CHAPTER 1
INTRODUCTION

This study explores the process of developing public policy required to introduce the Nurse Practitioner (NP) role to Australia, specifically to the state of New South Wales (NSW). Known as the Nurse Practitioner Project (NPP), the development of the public policy that enabled the introduction of the NP role took eight years. The study addresses the research question, 'What factors shaped the development of the public policy for Nurse Practitioners in Australia: 1990–1998?'

In the 1980s, the persistent medical workforce shortage was not meeting the health needs of rural and remote communities (Davis & George, 1993). One way of overcoming the shortage of doctors in rural and remote areas is to upskill alternative health workers such as nurses to undertake roles usually restricted to doctors (World Health Organization, 2010). However, the governing public policy at that time did not authorise nurses in their scope of practice to fill the gap in health service provision created by the doctor shortage. For example, the *Poisons and Therapeutic Goods Act 1966* (NSW) and the *Pharmacy Act 1964* excluded nurses from prescribing medication. If nurses were to be part of the solution to fill the gap resulting from medical workforce shortage, changes to public policy, and subsequently legislation, were required. Prima facie, all that was required to fill the gap in health care were changes to the relevant legislation. However, unforeseen by the government in proposing that nurses could meet the need was the extent of the impact of the longstanding tensions between nursing and medicine, and how these were an obstacle to the development of public policy designed to enable legislative changes that were necessary to the introduction of the NP role.

This chapter establishes the context of the study by providing an overview of the NPP as background to the study. In doing so, it describes the three stages of the NPP and presents a summary of the key documents produced throughout the project. The chapter then provides an overview of this study and explains how the thesis is organised.

The thesis defines advanced nursing practice as defined by the Nursing and Midwifery Board of Australia, as:

> … a continuum along which nurses develop their professional knowledge, clinical reasoning and judgement, skills and behaviours to higher levels of capability (that is recognisable).
>
> Nurses practising at an advanced level incorporate professional leadership, education and research into their clinically based practice. Their practice is effective and safe. They work within a generalist or specialist context and they are responsible and accountable in managing people who have complex healthcare requirements.
>
> Advanced nursing practice is a level of practice and not a role. It is acknowledged that advanced nursing practice is individually attributed within a regulated nursing scope (enrolled nurse, registered nurse or nurse practitioner)… (Nursing and Midwifery Board of Australia, 2016, pp. 2-3).

It also defines Nurse Practitioner in Australia using the definition adopted by the Nursing and Midwifery Board of Australia, such that:

> A Nurse Practitioner is an advanced practice nurse endorsed by the NMBA who has direct clinical contact and practices within their scope under the legislatively protected title 'nurse practitioner' under the National Law (Nursing and Midwifery Board of Australia, 2016, p. 3).

1.1 An overview of the Nurse Practitioner Project

In NSW during the 1980s, the health system was experiencing a medical workforce shortage (Palmer & Short, 2014), especially in rural and remote areas of the state. The gap in medical workforce was to some extent being filled by nurses who had been providing services to rural and remote patients on an informal basis. The proposal to introduce the advanced practice role of NP in 1990 by the NSW government was seen by some to be legitimising the existing clinical services that some nurses were providing to some rural and remote communities. Simultaneously, from the mid-1980s, the profession of nursing had been creating a clinical career pathway through the introduction of the Clinical Nurse Specialist (CNS) and Clinical Nurse Consultant (CNC) categories (Duffield, Gardner, Chang, & Catling-Paull, 2009). While these clinical pathways for advanced nursing practice were being proposed, the medical health workforce shortage remained problematic.

Public debate around the introduction of NPs began in Australia in earnest in 1990 when the then Health Minister for NSW, The Hon P.E.J. Collins, articulated his support for the development of independent nursing practice at the annual conference of the NSW Nurses Association (NSW Department of Health, 1992; Offredy, 2000). Subsequent to this public statement, Minister Collins instigated the establishment of the Independent Nurse Practitioner Task Force (INPTF), commissioned by the government to develop a discussion paper on the role and function of an NP. The NPTF discussion paper's stated aim was to 'engender discussion amongst health professionals, health care providers, consumers and government organisations' (NSW Department of Health, 1992, p. 1). The discussion paper produced by this Task Force was later referred to as 'Stage 1' of the NPP. In the responses to the discussion paper there was majority support for the concept of NPs, but strident opposition quickly emerged from doctors' groups (NSW Department of Health, 1993).

The subsequent governance of the NPP saw the implementation process led by working parties and steering committees. The government appointed an independent chairperson to oversee the steering committees for Stages 2 and 3. The steering committees consisted of the primary stakeholders: consumer associations; nursing, medical and allied health professional bodies; and industrial associations, along with the NSW Department of Health. It was members of these committees who were interviewed for this study.

As a response to the Independent Nurse Practitioner Task Force (INPTF) discussion paper, and the resultant opposition to its recommendations, the government formalised the NPP by establishing Stage 2, which brought together key stakeholders, not just nurses, to engineer and drive the policy development for NPs in NSW. This, along with Stage 3 of the process, resulted in recommendations to implement research to evaluate the role of an NP. Subsequently, NPP Stage 3 was the establishment of pilot projects across the state. From a total of 58 submissions received, ten (See Appendix A) were chosen to be included in the government-funded pilot program (NSW Department of Health, 1993).

A summary of the history and chronology of events surrounding the introduction of NPs in Australia, as well as key documents that informed the NPP during 1992–1998, is presented in Figure 1.1.

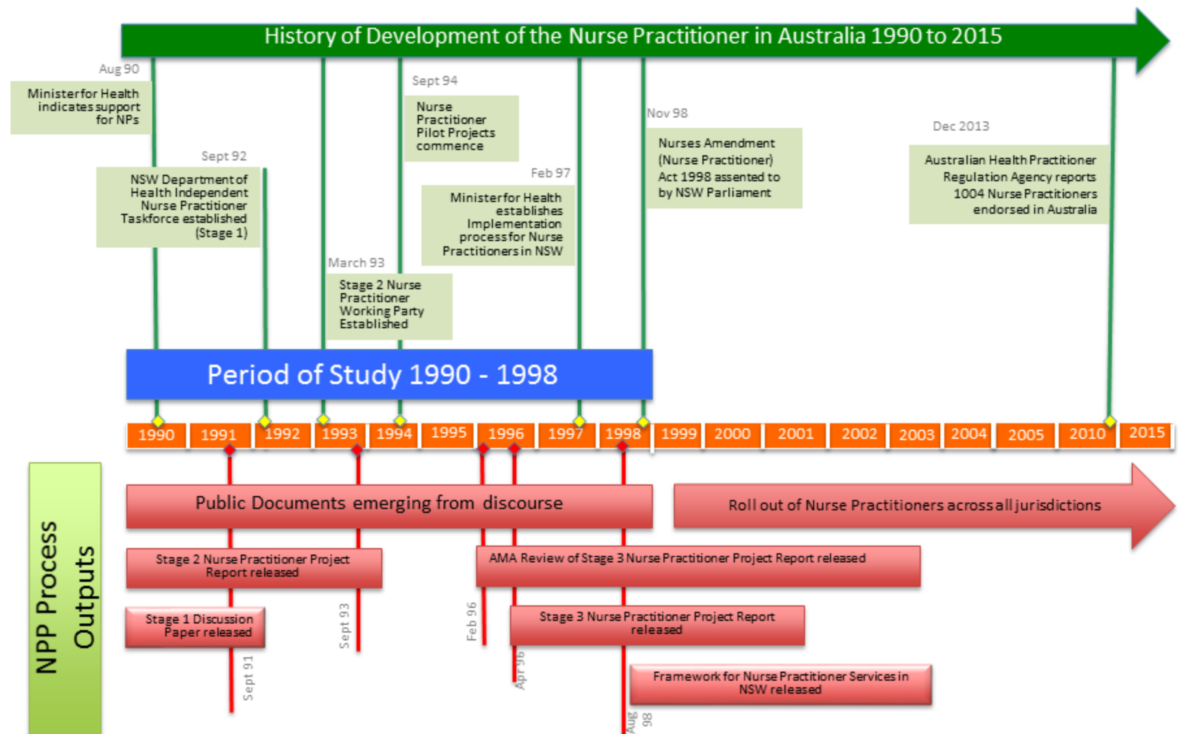


Figure 1.1 The study in context of the chronology of the NP development Source (Foster, 2010)

1.2 NPP key documents

As indicated in Figure 1.1, there were five key documents specifically relating to the period investigated in the study (1990–1998). These documents were produced as part of the policy development process for the NP role in NSW and paralleled the stages in the NPP. The documents were:

- The Role and Functions of Nurse Practitioners in NSW – Stage 1 (1992)
- Nurse Practitioner Review Stage 2 Volumes I and II (1993)

- Nurse Practitioner Project Stage 3, Final Report of the Steering Committee (1995)
- Review of Report on the Nurse Practitioner Project: Stage 3
- Nurse Practitioner Services in NSW – Policy Statement and Framework (1998)

Table 1.1 presents an overview of the NPP key documents in the chronological order in which they were published, outlining who produced them, their intent and a summary of contents.

Table 1.1: Summary of Key Documents related to the introduction of the NP role in NSW

Document	Stage of NPP	Time Period	Summary
The Role and Functions of Nurse Practitioners in NSW	Stage 1	June 1992	Discussion Paper to engender discussion among health professionals, providers, consumers and government on the proposal of introducing the role of the nurse practitioner. Prepared by the Nursing Branch NSW Health Department.
Nurse Practitioner Review Stage 2 Volumes I and II	Stage 2	September 1993	Response to Stage 1 Discussion Paper with recommendations for research to evaluate role for NPs and analysis of key issues raised from Stage 1 submissions, including clarity of role, collaboration and interdependence and opposition to the role. Prepared by NPP Steering Committee.
Nurse Practitioner Project Stage 3, Final Report of the Steering Committee	Stage 3	April 1996	Documents the research undertaken to examine the role and scope of practice of the nurse practitioner, finding they are feasible, safe, effective, deliver quality care and are cost effective. Prepared by NPP Steering Committee.
Review of Report on the Nurse Practitioner Project: Stage 3 – '*Logan Report'*	Stage 3	April 1996	Produced in response to the recommendations from Stage 3 Final Report. Discredits the research undertaken in the 10 nurse practitioner pilot projects and in doing so rejects all recommendations in the Stage 3 Final Report. Prepared for the NSW Branch of the Australian Medical Association (AMA).
Nurse Practitioner Services in NSW – Policy Statement and Framework	Final	August 1998	Policy Directive to guide District Health Services in introducing a nurse practitioner service. Prepared by the Nursing Branch NSW Health Department.

These five key documents provided a public record of the evolution of the public policy that enabled the development of the NP role in NSW. In addition, they identify some of the issues and debates within that process. In particular, these documents articulate the case for a health workforce to meet community need as well as an argument for a clinical nursing career pathway that supports nurses with an extended scope of practice designed to enable them to work effectively as rural practitioners. These key documents inform this study; however, they provide a distilled version of events and fail to unpack the processes behind the development and the experiences of the individuals involved in the development of the nurse practitioner role. Therefore, the study goes beyond these documents and examines the experiences of those directly involved in the shaping of the public policy.

1.3 An overview of the study

The preceding section of this chapter has established the focus of this study as the period from 1990–1998 when policy work for the introduction of the NP role to the Australian health workforce was undertaken. This section of the chapter provides the rationale for the study, identifies the study's significance and aims, and finally presents the approach taken in the study.

1.3.1 Rationale for the study

During the period 1990–1998, the NPP meetings and informal interactions were at times typified by intensely contested debate between professionals. This study captures the public policy development and rich discourse of change that, to date, has not been captured in scholarly or professional literature. There is no record or analysis of the experiences and interactions between individuals involved in the negotiations to establish the NP role in NSW. Understanding what occurred and why is important for the nursing profession in particular, and for health reform in the future.

While there has been substantial scholarly review and evaluation of the work of the NP role since its inception in Australia (Bourgeois, Blanchard, Doldissen et al., 2014; Duffield, Gardner, Chang et al., 2009; Foster, 2010; Gardner, 2010; Gardner, 2004; Mills & Fitzgerald, 2008), the process of the public policy development resulting in the development of the role has not been examined in detail. In contrast

to the change of a role with an expanded practice, such as CNS and CNC, the introduction of the NP was a new category of health worker that required the development of public policy. This study draws from the experiences of key individuals involved in the public policy development for the introduction of NPs, from when Minister Collins first advocated for discussion of a NP role in 1990 to enactment of the NP role in legislation in 1998. The findings of this study may inform future processes of public policy and assist health managers and the wider health system to engage in the debate, development and implementation of public policy required for the introduction of advanced practice roles for an existing health workforce across the professions.

1.3.2 Aims of the study

Rarely does an established health system introduce a new professional classification of health worker higher than those that already exist. Health workforce reform occurs often in response to care needs and changing trends in health care. Understanding, anticipating and planning for changing roles of workforce function, skill mix, and scope of practice will assist professionals and health services managers to negotiate reform of the health workforce into the future (Duffield, Gardner, Chang, Fry, & Stasa, 2011; Gardner, Duffield, Doubrovsky, & Adams, 2016; Turner, Keyzer, & Rudge, 2007). Therefore the aims of this study were to inform future health workforce policy development through:

- Revealing the experiences of health professionals and others involved in negotiations to establish the NP role in Australia and providing an account of the history of the NPP in Australia from the perspective of those involved; and
- Exploring the impact of known tensions between nursing and medicine and how these affected the processes of the NPP and ultimate outcomes.

1.3.3 Research Question

The absence of a prior examination of the processes underpinning the development of the public policy surrounding the NP role provided an opportunity to explore these factors and resulted in the following research question:

‘What factors shaped the development of the public policy for Nurse Practitioners in NSW, Australia: 1990–1998?’

1.3.4 Methodological approach to the study

In order to address the research question: ‘What factors shaped the development of the public policy for Nurse Practitioners in Australia: 1990–1998?’ this study employed a qualitative approach that used in-depth interviews with thirteen key informants. Analysis of interview transcripts was conducted through the lens of critical social theory using both content and thematic approaches to identify factors that impacted on the policy development processes and its outcomes.

1.4 Organisation of the thesis

This chapter has provided an introduction to the study and an overview of the chronological development of the public policy that enabled the introduction of the NP role in NSW. It has also provided an overview of the aims, the research question and the methodology chosen to conduct the study.

Chapter 2 provides a review of the literature, which identified three core elements:

- The case for an advanced practice nursing role in Australia as influenced by the issues of health workforce;
- Policy responses to meeting community health care needs; and,
- Challenges to implementation of policy to progress advanced practice nursing roles in Australia.

Chapter 3 introduces the theoretical position, Critical Social Theory, which was used as a lens through which to examine the experiences of individuals involved in the development of policy to introduce the NP role in NSW, Australia. This chapter also presents the interview protocol and describes the process of sampling and recruitment. This chapter describes the processes for data management and analysis in the study data, as well as the ethical issues related to the study.

Chapter 4 presents the findings of the study. It begins by confirming the known drivers for the introduction of NPs in NSW and then discusses the importance of having bipartisan support in the policy development. The chapter then identifies previous policy work and development of the nursing profession that assisted in facilitating development of NP policy. The personal challenges of those involved in

the policy development are then identified. Finally, the chapter identifies that the central theme to emerge from the study was power and medical dominance and highlights how protectionism and the vested interests of both the nursing and medical professions impacted on the development of the NP policy.

Chapter 5 discusses the implications of the findings and illuminates the factors that enabled and inhibited the work of the NPP. In particular, this chapter discusses how the historic tensions between nursing and medicine impacted policy development.

The final chapter summarises and concludes the study and identifies the relationship between the study and future public policy development, practice, education, and research as it relates to nurse practitioners in Australia.

1.5 Chapter summary

This chapter presented the research question and outlined the background to the study. It has identified the study aims and research question and provided an overview of the thesis. It has indicated that the study captured the experiences of individuals involved in the development of the NP role in Australia and identified the potential for the study to contribute to the scholarly literature on the development of public policy pertinent to the current and future health workforce in Australia. It has distinguished this study from others related to NPs in Australia, as other studies concerning advanced practice nursing roles in Australia have substantially focused on the individual nurses' practice and their experiences, or the operational and regulatory processes to support and maintain the role (Duffield, Gardner, Chang et al., 2011). In contrast to these, this study illuminates and examines stakeholder experiences during the process of policy development to enable the establishment of the nurse practitioner role in NSW.

The next chapter provides a review of the literature related to the study.

CHAPTER 2
REVIEW OF THE LITERATURE

This chapter provides an overview of the literature related to the evolution of the NP advanced practice role introduced in NSW, Australia in 2000 following the completion of the NPP. The aim of this literature review is to further illuminate the context in which the health policy required to introduce the NP role was developed.

Several researchers (Bourgeois, Blanchard, Doldissen et al., 2014; Duffield, Gardner, Chang et al., 2009; Gardner, 2004; Gardner, Carryer, Dunn, & Gardner, 2004; Gardner, Gardner, Middleton et al., 2010; MacLellan, Higgins, & Levett-Jones, 2015; Middleton, Gardner, Gardner, & Della, 2011; Mills & Fitzgerald, 2008; Schoenwald, 2011) have undertaken studies since the introduction of NPs in Australia, primarily focusing on the work and practice of NPs. Few studies, however, have explored the background to the policy development related to nurse practitioners. Foster's PhD study, *A history of the early development of the Nurse Practitioner role in New South Wales, Australia* (2010), examined the evolution of the NP role in the United States of America (USA), United Kingdom (UK), Canada and Australia and identified issues related to legislation, regulation, education and protection of title (Foster, 2010). Foster's study employed an historical descriptive research method that allowed examination of the chronology of events and an understanding of influences on the political, social, economic and cultural context of the development and implementation of nurse practitioners.

Unlike the work of Foster, this study sought to examine the experiences of leaders and public figures involved in the policy development and political processes supporting the introduction of the NP role as an advanced practice nursing role in NSW. The ways in which advanced practice roles have been established and implemented internationally varies by country, yet the literature reveals similar themes in terms of the complexity and challenges in providing a health workforce that accommodates and includes advanced practice roles for nurses.

The scope of practice of advanced practice nurses differs globally across the USA, Canada, UK and Australia. In Australia, as governments respond to community

health needs the NP scope has evolved to include access to the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) (Gardner, Chang, & Duffield, 2007; Lloyd Jones, 2004; Pulcini, Jelic, Gul, & Yuen Loke, 2010; Stasa, Cashin, Buckley, & Donoghue, 2014). It is evident that a significant variation in the use of terms throughout the literature is applied to describe nurses' work at an advanced practice level. Such terms include: advanced practice nurses, advanced practice registered nurses, registered nurse with extended or expanded scope of practice, and nurse practitioner (Duffield, Gardner, Chang et al., 2009). The World Health Organization (WHO) refers to NPs as mid-level health workers or mid-level practitioners/providers. This is a broad title that includes the different titles for NPs globally and some advanced practice roles. WHO (2010) states mid-level practitioners/providers include a health provider:

1. Who is trained, authorised and regulated to work autonomously, and
2. Who receives pre-service training at a higher education institution for at least 2-3 years, and
3. Whose scope of practice includes (but is not restricted to) being able to diagnose, manage and treat illness, disease and impairments (including perform surgery, where appropriately trained), prescribe medicines, as well as engage in preventive and promotive care (World Health Organization, 2010).

As the NP is an advanced practitioner, searches of electronic databases using key words including 'policy', 'change', 'change management', 'health' 'nurs*', 'advanced practice' and 'nurse practitioner' were conducted. Subsequent database searches included the word 'Australia'. The only exclusion was for non-English language publications. As it was important to capture the early literature prior to the commencement of the NSW NPP as well as the history of the development of nurse practitioners internationally, no limit was placed on the literature dates or place of publication. 'Hand searching' from identified references, citations and reference lists was undertaken and electronic links were followed to 'related articles' and 'cited by' links. There was a paucity of Australian literature prior to 1990 as advanced practice nursing roles evolved from that time.

The published literature reflects the evolution that occurred during the period of the policy development in Australia. Early literature identified the need for a workforce response to community need in filling service gaps (Francis, Boyd, Latham et al.,

2014), particularly in the area of primary health care (Carter, Owen-Williams, & Della, 2015). Subsequent literature continued the case for NPs, and both informed and emerged from the NPP, and later literature discussed continuing issues around acceptance of the nurse practitioner as a legitimate member of the health workforce. The literature identified medical workforce shortages, maldistribution of medical workforce and a limited clinical career pathway for nurses as the primary issues considered when proposing the need for an advanced practice role in NSW.

The literature spoke to professional, political, and regulatory discourses that have resulted in barriers and enablers to the regulation and implementation of advanced practice nursing roles. The literature review revealed the three principal contextual elements that shaped the development of policy for the NP as an advanced practice role in Australia were:

- The case for a NP role in Australia as influenced by health workforce issues;
- Policy responses to meeting community health care needs; and,
- Challenges to implementation of policy to progress advanced practice nursing roles.

Five key documents referred to in Section 1.2 related to the period investigated in the study period 1990–1998. These documents were produced as part of the policy development process for the NP role in NSW.

2.1 The case for nurse practitioners in Australia

It was evident from the literature that the two key drivers for the introduction of a nursing role that included advanced and extended practice were:

- An identified need for a policy response to medical workforce shortage in Australia, particularly rural areas during the late 1970s and 1980s (Humphrys, Jones, Jones, & Mara, 2002).
- The nursing profession's aspirations and the opportunity to continue to build a career path for clinical nurses, retaining experienced nurses in direct care roles and remunerating them accordingly (Foster, 2010, p. 174).

The discussion paper *Nurse Practitioners in New South Wales: The Role and Function of Nurse Practitioners in New South Wales*[1] referred to as Nurse Practitioner Project (NPP) Stage 1 document, was the first formal document prepared by the NSW Health Department on the role and function of the proposed NP role (Hamric, Spross, & Hanson, 1996; NSW Department of Health, 1992). The NPP Stage 1 Discussion Paper identified that the model and role of advanced practice nurses globally had been greatly influenced by the shortage of doctors (NSW Department of Health, 1992, p. 4). The development and evolution of the role of the NP in the USA commenced in the 1960s, initially in response to the lack of primary care doctors in disadvantaged areas of the country (Koch, Pazaki, & Campbell, 1992). This initiative proved successful in the USA in that it provided an effective, safe and accessible model of care (Duckett, 2005a; Duffield, Gardner, Chang et al., 2009; Hamric, Spross, & Hanson, 1996). Similarly, in Australia, two interrelated factors within the medical workforce were central to consideration of the introduction of the NP role. These were medical workforce shortage and maldistribution of the primary care medical workforce resulting in limited access to medical services for people in rural and remote areas.

2.2 Shortage and maldistribution of medical workforce

Literature on health workforce management and retention prior to 1990 overwhelmingly focused on the medical workforce with scant information on the larger nursing and allied health workforce (Cheek, Shoebridge, Willis, & Zadoroznyj, 1998). Subsequent literature looked at skill mix and health workforce alternatives (Duckett, 2005a, 2005b; Duffield, Gardner, Chang et al., 2011; Miller, Siggins, & Fowler, 2011). The scarce supply of medical workforce was acute in the USA in the 1960s and 1970s, as it was in rural and remote Australia in the late 1980s (Buykx, Humphreys, Wakerman, & Pashen, 2010). As in the USA, it was the scarcity of doctors in rural and remote areas of Australia that drove the development of the advanced practice role.

[1] From this point the *Nurse Practitioners in New South Wales: The Role and Function of Nurse Practitioners in New South Wales* (1992) will be referred to as the NPP Stage 1 Discussion Paper.

Maldistribution of the primary care medical workforce was identified as an issue in Australia, with an oversupply of general practitioners (GPs) in the urban cities and a shortfall in the rural and remote areas (Hamric, Spross, & Hanson, 1996). Despite the commonly used strategy of enhanced remuneration to GPs for working in these areas (Davis & George, 1993), recruitment and retention strategies for GPs in rural and remote areas of Australia have had minimal success. The NSW Government proposed that the gap in health service delivery be filled by an advanced practice nursing role and subsequently in 1990 commenced a systematic process of policy response with the development of the NP role as the goal.

Market economic forces and health workforce have long been drivers of change in delivery of health services in Australia (Hamric, Spross, & Hanson, 1996; Hegney, 1997; Masso & Thompson, 2014; Rogers, Villar, & Harman Practice, 2015). The shortage of doctors in rural and remote areas creates a financial burden to communities, individuals and the government in an effort to provide access to health services. This shortage of medical workforce has resulted in promotion of advanced practice nursing roles in an attempt to provide services to these communities and in part led to the development and creation of nurse practitioners in Australia. Australian rural and remote nurses, through their extended and expanded practice, provide a community with cost effective health services highly regarded by patients (Palmer & Short, 2014). However, advanced practice roles have generally evolved in an ad hoc manner specific to roles and responsibilities (Duffield, Gardner, Chang et al., 2009, p. 56). Notably, the ad hoc nature of the development of advanced practice nursing roles did not solve the problem of medical workforce shortages, particularly shortages in rural and remote areas of Australia. Consistent with other parts of the developed world, shortage and maldistribution of the medical workforce has led to the promotion of nurses as an alternative or substitute workforce (Duckett, 2005a).

Evidence exists that long-term cycles of the Australian medical workforce swing between periods of under and over supply (Foster, 2010). Increases of medical school intakes in 1973, recommended as a result of doctor shortages in the 1970s, led to an increase from 851 graduates in 1970 to 1278 in 1980, resulting in an oversupply of doctors (Palmer & Short, 2014, p. 160). The oversupply of medical graduates in 1980 led to reductions in future medical school intakes. Throughout the

1980s and into the 1990s the medical workforce was thought to be in oversupply, with medical school intakes remaining unchanged (Joyce, Stoelwinder, McNeil, & Piterman, 2007, p. 309). However, the issue of the perceived oversupply of doctors was problematic due to the lack of doctors to service rural and remote communities.

Continued attempts at health workforce reform have seen the medical supervised role of physician assistants gain momentum in Australia as an alternative classification of health care worker (Joyce, Stoelwinder, McNeil et al., 2007). The scope of responsibilities of a physician assistant in the US is compared to that of the NP and described as physician extenders (Forde & O'Connor, 2009). This is considered an inappropriate comparison; the role of the advanced practice nurse in many countries is undertaken without the supervision of medical practitioners (Pulcini, Jelic, Gul et al., 2010). The NPP Stage 1 Discussion Paper prepared by representatives of the nursing profession and nursing associations was the beginning of the nursing profession formally engaging in policy development for advanced practice nursing in Australia. In this discussion paper, the Independent Nurse Practitioner Task Force (INPTF) appeared to have the intent to disrupt the medical dominance and the medical dependence on nursing as a resource by providing a quote, outlining a 1985 initiative of the Director-General of the World Health Organization:

> The role of the nurse will change, some of them will move from the hospital to the every day life of the community, where they are badly needed. Nurses will become resources to people rather than resources to physicians, they will become more active in educating people on health matters. (Mahler 1985 cited in NSW Department of Health, 1992, p. 5)

The other key factor in the proposal to introduce a NP workforce was the development of the profession of nursing and the aspirations of the profession for advanced roles that enabled enhanced recognition, autonomy and remuneration.

2.3 Aspirations of the nursing profession

In 1987, a new clinical career pathway was established by the NSW Department of Health introducing clinical nurse specialists (CNS) and clinical nurse consultants (CNC) as advanced practice nursing roles. Prior to this move towards professional recognition of clinical expertise, nurses were leaving direct care roles and moving into areas of education and management to advance their career and to be

remunerated accordingly for their clinical expertise (Duffield, Gardner, Chang et al., 2011). At the time there were shortages of nurses across the regional, rural and remote areas of the state. It was argued that creating a clinical career ladder increased clinical nurse leadership opportunities, resulting in improved job satisfaction and potentially providing a positive impact on recruitment and retention within a skilled workforce (Davis & George, 1993; Pearson, 2000). This move recognised the importance of clinical leadership in nursing and established a career pathway other than the traditional nursing education and nursing management options (Duffield, Gardner, Chang et al., 2009). These roles are classifications of registered nurses (RNs) determined through an industrial arrangement embedded in the NSW Nurses Award (Duffield, Gardner, Chang et al., 2009) rather than being legislated, resulting in less differentiation of their scope of practice and less clarity in scope of practice than that of what was to become the legislated nurse practitioner role (Duffield, Gardner, Chang et al., 2009).

Advanced practice nursing roles in NSW have been described and defined by NSW Health Policy Directives and include clinical nurse specialists, clinical nurse consultants and nurse practitioners (Duffield, Gardner, Chang et al., 2009; NSW Government, 2015; NSW Ministry of Health, 2011). Recent Australian research reveals the role of the NP is significantly different from other advanced practice nursing roles in that the primary role of the NP is that of direct care (Gardner, Duffield, Doubrovsky et al., 2016). Other advanced practice nursing roles do include direct care; however, their patterns of practice are greater in areas such as education, supporting systems, and research than in direct care provision (Gardner, Duffield, Doubrovsky et al., 2016).

Duffield et al. (2009) have defined scope of practice of advanced practice nursing roles globally and compared these to the roles and functions of CNS and CNC in Australia (NSW Department of Health, 1992). As can be seen in Table 2.1, the introduction of CNSs and CNCs did not assist in meeting the identified health care needs of the communities where there was a lack of medical and other health services, as their scope of practice did not (and still does not) extend to prescribing of medication, referral to other health professionals and ordering of diagnostic services.

Table 2.1: Differentiation of Advanced Practice Nursing Roles

Commonalities of Advanced Practice scope (Duffield, Gardner, Chang et al., 2009) Key elements of nurse practitioner role in NSW	**CNC and CNS** (NSW Government, 2015; NSW Ministry of Health, 2011)
Right to diagnose	No
Authority to prescribe medication	No
Authority to prescribe treatment	Local policies
Authority to refer to other professionals	No
Authority to admit to hospital	Limited local policy
Legislation or regulation	No Personal grading governed by local policy
Legislation to protect title	No
Officially recognised as nurses working in advanced practice roles	Industrially

Current information on the roles and functions of CNS and CNC roles depicts the same situation as 1986 when the roles were introduced in NSW (Middleton, Gardner, Gardner et al., 2011; NSW Government, 2015; NSW Ministry of Health, 2011). This may be in part as a result of the successful introduction of the NP. Local policy assisted in meeting some health care needs; however, without legislative authority health professionals and patients could not access Commonwealth subsidy in the form of the MBS and PBS.

There is evidence that nurses had already been practicing informally in an advanced practice role sanctioned by those working within the health system (Walker, 2005). Much of this informal practice related to rural nurses practising in an extended role out of necessity to meet community needs (NSW Department of Health, 1992). This 'informality' of practice resulted in a variety of issues pertinent to scope of practice. For example, policy and regulatory arrangements as defined for an advanced practice nursing role such as NP are outside the scope of practice of the Australian CNS or CNC roles (Walker, 2005). Therefore, the introduction of NPs in Australia was the first attempt to create a distinctive, new nursing role that was regulated rather than a

new category of RN within existing regulation. The additional scope of practice that accompanied the NP role, such as prescribing medication, referral to other health professionals and ordering diagnostic tests, made the role distinct from the existing roles. It is also what necessitated inclusion of a wide range of stakeholders in the development of the public policy related to the role in response to community need.

2.4 Public policy response required to meet community health care needs

Public policy is the intentional course of action taken by government when resolving issues and achieving benefit for the public (Cochran, Mayer, Carr, & Cayer, 2009, p. 2). It is the business of the government, and includes legislation and regulation regarding scope of practice (Palmer & Short, 2014). Key documents generated during the period 1990–1998 specific to the NPP reflected the evolution of the policy development process.

The Stage 1 Discussion Paper proposed and explored the establishment of the NP role as a regulated health professional (NSW Department of Health, 1992). In addition to ensuring there is appropriate legislation and codes of conduct, the regulation of health professionals is intended to 'provide for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered' (Commonwealth Government of Australia, 2008 Clause 5.3). The Commonwealth Government's health and education policy decision to transfer nursing education from the vocational education, hospital-based programs to education in the tertiary sector in 1978 facilitated the argument that nurses could be appropriately prepared for advanced practice roles, including NP. As was acknowledged in the NPP Stage 1 Discussion Paper, university-based nurse education was viewed as an appropriate foundation for nurses seeking to become NPs because it provided preparation for advanced practice roles in primary care settings. The NPP Stage 1 Discussion Paper also noted that university education programs placed emphasis on health promotion and primary health care (NSW Department of Health, 1992, p. 3); health promotion and primary health care were identified in studies of NPs in other countries as having demonstrated 'increasing the health status of the population' (NSW Department of Health, 1992).

From a legislative perspective, a number of changes were necessary to enable NPs to fulfil a scope of practice that would resolve the issue of community access to health services in rural and remote areas of NSW (Duffield, Gardner, Chang et al., 2009, pp. 59-60).

As was identified in Table 2.1, the gaps in roles that could be undertaken by CNCs were prescribing, ordering diagnostic investigations and referral to other health professionals. Therefore, the Stage 2 NPP report identified the need to change a range of legislation such as the *Poisons and Therapeutic Goods Act 1966* and the *Pharmacy Act 1964* as part of the public policy reform required to capture the desired NP scope of practice.

As has been noted previously in this review of literature, the introduction of NPs in Australia and their subsequent entry into the Australian health care system required the development of the NP scope of practice The third key document that emerged during the period of this study was the *Nurse Practitioner Project Stage 3: Final Report: of the Steering Committee,*[2] released December 1995 (NSW Department of Health, 1995). This report documented the research undertaken to examine the role and scope of practice of the NP 'in terms of feasibility, safety, effectiveness, quality and cost under the auspices of a multi-disciplinary evaluation committee' (NSW Department of Health, 1993). The findings of the report were that the NP role was feasible, safe and effective, with the potential to deliver quality care that was cost effective (NSW., 1995).

Regulatory and legislative changes were required to enable the introduction of NPs into the NSW health system; these involved changes to laws at both Commonwealth and state levels of government. Ultimately as a result of the NPP, legislative amendments were introduced to NSW Parliament in 1998 and included changes to the *Nurses Act 1991* resulting in the *Nurses Amendment (Nurse Practitioner) Act 1998* as follows:

- Protection of the title 'Nurse Practitioner';

[2] From this point on the *Nurse Practitioner Stage 3: Final Report of the Steering Committee* will be referred to as NPP Stage 3 Final Report.

- Names of accredited NPs to be entered on the professional register, providing for the capacity to remove individuals from the register, thereby losing their accreditation and the right to use the title;
- Provision of a grandfather provision with a five-year sunset clause;
- An amendment to the *Poisons and Therapeutic Goods Act 1966*, providing granting and supplying rights to NPs for substances in sections of the Poisons Schedules; and,
- The *Pharmacy Act 1964*: amendments state that pharmacists can dispense medications prescribed by nurse practitioners.

The grandparenting provision was to allow immediate accreditation of nurses practicing in roles similar to NPs with the criteria for accreditation developed by the NPP Accreditation Committee and approved by the NSW Nurses' Registration Board (NRB), the regulatory body of the time (NSW Department of Health, 1995, p. vi). This enabled them to use the title of nurse practitioner and practice as an NP.

As part of the legislative changes the title 'nurse practitioner' was to be put in place as a mechanism to differentiate it from other advanced practice nursing roles and to protect the NP scope of practice governed by standards of care (NSW Department of Health, 1992). Protection of the title of 'NP' to differentiate the role from other advanced practice nursing roles is not uniform across all countries (Gardner, Chang, & Duffield, 2007).

Although the Final Report supported the role of NP and laid the platform for legislative change, as has been observed by Cochran (2009), implementation of policy is not a simple nor smooth process. The next section of the literature review presents the challenges inherent in developing health policy to progress advanced practice roles in nursing.

2.5 Challenges in developing health policy to progress advanced practice nursing roles

The challenges in developing health policy for advanced practice roles for nurses are longstanding and have been identified in a number of countries since inception of these roles in the USA and more recently in Australia. Issues that have consistently

been identified as problematic relate to the professional boundaries, scope of practice and autonomous practice as well as the historical medical dominance in health care in developed countries.

A review of the literature by Koch, Pazaki and Campbell (1992) addressed the first twenty years of the nurse practitioner role in the USA (Koch, Pazaki, & Campbell, 1992). The review suggested that much of the work undertaken by doctors can be undertaken by trained nurses or physician assistants, with research finding no significant difference in the quality of patient outcomes (Koch, Pazaki, & Campbell, 1992, p. 66). It was also identified that sections of the nursing and medical professions were increasingly uncomfortable with evolving NP roles despite doctors' groups at the time making plans to use nursing resources to solve their own manpower shortage (Welsh, Sanders, Richardson et al., 2014). Mitchell (2000) states that the Royal Australian College of General Practitioners (RACGP) and the Australian Medical Association (AMA) stated that they were developing a war plan against NPs (Mitchell, 2000).

More recently in Australia, a rapid review of the literature by Masso and Thompson (2014) found resistance to the role of NP originated from nurses undertaking traditional doctor's work (Masso & Thompson, 2014), competing with medical practitioners for patients, with an associated limited pool of resources. Competition to promote efficiency in the health system, deliberate or not, overlooks the fact most inefficiency in health care is embedded in customs, rules, work practices, professional values, institutional structures and professional balkanisation, achieved by licencing and certification (Masso & Thompson, 2014). In addition to competition having economic implications for all parties, whether they are losses or gains, change in the health workforce challenges the existing arrangements and leads to resistance. The Australian Medical Association's NP position statement (2005) states they do not support independent nurse practitioner roles (Australian Medical Association, 2005). The AMA remained sceptical in 2009 through the Submission to Senate document (2009) concerned with the NPs ability to provide some services funded under the Commonwealth Medicare Benefits Schedule (MBS) and to prescribe medications that are subsidised under the Pharmaceutical Benefits Scheme (PBS). They stated that 'if implemented carefully, the legislation may help address unmet

community health needs - provided it is done in a coordinated way and medical practitioners are still involved in the overall care of the patient.'

An analysis of the literature related to the development of advanced practice roles for nurses and associated public policy development in the 1990s reveals substantial challenges related to competition and professional identity. The extent of the challenges became apparent when the NSW government received responses to the release of the NPP Stage 1 Discussion Paper. Some responses were consistent with literature about the introduction of advanced practice roles for nurses in that they identified professional working relationships and role ambiguity as key factors influencing resistance to advanced practice roles (Cant, Birks, Porter, & Cooper, 2011; Turner, Keyzer, & Rudge, 2007). Other responses consistent with the literature at the time revealed resistance from three key stakeholder groups: the medical profession, the community and the sections of the nursing profession itself.

Within any social structure there are a range of influences operating at any one time, having a positive and negative effect on the individuals within the social structure (Kuhlmann & Annandale, 2012). In the context of the Australian health care setting the influencing traditional medical discourse dominates other health professional discourses (Kuhlmann & Annandale, 2012). The government's attempt to develop public policy making way for advanced practice nursing roles, via the NPP, would challenge a tradition (Turner, Keyzer, & Rudge, 2007).

2.5.1 The dominance of medical discourse

The government did not include the medical profession in the task force for what became known as the NPP Stage 1. That task force comprised only nursing group representatives. While doctor groups were included in subsequent NPP stages, the first published opposition to the development of an advanced nursing practice role from doctor groups did not emerge until the release of a report commissioned by the NSW branch of the AMA. The February 1996 publication of the report prepared by Logan Consulting and titled: *Review of the NSW Health Department's Report of the*

Nurse Practitioner Project: Stage 3 [3] proved to be a fourth key document in the early evolution of the public policy for the NP role.

The Logan Report critiqued the NPP as a whole, not just the NPP Stage 3 Report. It questioned the validity of the research and evaluation of the nurse practitioner pilot projects, and argued from an economic perspective that there was little to be gained from introducing an advanced practice nursing role. It rejected the qualitative nature of the evaluation methodology chosen in the majority of pilot site projects and disregarded and discredited the results, concluding that there was no evidence from any of the pilot projects that justified the recommendations of the NPP Stage 3 Final Report (Logan Consulting, 1996, p. 21). The Logan Report and the ensuing response of the AMA reinforced the changing positions of power and medical dominance.

The concluding response of the Logan Report to the NPP Stage 3 Final Report and its recommendations was that it failed, with no plausible justification to proceed with the NP role (Logan Consulting, 1996, p. 26). The authors of the Logan Report did, however, concede there was a community need in the rural and remote areas of NSW where an advanced practice nursing role would be appropriate. However, it argued if further remuneration and incentives were offered to doctors to practice in these areas, accrediting nurse practitioners would not be necessary (Logan Consulting, 1996, p. 26) and medical dominance could have been maintained.

2.5.2 Professional boundaries

Some view advanced practice nursing as substitution of the doctors' traditional role and a way of increasing health care efficiency when dealing with scarce resources (Welsh, Sanders, Richardson et al., 2014, p. 8). Foster (2010) has argued that as the government-funded health care system rationalises efficiencies and the need for quality of care to meet community needs, challenges to definition and control of scope of practice are ongoing, as was the case with the introduction of the NP role in Australia (Foster, 2010). Gaining a better understanding of the scope of practice and professional boundaries issues that arose in the development of public policy for NPs may enable enhanced policy responses to an increasingly efficiency-driven health sector.

[3] From this point on the *Review of the NSW Health Department's Report of the Nurse Practitioner Project: Stage 3* will be referred to as the Logan Report.

By their very nature, scopes of practice set boundaries. Any proposal to introduce an advanced practice nursing role meant the issue of professional boundaries would be a challenge. This was highlighted in the first NPP Stage 1 Discussion Paper, which discussed the 'blurring of roles'. It argued that roles fluctuate with increasing technology and changes to models of care and service delivery. The authors argued the blurring of roles 'should not be seen as a takeover by either party, rather than the natural and continued integration and interrelation of the roles of doctors and nurses in the delivery of health care' (NSW Department of Health, 1992, p. 5). There was no reference to how this blurring of roles or professional boundaries would be addressed. There was, however, intent for consultation with all health professionals to define an appropriate scope of practice for NPs.

The NPP Stage 3 Final Report discusses the overlapping of roles between nurses and doctors (NSW., 1995, p. v) further. The Report refers to the complementary nature of the two professions. It reports the success of the ten pilot projects in terms of the evidence from the research that NPs 'are feasible, safe and effective in their roles and provide quality health services in the range of settings researched' (NSW., 1995, p. ii). The introduction to the NPP Stage 3 Final Report discusses, in part, the need for an evolving and collaborative relationship between the roles and functions of nursing and medical professions in order to reduce confusion about the roles of NP and medical practitioners (NSW., 1995, p. 5). The Stage 3 Report discussed the 'arduous, tense and bitter at times' (NSW Department of Health, 1995, p. 120) nature of events surrounding the NPP Stage 2 Steering Committee and in doing so set operating norms for the NPP Stage 3 Steering Committee meetings. In an effort to promote collaborative practice, the two overarching guiding principles required medical practitioner agreement to the establishment of any NP service and the medical profession's ongoing involvement in planning, practice and evaluation of the individual NP services. The ongoing conflict, primarily between the medical and nursing professions, led to the development of the following guiding principles that underpinned the 48 recommendations made by the NPP Stage 3 Steering Committee and were deemed essential to establishing a NP service:

- 'A *local agreed need* is confirmed prior to establishing a service that includes nurse practitioners; and,

- Collaborative planning, practice and evaluation are the foundation of relationships across professional boundaries' (NSW., 1995, p. v).

There were 48 recommendations made by the NPP Stage 3 Steering Committee, which covered areas of education, collaborative relationships, legislative recognition of the role, accreditation, establishing NP services, scope of practice, funding, professional indemnity, and economic evaluation. The 48 recommendations were shaped by the knowledge of existing tensions around professional boundaries. The Logan Report, a response to the Stage 3 Final Report, was silent on the issue of professional boundaries; however, it did seek to compare the services provided by GPs to that of an NP (Logan Consulting, 1996, p. 2).

The development of public policy through the NPP provided the nursing profession with an opportunity to expand their professional boundaries, whereas the medical profession sought to retain the existing boundaries. Embedded customs and work practices influenced much of the resistance by the medical profession to the introduction of the nurse practitioner role. Role extensions and substitution of doctors' traditional practice are termed by Welsh et al. (2014) as 'boundary work' (Welsh, Sanders, Richardson et al., 2014). Boundaries between professionals are fundamental to maintaining professional identity and 'boundary work' is undertaken to maintain ownership over a sphere of work or practice (Light, 1992, p. 468). Welsh et al. (2014) argue that role extension is underpinned by the social theories of professional identity and boundary (Welsh, Sanders, Richardson et al., 2014). Closely linked to the notions of identify, boundaries and scope of practice is the concept of autonomy in practice. A study of advanced practice nursing education, practice, and regulation surveyed active members of International Nurse Practitioner-Advanced Practice Nursing Network of the International Council of Nurses. Of the 91 respondents from 32 countries, 54% (n=13) described their practice as autonomous or semi-autonomous without medical supervision (Pulcini, Jelic, Gul et al., 2010). Despite the study by Pulcini (2010) and that of Jokiniemi et al. (2015) seeking nurses' views about the degree of autonomy in advanced practice nursing, and the concept of autonomy being central to advanced practice nursing, it appears difficult to clearly define. Masso and Thompson (2014) conducted a rapid review of the NP literature, and concluded 'a nurse practitioner is a registered nurse educated

and authorised to function autonomously and collaboratively in an advanced and extended clinical role' (Masso & Thompson, 2014, p. 7). Masso and Thompson (2014) argue that advanced practice roles have increasing levels of autonomy in decision-making related to clinical practice. Any attempt by a government to fill a shortfall in health workforce through public policy that gave a degree of autonomy to nurses, though possibly not perceived as 'role substitution' by the community at large, was always going to be seen as such by the professions of nursing and medicine (Chiarella, 1998).

The creation of these overarching guiding principles across all recommendations were in response to the tensions between nurses and doctors and influenced the evolution of the role of the NP. The guiding principles set the tone for all discussions and communications in the subsequent public policy development and framework for the implementation of NP services in NSW (NSW Department of Health, 1993).

It was noted in the NPP Stage 3 Report that there may be resistance from communities to the services of a NP rather than a doctor, as arguably, the community measures health services with a medical model as a benchmark and this influence acceptance of an NP service. Despite the report stating that this was not reflected in the pilot phase of the NPP (NSW., 1995, p. v), it is important to be aware that the community is immersed in the dominant discourse that health service provision is largely dependent on there being doctors rather than nurses available. The challenge is, as Hegney (1997) argues, to develop an extended practice role for nurses who will 'provide a health service to a community who have been educated in a medical-specialist model of health care' (Hegney, 1997, p. 23).

Within the dominant medical discourse, historically nurses had been viewed primarily as resources to gather information and carry out doctors' orders (NSW Department of Health, 1992, p. 5). The introduction of an advanced practice nursing role provided opportunity and options for skill mix and workforce planning. It also provided opportunity for the aspirations of the nursing profession to be met. Yet, there was some resistance to this from within nursing.

2.5.3 Resistance to change within nursing.

The internal culture and out-dated yet persistent discourse of subordination within the nursing profession aimed at maintaining the status quo are barriers to progressing advanced nursing practice (Furlong & Smith, 2005). Contributing factors to the resistance from both doctors and nurses to the introduction of the NP were over core issues such as scope of practice, prescribing medications and access to government subsidy by accessing the Pharmaceutical Benefits Scheme and Medicare Benefits Scheme provider numbers (Bergeron, Neuman, & Kinsey, 1999; Elsom, Happell, & Manias, 2009).

In 1998 the fifth key document informing the development of public policy in advance practice nursing roles in NSW *The NSW Health Department policy framework "Nurse Practitioner Services in NSW"*[4] (NSW Department of Health, 1998) was published. The intent of the NP Framework was to guide district health services in establishing NP services. The NP Framework was silent on the opposition of some nursing groups to the NP role. The NP Framework is a policy document detailing accreditation processes, professional indemnity and clinical guideline development for NPs. There is no indication of the protracted interdisciplinary disputes between the nursing and medical profession at the time of the development of the NPP and the NP Framework. There is, however, reference to having 'professional links for consultation and review between the nurse practitioner and nominated medical practitioners' (NSW Department of Health, 1998, p. 5). The policy was silent on whether this is a reciprocal review, i.e. that nurses could review medical practitioners. The compulsory involvement of the medical profession in the day to day workings of the NP, supported by public policy, perpetuated the long standing tensions between the nursing and medical professions and impeded the capacity of an NP practicing autonomously.

There was little evidence in Australian literature of resistance from within nursing to an advanced practice nursing role at the time of the NPP. However, Lindsay (2008) and Ball and Cox (2003) did cite evidence of such resistance in other countries during implementation of advance practice nursing roles (Ball & Cox, 2003). Ball

[4] From this point on *The NSW Health Department policy framework "Nurse Practitioner Services in NSW* will be referred to as the NP Framework.

and Cox analysed advance practice nursing roles in adult critical care settings in the USA, Canada, the United Kingdom, New Zealand and Australia. Thirty-nine participant advanced practice nurses were interviewed and one of the findings of the study was evidence of resistance to an advanced practice role that was instituted by nursing staff. Medical and nursing resistance to an advanced practice nursing role was seen to limit patient outcomes, building relationships between colleagues appeared to mitigate the risk.(Ball & Cox, 2004, p. 16).

The NPP Stage 1 Discussion Paper prepared by representatives of the nursing profession and nursing associations was the beginning of the nursing profession formally engaging in policy development for advanced practice nursing in Australia. Implementation of changes to scope of practice, even those supported by health policy, professional development and competencies continue to be challenged by barriers to the change (MacLellan, Higgins, & Levett-Jones, 2015). An ongoing systematic approach to managing the changing roles of nurses and the implicit challenges requires the commitment of government and the nursing profession.

It is important to be aware of how responses to key documents generated during the NPP shaped the membership of committees of the NPP, as members of those committees were those interviewed for this study. For example, the feedback received about regulatory and legislative issues identified in the NPP Stage 1 Discussion Paper, the *Nurse Practitioner Review Stage 2* (NSW Department of Health, 1993) resulted in establishing working parties comprising nursing, medical, pharmaceutical, government and consumer representatives. These working parties were chaired by an independent person, to advise on advanced practice nursing scope of practice such as prescribing of medication, including amendments to the Poisons Act; and referral of patients to other health professionals. Although initially NP regulation and legislation were state based, the Commonwealth government had a role to play in terms of their responsibility for administering the PBS and MBS. Access to the PBS would be required to facilitate future nurse practitioners prescribing medicines within their scope of practice, and the MBS would be required for requesting diagnostic tests; referrals to specialist doctors and allied health professionals; and to enable bulk-billing of NP patient consultations (Grant, 1985, p.

24). The Commonwealth government's responsibilities warranted their involvement in the development of an advanced practice nursing role.

2.6 Chapter summary

This literature review has identified the factors that led to the proposed introduction of the NP role in NSW in 1990 and presented a synopsis of issues pertinent to the development of public policy for NPs in order to provide the context in which the NPP occurred.

Three central themes emerged from the review of the literature:

- The case for an advanced practice nursing role in Australia as influenced by health workforce issues;
- The need for a public policy response to meet community health care needs;
- Challenges to the implementation of policy to progress advanced practice nursing roles.

Underpinning the literature was the issue of the longstanding tensions between nursing and medicine in regard to professional boundaries and autonomous practice impacted by:

- The lack of clarity of an advanced practice nursing role;
- Public policy debate around workforce issues regarding which member of the health care team could undertake what practice, and where this could occur. Public policy debate also involved industrial relations and the remuneration for work undertaken;
- The impact that the proposed changing scope of practice of an advanced practice nursing role had on established professional boundaries, resulting in role overlap between nursing and medicine creating resistance to change; and
- Aspirations for professional independence for nurses and midwives and the market forces that affected this.

These four elements have helped to shape advanced practice nursing since the concept was first mooted in the 1980s. This literature review assisted in

understanding the factors that impacted policy development and the barriers to change in the status quo.

The published literature does not reveal the forces that conspired to resist the change in health policy, which would allow the advanced practice role of nurse practitioner to be introduced. Also the literature did not discuss the extent or depth of negotiation and strategy employed by individuals to influence debate and ultimately health policy.

The next chapter presents the guiding methodology and outlines the methods used in the study.

CHAPTER 3
STUDY METHODOLOGY AND METHOD

This chapter presents the methodology and methods used in the study. While the previous chapters provided an overview of the study and a review of the literature pertinent to the study, this chapter presents a description of, and rationale for, the approach taken in the study.

In order to address the research question: ‘What factors shaped the development of the public policy for Nurse Practitioners in Australia: 1990–1998?’ this study employed interviews and content and thematic analysis processes to explore the events surrounding health policy that supported the introduction of an advanced practice nursing role in Australia.

This chapter discusses the way in which Critical Social Theory was used to guide the study and justifies the use of key informant interviews as a data collection method. The chapter details the process of participation selection and recruitment. The questions used to guide the semi-structured interviews in the study are described and justified. Data management, data analysis and ethical considerations are addressed. Finally, the limitations of the study method are identified.

3.1 Critical Social Theory

This study adopts a qualitative interpretive approach using a critical social theory lens. Critical Social Theory (CST) originated in the Frankfurt School in 1920s and 1930s in Germany as left-wing thinking attempted to reconsider Marxist theory (Browne, 2000, p. 38). CST proposes that certain groups hold subordinate positions. Those who subscribe to CST see social institutions such as health as havens for imbalance in power and privilege. Medicine and nursing are seen as examples of these systems (Casey, Saunders, & O'Hara, 2010). Browne (2000) suggests embedded in CST are assumptions of the prevalence of unequal power relations and oppressive structures within society and the belief in the need for emancipation to liberate those oppressed (Browne, 2000, p. 39). Browne (2000) clarifies that the role of CST in supporting change in nursing is through challenging social order (Browne, 2000, p. 35).

CST broadens knowledge and presents opportunity to challenge cultural and social models and fundamentals that maintain the status quo (Bountain, 1999; Browne, 2000; Fulton, 1997; Mill, Allen, & Morrow, 2001; Wilson-Thomas, 1995). CST is one way to understand the negotiations for change in nursing practice and shifts in approach to care delivery across the wider health care system.

The introduction of the nurse practitioner in NSW was the first attempt to recognise and formalise an advanced practice role for nurses in Australia. It was a challenge to the status quo, which was founded on medical dominance whereby nurses were regulated to a subordinate position as a resource for the practice of doctors.

Efforts to explore experiences of health professionals are primarily to improve health outcomes (Browne, 2000, p. 38). This study is important because it is centred on the NPP meetings and informal interactions that were typified by intensely contested debate between professionals. The study reveals the experiences of health professionals and others involved in negotiations to establish the NP role in Australia while exploring the impact of known tensions between nursing and medicine. As the study was about a role intended to enhance access to care through an advanced practice role for nurses, the study is important and CST is appropriate for this study.

This study captures and analyses the experiences of individuals involved in the development of public policy required for the introduction of an advanced practice nursing role in NSW. Shedding light on how several individuals experienced the same event may enhance understanding of what emerged as a result of the NPP by filling in some of the perceived gaps in the formal, structured and publicly available discourse recorded in key documents produced during the NPP.

As discussed in the previous chapter, the introduction of advanced practice roles for nursing have been reported to result in issues of shifting professional boundaries and power. Proponents of CST argue that the use of a CST approach illuminates how power relations are inherent in social structure (Browne, 2000; Casey, Saunders, & O'Hara, 2010; Mill, Allen, & Morrow, 2001). Thus CST is an appropriate lens through which to explore the NPP, which shifted professional boundaries, changed roles of health professionals and guided health policy development.

As revealed in the literature review, resistance to the new public policy arose from three key stakeholder groups – the medical profession, and to a lesser extent, the community and the nursing profession (Carter, Owen-Williams, & Della, 2015; Chiarella, 1998; NSW Department of Health, 1993; Australian Medical Association, 2005) this resistance can be understood by an analysis of power and control. In terms of medical dominance and power, Foucault described power as a network of power relationships extending throughout society (Browne, 2000, p. 35). He approached the issue of medical dominance from the perspective that ideology pervades structure and policy. He believed that the development of scientific medicine, as well as several other disciplines, arises out of the need for the 'State' to control its population expressed as public policy (Cheek, Shoebridge, Willis et al., 1998; Rabinow, 1997). Foucault's concept of power/knowledge suggests that the state uses scientific knowledge as a powerful form of social control, therefore suggesting that medicine is a discipline of social control whilst under regulation by public policy (Rabinow, 1997).

A Marxist view of the development of advanced practice nursing roles could be interpreted as a challenge by the previously proletariat class of nursing to aspire to the position of the bourgeoisie class of the medical profession (Cheek, Shoebridge, Willis et al., 1998). The challenge to medical dominance by the nursing profession in pursuit of an advanced practice nursing role created tension and at times conflict, resulting in resistance from the medical profession and an opposing struggle on the side of the nursing profession.

3.2 Study design and method

The study used a qualitative approach in which interviews were the data collection strategy. There are many definitions of qualitative research; however, for the purposes of this research, I have chosen the following:

> Qualitative research is a situated activity that locates the observer in the world. Qualitative research consists of a set of interpretive, material practices that make the world visible. (Denzin & Lincoln, 2011, p. 3)

Qualitative research is useful when interpreting events and situations in a set context. The study sought to explore the experience of participants in the NPP in order to

describe and explain what occurred during the process. Participants in the study were key informants who were actively involved in the development of public policy during what became known as the NSW Nurse Practitioner Project (NPP) over the period 1990–1998. Thirteen semi-structured interviews were conducted between July 2011 and May 2012.

Interview was selected as the data collection method in the study as it allowed exploration of the challenges, limitations and strengths of the processes and offered the opportunity for an in-depth exploration of the understanding of the development of policy for the establishment of the role of the NSW NP. Employment of interviews as a method to gather data allows researchers access to information otherwise inaccessible (Perakyla & Ruusuvuori, 2011, p. 529). Semi-structured interviews, where interviews are guided by structured open-ended questions that the researcher can then supplement with further probing questions as required, allows for the introduction of a broad account, which in this case was the participant's involvement in the NSW NPP development. This approach allows the interview to take unexpected turns as needed through the use of probing questions.

The use of semi-structured interviews in this study facilitated the in-depth exploration of what happened behind the scenes, and enhanced understanding of the structural reforms and public policy that influenced the development of an advanced practice nursing role that was not otherwise captured in formal records. The intent of this study was to elicit the authentic experiences of the participants as well as to enhance understanding of the structural reform and change to public policy required to develop this advanced practice nursing role. Therefore, the use of semi-structured interviews was appropriate as it enabled participants to share and reflect on their experience of participating in the process of policy development.

While the written word can relate actual facts and events, verbal narrative by those individuals who present an experienced event is history brought back to life; histories give stories life, they are narratives with meaning, enhancing meaning for the next generation (Weatherford-Stevens & Latham, 2009). This study provides an account of history as experienced by those involved in the development of the nurse practitioner role in NSW; providing public policy makers and the next generation of nurse practitioners with insight into how the advanced practice nursing public policy

developed. This gives meaning to how and why an advanced practice nursing role evolved in NSW.

3.3 Interview questions

To inform the preparation of interview questions, the researcher reviewed public documents, including minutes of meetings, reports and other relevant documents that evolved during the NPP in NSW 1990–1998. The information gained from this activity was used to develop the interview guide.

Interview questions centred on the involvement of the participants in the Nurse Practitioner Project, the processes they engaged in, and whether there was anything they would have done differently. Participants were asked about particular events they remembered as significant, and if there were any that remained in their memory. Interview questions were open-ended to stimulate storytelling, aiming to encourage open and frank discussion (See Appendix B).

The interview questions were reviewed and critiqued by one of the researcher's supervisors to ensure alignment between the research question and study aims. Each question was mapped to ensure it would provide a response aligned to capturing the drivers, process and outcomes of the NPP.

3.4 Participant selection criteria

Criteria for participant selection included ensuring representation across a wide range of key stakeholder groups – professional, government, political, industrial, nursing and medical – involved in the NSW Nurse Practitioner Project.

Key individuals who participated in the entire eight years of the NPP were identified as having the potential to provide insight into the policy development process. These individuals were approached and all but one agreed to participate in the study. Other individuals recommended by participants were approached directly to be involved in the study, resulting in a snowball effect for participant recruitment. One participant, a politician during the development phase of the NP role, suggested another politician and agreed to give the researcher an introduction. Subsequent to that introduction, the second politician was recruited to the study.

The informants were able to discuss the views of all steering committee members. Therefore not all members of the steering committees, such as advanced practice nurses, midwives, allied health and consumer representative members, were approached to participate in the study. However, both the researcher and key informants saw the involvement of one group, the AMA, as significant. The researcher approached a representative of the AMA to participate, following which a person was recruited to the study.

3.5 Participant recruitment

Purposive and snowball sampling was used in the study to attract participants. Fourteen potential participants were contacted, initially by email and phone, and invited to participate in the study. One individual declined to participate; however, that person did refer the researcher to another individual who was representative of the same professional body. During the course of the interviews, one participant referred the researcher to another individual who was involved in the Nurse Practitioner Project. The researcher approached the two referred individuals and both agreed to be participants in the study. Individuals who agreed to participate were provided an information sheet and consent form and indicated their consent to participate by providing a signed 'Consent to Participate Form' (Appendix C).

Inclusion of key informants from each level of policy development was essential in providing insight into the entire stakeholder consultation process of policy development (see Figure 3.1). Key informants from each consultative level were approached to participate in the study.

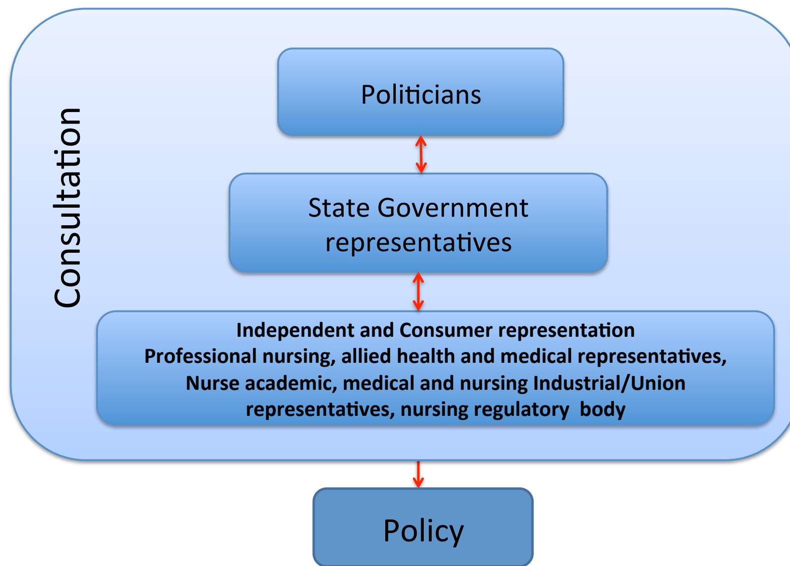


Figure 3.1: Process of Consultative Policy Development

The purposive-snowball sampling approach resulted in fourteen people being approached and thirteen (n=13) individuals agreeing to participate in the study as summarised in the following table.

Table 3.1: Stakeholder Representation

Participant	Representation
N1	Representative, professional nursing organisation
N2	Nursing Department, NSW State Government
N3	Representative, nursing union organisation
N4	Nursing Department, NSW State Government
N5	Representative, professional nursing organisation
N6	Nurse Academic
N7	Representative, nursing regulatory body
D1	Representative, professional medical organisation
IR	Independent (non-nursing, non-medical)
P1	Politician
P2	Politician
GR	Department of Health, non-nursing NSW State Government
D2	Representative, medical union organisation

Over the course of the interviews, particularly during later interviews, participants were recommending the researcher contact other key informants to participate in the study. At this time, similar information and data were emerging. The decision was made not to pursue any further participants as no new themes were emerging; saturation of data had been reached. Data saturation can be explained as the point at which data collection reveals no new or relevant emerging information (Schwandt, 2009).

Throughout the data collection phase, participants would recommend the researcher approach others to participate. This validated the approach to participant selection, as many of the people put forward by participants were previously on the list of people to be approached by the researcher, confirming the appropriate participants had been chosen.

3.6 Conduct of interviews

All interviews were conducted face-to-face. One interview was conducted using video conferencing via Skype due to distance, and in all other interviews the researcher and participant were in the same room. In order to enhance a feeling of trust and comfort with participants, the researcher offered for participants to elect where their interview was held; some participants elected to be interviewed in their home.

3.7 Data management

When employing interviews to assist individuals in recalling events, it is the researcher's responsibility to ensure the accounts are told as the participants remember them. Interviewers 'strive for intellectual honesty … while avoiding stereotypes, misrepresentations of the narrator's words' (Oral History Association, 2009). Interviews were digitally audio recorded and transcribed verbatim. The transcribed file was returned to the participant by email for verification of content and intent. Two participants requested amendment of their transcript. The transcripts were amended to include the participant's feedback. The remaining participants agreed their transcripts reflected their interview.

A third party, who agreed to maintain confidentiality, transcribed the interviews. Transcripts were entered into NVivo software to enable the researcher to manage the data and to assist in content and thematic analysis. Data were kept confidential on the researcher's password-protected computer and were also held and stored on a password-protected computer in the School of Health at the University of New England by the student's principal supervisor. Participants in the study consented to interview transcripts being made publicly available in the archives of the Australian College of Nursing. This will occur following completion and examination of this dissertation.

3.8 Data analysis

This study took a content and thematic analysis approach. Content analysis is a method where quantitative measures of the frequency and appearance of particular elements of text are analysed (Jupp, 2006 p. 40). The use of content analysis allows

the researcher to examine documents where content emerges in the process of analysing text relative to a particular context (Krippendorff, 2013 p. 25). Thematic analysis allows the researcher to identify and group common elements and particular events and experiences as expressed by research participants (Jupp, 2006 p. 187).

In this study, the interview transcripts were read in their entirety by the researcher for content. Transcripts were analysed for content and examined for recurrent instances of the frequency of issues occurred. The top fifteen ranking categories were identified by the frequency with which the participants raised the issues. Category ranking was capped at fifteen, as this was where they aligned as reported in the literature. These top ranking issues were analysed to find common thematic elements across study participants and the events and experiences they were reporting.

A theme captures something important about the data, generally in relation to the research question, and reveals some patterned response or meaning evident within the data (Braun & Clarke, 2006). In this study, identification of particular content patterns or themes allowed the researcher to identify themes that were then expanded on with all of the responses that fitted under particular patterns coded and grouped into sub-themes. Themes were then categorised according to whether they were or were not reported in the literature and what was not reported in the literature was revealed as new information in this study.

Audio recordings were listened to carefully for intonations, pauses and inflexions as these added to the researcher's interpretations of the participants' words. These intonations, pauses and inflexions are reflected in the quotes in the next chapter.

3.9 The researcher in qualitative research

I am a female of fifty-five years and have a professional background of nursing. I was practicing as a nurse manager in rural NSW during the focus period of this study, 1990–1998. To facilitate analysis of data collected through interviews conducted by the researcher, the researcher needs to acknowledge they were active in the process and must set aside preconceived ideas and interpretations of their own (Perks & Thomson, 2006, p. 116).

Participant recruitment and development of interview questions were informed by the professional experiences of the researcher in the NSW health system. This phenomenon, referred to as 'insider status', gives the interviewer an 'insider' perspective that brings with it benefits of insight otherwise obscured to 'outsiders' (Perks & Thomson, 2006, p. 117). The researcher was aware of potential bias and remained objective in developing interview questions and when interacting with the participants within the interview process. Bias is generally viewed as a negative feature of research and recommended as something to be avoided in research (Jupp, 2006 p. 17). To ensure objectivity and avoid bias the researcher kept notes and reflections as well as seeking guidance from academic supervisors as to participant selection and question development, and during analysis and interpretation of study findings.

3.10 Ethical considerations

Approval for this study was sought and granted by the University of New England Human Research Ethics Committee (Approval Number: HE10/160) (see Appendix D).

Ethical practice in qualitative research has four guiding principles: informed consent, freedom from deception, privacy and confidentiality, and accuracy (Denzin & Lincoln, 2000, p. 22). All of these ethical principles were adhered to when conducting participant interviews in this study. To this effect, participants were provided with a Participant Information Sheet (Appendix C) at recruitment and were required to provide formal agreement to participate in an interview via a Consent Form (Appendix C).

The events being examined in this study are on public record; however, the arguments and tensions between groups and individuals are not. Disclosure of information of a sensitive nature that was revealed to the researcher was managed in a confidential manner in accordance with the participants' consent. Participants were asked how they would like to be recorded in history and allowed to request anonymity if and when they wished to provide anonymous commentary.

Although this study has de-identified individuals when using direct quotes, the different professional categories of participants have been presented in Table 3.1.

Complete anonymity is difficult to maintain due to the positions they held and the public nature of the events and public records of the NPP. Participants were advised of this as part of the informed consent and were invited to edit transcripts and identify any information they did not wish to be made public. It was felt by the researcher that in two quotes in Chapter 4 anonymity might not be maintained for one participant. The participant was contacted by email explaining their name was not mentioned and the quotes were de-identified, however, due to the nature of the project there was only one independent chair of the steering committee and some who were intimate with the process may identify them. The participant gave consent to use the quotes; see Appendix E for correspondence between the researcher and the participant.

3.11 Limitations of the study methods

This study invited participants to share their recollections and reflections on a situation that occurred in their professional lives more than twenty years ago. It is recognised that there are limitations when using an interview approach to examine past events due to time lapse resulting in, at times, flawed recall of events and that people remember significant events that are most important to them (Perks & Thomson, 2006; Robertson, 2006; Tropello, 2000). While this is a limitation of interview, it could also be possible that the time between the experiences and recall of them enabled participants to be more detached from the process. However, what they did recall and spoke of so emotively indicates the significance of the events of 1990–1998 surrounding the NPP.

Another limitation of interview technique is that the direction, and therefore content of the interview, is largely dependent on the interviewer and how they approach the interview in terms of questions, dialogue and personal relationships (Perks & Thomson, 2006). It is possible that different questions may have elicited different responses from different participants. The use of semi-structured interview questions provides guidance and focus as well as opportunity to add to the interview through the use of probing questions. In addition, transcripts were reviewed to ensure the researcher had used open-ended questions as a guide for the interview.

The nature of this study required a purposive snowballing approach to participant recruitment. Selection of participants in the research was driven by review of key documents containing names of potential key informants, professional associations, the researcher's knowledge of events and later by the participants. Some believe the subjectivity exercised by a researcher in choosing study participants is a disadvantage of purposive sampling that may lead to bias (Schwandt, 2009, p. 245). However, in this study the researcher cast the net widely to include representation from all major stakeholders.

3.12 Chapter summary

This chapter has presented the theoretical basis for the approach taken in the study. It has justified critical social theory as an appropriate lens through which to view the events and circumstances experienced by individuals brought together for the development of the NP role in NSW. Interview as a method provided an expansive amount of data that allowed thematic and content analysis to examine discourse created during the development of public policy to enable the establishment of the NP role in the state. An interview method provided a process that allowed study participants to reveal events and experiences not previously captured. The next chapter will present the findings of the study and provide a brief discussion of the findings.

CHAPTER 4
PRESENTATION OF FINDINGS

This chapter presents the findings of the study in response to the research question 'What factors shaped the development of the public policy for Nurse Practitioners in Australia: 1990–1998?' While the previous chapters provided an overview of the study, a review of the literature pertinent to the study, and a description and rationale for the approach taken in the study, this chapter presents the study findings.

Data were analysed for content and examined for recurrent instances of the frequency of issues occurred. The top fifteen ranking categories were identified by the frequency with which participants raised an issue, and these are presented in Appendix F. These top fifteen ranked categories were chosen, as subsequent incidence of other categories was substantially less. Participants related to feelings and emotions seventy-three times, this being the most frequently mentioned; nine of the thirteen participants made reference to this. Of those nine participants, seven were nurses, one was the independent and one was a doctor. Eleven of the thirteen participants identified the government as essential to the NPP and within this comments relating to both the Commonwealth and state governments were evident. When content was clustered and reviewed, common themes emerged across study participant responses. Five themes emerged from data analysis:

1. The known drivers of the case for establishing an advance practice role as distinct from the existing CNS and CNC roles.
2. The importance of the need for bipartisan political support in developing public policy.
3. The development of the nursing profession since the early 1970s and a raft of previous policy development laid the foundations of the development of NPs between 1990 and 1998.
4. For some of those involved, the work of the NPP presented substantial personal challenges.
5. The way in which aspects of protectionism and self-interest of professional groups, in particular, doctors, influenced this public policy development.

The following diagram represents the issues identified by the participants and the themes that emerged from the analysis of the data.

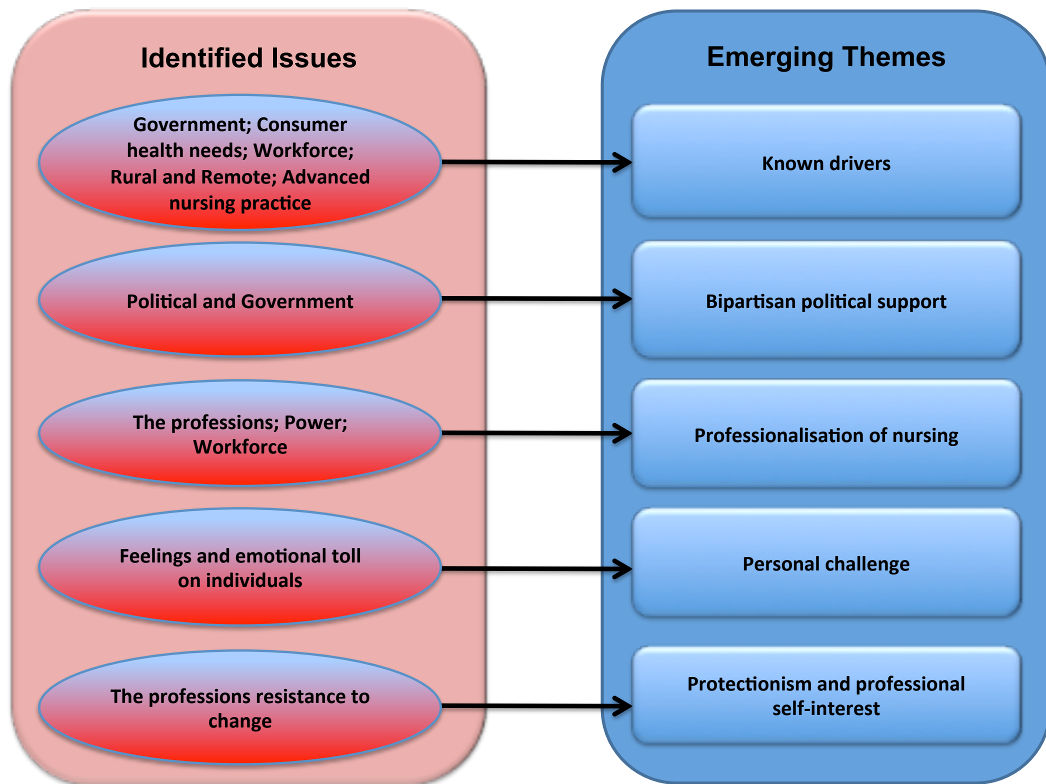


Figure 4.1: Relationship of content to themes

While the case for the NP role in NSW is largely known, interviews with participants in this study revealed that the pathway of development and eventual implementation of public policy were impacted by politics, history, personal challenges and professional protectionism. The remainder of this chapter presents finding related to each of the key themes that resulted from analysis of participants' experiences of the NPP.

4.1 Known drivers for the role of NP

The need for change is always in response to forces that drive it. In the case of the NP role in NSW, the study data revealed there were a number of drivers that influenced the need for its establishment. These were:

- a maldistribution of medical workforce in rural and remote areas while metropolitan areas were oversupplied;

- a reduction in government-funded GP training positions;
- nurses working outside their scope of practice and aspirations for autonomous practice and further advancement of the clinical career pathway for nurses, which had previously seen the development of the Clinical Nurse Specialist (CNS) and Clinical Nurse Consultant roles (CNC).

4.1.1 Maldistribution of medical workforce – a shortage of doctors in rural and remote areas

Prior to 1990, when the NPP project commenced, there was an oversupply of GPs in metropolitan areas and a concomitant shortage in the rural sector. Over a number of years successive federal governments had tried to incentivise doctors to relocate their practices to rural and remote areas of Australia. However, these incentivisation programmes met with limited success and a shortage of doctors remained in rural and remote areas.

As one doctor participant noted:

> *... in the early 1990s there were general practitioners on practically every corner in many suburbs in Sydney ... even in Newcastle this was the case although not in outer suburbs or in the country. D1*

Despite the doctor shortage, the health care needs of rural communities were being partly met by the nursing workforce. One participant commented on the shortage:

> *Again there were particular shortage areas in rural New South Wales, regional New South Wales, there was then and still is the problem about having enough doctors to go around and do the job. And in many regional centres there were nurses who were perfectly competent, perfectly capable, fully aware of patient histories, had known the people for years and knew how to administer drugs ... So the solution ... nurse practitioners could play an invaluable role in filling the gap that was left by doctors who either didn't find sufficient base for their practice in small country towns or didn't want the isolation, weren't prepared to accept the isolation of living in regional Australia. P2*

The start of the public and formal development of the NP role in NSW, as part of the solution to medical workforce shortage, particularly in the rural and remote areas of NSW, can be attributed to a question to the then NSW Health Minister Peter Collins at a nursing conference, as recounted by a nurse participant and confirmed by other participants:

> *… it all started in 1990, at the Nurses' Association conference when Peter Collins was speaking to the delegates and someone got up and asked a question [do you support the introduction of nurse practitioners?]. … And so we [nurses] set up a meeting, an open forum at the Nurses Association just to discuss issues surrounding it and from that a working party was put together and that was stage 1 and that report came out and made a series of recommendations and that then moved into Stage 2 … N4*

One politician spoke of the intent of the government to fill the gap in health service provision created by the inability to recruit doctors with nurses:

> *There was an informal alliance where I believe nurses at all levels from enrolled nurses through to professors of nursing recognised that this was a move in keeping with the times and it was a necessary extension of nursing responsibilities to fill a void that doctors couldn't fill in certain areas of the state or at certain times. And I've never taken a backward step from that, I think that that is absolutely the case, if anything the whole idea of nurse practitioners is one that even then was overdue by probably twenty years. P2*

While the need for an advanced practice nursing role might have been identified twenty years previous, it was not until late 1989 and the 1990s that change was seen as imperative and was progressed.

There was clear intent by the government to address the shortage of doctors in rural and remote areas by substituting doctors with nurses as substantiated by study participants. If demand for regional, rural and remote health services had been met by the medical profession, the need for the role of the nurse practitioner may not have been required:

> *… if there had been an adequate supply of doctors across regional Australia, if they had been prepared to work across regional Australia and do the sorts of things that nurse practitioners ended up doing maybe the … well the need would've been less pressing. P2*

The same participants confirmed that if the medical profession had been able to provide equity of access to health services, the need for an advanced practice nursing role would have been negated:

> *The fact is there was a pressing need not being met by the medical profession at the time despite successive governments turning themselves inside out to provide incentives for doctors to practice in the country… There was a desperate need that needed to be filled and so as far as I was concerned time was up. P2*

4.1.2 Reduction of government funded training positions for General Practitioners

Attempts to respond to medical workforce maldistribution and oversupply in some locations, combined with the introduction of compulsory post graduate GP training and a subsequent decrease in Commonwealth funded GP training positions, resulted in suspicions arising in the medical workforce about NPs. The perception that the government decision to control the numbers of GPs in training was in anticipation of the introduction of NPs was interpreted as a conspiracy to pave the way for nurse practitioners:

> *… the Commonwealth government had decided that to reduce the overall number of GPs, instead of having eight hundred medical graduates training for general practice each year this should be reduced to four hundred (and as the Commonwealth provided the funding it could make this decision). So there were again graduates who were wanting to get into general practice who saw the introduction of nurse practitioners as being the reason why the government was making these changes. D1*

4.1.3 Nurses working outside their scope of practice

At all levels of the nursing profession and within government, it was widely known, yet not formally recognised, that in some situations registered nurses were practicing outside their scope of practice. It was generally believed by advocates of an advance practice nurse role that the NP role would go some way to providing a solution and legitimising their work. Both nursing and government study participants spoke of the 'illegal' practice of some nurses in rural and remote areas of the state as supported by the literature. Nurses were practicing outside of their scope of practice as there was no one else to provide the necessary health care. One nursing participant recalls:

> *… they have no support and they had no links really, but nobody admitted that so they were doing things … she would drive around in her car with drugs in the back that she'd be giving out but totally illegally, and a lot of them would do that, and the GPs say "Oh we'll cover you…" so they were really doing it so the GPs didn't have to do extra work and do after hours stuff, which is understandable if you don't then pretend that it's not happening, and I was thinking if anyone does something wrong here the nurse will go to the clink … I talked to a doctor about it, and you're willing for that to happen, because they're doing underhand things, they're not allowed to do this… if I was out in*

a rural and remote area I'd give them morphine, they weren't supposed to, it was illegal but of course you would, you're a nurse, you're not going to have them in pain … I can remember being absolutely incensed that we'd put people under this horrible pressure and responsibility but gave them no coverage. N6

In what appeared, ostensibly, to be collaborative practice, doctors were arguably exploiting nursing staff working in rural and remote areas by expecting them to practice outside their scope of practice. Some within the nursing profession saw the implementation of the NP role as an opportunity to gain recognition and legitimise advanced practice, protecting nurses at law. It wasn't just about legitimising advanced nursing practice; it was also about equity and remuneration for services rendered, as reflected by one participant:

… if I don't get nurse practitioners into this [area of health service] it will be the biggest travesty of justice I have ever known. That is what it is all about as far as I am concerned so it is about nothing else other than these utterly fantastic nurses who are doing the most wonderful clinical work but absolutely not recognised and not remunerated for the work they are doing. N1

4.2 Furthering the clinical career pathway for nurses through autonomous practice

The introduction of clinical nurse consultants (CNC) and clinical nurse specialists (CNS) roles in NSW in 1986 created a clinical career pathway for nurses. This meant nurses choosing to continue in clinical practice would be recognised and rewarded both financially and in status with the introduction of such advance practice roles; prior to this only education and management roles provided reward and status.

There was confusion among some in the profession as to where the NP fitted on the professional ladder. There was a lack of knowledge and the distinction between the roles of the existing CNCs and that of the NP role was not well understood within nursing:

… we struggled with the difference between a nurse practitioner and a clinical nurse consultant because it seemed a lot of the things people were saying, you know, what they wanted or what they expected of a nurse practitioner seemed to reflect very much what was written as the role of a clinical nurse consultant at the time. N7

In developing the scope of practice for an additional advanced practice role, the NP, it was necessary to consider how they would become part of the health care team and how they would work beside other nurses such as CNCs. As a relatively new classification in NSW, some were still finding their place in the health workforce, nevertheless practicing within a medical model of care. The concept of autonomy was deliberated during the NPP in relation to the CNC and clinical nursing career structure and how the role of the NP would function as a member of the health care team:

> *I think we probably thought it [the nurse practitioner] was a progression on from the CNCs who were pretty much specialists in their own right and they were ... whilst they weren't autonomous, entirely autonomous in their scope of practice, they were relatively autonomous in the early days of that career progression. N5*

This comment from the respondent points to the wider issue of some nurses struggling to understand that CNCs did have autonomy in their existing scope of practice. While the CNCs and CNSs working in public hospitals and community health services, and to some extent general practice nurses, did give nurses a clinical career pathway, the roles did not fill the gap in health service provision created by the shortage of doctors in the rural and remote communities. Communities' health needs to some degree were still going unmet, creating an opportunity to pursue an advanced practice nursing role, the NP, to fill the gap in services such as prescribing medication, ordering diagnostic services and referrals to specialist medical services.

4.3 Regulation of the NP role

As the NPP progressed there was recognition that NPs would require access to the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) to provide the community with needed health services and in doing so, optimise the level of service and care they could provide to the community. This was evidenced by the composition of the NPP Stage 3 Steering Committee with Commonwealth representatives joining the committee. As one participant recalls the challenges ahead:

> *The difficulty was going to be in getting access to the PBS and the MBS [pause] that was going to be the difficulty. N3*

The same participant recalled others not being supportive of this access, with some being vigorously opposed to it:

> *... it was the [Commonwealth] Department of Health who said nurses and midwives will get PBS and MBS over the government's dead body... N2*

The resistance arising from the Commonwealth government may have been associated with a perceived increase in expenditure by NP access to MBS and PBS, which were traditionally only accessible by doctors. Given the known drivers for the introduction of a NP role, the government of the day and prospective governments enjoyed the support of the respective political oppositions across the period of the NPP.

4.4 Bipartisan political support

In Australia, the two major political parties generally form the political environment in both national and state spheres. Typically, the conservative side of politics is represented by a coalition of the Liberal Party and the National Party with the latter primarily representing rural constituents. The Labor Party represents the socialist branch of politics. Before and during the work of the NPP, both parties were openly supportive of the introduction of NPs.

The traditional affiliations of the AMA with the Liberal Party, and the NSW Nurses' Association with the Labor Party, with both union membership organisations representing different health professions, did not seem to hinder the progression of the NP legislation. The introduction of the nurse practitioner role was not simply medicine versus nursing; it was also seen by some study participants as Liberal versus Labor.

> *... it started with the Liberal government and finished with a Labor government, and I do wonder whether the process would've been different if it'd been a Liberal government who had the carriage of it, because in those days whilst Peter Collins was very supportive of nursing and nurses and what was going on, I can't honestly say the same for his Party because they had a fairly influential health care committee who were very, very conservative. N5*

> *... he is a politician and he is a Labor politician, and the [Australian] Nurses Federation are a strong Labor organisation and that was it in a nutshell. D2*

During the course of the NPP from 1990 to when the Nurse Practitioner Bill was passed in 1998, there was a change in NSW government – from Liberal/National to Labor. A Liberal/National government held office at the commencement of the NPP process and a Labor government was responsible for introducing the Nurse Practitioner Bill into Parliament in 1998. The government had changed midway through the NPP process, and some nurse participants spoke of a perceived risk that the incoming government would not support the introduction of NPs; however, this was not the case. To the contrary, the Labor government supported and eventually introduced the Bill for consideration by the Parliament.

This bipartisan approach in part contributed to the passing of the Bill as recalled by nursing and politician study participants:

> *I can remember the day when it went through - the Act was changed to recognise nurse practitioners and the members of the opposition who got up and spoke in favour of the legislative changes, that was really good, that was fantastic and I knew that we had the support - we had bipartisan support for what we were doing. N4*

The bipartisan relationship that assisted the progression of the legislation was recalled by a politician participant speaking of a time when their political party was not in government and he was the 'shadow' Minister for Health:

> *… the Health Minister and I had developed a good personal dialogue in terms of health policy. We got on well, I mean while we certainly fought tenaciously from a political point of view, we were perfectly capable of having discussions which really cut to the core of the issue at hand and where genuine problems as opposed to political problems could be identified, so we had a good relationship and I think that was the context in which this legislation developed. P2*

Some participants spoke of the long length of time the NPP took as an advantage in building bipartisan understanding and support as it allowed the involvement of many stakeholders, including both sides of politics. One politician participant recalls the lengthy process as an advantage:

> *Time was an advantage as it allowed the passing of governments and hence the involvement of both the Labor and Liberal parties. There appeared to be no bureaucratic or political hold up in the process… P1*

4.5 A foundation of previous policy work and development of the profession

As identified in the literature and recalled by study participants, several significant events and changes to health policy in NSW and Australia in the mid to late 1980s influenced the health system. These events included a range of policy initiatives by Commonwealth and state and territory governments to address a gap in health service provision created by a shortage of doctors; the move from hospital based vocational nursing training to university education for nurses; the creation of a clinical pathway with the introduction of Clinical Nurse Consultants (CNC) and Clinical Nurse Specialists (CNS); the introduction of universal health care via the Medicare legislation and consumer participation in the development of health policy.

4.5.1 Professionalisation of nursing through education and career pathways

Education Factors

As evidenced in the literature, appropriate education needed to be considered and addressed during the development of public policy for the NP role. What was revealed in this study was the way in which changes in nurse education that occurred in the 1980s and 1990s had positioned the profession for new roles and responsibilities. In 1984, the Commonwealth government announced an in principle agreement to transfer all nurse education to the tertiary sector. A politician study participant noted:

> *We were just at the tail end of the do nurses need degrees or can't they just go back to being hand-maidens argument. There was still a kind of ... the last remnants of push back by some elements of the medical profession about not letting nurses get too qualified or not handing too much responsibility to nurses. P2*

While nursing organisations were ostensibly united, not all agreed with the move of nursing education to the tertiary education sector. Some participants recalled this view when recalling the role of nursing education in the development of the NP role:

> *I remember when Laurie Brereton announced that nursing shall move from being hospital based to being a university degree, the nursing profession was sort of split on that at the time. It was part of the Nurses' Association's policy*

but nurses at the time in the Association tell me that in fact they were looking at changing it, so it was split, and it led to a long time of people whining about that, helped to some degree by I suppose the nurses who'd gone through the older system who would regularly find reasons why the new ones weren't good enough, so that split didn't help bedding [higher education for nurses] it down but it didn't stop it. P1

From vocational training to university education

The move from vocational, hospital-based training to university education for nurses helped underpin the political confidence for the NSW government to endorse progression of an advanced practice nurse role. This federal policy initiative undoubtedly helped facilitate the work of the NPP in introducing the NP role in NSW.

One of the things that became quite evident was that nurses were now more highly trained than ever, that nurses had degrees whereas a decade, two decades earlier they hadn't. P2

Clinical career pathway

During the mid-1980s, the NSW government introduced public policy to enable the Local Area Health Services to develop local policy that acknowledged personal gradings of nurses via the CNC and CNS designation. In speaking about the delineation of CNCs and CNSs to the NP role, a nurse participant noted:

…particularly say the comparison [of the NP role] with a clinical nurse consultant was more this emphasis on the clinician who will provide direct care to clients…N7

This points to recognition that CNCs and CNSs were not able to provide the type of service required to fill the gap in health service provision resulting from the doctor shortage. It also highlights that the concept of an NP was not being compared to a Registered Nurse but rather it was being contrasted to that of existing advanced practice roles. The existence of a professional framework (CNCs and CNSs) helped to facilitate discussion around an additional advanced practice role, the NP, and the public policy that emerged over time.

4.5.2 Public policy to impact change in practice

Medicare

While not designed to do so at the time, the introduction of the Medicare legislation in 1984 by the federal government provided a framework via which funding for clinical services provided by an NP could be met. In the NPP Stage 1 Discussion Paper in 1992, it was noted that the Medicare Benefits Scheme (MBS) was one existing option that might be accessed for NP fee-for-service reimbursements:

> *The Commonwealth were brought into stage 3 because it was clear that we were starting to talk about MBS, PBS access to Medicare things like that. Had to be because the role couldn't reach its full potential without nurses being able to make clinical decisions and prescribe and treat and order imaging, all those sorts of things. N2*

Consumer participation

Since the formation of the Consumers' Health Forum in 1987, consumers have been formally involved in the development of health policy in Australia. The policy outcome of their involvement has received mixed opinion. A politician study participant promoted the value of having consumers involved in public policy development:

> *... a few champions [of change] out in the community can be very useful… it could be the local group of Mayors saying, you know, this is something that we're missing out at the moment, we could really do with that. P1*

A nurse participant recalled:

> *... it was very much a point where I realised how critical consumers were to these sorts of policy debates and how in fact the nurses needed to use consumers' voices to articulate the value of that role. N2*

The value of consumer participation in the development of public policy was reinforced through the NPP process.

> *... the consumers didn't know what we were talking about and that was played upon largely by doctors talking about nurses wanting to be doctors taking over doctors' roles and all that stuff. N2*

However, not everyone involved in the NPP valued consumer participation. One nurse participant recalled:

> *... one meeting of the steering committee when I was sitting next to the Director General [of Health] and the RDA [Rural Doctors Association] representative ... something came up about consumers and he [the RDA representative] leant across the table and said: "What would they know?" when there was two consumers sitting around the table. N4*

It is apparent the doctor saw little value in consumer representation on the NPP; a view that suggests only a tokenistic tolerance of consumer representation. From a political perspective, consumer representation on the NPP was not valued as highly as the representations from the nursing and medical professions. A politician study participant commented:

> *A group of consumers tend not to have quite the same strength of voice on something like that on a professional basis than you do [get] from other professionals. P1*

However, nurse participants recalled their experiences with consumer participants and the importance of their presence on the NPP:

> *And I think as much as possible we were really conscious even then that it was necessary to engage the community… N3*

> *And they were a really key stakeholder group that we tried to engage with because one of the things that we found very early on was that health consumers didn't know what we were talking about when we talked about nurse practitioners. N2*

When asked if there was anything that could have been done differently during the process of nurse practitioner role development, one nurse participant recalled how consumers were seen as allies against a common foe and recognised the unrealised value of consumers:

> *…Yeah yeah, I would, I would have made much stronger coalitions with consumer groups and other groups ... N1*

Nurses' involvement in developing public policy

In the late 1980s, nurses in Australia were largely not involved in the development of health public policy even though it significantly determined their scope of practice.

Formal contribution to health policy came in the form of the appointment of the first Chief Nursing Officer (CNO) of NSW in 1990. The CNO gave nursing a clear voice and direct communication to the Minister for Health. At this time nurses became more of a collective as opposed to disparate groups with their own issues and agendas:

> *I think generally nurses were renowned for having a very fragmented and non-collective response to things. I mean my own personal view is that to some extent there was a great fear if nurses actually ever realised their collective potential in the health system it would be a pretty challenging zone. N2*

During the establishment of the NPP it was clear to nursing groups that policy development would be a requisite skill for individuals invited to participate in the process, and the Department of Health actively recruited nurses with policy knowledge to assist in this process. One nurse participant who was involved in NPP Stage 3 spoke of the Department of Health needing an 'insider'; a nurse who was policy oriented but also with recent clinical experience:

> *… and I think that was the fact that I had a kind of a broad understanding of the politics/policy zone of health. Which I'm not sure all nurses had, and that I guess I'd had runs on the board in certain other areas of work that I'd been involved in. I'd also been working relatively recently actively in a clinical area so I had to have experience with what was happening out on the ground clinically. N2*

In addition to policy experience and knowledge, when identifying who should represent a stakeholder group on the NPP Steering Committees, an individual's personal strengths and attributes were deemed to be an important consideration by one group:

> *I only went to the very first meeting … and I decided there and then that it wasn't for me… I'm not going to sit on this committee but I'm going to put [Name] … she's an eternal optimist, she's dogged and she doesn't allow anybody to walk over the top of her, … I mean there are times when I think [name] can get blood out of a stone and I think she can talk most people around … N5*

4.6 Personal challenges of public policy development

The pathway to public policy implementation is rarely unfettered. It is often typified by disagreements, negotiations and tensions, at both an organisation and personal level, in search of consensus. The work of the NPP was similarly challenging for the individuals, and several study participants highlighted their personal learnings and the emotional impact it caused. The emotional impact the NPP had on some of those involved was palpable and has not been previously documented:

> *... I learned an awful lot about how government worked and how policy development happens and the intrusion of politics into what is good clean policy, and good clean policy, and there is no such thing as good clean policy, frankly. N2*

By their very nature, negotiations about the introduction of NPs pit two opposing viewpoints against each other. In the early 1990s when setting up the NPP Steering Committee it was recognised that there was a high chance of failure by one participant:

> *... that there was a high chance of failure and if there was failure I would be blamed, if there was success Judith and the Department will take the credit for it. But that's a very strong memory I have of this being a difficult assignment without necessarily an expectation of success and that was a risk for me publicly and professionally to take it on, but it felt like an exciting project as well ... IR*

Importantly, some within the medical profession could see the value and benefit of an advanced practice nursing role. However the political power of the AMA was greater than some individual medical practitioners. A doctor participant who was willing to support the introduction of NPs recalled the personal experience:

> *But equally I was being vigorously lobbied by both the AMA in New South Wales and also the faculty people in New South Wales most of whom felt that I was some sort of a pinky who was going to make concessions that they weren't prepared to agree to anyway. So it was a difficult time. D1*

When the AMA did not sign off on the NPP Stage 3 Final Report, the personal impact was readily recalled by another study participant:

… on a personal level, I had a recurrent nightmare for about six months afterwards, and my recurrent nightmare was a very, very simple nightmare. I was driving along in George Street in the city coming to a zebra crossing and the AMA representative stepped out on the zebra crossing and the nightmare ended with me deciding whether to put my foot on the accelerator or the brake. [laughs] It went away but clearly I was enraged at an emotional level with what had happened. IR

Maintaining the position of the medical profession during the negotiations of the NPP was very difficult for one doctor participant, who described feeling marginalised and at times bullied by other steering committee members in meetings and not being able to fully participate in meetings:

Well it was a very ugly, ugly, process and there was a lot of bullying and intimidation, a lot of misinformation and they were very difficult meetings and the projects [NPP pilot projects] themselves were biased and subjective. The policy outcome was going to happen, so whatever anyone said or did was totally irrelevant, it was just something that was going to happen. D2

The inability to influence outcome was distressing to a doctor participant. The sense of powerlessness and not being able to influence or stop an outcome was palpable in this interview with one emotional doctor participant, speaking more than two decades later:

It was really awful, it was really … you and I have both probably been in situations where we felt that people are trying to bully us or intimidate us and things and, you know, you can usually either … you can sort of read it the way it is and either choose to become that victim or you can choose not to do it and you'll have your reasons for doing it or not doing it. But really … there are very few times that you can actually think to yourself that was really bad, I felt really bad, and I did. D2

From the nursing perspective, the actions of the AMA in not supporting the NPP Stage 3 Final Report distressed some. It was apparent there had been substantial compromise by the NPP Steering Committee and a view that the AMA had been given everything it had asked for and yet they still did not support the introduction of NPs. One participant recalls such compromise with obvious frustration:

Because we had given up so much to move to a place of consensus, all sorts of stuff, we had given up MBS [access to Medicare Benefits Scheme funding] and PBS [access to Pharmaceutical Benefits Scheme] we had given up the hope of that, we had given up the hope of professional indemnity there was a whole

load of stuff we had given up the hope of privately practicing medical practitioners and nurse practitioners at that stage, just all this stuff you know OK and referrals, referrals were the big one for the RACGP because what we'd wanted was for nurse practitioners to be able to refer directly to consultants but of course if they did that that then the GP would have missed out on a MBS charge, and so we agreed that nurse practitioners couldn't refer to a specialist they had to refer to a specialist via a GP so the GPs would still get their money for referrals. We had given up all of that just to get this bloody report through as a consensus report and then the AMA reneged so as far as [name] and I were concerned all bets were off. N1

The recollection of the nurses involved in the NP role development was that there were a lot of compromises made. They compromised to appease the medical profession and to keep the NPP moving forward.

Maintaining the 'party line' and progressing the agenda of some groups, particularly the doctor groups, was difficult at times. Some participants spoke of this being due to the NPP doctor representatives getting too close to the issue by finally seeing that the NP role could add value to the health outcomes of patients. It was apparent that in doing so they were not adhering to the doctor groups' agenda:

Yes I think when suddenly the representative we had had from the RACGP stopped coming [to meetings] towards the end and the AMA person changed. The two AMA people and the secretary of the NSW branch [of the AMA] resigned and stood down and we subsequently heard later that it was because of the project, because we had convinced him that it was a good thing that we had evidence … and he could no longer live with the ethical position he was being asked to take. N2

One participant recalls how the actions of another involved in the NPP steering committee were not in the best interest of the group they were representing:

… she's lovely, she is a really, really nice lady, but really … the College of General Practitioners, I think became swept along in that it is inevitable and didn't do any discussion with those who were actually involved in the pilot projects, and looked at them and the recommendations and believed the outcome. D2

This selection of study participants' responses also illuminate the extent to which the NPP work was personally quite challenging for some and also highlights that for some, positive aspects resulted:

That committee included initially … poor [name], and he found it extremely difficult to argue against the … he tried really hard 'cause [name] had a mandate from the [doctor group] and [name] tried really hard to argue for their position but in the end found it untenable and they replaced [name] … N3

I think I went in with some naivety I could say I don't think I did appreciate all of the politics and deep seated issues that were there so yes my general understanding of politics and gaming grew and developed dramatically over the time and I learnt to be able to diagnose and deal with and come back. N2

I probably would do it again it was really a very exciting time I think that the time for that sort of project has gone so it probably wouldn't come up again. What would I do differently? I would probably take a much harder line on some of the things that we gave in on. Would probably be the you know we'd probably played too much of the game for too long. N2

I think there was public and private, and I think there was personal and professional. Yeah, I mean the interesting, I developed an enormous respect for people I didn't expect to as individuals and their courage to be able to speak out, to recognise that they had changed their minds and that's always refreshing … N2

Very elated, very elated it'd been ten years long but it was good to be involved, and in some respects I felt very satisfied that I'd been in a position, a privileged position to influence the way the role developed. N3

I remember the jubilation the day that the announcement was made. N5

The professional tensions referred to by N2 and D2 earlier points to the atmosphere of protectionism, which pervaded much of the early work of the NPP. It became a battle fought largely over the protection of commercial interests and perceived superior education versus professional aspirations.

4.7 Professional protectionism and self-interest

Of the many challenges to the introduction of the NP role in NSW the most prominent was the need to develop policy in an atmosphere of longstanding tensions between nursing and medicine. The findings of this study highlight the impact that professional protectionism and vested interests had on the work of the NPP and the eventual public policy framework.

Professional socialisation

In the course of their education and training, professionals are taught how to behave within their professional environment. The resultant behaviour, known as professional socialisation, over many generations of professionals, becomes central to the accepted sub-culture of the profession – those aspects that form the values, attitudes and skills of the profession and become the norms of the profession. It forms the basis of their interaction with their professional colleagues, and their interactions with other professions, and shapes the hierarchical structure within their fields. The findings of this study reveal how the professional socialisation of doctors impacted on the work of the NPP:

> *… there was this strong sense … in the room of a hierarchy not felt by the nurses but certainly felt by the doctors … it was really about their professional socialisation … very difficult for a person to step away from their professional socialisation and the way that they see the world. IR*

The misplaced assumption by the medical profession that they would be held accountable for the actions and practice of the NP led to fear among doctor groups. This assumption and misunderstanding was perpetuated during the development of the NP role, with one doctor study participant recalling the feeling of the day:

> *… and the idea that a medical practitioner should somehow be taking some responsibility for the actions of a NP, where the NP wasn't obliged to take any notice, was seen to be a risk too far. D1*

The assumption appears to have been based on a belief, by some doctors, that the doctor would still be the health care service delivery leader after the commencement of NPs. One participant recalled the sense of assumed leadership and patient ownership and the doctors 'allowing' other health professionals to participate in patient care only when it suited them; ultimately, doctors were claiming they maintained 'patient ownership' and ultimate control.

> *They have allowed other people into, well the big patch, they own it all … they enabled people to come into that patch to play in their space as long as they could still be their supervisors, their overseers, their controllers, and this was a direct challenge to that … N2*

> *I guess there was an argument at the time from the medical profession, [it] was about that they think they're the stewards of the ship, they were the final*

> *decision maker. They had a bit of difficulty recognising that other people had a very important role to play, the health care team. N4*

> *In that era, and maybe even today I don't know, doctors saw themselves … they didn't mind having a nurse in their team but they didn't want someone who would challenge their knowledge or their authority. N3*

Power and paternalism

By the late 1980s, for decades nurses had been influencing medical decision-making and patient care by not openly challenging doctors' decisions but through participating in the so-called 'doctor-nurse game'. The doctor-nurse game involves nurses taking a passive route, not directly challenging doctors but making indirect 'suggestions' to the doctors that influence their decision-making. One participant spoke of how this game was usually 'played':

> *… the premise was that nurses, and this was probably in the '60s I suppose, nurses who knew what had to be done, to get what they wanted done, had to convince the doctor that it was his idea and I think we played that game as nurses very well for a very long time. N3*

The introduction of NPs was a direct challenge to the medical profession; the doctor-nurse game would no longer be played as NPs would be making their own, autonomous, decisions openly challenging medical decision-making and further perpetuating the tensions between doctors and nurses. However, the aspirations of the nursing profession were widely recognised, as recalled by a doctor participant:

> *Equally I don't think that nurses could abide the idea that they were going to be dominated by the medical profession anymore, and so it really became one of those unfortunate situations where, um, so if … the militants on both sides drove the arguments and drove it all apart. D1*

The release of the NPP Stage 1 Discussion Paper, prepared solely by nursing groups, led to an exacerbation of the longstanding tensions between the nursing and medical professions. As the NSW NPP progressed to Stage 2, there was recognition by the government of the need to engage a wider range of stakeholder groups, and representatives from government, medicine, pharmacy, radiography and consumer groups were added to inform the policy development more broadly. Some nurses were not happy about having doctors involved in the policy development process:

... we're not asked to be on their [doctors'] steering committees, why do have to have doctors on ours. But I realise that politically that was a wise thing to do or they may have come in and thrown rocks from outside and I have learnt of course how important it is to have the rock throwers brought in on the steering committee ... N6

Two nursing participants reflected on the NPP steering committee membership and one spoke of an eventual acceptance of the need to have doctors involved in what they initially believed to be a nursing issue:

Yeah, sometimes in the steering advisory committees I felt we're never gonna make it here, because the doctors are very strong and they have a lot of power and control. I spoke out against them being on the steering committee, I said why are they on the steering committee? I understand why that was so now, ... but at the time I was angry, I said this is about nursing, we're not invited to any discussions around medicine or changes in medicine, and we're not. N6

And yet to some others involved in the NPP, there were clear strategic reasons why all steering committee meetings had to be inclusive of all stakeholders:

Well it was several layers, always, going on, in [NPP] Stage 2 the medical professionals and other government agencies had been brought to the table, to be part of the discussion because it was clear that, they need to be inside the tent to continue the discussion, they were certainly going to be throwing bombs from outside. N2

The impending change to the longstanding subservience and paternalistic relationship between the nursing profession and medicine, reflected in the following participant's recollection of dialogue with a doctor, mirrored a genuine sense of loss.

But one of the doctors sat there and he said "We used to teach you girls, you know, you don't like us anymore, you don't want us anymore." I thought to myself this is really, really sad, these people, these doctors they're just back in another century. He was so upset, he was almost in tears because you don't want us anymore, we used to teach you and now you don't want us, you're casting us off, you want to be independent from us, you don't need us anymore. N3

The introduction of NPs was not just about the change in the order of things in the health system, it was also about the position held by men and women in society and of the predominantly male medical profession and the predominantly female nursing profession, as recounted by the following study participant:

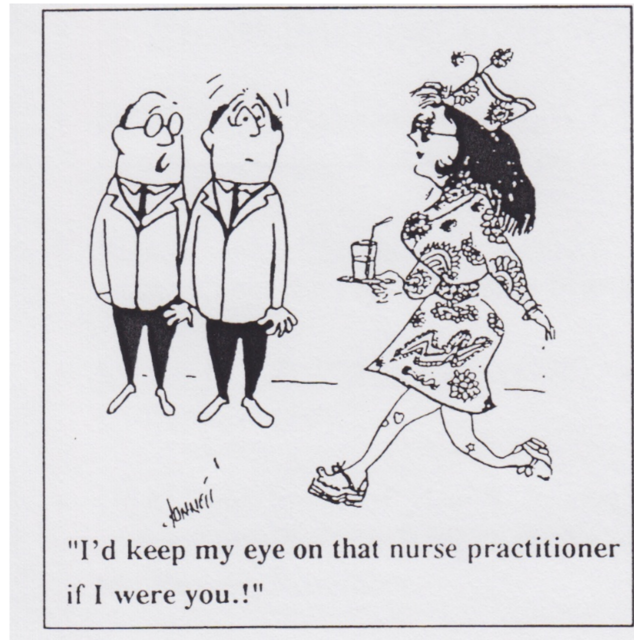
So when I think about the change, because I think there's huge change in society as well, I think we have to factor that in that it was time, we got into universities, women were emancipated and still we've got ninety percent of nursing is female, so we have to think about the change in the status of women has also impacted on this whole thing. It's not simply something that's in a sort of a bubble, you've got huge social change that took place around that ... N6

A finding of this study was how participants, predominantly the male non-nurse participants, openly spoke of gender as an issue during the NPP. Interestingly, female nurse participants did not explicitly raise the issue to a great extent. A government participant spoke of the need to 'manage' the gender issue during meetings where the AMA and the nursing representatives were again in disagreement:

I think [female doctor] probably annoyed her [female nurse] more than [male doctor] 'cause [female doctor] was a woman who should've known better, [male doctor] was there to stir her up and called her girly, you know, there was this kind of ... you've got to remember at this stage too the girls can't do this kind of thing … it wasn't a nurse/AMA thing, it was a gender based issue, so there was a lot of gender based imputations around the table … GR

It could be argued that doctors could see that the nurse they knew was disappearing and a new one emerging; one who was unpredictable and who would question and challenge medical dominance in health service delivery. A nursing participant shared their reaction to a cartoon from 1992 during the early period of the NPP:

There was a cartoon, ... which shows this very modern nurse who's still got a cap on but that's I guess to depict, and it says I'd keep my eye on that nurse practitioner if I were you, and that was in Aus Doctor. Yeah and nice shoes … I think this is a very typical cartoon, the nurse practitioner was different, she didn't fit the image that doctors were comfortable with, you know, they were frightened of this being… one of the things they were frightened about was their income … the constant refrain was that they would be setting up on the street corner opposite a GP and taking the patients away, so a lot of the fear was related to their income. N3



Original publication 'Australian Doctor' date unknown. Cartoon used discussed by N3 in her interview and cited in a presentation (Spilsted ne Iliffe, 1992)

Nurse participants were cognisant of the extent to which the power base of doctors would be changing with the introduction of NPs to health service delivery. There were changes in the way nursing was presenting itself and the way they were being perceived by the medical profession:

> *… and when you think medicine in this country a hundred years plus of medicine being the authority on everything, they must be pissed to hell, you know, pissed off really about the fact that somebody might be questioning them. N6*

There had been resistance from doctors prior to the commencement of the pilot projects, culminating in industrial action by the doctors and a walk out by a group of resident medical officers. One participant recalled the events:

> *... They [doctors] walked out and they said they wouldn't return until the nurse practitioner was removed from the emergency department. And this is where personalities are important. The Director of Nursing at the time came out to the lawn … she spoke to the masses and said that's absolutely fine, we don't need you, we'll put nurses in your places, we don't need … you residents can nick off and you can stay out as long as you like. She was absolutely fabulous … they came back the next day. N6*

During the eight years of the NPP there were times when positions of power were tested by both nursing and medical professions alike. Historically, nurses were

unfamiliar with realising their power. On one such occasion, a delegation of nurses met with the AMA to negotiate and progress the NPP. The realisation by the AMA that their existing power bases were no longer going to be guaranteed, and in fact were being threatened, is reflected in this:

> *They ushered us in they said ladies, ladies see you come in sit down … they basically started on the safety and quality stuff and all the rest of it and [nurse] the wily old dog that she is, said I am glad you mentioned the safety and quality because we are worried about that too … I probably have every director of nursing in the state in my College and if I was [to] suggest to my membership that nurses should stop doing things for doctors for which they are not remunerated, I think you would probably find that your practices would grind to a halt. … you are threatening us, don't you dare, you can leave, but he said just let me tell you this (N1 leans forward and taps on the table) he said I want you to be really clear he said if you interfere with our income we will finish you off, he said make no doubt about it this will go nowhere if you interfere with our income and then we left. N1*

The participant subsequently recalled a later conversation with a medical colleague in which she related how the nursing delegates walked out of that meeting:

> *… I told him what had gone on and he said congratulations you have really got them rattled. He said this is the first time they have told you truth and put their cards on the table so this is the first time they have not said it is about safety and quality and they have actually told you it is about money and turf he said so you really did rattle them that night and he said they must know that they're at risk of losing. N1*

These events were towards the end of the NPP process when it was apparent to the medical profession that NPs were going to be a part of the workforce and presented a threat to their livelihood. The nursing profession had unwittingly lured the AMA into an admission; the material reason behind their resistance to the introduction of nurse practitioners was their fear of loss of income.

The AMA's rejections of the NPP Stage 3 Report recommendations in 1996 took some stakeholders by surprise. Nurse participants believed that the consultative process of policy development leading up to NPP Stage 3 had provided the AMA with ample opportunity to voice concerns about the research methodology:

> *… the other thing we also worked really hard on doing is making sure that the evidence was as unchallengeable as possible … it involved all stakeholders in*

the development of the methodology the instruments all of the things so they had opportunity to have a say about the review and all the other strategies. N2

I was disappointed however when they wouldn't sign off on the reports 'cause they'd been a part of it, disappointed but not surprised. N3

Early in the work of the NPP, many saw the issue of NPs prescribing medications as the one factor that caused the greatest angst to doctor groups. This was at a time when doctors believed they would be held accountable if the prescribing was inappropriate or incorrect. Allaying these fears formed a large component of the work for the Stage 2 and 3 Steering Committees and sub-committees in order to reach an outcome that was palatable to all groups; the process was influenced by the power struggle:

And I mean I keep referring to the administration of drugs, I know that's not where it begins and ends, but that certainly was a fairly seismic shift in terms of what nurses could do and probably the most obvious of the changes that came with nurse practitioners. And therefore we needed to I think tick all of the boxes, we needed to allay fears before putting it in place, but it is a pity it took so long. P2

The early work of the NPP focused on arguments against extending prescribing authority to NPs rather than finding a solution on how to best prepare and support them in their role. A nurse participant explained the resistance in one-quarter of the medical profession to the concept of advanced practice nursing and tertiary education for nurses:

I went and talked to [AMA Representative] at the time with the idea that when [they] became President of the AMA that we might work together ... [they] said I have to tell you right from the beginning I don't believe nurses should be in universities and I don't believe in nurse practitioners. N6

Perceived inadequate nursing knowledge and a view that registered nurses were incapable of undertaking extended clinical roles were views shared by doctor groups involved in the NPP. However, those views failed to acknowledge that preparing nurses for the role was a high priority for the NPP and drove many recommendations in the NPP Stage 3 Final Report, which was released in 1995. The following interview excerpt with a nurse participant echoes the intention of the NPP to adequately prepare nurses for the NP role:

... I had all sort of concerns about regulating NPs and about having a proper safety framework in place, about how you prepared them from an educational perspective, how you prepared them from an accountability perspective how they were made accountable for their actions ... N1

However, in response to the NPP Stage 3 Report – the Logan Report – the AMA commissioned an independent study of the recommendations in the report. One doctor study participant recalled:

So [sigh] we had these discussions and we thought well OK we've got the [NPP] pilot projects, we've got the recommendations, let's get an independent audit of it, let's go and get somebody to have a look at all this stuff ... people who look at research projects and get an independent analysis of it. We did and it was damning. We gave New South Wales Health, we gave the College, we gave anybody who wanted to look at it we gave copies of this, no one wanted to know. D2

That action by the AMA was, to some extent, an attempt to exercise power over the Stage 3 Report recommendations and could be seen as a last ditch attempt to exercise control over public policy development. By releasing the Logan Report, the AMA was attempting to discredit the NPP Stage 3 Report recommendations.

Participants spoke of delaying strategies exercised by the AMA to further their cause being perceived by participants as the medical profession attempting to exercise their power and lengthen the process of the NPP, possibly with the intention of the project losing momentum:

My own view is that the [pilot project] research was agreed to [by the AMA] as a delaying tactic. It was seen to delay and derail. N2

Much has been written about the deliberate media campaign to derail and discredit the introduction of NPs employed by the AMA during the NPP process. However, there was also an informal strategy against the introduction of NPs, where doctor groups actively spread their dissent by word of mouth, as discussed by one politician participant:

I think the medical profession campaigns largely by word of mouth and they are articulate, influential and powerful persuaders ... as an interest group in the provision of public sector services they're [the AMA] one of the strongest, if not numerically strong, certainly in terms of force of argument, the conviction that goes behind it, they're a very strong lobby group. P2

The power of the AMA to influence outcomes for their members was cited by several study participants. That power was well known by stakeholders, and a nurse participant noted the potency of the AMA's public relations capabilities:

> *... and politically the reality is that the medical profession have got a very loud voice and they have got the media attention and they have got the politicians attention they have got everybody's attention and they can stymie everything because they [have] a media machine second to none ... N4*

Vested commercial interests

In arguing against the introduction of NPs, with the NPs' income potentially impacting negatively on the doctors' income, doctors claimed they were the only health professionals who could safely provide services such as the prescribing of medication and ordering diagnostic tests. This was the default opposition of the medical profession during the development of the NP role. Typically, medical professionals do not openly discuss their remuneration and they were similarly reluctant to confirm the potential financial threat NPs would pose to their income, as evidenced by the meeting of the nursing group and the AMA. One politician study participant recalled doctors' reluctance to move their practices to rural and remote areas of NSW, areas in high need of health services, and yet they were resisting the appointment of NPs in those areas:

> *No they didn't say you're taking away our livelihood, they weren't game to say that because not enough of them were prepared to take that livelihood. And I would've thought ultimately that rather embarrassing fact constrained some of the more vociferous opponents of nurse practitioners. P2*

During the NPP Stage 3 Pilot Projects, as NSW government salaried practitioners, NPs were under much less financial pressure than doctors in private practice under a fee-for-service model in regard to how much time they could spend with a patient. By contrast, doctors, especially GPs and private specialists, were financially dependent on fee-for-service to generate their income. The fact that an NP was generally unconstrained by time led to a high level of patient satisfaction, as evidenced in the results of the NPP pilot projects, which frustrated doctor groups as they felt this was not an equitable comparison of service provision :

> *I think time's a definite factor. GPs look at their specialist colleagues who are earning mega bucks and then look at their own earnings so it becomes a money*

> *factor, and so it then does become a case of well you can only spend a very limited time with a patient because you simply can't afford to spend that time. D1*

This reflects the broader issue of private business, underpinned by financial imperatives, versus the publicly funded NP who are not constrained by the financial pressures of running a business. The vested interest of the doctor groups, the financial survival of their members, was undoubtedly permeating the opposition to a new advanced practice nursing role. In the eyes of medical profession, with the introduction of NPs, the envisaged scope of practice for the NPs would see them consulting and treating patients of a low acuity. Arguably such patients require less time of the treating health professional as opposed to the time required to treat patients with complex, chronic illnesses. In financial terms, fewer patients being treated by a doctor would translate into decreased income.

The study found no evidence that doctor groups gave consideration as to what services rural communities required. It was noted by one study participant that the position taken by doctors was one of 'no health service is a better option than a service offered by a NP', as depicted in the following:

> *... the conclusion I reached was that it wasn't appropriate for doctors to simply reserve the territory in case their fellow doctors wanted to work in the area but keep everybody else out, nurse practitioners, because some doctors might end up wanting to work in regional Australia, I mean it struck me as a rather short sighted and selfish view of the world. P2*

Doctors had a widely recognised financial interest at stake and an interest in preserving their social status within their own, and the broader, community. However, the nursing profession also had vested interests, with aspirations for autonomous practice and remuneration commensurate with the extended role and responsibilities.

> *Everybody there had a vested interest and an agenda because it would be naïve to think that they didn't ... Everyone has a vested interest you wouldn't be a stakeholder if you didn't have a stake. N1*

'Turf' protection

As discussed in the literature review and corroborated by the participants of this study, the very nature of the proposed change to introduce an advanced practice

nursing role meant the professional boundaries would be challenged in progressing the NPP. In short, nurses wanted some of the 'turf' previously quarantined by public policy for doctors, and doctors were not prepared to let go of that turf. Doctors based their opposition on a view that only doctors could provide such health care. An independent observer noted:

> *But certainly the nurses within the room and the doctors within the room initially were very fixed upon their own professional role … they saw the world through their own profession. IR*

When participants spoke of discussions about changing professional boundaries and the related scope of practice of nursing to support the planned change, they often used the language of war. Such language was used by participants from both nursing and medicine. The literature, however, did not reveal what came to light during the study; the differing opinions of doctor group representatives on the concept of 'turf' being a source of their resistance to NPs. One stated that turf was not the reason for their opposition, while another spoke strongly of their preparedness to defend their territory:

> *This is not turf war, it's always produced as turf war, it's not turf war, this is about actually giving appropriate health care to our patients. D2*

> *But in talking with medical practitioners in New South Wales and in fact in talking with medical practitioners generally, nurse practitioners are still regarded as something that they sort of are prepared to die in a ditch about … It really was a turf war and that's what it's remained to until today. D1*

Nursing participants confirmed the opposition from the doctor groups as a turf war and that doctors were protecting their 'patch'; defending medical dominance and their historic exclusivity:

> *We never negotiated in those sorts of circles and that sort of stuff, this was a turf war, this was about taking medical territory and medical money and nothing else as far as the AMA was concerned … N1*

> *Because in my own sense this was about territory, this was absolutely about territory … N2*

For nurses, the NPP was about gaining more turf; turf that was previously the sole, formal domain of doctors, and they were seeking an unfettered role expansion.

In the early stages of the NPP, it was difficult to provide a clear definition of the proposed NP role, and that caused substantial confusion among stakeholder groups. One nurse participant recalled with frustration the challenge of defining the scope of practice:

> *... Oh lots of discussion the argument (from our [nursing] side) was that the scope of practice shouldn't be confined, that it should relate to their [nurse practitioner] employment, and that basically a nurse practitioner was a nurse practitioner was a nurse practitioner. We were very keen not to confine the scope of practice. N1*

While nurses wanted more 'turf' and the government was prepared to drive that agenda in order to meet a community need, there appears to have been scant workforce modelling of how the NP would fit within, or complement, the existing health care team. How the NP role would assimilate into the existing health care team was not well understood, as highlighted by one politician participant:

> *... wherever nurse practitioners are going to work there's going to need to be a multi-disciplinary team. And so you don't want to crunch somebody in over the wishes of everybody else that they've got to work with 'cause you're then going to have a problem and they may be not able to do their job. P1*

Doctor groups founded their opposition to NPs around the fact that nurses did not have the same level of training as doctors, particularly in the area of diagnosis. However, this attempt to justify their turf protection was based on a lack of knowledge of the intended role and the scope of practice of the NP. The next two interview excerpts by the one doctor participant point to a lack of understanding of the NP role leading to resistance among the doctor groups:

> *However, there were people who felt that nurse training didn't really equip nurses for the diagnostic role of the general practitioner, in other words that nurses were very able to fulfil a treatment role but lacked the basic skills to be able to work from first principles in arriving at a diagnosis ... I'm really repeating the arguments rather than necessarily using this as a justification but these were the sorts of arguments that were put forward. D1*

> *And so in terms of issues of quality and safety if you can't diagnose then it becomes difficult to initiate treatment that's going to be effective, that was the argument, and diagnosis is based on a sound understanding of pathology. I'm simply trying to present to you the arguments as they were put rather than that being a personal argument of mine. D1*

Despite state and federal government public policy initiatives designed to encourage doctors to practice in rural and remote areas of Australia, the incentives had minimal success and the doctor shortage in these areas remained.

> *There weren't enough doctors willing to base themselves in small regional centres, that was a trend that was irreversible despite every expensive effort taken by government to provide cash and other incentives to get them out there, and cash and academic incentives, I mean the kind of arrangements that have been made with teaching hospitals to do some of their teaching in regional centres. P2*

With the problem unresolved, an alternate public policy approach to resolving the health service provision gap was required. Scope of practice, and therefore 'turf', is influenced by context and the issues of where, and by whom, a service is provided determine the practice of individual health professionals. One politician participant spoke of scope of practice evolving out of context:

> *I suppose seeing them [nurse practitioner] being different to what was the Russian felchers and the physician's assistants in the States both of whom were basically medics from wars coming back and wanting a role to play that they were allowed to play in war but were not allowed to play in peace, and those were pushers for those nurse practitioners we saw as different … they may do similar jobs but they [NPs] were coming from a nursing profession rather than from displaced medics usually men coming back to peace time. P1*

However, regardless of the 'turf' aspirations of individuals and professions, government is responsible for developing public policy to meet the health service needs of communities.

The role advanced practice nursing would offer was not clearly understood by all members of the health care team. Despite the need to respond to medical workforce shortages, there was disquiet among some nurses that this would send mixed messages among the wider health workforce:

> *… because it was not about creating a second class doctor it was about legitimising advanced nursing practice … this was about creating advanced nursing practice roles but then it became about roles for where doctors did not want to work and that disturbed me a great deal because that was never the intent … we worked very hard to make sure that we always communicated very clearly to people this was not about second class or sub medical service, this was about advanced nursing practice. N4*

Strategy in response to internal dissent

Despite nursing's pursuit of the NP role and aspirations to gain more turf, it was evident from the study that some participant nurses believed the profession was fighting on two fronts. Firstly, they fought the resistance of the medical profession and secondly, and more surprisingly for some, the resistance from within the nursing profession. When the internal resistance began to be aired, it resulted in deliberate caucusing by different nursing groups to address the in-house conflict. Participant nurses spoke of meetings where nurses representing different nursing groups would come together in an alliance to negotiate from differing viewpoints, with one participant recalling the caucusing before NPP meetings:

> *… and you know in our kitchen, what [Name] used to call my bitching kitchen, we would have lots of conversations and lots or arguments about that from my perspective versus the union's concerns not to see these people [NPs] overburdened and so that was a big issue for us that was sort of balanced between the two. N1*

These informal meetings were inclusive of all the nursing groups represented at the NPP meetings. One study participant recalled:

> *… what we would do before we ever went into Stage 2 and Stage 3 we would caucus the night before in my kitchen to make sure that what we definitely agreed on we agreed on and whatever we disagreed on we wouldn't talk about. N1*

The comments of some nurse participants suggest their actions were designed to reflect a public face of nursing as a united profession. Another nurse participant recalled the need to have alignment among nursing representatives on the NPP:

> *The really clear understanding that the dirty washing had to be sorted out behind the scenes so if the nursing groups disagreed, [if] the College and the other nursing professional groups that were part of the process disagreed, they had to sort it out before they actually sat at the table, each a position, because we've got to have a collective common view. N2*

Some participants attributed the resistance within nursing as a response to medical dominance. The following nursing participant recalled:

> *Yes, yes, yes, because it surprised me but I also recognised being a country girl that it's very difficult to live in a country town where you have very strong*

powerful GPs who clearly didn't want it [the nursing profession] to stand up against them, and even though we were offering all of the support [to nurses] from Sydney to go up … or down and talk to whoever was opposing and we did that there was still some covert resistance to it there that again delayed the roll-out. N4

A perceived unfair advantage

A perception by the nursing participants emerged that at least one doctor group, the AMA, had an advantage in their endeavours to protect their turf. The perceived advantage was resultant of the then Minister of Health being a medical practitioner and possibly not supporting the implementation of NPs:

> *The risks in that we had a Medical Practitioner as a Minister and as much as he was a doctors' reform person who really could see the bigger picture, at the end of the day he was very much at the mercy of his colleagues and the AMA felt like they had an open door because he was one of their colleagues and I think he probably was subjected to an enormous amount of bullying and, and challenge so, I think the risk aversion increased as the project roll out went on … N2*

However fears about the risk of the Minister being influenced by the AMA were unfounded, as recalled by a politician participant:

> *… there was very little outcry by the AMA, the AMA ran a few attempts to undermine it but they also talked to me directly about it and I said don't bother fighting about it 'cause it's going to happen, get lost. [laughs] P1*

The historic tensions between the primary stakeholders, nursing and medicine, were abundantly evident to one participant. This person spoke of the need to maintain progress of the NPP's work within such tensions:

> *… keep us on track and to keep us progressing because it was very clear that there were going to be times when we would fall back into the internecine fights between the professional groups … this group of people who I thought hated one another, it was quite clear they hated one another, enormous tensions, enormous historical feelings … this group of people to begin to think about what professional roles might be in the future rather than to think about the past and protecting the turf. IR*

Managing a group of people with polarising views was difficult and the chairperson of both NPP Stages 2 and 3 Steering Committees spoke of the principles and challenges:

> *The first level of the process was to build an image of the future, the second level which was critically important was to build trust, and to build trust it meant that people had to come together to talk to understand each other's viewpoints, to begin to understand that people were looking at the world through very, very different eyes with different expectations, to build a sense of commonality … meeting and meeting and meeting until people began to understand one another thrashing around these issues. IR*

The oversupply of doctors in the cities had led to competition between GPs for patients and the suggestion of any further competition from introducing another health professional, in this case of nurse practitioners, was seen as a threat to their practice and hence livelihood. This view was shared by the Royal Australian College of General Practitioners (RACGP) referred to in the following interview excerpt as 'the College':

> *Many GPs were bulk billing and were cutting one another's throats, and so the idea of having yet another competitor coming into the market was seen by the NSW Faculty as being something that they weren't prepared to accept. D1*

Some participants believed the doctor groups portrayed their opposition to the NP role as a patient safety and quality of care issue, while others believed it was an effort to maintain medical dominance of health care services. The following highlights a more balanced view acknowledging both aspects of the medical resistance to the introduction of the NP role:

> *… some of the doctors were just protecting their patch and obviously wanting to protect their income, but other doctors I think had genuine concerns about whether nurses had the knowledge to practice safely in the extended role that started to distil out, now clarifying what they were wanting this NP to do, some doctors were genuinely concerned whether nurses would have the knowledge. N7*

The NPP Stage 3 Final Report recommendations were rejected by the AMA. The AMA's response was to commission its own review, which they referred to as being an independent review, by Logan Consulting. Participants spoke of the process and the responses following the release of the NPP Stage 3 Report:

> *The final report was issued in 1996 and that was put out for comment by everybody with talking about the 10 pilots and the results of the pilots etc and then we had a lot of response to that whole range of groups 88% of the responses recorded a positive endorsement 6% responded still opposing the*

report and the recommendations saying the research was flawed and the AMA went into overdrive the minute it was released and had a group of people waiting to absolutely slam the research even though it had been done very methodically. N4

My recollection is that the AMA came out with a very slamming document after the [NPP] Stage 3 report was released … [we] were able to dispute everything that was in that paper … the results were that they were a safe effective model of care. N4

… that's why the research was so successful, but interestingly enough when the research came out the only thing the AMA could do, was to say we think it is flawed, the research is flawed, they actually commissioned a study of the research just to challenge the methodology. N2

… that's how I believe it got up and running, that's why I believe it's going to be inevitable, and that's why I believe that no one listened, no one listened to reality in that these pilot projects were not acceptable, they did not practice an acceptable level of health care … we refused to sign off because we were not confident that it was an appropriate document nor research project nor the recommendations that followed, and we felt that it wasn't based on objective evidence and therefore we couldn't ethically sign off on the recommendations and the project. D2

The medical profession's campaign and strategy was not simply concentrating on the government as the sponsors of the change, or the nursing profession who was seen to gain from the presumed losses of the doctors, they also campaigned against some within the medical profession itself. One such event that was spoken about by two study participants was of the pressure being bought to bear by the AMA on doctors to maintain control, a strong sign that there was distrust among doctors:

There were stories bandying about at the time how black cars used to pull up outside the GPs practice and wind the window down and give them a few words of warning … I don't know whether that ever happened I don't know … N4

Many of the doctors who lived in remote communities wanted the nurse practitioners and saw the benefits of them but they were entirely and utterly overridden by the politics of the AMA. GR

There was a feeling among nurses recently rewarded for remaining in clinical practice that the prestige they had gained was being surpassed by a yet higher classification of clinical nurse, and those feelings manifested in the resistance to the introduction of nurse practitioners.

The following excerpts reflect the clinical nurses' resistance:

> *There was an element of resistance from nurses who could see their colleagues were about to go for authorisation that means they would have been a nurse practitioner there was a bit of jealousy there a bit of envy. N4*

> *What I don't think we actually foresaw was the degree of angst that we got from some areas of the profession, there were some nurses who did not think it was an appropriate thing to do, and there were … whether it was that they didn't think it was an appropriate thing, to do or whether they were jealous that there would be people who could do this and they knew they couldn't do it themselves, I'm not sure what was behind it, but it was a small group of people who really were quite vocal for a bit. It wore off and it went away, but I don't think any of us foresaw that. N5*

> *… it was about you know tall poppy stuff I think there were a couple of instances where people didn't want a nurse practitioner because they didn't believe in the position obviously been brain washed by the local GPs. N4*

The lack of clarity in the role of the nurse practitioner contributed to the lack of understanding of the different role they would play in the health workforce, as reflected by this participant;

> *… struggled with the difference between a nurse practitioner and a clinical nurse consultant because it seemed a lot of the things people were saying, you know, what they wanted or what they expected of a nurse practitioner seemed to reflect very much what was written as the role of a clinical nurse consultant at the time. N7*

Initially some within the CNC cohort were openly resistant to the introduction of nurse practitioners. However, once the distinction between the two roles had been made, the CNC group's resistance diminished::

> *I had the clinical nurse consultants come to me and say they we're the top people, why were we putting nurse practitioners in, so there was some difference from CNCs and CNSs because they said we've now got these two groups, "Why are we having nurse practitioners?". And some held out going for nurse practitioner who felt they'd already reached [the top of the clinical ladder] … That's moved and changed with some of those people, they were very angry about it because they were a fairly strong group the clinical nurse consultants. N6*

4.8 Chapter summary

This chapter discussed the findings of the study and firstly addressed the known issues that drove the development of the public policy for the advanced practice role of NP in NSW. It then moved to discuss the importance of bipartisan political support in the public policy and then identified how previous public policy and the development of the nursing profession had facilitated the development of the public policy that enabled the establishment of NPs in NSW.

The following diagram presents a summary of the study, the information sources informing the study, the analysis of these sources, the process of the NPP and how the outcomes discussed in this chapter were derived.

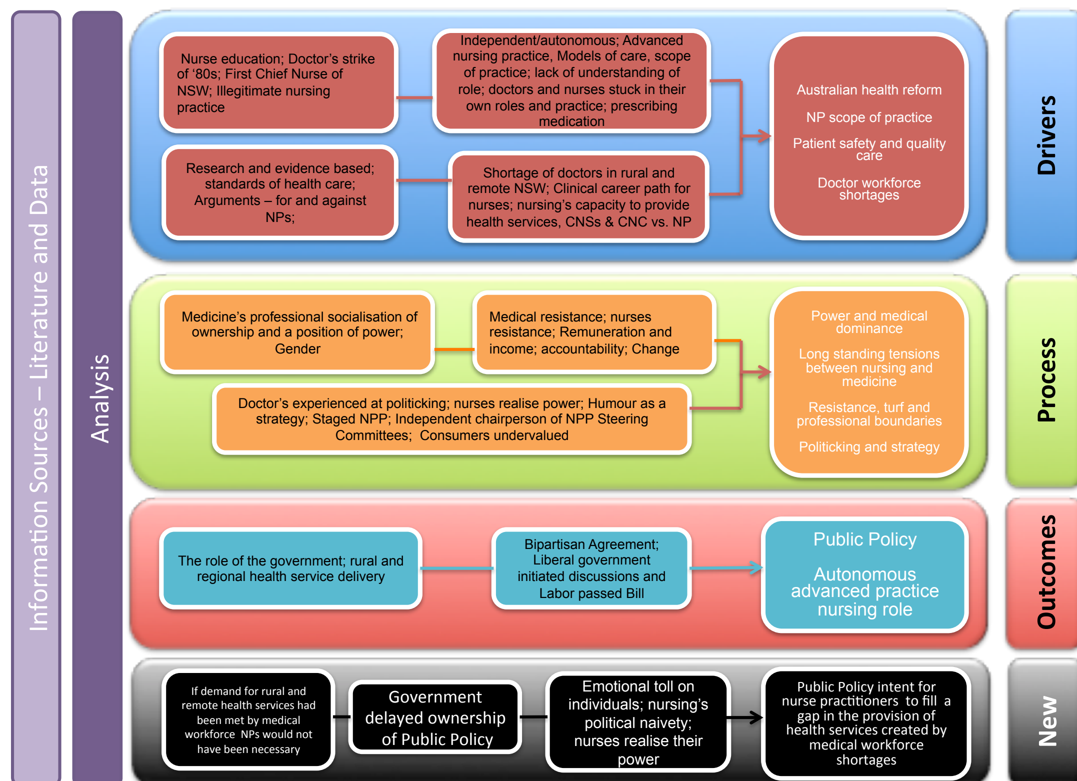


Figure 4.2: Summary of Findings

This chapter presented the known drivers for the development of the NP role. The first was the government's recognition of the need to meet the rural and remote community's health needs resultant of the gap in health service delivery due to a shortage of doctors practicing in rural and remote communities. Simultaneously the nursing profession's aspirations for advanced practice autonomous from the medical

profession, and to realise the professionalisation of nursing by creating a clinical nursing ladder, exposed longstanding tensions between nursing and medical professions. This chapter also identified that some NPP participants found the process of the public policy development personally challenging. The chapter highlighted the protectionism and vested interests of both the nursing and medical professions, in particular the medical profession.

The next chapter will discuss the implications of these findings.

CHAPTER 5
DISCUSSION OF FINDINGS

The previous chapter discussed the findings of the study, confirming the known drivers for the implementation of NPs and highlighting the protectionism and vested interests of both the nursing and medical professions during the development of public policy and subsequent role development for NPs in NSW. In particular, the chapter addressed the vested interests of the medical profession along with the push by nurses to claim more 'turf' while doctors sought to retain it. Also discussed was previous policy work and development of the nursing profession as it impacted on the development of public policy to enable the introduction of NPs.

This chapter draws on the study findings to discuss how they impacted the work of the NPP. It will identify how this public policy development was a drawn-out process based on changed objectives and the need for compromise. It will also discuss how new public policy development is facilitated by previous policy work. The evolution of the NPP process was affected by the power and dominance of the medical profession, and longstanding tensions between the nursing and medical professions impacting on its outcomes in terms of the role and scope of practice of the NP. As a result of the NPP processes and outcomes, the gap in the health service provision remains unresolved.

5.1 The gap in health service provision – an unresolved need

Health workforce issues and challenges featured strongly in the experiences of those involved in the implementation of the NP in NSW. Health workforce shortages are not isolated to Australia; they are a global phenomenon and it would appear the more remote the health service delivery requirements are, the greater the problem (Buykx, Humphreys, Wakerman et al., 2010). Australian research found workforce shortages inevitably reshaped professional boundaries, creating opportunity for substitution between professions to meet health care needs (Stevens & Vecchio, 2009).

The Productivity Commission in its *Research Report on Australia's Health Workforce* in 2005 raised the concept of task substitution and cited Professor Stephen

Duckett, who identified a wide range of areas where substitution of doctors for nurses could occur with additional training and clear protocols, including patient management. Duckett suggested that patient management, historically the domain of doctors, could be undertaken by NPs (Duckett, 2005a).

In the late 1980s the rural doctor shortage was made more complex by the oversupply of doctors in the metropolitan areas (Palmer & Short, 2014). However, in 2016 this issue remains unresolved, with doctors still reluctant to practice medicine outside metropolitan areas (Stevens & Vecchio, 2009) and the majority of NPs not practicing in rural communities.

Despite a protracted process of public policy development during the 1990s, the need for improvement in health service provision to the areas in the community with the greatest need for it remains a challenge for policy makers and health service providers. This suggests there should be a statutory requirement for NPs to work in rural and remote areas for a prescribed period of time, somewhat akin to the recent federal policy requirement for medical practitioners to practice in rural areas for two of their first six years post medical training (Australian Government Department of Health, 2015).

5.2 The quest for extended professional boundaries

There were two primary factors that led to the lengthy period of NP policy development and the escalation of the historical tensions between nursing and medicine. Firstly, the NSW government identified the need for improved health service delivery, especially for rural and remote areas, and looked to nursing as a means of meeting the need (NSW Department of Health, 1992). Secondly, the nursing profession saw the discussion about meeting that need as an opportunity to further the clinical career pathway for nurses (NSW Department of Health, 1992).

One factor identified as an issue in the early development of the role of the NP in NSW was the clinical practice of rural and remote nurses who, for reasons of necessity, were practicing in an advanced role and at times outside of their legal scope of practice with little, if any, protection at law (Elsom, Happell, & Manias, 2008; Hegney, 1996). The NPP Stage 1 Discussion Paper acknowledged this was an

issue in NSW and identified nurses operating out of their scope of practice through necessity (NSW Department of Health, 1992). If the government was looking to solve a health service provision need through the nursing workforce then it needed to provide nurses with a public policy framework within which nurses could practice (NSW Department of Health, 1998).

5.3 Previous policy work and NP role development

The study confirmed that both federal and state governments had implemented policies to encourage doctors to locate their medical practices in rural and remote areas of NSW (Buykx, Humphreys, Wakerman et al., 2010). The financial incentives offered to doctors were an attempt to bridge the gap in health service provision in rural and remote areas of the state. However, the availability of the incentives and the introduction of NPs have both not met the health service needs of rural and remote communities in NSW. Buykx et al. 2010 suggest that 'Rural health workforce issues are unlikely to ever be completely resolved' (Buykx, Humphreys, Wakerman et al., 2010, p. 107).

The nursing profession had developed its clinical pathway beyond the Registered Nurse designation with the introduction of the CNS and CNC classifications in the 1980s (Duffield, Gardner, Chang et al., 2011). These initiatives were achieved internal to the profession whereas the process of NP policy development was an arduous process, external to the nursing profession, to engage stakeholders while simultaneously shaping the parameters of the NP scope of practice.

This study found there was an alignment of politicians and the NSW Department of Health in the area of health workforce reform. Both agreed these reforms were about ensuring adequate, safe health services were being provided to marginalised rural and remote communities. Both politicians and the government of the day were focused on providing health services where doctors would not practice and supporting the substitution of doctors with nurses to fill the gap in heath service provision. However, the nursing and medical positions were very different and can be described as adversarial, argumentative and at times steeped in the self-interest of their respective professions.

Yet while there was bipartisan political agreement in NSW to introduce NPs, the government still found it necessary to engage health professionals and consumers in the policy development. This consultative approach gave rise to an atmosphere of 'argy bargy' between stakeholders and exposed longstanding tensions between nursing and medical groups. The wider consultative approach in effect resulted in a temporary hijacking of the process as nurses fought for increased scope of practice and doctors retreated to the traditional defences of their superior education and training.

While the need to fill the gap in health service provision and the aspirations of the nursing profession were primary drivers of the initiation of the development of the public policy, the earlier move of nurse training to tertiary education helped facilitate the development of NP policy. Tertiary education meant that nurses were more highly trained and had furthered their own professional socialisation. This in turn eased the passage of public policy; the government was less concerned about the knowledge base and capacity of nurses to fill the gap in the provision of health services than doctors claimed to be.

The existing Medicare legislation provided a funding framework from which a new advanced nursing role could be funded. In effect, consulting with an NP in private practice would not financially disadvantage patients of NPs. This study found the levelling of the financial 'playing field' elevated the concerns of doctor groups, who foresaw a lowering of barriers to entry and a subsequent threat to their livelihood. This challenge to the power and control of doctors and their resultant resistance and responses can be explained through critical social theory (Browne, 2000).

5.4 Elevating the status of nursing through policy

The policy decision in 1990 to appoint the first Chief Nursing Officer (CNO) for the NSW Department of Health was the first time that a nurse had worked within government at a very high level: taking part in government reviews, influencing health policy, lobbying and participating in public policy development on a regular basis with the health minister of the day. This government appointment of a CNO provided the opportunity to increase the presence and profile of nursing within the government. Representing nurses and midwives from the public, private and

academic sectors, the CNO was the interface between the Minister for Health and the Director General for Health, commenting on strategy and policy that impacted the nursing profession and related issues (Meppem, 2003). The appointment of a CNO can be seen as an enabler to the work of the NPP in developing public policy for an advanced practice nursing role, the NP in NSW

For the nursing profession, the CNO appointment was a realisation by government of the importance of nursing in the health workforce. This study found that the involvement of the NSW CNO was critical and played a major leadership role both within the nursing profession and within the government in progressing the NP role.

The introduction of new classifications for registered nurses practicing in specialty areas, CNS and CNC, were policy decisions within nursing that were the first steps in developing advanced practice nursing beyond registered nurses (Duffield, Gardner, Chang et al., 2009). These nursing classifications partly met the aspirations for advanced nursing practice; however, they were not sufficient in scope to fill the gap in the provision of health services.

5.5 Nursing resistance to change

While the nursing profession was a strong advocate for the introduction of NPs, there was internal resistance to the objective. As found in this study, a theme of resistance emerged from some sections of the nursing profession. Study participants spoke of how CNCs had seen themselves as the pinnacle of the nursing profession and viewed the introduction of NPs as a threat to their status within the profession's hierarchy.

Under the eventual agreement reached with doctor groups, an NP service can only be established in a community with the agreement of the local GP. The study found resistance from some within the senior echelons of nursing who, based on the historic tensions between doctors and nurses, did not want to have to engage in negotiations with local GPs in such communities.

5.6 Speaking with one voice

The resistance to change from within nursing posed a risk that nurses would not be speaking in alignment. However, nursing groups learned lessons from their disparate

responses to the 1980s federal government initiation of a move from hospital-based nursing training to tertiary education. Two study participants spoke of the move from hospital-based nursing training to tertiary education, noting that when nursing responses arose from multiple voices, it made that public policy development more complex. So as not to repeat history, with the establishment of the NPP, nursing groups were conscious of the need to speak with one voice. A combined strength was required if they were to succeed in establishing NPs in NSW. It was a conscious and concentrated effort by all nursing groups to be aligned on the way forward to the introduction of NPs.

One of the implications of the coalition of otherwise disparate nursing groups was that the government was listening to a consistent response from nursing. By contrast, doctor groups were not aligned with a single voice. The AMA and the RACGP, for example, were centring their responses on different issues. The AMA initially relied on claims about inadequate education and sub-optimal quality of care; in time it emerged that their primary concerns were financially motivated. The RACGP was concerned primarily with quality of care and patient safety. Ultimately government noted the AMA's view and the recommendations of the NPP Stage 3 Report were accepted with all other participant groups aligned in agreement.

However, the much broader implication for the nursing profession is that it signalled the need for speaking with alignment when working with government on public policy issues. In the NPP process, the caucusing between nursing groups between meetings enabled gains to be achieved and compromises made in order to arrive at a position of consensus.

The business of government in developing public policy, particularly large impact public policy, in the first instance often results in gathering multiple stakeholders with differing views (Palmer & Short, 2014). This can make for protracted, cumbersome policy development if stakeholders cannot find a consensus response. An alignment of stakeholder positions can make for more efficient policy development. However, while the nursing group stakeholders in the NPP were aligned, the development of the NP policy still took eight years to the point of becoming law in 1998.

5.7 The AMA's lobbying experience and resistance to policy

In contrast to the 1980s experiences of the nursing profession speaking with multiple voices on the changes to nursing education, the AMA's campaign in resisting the introduction of Medicare in the 1980s equipped the medical profession with political and strategic lobbying experience. In the 1990s it was able to speak with a loud voice in its campaign against the introduction of NPs. While the AMA failed to stop the introduction of Medicare, arguably its 1980s lobbying experience left it with strong political skills in opposing legislative changes that it deemed as threats to its members.

5.8 Ambiguous claims

The study found claims from some nursing representatives on the NPP Steering Committees that the intent of the NP role was not to replace doctors. However, the objectives that the steering committees were trying to achieve were very much tasks that had been the primary, official domain of the medical profession, those being: prescribing medication (limited); requesting pathology and radiology services for individual patients; and referring patients to medical practitioners, including specialists and GPs (NSW Department of Health, 1992); all previously the sole domain of medical practitioners. Therefore, on one hand the nurses were saying: 'We do not want to practice medicine' whereas conversely they were advocating for rights to practice specific components of a doctor's role.

5.9 Medical dominance – power – resistance to change

The longstanding paternalistic nature of medicine towards nursing and its dominance over nursing were supported by the findings of this study. The study found power relations between doctors and nurses underpinned by gender.

The notion of 'all working as one health care team' with power evenly distributed to all members has remained rhetoric, with power distribution and relations of doctors and nurses barely changing in decades (Grbich, 2004, p. 247; McMurray, 2010). French philosopher Michel Foucault has written extensively on the effect of power

and knowledge and claims, 'there are no relations of power without resistances' (Foucault, 1980, p. 142). Foucault argues that resistances 'are all the more real and effective because they are formed right at the point where relations of power are exercised' (Foucault, 1980, p. 142). Foucault wrote of power that is exercised by those who can no longer access positional power (Gibb, Forsyth, & Anderson, 2005); power that is being lost. It can be argued that the resistance displayed by the AMA towards the introduction of NPs represented behaviour in response to an impending loss of positional power.

A finding of the study was that both nurses and doctors experienced frustration and disempowerment with the NPP. The NPP Stage 1 initial policy developments and workings were entirely internal to nursing. With an absence of doctors at that stage, nurses felt empowered by an opportunity to design an extension of their clinical pathways. That power quickly faded when the government introduced doctors and consumers to subsequent stages of the NPP. Nurse participants spoke of their frustration that doctors were again being given a voice in determining nursing practice and professional advancement.

For doctors, frustration and fear of an impending loss of power initially arose after release of the NPP Stage 1 Discussion Paper. The Discussion Paper amplified the historic tensions between doctors and nurses, which were seated in medical dominance and power. The study found doctors not being able to influence the outcome and stop the development of an advanced practice nursing role that would have usurped some of the traditional medical tasks, such as prescribing and referring to medical specialists, led to substantial frustration within doctor groups, particularly the AMA. While frustrated, the resistance from doctor groups nevertheless saw the government choose a path of less resistance when the locations of NPP pilot programmes were being determined.

During the NPP pilot projects, the NP role was developed in specialist practice settings, with only one pilot project conducted in a general setting in a remote community of NSW. Arguably, had the government chosen to conduct more pilot projects in generalist settings and if such projects proved to be successful in meeting community needs, it would have represented a much greater potential threat to doctors. With the prospect of patients across the state, but especially in rural and

remote areas, being able to access NP services, the threat to the status, power and influence held by doctors was heightened.

5.10 Pilot error

Following the publication of the NPP Stage 3 Final Report, the decision made by the government was to implement NPs in generalist roles across the rural and remote sectors of NSW, not into specialist areas where it had been developed and tested. This finding evidences a process flaw in the work of the NPP. This was government implementing public policy to ease the political pressure on itself from communities seeking the provision of better health services. The government also was cognisant that such deployment of NPs would attract less resistance from doctors to the introduction of NPs because the majority of doctors did not want to practice in rural and remote areas.

Despite the 1991 ‘definition’ of a NP in the Stage 1 NPP Discussion Paper, professional boundaries continued to be a dilemma for both the medical and nursing professions. These historical struggles for power to control the future of the nursing profession and its various regulation and scope of practice issues are ongoing (Bergeron, Neuman, & Kinsey, 1999; Wilkinson, 2008). Some argue that the NP model would finally legitimise a role that in some form had already existed in rural and remote Australia (Elsom, Happell, & Manias, 2008; Koch, Pazaki, & Campbell, 1992; Wilkinson, 2008).

5.11 Politicking and strategies for change

A theme of strategising and politicking to gain advantage was recurrent throughout the study. While doctor study participants were relatively silent on the issue, the experiences shared by nursing participants were rich with an intentional strategy to align the profession to gain advantage in the NPP. For nursing, the need to be politically active and speak strategically with one aligned voice was breaking new ground. In contrast, the medical profession, the AMA in particular, was very experienced at political lobbying and the use of media to promote their interests.

Medicine is professionally segmented with representative associations and colleges (Davis & George, 1993, p. 120) and only 50% of doctors are members of the AMA.

Notwithstanding the unrepresentative structure of the AMA, it is a politically powerful lobby group for doctors. While in the past a comfortable relationship existed between the Department of Health and the AMA, described by some as a 'co-operative partnership' that was far from separate (Mathews, 1990, p. 225), the relationship was eroding. An erosion of the co-operative partnership between doctors and government first appeared during the development and implementation of the Medicare legislation in the 1980s (Davis & George, 1993).

5.12 A consultative approach led to a hijacking of public policy development

The commencement of the NSW NPP saw a heightened level of tension between doctors and government due to initiatives that were set to cede power and control from doctors to some extent by the introduction of NPs. Arguably, had the NSW government not moved to engage doctors in the NPP from Stage 2 onwards, the prevalence of doctors' dominance and power over the nursing workforce would not be manifested in the *Nurse Practitioner in NSW Policy Statement and Framework* (NSW Department of Health, 1998). It can be further argued that had the government not chosen to consult with doctor and nurse groups, it could have simply implemented NP legislation; it enjoyed bipartisan support for the initiative. In effect the government's decision to be consultative allowed for a 'hijacking' of the policy development. This was especially evident in the influence of doctor groups on the legislated scope of practice for the NP role.

5.13 Overregulation

In 1998, the legislation passed by the NSW government to enable the NP role did not reflect the original aspirations of the nursing profession as discussed in the NPP Stage 1 Discussion Paper (NSW Department of Health, 1992). Aspirations such as access to PBS and MBS and a broad, somewhat unfettered, scope of practice were lost. The unfulfilled aspirations represented compromises made by nursing in response to persistent opposition from doctors about the extent of the role.

For both the so-called 'grandparenting' period and beyond, NPs have had to undergo an accreditation process by the NRB. The composition of the Nurse Practitioner Accreditation Committee, for nurses applying for NP authorisation, must include

doctors. The *Nurse Practitioner in NSW Policy Statement and Framework* (NSW Department of Health, 1998, p. 4) stipulates that introducing an NP service to a community requires endorsement by a local multidisciplinary team that includes a doctor. Additionally, the multidisciplinary team is responsible for developing the formulary for NP clinical guidelines for each individual NP service.

The pressure for these requirements arose from the doctor groups during the NPP process. While the nursing profession agreed to the demands of the doctor groups, they did so in order to keep the NPP process moving forward. Arguably, the nursing profession itself would never have imposed doctors into the NP endorsement process; nursing's aspirational losses evidence a continued manifestation of doctors' dominance and power over nurses.

5.14 Self-interest before altruism

For both doctors and nursing, prima facie, the importance of patient safety and quality care was a central theme during the course of the NPP, with patient safety highlighted as non-negotiable in all three NP Staged Reports (NSW Department of Health, 1992, 1993, 1995). While both professions pursued their respective positions on the introduction of NPs with patient safety and quality of care central to their arguments, they did so with diametrically opposed justifications. Doctors claimed that patient safety and quality of care would be at risk, whereas nursing relied on its claim that the pilot projects confirmed patient safety and quality of care were not compromised by NPs.

However, despite both professions publicly espousing a commitment to patients, the virtue of these claims is lost when considered against the protectionism and self-interest that were pervasive throughout the NPP. While consumers were seconded to the NPP by the government, their role did not feature strongly in the recollections of doctor and nurse study participants. The only exception to this was when consumers had supported an argument from one or the other profession. The doctor and nurse study participants spoke of how the consumer could promote their respective causes rather than valuing their input to benefit health care provision. This study found the process of the development of the role of the NP was professionally driven rather than for the benefit of the consumer, the patient. All stakeholders did not appreciate

the value of the consumer perspective during the NPP process and the study also found that the government placed a greater level of importance on the opinion of the professions over the consumer's perspective. Subsequent to the work of the NPP, consumers have since been recognised by health ministers and senior public servants as powerful allies in the political market place (NSW Department of Health, 1998).

5.15 The cost of protectionism and vested interests

The lengthy policy development process resulted in a delay in legislation designed to bridge the gap in health service provision resultant of the medical workforce shortage. The eight-year period was underscored by the protectionism and vested interests of both the medical and nursing professions and saw the medical profession attempt to maintain its dominance over nursing and the wider health system. Both nursing and medicine espoused a commitment to the community in arguing their respective positions throughout the policy development period. So too did the government in initiating the policy development under what became known as the NPP.

With such large impact change, resistance was inevitable:

> And it ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. Because the innovator has for enemies all those who have done well under the old conditions, and lukewarm defenders in those who may do well under the new. This coolness arises partly from fear of the opponents, who have the laws on their side, and partly from the incredulity of men, who do not readily believe in new things until they have had a long experience of them. (Machiavelli, 1515, pp. 24-25)

The NP public policy process during the introduction of the NP role in Australia was reflective of this Machiavellian theory of the order of things. Several hundred years earlier Machiavelli spoke of the interested parties who 'had done well' and would continue to benefit if circumstances were to remain unchanged, if they were to be the resisters of change. Until the commencement of the NPP in 1990, those who had done well under the existing circumstances were doctors who had benefitted from decades of power, financial rewards and social status, which were being challenged by the aims of the government-initiated NPP. The medical profession's fear was that

their ‘opponents’, the nursing profession, would in time have the law on their (nursing’s) side; that legislation could erode doctors’ power, status and income. Doctors had much to lose and, in their eyes, nothing to gain from the aims of the NPP. By contrast, the nursing profession had the opportunity to benefit from the stated aims of the NPP through further advancement of the clinical career pathway and autonomy of practice. Notably absent in their respective discourse was the interests of the community.

Adjacent to the protectionism and aspirations resident in the aims of the medical and nursing professions was the community as a major stakeholder, which stood to gain via the development of public policy aimed at bridging the gap in health service delivery. The community had much to gain if the NPP aims, the NP scope of practice, were fully achieved and little to gain if the interests of doctors were protected through a dilution of those aims.

This study found that resistance from doctor groups to the aims of the NPP initially arose following release of the NPP Stage 1 Discussion Paper. The resistance was immediate, and over the next eight years a thread of arguments opposing the establishment of NPs in the community inhibited the work of the NPP and contributed to the delay in the drafting and enacting of legislation. Doctor groups initially staked their opposition on the mistaken assumption that doctors would be legally accountable for the actions of a NP delivering care to ‘their’ (the doctor’s) patient. Despite legal confirmation to the contrary, doctors continued to base much of their opposition on this view. Arguably, the NP policy development process would have been expedited if the government had legislated the policy framework to match the community needs in the first instance. That notwithstanding, it would not have negated the opposition – the protectionism and vested interests – of the medical profession. Doctors groups would have likely sought amendments to legislation – a dilution of the legislation resulting in a similar outcome to what was eventually achieved in 1998.

However, their opposition also rested on claims of inadequate education of nurses and patient safety issues. Interwoven with the doctors’ opposition was the longstanding tensions between the medical and nursing professions. As the tensions manifested more openly during the early work of the NPP, at Stage 2 the government

appointed an independent chairperson to arbitrate the competing claims of the professions.

The government's primary aim to was to fill the gap in the provision of health service delivery resultant of the shortage of doctors; nursing's professional aspirations were not a priority per se. Notwithstanding, the government did recognise that the nursing workforce was part of the solution and arguably the original proposed scope of practice for the NP would have achieved the government's goal. However, the final legislation resulted in a compromised scope of practice, which has not achieved the government's health service delivery objective.

Despite the overall success of the NPP pilot projects, opposition from doctor groups resulted in an erosion of the scope of practice as initially envisioned. In order to appease the doctor groups and maintain the momentum of the NPP, all other stakeholders conceded on the scope of practice.

5.16 Chapter summary

The study highlighted a range of factors that enabled or inhibited the work of the NPP. The medical workforce shortage and previous policy developments were enabling factors. In addition the NSW government, by virtue of its obligation to meet a community need, enabled the introduction of NPs. The government saw the nursing workforce as a way in which to meet the shortfall in the provision of health service delivery in NSW, and it was afforded bipartisan support by its political opponents. The earlier establishment of CNCs and CNSs by the nursing profession was the initial step in advanced practice nursing roles towards autonomous practice unencumbered by medical dominance.

While the nursing profession sought an advanced practice nursing role independent of supervision by doctors, the dominance of and power over nurses by doctors remained in the 1998 regulations. The requirement for doctors to be involved in the NP accreditation process was a continued manifestation of their power. In effect, in an effort to keep the NPP process moving forward, the nursing profession acquiesced on the key aspiration of independent practice and in doing so, compromised the NP scope of practice that they initially sought.

Central to the work of the NPP was a need to solve a health service delivery problem in the community. Despite both professions espousing a primary commitment to the patient, ironically, it appears that focus was lost and protectionism and self-interest were predominant.

The following chapter will draw a conclusion to the study and make recommendations for future research and areas of work to further public policy concerning NPs in Australia.

CHAPTER 6
CONCLUSIONS AND RECOMMENDATIONS

After eight years of public policy development aimed at resolving a health service delivery problem in NSW, and ultimately an Australia-wide problem, communities still lack the health services they need. The needs and aspirations of all stakeholders – the community, government, the nursing and medical professions – have not been met. The needs and aspirations have not been met due to the combined effects of self-interest and professional protectionism resulting in a compromised NP scope of practice.

6.1 Conclusions

6.1.1 Government management of the public policy process

The commencement of the NP policy development was driven by a maldistribution of the medical workforce and the nursing profession's aspirations for an autonomous advanced practice nursing role as an extension of its clinical pathway. With the best of intentions, the government embarked on a public policy development process that it hoped would fill the gap in health service provision resultant of the doctor shortage in the state, especially in rural and remote areas. The government of the day enjoyed bipartisan political support for its objective and could have enacted the legislation required to permit an advanced practice nursing role without engaging the professions. The government knew of the difficulties in getting doctors to locate to the areas most in need of health service delivery and was being lobbied by communities across the state for the problem to be solved. Yet it chose to proceed on a consultative basis to develop the advanced practice nursing role. It was this that led to an arduous, drawn-out, policy development process ultimately resulting in an outcome in which no stakeholder achieved their objectives.

6.1.2 Professional tensions

In choosing to develop policy on a consultative basis, initially solely with the nursing profession, the government was either not aware of, or did not anticipate, the

problems that would result from the longstanding tensions between the medical and nursing professions. The longstanding medical dominance within the health care system, which can be understood when viewed through the lens of critical social theory, substantially contributed to the delay in the public policy.

The tensions manifested in claims and counter-claims throughout the eight year public policy development period and exacted a personal toll on individuals from both primary, professional and stakeholder groups as well as at least one person independent of those professions. Some found the process very challenging and memories of the personal impact remain to this day. There is a continuing impact for some.

6.1.3 Little effective change

Despite there being a policy framework for the NP role, nurses continue to practice outside their scope of practice in some settings. New roles under the direction of doctors, such as practice nurses and physician assistants, have had mixed success; however, the gap in health service provision remains. In the late 1980s, there was a maldistribution of the medical workforce across NSW and the government attempted to resolve this with the introduction of an advanced practice nursing role. It could be argued that the shortfall in health service provision is now represented by a maldistribution of both doctors and NPs. With the concentration of NPs centred on metropolitan areas, the need for health service provision in rural and remote areas remains unmet. Essentially, not a lot has changed.

6.1.4 Framework does not go far enough

While the NP policy framework is established and has the potential to provide health services in areas of need, it is cumbersome in its regulation of the NP role. The regulation impedes the supply and distribution of NPs due to requirements for the agreement of the medical profession. This points to the need for a revision of the public policy to liberate the NP scope of practice, and the location of an NP service, from the need for doctor approval.

6.1.5 The problem remains

In rural and remote areas, the NP policy framework has brought about little change and the problem remains. There is a highly controlled supply of NPs and that control was brought about by the protectionism and vested interests of the professional stakeholders, particularly doctors.

Throughout the period of developing the NP policy framework, the loudest voices were those of the medical and nursing professions. With the risk of potential losses, both financial and social for medicine and professional pathway enhancement opportunities for nursing, the longstanding tensions between these groups overshadowed the primary stakeholder, the community.

While it was the government that maintained its focus on a community need and was, effectively, the stakeholder most focused on patients, its stewardship of the policy development was hijacked by the professions. Allowing that to happen means the final policy outcome has not met the needs of the community.

Ironically, a large number of NPs practice in emergency departments supporting a nurse-led model that some would argue is under the domain of a medical model of care. Such an outcome is not meeting the needs of rural and remote communities where the need for improved health service delivery is greatest. A politician participant noted that the NP development was the biggest health workforce issue in the previous fifty years and that the community would likely face a similar issue in the future when NPs prefer not to practice in rural and remote areas. Arguably, with the prevalence of NPs predominantly in metropolitan areas, the community has already reached that time.

6.2 Recommendations

6.2.1 The need for policy revision

Providing an appropriate health workforce is complex and remains a challenge for both government and health service managers. With particular reference to rural and remote communities, health service provision remains a pressing need in parts of the community. While doctor groups are ostensibly unhappy that the concept of an

advanced practice nurse even exists, the nursing profession remains well short of its goal of an autonomous scope of practice free of medically imposed covenants.

There is ample evidence that the rural and remote communities' health care needs have been largely unmet in some sectors. This points to the need for a revision of the public policy that enabled NP services eighteen years ago, originally intended to resolve the gap in health service provision to such sectors. Arguably, doctors will continue to be largely unresponsive to any incentives to locate to rural and remote areas; that initiative failed in the 1980s and will likely do so into the future. Despite incremental enhancements to the NP role since 1998, such as access to the MBS and PBS, NPs remain largely unrepresented in the areas most in need of health service provision – rural and remote communities. While ever medical dominance impedes the NP policy framework, it is highly likely the health service provision shortfall will remain.

This highlights the need for the nursing profession to step forward and lead calls for a revision of the legislation with a view to, finally, resolving the shortfall in health service provision. The nursing profession's leadership of such advocacy should be focused on the needs of rural and remote communities, which remain unmet twenty-six years after the NSW government first sought to find a solution to the problem. In doing so, the nursing profession should not speak of its own interests of professional pathways; that is incidental to resolving the community's need. By maintaining a focus on the needs of the primary stakeholder, the community, its case for reform will be strengthened. A move by the nursing profession for the government to undertake a policy revision would without question attract strident opposition from the medical profession. The tensions between doctors and nurses will not ease in the foreseeable future; however, this should not discourage the nursing profession or the government from seeking to resolve the gap in health service delivery with a NP role unimpeded by medical dominance.

REFERENCES

Australian Government Department of Health. (2015, 04 September 2015). Medical Rural Bonded Scholarship Scheme (MRBS) Retrieved 06/01/2016, from http://www.health.gov.au/mrbscholarships

Australian Medical Association. (2005). AMA Position Statement - Regional/Rural Workforce Initiatives, from https://ama.com.au/sites/default/files/node/2171/AMA_Position_Statement_on_Regional-Rural_Workforce_Initiatives.pdf

Ball, C., & Cox, C. (2003). Part one: Restoring patients to health - outcomes and indicators of advanced nursing practice in adult critical care. *International Journal of Nursing Practice, 9*(6), 356-367.

Ball, C., & Cox, C. (2004). Part two: the core components of legitimate influence and the conditions that constrain or facilitate advanced nursing practice in adult critical care. *International Journal of Nursing Practice, 10*(1), 10-20.

Bergeron, J., Neuman, K., & Kinsey, J. (1999). Do Advanced Practice Nurses and Physician Assistants benefit small rural Hospitals? *Journal of Rural Health, 15*(2), 219-232.

Bountain, D. (1999). Critical Language and Discourse Study: Their Transformative Relevance for Critical Nursing Inquiry. *Advances in Nursing Science, 21*(3), 1-8.

Bourgeois, S., Blanchard, D., Doldissen, R., Maher, L., Stoddart, K., Johnston, N., & Hungerford, C. (2014). Nurse practitioner work: A case study. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 47*(1/2), 61-68.

Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology, 3*(2).

Browne, A. J. (2000). The Potential Contributions of Critical Social Theory to Nursing Science. *Canadian Journal of Nursing Research, 32*(2), 35-55.

Buykx, P., Humphreys, J., Wakerman, J., & Pashen, D. (2010). Systematic review of effective retention incentives for health workers in rural and remote areas: Toward evidence based policy. *The Australian Journal of Rural Health, 18*, 8.

Cant, R., Birks, M., Porter, J., & Cooper, S. (2011). Developing advanced rural nursing practice: A whole new scope of responsibility. *Collegian, 18*, 177-182.

Carter, M. A., Owen-Williams, E., & Della, P. (2015). Meeting Australia's Emerging Primary Care Needs by Nurse Practitioners. *Journal for Nurse Practitioners, 11*(6), 647-652 646p. doi: 10.1016/j.nurpra.2015.02.011

Casey, M., Saunders, J., & O'Hara, T. (2010). Impact of Critical social empowerment on psychological empowerment and job satisfaction in nursing and midwifery settings. *Journal of Nursing Management, 18*, 24-34.

Cheek, J., Shoebridge, J., Willis, E., & Zadoroznyj, M. (1998). *Society and Health, Social theory for Health Workers*. Melbourne: Longman.

Chiarella, M. (1998). Maximising the use of the Workforce. *Australian Nursing Journal, 6*(2), 4.

Cochran, C., Mayer, L., Carr, T., & Cayer, J. (2009). *American Public Policy: An Introduction* (Ninth ed.). Boston, MA. USA: Wadsworth, Cengage Learning Academic Resource Centre.

Commonwealth Government of Australia. (2008). *INTERGOVERNMENTAL AGREEMENT FOR A NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR THE HEALTH PROFESSIONS*. Retrieved from https://www2.health.vic.gov.au/getfile//?sc_itemid=%7b70204869-9458-4743-A786-C42726B1A666%7d.

Davis, A., & George, J. (1993). *States of Health. Health and Illness in Australia* (2nd ed.): Harper Educational.

Denzin, N. K., & Lincoln, Y. S. (2000). Introduction and Practice of Qualitative Research *Handbook of Qualitative Research* (pp. 1-28). Thousand Oaks, California: Sage Publications.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The SAGE Handbook of Qualitative Research* (4th ed.).

Duckett, S. (2005a). Australia's Health Workforce, Research Report (pp. 435). Melbourne: Productivity Commission Australian Government.

Duckett, S. (2005b). Health Workforce design for the 21st Century. *Australian Health Review, 29*(2), 201-210.

Duffield, C., Gardner, G., Chang, A., & Catling-Paull, C. (2009). Advanced Nursing Practice: A Global perspective. *Collegian, 16*, 55-62.

Duffield, C., Gardner, G., Chang, A., Fry, M., & Stasa, H. (2011). National regulation in Australia: A time for standardisation in roles and titles. *Collegian, 18*, 45-49.

Elsom, S., Happell, B., & Manias, E. (2008). Expanded Practice Roles for Community Mental Health Nurses in Australia: Confidence, Critical Factors for Preparedness, and Perceived Barriers. *Issues in Mental Health Nursing, 29*(7), 767-780. doi: doi:10.1080/01612840802129269

Elsom, S., Happell, B., & Manias, E. (2009). Nurse Practitioners and Medical Practice: Opposing Forces or Complementary Contributions. [Periodical]. *Perspectives in Psychiatric Care, 45*(1), 7.

Forde, A., & O'Connor, T. (2009). *Augmenting the Rural Health Workforce with physician assistants*. Paper presented at the 10th National Rural health Conference - Rural Health: The Place To Be, Cairns - Queensland, Australia. http://10thnrhc.ruralhealth.org.au/papers/docs/Forde_Allan_E4.pdf

Foster, J. (2010). *A History of the early development of the Nurse Practitioner Role in New South Wales, Australia.* (Doctor of Philosophy), University of Technology, Sydney.

Foucault, M. (1980). *Power/Knowledge. Selected Interviews and Other Writings* (C. Gordon, L. Marshall, J. Mepham & K. Soper, Trans.). New York: Pantheon Books.

Francis, K., Boyd, M., Latham, H., Anderson, J., Bradley, A., & Manners, J. (2014). A regional approach to the education of nurse practitioner candidates to meet the health needs of rural Australians. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 49*, 27-34 28p. doi: 10.5172/conu.2014.49.27

Fulton, Y. (1997). Nurses' views on empowerment: a critical social theory perspective. *Journal of Advanced Nursing, 26*, 529-536.

Furlong, E., & Smith, R. (2005). Advanced nursing practice: policy, education and role development. *Journal of Clinical Nursing, 14*(9), 1059-1066.

Gardner, D. (2010). Expanding Scope of Practice: Inter-Professional Collaboration or Conflict? *Nursing Economic$, 28*(4), 264-266.

Gardner, G. (2004). Issues in Nurse Practitioner Developments In Australia. *Cancer Forum, 28*(3), 132-134.

Gardner, G., Carryer, J., Dunn, S., & Gardner, A. (2004). The Nurse Practitioner Standards Project: Report to the Australian Nursing & Midwifery Council.

Gardner, G., Chang, A., & Duffield, C. (2007). Making nursing work: breaking through the role confusion of advanced practice nursing. *Journal of Advanced Nursing, 57*(4), 382- 391.

Gardner, G., Duffield, C., Doubrovsky, A., & Adams, M. (2016). Identifying advanced practice: A national survey of a nursing workforce. *International Journal of Nursing Studies, http://dx.doi.org/10.1016/j.ijnurstu.2015.12.001*

Gardner, G., Gardner, A., Middleton, S., Della, P., Kain, V., & Doubrovsky, A. (2010). The work of nurse practitioners. *Journal of Advanced Nursing, 66*(10), 2160-2169 2110p. doi: 10.1111/j.1365-2648.2010.05379.x

Gibb, H., Forsyth, K., & Anderson, J. (2005). Culture of Rural Nursing Practice: A Critical Theoretical Analysis of Determinants of Power in Nursing. *Australian Journal of Advanced Nursing, 23*(2), 34-39.

Grant, C. (1985). *Australian Hospitals Operational Management* (2nd ed.). Edinburgh: Churchill Livingstone.

Grbich, C. (2004). *Health in Australia, sociological concepts and issues* (3rd ed.). Sydney: Pearson Education Australia.

Hamric, A. B., Spross, J. A., & Hanson, C. M. (1996). *Advanced Nursing Practice: An Integrative Approach*. Philadelphia: W B Saunders Company.

Hegney, D. (1996). The status of rural nursing in Australia: a review. *Australian Journal of Rural Health, 4*, 1-10.

Hegney, D. (1997). Extended, expanded, multi-skilled or advanced practice? -Rural nurses in Australia, 1991-1994. *Collegian: Journal of the Royal College of Nursing Australia, 4*(4), 22-27. doi: 10.1016/s1322-7696(08)60252-8

Humphrys, J., Jones, M., Jones, J., & Mara, P. (2002). Workforce Retention in Rural and Remote Australia: Determining the factors that influence length of practice. *Medical Journal of Australia, 176*, 472-476.

Joyce, C., Stoelwinder, J., McNeil, J., & Piterman, L. (2007). Riding the wave: current and emerging trends in graduates from Australian university medical schools. *Medical Journal of Australia, 186*(6), 309-312.

Jupp, V. (Ed.). (2006). *The SAGE Dictionary of SOCIAL RESEARCH METHODS*. London: SAGE Publications Ltd.

Koch, L. W., Pazaki, S. H., & Campbell, J. (1992). The First 20 Years of Nurse Practitioner Literature: An evolution of Joint Practice Issues. *Nurse Practitioner, 17*(2), 64-68.

Krippendorff, K. (2013). *Content Analysis: An Introduction to Its Methodology* (Third ed.). United States of America: SAGE.

Kuhlmann, E., & Annandale, E. (2012). Researching Transformations in Healthcare Services and Policy in International perspective: An Introduction. *Current Sociology 60*(4), 401-414.

Light, D. W. (1992). Equity and Efficiency in health care. *Social Science and Medicine, 35*(4), 465-469.

Lloyd Jones, M. (2004). Role development and effective practice in specialist and advanced practice roles in acute hospital settings: systematic review and meta-synthesis. *Journal of Advanced Nursing, 49*(2), 191-209.

Logan Consulting. (1996). Review of the NSW Health Department's Report on the Nurse Practitioner Project: Stage 3 (pp. 27): Prepared for The NSW Branch of the Australian Medical Association Limited.

Machiavelli, N. (1515). *The Prince*. http://www.constitution.org/mac/prince.pdf.

MacLellan, L., Higgins, I., & Levett-Jones, T. (2015). Medical acceptance of the nurse practitioner role in Australia: A decade on. *Journal of the American Association of Nurse Practitioners, 27*(3), 152-159 158p. doi: 10.1002/2327-6924.12141

Masso, M., & Thompson, C. (2014). Nurse Practitioners in NSW 'Gaining Momentum': rapid review of the nurse practitioner literature. (pp. 60): Centre for Health Service Development, University of Wollongong.

Mathews, T. (1990). Interest Groups. In R. Smith & L. Watson (Eds.), *Politics in Australia* (pp. 285). Sydney: Allen & Unwin.

McMurray, R. (2010). The Struggle to Professionalize: An ethnographic account of the occupational position of Advanced Nurse Practitioners. *Human Relations, 64*(6), 21.

Meppem, J. (2003). *1990 - 2002. Reflections the NSW Chief Nursing Officer*. North Sydney.

Middleton, S., Gardner, A., Gardner, G., & Della, P. (2011). The Status of Australian nurse practitioners - the second national census. [Feature]. *Australian Health Review, 35*(4), 448-454.

Mill, J., Allen, M., & Morrow, R. (2001). Critical Theory: Critical Methodology to Disciplinary Foundations in Nursing. *Canadian Journal of Nursing Research, 33*(2), 109-127.

Miller, M., Siggins, I., & Fowler, G. (2011). The Potential role of Physician Assistants in the Australian context (Vol. 2: Literature Review, pp. 68): Health Workforce Australia.

Mills, J., & Fitzgerald, M. (2008). The Changing role of practice nurses in Australia: an action research study. *Australian Journal of Advanced Nursing, 26*(1), 16-20.

Mitchell, B. (2000). *Rural and remote nurses: Third world practitioners or saviours of the bush?* Paper presented at The New South Wales College of Nursing Forty-Eighth Annual Oration, Great Hall, Sydney University, Australia.

NSW Department of Health. (1992). *The Role and Function of Nurse Practitioners in NSW*. NSW Department of Health.

NSW Department of Health. (1993). *Nurse Practitioner Review Stage 2*. North Sydney: State Health Publication No. (NB) 93-120.

NSW Department of Health. (1995). *Nurse Practitioner Project Stage 3 - Final Report of the Steering Committee*. (ISBN 0731007743) State Health Publications Number (NB) 96 0027). North Sydney: NSW Department of Health.

NSW Department of Health. (1998). *Nurse Practitioner Services in NSW*. North Sydney: State Health Publication.

NSW Government. (2015). *Public Health System Nurses' and Midwives (state) Award 2015*. Sydney: Industrial Relations Commission of NSW.

NSW Ministry of Health. (2011). *Clinical Nurse Consultants - Domains and Functions*. (File No. 09/7533). Sydney: NSW Ministry of Health.

Nursing and Midwifery Board of Australia. (2007). A national framework for the development of decision-making tools for nursing and midwifery practice (pp. 22). Melbourne VIC: Nursing and Midwifery Board of Australia.

Nursing and Midwifery Board of Australia. (2016). Registration Standard: Endorsement as a nurse practitioner (pp. 4). Melbourne VIC: Nursing and Midwifery Board of Australia.

Offredy, M. (2000). Advanced Nursing Practice: the case of Nurse Practitioners in 3 Australian States. *Journal of Advanced Nursing, 31*(2), 274-281.

Oral History Association. (2009, October 2009). Principles and best practices for oral history. Retrieved 06/12/2015

Palmer, G., & Short, S. (2014). *Health Care & Public Policy, an Australian Analysis* (5th ed.). Melbourne: Palgrave McMillan

Pearson, A. (2000). Clinical Nursing: The core of our Profession. *Australian Nursing Journal, 8*(3), 1.

Pearson, A., Fitzgerald, M., Walsh, K., & Borbasi, S. (2002). Continuing competence and the regulation of nursing practice. *Journal of Nursing Management, 10*(6), 357-364.

Perakyla, A., & Ruusuvuori, J. (2011). Analyzing Talk and Text. In N. Denzin & Y. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research*. Los Angeles: SAGE.

Perks, R., & Thomson, A. (2006). *The Oral History Reader* (2nd ed.). London: Routledge.

Pulcini, J., Jelic, M., Gul, R., & Yuen Loke, A. (2010). An International Survey on Advanced Practice Nursing Education, Practice and Regulation. *Journal of Nursing Scholarship, 42*(1), 31-39.

Rabinow, P. (1997). *Ethics: Essential Works of Foucault 1954-1984* (R. Hurley, Trans.). London: Penguin.

Robertson, B. (2006). *Oral History Handbook* (5th ed.). Adelaide South Australia: Oral History Association of Australia (South Australian Branch) Inc.

Rogers, C., Villar, R., & Harman Practice, J. (2015). Turning the tide of childbirth: Are we still adrift? *British Journal of Midwifery, 23*(1), 42 -49.

Schoenwald, A. V. (2011). Two hundred days of nurse practitioner prescribing and role development - a case study report from a hospital-based acute pain management team. *Australian Health Review, 35*(4), 444-447.

Schwandt, T. A. (2009). The SAGE Dictionary of Qualitative Inquiry Third. Retrieved 06/04/2015, 2015, from http://srmo.sagepub.com.ezproxy.une.edu.au/view/the-sage-dictionary-of-qualitative-inquiry/n343.xml?rskey=7rOJmc&row=3

Spilsted ne Iliffe, J. (1992). *The Nurse Practitioner "Breaking New Ground"*. Paper presented at the NSW Nurses Association Annual Conference.

Stasa, H., Cashin, A., Buckley, T., & Donoghue, J. (2014). Advancing Advanced practice - Clarifying the conceptual confusion. *Nurse Education Today, 34*, 5.

Stevens, S., & Vecchio, N. (2009). Substitution across professions within the Home Care Sector: an Investigation of Nursing and Allied Health Services. *Australian Health Review, 33*(1), 8.

Tropello, P. (2000). *Origins of the Nurse Practitioner Movement, An Oral History.* (Doctor of Education), The State University of New Jersey, Rutgers.

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

Walker, K. (2005). Reaching for the stars: Career advancement and the registered nurse. *International Journal of Nursing Practice, 11*, 6.

Weatherford-Stevens, K., & Latham, B. (2009). Giving voice to the past: digitizing oral history. *Online Computer Library Centre (OCLC) System and Services, 25*(3), 212 -220.

Welsh, V., Sanders, T., Richardson, J., Wynne-Jones, G., Jinks, C., & Mallen, C. (2014). Extending the authority for Sickness Certification beyond the Medical Profession: The Importance of 'Boundary Work'. *BMC Family Practice, 15*(100), 1-11.

Wilkinson, J. (2008). *The New Zealand nurse practitioner polemic: a discourse analysis.* (Doctor of Philosophy in Nursing), Massey University, Wellington.

Wilson-Thomas, L. (1995). Applying critical social theory in Nursing Education to bridge the gap between theory, research and practice. *Journal of Advanced Nursing, 21*, 568-575.

World Health Organization. (2010). Mid-level health providers: A promising resource to achieve the health Millennium Development Goals.

APPENDICES

Appendix A

Nurse Practitioner Pilot Program Location and Context (Department of Health, 1995)

Nurse Practitioner Pilot Program	NSW Location	Setting and focus
Area/District Health Service	Rural and Remote Wilcannia	1. District Hospital emergency department and local population primary care services
	Sydney	2. 2 Emergency Departments. Triage 4&5 Category consumers and patients presenting to emergency departments.
	Sydney	3. 'At risk' youth, sex workers and injecting drug users Specialty Primary Care Service in Metropolitan centre
	Shoalhaven	4. Women having 'low risk' deliveries - Hospital Maternity Service in regional NSW urban centre.
	Urana Rural	5. Multipurpose Service remote NSW, local population <1500 requiring primary care services
	Wagga Wagga	6. Emergency Department with urban and rural population. Triage 4&5 Category consumers and patients presenting to emergency departments.
GP Practices	Hunter Valley	1. Small mining towns Women's Health Screening services
	Windsor	2. Regional NSW city - urban and rural populations – Persons over 60 years
	Wallsend Newcastle	3. Causality and primary care service in Metropolitan centre
Non-Government Organisation	Newcastle	1. Matthew Talbot –Homeless and Itinerant Men in Metropolitan centre

Appendix B

Semi-structured interview questions

Q.1	How were you involved in the nurse practitioner development project?
Q.2	During the nurse practitioner developmental stages why do you think you were approached to be involved in the project?
Q.3	Can we talk about your role and work with different levels of development, e.g. policy, politics (govt, and other), regulatory authority, professional bodies, what was your role, how did it go, what went well, what were your frustrations, who did you rely on?
Q.4	Prior to and subsequently, what did you see as the central challenges the project faced?
Q.5	Who did you see as the key players in the development project and why?
Q.6	There are many stakeholders that influence a health system and the workforce; government; community; and the professions are examples; can you discuss how each of these stake holders influenced the project and how did this influence play out?
Q.7	How did each of the key players: [government, community, medical practitioners and nurses] influence debate?
Q.8	Were there particular groups that challenged of frustrated you more than others?
Q.9	During the developmental process, what were your perceptions of the role of a nurse practitioner, before, during, and after? What did you see nurse practitioner's scope of practice to be?
Q.10	Did the discussion of scope of practice change over the 8 years of the development project?
Q.11	Was there any time when the group could not reach agreement and you thought "this is not going to get up"?
Q.12	Was there any particular event that stays in your memory and why?
Q.13	Were there factions within the group?
Q.14	Did you feel there were a lot of "behind the scenes strategising going on? Were you involved in it? *If they say yes I will ask them to expand on this as this is what I am after.*
Q.15	What were your thoughts – feelings on the final outcome of the process?
Q.16	If you were to do it again would you do it differently?
Q.17	How would you like your involvement to be recorded in history?

Appendix C

School of Health
Faculty of The Professions
Armidale NSW 2351
Phone 61 2 6773 3650
Fax 61 2 6773 3666
Email: hdr-health@une.edu.au

INFORMATION SHEET for PARTICIPANTS

Research Project:

How has the public and professional discourses influenced current policy framework of Nurse Practitioners in New South Wales? Would we do the same again?

I wish to invite you to participate in my research on above topic. The details of the study follow and I hope you will consider being involved. I am conducting this research project for my Doctor of Health Services Management at the University of New England. My supervisors are Adjunct Professor Jeanne Madison and Dr. Yoni Luxford of University of New England. Adjunct Professor Jeanne Madison can be contacted by email at jmadison@une.edu.au or by phone on 02 67733667. Dr. Yoni Luxford can be contacted by email at Yoni.Luxford@une.edu.au or by phone on 0408832948 and I can be contacted by email at lmorton2@une.edu.au or phone on 02 67696633.

Aim of the Study:
The aim of the study is to investigate whether the public and professional discourses influenced current policy framework of Nurse Practitioners in New South Wales

Time Requirements:

Interviews:
There will be a series of open-ended questions that allow you to explore your views and practices related to your involvement in the nurse Practitioner Project and subsequent policy framework. These interviews will be voice recorded or electronically captured. Following the interview, a transcript will be provided to you if you wish to see one. Any information or personal details gathered in the course of the study will remain confidential. No individual will be identified by name in any publication of the results. All names will be replaced by pseudonyms.

Participation is completely voluntary. If you decide to participate, you are free to withdraw your consent from the project and discontinue at any time without having to give a reason and without consequence if you decide not to participate or withdraw at any time.

It is unlikely that this research will raise any personal or upsetting issues but if it does you may wish to contact your local Community Health Centre.

The voice recordings will be kept in a locked filing cabinet at the researcher's office. The transcriptions and other data will be kept in the same manner for five (5) years following thesis submission and then offered to The College of Nursing Archives. Only the investigators will have access to the data.

School of Health
Faculty of The Professions
Armidale NSW 2351
Phone 61 2 6773 3650
Fax 61 2 6773 3666
Email: hdr-health@une.edu.au

Research Process:

It is anticipated that this research will be completed by the end of 2012. The results may also be presented at conferences or written up in journals without any identifying information.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No. …….., Valid to ../../….)

Should you have any complaints concerning the manner in which this research is conducted, please contact the Research Ethics Officer at the following address:

Research Services
University of New England
Armidale, NSW 2351.
Telephone: (02) 6773 3449 Facsimile (02) 6773 3543
Email: ethics@une.edu.au

Thank you for considering this request and I look forward to further contact with you.

Regards

Leanne Morton

School of Health
Faculty of The Professions
Armidale NSW 2351
Phone 61 2 6773 3650
Fax 61 2 6773 3666
Email: hdr-health@une.edu.au

Consent Form for Participants

Research Project:

How has the public and professional discourses influenced current policy framework of Nurse Practitioners in New South Wales? Would we do the same again?

I, ________________________________ have read the information contained in the Information Sheet for Participants and any questions I have asked have been answered to my satisfaction. Yes/No

I agree to participate in this activity, realising that I may withdraw at any time. Yes/No

I agree that research data gathered for the study may be published using a pseudonym Yes/No

I agree to the interview having my voice recorded and transcribed. Yes/No

I agree to photographic records being published Yes/No

I agree to the transcripts to be given to the College of Nursing Archives. Yes/No

……………………………….. ……………………………
Participant Date

……………………………….. ……………………………
Researcher Date

Appendix D

Ethics Office
Research Development & Integrity
Research Division
Armidale NSW 2351
Australia
Phone 02 6773 3449
Fax 02 6773 3543
jo-ann.sozou@une.edu.au
www.une.edu.au/research-services

HUMAN RESEARCH ETHICS COMMITTEE

MEMORANDUM TO:	Prof J Madison, Dr Y Luxford & Ms L Morton School of Health

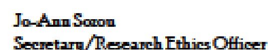
This is to advise you that the Human Research Ethics Committee has approved the following:

PROJECT TITLE:	How has the public and professional discourses influenced current policy framework of Nurse Practitioners in New South Wales? Would we do the same again?
APPROVAL No.:	HE10/160
COMMENCEMENT DATE:	25/01/2011
APPROVAL VALID TO:	25/01/2012
COMMENTS:	Nil. Conditions met in full.

The Human Research Ethics Committee may grant approval for up to a maximum of three years. For approval periods greater than 12 months, researchers are required to submit an application for renewal at each twelve-month period. All researchers are required to submit a Final Report at the completion of their project. The Progress/Final Report Form is available at the following web address: http://www.une.edu.au/research-services/researchdevelopmentintegrity/ethics/human-ethics/hrecforms.php

The *NHMRC National Statement on Ethical Conduct in Research Involving Humans* requires that researchers must report immediately to the Human Research Ethics Committee anything that might affect ethical acceptance of the protocol. This includes adverse reactions of participants, proposed changes in the protocol, and any other unforeseen events that might affect the continued ethical acceptability of the project.

In issuing this approval number, it is required that all data and consent forms are stored in a secure location for a minimum period of five years. These documents may be required for compliance audit processes during that time. If the location at which data and documentation are retained is changed within that five year period, the Research Ethics Officer should be advised of the new location.



Jo-Ann Sozou
Secretary/Research Ethics Officer

25/01/2011

A09/2599

Appendix E

Hi Leanne

You have my permission to use the quotes

Larry

-----Original Message-----
From: Leanne Morton [mailto:leanne521@bigpond.com]
Sent: Sunday, 24 July 2016 3:37 PM
To: Marlow Hampshire <mh@marlowhampshire.com.au>
Subject: Enquiry from Marlow Hampshire website

Below is the result of your feedback form. It was submitted by Leanne Morton (leanne521@bigpond.com) on Sun Jul 24 15:36:36 EST 2016
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comments: Hello Larry Back in 2011 you agreed to participate in my research project around the NSW Nurse Practitioner project and undertook an interview with me. During the interview you discussed your role as the independent chair of the Nurse Practitioner Project Stage 2 and 3 Steering Committees. I am planning to submit my thesis in the next month or so and there is one section of the findings where I use a couple of your quotes. Your name is not mentioned and the quotes are deidentified however due to the nature of the project there was only one independent chair of the steering committee. Reference to IR after the quotes represents Independent Representative, others used are NR - Nursing Representative and GR - government Representative. Some who were intimate with the process may identify you. I have attached the section of my findings I am referring to. What I am seeking from you is permission/consent from you to include the quotes. If you agree could you please email back stating you consent. If you do not consent please email back stating you do not consent and I will remove quotes from the thesis.

____

Send: Send

____

Appendix F

Data ranked by number of participant response categories

Category	Participants	References
Government	11	47
Power	10	49
Politics	10	36
Political	9	43
Time	9	28
Feelings and emotions	9	73
AMA	8	58
Consumers	8	25
Strategy	8	64
Medical profession	7	47
Advanced nursing practice	6	23
Evidence and research	6	19
Medical resistance	5	32
Rural and remote	5	20
Workforce	5	20