	Emergency care	7
	Inpatient ward	10
	Outpatient clinic	36

for overseeing what was happening with the patients before and during their treatments. They ensured that patients followed clinical pathways as efficiently as possible that patients received their treatment on time, and when they were ready for it. *Sometimes, a child was scheduled to undergo facial surgery one month after correction of strabismus. That's a shame, because facial surgery affects the eye muscles and therefore the child will need another operation. These things were overlooked before. Now I keep an eye on it (CS2, OPD).* Central in the NP competency framework is the contribution to patient care by providing complex evidence-based nursing care combined with medical care. The students viewed the monitoring of a patients' health status as part of their responsibility in order to assure the continuity of nursing care and medical treatment.

Attending to Psychosocial Problems

In the case studies, most students considered attending to psychosocial problems their responsibility because they believe that successful medical treatment depends on adequate care to psychosocial problems as well. However, the way they took up this responsibility differed. Many students offered some help if the patients mentioned their problems openly and asked directly for support, and some students were willing to deviate from the protocols, e.g. about patient education, to foster patients' well-being. *It is better to talk*

Table 2: Findings

Students Perceptions		Students Reasoning
Monitoring patient' physical health status	Identifying changes in the patients' physical condition Taking action based on physical changes Starting appropriate medical interventions, or change medical treatment Following the clinical pathway efficiently	Patients should receive the right treatment just in time, when they are ready for it Unnecessary hospitals admissions must be avoided and patient safety guaranteed To reduce length of hospital admission
Attending psychosocial problems	Looking at yet undetected problems, sometimes with a checklist Attend when patients initiate a discussion and directly ask for support Avoidance of existential questions, or showing their emotions, but seemed reluctant to talk about it Give room to ventilate emotions and then refer to other care providers	Successful medical treatment depends on adequate attention to psychosocial problems as well Patient autonomy is leading Hard to talk about psychological and social difficulties Emotions affect patients' healing negatively Heavy workloads, time pressures make it hard to get involved with patients psychosocial problems
Emphasizing compliance	Inform and instruct about practical aspects related to living with an illness. Be strict with patients who are not compliant Confront patients with results of unhealthy behavior, challenge them to do 'the right thing' Adapt patient education to individual circumstances	To take the right decisions in order to achieve medical treatment goals Patients' cure is highest priority Medical supervisors stimulate strict approach to patients Ideal patients want to be cured and adhere to treatment Information will not reach patients when they are not capable of adhering
Optimizing the family's role as informal caregivers	Simulate families to support medical treatments Decide when patients with dementia or young children are at risk for neglect rather than letting the informal caregivers decide	To cure patients or to prevent patients from becoming more ill When patients are fully dependent upon others, you cannot fully trust the family's care giving abilities

about her feelings at the moment. Right now, I cannot give her the information about the cancer treatment. Not a single word will reach her (CS6, OPD). However, most students found it hard to address patients' psychosocial problems. Some did no more than letting patients vent their emotions and then refer them to e.g. a psychologist. If patients were reluctant to discuss problems, the students hesitated to explore these. The students expected patients to explain problems in clear terms and to ask directly for support. It was argued that keeping emotions at bay was the patients' own choice. The students feared that strong emotions, such as anger, would affect patients' recovery negatively. When patients' reactions to disease and suffering were different from what the students perceived as 'normal', this was seen as an obstacle for attending to psychosocial problems. The students

also referred to organizational barriers such as a heavy workload and time pressure. Students felt particularly uncomfortable when patients presented existential questions about death or feelings of senselessness, and often did not know what to say. The following narrative from a case study illustrates this point.

> *Mr. and Mrs. Watts visit my clinic. They look sad. Mr. Watts has Parkinson's disease and he tells me that he is immensely tired and lacks motivation to do anything. He is also suffering from tremors in his left leg. In his opinion, the medication is not working well; there is some anger in his voice, while he gives me a questioning look. I tell him that the neurologist is awaiting the psychiatrist's opinion on a potential depression, and will not increase the medication until then. I tell Mr. Watts that I should like to discuss his problems with the neurologist. A week later, Mrs. Watts calls me on the phone. Crying, she tells me that her husband is not doing well. The tremors are worsening and Mr. Watts keeps saying he cannot live any longer. He is afraid of the future. I encourage Ms. to tell her story. I want to tell her that I 'm going to consult with the doctor because something must be done, but that I am not in the position to control it.*
>
> ***Reflection***
>
> *I could not do anything about Mr. Watts's stress. I was not able to offer Mr. and Mrs. Watts concrete support that would have had an impact on their quality of life. I can only listen and I feel also sad on their behalf. I have failed. Because I lack of the necessary knowledge I do not know how to proceed. My plan is to implement the new patient education program Parkinson (PEPP). I have read about this standardized psychosocial intervention of eight sessions. There is some evidence that each session improves patients' and their caregivers' mood improves after (CS22, OPD).*

This case study illustrated that, as in many settings, medical care and coaching patients and their relatives were still assigned to separate professionals. Because in this case study the physician assumed the patient' problems were caused by a depression that probably could be treated by medication, the student was hindered in helping the patient in this respect. Nonetheless, the student felt responsible for the patient's well-being and decided to search the literature for an intervention that could help her in supporting the patient and his wife. However, not all students acknowledged patients' struggles in dealing with their disease, as demonstrated in the next sections.

Emphasizing Compliance

In the case studies, the students reasoned that if patients understand their diseases and the treatments well, they would be empowered to take the 'right' decisions to achieve the medical treatment goals. Because the students perceived their contribution to cure as their main responsibility, they advised the patients about the decisions to make for a successful medical treatment, such as to continue chemotherapy or to stop smoking. They also provided patients with information and instructions about the practical aspects related to living with illness. The students emphasized that they were able to do this in a more understandable way than the physicians. *I explained his heart failure and his medication to him in a very simple way, using pictures, and tried to make clear that he should follow these guidelines even when he is feeling fine (CS29, OPD).*

Most students were concerned when patients did not follow the medical advice given to them. In their perception, patients ought to follow the instructions in order to be cured. Therefore, students applied various strategies (such as explanation, information, instructions, and advice) to enhance patients' compliance, with varying but often disappointing results. They also tried to persuade patients to follow health management recommendations properly and confronted the patients with the results of unhealthy behavior in order to motivate them to do 'the right thing'. Some students mentioned that their medical supervisors had advised them to be strict with patients. Many students stated that patients themselves are ultimately responsible to be compliant to treatment and not the care providers. Still, they tried hard to foster the patients' compliance. When students felt disappointed by the result, they repeated the information and instructions, hoping that their patients would eventually adhere to the proposed medical regimen. Some students reasoned that information provision was not indicated when patients worried much about the disease. However, most of them did not give attention to the meaning of the disease, the treatment, or to the burden of the consequences of the disease for the patient's personal life. They were not assisting patients in weighing the cost of each treatment against the benefits, as the patients perceive them. This narrative demonstrates this point.

> *Mrs Young is 83 years old and visits my clinic for the first time, accompanied by her daughter. Since a few days Mrs Young has known that she has lung cancer. This surprised her because she was coughing only a little bit. Within a few days, she will start with the chemotherapy. I ask them what they expect from this visit. Mrs Young says: 'it is your job to tell me everything about the therapy', and her daughter expects that I can help with the arrangements at home. When I ask Mrs Young what she expects from the medication, she answers that she has some doubts. She asks: 'is there a choice for me'? I want to give her some answer, but at the same time I do not want to have more*

questions raised at this point. I inform them about the medical procedure and possible side effects, and notice that Mrs Young has fallen silent; she is not looking at me anymore. When I tell her she seems to be withdrawn, she shows no emotions and tells me that she will wait and see.

Reflection

I am not sure if I acted sensibly. It was not my intention to make her doubt the treatment. Was my explanation about the side effects too much for her? Still, there was no doctor available on Friday to explain things, so there was no other option for me. The literature showed me that elderly patients have a different timeframe for processing new information, so I acted adequately because I did not push Mrs Young to talk with me (CS18, OPD).

In this case, the student did not see it as an option to discuss choices related to the patient's treatment. The physician expected that the patient was prepared and ready for therapy on Monday. The patient had also mentioned that proper information was the students' task at that moment. Although the student had some doubts about her conduct, she failed to critically reflect on her professional behaviour. This student referred to the literature to justify her decision, as many students do in order not to get involved and to ignore the patient's emotions and concerns on behalf of the continuation of the medical therapy.

Optimizing the Family's Role as Informal Caregivers

The students perceived it as their responsibility to optimize the family's role as informal caregivers, reasoning that the family had an important role to play in adherence to medical treatment in order to effectively cure patients and to prevent complications or decline. In line with this narrow focus on family care, most students did not view family members as persons who were also in need of care. *They [the relatives] are present primarily for the sake of their ill relative, to lend an ear to remember what I have just told. One should see it in the context of the patient; one does not treat the family (CS21, IPD).* In the case studies the students described several situations in which families struggled to perform as caregivers in the way that was expected from them. The student handled these problems differently. When family members did not support an adult patient, the students felt they should not intervene because they did not want to disturb family relationships. In contrast, students attending to patients with dementia or young children were inclined to have them hospitalized, especially if they did not fully trust the family's care giving capabilities, such as in the following narrative.

Peter is two years old. This is his first visit to my clinic with his mother. She tells me that because he underwent so many medical procedures, Peter is terrified when a doctor or a nurse approaches him. The mother then starts crying. Peter looks at her and starts crying too. The mother says she is very worried about Peter since the time he was admitted to the ICU because of an infection. At home there were also difficulties. Peter refused to take his cancer medication, even when crushed or mixed with food, and for this reason a gastric nasal tube was placed. The mother is not sleeping well because Peter is crying a lot during the night. While she tells me this, she keeps on crying, while holding the little boy very close to her.

Reflection

I found this a difficult situation because I could not comfort the mother and also could not make any contact with Peter. At the same time I worried whether the mother was capable of caring for Peter in view of his medication and his special diet. For this reason, I considered a hospital admission for Peter (CS7, OPD).

In this case study, the student was well aware of the mother's suffering. However, he did not felt responsible to support the mother and to consult other healthcare providers on the child's anxiety. The student considered the mother a liability in this situation, seeing that she would not be able to comply with the treatment plan. Most students did not offer support to the family to alleviate their sorrow. Their major concern was the adverse influence of the family's suffering on the patient's recovery. Consequently, these students were not able to partner with informal caregivers on behalf of the patient.

DISCUSSION

The analysis of the data showed that the students mainly felt responsible for their contribution to the curing of patients' diseases or helping them at least remain physically stable. The themes revealed in this study could be all related to this main responsibility.

The first theme, 'Monitoring patients' health status' is in line with the surveillance function of nursing care for the prevention and early detection of adverse patient events in hospitals (Lucero, Lake & Aiken, 2009). The students emphasized that they were able to adequately solve the patients' disease-related physical problems that were entrusted to them. At the same time, many students found it hard to 'Attend to psychosocial problems', i.e. the second theme in our findings. This is remarkable considering that the specific domain of nursing is people's unique responses to and experience of health, illness, frailty,

disability and health-related life events (www.rcn.org.uk) and the curriculum, in theory, emphasizes the nursing role. Coupled with care for physical health problems, attending to psychological responses and the social impact of disease are inevitable parts of NPs competency framework as they are expected to support patients' quality of life (see Box 1). These findings, that indicate the students' difficulty to attend to psychosocial problems, could perhaps be related to the dominant position of the biomedical model in a hospital, and its focus on acute care. In this model, disease is considered an organic condition, while factors associated with the human mind and social circumstances are considered less important (Callahan & Pincus, 2014).

The third theme, 'Emphasizing compliance' was also in line with the perceived responsibility of helping the patient to be cured. The NP competency framework sees supporting patients' self-management as an important part of NP care, and the curriculum places some emphasis on this, but the students experienced difficulties in building collaborative partnerships with patients as a way to reach that goal. The students' most common strategy to facilitate patient treatment compliance was transference of knowledge and persuading patients to adhere to recommendations. Therefore, it seems that the students were not yet ready to make the shift from emphasizing compliance to focusing on self-management support, as is proposed in the competency framework and presented in the course.

The fourth theme showed that most students did not see supporting the family as part of their responsibility. This view is not in accordance with the competency framework, which also sees the family as care recipients. Students' focus on the family as care providers may be reinforced by the current health care policy in the Netherlands, which promotes greater involvement of informal caregivers (RVZ, 2011). Bauer, Fitzgerald, Haesler & Manfrin (2009) showed that this policy, combined with shorter hospital stays, has led to a significant increase in the responsibilities families have to take on, often with little or no training and only minimal support from healthcare providers. Taking care of patients with chronic illnesses asks for a proactive approach in supporting the family as informal caregivers, both in chronic as well as in acute care settings (Verhaege, Defloor, Van Zuuren, Duijnstee & Grypdonck, 2005).

These four themes showed that perceptions of responsibility by the professionals themselves were influential to their patient care, as described in the case studies. Niezen and Matthijsen (2014) also found that NPs self-knowledge of their own limitations and confidence in terms of capabilities facilitated NP role development as well as interpersonal skills. However, perceptions on the individual level are interrelated with characteristics of the organizations where the professionals are active (Brandsen, Helderman & Honingh, 2011). The NP students' learning environments are small communities of mostly physicians and some nurses with shared norms and values. The students' struggles with the tasks' complexity may have been a point of conflict because there is an emphasis on

the standardized medical care in these communities. The obligation to strictly follow medical protocols, combined with a focus on evidence-based care, may stand in the way of consulting with patients so as to elicit their preferences for alternative treatment options, and to account for patients' treatment preferences in providing (Hasnain-Wynia, 2006). Although efforts have been made to incorporate individual circumstances and preferences into evidence-based decision protocols, evidence-based care has typically been implemented through clinical guidelines or protocols, all of which are used to standardize, not personalize, patient care. The legal framework for Dutch NPs regarding prescriptive authority created more opportunities for NPs to work independently, but our study showed that health care organizations determine how NP students perform their role in practice and that the context within which learning takes place dominates NP students' competency development.

To learn from these complex contexts and to become change agents as described in the competency framework, reflective skills are necessary. NP students are expected to be able to reflect on particular situations, in order to deepen one's understanding of the salient theoretical knowledge; to recognize the important aspects of the particular clinical situation, and to clarify one's own vision of good nursing practice. In the case studies, the use of reflective practice was diffuse; personal values and behaviors were explored, albeit mostly to motivate activities and not to critically question performances. In an earlier study, we also found that the acquisition of reflective abilities is a complex transitional process for APN students (Ter Maten-Speksnijder, Grypdonck, Pool & Streumer, 2012). Because the case study method encourages and facilitates this process, the results of this study showed the importance to improve the use of this educational tool in Master programs, especially when organized as a work-study program.

To support the professional transition from RN to NP in the workplace, a nurse mentor who has experienced the same developmental process may be helpful. Master curricula should be based on the nature of the accepted discipline model; in other words, on nursing theory. NP programs need to make clear what integration of nursing and medical knowledge means and articulate the nursing dimensions of advanced practice (Brykczynski, 2012).

Strengths and Limitations

This study was the first to ask participants to critically reflect on their NP-patient encounters. In spite of the limitations in their reflective practice skills, the case studies yielded rich data, which was the strength of our study. That the case study is a formal course assignment may have contributed to the quality of the data in several ways. One could debate whether our data relate to actual practices, because these may differ from students' self-reported opinions on their role enactment. The students may have presented a more positive image of themselves than what happened in practice, but on the other

hand, what they presented is influenced by what they think they should present. Future studies should include observations to comprehensively investigate NP students' actual work to better explain and to complement the findings.

CONCLUSIONS

The NP students showed that they struggled with the full range and the advanced level of their new role. Working on medical problems on the basis of protocols was less difficult to articulate for students than the challenge of managing the healthcare needs of their patients, which integrates nursing care and medical treatment. It is quite an achievement that NPs become increasingly proficient in the treatment of diseases but if they remain unaware of their full scope of practice, they risk staying in the comfort zone of standardized medical care. Using reflection as the core for NPs' development towards an advanced level is needed when nurses are eager to progress beyond the level of following a prescribed set of rules.

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PART III

ROLE DEVELOPMENT

CHAPTER 4

DRIVEN BY AMBITIONS: THE NURSE PRACTITIONER'S ROLE TRANSITION IN DUTCH HOSPITAL CARE

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ABSTRACT

Introduction. Insight into nurse practitioners' role transition can help nurse practitioner students and new graduates in taking on new responsibilities in a changing and demanding healthcare context. The aim of the research was to explore the role transition from nurse to nurse practitioner using the components of Meleis's Framework of Transitions (2010). **Method**. A qualitative descriptive design was used. Individual interviews (n=9) and two focus group discussions (n=12) were held with nurse practitioners. Data were analyzed with the Directed Content Analysis method. **Findings.** The Framework component *Transitions' nature* was characterized by changes in healthcare system, combined with professional and educational role changes. *Transition conditions* showed that the respondents felt distressed after they became accountable for patient's care and wellbeing. Although the respondents were authorized to do medical procedures they initially lacked nursing role models and NP protocols. *Process indicators* showed ongoing transition; the respondents were still developing clinical competencies and confidence in patient care while relying on earlier acquired nursing competencies. *Outcome indicators* showed that the respondents found themselves successful in the medical extension of two different nursing roles, i.e. continuity of medical care for hospitalized patients in acute and intensive care settings, and being responsible for continuity of care for chronic patients in outpatient clinics. **Conclusions.** Role transition was characterized by coping with feelings of distress at the cost of time and effort. The respondents' strategies to adapt to new expectations, combined with organizational support, determined the outcomes as well as the start of new transitions. **Clinical relevance.** NP' role transition in hospital care does not simply equal a change, but is a dynamic ongoing process that needs to be facilitated. Insight into facilitators and inhibitors are needed to support renewed self-confidence as well as a novel identity as an advanced nurse.

INTRODUCTION

It could be challenging for nurses to develop new roles under the umbrella term 'advanced practice nursing', such as the nurse practitioner [NP] role. Advanced nurses are expected to have more comprehensive insights of the complexity of healthcare situations than nurses working at a lower level; which means they have to redefine themselves in their healthcare contexts (Bryant-Lukosius, DiCenso, Browne & Pinelli 2004). NPs are qualified to diagnose and treat a variety of health problems, activities that are perceived to belong to the doctor's repertoire of skills. Therefore, the professional boundaries of nursing and medicine are challenged, which can be stressful for new NPs. Brown & Olshansky (1997) described the first years' practice of primary care NP graduates as a process, in which a crisis in confidence and competence associated with taking on a new position may lead to anxiety. Kelly and Mathews (2001) and Heitz, Steiner & Burman (2004) described similar findings for NPs working in hospitals and for family NPs, respectively. Taking on a new role can be seen as a transition with profound changes in role relationships, expectations, and abilities. According to Meleis (2010), a transition like this does not simply equal a change, but is rather a process to incorporate changes in or disruptions of one's life. To do this well, it is important to know what may influence this process and its outcomes.

Background

In the Netherlands, the NP role exists since 2000. Master's in Advanced Nursing Practice [M ANP] programs especially designed for NPs, are organized as 2-year work-study programs. The students work as NPs in training for 32 hours a week in their clinical work settings, and attend class one day per week. In medical courses they are trained in physical examination, medical diagnosis and treatment planning. Moreover, courses are offered on leadership, patient education, coordinating clinical pathways, guidance, and coaching. These courses provide the tools to deepen their understanding of clinical, professional and policy issues, allowing them to move beyond their present Bachelor's degree level and to cope with the demands of complex patient care. In research courses they learn how to read and understand scientific research, and to design and conduct practice-oriented research. All programs are concluded with a Master's thesis on a clinical topic related to NP practice (VBOC, 2008). The professional master degree entitles NPs to use the protected title 'Nurse Specialist'. In 2011, they gained direct legal authority to perform medical procedures within their areas of expertise (e.g. emergency care, rheumatology, diabetes care, etc.).

As soon as the NP role was initiated in the Netherlands a fierce debate started on whether deployment of NPs could solve healthcare and workforce problems (Ter Maten-Speksnijder, Grypdonck, Pool, Meurs & van Staa, 2014). In the debate's efficiency discourse, the arguments in favor of a formal transfer of medical tasks to nurses included the expected shortage of physicians, increased healthcare spending, and the need for coordinated care. The debate's

professional discourse, however, focused on the desirability of combining comprehensive nursing care with medical care. Although most physicians were found willing to delegate tasks to NPs, and the government urged physicians and NPs to realize the formal transfer of tasks (KNMG et al., 2012), the physicians wished to retain final responsibility for medical care. Nurse leaders, on the other hand, found it important to strengthen the core values and practices of nursing (i.e. promoting health, healing and hope in response to human condition) rather than merely extending the profession to a medical role (Ter Maten-Speksnijder et al., 2014). Thus, the debate made clear that the NP role had not yet crystallized, and that the different demands placed on NPs may lead to distinct NP roles in the Netherlands.

However, little is known about NPs' role transition in the changing healthcare context as earlier described. The purpose of the study presented here was to explore, using Meleis's Framework of Transitions (2010), aspects of the transition from RN to NP. The research question was: *What characterizes the NPs' role transition to an advanced nursing role and how do the NPs experience their transition?*

Meleis's Framework of Transitions

Schumacher and Meleis's review of the nursing literature (1994) supported the claim of the centrality of transitions in nursing, which concept is relevant to many areas in nursing including the development of professional roles. Therefore, NP role development could be explored by Meleis's Framework of Transitions (2010), which consists of four elements: Nature of Transitions, Transition Conditions, Process Indicators and Outcome Indicators, and Nursing Therapeutics (Figure 1). We will first describe these.

The nature of transitions refers to physical, social, emotional and/or environmental changes caused by, or being a result of, transitions. The changes occur sequentially to or simultaneous with critical events, such as disruptions in relationships and routines, or in response to ideas, perceptions, and identities that trigger the transitions. The different types of developmental, health/illness, organizational, and situational transitions can be experienced separately but often co-occur.

Transition conditions on different levels either facilitate or hinder progress toward successful transition. On a personal level we see meanings attributed to events and to the transitions itself; the cultural beliefs and attitudes; socioeconomic status, and the preparation and knowledge about what to expect during a transition and what strategies may be helpful in managing it. Community-level conditions include support from relevant others and the availability of role models. And then there is the level of the society at large in terms of the public opinion on legitimation of the NP's role transition.

Process and outcome indicators demonstrate whether a transition is experienced as successful. The two most important process indicators are: 'feeling connected' to a meaningful interpersonal network, and 'being situated in terms of time, space, and relationships with supportive others'. The outcome indicator 'mastery' covers the blending

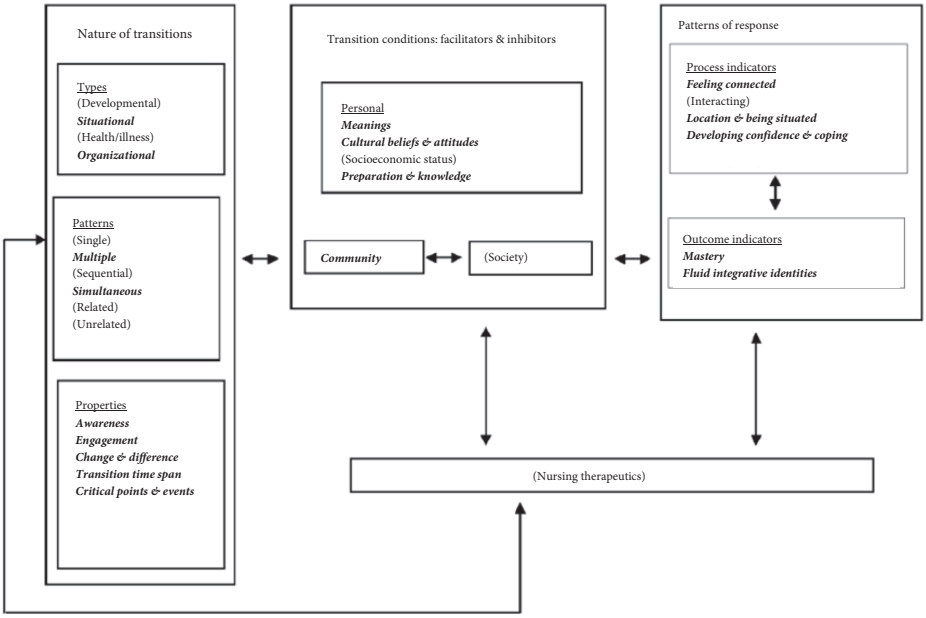

Figure 1: Meleis, A., Sawyer, L., Im, E., Massias, D., & Schumacher, K. (2000) Experiencing transitions: An emerging middle range theory. *Advances in Nursing Science*, 23(1),17. Reprinted with permission.

of previously acquired skills with skills newly developed during the transition process. Transitions results also in identity reformulation; the new identities are fluid rather than static, and dynamic rather than stable.

Lastly, **Nursing therapeutics** are interventions to promote healthy transitions. Although this element fits with supporting career transitions, it was outside the scope of this study.

METHODOLOGY

Design

The study used a descriptive qualitative design, which is the method of choice when descriptions of phenomena are desired (Sandelowski, 2000). The focus was on the hospital setting, because this is where three quarters of NPs in the Netherlands work. A purposive sample with maximum variation (Polit & Beck, 2013) was recruited of NP graduates from different hospitals who had been working minimally two to six years post-graduation in acute care, intensive care, or chronic care. They all had been trained in the same University of Applied Sciences.

Methods

First, qualitative semi-structured interviews were held with nine NPs. The opening question was broadly related to the research topic: What were your experiences during the transitional process from RN to NP? A self-developed topic list guided the researchers through the rest of the interview. Topics discussed were: a new job, NP education, collaboration with physicians and nurses, NP responsibility, and patient relationships. The preliminary analysis of the interview data showed a wide variety of views and experiences, such as the new professional relationships with nurses on the wards and diagnosing medical problems. Second, as group interactions can bring out similarities and differences between participants (Lambert & Loiselle, 2008), we held two focus group sessions with another group of 12 NPs. One of the researchers (AP) functioned as moderator and created a safe environment, inviting all to share opinions while sticking to the group discussion topic (Sim, 1998). The group discussions and the interviews were audio-recorded and transcribed verbatim.

Ethics

All participants had provided informed consent after having been informed about the study, both orally and in writing, and having been assured of complete confidentiality. The University's Doctoral Research Board approved the study protocol in compliance with the Dutch ethical research regulations.

Analysis

The NP role transitions were explored using the Directed Content Analysis (DCA) method, which is considered appropriate when there exists theory or prior research about a phenomenon that is incomplete or would benefit from further description (Hsieh & Shannon, 2005). DCA coding can begin with either one of two strategies. One of the strategies is to code inductively and then categorize the codes into a predetermined matrix; the other strategy involves applying predetermined codes. We thought the first strategy was best suited to gain insight into all aspects of NPs' role transitions. After the researchers (AM, AP, MG) had painstakingly read the transcripts of the interviews and the group sessions to get an impression of the data (Polit & Beck, 2013), the transcripts were loaded into the computer-based package for qualitative analysis Atlas.ti, version 7.0. The main researcher (AM) reread them line-by-line, and labeled each passage with an adequate code. After exploring commonality between the codes and the connected text fragments, the codes that were related to each other were linked to the components of Meleis's Framework. The research team discussed data labeling until agreement was reached.

Quality Procedures

Methodological rigor was ensured by several procedures. Selecting participants with diverse backgrounds and varied years of experience as NPs allowed to explore more dimensions of the NP role transition and to learn about the research topic (Polit & Beck, 2014). As a result, the interviews yielded rich and varied descriptions of individual role transitions. The focus group discussions, in which participants questioned one another and commented on each other's experiences, also provided useful information. Agreement from the whole research team on how to label the data helped strengthen the internal validity of the analysis (Graneheim & Lundman, 2004).

FINDINGS

Data were collected from NPs working in six hospitals in the western part of the Netherlands (Table 1). They all were among the first nurses employed as NPs in their hospitals. In Figure 1, elements of Meleis's Framework that can be related to the findings of this study are presented in bold, while those that were unrelated are shown in brackets. The findings are reported under the headings of Meleis's Framework of Transitions (Figure 2).

The Nature of Transitions

Experiencing organizational and situational transitions

Organizational transitions in the healthcare system and situational transitions were influential to the role transitions of nurses. For example, a policy to strive for shorter hospital stay resulted in more complex care in the outpatient clinics. Furthermore, new standards for working hours and the modernization of the training of medical specialists resulted in fewer medical residents working in some hospital wards. These changes offered opportunities for task reallocation from physicians to nurses. However, the hospital context with its efficiency requirements and the takeovers of junior doctors' duties pushed many participants into a doctor substitution model, often at the expense of their core duties.

> *We take over a lot of doctors' tasks, such as contacts with GPs, writing letters, etcetera. (Int Eva) Before I became an NP in the outpatient clinic, the nurses had to wait until the doctors could formulate their treatment plans for new patients after they had finished work in the outpatient clinic or operating room. Now, I inform the nurses on the ward about the patient's diagnosis and already start some tests. In some cases the patient is not admitted until I have arranged everything. This could save one or two days of hospitalization for the patient. (Int Daan)*

Table 1: Description of study participants

	Interviews	Focus groups (n=2)
Number of participants	9	12
NP specialties	Chronic care (n=5)	Acute care (n=4)
	Intensive care (n=4)	Intensive care (n=4)
		Chronic care (n=4)
Medical specialties	Oncology (n=2)	Emergency Care (n=3)
	Surgery (n=2)	Oncology (n=5)
	Neonatology (n=1)	Pediatrics (n=1)
	Internal medicine (n=4)	Internal medicine (n=3)
Work settings	Hospital wards (n=3)	Emergency room (n=3)
	Outpatient clinics (n=6)	Hospital wards (n=1)
		Outpatient clinics (n=8)
Age (range)	30-40 (n=5)	25-35 (n=5)
	40-50 (n=2)	35-45 (n=6)
	50-55 (n=2)	45-50 (n=1)
Gender	Male (n=2)	Male (n=3)
	Female (n=7)	Female (n=9)
Years of graduation	2006/2007 (n=4)	2006/2007 (n=6)
	2008/2009 (n=5)	2009/2010 (n=6)
Years in nursing role before the advanced nursing practice program	10-20 (n=5)	5-15 (n=5)
	20-30 (n=3)	15-25 (n=5)
	30-35 (n=1)	25-30 (n=2)

The situational transitions included professional and educational role changes that made a reorientation of one's professional identity desirable. For one thing, they had to proceed from experienced, specialized nurses to advanced beginners NP students who are supposed to be supervised by physicians. Besides, because they followed a work-study program they had to combine the student role and the employee role. They were also expected to develop competencies at the master level, of which the most challenging were the research competencies.

> *It is hard, I have to learn how to do physical examinations, improve my clinical reasoning, and I have to work on a master thesis. (Int Fred)*

Developing ambitions

One of the transition properties was awareness of new possibilities in the professional career. Inspired by experiments and the experiences of NPs or clinical nurse specialists in other countries, all participants had wished to become NPs because they wanted to be involved in medical decision-making for their patients. Some even had the ambition to enhance the level of patient care after noticing that expertise in the care for certain patient groups was lacking.

> *More children were admitted to the hospital because the surgical technology improved. But, in our department, many questions were raised, e.g. about nutrition, or how to prevent complications. It became my project to improve the care for these children and I started to see them with their parents before treatment in the outpatient clinic. (Int Sophie)*

Changing professional relationships and routines

Entering the medical domain implied major changes in professional relationships and routines. The participants transitioned from disciplinary team players with shared responsibilities to multidisciplinary teams members each with their own professional responsibilities – to which patients and ward nurses can turn to.

> *In the morning we start doing medical rounds, and then the surgeons go to the operating room and my colleague NP and I stay on the ward. If there are any problems related to medical treatment, we can intervene immediately, and the nurses always have someone they can turn to. (Int Sanne)*

Relationships with patients also altered. Some participants at first felt uncomfortable being alone with the patient in the consultation room. In the early phases of the transition, they had no clear view on how to deal with such encounters.

> *The one-to-one contacts were demanding. You ask the patient, who you do not know, to come in, the door closes and there you are, alone with the patient. What am I going to ask, what will he tell me? (Fg Ilse)*

Being accountable

In the first stage of transition, the participants' most challenging experience was to be primary accountable for a patient's welfare. They had to meet a broader spectrum of patient care demands, and a higher performance was expected, easily resulting in distress. Although all participants could rely on back up from physicians, the idea of being accountable for their own actions weighed heavily on them. After graduation, this sense of accountability further intensified, because in their 'new life' they were afraid of making wrong decisions. Above all, they wanted to be sure they could foster the patients' wellbeing.

> *I lay awake at night, worrying whether I had made the right decision. (Fg Lotte)*

In summary, the analysis of Meleis's transitions' nature in this study showed a disruption of the participants' professional lives, to which they needed to respond. Nevertheless, they showed commitment to the transition by developing new ambitions in spite of the inevitable critical points and events suggested by Meleis, such as the changes in relationships, routines, and responsibilities. The participants also had to deal with certain conditions that determined these changes on the community-level, as is shown in the next section.

Transition Conditions

Formal transfer of tasks

One of the conditions that facilitated the NP role transition was the legitimation for certain medical procedures within a specified area of expertise for selected patients, on an experimental basis from 2012 until 2016. Responsibility for medical tasks, varying from physical examinations to prescribing medication, was eventually formally reallocated from physicians to the NPs, although they were still supervised by physicians. In one focus group discussion, however, participants working with people with cancer maintained that diagnosing should not be entrusted to NPs. Others stated that normally medical specialists would formulate the medical diagnosis, but yet expected NPs to diagnose any alterations in a patient's medical conditions. Participants working in the outpatient clinics and emergency departments argued that formulating medical diagnoses was part of the job.

> *In my opinion, it depends on where you work as an NP, and what the impact of the medical diagnosis is for the patient, and whether you can instantly consult your supervisor. (Fg Maud)*

Support from physicians and healthcare managers

All participants found support from physicians and healthcare managers the most influential condition to successfully complete the transition. Some referred to colleagues who stopped the work-study program because support was missing, especially that from the physicians. As pioneers, many of the participants started without a clear job description, which was not conducive to development of the new role. NP role models in the hospital setting were lacking, too. Some participants therefore searched for practice protocols in other hospitals, and some started developing NP protocols together with physicians. Protocols, as statements of agreement between the NPs and medical supervisors, gave them a feeling of support and of control over the situation. However, physicians did not always support this.

> *The physicians agreed with the protocols we got from our colleagues in another hospital, but they didn't seem interested, which made us feel very insecure. (Fg Lisa)*

In summary, Meleis (2010) defined personal and environmental factors that affect transitions. In the present study the 'support' condition proved crucial for the participants' capacity to adapt to the new role. Particularly physicians' support proved important. Although the participants were authorized to do medical procedures, they initially lacked role models and NP protocols. At the same time, they had to deal with the boundaries to their new role, such as the extent to which the medical tasks could be reallocated. In the end, all participants had to accept the level of autonomy granted by the physicians. How they responded to new and sometimes unclear expectations had a great impact on the transition process, as is explained below.

Process Indicators

Developing medical competencies

Several signals showed that participants were highly motivated to develop medical competencies that would help them in the transition process towards the new NP role. For example, they followed lectures about clinical management for medical students delivered by medical specialists; studied medical guidelines; and searched the medical databases for evidence. At the same time, their interest in nursing research appeared low.

> *Of course I search PubMed, but not because of nursing problems; I am familiar with nursing already. (Fg Bas)*

Although participants aspired to improve quality of patient care, most of them had no nursing innovations on their agendas. They argued that they were adding a nursing perspective to medical treatment that was defined as *the competency to care*. Examples included relieving a patient's physical discomfort and being attentive to small things such as helping them to dress after physical examinations, or fluffing up the pillow. All participants were proud of their caring competencies and emphasized they would never lose such competencies. Providing nursing care is done "intuitively":

> *I can tell at a glance that someone is uncomfortable with his broken leg; I don't have to think about it (FG Bas). When it comes to emotions, we are more humane than physicians. (Int Sanne)*

Developing confidence

The participants reported that over time they became more skilled in managing patients and medical procedures. They felt closely connected to physicians, the most important persons to interact with about their new role. Knowing that the physicians, also those outside the own team, valued their expertise, they had greater confidence in being competent in medical care.

> *I gave a presentation for GPs about new developments in the medical care for chronic heart failure. I sensed that they appreciated me for what I did as an NP. Afterwards, some of them came to ask me: I have a patient with such and such complaints, what would you recommend? (Int Nienke)*

The participants also felt appreciated by the patients, and ascribed that to being easily accessible. They emphasized they could explain things in a way that patients could understand, and were better at this than physicians. Many patients thought they were dealing with physicians, although all participants always explained they were nurses.

> *Recently, I had a patient who said: 'I would like to hear the result of the CT-scan from you; if it's negative, then I want to hear it from you'. (Int Daan)*
> *When they leave the office, they all say: goodbye doctor…(Int Nienke)*

Most participants were not involved with the work of RNs on the wards. However, because they had obtained the physicians' support, some of them felt safe to intervene, such as to discuss good conduct.

> *In my opinion, the [ward] nurses are sometimes too informal with the patients on the dialysis ward. 'Ate and drank too much yesterday, huh?' I try to address this issue. 'Is this the right way to tell patients they must comply with the guidelines?' As NPs we can more easily than physicians talk with nurses about sensitive issues, but you need the physicians' support for an intervention like this. (Int Pascal)*

In summary, flow and movement over time characterized the participants' transitions. Committed to the professional role changes, they focused on developing medical care competencies while relying on earlier acquired nursing competencies. Their confidence grew from the positive feedback from physicians and patients. This unfolding subjective sense of wellbeing is also described by Meleis (2010) as an indicator of a successful transition. To which outcomes this process has led, is clarified in the next section.

Outcome Indicators

Mastery in providing patient care

One of the indicators was a sense of 'mastery' in providing specialized patient care.

> *I can auscultate the lungs, palpate different organs, and I talk about the situation at home. You can compare me with a medical resident, but I have much more to offer. The medical specialist knows that I can manage these patients fully on my own. (Int Nienke)*

At the same time, the participants found it hard to define the nursing part of their NP role, although some brought up that they maintained a broad view on patient problems. This emphasized that the NP role is still an ambiguous one despite the transitional process.

> *I don't really know where cure stops and where care begins. In my opinion, I've blended nursing and medical care, and it's difficult to explain this mixture to others. (Int Eva)*

New identity

The second outcome indicator of successful transition is 'new identity', in whith differs between the acute and intensive care settings on the one hand, and the chronic care setting on the other hand.

New identity in acute and critical care

The participants working in hospital wards became responsible for the continuity of care for patients with critical health conditions, so as to prevent delay in medical treatment. They provided no bedside nursing anymore. During day shifts they took over the work of the medical residents who were busy in the operating rooms or in the outpatient clinics. While medical specialists made the key decisions, the NPs monitored the medical care on the wards. They interpreted chest x-rays, ordered and interpreted laboratory tests, and informed the patients and their families about medical treatments. NPs working in the emergency rooms shifted from a physician-assisting role for trauma patients to diagnosing and to treating minor illnesses and injuries, alongside the residents. In the outpatient clinics, the participants met patients individually before or after hospitalization.

> *Before the operation, patients come to my clinic and I check their physical parameters and explain the whole procedure. If the bile ducts are blocked I see to it that a drainage tube is placed. (Int Daan)*

New identity in chronic care

Other participants, working in outpatient settings, felt they had become responsible for ensuring continuity of specialized long-term care. They expanded the teacher-coach role for chronically ill people of patients with complex medical treatments with medical history taking, physical examinations, prescribing medication, and referrals to other care providers. The participants working in the chronic care domain described their responsibility as helping formerly hospitalized patients to stay as healthy as possible and to do well in their daily lives. Therefore, this new role focused on quality improvement. These participants had a more solitary role than those working in acute and intensive care settings; their window on patient care was patients' lives from the perspective of the patients themselves, and these NPs were one of a small number of care providers.
I am responsible for the medical management of patients with chronic heart failure, and if necessary I visit them at home, I follow them over the whole course of disease. (Int Nienke)

New ambitions

The NP role transitions resulted not only in new identities but also in new ambitions. The participants wanted to realize more efficient and effective patient care by implementing new guidelines and procedures.

> *The evaluations showed many complaints from patients. The meeting we had on this problem resulted in a new guideline to the effect that I will visit each patient one time more before discharge, so I can check whether they are well informed. (Fg Lieke)*

The participants wished to have more responsibilities in the whole process of patient care. The participants working in hospital wards wanted to participate in after-care clinics for hospitalized patients. Some of them wanted to participate in surgical procedures too. The participants working in the outpatient clinic would like to care for their patients who were hospitalized for exacerbations.

> *I have known my patients for so many years, I try to prevent deterioration, but if it happens that one of my patients has to stay in the hospital, I also want to provide medical care on the ward. (Int Nienke)*

In summary, the sense of mastery, one of the universal outcomes of a successful perceived transition in Meleis's Framework of Transitions (2010), marked the completion of the participants' transition. The new role varied as to the different contexts. One common element in acute and chronic care was ensuring continuity of care. Eventually,

confidence encouraged the participants to becoming more involved in patients' clinical pathways. This new ambition is in line with coordination as the central part of the NP role.

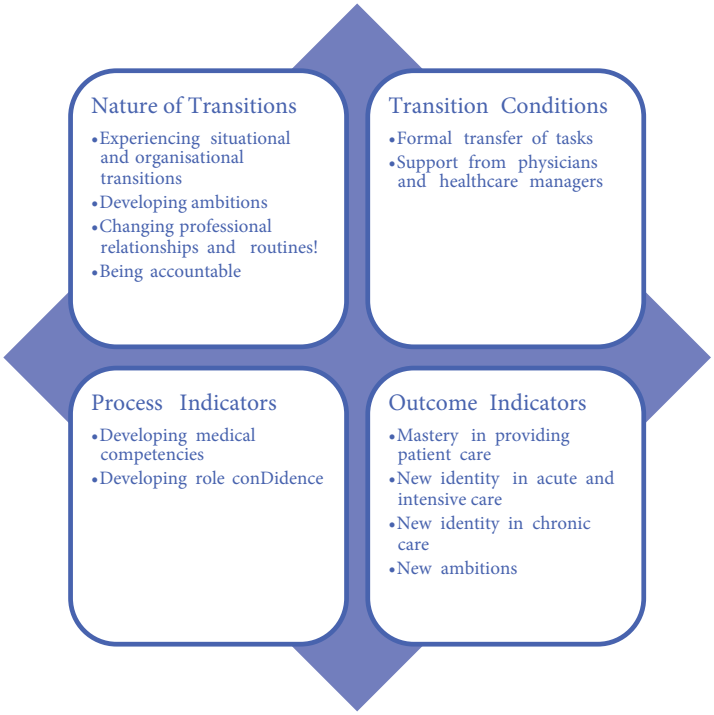

Figure 2: Study findings connected to the Transitions Framework of A. Meleis (2010)

DISCUSSION

This study was undertaken to explore the role transition from nurse to NP. All findings could be connected to elements of Meleis's Framework of Transitions, but not all elements of the Framework were connected to the findings. The finding of this study is further discussed in relation to existing literature below.

Nature of Transitions

The participants' ambition of taking more responsibility in providing patient care marked the beginning of their transition, and could initiate also a next cycle of transitions. This corresponds with the notion that transitions have no ending point (Meleis, 2010). Meleis emphasized that persons repeatedly experience transitions, leaving behind one set of roles and relationships while establishing new ones. This was confirmed in this study. Studies in other countries have focused on NP role transitions during education (role

acquisition) or at work (role implementation) (Hamric, Hanson, Tracy, & O'Grady,, 2014), but in the Dutch context, these phases could not be distinguished. In the work-study program that our participants followed, educational and professional role changes occurred simultaneously. The study results were comparable with the findings from Brown & Oshansky (1997), Kelly & Mattews (2001), and Heitz et al. (2004): all described an initial crisis in confidence and competence. In our study, the participants felt particularly distressed after they became accountable for patients' care and wellbeing. All transition properties from Meleis's Framework were visible in the findings.

Transitions Conditions

The participants' personal meanings were influenced by existing cultural beliefs about good care in hospital settings that are dominated by medical discourse. As pioneers, they lacked good nursing role models and NP protocols. At the same time, they depended on the physicians' support and encouragement to take on their new authorized medical tasks. This resulted in the development of a medicalized role content. These conditions were in congruence with what happened in the USA at the start of the NP movement. In the first educational programs, physicians served as instructors teaching physical examination and clinical reasoning (Fairman, 2008). Consequently, the first American NPs themselves were ambiguous about their new role. Were they being trained to become the doctor's assistant, or were they enlarging a special set of skills and knowledge particular to nursing? Many studies, cited in Bryant-Lukosius et al. (2004), showed that initially all advanced nursing roles had an emphasis on physician replacement rather than on a patient-centred, health-focused, holistic nursing orientation. As new activities become more medically driven and focus on the disease, the nursing elements of the role could become less visible. Therefore, greater involvement of NP instructors in the master programs is needed for a new phase in the Dutch NP role development.

Process Indicators

The findings related to the process indicators as defined by Meleis (2010) showed that the participants transitioned from being disconnected from the nursing profession to being connected with NP colleagues and physicians. The participants perceived the role transition as a push outwards into new territory, and rather not as advancing in the nursing profession so as to be able to address patients' needs that physicians fail to meet. In this study, 'being situated' meant that the participants had gained a place in the medical care process next to physicians. The participants' subjective appraisal of the transition was that they needed to become skilful in medical reasoning, managing patients' medical care, and handling medical procedures next to 'settling in'. Therefore, they spent time and energy to gain knowledge and skills in the medical domain, while they felt indifferent to advancing in nursing. The participants claimed they could solve nursing care problems

intuitively. This 'understanding without a rationale', as Benner and Tanner (1987, p.23) defined intuition, agrees with the finding that most of the participants were not able to explicate the essence of nursing. Formulating a diagnosis was interpreted as searching for a pathological abnormality and not as gaining a comprehensive insight into patients' health-related problems. The jurisdiction over medical diagnosing was subject to dispute because the participants realized they needed special knowledge and skills for an accurate diagnosis. However, they did not consult a nursing knowledge base to find out how to address specific health problems. The participants defined the nursing part of their NP role merely as 'being concerned about the patient' – a type of caring that does not require expert knowledge. But there is more to it. Nursing is the offering of various aspects one possesses as a human being: intellectual (analytical thought and clinical judgments to meet health needs), psychological (feelings that are part of human experiences), spiritual (to answer the question: what is the meaning of this), and physical (Scotto, 2003).

Outcome Indicators

The participants developed NP roles in line with the typical organizational environments of hospital wards and outpatient clinics. The NP role on the hospital wards was related to continuity of medical treatment in acute and intensive care settings and comparable with the evolving of the hospitalist's role in the USA, as described by Rosenthal and Guerrasio (2010). Although hospitalists are mostly physicians, currently also NPs are working as hospitalists, whose primary focus is the general medical care of hospitalized patients including critical patient care and the improvement of the systems of care surroundings those patients (Kleinpell et al., 2008). The second NP role the participants developed was also related to continuity, and particularly that in chronic care. This role is comparable to the primary care role of NPs in many countries that seems to be well suited to address the needs of persons with chronic diseases (Barkauskas, Hanson, Tracy & O'Grady, 2011). Still, the coordination of complex situations was not perceived as mastery in nursing, although this is essential for moving patients safely and efficiently through the system (Hamric et al., 2014). Developing this core activity, as well as convincing others that NPs' care coordination is quite effective, will enrich professional practice as a whole.

Strengths and Limitations

The concept of transition was useful for describing the development of NP roles. However, our findings are limited to the perspectives of the NPs themselves. Meleis's Framework has more elements than the ones we used in this study, and in particularly these related to the healthcare community. Inclusion of registered nurses and physicians in the study could have provided different perspectives on the transition outcomes. Another limitation was that the respondents only worked in hospital settings. NPs working in general practices and in nursing homes could have a different focus on advanced nursing. Still, this is the

first study of NP role transitions in the Netherlands and the findings could form the basis for further research. Ethnographic studies such as the one by Johnson on NP-patient conversations (1993) could help understand the actual NP role and practice in daily care. Subsequently, the 'Nursing therapeutics' element of Meleis's Framework deserves to be studied.

Directed Content Analysis, as described by Hsieh and Shannon (2005), was useful because it helped to explore transitions in this context. An inductive approach was still useful to gain deeper understanding of the components of the transitions. The linking of inductively developed codes to an existing framework enabled interpretation of the findings and positioning them in a well-established middle range theory.

CONCLUSION

A transition is an intense process towards renewed self-confidence and a novel identity that can induce feelings of distress. These universal elements of Meleis's Framework also characterized the NPs' role transitions explored in this study. The outcome indicators showed varied roles on behalf of the continuation of patient care with an emphasis on the medical part. A healthy transition towards new roles requires NPs to have the ability to define the higher level of their nursing skills and to communicate the value of nursing.

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CHAPTER 5

RHETORIC OR REALITY? WHAT NURSE PRACTITIONERS DO TO PROVIDE SELF-MANAGEMENT SUPPORT IN OUTPATIENT CLINICS: AN ETHNOGRAPHIC STUDY

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ABSTRACT

Aim. The aim of this paper is to describe how nurse practitioners enact their role in outpatient consultations, and how this compares to their perception of their responsibility for patients with chronic conditions. **Background.** Nurse practitioners working with patients with chronic conditions seek to support them in self-managing their diseases. **Design.** An ethnographic study. **Methods.** Episodic participant observations (in total 48 hours) were carried out combined with formal interviews. The study population consisted of a purposive sample of nurse practitioners working in five outpatient clinics related to chronic care in one university medical centre in the Netherlands. Two different types of clinics were selected, namely 1) for patients with episodic flare-ups, and 2) for patients with diseases requiring life-saving procedures. **Results.** The nurse practitioners perceived the monitoring of patients' treatment as their main professional responsibility. Four monitoring strategies could be distinguished: 'Assessing health conditions', 'Connecting with patients', 'Prioritizing treatment in daily living', and 'Educating patients'. **Conclusion**. While nurse practitioners considered building a relationship with their patients as of utmost importance, their consultations were mostly based on a conventional medical model of medical history taking. Little attention was paid to the social, psychological, and behavioural dimensions of illness. Nurse practitioners in this study seemed quite successful in their extension into medical territory, but moving patients' illness perceptions to the background was not conducive to self-management support. **Relevance to clinical practice.** By their medical subspecialty expertise, nurse practitioners have a major role in the longitudinal process of the management of chronic diseases' treatment. Supporting patients to reduce the impact of the disease and its complications requires nurse practitioners to develop new coaching strategies designed to meet patients' individual needs.

What does this paper contribute to the wider global clinical community?

- No studies have been conducted on how NPs fulfil their role in chronic care related to self-management support;
- Observational data in addition to earlier collected interview data in interviews gave insight into NP role enactment in relation to the support of patients with various chronic conditions;
- The study participants perceived the monitoring of patients' treatments as their prime professional responsibility;
- To provide effective self-management support to patients with chronic conditions, nurse practitioners need to develop a goal-oriented coaching style, sharing patients' ideas about a good life, taking patients' emotions and their social networks into account.

INTRODUCTION

The medical management of acute symptoms is considered insufficient for patients with chronic conditions. Care providers need to understand the fundamental difference between episodic illness that is identified and cured, and chronic conditions, which require coping with the demands of daily life (WHO, 2005). A person's ability to manage the symptoms, treatment, physical and psychosocial consequences, and life style changes inherent in living with a chronic condition is called 'self-management' (Barlow, Wright, Sheasby, Turner & Hainsworth, 2002, p.178). This ability is key to the concept of 'health' as formulated by Huber et al. (2011, p. 237): 'health is the ability to adapt and to self-manage one's own wellbeing, in the light of physical, emotional and social challenges of life'. As nursing includes the protection, promotion, and optimization of health and abilities (ANA, 2003), supporting chronic patients' self-management activities is part of nurses' responsibility. From Dwarswaard, Bakker, van Staa & Boeije's review (2015) we know that chronic patients appreciate instrumental-, relational-, and psychosocial support from family, co-patients, and healthcare providers. In particular, nurse practitioners [NPs] can make a positive difference to care by incorporating research, education, and a leadership role in their practices (Hamric, Hanson, Tracy, & O'Grady, 2014). This paper aimed to demonstrate what NPs actually perceive as their responsibility to chronic patients and how they fulfil their role in chronic care, in particular related to self-management support.

BACKGROUND

By their medical subspecialty expertise, NPs have a major role in chronic diseases treatments (Borgmeyer, Gyr, Jamerson, & Henry, 2008; Greene & Dell, 2010; Rideout, 2007; Schuttelaar, Vermeulen, Drukker & Coenraads, 2011). Brooten , Youngblut, Daetrick, Naylor & York (2003) showed that the main NP function was the monitoring of physical problems and the subsequent patient education and counselling. In the Netherlands, three quarters of all NPs work in hospitals and fulfil two different roles in his setting. One role is related to continuity of medical treatment on hospital wards; the other is also related to continuity of care, but in addition addresses the needs of patients with chronic diseases in outpatient clinics (Ter Maten-Speksnijder, Pool, Grypdonck, Meurs, & van Staa, 2015). Been-Dahmen, Dwarswaard, Hazes, van Staa & Ista, (2015) showed that Dutch nurses (registered nurses as well as NPs) working in hospital care had mainly a medically oriented perception on self-management support. However, supporting patients to reduce the impact of the disease and its complications requires NPs to develop their specific nursing expertise (Grypdonck, 2013). Information about day-to-day in-depth experiences could give insight in the priorities NPs are setting in their daily work. We formulated

the following research question: *How do nurse practitioners enact their roles in outpatient clinics and how does this compare to the perception of their responsibility to patients with chronic conditions?*

THE STUDY

Aim

The aim of this study was to examine how NPs support patients' self-management during outpatient consultations.

Design

A qualitative ethnographic design was chosen, combining semi-structured interviews with participant observations. This approach is particularly suited to focus on practice with opportunities to gather data directly from the participants' field of work (Creswell, 2013).

Sample

The study population consisted of a purposive sample of NPs working in outpatient clinics related to chronic care in one university medical centre. Participants were recruited from medical departments involved in the scientific program Nursing Research into Self-management and Empowerment in Chronic Care [NURSE-CC] (Van Staa & Dwarswaard, 2013). To reach a variation of participants (Polit & Beck, 2013), two different types of clinics were selected, namely 1) for adult and adolescent patients with diseases with episodic flare-ups, (rheumatoid arthritis [RA]), and 2) for adult and adolescent patients with diseases requiring life-saving procedures (kidney transplants [KT] or radiotherapy [RT]). After initial analysis of the data, one NP working in a clinic for children with severe eczema [E] who already applied aspects of self-management support was added to the sample. The NP clinics represented patients across the entire lifespan and with varied cultural backgrounds.

Data Collection

Interviews

In 2014 twenty-seven registered nurses and nurse practitioners were administered semi-structured interviews. The first question was: 'could you tell me something about your experience in working with patients with a chronic condition?' To gain understanding of their practices the interviewees were encouraged to give examples and details. The interviews were audio-recorded and transcribed verbatim. From this sample five NPs,

including the added one, were selected for the observations and their interviews were analysed secondly.

Observations

Outpatient consultations of five NPs were observed not until one year after the interviews, to avoid contamination with the interviews. Each NP was observed one day a week for two weeks. The NPs had been told that the overall goal of the research was to gain insight into their consultations related to self-management support, which might help to develop new interventions. The field notes made were retyped the same day to ensure that the NPs' precise spoken words during the consultations were recorded. Notes of informal interviews with the NPs, alongside the observations, were also included in the observation transcripts (Pope, 2005). The observer (AM) also kept a reflective diary about the process and outcomes of the observation events to avoid reaching premature or unsupported conclusions as well as to suggest points for further observation (Emerson, Fretz & Shaw 2011). Data collection was stopped after saturation of the data was found.

Ethical Considerations

Ethical approval of the protocol including recruitment methods was obtained from the Erasmus MC Medical Ethics Review Committee (MEC-2014-629). The principal investigator (AM) recruited the NPs and made clear that data would be handled confidentially and could not lead to identification. A code was assigned to each participant. The main researcher (AM) safeguarded the code. Participation was voluntary and a written informed consent was obtained from all NPs. They were free to end their participation at any time for any reason without any consequences. The NPs explained the purpose of the study to their patients prior to the consultation observations and sought their consent. Patients were informed that the focus of the research was on nursing practice, not on them, and that no identifying data would be shared. They were free to ask the researcher to leave the room.

Data Analysis

The data were analysed according to the spiral of analysis as described by Boeije (2011). This means that the researchers engaged in a process of moving in analytic circles rather using a fixed linear approach. Analysing the data started at the moment the researcher recorded the field notes and considered what the interactions and field notes meant. Memos were written about the essence of what was happening in the NP-patient encounters. First, two researchers (AM, JD) each independently read the field notes several times and discussed the memos. This was important to determine what should be looked for in the data (Dierckx de Casterlé, Gastmans, Bryon, & Denier, 2011). In the actual coding process, the principal investigator (AM) looked for patterns of thought

and behaviour across both the notes and the interview transcripts. As soon as categories emerged, the data from these categories were pulled together and compared before they were adopted into the final categories. Identified categories were discussed within the research team until consensus was reached. The qualitative data analysis software package Atlas.ti 1.0.25 for Mac was used.

Rigour

Using two ways of data gathering we were able to contrast the NPs' stated intentions in the interviews with their actual patient care. The interview transcripts were used to triangulate the observational data for the purpose of validating conclusions (Polit & Beck, 2013). To establish credibility and to ensure that the NPs' work was accurately reported, the researchers' interpretations were discussed within the research team. To enhance accuracy of the findings, the results of each observation cycle were presented to the observed NP. The NPs were asked whether the field notes represented their practice properly. When the analysis was completed, preliminary findings of one case were discussed in a meeting with NPs and chronic care experts to check the researchers' interpretation of the situation (Polit & Beck, 2013).

FINDINGS

Participant Characteristics

The participants were five women in the age range of 35 to 45 with a Master's degree in advanced nursing practice. They had previously worked as senior nurses in a variety of clinical settings; they all had been in post as NPs for 4 to 8 years.

The Categories

A recurrent pattern in the data was a focus on identifying and reducing side effects of the medical treatments, ensuring that patients could hold on to their treatments initiated by the medical specialists. This led to the overarching core category of 'monitoring patients' treatments' (Table 1. Findings). Related to the core category, four subcategories were identified: 'Assessing health conditions', 'Connecting with patients', 'Prioritizing treatment in daily life, and 'Educating patients'. The core category and subcategories will be described illustrated with citations from the observations [Obs.] and interviews [Int.].

The core category: Monitoring patients' treatments

'Monitoring patients' treatments' meant that NPs checked the progress or regress of the diseases and the development of complications. Patients with diseases characterized by episodic flare-ups needed treatments to keep their symptoms in remission as long

Table 1: Findings

Core Category	**Monitoring Patients' Treatments** Checking disease regression or development of complications			
Subcategories	**Assessing health conditions**	**Connecting with patients**	**Prioritizing treatment in daily living**	**Educating patients**
Characteristics	Start with an open question, but no further exploration of patient experiences NPs' priority is review of clinical signs and symptoms Stimulating patients being actively involved in health assessment sometimes	Interacting socially Establishing NP-patient relationship Barriers by patients' reluctance to talk and acute problems	Stimulating to live as healthy as possible Putting disease at the forefront of life	Information about the disease is seen as a prerequisite for adherence Instruction is often used to stimulate patients to control symptoms Coaching of patients' goal-setting to deal with consequences of the disease sometimes

as possible, and to prevent complications like deformity and disability in the case of rheumatic arthritis. Patients with diseases that needed to be treated with life-saving procedures, take high doses of medications in the early months e.g. to prevent kidney transplant loss. NPs realized that side effects could negatively affect treatment adherence and told their patients they should adhere to the therapy for the sake of their well-being:

> *Children with chronic skin diseases have to break through the damaging 'itch-scratch cycle' by the consistent use of creams. (Int. E)*

Subcategory: Assessing health conditions

After medical specialists had initiated treatments, NPs assessed patients' health conditions conform medical standards. When side effects became too severe treatments were adjusted according to protocol. The NPs usually started the consultation with a single question: 'How are you?' In the interviews, the NPs explained this question is the perfect way to get insight into patients' problems:

> *[Patients] want to talk and after one open question they tell their problems, which could be anything. Such as: not being able to accept the disease or doing exercises, worrying about nutrition, a divorce, just anything. (Int. RA)*

Most patients who visited the RA clinic answered this question with: 'bad', even when the disease was still in remission. This was in sharp contrast to the answers from patients who visited the KT clinic. They always answered: 'fine', as the NP explained:

> *Although they have a wound problem, or fluctuating blood glucoses, etcetera, these patients perceive an enormous progress in their energy levels because of the new kidney. (Int. KT)*

The consultations were loosely structured, and it was not clear when assessment of the health condition actually began. Often when a patient started to tell his or her problems after the opening question, the NP explained she would respond to that later on. Firstly, the NP wanted to obtain the medical signs and symptoms as an indication of the disease regression and then informed about bodily functions such as sleep quality, fever, morning stiffness, or blood sugar levels. Many patients had prepared the consultations, sometimes resulting in a shared assessment:

> *The patient puts her notebook on the table, 'here are my results'. 'Let's have a look', says the NP, and she opens a file on her computer with the blood tests results. Together they discuss the findings. (Obs. KT)*

After the initial assessment, NPs performed physical examinations to collect more data, and measured the disease activity from the combined data, sometimes using specialized tools. Although the NPs took notice of the patients' experiences, they usually adjusted treatments based on their own examinations. Patients' experiences were subordinate to their own judgment as in the following case:

> *'How are you?' the NP asks. Alice answers: 'Bad, I had a lot of pain last week', and she hands over a piece of paper. This contains Alice's recordings on when she suffered from pain in different joints. The NP does not pay much attention to it but starts a physical examination. From the tenderness of Alice's joints in combination with her blood levels as well as her mark on the VAS scale it is concluded that the disease is still in remission. The NP explains how she came to this conclusion, for which Alice's notes were not influential. The NP advises Alice to take paracetamol more frequently. (Obs. RA)*

All NPs felt they had to deal with a tight schedule. Information usually needed to be collected within 15 to 20 minutes, including solving problems regarding wounds, diet, and drug side-effects etcetera; answering questions of patients and relatives, and reporting all findings in the electronic patient record [EPR]. One NP held 30-minute clinics and took

time to report in the EPR after the patient had left. During the consultations most NPs were checking the EPR constantly, e.g.:

> *While the patient tells about his wound leaking fluid, the NP compares the patient's wound status with a week earlier in the EPR. Also she checks the haemoglobin and albumin concentrations. (Obs. KT)*

The strategy 'Assessing health conditions' implied that NPs stimulated patients to be actively involved into treatment monitoring. However, the NPs mainly picked up the clinical signs and symptoms they considered as relevant to the outcomes of their health assessments. The consultations were mostly based on a conventional medical model of medical history taking, assuming that someone's health condition can be fully accounted for by deviations from normal biological function. Little attention was paid to the social, psychological, and behavioural dimensions of illness.

Subcategory: Connecting with patients

NPs invested in social interaction with the patients, and the patients did the same, as they usually had known each other for a long time. One patient for example asked about the pregnancy of the NP's colleague. NPs tried to establish a relation to the patient as soon as possible:

> *Ann takes her seat as if she wants to leave the room as soon as possible. Ann's face is dismissive while she looks at the NP behind the desk. The NP says: 'this is the first time we meet and as a nurse I support you in bearing the consequences of the radiotherapy, which are quite heavy. So, I have the same question I always ask: how are you?' Ann looks a bit sceptic and says: 'well, this weekend I had a lot of diarrhoea, I had this earlier, but now I had it all day long'. The NP explains why the intestines may give trouble after radiotherapy. Ann understands what is going on and she has a friendlier look on her face now. The conversation continues about diet and the impact of the treatment on Ann's condition. Ann looks more relaxed now and before she leaves the room, she gives a little tap on the NP's hand and says: 'thank you!' (Obs. RT)*

In this case, the patient connected with the NP by recounting her physical problems. The NP's explanation of the origin of the symptoms transformed Ann's dismissive attitude into openness. In the interviews, NPs emphasized that having a good connection with patients was of utmost importance to reach treatment goals. Still, the NPs did not always

invest in this, especially when patients did not communicate spontaneously or when a relative 'did the talking':

> *The patient occasionally whispers something in Hindi to her daughter. It is not entirely clear whether the patient participates in the conversation. The daughter does most of the talking; only occasionally she translates some information. (Obs. KT)*

Although keeping a record is a key element of continuity of care, the constant use of the EPR was influential to the conversations also. Some NPs stopped talking while making electronic notes. Others switched to a lighter topic during typing, such as holidays or school. In both situations, they lost eye contact with the patient. After having finished making notes they switched back to illness' issues, thereby sometimes confusing the patient.

> *The NP's fingers are tapping on the keyboard. While making her notes, she tries not to lose contact with her patient by asking the girl about school. But the girl did not seem very keen on answering this question. (Obs. RA)*

Making contact was problematic when patients had acute health problems that were difficult to handle in a tight time frame. Although in the next example it was obvious that both patient and her partner were shocked by the bad news, NPs rarely addressed the emotional aspect of the situation.

> *After the blood sample was taken, the young couple sits in front of the NP' desk waiting for the results. The woman looks ill and her husband looks very worried. The NP tells them that the blood results are not good and the young woman says, 'just as I expected, I am so tired'. The NP says that she regrets that the serum creatinine level has risen. Then, events rapidly accelerate. The NP calls the physician in for a consultation, and he tells the patient a percutaneous nephrostomy is needed to save the kidney transplant. The husband remains silent; his wife asks for some explanations. After the physician has left the room, the NP informs the patient how she can manage the catheter at home. The NP has to arrange the hospital admission, and she asks the couple to wait in the full waiting room. The NP works quickly because she is already running 20 minutes late. Eventually she informs the couple in the waiting room where they are expected to go to. (Obs. KT)*

The strategy 'Connecting with patients' was also undermined when patients, for different reasons, were reluctant to talk about their experiences. In the interviews, the NPs emphasized they possessed empathy 'because they were nurses'. Empathic behaviour during the consultations was indeed observed. On the other hand, when acute problems needed to be solved, the NPs focused on the physical problems and the practical tasks they had to perform while leaving little room for the emotional impact of these problems.

Subcategory: Prioritizing treatment in daily living

In the interviews, NPs explained that prioritizing treatment in daily life would enable patients to reduce symptoms and improve their quality of life. They emphasized that patients should accept medication and its ramifications, such as having insulin injections daily. Patients with a kidney transplant must live as healthy as possible to preserve the new kidney but also take immunosuppressive drugs. These normative expectations were also addressed during the observations. Patients treated for cancer were told to reduce other activities, such as work, until the end of treatments. Patients with RA must follow the treatment' policies strictly to reduce the disease activity and to minimize possible long-term effects. The NPs expected patients to put the disease at the forefront of their lives as the next observation illustrated:

> *Femke, a 15-year-old girl came in with her mother. The NP asks: 'hi, how are you'? 'Terrible!' answered Femke, She tells that she is very tired, probably because of the medication. Femke's mother adds: 'Femke's teacher asks me as well: what is going on? Why is Femke not happy anymore?' After some discussion between the NP, Femke and her mother about the cause of her fatigue and what to do about it, the mother says: 'I don't believe Femke really understands what is going on with her and the disease'. Femke reacts: 'I do understand, but I don't believe the half of it.' The NP shows Femke were she can find a lot of information about the disease on the Internet. She explains: 'this could be helpful to explain to others what it means to have rheumatoid arthritis.' She suggests Femke's mother to contact the nurse counsellor who is familiar with problems of young people with RA. (Obs. RA)*

This case shows patients' stressful life circumstances as well as the complex problems NPs may have to handle. Femke's mother opined that Femke resisted her body failure, which affected her activities, while Femke struggled with her identity as a person with a chronic condition. The NP talked about her wellbeing in class and the importance of being connected to her classmates, while Femke communicated that she refused to believe that her health and life had changed for the worst. The strategy 'Prioritizing treatment in daily living' implied that NPs stimulated patients to cope with the burden of the disease and

inform significant others when and why they were feeling not well, while the emotional impact was overlooked.

Subcategory: Educating patients

In the interviews, NPs mentioned struggles with tackling adherence problems with patients. Even if patients say they understand the information given, they often seem to forget it all when they get home. Educating patients is therefore considered an important and repeated activity of NPs. The observations showed that the NPs indeed provided a great deal of information and instructions, and – to a lesser extent –coaching.
The NPs exerted themselves to tell patients about the treatment and its effects. Knowing how medication and treatment outcomes are related was seen as the main prerequisite for patients to adhere to their treatments. In the interviews, NPs made clear that following instructions is an effective way to control symptoms or feel better. The NPs strived to give their patients accurate knowledge about the medicines they take, and how these work. They discussed physical conditions related to abnormal blood levels, explained the relations between the results of the examinations and told the patients why they had to adjust the dose of the medication. The importance of taking proper pain medication, physical exercise, and good nutrition was explained over and over again. To complement their educational tasks, NPs used brochures and websites from patient organizations, or referred patients to trained nurse counsellors. Indeed, the NPs were successful in this regard as some consultations resulted in 'expert talk' about the medical condition:

> *A asks, 'you also take Selokeen® 3 times a day?' The patient answers 'no, 1 time 200 milligrams'. And what were the lab results?' 'Well', says the NP, 'the creatinine went down, so your kidney is doing well. Only the potassium should be lower, so be careful with your food'. The patient answers, 'yes, I am. But I am still a little bit out of breath, I see that the haemoglobin is not so high still, could that be the cause of it?' (Obs. KT)*

Some NPs talked with patients and families about making choices. These NPs gave support in end-of-life issues, or invasive treatments meant not to cure but only to relieve signs and symptoms. The coaching implied that patients were explicitly asked to ultimately make choices. During consultations, one of the NPs helped the parents and their child through the process of learning how to incorporate the treatment into daily life. She had developed a goal-setting coaching program to encourage patients to think systematically about actions and consequences. After a consultation with a patient who wanted to step over to a higher educational level school, she explained:

'Sooner or later he has to think how he should cope with his eczema as a condition to reach that goal'. (Fieldnote E)

So, NPs used different strategies to help patients get informed about their conditions and the choices they have regarding treatment. In the interviews they said that their educational activities were often unsuccessful and they preferred to coach patients rather than to tell them what to do. However, the observations showed that the latter was still a challenge for most of them.

DISCUSSION

Monitoring patients' treatments as prime professional responsibility makes NP care exchangeable with care provided by a junior doctor. Earlier research showed already that NP care could be equivalent to medical care (Newhouse et al., 2012). The added value of NPs for care provided by a junior doctor is that NPs are expected to blend the medical management of patients into their nursing role in order to explore both the disease and illness experience, and incorporate prevention and health promotion (Bryant-Lukosius DiCenso, Browne & Pinelli, 2004). Supporting self-management in patients with chronic conditions requires more than the technical competence of monitoring a patient's treatment. A chronic care approach demands a shift from disease-oriented, provider-centred, and hospital-driven care to care that is person- and family centred (WHO, 2005). A major challenge of nursing is to intertwine instrumental, technical-scientific work with effective communication and relational skills (Benner, Tanner, & Chesla, 2009). During their clinical encounters, NPs have the opportunity to develop a relationship sensitive to patients' perspectives. Interpersonal interactions are fundamental to promoting patient partnership in nursing care, which is needed to support patients' self-management in congruence to their needs (Brykczynski, 2012).

However, in this study the NPs were **connecting with patients** with the aim to reach treatment goals. They seemed to overlook the therapeutic value of a caring relationship that honours the wholeness of others (Swanson & Wonjar, 2004), and that answers to the complex variety of patients' needs (Attree, 2001). The NPs assumed that open questions would lead to open conversations. However, the 'how are you' opening question did not always encourage patients to speak up about other issues than physical symptoms. Furthermore, most NPs continuously multi-tasked during consultations. By making small talk on other topics than medical issues, conversational dead space was avoided, but the disruption interfered with the quality of the communication and consequently the patient involvement (Street et al., 2014). NPs' communication style was more biomedical than biopsychosocial as they predominantly focused on signs and symptoms and gave

directions with little to no patient input. Still, a review (Charlton et al., 2008) found that the biopsychosocial communication style was associated with increased patient satisfaction; better adherence to treatment plans and improved health. A likely explanation is that this style of communication encourages patients to share ideas; establishes patients and NPs as partners; and takes patients' emotions and social environment into account (Anderson, 2002).

The NPs **assessed the patients' health conditions conform medical standards.** The NPs gave some attention to patients' experiences but adjusted treatments solely based on their own examinations. Mudge, Kayes and McPherson (2015) reviewed the literature and also found that clinicians used clinical markers as the primary indicator of successful disease control. The NPs in this study showed a traditional approach of medical history taking that concentrates on the pathological disease but leaves unaddressed the needs and perspectives of the patients. Consequently, self-management practices and problems encountered were rarely elicited. Furthermore, a mutual agreement about what to discuss during the consultations, as recommended by Mauksch et al. (2008), was not reached. Additionally, time pressure pushed the NPs towards a directing rather than a guiding communication style, confirming findings of Howie, Heaney & Maxwell (2004) in general practitioners.

Patients' illness-specific concerns, such as managing bodily responses were a central and well-developed element in the NP-patient encounters. Nevertheless, Barlow et al.'s (2002) broad definition of self-management support implies that healthcare providers also need 'the ability to listen to patient's stories of illness, grasp and honour their meaning, and be moved to act'. Charon (2001, p.1897) argued that story telling is a therapeutically central act, because finding the words to contain the disorders and worries gives shape to and control over the chaos of illness. Therefore, next to taking a full and accurate biomedical history the patients' ideas and concerns should be listened to. This might imply a restructuring of the consultations.

NPs focused on **prioritizing treatment in daily living,** which is a providers' perspective in which patients' illness' perceptions are easily moved to the background. In line with Kang and Stenfors-Hayes' results (2015), the consultations were set up in such a way that patients are expected to tell stories about their lives not therapeutically but relevant to the medical issues at hand. Kang and Stenfors-Hayes (2015) argued that for patients the obligation to be involved in the management of their illness could become an extra burden. Likewise, when health professionals take a greater authority to define what it means 'to live well' with the disease than patients this may result in an emotional burden. Schulman-Green et al. (2012) have related self-management tasks of patients with chronic conditions to 1) illness needs, 2) activating resources, and 3) living with a chronic illness. Most NPs did not systematically support patients in the latter two tasks. If they did, it was usually done in the consultation slack time.

Intensive **patient education** was the most used strategy to stimulate treatment compliance. Still, this did not necessarily result in behaviour change. For this reason, some NPs wished to shift toward a coaching strategy, which may provide alternative means for facilitating behaviour change (Hayes & Kalmakis, 2007). Spross and Babine (2014) propagate a goal-oriented coaching style as appropriate to NP care as it supports patients and families to achieve health-related goals. Apart from having unique needs, people also differ across age, gender, and ethnicity in their preferences for an active or a more passive role in the monitoring of their treatments and in the extent to which they need self-management support (Dwarswaard et al., 2015). By building collaborative relationships NPs' could support patients to make their own choices, create a plan to achieve realistic goals, commit to the plan, and stay with it (Hayes & Kalmakis, 2007). The interviews and the observational findings related to patient education showed a difference between what the NPs perceived and what they really did in practice. In a qualitative meta-synthesis of four studies on person-centred nursing, McCormack, Karlsson, Dewing, & Lerdal,. (2010) also found differences between ideals and the concrete routine practices that remained routinized and ritualistic, and offered few opportunities to form meaningful relationships. Argyris and Schön (1974) referred to this phenomenon in terms of the espoused theory and the theory-in-use; the authors suggested that reflection could play a key role to reveal the theory-in-use. This is confirmed by Mudge et al's literature review (2015) on self-management support. Clinicians emphasized that training alone was not sufficient to change their approach to patients. Especially, the training packages that included a reflection component could facilitate the transformation of clinical practice from a traditional patient education model toward patient-centred education.

The difference between rhetoric and reality could be explained by several factors related to the hospital context, such as the medical culture of the emphasis on cure and the limited length of consultations (Harding et al., 2008; Davidson, 2007). The NPs' working environments are small communities of mostly physicians and some NPs with shared norms and values. The NPs are supervised by the physicians and obligated to strictly follow medical protocols (Wallenburg, Janssen & de Bont, 2015). The medical specialists also defined which medical tasks the NPs are permitted to do. Therefore the lack of control over their own practices could be a barrier for NPs to involve patients in decision-making with respect to the management of their condition (Tracy, 2014). Physicians' support and encouragement to take on new authorized medical tasks stimulated the NP role development towards medicalized roles (Ter Maten-Speksnijder, Pool, Grypdonck, Meurs, & van Staa, 2015). Thorne et al. (2000) noticed that health care professionals say they are supporting the empowerment model of health care without accepting its underlying goals. The NPs in this study mainly attended the technical aspects of disease management while they emphasized their ambitions to shift toward a more person-centred coaching

approach. Further research is needed to fully study possible factors to understand the dissonance between the NPs espoused values and the enacted practices.

Strengths and Limitations

The strength of this study was that its observational data in addition to earlier collected interview data in interviews gave insight into NP role enactment in relation to the support of patients with various chronic conditions. Second, the NPs were given the opportunity to inspect the researcher's field notes so as to verify that these reflected the NPs' perspectives. A limitation was that we explored one side of NP-patient encounter at the expense of the other— the patient. Furthermore, the study was conducted in one university hospital setting only and was limited to five outpatient clinics.

CONCLUSION

NPs in this study perceived the monitoring of patients' treatments as their prime responsibility. While their extension into medical territory seemed quite successful, their core role, building supportive relationships with their patients to facilitate living a good life received far less attention. We recommend NPs to develop care strategies designed to meet patients' individual needs. Next to taking a full and accurate medical history, it is important to uncover what patients view as problems, how they are responding to these, and what the implications are for daily life and life goals. Implementing a coaching intervention will be one step forward in supporting patients' self-management. Further steps would be the following: asking patients to prepare for the consultations, communicating the aim of the consultations as well as agreeing on the role of the patient and the NP in these consultations, and using research-informed learning strategies adapted to patients with chronic conditions. This could start the process of shared decision making whereby the NPs and patients work together to make healthcare choices that enables patients to manage their health well.

Relevance for Clinical Practice

Nursing includes the protection, promotion, and optimization of health and abilities, so supporting chronic patients' self-management activities is part of nurses' responsibility. In particular, NPs can make a positive difference to care by a goal-oriented coaching style, sharing patients' ideas about a good life, and by taking patients' emotions and their social networks into account in their practices.

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CONCLUSION

GENERAL DISCUSSION AND FUTURE DIRECTIONS

This thesis was set out to explore how NPs perceive, develop and enact their professional responsibility. They have to distinguish themselves from registered nurses by three criteria: independency, expertise, and an active attitude to role development. The first part of the thesis addressed the public debate's impact on the development of the NP profession in the Dutch healthcare arena, and the opportunities to provide care in an independent capacity. The second part focused on NPs' expansion of expertise through adopting a reflective attitude, while the third part explored the role transition from nurse to NP, and examined how NPs enacted their roles in outpatient clinics for patients with chronic conditions. In this concluding chapter, I will present and discuss the main findings of the studies in this thesis, and reflect on the strengths and limitations of these studies. Lastly, directions for future practice, education, and research will be laid out.

NURSE PRACTITIONERS' INDEPENDENCY

The first aim was to explore the public debate on the NP' role development in the Netherlands and how this shaped NPs' professional responsibility.

Conclusion

The document review on the Dutch debate on the new role showed an emphasis on task substitution from physicians to NPs (*Chapter 1)*. Nurse leaders made the point that the expanded role may benefit patients with complex problems. But, doctors and policymakers overshadowed them with arguments relating to efficiency increase and cost reduction in healthcare. The interviewed NPs indeed wished to be more involved in medical decision-making (*Chapter 4)*. They reasoned that patients could benefit from their broader task scope, while it would also boost their careers. The limitations with respect to these ambitions came to light in the debate *(Chapter 1)*. Physicians were reluctant to transfer the final responsibility for patient care to NPs. The NPs were only allowed to provide medical care if they would strictly follow the medical protocols and accepted the necessity of being supervised by physicians. When the new NP role was still in its infancy, physicians expressed doubts about NPs' medical competences, although the research studies described in *chapter 1* provided preliminary evidence that NPs could manage condition-specific cases and achieve outcomes similar to those in medical management.

The NP students who participated in our studies indeed felt the restrictions of a limited authority (*Chapter 2)* as their scope of practices seemed limited to nursing homes, general practices, and hospitals. Their colleagues, the physicians, took the view that translating a patient's signs and symptoms into a medical diagnosis with the action

plan as the end point still was a doctor's task. The findings in *the chapters 4* and *5* showed that the NPs working in hospital wards such as cardiothoracic surgery, and in outpatient clinics for patients with chronic illnesses, agreed with them. They saw the NP role as mainly monitoring the on-going interventions once the medical specialists had made the diagnosis and started the treatments. Only NPs who worked in emergency departments or neonatal intensive care units seemed to be permitted (and thus should be able) to diagnose a medical condition and to start treatments without direct oversight from doctors, in light of the acute care needs *(Chapter 4)*.

After some years, the NPs felt less restricted to provide care in an independent capacity than they had experienced in the beginning of their new careers *(Chapters 4, 5)*. They were permitted to order, perform, and interpret laboratory, diagnostic and imaging studies, prescribing medication and durable medical equipment; medical procedures that until then tended to be the preserve of physicians. Thus, although supervised by medical specialists, most NPs in our studies eventually developed a role with an extended responsibility for care providing in an independent capacity that differs from that of registered nurses with respect to the medical tasks and continuity of care.

Discussion

The claim that NPs should distinguish themselves from registered nurses through more independent practice is in line with international characteristics of the role, identified by the International Council of Nurses [ICN] (ICN, 2002). These characteristics are: - the right to diagnose, - the authority to prescribe regulations, - the authority to prescribe treatments, - the authority to refer clients to other professionals, and – the authority to admit patients to hospital. In the USA this is called 'full practice authority' allowing care providers to assess, diagnose, interpret diagnostic tests, and prescribe medications independently ("Issues At-A-Glance: Full Practice Authority," n.d.). In 21 US states, NPs gained the full practice status and they are also free to establish and operate their own independent practice in the same way as physicians do, so patients have full and direct access to NP-provided care. Although Dutch law authorizes the NPs to practice independently without direct physician oversight, in practice they are restricted by local regulations (*Chapter 1)*. In the USA and Canada, the introduction of NPs dates back to the 1970s and they experienced similar barriers and facilitators as in the Netherlands. In most countries, opposition of the medical profession has been identified as one of the main barriers to the transferral of final treatment responsibility to NPs (Delamaire & Lafortune, 2010). In their study on Dutch NP practices in nursing homes, hospitals and general practices, Wallenburg, Janssen, and de Bont (2015) confirmed our findings that local regulations influenced the extent to which NPs are permitted to provide care in an independent capacity.

In the Netherlands, as in many other countries, role expansion was called for in order to develop new models of advanced nursing practice in collaboration with other disciplines. However, the NPs involved in our studies accepted the norms of medical care, and fitted the new role into existing practices rather than challenging these. The aforementioned study of Wallenburg et al. (2015) also confirmed these findings, concluding that subservience does not support the development of an independent role in Dutch healthcare. Although the NPs we interviewed over the years became more successful in implementing their role, their subservient position to physicians remained. So the lack of control over their own practices could be a barrier for NPs to involve patients in decision-making on the management of their condition (Tracy, 2014). This was presumably the case in the ethnographic study described in *chapter 5*. We found that NPs continued to focus on top-down patient education even when confronted with well-informed patients. Patients' own health condition assessments were not taken into consideration and shared judgments on how to solve the patients' problems were the exception rather than the rule. Aiken et al. (1998) showed that patient outcomes are better when nurses are able to render professional judgments about patients' needs and to act on the basis of those professional judgments. Therefore, NPs can only fully participate in collaborative practices through the authority to independently carry out the responsibilities of their position.

NURSE PRACTITIONERS' EXPERTISE

The second aim was to identify the learning opportunities of reflective case studies for NP education and to study how NP students reflected on their professional responsibility for patient care in these case studies.

Conclusion

NPs are expected to have expertise characterized by creativity, dealing with complexity, and being able to use competences in novel and unpredictable environments, so that they can make safe decisions for individuals *(Chapter 1)*. Reflection on one's own practice has been recognized as a key requirement for appropriate performance in healthcare (Mamede, Rikers & Schmidt, 2012). The NP students' use of reflective practice was diffuse and often rather superficial *(Chapters 2, 3)*. Their explorations of the situations in which they had acted were mostly aimed at finding justifications for their actions and not at critically questioning their decision-making and actions. In the first WHAT phase of the case study, as described in the *chapters 2 and 3*, the NP students narrated on direct care issues. In the second SO WHAT phase, the NP students rarely questioned the values that shaped their daily practices. They did not thoroughly analyse interactions of different

illness-related patient problems, although they were well aware of the complexities of patients' lives. Many NP students found it hard to apply their knowledge and skills in the complex combination of medical, psychological, and social problems in the final NOW WHAT phase of the case study. Thus, having just one assignment of this type in the Master program is likely not enough to acquire reflective skills.

In the interviews and focus group discussions described in *chapter 4*, the NPs explicated their learning needs when they set out to work within the new role. They emphasized nursing care was performed 'intuitively' because they could rarely provide an immediate, rational explanation for why they behaved in a particular way. They also explained that during their transition from nurse to NP they did not need to explore nursing issues or further develop their nursing skills. Meanwhile, they felt the urgency to become skilful in medical reasoning, in managing patients' care, and in handling medical procedures, next to becoming respected members of the medical team. Over the years, the NPs indeed developed expertise in managing patients and medical procedures *(chapter 4)*. Their confidence grew because their expertise was highly appreciated by the physicians and patients. *Chapter 5* showed that the NPs focused on the monitoring of patients' treatments during NP-patient encounters. In particular, the NP's expertise enabled them to provide care continuity for patients with critical or chronic health conditions *(Chapters 4, 5)*. Although this is essential for moving patients safely and efficiently through the system, the NPs themselves did not perceive the coordination of complex situations as mastery in nursing *(Chapter 4)*.

Discussion

Many NP students were unaware that they were largely unskilled to handle the complex problems of their patients; they stated that they could handle nursing problems intuitively. Although there is a lack of consensus over the definition of the term 'intuition' (Rashotte & Carnevale, 2004), Benner et al. (1996) explained this concept as the ability to look at a situation and intuitively judge what is wrong and what should be done supported by a large reserve of experienced situations. However, our findings showed that many NPs, students and graduates, did not attend to psychosocial patient problems. Also, they did not prioritise in collaborative partnerships with patients, and they did not regard family members as care recipients. Several factors could explain, as Mager (1997) already pointed out, why students/NPs did not practice what they were taught. This is not a matter of training alone. Practicing advanced nursing within the multiple constraints of the current healthcare system is a challenge. More education, then, is unlikely to bring about the desired change. Education in combination with reflective practice could help to overcome some of the barriers on the individual NP level. Schön (1983) emphasized that active reflection is associated with meaningful questioning of the situation, which can only be derived from a deep immersion in nursing theory and practice. It could be questioned

whether the NP students who participated in our studies were ready for the demands of developing critical, thoughtful approaches that are essential for care providing in the complex hospital environment. Bryckczynski (2014) emphasized that NPs starting in their new position may experience a return to the 'advanced beginner' stage. Glaze (2001) found in her study that the NP students reflected on a superficial level because they felt constrained and oppressed. This could also be the case in the Dutch situation with its restrictions to the students, who were pushed to hold on the traditional sub-professional role boundaries.

NURSE PRACTITIONERS' ROLE DEVELOPMENT

The third aim of the thesis was to study the role transition from nurse to NP, and to examine how NPs develop their role in outpatient clinics.

Conclusion

Role clarity is of utmost importance in the development of a new role. This clarity did not always exist in the public debate since different opinions were brought forward on what the NP role should be *(Chapter 1)*. The managers and also the physicians mostly focused on a coordinator role for NPs in the hospitals. Nurse leaders argued that an advanced role could add quality to care because of a broader perspective in particular for patients with complex problems such as those related with chronic illness. Others emphasized that junior doctor' hours and healthcare costs could be reduced by transferring certain tasks from more expensive doctors to less expensive NPs. The changes in the nursing profession as shown in *chapter 1* illustrated the policy climate that actively supported nurses to encroach on traditional medical roles such as prescribing medications.

Chapter 4 showed how NP students transitioned from being disconnected of the nursing profession towards being connected with NP colleagues and physicians. Looking back, the NPs explained how they perceived the role transition as a push outwards into new territory, but not really as advancing to addressing patients' needs that physicians fail to meet. Initially, the NPs felt anxious because they became accountable for their own actions.

Because in the early days the NP role was not yet crystallized, different demands placed on NPs in different settings could lead to distinct role definitions. Still, our studies described in *chapters 4 and 5* showed similarities in roles. In the hospitals, all NP specialty roles were in congruence with the medical specialties although restricted to a particular part of the patient population (e.g. patients with kidney transplants) or restricted phases in the patients' processes (e.g. hospital admission). In the outpatient clinics and as well at the hospital wards, the NPs coordinated and monitored the patients' medical treatments.

Chapter 4 showed that NPs had gained their place in the medical care process on the wards mainly because of the absence of the medical residents during day shifts. They acted as the first contacts for medical care problems for ward nurses, patients, and their families during the day. In the outpatient clinics NPs managed the episodic and chronic problems experienced by patients with chronic illness *(Chapter 5)*. Nevertheless, they also provided certain nursing activities: wound care, preventing surgical complications, and attending to different physical patient problems, related to for example nutrition, pain, sleep, and fatigue. The NPs perceived as their main task the monitoring of treatments, and stimulating patients' adherence to treatment. Therefore, they viewed patient education as the most important nursing intervention. While NPs' extension into medical territory seemed quite successful, their core challenge, building supportive relationships with the patients to facilitate living a good life, received far less attention. They had difficulties to engage patients in decision-making. Only some NPs were aware of the relation between how they approached patients and patients' motivations to change lifestyles. These NPs experimented with a coaching style encouraging the patients to self-manage their disease and make their own choices.

Discussion

The findings in the thesis showed that the NPs were ambitious to enhance the level of patient care. But the development of an advanced role is still a dynamic on-going complex process, with lots of forces influencing the outcome, as expected by the national and international professional nursing organizations. The Advanced Practice Nursing care model encourages exploring both the disease and illness experience, understanding the whole person and incorporating prevention and health promotion (*Chapter Introduction*). We found that many NPs seemed subsumed by the medical model and handled difficult situations by distancing themselves from the patients' illness experiences. Since the new NP roles were developed in congruence with the medical subspecialties, the full range of their advanced nursing specializations (acute care, chronic care etc.) was not met.

The NPs' difficulties to fulfil their ambitions could be explained by various reasons. Most influential drivers were the medical culture in the hospitals with its emphasis on cure and task substitution on behalf of efficiency, the NPs being pioneers, and the organization of the work-study programs in the Netherlands.

In the hospitals, the NPs' working environments are small communities of mostly physicians and some NPs with shared norms and values. The NPs are supervised by the physicians and obligated to strictly follow medical protocols. The medical specialists also define which medical tasks the NPs are permitted to do. Physicians' support and encouragement to take on new authorized medical tasks stimulated the NP role development towards medicalized roles. The urgency for task substitution was the result of the postgraduate medical training reforms. The competency-based programs with

various clinical assessment tools instead of learning-by-doing substantially altered junior doctors' internships (Wallenburg, 2012). This, combined with the sharp reduction in the number of hours the medical residents are spending in the hospitals made it attractive to replace junior doctors with NPs. The importance placed on task substitution for efficiency reasons is one of the drivers towards a physician extender role. Role extension means a one-dimensional increase of duties during the absence of other professionals or by virtue of enlarged healthcare demands (Daly & Carnwell, 2003).

Another explanation for NPs' struggle to develop their role in the Netherlands was how Dutch NP education was organized. In the work-study programs, the NPs simultaneously have to identify with the new professional group and to learn its specialized language, skills and knowledge. In most other countries, the educational component of role acquisition and the occupational component of role implementation are separated. Actually, in these countries NPs perform the role not until after program completion (Brykczynski, 2014), which offers them the opportunity to let go the traditional nursing role more smoothly than the NP students in the Dutch situation.

Another issue was that the first NP graduates who participated in our studies were pioneers of the new NP profession, and they lacked good nursing role models and NP working standards. These conditions corresponded with what happened in the USA at the start of the NP movement. In the first educational programs, physicians served as instructors teaching physical examination and clinical reasoning (Fairman, 2008). Consequently, the first American NPs were ambiguous about their new role. Were they being trained to become the doctor's assistant, or were they enlarging a special set of skills and knowledge particular to nursing? Bryant-Lukosius et al. (2004) showed that initially all advanced nursing roles placed an emphasis on physician replacement rather than on a patient-centred, health-focused, holistic nursing orientation. As new activities become more medically driven and focused on the disease, the nursing elements of the role could become less visible. Therefore, a broad range of strategies is necessary to adequately facilitate the acquisition and implementation of the new NP role.

METHODOLOGICAL CONSIDERATIONS

To uncover new knowledge, understandings, and meanings of NPs' professional responsibility, this complex concept was broadly explored by employing a qualitative approach. In *chapter 1* the public debate on NPs in the Netherlands was investigated through a review of policy documents, opinion articles from nurses, and as well as from physicians, and Dutch research papers. By using a variety of sources we could build on the strengths of each type of documents, minimizing the weakness of the single approach (Patton, 2002). However, only published material does not provide all aspects

of the debate, for instance the issues in behind-the-scene discussions. Interviewing the stakeholders could have solved this limitation. A potential flaw in this study could be selectivity because only opinion articles in the professional journals were included. Today, social media would give other information than available in journals; nowadays nurses are reacting on events via Twitter accounts of nursing magazines for instance. The review of the research papers was obviously limited to the Netherlands because the aim of the study was to explore the Dutch debate on the NP role. Although this review gave an overview of existing evidence, a critical appraisal of the findings could have shown whether there are inconsistencies in the studies (Polit & Beck, 2013).

In the *chapters 2 and 3,* the analysis of the reflective case studies written by NP students was reported. Because the NP students had to consider what alternative strategies could have been applied to the situation, the case studies gave valid information of the NP students' competences in difficult situations. After all, the writing about actual situations gives better access to practice and practical knowledge than do questions about beliefs, ideology, theory, or whatever the NP students typically do in practice (Benner, Tanner & Chesla, 2009). One of the limitations of the study might have been the quality and consistency of these assignments across the student participants. It was the first time they were asked to critically reflect on their NP-patient encounters. Learning from practice by reflection has to be learned. So a lack of this type of self-learning skills could have influenced our results. That the case study is a formal course assignment may have contributed to the quality of the data too. One could also debate whether the data relate to actual practices, because these may differ from students' self-reported opinions on their role enactment. The students may have presented a more positive image of themselves than what happened in real life, but on the other hand, what they presented is limited by what they think they should present. In spite of the limitations in their reflective practice skills, the case studies gave us insight into NP students' clinical reasoning and what they perceived as their responsibility toward patients.

In *chapter 4* the concept of transition was useful for describing the development of NP' roles. However, our findings are limited to the perspectives of the NPs themselves. Meleis's Framework (2010) has more elements than the ones we used in this study, and in particularly those related to the healthcare community. Inclusion of registered nurses and physicians working with NPs could have provided different perspectives on the transition outcomes. Still, this is the first study of NPs' role transitions in the Netherlands and the findings could form the basis for further research.

In analysing the data retrieved from interviews and focus group discussions, the 'Directed Content Analysis' method, as described by Hsieh and Shannon (2005), helped to explore transitions in this context. Combining the deductive approach with inductive reasoning as well proved useful to gain deeper understanding of the components of the transitions. The linking of inductively developed codes to Meleis's transition framework

enabled interpretation of the findings and positioning these in a well-established middle range theory. The middle-range theory itself can be strengthened by the findings too (van Staa & de Vries, 2014).

A strength of the study described in *chapter 5* was the combination of the observational data to gain insight into NP's role enactment with earlier retrieved interview data that covered the same NPs' opinions. The interview findings underpinned the way NPs work for patients with a chronic condition, and therefore increased our understanding about it. A limitation was that one side of the NP-patient encounter was emphasized at the expense of the other, the patient. Another drawback could be that we viewed the NPs only in the setting of the consultations, which are part of social processes in which experiences of both parties may have influenced the face-to-face contacts.

The NPs perceived as their main responsibility the monitoring of patient's treatment. Facilitating patients living a good life requires the NPs to develop care strategies to meet patients' individual needs. Van Meijel et al. (2004) showed that a qualitative study approach could provide a foundation for developing nursing interventions that then could be pilot tested in case studies and subjected to qualitative evaluation and finally tested in a randomized controlled trial. Therefore, the study described in *chapter 5* made a start with addressing factors that are in play at self-management support. The findings were used to develop tailored self-management interventions within the research program NURSE-CC (Rotterdam Consortium for Nursing Research into Self-management and Empowerment in Chronic Care) (Van Staa & Dwarswaard, 2013).

The two studies, described in *chapters 4 and 5*, had a small sample approach. Still, purposeful sampling was chosen because we aimed to study information-rich cases to understand important cases rather than generalizing from a sample to a population (Patton, 2002). Consequently, extrapolating to other situations and other people has to be considered very carefully. Another limitation was the inclusion of respondents only working in hospital settings. The role transition experiences of NPs working in general practices or home care, mental health settings, and in nursing homes may have been different because of the different context that is an influential element determining the process and outcomes of transition.

A limitation of the thesis was that our studies did not reveal a broad scope on NPs perceived responsibility, and that our sample was limited to students and graduates from one Master program. So generalization of our findings could be a methodological issue here. A survey on the scope of the activities the NPs performed could have enriched the thesis, as a survey obtains information about the prevalence, distribution, and interrelations of the phenomena within the Dutch NP population (Polit & Beck, 2013). Also an extended survey on NPs' perceptions of required competencies combined with NPs' self-evaluation of existing competencies could have given new insights on NPs' clinical performance. The gap between NPs perceived role competencies and actual

competencies could serve as a reference to improve the Master programs and the clinical training in the hospitals.

GENERAL DISCUSSION

In this thesis 'professional responsibility' is seen as a concept that encompasses both active and passive dimensions (responsibility –as a virtue– and responsibility –as accountability), and is defined as: *to take actions, which I can and want to vouch for, even if I will never be held accountable*. In accordance with this definition, NPs need to balance the needs of patients as their 'internal' responsibility with 'external' accountability claims. Because responsibility implies proactive action, in which professionals initiate and decide what is best for patients, new healthcare professionals such as NPs may have difficulty taking on this responsibility. The new role implies that NPs have to distinguish themselves from registered nurses by the criteria: independency, expertise and an active attitude to role development. Thus, what do we know of the way the Dutch NPs perceive, develop and enact their professional responsibility?

Views and visions: to perceive a new professional responsibility

NPs perceived as their professional responsibility to enhance the level of patient care; they viewed their involvement into medical treatment as instrumental to reach that goal. This view hindered a focus on the whole patient at the centre of NP care. The NPs had the ambition to pay attention to the disease and as well as to the illness experience, and to incorporating prevention and health promotion into their practices. But, the NPs did not show a clear vision on advanced practice nursing that is compatible to the NP role expectations of the national and international professional nursing organizations (venvs.nl; http://international.aanp.org). The consequences of a narrow focus entails the risk that the NP role may result into a physician extender role in which only delegated medical tasks are performed instead of a wider professional scope.

The NPs working in outpatient clinics for patients with chronic conditions considered tackling adherence problems with patients by educating them as very important. The NPs' rationale was that if patients understand why and how to prioritize their treatments in daily life, they would be more adherent and see their symptoms relieved, and thus experience a better quality of life. However, these assumptions are incorrect.

The NPs who were working on the hospital wards viewed their role as supportive to continuity of care. They mentioned that moving patients through the treatment system was insufficient with regard to medical procedures and patients' discharge when the medical residents were absent on the wards during dayshifts. Seeing that a better continuity of medical treatments would improve efficiency they aspired to fill the gap.

However, a narrow focus on continuity tends to position NPs solely as managers of the clinical pathways.

On the road: to develop a new professional responsibility

The NP students proceeded from experienced specialized nurses to advanced beginners supervised by physicians. To take a position into the medically dominated teams implied a huge challenge for NP students. The initial crisis in confidence and competence as experienced by the NP students was ambiguous. On the one hand, the NP students were anxious because they became accountable for a patient's care and well-being. On the other hand, the actual dependence on physicians, and the organizational rules, caused stress especially if the NPs felt capable of making decisions in the best interest of patients but were not allowed to do so. The NP students solved these inner conflicts by giving high priority to becoming skilful in medical reasoning, managing patients' medical care, and handling medical procedures, next to becoming respected members of the medical teams. So they spent time and energy to gain the medical knowledge and skills that they felt were necessary to help them in the transition process towards the new role. Their confidence grew because they gained a new enhanced expertise on monitoring patients' treatments that was highly appreciated by the physicians and patients. NP students basically accepted the restrictions placed upon them because they felt they had no other option. And although the NPs we interviewed and observed were competent to manage patients' treatments, there is still a discrepancy between the policy rhetoric assuming an independent role in practice and the NPs' experiences with being kept within the traditional sub-professional role boundaries.

One of the educational changes was that the NP students had to develop competences at the master level, of which the competences on research-based practice were most challenging. As pioneers, the Dutch NP students lacked good nursing role models and NP working standards. Most students felt that they were adding a nursing perspective to medical treatment already, particularly by maintaining a broad perspective to patient problems. They explained they did not need to develop their nursing competences further by searching on nursing science issues. Their explorations of the situations in which they had acted mostly were aimed to find some motivations to the activities and not to critically question their decision-making or their performance.

Organizational changes in the healthcare system, too, influenced NPs' role transitions during the work-study program and many years after graduation. The policy emphasis on efficiency, growing cost constraint on healthcare organizations, and the transfer of medical tasks from junior doctors to NPs was supportive to develop a medicalized role content. However, the NPs started with ambitions to enhance the level of patient care. Our studies showed that these ambitions were still alive and over the years were expanded with the desire to have increased responsibility for the whole process of patient care. As Meleis

(2010) mentioned: transitions do not have an ending point; therefore the NPs' road never ends.

On stage: to enact a new professional responsibility

Finally, the NPs had gained their place in the medical care process next to physicians. The NPs enacted the monitoring of patients' treatment as their prime professional responsibility. Their aim was to support patients to recover or not getting sicker in case of a chronic condition. Most NPs defined health as the ability to live well, although our studies showed that, in practice, they approached health as the absence of a disease. Many NPs prioritized treatment over daily life, meanwhile moving patients' illness perceptions to the background of attention. But, attention to the implications for the patient's daily life and life goals has to be part of NPs' responsibility also. Toombs, a physician suffering from multiple sclerosis (1993), explained that illness in its complexity cannot be reduced to its conception as a pathophysiological fact. She stated that should the goal be to alleviate the patient's suffering, it is necessary to inquire what it is like to live with a chronic condition. Only by a shared understanding of the meaning of illness, the 'voice of healthcare' (representing its technical-scientific assumptions) can be expanded by listening to the 'voice of the lifeworld' (representing the natural attitude of everyday life) (Toombs, 1993). Nursing includes the protection, promotion, and optimization of health and abilities (ANA, 2003). In particular, NPs are expected to use their nursing competencies on an advanced level of care, which is the ability to use theory, research evidence, observations, and experience to tailor nursing practice in complex and challenging clinical situations. NPs need comprehensive assessment ability including advanced physical assessment and an analysis of the person context, so they can view all a patient's aspects in the present situation. This implies meeting patient's needs relevant to treatment, including physical, psychosocial, and spiritual needs (the need to feel useful, the need for hope and the need for human dignity) (Tracy, 2014).

FUTURE DIRECTIONS AND CHALLENGES

What are the implications of our research for the NP profession and for the clinical performance of its members? And what does the study imply for NP education, and further research? This section clarifies the implications of our research.

Implications for Clinical Practice

Practice what you preach

If you say you wish to add a holistic perspective to patient care, do so. Although technical and clinical competences are sufficient to educate patients about certain skills, the success of coaching patients through transitions to health depend on the quality of the therapeutic relationships that NPs establish with patients. As NPs assess, diagnose, and treat a patient, they have the opportunity to attend closely to the meanings that patients attach to their condition. A holistic perspective means that you are interested in what the person views as problems, how he or she is responding to these, and what the problems and responses mean to the person in terms of daily living and life goals. Seeing and understanding a whole clinical situation requires to know the patient as a person, and understanding the values upheld by the patient and the family.

According to Swenson and Sims (2010) the way we talk can change the way we think and also the way we work. NPs should stop asserting they provide medical care in combination with nursing care. Medical means having to do with medicine and specifically, with physician-delivered care. Because NPs are advanced practice nurses, they practice an expanded role in nursing, not in medicine. For instance, for medical advice, substitute the phrase 'healthcare advice' which is broader in scope and more clearly reflects actual practice. NPs provide healthcare; they should avoid labelling this care as a medical practice. What advanced practice nurses do is nursing.

Partner with patients

NPs are expected to develop a therapeutic relationship with patients as the cornerstone of patient-centred care. The challenge is to shift the NPs provider's perspective on treatment adherence towards real involvement of patients in the NP-patient consultations. It is recommended to develop a patient-centred communication style based on open questions, asking for the patient's opinions, understanding, or suggestions, or reflecting on patient's statements. NPs can use several toolkits (e.g. www.vilans.nl; zelfmanagement.com; zorginnovatie.hr.nl) to transform their relationships with patients into a collaborative partnership. High impact changes can be realized before, during and after patient consultations. Such as: ask patients to gather clinical data, and information about daily experiences in a chart before the visit and to bring questions and concerns and health monitoring information. Develop an agenda during the visit with the patient, handle as many concerns as possible, ask them how they intend to improve their health and support them to make action plans that build confidence in their ability to reach these goals. Prepare a written care plan or visit summary that includes goals and action plans to ensure patients know what they do when they leave the visit. In many toolkits NPs are recommended to organize follow-up support to help patients sustain healthy behaviours

between visits. The community nurse could be involved as a member of the chronic care team. NPs are the experts to lead those teams and coordinate the care processes across the walls of healthcare organizations.

Advance nursing practice

Providing care to the ethnically diverse, ageing, highly unstable patients on the wards and in the outpatient clinics challenges NPs to intertwine instrumental, technical-scientific work with effective communication and relational skills. This opens up the opportunity to rethink the concept of advanced practice and how to address patient nursing care needs for which doctors lack the skills and qualifications. Taking professional responsibility for advanced practice nursing implies to give meaning to the NPs' independency, expertise and role development. NPs can make a positive difference to the care sector by doing, thinking, learning, evaluating and leading, which activities might be reflected in terms of clinical practice, research, education and leadership. Their only agenda should be advancing their practice. Advancing practice depends less on *what* nurses do than on *how* that they do it. One possibility is to bring together professional teams working towards a common goal of innovating, developing and advancing nursing care and treatment. Nurse educationalists, nurse academics, nurse researchers and nurse managers can work alongside the NPs in so called 'advanced practice units' in community healthcare, in nursing homes or in the hospitals. In those units NPs can make a big difference to patients' quality of life.

Develop NP-led care

For example, the initiative of an NP-led clinic alongside general practitioners undertaken by the *Hogeschool Utrecht* and the Julius Centre, University Medical Centre Utrecht ("Hogeschool Utrecht start Nurse-Led Clinic," 2016) deserves to be followed in other parts of the Netherlands. The NPs in this clinic are qualified to work as primary care providers who are referring patients to the general practitioner only if the (health) problems are too complex. NP-led clinics can also be organized to provide specialty care. In particular the management of chronic illness in which physicians play a more peripheral role can be of benefit to patients with e.g. diabetes, depression, heart failure and hypertension or elderly persons.

A similar initiative undertaken by the *Hogeschool van Amsterdam* and the Amsterdam Medical Centre to start a '*buurthospitaal*' (community hospital) ("AMC zet buurtziekenhuis op," 2016) provides an excellent opportunity for NPs to develop advanced nursing practice. NPs can be involved in this type of care, in particular for patients with chronic illnesses and their complex management demands that overwhelm the acute-care oriented healthcare system and individual primary care providers. NPs are expected to have the competences to provide care in an independent capacity.

NP-led clinics can be designed using the Chronic Care Model developed by Wagner (1998) in ambulatory settings. The model includes the following elements: health system (to create a culture and organization that promote safe, high quality care); delivery system design (to assure the delivery of effective, efficient clinical care, and self-management support); decision support (to promote clinical care that is consistent with scientific evidence and patient preferences); self-management support (to empower and prepare patients to manage their health and healthcare); the community (to mobilize community resources to meet needs of patients). Wagner's idea was to set up a team of professionals who collaborate with patients in their care beyond medical management and clinical markers. NPs can initiate the development of NP-led clinics to improve chronic care delivery; as advanced nurses they are needed in the overall integration of the elements of the Chronic Care Model.

In the hospital wards the NPs can advance their practices by supporting patients in the transition from the hospitals to their homes. They can have a role in discharge planning and home follow-up. Many patients have comprehensive discharge planning needs. The NPs can provide a physical and environmental assessment to support self-management, make home visits and coordinate home services. This care model gives the NPs the opportunity to reform their present physician's extenders' role on the wards into a transitional care model in which they are involved in continuous patient care processes.

Implications for Education

Organise mentorship

To support the professional transition from a registered nurse to a NP in the workplace, support from a nurse mentor who has experienced the same developmental process may be helpful. Work-study programs should encourage creative and critical thinking, questioning, and innovation as central aspects of learning in professional practices. The students have to be supported in a supervised practice to understand, reflect on, and articulate their practice, particularly the nature of the clinical situation, gaining situated understanding, skill, and the ability to use knowledge.

Improve reflective skills

It is quite an achievement that NPs become increasingly proficient in the treatment of diseases; but when they remain unaware of their full scope of practice they risk staying in the comfort zone of standardized medical care. Evidence suggests that students who lack reflective skills cannot assess the need for further learning and are not aware that their routines are inadequate, or that a change in perspective is needed (Kuiper & Pesut, 2004). Developing a reflective capacity is a continuous process that needs to be fostered by educators and supervisors in the clinical practices, who skilfully support and

challenge learners to take full responsibility for their actions. The reflective case study assignment stimulates thinking about practice in a way that considers factors other than the immediate event or circumstances. The ability to make personal choices in accordance with a knowledge base and moral code of conducts depends on the capacity of daring to reflect on what constituted good practice. Because the case study method encourages and facilitates this process, it is important to expand the use of this educational tool in Master programs, especially when these are organized as a work-study program.

Rethink NPs' competences

Competences refer to the state of having the knowledge, judgement, skills, and energy, experience and motivation to respond adequately to the demands of one's professional responsibility (Roach, 1992). The new competency framework is setting a series of task-orientated actions or practical activities for nurses and NPs. So, nursing practice is defined as isolated units of behaviour, without the significance of those actions (the in-order-to's, for-the-sake-of's, for-that-purpose, and to-that-end formulations). Consequently, the nurses become disconnected from the integrative knowledge that is needed for engaged reasoning in particular situations. Therefore, it is a necessity to enhance nursing competences with …in order to…, so that…, etc. For example: 'providing patient education in such a way that the patient understands, etc.…**so that** the individual and his family are better able to maintain a healthy lifestyle'. Or: 'To support the person in self-care for his or her diabetes you should be able to (…) identify the need for change, proactively generate practice innovation, and lead new practice and service redesign solutions **in order to** better meet the needs of patients and the service'.

Vitalize the Master programs

Master curricula should be based on the nature of the accepted discipline model; in other words, on nursing theory. Master programs in Advanced Nursing Practice need to make clear what integration of nursing and medical knowledge means and better articulate the nursing dimensions of advanced practice. The curricula should be based on the much needed paradigm shift towards chronic illness management. Supported by the International Council of Nurses, the WHO (2005) proposed that the following five basic competencies are needed to prepare the health care workforce for the 21st century: 1) patient centred clinical care, 2) partnering 3) quality improvement, 4) information and communication technology, and 5) public health perspective. Next to learning the principles of bioethics with a focus on care dilemmas, teaching staff has to centre on everyday ethical comportment, on becoming good practitioners who are constantly improving their practice, always with the patient in mind. Lecturers must have an in depth understanding of practice realities to keep pace with rapid changes in a practice driven by research and new technologies. In the classroom, teaching staff must engage students

in clinic-like learning experiences that ask them to learn to use knowledge and practice thinking in changing situations, always for the good of patients.

Implications for Research

All the above-mentioned recommendations need to be studied to further develop the nursing profession, to guide nursing practice and to improve the health and quality of patients' lives. To acquire trustworthy evidence, research should focus on NP practice, particularly on the benefits for patients of the NP role e.g. in terms of outcomes related to improved patient empowerment, shared decision making, self-management, rather than on effectiveness and the 'unique selling points' of the NP role. Future studies should include observations to comprehensively investigate NPs actual work. This is needed to better explain and to complement the findings on NPs' (current or future) virtuous professional behaviour.

POSTLUDE

'Finding Florence' is the metaphorical title of this thesis and represents an effort to connect with the complex foundation of nursing. The foundation of nursing has been extensively described, not only by the well-known Florence Nightingale, but also by many other nurse leaders. Their enlightenments and scholarly insights can still guide our actions and direct the knowledge development in nursing. Grypdonck pleads for 'presence' to be the central focus of nursing care, implying that nurses relate to their patients with dedication, and develop an understanding of what is at stake for them, and realise how the patient needs nurses to respond and to provide care accordingly (Baart & Grypdonck, 2008). Peplau introduced the concept of advanced nursing practice; Wiedenbach concentrated on the art of nursing and focused on the needs of the patient; Travelbee proposed that nursing was accomplished through human-to-human relationships, and many others showed the richness of the larger discipline of nursing (Tomey & Alligood, 2010). Advanced practice nurses such as NPs should be embedded in the nursing discipline to provide good care, which means assisting people to live well in spite of illness and disability, while the human dignity is protected, even if the NPs never were held accountable.

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SUMMARY

SUMMARY

A new professional role for nurses has sprung up in Western countries in the last decades, which is named 'nurse practitioner' [NP]. In the Netherlands, the government started to subsidize Master programs designed for NPs in 2000. The legal framework for healthcare professions was adapted in 2011 to the effect that only NPs with a professional Master degree can use the protected title 'Nurse Specialist', based on expertise in acute care, chronic care, preventive care, intensive care, or mental health care. The NPs are expected to have expert knowledge, complex decision-making skills and clinical competencies. Functioning at an advanced level should enable them to promote and sustain a patient's health. Consequently, the new NP role comes with greater responsibility for patient care, which can be taken to mean: *to take actions, which I can and want to vouch for, even if I will never be held accountable*.

In the Netherlands, NPs have to distinguish themselves from nurses educated at the Bachelor level by the criteria: independency, expertise, and an active attitude to role development. The first criterion implies acting as the first point of contact for patients and making responsible decisions about the patients' service needs independently of physicians. The second criterion, 'expertise', requires graduate education to acquire more knowledge on diseases and their clinical implications. A reflective attitude is seen as conducive for careful decisions based on a moral framework of good care. Apart from a continuous refinement of knowledge and skills, the NP role also requires leadership. Only then, NPs will be able – in collaboration with other professionals – to transform clinical care for the better, which is a crucial aspect of their new role.

Little is known about the NP role development in the Dutch healthcare context and whether the NPs have a shared vision on their greater responsibility. Also knowledge on NPs' actual practice-related actions is lacking as well as the extent to which these flow from nursing knowledge and are anchored in nursing goals. To understand what it means to be an NP, many factors must be taken in to account; these include ethics, job and task analysis, training, and development needs. Therefore, the NP role criteria as described above were supportive to the overall research question of the thesis: *How do NPs perceive, develop and enact their professional responsibility with respect to their independency, their expertise and the development of their role?*

Chapter 1 deals with the public debate in the Netherlands on the NP role. Two major discourses were revealed by a qualitative content analysis of relevant documents published from 1995-2012. One discourse was related to efficiency seen in light of the increase of healthcare costs and the expected shortage of care providers. The other one concerned the development of the profession. In both discourses the deployment of NPs was presented as a solution for healthcare and workforce problems. For example, by acting as a care

coordinator NPs should be able to reduce the number of hospital readmissions, length of hospital stay and volume of resource utilization.

The professional discourse was related to combining comprehensive nursing care with medical care, on the one hand, and the issue of transferring final responsibility to NPs on the other hand. Opinions of NPs themselves were underrepresented, however; for them, the wish to improve patient care drove them to take up new responsibilities. While most physicians were willing to delegate tasks to NPs, they still wished to retain final responsibility for medical care. Research was addressed only indirectly in the debate. Studies have provided some evidence that NPs can manage condition-specific cases and achieve outcomes similar to those in medical management.

The dominance of efficiency arguments combined with the protection of the medical jurisdiction entails risks for the proper development of the NP role. Dutch NPs are caught between conflicting expectations about reducing costs and improvement of quality of care, the latter of which is the main target of the nursing and medical professions. This target, however, requires complementary tasks that may clash with the cost-effectiveness. There is a risk that the NP role will be assessed in terms of efficiency and costs or benefits only, which may undermine the development towards nursing care that really benefits patients.

Chapter 2 identified the learning opportunities of reflective case studies written by students enrolled in an Advanced Nursing Practice Master program. A reflective case study entails both a narrative about a nurse-patient encounter and the student's reflection on this experience. Students have to consider how the situation could have been handled differently and what other knowledge could have been brought to bear on the situation.

Analysis of 77 case studies revealed two categories of learning opportunities, 'Direct care and 'Increased performance demands'. The first category was categorized into: Focusing on patients' needs, Exploring one's own values, and Providing comprehensive care. Working on an advanced level implicates active involvement with the patient, family, and health care team in understanding and seeking ethical resolutions to complex problems. In the reflective case studies the students are expected to analyze possible dilemmas and to explore their own beliefs and value systems. Furthermore, they are expected to reflect critically on how they handled complex situations that require coordination with other care providers and guiding of the family. The second category 'Increased performance demands' was categorized into: Handling independence and dependence, and Dealing with emotions. These subcategories covered the struggles related to the new role as a NP student. The reflective case studies offered opportunities to analyze the context in which the students have to work and reflect on strategies that enhance a patient's welfare enhancing when their authority is limited. Increased confidence in the ability to soundly contribute to care will stimulate students to develop firstly towards independency and secondly towards a renewed appreciation of the interdependence of nursing and medicine. When NP students reflect on their emotions in the case studies

they can learn to view these emotions from another (more positive) perspective. This will help to be open to feelings of unhappiness and to search for their own source of empowerment.

Chapter 3 explored NP students' perceptions of their professional responsibility through analysing 46 reflective case studies written by NP students working in a hospital setting. Most students included attending to psychosocial problems in their responsibility because they believed that this contributes to successful medical treatment. They feared that strong emotions, such as anger, would affect patients' recovery negatively. However, most students found it hard to address patients' psychosocial problems, particularly when patients presented existential questions about death or feelings of senselessness, to which they often did not know what to say.

The students reasoned that good understanding of the diseases and the treatment would empower patients to make the 'right' decisions to achieve the medical treatment goals. So, intensive patient education was the most used strategy to stimulate treatment compliance. Apart from education, they also gave practical instructions about living with illness for which, in their opinion, they were better suited than the physicians. Most students worried when patients did not follow the medical advice and applied various strategies to enhance compliance, with varying but often disappointing results.

The students perceived it as their responsibility to optimize the family's informal caregiver role, reasoning that family members had an important role in enhancing adherence to medical treatment. Still, several situations were described in which families struggled with this role. The students handled these problems differently. In the case of an adult patient, the students felt they should not intervene because they did not want to disturb family relationships. In contrast, students attending to patients with dementia or young children were inclined to have them hospitalized, especially if they did not fully trust the family's care giving capabilities.

The NP students showed that they struggled with the full range and advanced level of their new role. Working on medical problems on the basis of protocols was less difficult to articulate for students than the challenge of managing the healthcare needs of their patients, which integrates nursing care and medical treatment. It may be considered an achievement that NPs become increasingly proficient in the treatment of diseases, but if they remain unaware of their full scope of practice, they risk staying in the comfort zone of standardized medical care. Using reflection as the core for NPs' development towards an advanced level is needed when nurses are eager to progress beyond the level of following a prescribed set of rules.

Chapter 4 explored the role transition from nurse to NP using the components of Meleis's Framework of Transitions (2010). Individual interviews (n=9) and two focus group discussions (n=12) were held with NP graduates from different hospitals who had

been working at least two to six years post-graduation in acute care, intensive care, or chronic care.

The framework component 'Transitions nature'– which refers to physical, social, emotional and/or environmental changes caused by, or being a result of, transitions – was reflected by healthcare system changes, combined with professional and educational role changes. These changes may disrupt one's professional life and require adaptation. In this case, NPs felt distressed after they became accountable for a patient's care and wellbeing. Support was considered crucial to adapt to the new role; particularly support from physicians. Regarding the framework component 'Process and outcome indicators', the NPs were still developing clinical competencies and confidence in patient care, focusing on developing medical care on the basis of their nursing competencies. Their confidence grew from the positive feedback from physicians and patients. Regarding the outcome indicators, the NPs found themselves successful in the medical extension of two different nursing roles, i.e. continuity of medical care for hospitalized patients in acute and intensive care settings, and being responsible for continuity of care for chronic patients in outpatient clinics. The sense of mastery marked the completion of the NPs' transition. The new role varied between different contexts. One common element in acute and chronic care was ensuring continuity of care. Eventually, confidence encouraged the NPs to becoming more involved in patients' clinical pathways. This new ambition is in line with coordination as the central part of the NP role. We concluded that the NPs' role transition was characterized by coping with feelings of distress, which required much effort and time to reverse. Strategies to adapt to new expectations, combined with organizational support, determined the outcomes as well as the start of new transitions.

Chapter 5 described how NPs enacted their role in outpatient consultations for patients with chronic conditions. In particular, NPs can support these patients' self-management activities. These are defined as a person's ability to manage symptoms, treatment, physical and psychosocial consequences, and life style changes inherent with living with a chronic condition (Barlow et al., 2002). Episodic participant observations (a total of 48 hours) and formal interviews were carried out in a purposive sample of NPs working in five outpatient clinics related to chronic care 1) for patients with episodic flare-ups, and 2) for patients with diseases requiring life-saving procedures. Monitoring treatment progress was perceived as their main professional responsibility. Four monitoring strategies could be distinguished: 'Assessing health conditions', 'Connecting with patients', 'Prioritizing treatment in daily living', and 'Educating patients'. The consultations were mostly based on a conventional medical model of medical history taking, assuming that someone's health condition can be fully accounted for by deviations from normal biological function. Connecting with patients was difficult when patients were reluctant to talk about their experiences. In the interviews, the NPs emphasized they possessed empathy 'because they were nurses'. Empathic behavior during the consultations

was indeed observed. On the other hand, when acute problems needed to be solved, the NPs focused on the practical management of physical problems while leaving little room for the emotional impact of these problems. The NPs used different strategies to inform patients about their conditions and the choices they have regarding treatment. In the interviews they said that their educational activities were often unsuccessful and that they preferred to coach patients rather than to tell them what to do. However, the observations showed that coaching was still a challenge for most of them. The NPs in this study seemed quite successful in their extension into medical territory, but they moved patients' illness perceptions to the background, which is not conducive to self-management support.

Conclusion

The NPs who participated in our studies had the ambition to enhance their level of patient care; they viewed their involvement in medical treatment as instrumental to reach that goal. As NP students, they found it difficult to take a position in the medically dominated teams, and to be accountable for a broader spectrum of patient care demands. They tried to cope with it by becoming skilful in medical reasoning, managing patients' medical care, and handling medical procedures, next to becoming respected members of the medical teams. Most students felt that they were adding a nursing perspective to medical treatment already, particularly by maintaining a broad perspective to patient problems. They explained they did not need to further develop their nursing competences. The NP students' explorations of the situations in which they had acted were mostly aimed at finding motivations for their actions rather than at critically questioning their decision-making or performance.

Finally, the NPs gained a place in the medical care process next to physicians. They enacted the monitoring of patients' treatment as their prime responsibility, aiming to support patients to recover or not getting sicker in case of a chronic condition. Most NPs prioritized treatment over daily life while moving patients' illness perceptions to the background of attention. It may be concluded that the NPs perception of their professional responsibility was limited. They saw contributing to a successful treatment of the patient's disease as their prime responsibility. They expected this attitude from patients as well. However, NPs are expected to apply interventions that are based on a thorough understanding of people's responses to changes of their health. Advanced nursing implies meeting patient's needs with the use of theory, research evidence, observations and experience to tailor nursing practice in complex and challenging situations.

We undertook several qualitative studies to find an adequate answer to our research question and to remain as close as possible to the NPs perceptions of their responsibility. Because of the modest scale and contextual influences, the use of our findings in this study is limited. Nonetheless, the resulting insights are useful to understand how NPs shape their professional responsibility in similar situations.

Implications for Clinical Practice

Seeing and understanding the whole spectrum of clinical situation requires knowing the patient as a person and understanding the values upheld by the patient and the family. NPs should be interested in what patients view as problems, how he or she is responding to these, and what the problems and responses mean to the patient in terms of daily living and life goals.

Nurse educationalists, nurse academics, nurse researchers and nurse managers can work alongside the NPs in so called 'advanced practice units' in community healthcare, in nursing homes or in the hospitals. To improve chronic care delivery in ambulatory settings, NPs should initiate the development of NP-led clinics. In hospital wards, the NPs can have a role in discharge planning and home follow-up, thus supporting patients in the transition from the hospitals to their homes. By providing functional and environmental assessments, advanced self-management support, home visits and the coordination of home services they can meet the increased need to fill the gap between hospital and community care.

Implications for Education

A nurse mentor who has experienced the same developmental process may be helpful to support the transition from a registered nurse position to an NP position in the workplace. Reflection is highly commendable for nurses who are eager to progress towards an advanced level, which implies more than following a prescribed set of rules. The reflective case study assignment is a valuable tool to stimulate thinking about practice by considering factors other than the immediate event or circumstances. Master programs in Advanced Nursing Practice need to make clear what integration of nursing and medical knowledge means and better articulate the nursing dimensions of advanced practice.

Implications for Research

Future research should focus on the benefits for patients of the NP role rather than on effectiveness and the 'unique selling points' of the NP role; for instance, in terms of outcomes related to improved patient' empowerment, self-management and shared decision making. Future studies should comprehensively investigate the work done by NPs. This is needed to better explain and complement the findings on NPs' (current or future) virtuous professional behaviour.

SAMENVATTING

Het jaar 2000 luidde een nieuwe periode in voor de Nederlandse verpleegkunde. Zoals in veel Westerse landen werd de beroepsgroep uitgebreid met een nieuw type verpleegkundige, namelijk de nurse practitioner. Om hen goed voor te bereiden op deze functie ontwikkelden diverse hogescholen verspreid over heel Nederland professionele masteropleidingen 'Advanced Nursing Practice', in nauwe samenwerking met de beroepspraktijk. Door veel verpleegkundigen werd de mogelijkheid om nurse practitioner te worden enthousiast begroet. Dit bood hen een kans om zich professioneel verder te ontwikkelen en tegelijkertijd in de patiëntenzorg werkzaam te blijven. In 2009 werd het nieuwe beroepsniveau wettelijk erkend. Sindsdien gebruiken verpleegkundigen met een getuigschrift van een masteropleiding Advanced Nursing Practice niet meer de functienaam nurse practitioner, maar de wettelijk beschermde titel 'verpleegkundig specialist'. De specialismen waarvoor zij worden geregistreerd zijn: acute zorg, chronische zorg, preventieve zorg, intensieve zorg (allen bij somatische aandoeningen) of de geestelijke gezondheidszorg. Van de nieuwe zorgprofessionals wordt verwacht dat zij hoogwaardige verpleegkundige zorg verlenen en in staat zijn om de bij wet vastgestelde voorbehouden handelingen (zoals katheterisaties, heelkundige handelingen en het voorschrijven van geneesmiddelen etc.) te indiceren, uit te voeren en te delegeren. Door dit laatste zijn de grenzen tussen de bevoegdheden van artsen en verpleegkundig specialisten verlegd en werd de door velen gewenste taakherschikking geformaliseerd.

Om zich te kunnen onderscheiden van verpleegkundigen moeten verpleegkundig specialisten voldoen aan criteria met betrekking tot zelfstandigheid, deskundigheid, en rolontwikkeling. Het criterium 'zelfstandigheid' houdt in dat verpleegkundig specialisten als eerste contactpersoon fungeren voor patiënten en met hen zelfstandige behandelrelaties aangaan. Dit wil zeggen, dat zij zelfstandig beslissingen *mogen* nemen over de zorg die patiënten nodig hebben. Het tweede criterium 'deskundigheid' vereist dat verpleegkundig specialisten in het bezit zijn van diepgaande kennis over gezond- en ziek-zijn om deze beslissingen te *kunnen* nemen. En zij moeten een reflectief vermogen bezitten om de beslissingen vooral zorgvuldig te nemen, op basis van een moreel kader van goede zorg. Bij het criterium 'rolontwikkeling' moeten verpleegkundig specialisten zich onderscheiden van verpleegkundigen door hun nieuwe beroepsrol te *willen* ontwikkelen en dit actief zichtbaar te maken, niet alleen aan beroepsgenoten, maar ook aan de samenleving. Dit vereist leiderschap. Wanneer verpleegkundig specialisten zich op deze wijze onderscheiden van verpleegkundigen dan zijn zij in staat om, in samenwerking met andere professionals, de zorg te verbeteren. Beroepsorganisaties en overheid verwachten namelijk dat met de komst van verpleegkundig specialisten een betere patiëntenzorg zal worden gerealiseerd.

Hoogwaardige verpleegkundige zorg verlenen, in combinatie met de uitbreiding van bevoegdheden, legt een grote verantwoordelijkheid op de schouders van deze nieuwe professionals. Omdat hier nog weinig over bekend is, luidde de centrale vraagstelling voor dit proefschrift: '*welke opvatting hebben verpleegkundig specialisten over hun professionele verantwoordelijkheid, hoe ontwikkelen zij deze en hoe geven zij dit vorm in het licht van de criteria zelfstandigheid, deskundigheid en rolontwikkeling*? Het centrale concept in deze vraagstelling 'professionele verantwoordelijkheid' wordt in dit proefschrift gedefinieerd als: '*datgene doen wat nodig is tijdens de uitoefening van je beroep, ook als je er nooit voor ter verantwoording wordt gehouden*'. Om de centrale vraag te beantwoorden zijn verschillende wetenschappelijke studies uitgevoerd waarvan de resultaten in dit proefschrift worden gepresenteerd.

Het proefschrift bestaat uit drie delen die corresponderen met de drie onderscheidende criteria van verpleegkundig specialisten. Het eerste deel verkent het debat in Nederland over de verpleegkundig specialist en de invloed van het debat op de kansen om als verpleegkundig specialist te mogen functioneren. Het tweede deel richt zich op de mogelijkheden van reflectie bij het ontwikkelen van nieuwe expertise. Het derde deel onderzoekt de transities die verpleegkundigen doormaken in hun ontwikkeling naar verpleegkundig specialist, hoe zij de nieuwe rol willen vormgeven en hoe zij dit realiseren in de praktijk.

Hoofdstuk 1 geeft door middel van een literatuurreview een overzicht van het publieke debat over de komst van de nieuwe zorgprofessional. Wij analyseerden opiniërende artikelen van artsen (n=365) en van verpleegkundigen (n=35), beleidsrapporten (n=14) en wetenschappelijke artikelen (n=24) van Nederlandse studies over verpleegkundig specialisten, allen gepubliceerd tussen 1995 en 2012.

Het debat viel in twee discoursen uiteen. In beide discoursen werd de inzet van verpleegkundig specialisten gepresenteerd als een oplossing voor de problemen in de gezondheidszorg. In het efficiëntie discourse lag het accent op de stijging van de kosten van de gezondheidszorg en het verwachte tekort aan zorgverleners. In het professionele discourse daarentegen ging het vooral over de taakherschikking van artsen naar verpleegkundigen en de hierbij behorende overdracht van verantwoordelijkheden. Artsen toonden zich meestal wel bereid om taken te delegeren naar verpleegkundig specialisten, maar in de meeste opinieartikelen kwam naar voren dat zij de eindverantwoordelijkheid over de uitvoering van deze taken wilden behouden. Verpleegkundige leiders benadrukten in het debat dat verpleegkundig specialisten taken van artsen kunnen overnemen en hieraan verpleegkundige waarden toevoegen, zoals: een meer globaal perspectief, meer tijd, aandacht voor de beleving van de patiënt en zijn familie, educatie van patiënten, en een actievere rol voor de patiënt. De wetenschappelijke publicaties lieten zien dat de verpleegkundig specialisten, die betrokken waren in de studies, in staat waren om

gezondheidsproblemen te behandelen en dat de uitkomsten van hun zorg vergelijkbaar waren met die van artsen.

De nadruk op efficiency gecombineerd met een ondergeschikte positie aan artsen vormt een risico voor de rolontwikkeling van verpleegkundig specialisten. Deze ontwikkeling kan stagneren door de tegenstrijdige verwachtingen over het verlagen van de kosten en het verhogen van de kwaliteit van de zorg; dit laatste is het belangrijkste doel van zowel artsen als verpleegkundigen. Om dit doel te bereiken moeten verpleegkundig specialisten naast het overnemen van taken van artsen ook aanvullende taken vervullen, zoals mensen met een chronische aandoening begeleiden bij hun transities of hun zelfmanagement ondersteunen, wat mogelijk botst met de wens om de kosten te verlagen. Wanneer de nieuwe rol van verpleegkundig specialisten in de gezondheidszorg slechts wordt beoordeeld op efficiency en kosten, belemmert dit de ontwikkeling van hoogwaardige verpleegkundige zorg die patiënten werkelijk ten goede komt.

Hoofdstuk 2 brengt de mogelijkheden aan het licht om te leren van reflectieve casestudies. Deze methode is binnen dit promotieonderzoek ontwikkeld voor de masteropleiding Advanced Nursing Practice van Hogeschool Rotterdam. Een reflectieve casestudie bestaat uit drie fasen die de student doorloopt betreffende één casus. In de WHAT- fase beschrijft de student zo gedetailleerd mogelijk een ontmoeting met een patiënt waarin de student zich onzeker voelde over wat te doen. Hierna volgt in de SO WHAT- fase een reflectie op deze ontmoeting waarin de student zorgvuldig de eigen besluitvorming onderzoekt door zichzelf kritische vragen te stellen op welke wijze hij/zij de situatie anders had kunnen benaderen. Deze fase eindigt met het opstellen van een onderzoeksvraag. In de NOW WHAT - fase doorzoekt de student relevante bronnen om tot beantwoording te komen van deze onderzoeksvraag en te heroverwegen wat hij/zij had kunnen doen om de situatie te verbeteren. Iedere student bespreekt met twee medestudenten (z.g. critical friends) de uitwerkingen van elke fase om elkaar te stimuleren kritische vragen te stellen. De docent ondersteunt de studenten bij het toepassen van de methode. Dit wil zeggen om te komen tot een rijke casusbeschrijving, om genuanceerd te reflecteren op de thema's in de casus, om een onderzoekbare vraagstelling te formuleren, deze systematisch te beantwoorden en een zorgvuldige afweging te maken over de beslissingen die genomen moeten worden in dergelijke situaties. Vooral de laatste fase is van belang wanneer het leren in de praktijk een belangrijk onderdeel is van de opleiding, zoals bij de masteropleiding Advanced Nursing Practice het geval is. Het gaat bij een reflectieve casestudie namelijk niet alleen om het leren van de situatie en hoe men tot een meer adequate handelswijze kan komen in een volgende situatie (reflection-on-action). Het gaat er ook om te leren een actuele situatie te verbeteren door te reflecteren tijdens de situatie (reflection-in-action).

De kwalitatieve analyse van 77 reflectieve casestudies, geschreven door studenten tijdens hun masteropleiding Advanced Nursing Practice, liet twee categorieën

leermogelijkheden zien, namelijk over: Directe zorgverlening en Hogere verwachtingen. De eerste categorie kon worden verdeeld in de subcategorieën: - Aandacht voor de behoeften van patiënten, - Verkennen van eigen normen en waarden en - Uitgebreide zorg bieden. Deze subcategorieën lieten zien dat studenten met de nieuwe methode inderdaad konden leren kritisch te reflecteren op hun zorgverlening. Dit wil zeggen op welke wijze zij beter kunnen aansluiten bij de behoeften van patiënten; of hun morele uitgangspunten wel passend zijn bij wat van verpleegkundigen wordt verwacht en hoe zij de problematiek als geheel kunnen gaan overzien. De tweede categorie Hogere verwachtingen, had betrekking op de moeilijkheden die de studenten ervoeren met hun nieuwe rol en kon worden onderverdeeld in de subcategorieën: - Omgaan met afhankelijkheid en onafhankelijkheid en – Omgaan met eigen emoties. De eerste subcategorie betrof de mogelijkheden voor studenten om de context waarin zij werken te analyseren en te reflecteren op hoe zij, ondanks beperkte mogelijkheden om beslissingen te nemen, een bijdrage konden leveren aan het welzijn van patiënten. Wanneer het zelfvertrouwen van studenten toeneemt om werkelijk van betekenis te zijn voor patiënten, dan heeft dit een positieve invloed op de zelfstandige houding die van hen wordt verwacht. Vervolgens kan hierdoor, zowel bij artsen als bij verpleegkundig specialisten, de waardering voor goede samenwerking toenemen. De tweede subcategorie over het omgaan met emoties toonde dat studenten door reflectie konden leren om gevoelens van ongemak onder ogen te zien, deze vanuit een ander (meer positief) perspectief te bekijken en op zoek te gaan naar eigen kracht.

Hoofdstuk 3 verkent de opvattingen van verpleegkundig specialisten in opleiding over hun professionele verantwoordelijkheid. Er werd hiervoor een kwalitatieve analyse uitgevoerd van 46 reflectieve casestudies, geschreven door studenten die werkzaam waren in een (academisch, topklinisch of algemeen) ziekenhuis. Uit de analyse bleek dat de studenten zich voornamelijk verantwoordelijk voelden om een bijdrage te leveren aan de genezing van patiënten, of minstens deze te helpen om fysiek stabiel te blijven. De thema's die uit de analyse naar voren kwamen kunnen worden gezien als strategieën die de studenten toepasten om te voldoen aan hun opvatting van verantwoordelijkheid. De strategie 'monitoren van de gezondheidstoestand' was geheel in lijn met de functie van verpleegkundigen in ziekenhuizen om complicaties bij patiënten te voorkomen of zo vroeg mogelijk op het spoor te komen, de zogenaamde bewakingsfunctie. De strategie 'aandacht voor psychosociale problemen' liet zien dat de studenten het als hun verantwoordelijkheid zagen om hier aandacht te besteden omdat dit zou kunnen bijdragen aan het succes van een medische behandeling. Zij vreesden dat negatieve emoties, zoals angst en depressie, het herstel van patiënten zouden belemmeren. Toch vonden de meeste studenten het moeilijk om de psychosociale problemen bij patiënten aan de orde te stellen en met hen te bespreken. Dit was in het bijzonder het geval wanneer patiënten existentiële vragen stelden over de dood of over gevoelens van zinloosheid; in hun casestudies lieten de studenten zien dat zij vaak niet wisten hoe hierop te reageren.

De derde strategie die studenten toepasten was het 'stimuleren van therapietrouw'. De studenten beargumenteerden dat wanneer patiënten de ziekte en de behandeling goed zouden begrijpen, zij dan in staat waren de juiste beslissingen te nemen om de medische behandeldoelen te bereiken. Educatie van patiënten was de meest gebruikte strategie om therapietrouw te bewerkstelligen. Naast educatie gaven zij veel praktische adviezen en instructies over het leven met de aandoening en zij vonden dat zij hiervoor beter waren toegerust dan artsen. Tegelijk hadden zij moeite om de eigen keuzen van patiënten en (redenen voor) therapieontrouw te begrijpen en te respecteren.

De studenten zagen het ook als hun verantwoordelijkheid om ervoor te zorgen dat de familie de rol van mantelzorger zo goed mogelijk kon vervullen. Hun argument hiervoor was dat patiënten zich kunnen houden aan de voorschriften van de medisch behandeling wanneer zij optimaal worden ondersteund door hun familie. In de casestudies beschreven de studenten diverse situaties waarin de familie worstelden met hun rol als mantelzorger. Uit de analyse bleek dat de studenten verschillend met deze problemen omgingen. Wanneer het een volwassen patiënt betrof, stelden de studenten zich terughoudend op omdat zij de familierelaties niet teveel wilden verstoren. Maar bij mensen met dementie of bij jonge kinderen waren de studenten veel meer geneigd om in te grijpen. Zij stelden dan bijvoorbeeld voor om de patiënt in kwestie op te nemen in het ziekenhuis, vooral wanneer zij weinig vertrouwen hadden in de capaciteiten van de familie om de juiste zorg te verlenen.

De studenten die participeerden in deze studie lieten zien dat zij nog worstelden met de volle omvang van hun nieuwe rol en met het niveau van zorgverlening wat van hen wordt verwacht. Zorgverlening gericht op ziekte op basis van protocollen was geen enkel probleem, in tegenstelling tot het behandelen van problemen die betrekking hadden op een combinatie van zowel de ziekte als het ziek-zijn. Het is een vooruitgang voor de directe patiëntenzorg dat verpleegkundigen hun taakgebied verruimen door medisch handelen en hier ook verantwoordelijk voor kunnen zijn. Wanneer verpleegkundig specialisten zich beperken tot het overnemen van artsentaken, komen zij in hun nieuwe rol niet volledig tot hun recht. Want hoogwaardige verpleegkundige zorg betekent een holistisch perspectief, een therapeutische relatie met patiënten, op expertniveau klinisch redeneren, de praktijk baseren op wetenschappelijke kennis en verschillende methoden kunnen toepassen om gezondheid te bevorderen. Reflectie als onderzoek van het eigen handelen kan studenten hiervan bewust maken wanneer zij meer van hun beroep willen maken dan het slechts volgen van een voorgeschreven set regels.

Hoofdstuk 4 onderzoekt de transities die verpleegkundigen doormaakten tijdens hun rolontwikkeling van verpleegkundige naar verpleegkundig specialist, met behulp van Meleis *Theory of Transitions* (2010). Er werden met verpleegkundig specialisten individuele interviews gehouden (n=9) naast twee focusgroepdiscussies (n=12). Zij waren gespecialiseerd in acute zorg, intensieve zorg of chronische zorg en zij werkten

in verschillende ziekenhuizen gedurende twee tot zes jaar na het behalen van het getuigschrift van de masteropleiding Advanced Nursing Practice. De transities die de verpleegkundig specialisten doormaakten toen zij student werden waren veranderingen in hun professionele loopbaan en veranderingen omdat zij met een nieuwe opleiding begonnen. Zij raakten een deel van hun vertrouwde routines kwijt en zij verloren houvast in hun werk. Als verpleegkundig specialist in opleiding voelden zij zich in het begin vooral onzeker, omdat zij nu als individu en niet meer vanuit een team van verpleegkundigen verantwoordelijk waren voor de zorg en het welbevinden van patiënten. Om de nieuwe verantwoordelijkheid te kunnen dragen was goede steun onontbeerlijk: de studenten verwachtten dit vooral van de artsen te krijgen. Na verloop van tijd ontwikkelden zij klinische competenties gericht op de medische zorg, waardoor hun zelfvertrouwen toenam. Dit werd versterkt door de positieve feedback van artsen en patiënten over de zorg die zij verleenden. Uiteindelijk waren de verpleegkundig specialisten na hun opleiding het meest succesvol in de uitbreiding van hun taken op het medisch terrein. Vanwege hun bekwaamheid om handelingen uit te voeren die voorheen voorbehouden waren aan artsen konden zij, bij afwezigheid van artsen, de continuïteit van de behandeling realiseren voor patiënten die waren opgenomen in het ziekenhuis voor acute of intensieve zorgverlening. Ditzelfde gold voor de verpleegkundig specialisten op de poliklinieken voor patiënten met chronische aandoeningen. Vanwege de bevoegdheid om medicatie voor te schrijven gebaseerd op eigen diagnostiek konden verpleegkundig specialisten ook daar zorgen voor de continuïteit van de behandeling. Het gevoel grip te hebben op hun taken markeerde de transitie van verpleegkundige naar verpleegkundig specialist. Dit eindpunt was ook een nieuwe start voor de verpleegkundig specialisten. Zij hadden nieuwe ambities om meer betrokken te worden in het gehele zorgproces van patiënten dan zij tot nu toe waren.

Hoofdstuk 5 beschrijft hoe verpleegkundig specialisten hun nieuwe rol in de praktijk vormgeven op de polikliniek voor patiënten met een chronische aandoening. Van verpleegkundig specialisten wordt verwacht dat zij patiënten ondersteunen bij het dagelijks leven met een chronische aandoening. Dit houdt in dat patiënten behandelvoorschriften uitvoeren, de consequenties van de ziekte in het leven van alledag opvangen, inclusief betekenis geven aan het lijden aan een chronische aandoening. Om inzicht te krijgen welke opvatting verpleegkundig specialisten hebben over hun verantwoordelijkheid en hoe zij deze vormgeven, werden interviews (n=27) gehouden en één jaar later bij vijf van hen participerende observaties gedaan van de spreekuren (totaal 48 uur). Wij kozen verpleegkundig specialisten werkzaam op poliklinieken voor patiënten met een wisselend verloop van hun chronische aandoening (reuma en ernstige eczeem) en voor patiënten die een behandeling moeten ondergaan voor levensbedreigende gezondheidsproblemen (radio-, chemo, en hormoontherapie bij kanker en niertransplantaties). De verpleegkundig specialisten zagen het monitoren

van de medische behandeling bij patiënten als hun voornaamste verantwoordelijkheid. De analyse van de onderzoeksgegevens liet zien dat zij hiervoor de volgende strategieën hanteerden: - Beoordelen van de gezondheidstoestand, - Contact aangaan met patiënten, - Behandeling prioriteit geven in het dagelijks leven en - Educatie van patiënten. De gesprekken tijdens het spreekuur waren meestal gebaseerd op de structuur van het medisch consult: kennismaken, voorgeschiedenis, onderzoek en beleid. Het uitgangspunt was dat afwijkingen van de normale lichamelijke functies een betrouwbaar beeld geven van iemands gezondheidstoestand. Het lukte verpleegkundig specialisten minder goed om contact te maken met patiënten wanneer deze terughoudend waren om te spreken over hun ervaringen of als deze 'onverstandige' keuzes maakten. Tijdens de interviews benadrukten zij dat zij empathie met patiënten hadden omdat zij verpleegkundigen waren, en dit was inderdaad zichtbaar tijdens de observaties. Aan de andere kant, wanneer een patiënt acute problemen had, richtten de verpleegkundig specialisten zich op het oplossen van de lichamelijke aspecten, waarbij zij weinig aandacht besteedden aan de emotionele impact van deze problemen. De verpleegkundig specialisten informeerden patiënten op diverse manieren over hun lichamelijke conditie en de behandelmogelijkheden. In de interviews zeiden zij de voorkeur te geven aan een coachende stijl in plaats van aan patiënten voor te schrijven wat zij zouden moeten doen; zij realiseerden zich dat educatie alleen vaak niet succesvol is. Echter, uit de observaties bleek dat coaching een uitdaging was voor de meeste verpleegkundig specialisten. De studie liet zien dat verpleegkundig specialisten succesvol waren in het overnemen van artsentaken en dat zij hun verpleegkundig domein hiermee hebben uitgebreid. De aandacht voor de beleving van patiënten van ziekte en ziek-zijn bleef echter op de achtergrond, waardoor zij niet voldoende in staat waren om patiënten te ondersteunen bij zelfmanagement van hun aandoening.

Conclusie

De verpleegkundig specialisten die participeerden in onze studies hadden de ambitie om de kwaliteit van de patiëntenzorg te verbeteren en zij zagen hun betrokkenheid bij de medische behandeling als een mogelijkheid om dit doel te bereiken. Toen zij nog student waren, vonden zij het moeilijk om een positie te verwerven in de behandelteams en om zelf aansprakelijk te zijn voor een breder scala van patiëntproblemen. Zij probeerden dit op te lossen door vaardig te worden in medisch klinisch redeneren en het uitvoeren van medische procedures. De meeste studenten waren van mening dat zij aan de medische behandeling verpleegkundige aspecten toevoegden door vanuit een breed perspectief te kijken naar de problemen van patiënten. Het was daarom volgens hen niet nodig om hun verpleegkundige competenties verder te ontwikkelen. Uiteindelijk verwierven de verpleegkundig specialisten een plaats in het medische zorgproces naast de artsen. Zij gaven vorm aan wat zij zagen als hun belangrijkste verantwoordelijkheid, het monitoren

van de behandeling van patiënten opdat patiënten herstellen van hun ziekte of niet zieker worden in het geval van een chronische aandoening. Terwijl ziekte op de voorgrond stond van hun aandachtsgebied schoven de meeste verpleegkundig specialisten de beleving van patiënten naar de achtergrond. Hieruit kan worden geconcludeerd dat de verpleegkundig specialisten een beperkte opvatting hadden over hun professionele verantwoordelijkheid. Zij zagen als hun belangrijkste verantwoordelijkheid om bij te dragen aan een succesvolle behandeling van de ziekte van patiënten. Zij verwachtten deze verantwoordelijkheid ook van de patiënten zelf. Maar de opdracht voor verpleegkundig specialisten is om interventies toe te passen die gebaseerd zijn op een diepgaand begrijpen van de reacties van mensen op veranderingen in hun gezondheidssituatie. Hoogwaardige zorg impliceert dat er gebruik wordt gemaakt van theoretische kennis, wetenschappelijke inzichten, eigen observaties en ervaringen in de dagelijkse praktijk om maatwerk te leveren in complexe klinische situaties.

Om een adequaat antwoord te vinden op onze onderzoeksvraag en om zo dicht mogelijk aan te sluiten bij de betekenis die de verpleegkundig specialisten zelf geven aan hun professionele verantwoordelijkheid, zijn er verschillende kwalitatieve studies gedaan. Door de uitgebreide verkenning van opvattingen, ervaringen en praktijken leveren deze een dieper begrip op. Tegelijk is vanwege de bescheiden schaal van de studies aangaande het aantal participanten en de afgebakende context de reikwijdte van onze bevindingen beperkt. Wel zijn de verkregen inzichten te gebruiken om in vergelijkbare situaties de wijze waarop verpleegkundig specialisten hun professionele verantwoordelijkheid vormgeven te begrijpen.

Implicaties voor de klinische praktijk en de relatie met de patiënt

Het geheel van een klinische situatie overzien en begrijpen vereist kennis van de patiënt als persoon en van de waarden die deze en diens naasten nastreven. Verpleegkundig specialisten moeten daarom willen weten wat patiënten zien als problemen en hoe deze hierop reageren, en wat dit vervolgens betekent voor het dagelijks leven van patiënten en voor hun levensdoelen.

Implicaties voor de klinische praktijk en de organisatie van de zorg

Verpleegkundig opleiders, onderzoekers en managers zouden samen moeten werken met verpleegkundig specialisten in zogenaamde 'hoogwaardige zorgunits' dichtbij de leefomgeving van patiënten in de thuiszorg, in het verpleeghuis of in de ziekenhuizen. Om de chronische zorg te verbeteren in de ambulante setting kunnen verpleegkundig specialisten verpleegkundige poliklinieken opzetten die ook door hen worden geleid. Hier kunnen zij de kloof dichten tussen de zorg in het ziekenhuis en de zorg thuis door het functioneren van mensen en van hun omgevingssituatie te onderzoeken, het bieden van hoogwaardige zelfmanagementondersteuning, het afleggen van bezoeken thuis en de

coördinatie van de zorg. Op de ziekenhuisafdelingen kunnen verpleegkundig specialisten een grotere rol spelen in het voorbereiden op het ontslag en de nazorg die thuis of elders geboden moet worden om zo patiënten optimaal te begeleiden in de transities van het ziekenhuis naar huis en andersom.

Implicaties voor het onderwijs

Verpleegkundig mentoren die hetzelfde ontwikkelingsproces hebben doorgemaakt als verpleegkundig specialisten moeten worden ingezet om op de leerwerkafdeling de transities te ondersteunen van verpleegkundige naar verpleegkundig specialist. Reflectie is van belang wanneer verpleegkundigen zich willen ontwikkelen naar een hoger niveau van zorgverlening met een breder scala aan diagnostiek en interventies wat meer inhoud dan het volgen van de richtlijnen. De reflectieve casestudie kan hiervoor als methode worden ingezet. Docenten van de masteropleidingen Advanced Nursing Practice moeten duidelijk maken wat integratie van medische en verpleegkundige kennis inhoudt en de kenmerken van een hoogwaardige verpleegkundige zorgverlening met studenten bespreken.

Implicaties voor onderzoek

In plaats van onderzoek te doen of verpleegkundig specialisten even goede zorg bieden als artsen, zou nieuw onderzoek zich moeten richten op de voordelen van de verpleegkundig specialistische zorg voor patiënten. De voordelen van deze zorg moeten worden vertaald naar meetbare uitkomsten die verband houden met bij patiënten toegenomen empowerment, zelfmanagement en gedeelde besluitvorming. Er moeten vervolgstudies worden uitgevoerd naar de dagelijkse zorgpraktijk, zodat de bevindingen van onze studies uitvoeriger kunnen worden begrepen en aangevuld met inzichten over het huidig en toekomstig professionele handelen van verpleegkundig specialisten.

APPENDICES

PHD PORTFOLIO SUMMARY

Naam PhD student: Ada ter Maten-Speksnijder
Erasmus Universiteit Rotterdam, instituut Beleid & Management Gezondheidszorg
PhD Periode: 2008 – 2016; Promotor: Prof.dr. P.L. Meurs

Onderzoeksvaardigheden	**Jaar**	**Uren**
Cursus Kwaliteit van kwalitatief onderzoek	2006	28
Cursus Focusgroepdiscussies	2006	28
Cursus Analyse van kwalitatieve data	2006	28
Cursus Kwalitatief interview	2008	28
Cursus Atlas ti. 5.0	2008	28
Cursus Discoursanalyse	2011	28
Cursus Atlas ti. 7.0 voor gevorderden	2014	28
Cursus Endnote	2014	8
Reviewer: International Nursing Review, International Journal of Health Policy and Management	2013 - nu	12
Editorial Advisory Board of Nursing Management, RCN, UK	2011 - nu	76
Onderwijsactiviteiten		
Begeleiden Mastertheses Masteropleiding Advanced Nursing Practice	2002 - 2011	∞
Begeleiden Bachelortheses HBOV	2014 - nu	∞
Masteropleiding ANP: Verantwoordelijk voor de leerlijn Wetenschap; Begeleiding studiereizen naar Rochester, NY; Houston, Texas, USA	2002 - 2011	∞
HR, HBOV: Colleges / Trainingen Onderzoeksvaardigheden; Cursussen Reflectieve Casestudie en Informatief Schrijven; Minor Take the Lead	2014 - nu	∞
Bacheloropleiding Medische Hulpverlening: Colleges Kwantitatief onderzoek, kwalitatief onderzoek en epidemiologisch onderzoek	2012 - 2013	∞
HR Academy: Docententrainingen afstudeerbegeleiding Bachelors	2014 - nu	56
HR: Minor Geweld tegen hulpverleners	2013 - 2014	150
HR: Elective Course (in English): History of Healthcare	2013 - 2015	∞
Opleiding Casemanager Dementie (post hbo): Reflectieve Casestudie	2011 - 2016	∞
Erasmus MC, (post hbo) opleiding Decubitus en Wondzorg: Module EBP	2004 - 2011	∞
Universiteit van Gent, MSc Verpleegkunde en Vroedkunde: College APN	2014	8

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ABOUT THE AUTHOR

Born in the small village of Ouderkerk aan den IJssel in the rural Krimpenerwaard area, the Netherlands, Ada ter Maten-Speksnijder grew up with an elder brother and sister, and three younger brothers. Her parents were determined to help their children in building up a good life using all their capacities, and taking advantage of all opportunities they would meet on their life paths. They emphasized that girls have to be able to lead an independent life, assuming that boys would have this drive by themselves already. Their children were successful to break through the cultural segregation of the higher-, middle-, and low classes with respect to education. However, the third one had something else on her mind than schoolwork. Particular on Sundays, which were dedicated to contemplation, Ada took her chance to do what she liked most: reading … novels, short stories, science fiction, fairy tales and poetry. Next to devouring literature, also paintings and movies (watched on the invention of the 20th century: television), added to a lifelong commitment to grasp insights and meaning of the, mostly, hidden world of human experiences and emotions.

After having obtained her HAVO diploma, Ada started with her nursing study at the age of 18. Confronted with the suffering of patients, she learned how to care for patients by doing, as well as by exchanging experiences with her best friend in those days until today, who is also named Ada. Telling stories heals and makes you grow, both the reader and the storyteller. Today, the author of this thesis is still a nurse, specialized in education, and by this doctoral thesis specialized in research also. Blessed with two daughters, Laura and Julia, Ada and her husband Henk were living happily together (and still do so today) while Ada continued studying to become a teacher and finally a nurse scientist. She worked subsequently as a nurse, a head nurse, and a teacher in a vocational nursing program and lastly in the Master program Advanced Nursing Practice and in the Bachelor in Nursing program. Next to traveling, cooking, talking with colleagues and students, and giving lectures, reading a good story is still her most favourite activity.

De foto op de voorkant van dit proefschrift toont de kwetsbaarheid van een libelle die een bloemstengel krachtig omarmt. Kwetsbaarheid en kracht zijn thema's die nauw verbonden zijn met verpleegkunde, waarbij het de kunst is om bij beiden aan te sluiten. Want de essentie van goede zorg is mensen te ondersteunen om ondanks hun ziekte goed te leven en hun menselijke waardigheid te behouden.

Dit proefschrift beschrijft hoe verpleegkundig specialisten hun professionele verantwoordelijkheid in de directe zorgverlening aan patiënten opvatten, ontwikkelen en vormgeven. Het eerste deel verkent het debat in Nederland over deze nieuwe zorgprofessionals en de invloed van het debat op de kansen om als verpleegkundig specialist te mogen functioneren. Het tweede deel richt zich op de mogelijkheden van reflectie bij het ontwikkelen van nieuwe expertise. Het derde deel onderzoekt de transities die verpleegkundigen doormaken in hun ontwikkeling naar verpleegkundig specialist, hoe zij de nieuwe rol willen vormgeven en hoe zij deze realiseren in de praktijk.