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A deconstruction and reconstruction of advanced nurse specialisation and education

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ABSTRACT

The purpose of this study was to present the issues and the paradoxes surrounding advanced nurse specialisation (ANS) and education. This study was conducted in two parts. Part A examined the prospective experiences of 13 registered nurses (RNs) who were advancing in an area of specialisation: they were working in a specialist area of practice and studying in a course specific to their specialisation. Two rounds of interviews were completed over six-month intervals. Part B examined the data gathered from a focus group interview and follow-up feedback from 10 nurse executives as stakeholders. The intersubjective data from this group of nurses expanded on the political, economic, and social complexities surrounding the same phenomenon of interest.

A methodological framework of intentional phenomenology (Crotty, 1996, 1998; Husserl, 1960, 1973; Moustakas, 1994) and critical phenomenology (Crotty, 1998) was used. Such an interpretive approach enabled exploration of the issues from a multiple perspective. The triangulation of data sets obtained from Part A and Part B captured the meanings and understanding of the phenomena experienced by nurses involved in ANS and education. Overall, the deconstruction of the interviews in Part A and Part B enabled a reconstruction of the multiple realities of ANS and education. The "analyzing approach" (van Manen, 1990) was used for the purposes of data analysis. The data sets were stored, retrieved and analysed with the use of The Ethnograph computer software program.

The findings in Part A identified the nature of ANS and education by RNs who were experiencing ANS. The core theme of **'moving toward ANS and education'** showed the noematic textural quality of the phenomenon. This included the nature of the competing forces that the RNs faced. This required the RNs to set personal goals, to sustain a level of tolerance related to change in the work place, and to negotiate with stakeholders, options that were conducive to their practice and study. The RNs told of the rewards and limited rewards of being an advancing specialist, when they succeeded in becoming a credible practitioner and of being multiskilled and versatile as specialists. They maintained an ideology about advanced practice that was achieved by ensuring best practice, or by doing nursing research, or both.

Five sub-themes emerged metaphorically as **the way through the labyrinth.** These themes provided the noetic structural characteristics about the phenomenon. The first sub-theme described how the RNs had the **freedom to choose** ANS and education. This included the way that they reasoned about the choices they had. They took reflexive action, problem-solved, and, compared and rationalised organisational activities in the face of the nursing shortage to enable them to advance. The second sub-theme related to their **knowing through experiential learning and advancing.** As consumers of education, the RNs were described in terms of the cost associated with their advancement, which was offset by the education gained, and the enlightenment felt. They identified with the transportability of their prior knowledge as an advancing RN, the need for nurse credentialling, and responded favourably to the use of technology. However, they were disappointed by RNs, other than current advanced specialists, who failed to share knowledge with nursing colleagues in general. The third sub-theme outlined how the RNs wanted to **maintain their interdependence** of practice as advancing specialists. They were enterprising and wanted to connect with other specialists, particularly those within their professional nursing organisations. In so doing, it was important for them to maintain a sense of personal integrity. Therefore, they were mutually responsive to colleagues about nursing care issues. However, they expected to be acknowledged by colleagues as well as family members for their advancement as specialists in return. The fourth sub-theme described their need to be **profiling, requiring them to be able to visualise and situate themselves** as advancing specialists. That is, they persevered with their studies and practice and created opportunities for their likely advancement. Furthermore, they felt a need to develop a nursing profile that was self, as well as publicly oriented. The former was achieved by being self-praising of their current advancement; the latter, by focusing on the need for the community and colleagues to view nursing as a legitimate and worthwhile profession, rather than being undervalued in spite of the workload that nurses and the advancing specialists had. The fifth sub-theme described how vulnerable the RNs felt but at the same time, liberated because of their progressive self-assurance and influence over others because of their advancing practice. They enjoyed the challenges that they faced, were open about their ambitions, and able to move on once they had reached a plateau relevant to their practice. At this stage, they continued in advanced practice because they had discovered a pathway that best suited them. This was realised as **meeting the crossroads.**

Part B findings emerged from the stakeholders as three intersubjective but discrete themes. The first emerged as **the debate** about the stakeholder and employer concerns regarding the phenomenon of interest. From their point of view, the advanced specialist was of enormous benefit to them and the profession. However, the stakeholders as employers, were concerned about the recruitment, retainment, and opportunity for promotion of RNs as advanced specialists. The second theme emerged as **the solutions** that describe the desired pathways for ANS. The stakeholders desired a pathway that enabled them to facilitate advancing RNs during their practice and studies, and one that the profession would support. Nursing should take an integrate approach to ANS and education. It was optimal that joint specialist programs between all health care facilities and education providers including university schools of nursing, be pursued in order to maintain ANS that could provide advanced care to an increasingly complex population that expected an acceptable standard of care. In order to meet the increasing demand for advanced specialist RNs, it was necessary to provide a specialist clinical program in the hospital setting in which the RN worked. The stakeholders indicated that RNs who wanted to advance further into master or doctoral programs should be able to gain advanced standing for their hospital based clinical program into a nursing school within the university setting. Finally, based on the stakeholders' reflections and shared experiences about the phenomenon of interest, a **philosophy of nurse education** that is able to uphold the increasing value of specialist practice for RNs was considered necessary. The dilemmas that each of the stakeholders had themselves faced as advancing specialists, resulted in a rewarding experience along with career advancement for nine of the 10 nurse executives who participated in the study.

Overall, moving toward ANS and education is a continually dynamic process in which the benefits to the majority of participants in this study were attainable. However, the recruitment and retainment of advancing specialists remains uncertain because life of RNs today is less stable than it was. There is no one pathway for advancing specialists to take that is based on a linear progression. Globalisation had created greater diversity in society, whereby the majority of the RNs and stakeholders embraced the diversity while a few did not because of the turmoil of contemporary competitive life. This could leave many RNs feeling disenfranchised by change and more specifically by the nexus between commodified health care and education.

As an outcome of this study, the recommendations are that a merger of all advanced clinical programs, which are offered by a hospital or agency, should be undertaken in collaboration with private and public agencies, and in collaboration with university schools of nursing. Secondly, course fees should be detailed as an up front fee by an agency that is a quality endorsed education provider for specialist nurse programs, rather than the fees be subsumed in a contract of employment for the specialist work and education that a RN undertakes. In the case of the consultant, rural, or outer metropolitan nurse, the RN should apply for external scholarships from his or her professional organisations. Fourthly, in the case of RNs who undertake a research project as a part of their course, the agency or hospital employer of these RNs should be funded to support the employment of additional relief or casual staff to supplement a reduced patient load for the advancing specialist. This should be for the period that the advancing RN is undertaking a research project specific to the specialisation, with the understanding that the project is part of the RN's study program. Finally, it is recommended that graduate nurses who wish to advance in an area of specialisation, should compete, validate, justify, and show performance that can be measured against monetary rewards by gaining national competency standards or credentialling through the advancing specialist's professional organisation. In turn, the hospital or agency should have an on-going review of specialist practice in departments of a hospital where external auditors, through the accreditation process, can adequately reflect on the common expectations of health care standards nationally.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education; and that to the best of my knowledge and belief it does not contain any material previously written by another person except where due reference is made in the text.

Signature

Date 1st June 2002

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CHAPTER ONE

The Issues Surrounding ANS and Education

Introduction: The Researcher's Narrative

Not so long ago nursing had simple divisions: charge nurses, registered nurses (RNs) and enrolled nurses. There was the choice of working in an acute teaching hospital or a non-teaching department such as a private hospital, nursing home or in the community. Specialisation was limited to double or triple certification. There was one graduate qualification, the apprenticeship model for between three and four years, depending on the range of experiences offered by a training hospital. Textbooks were once limited to medical literature or to Maggie Myles' book on midwifery. Experienced RNs generally wore a white uniform with some form of protective clothing, usually in the style of a starched apron and cap or veil.

Then everything started getting complicated. Hospital departments changed services owing to the change in health demands. Some hospitals merged because they were required to compete for the health dollar and area of specialism. Hospital mission statements or codes of practice became tailored specific to match the religious domain or center of excellence offered to the consumer. By 1975 nurse education in Australia had started to transfer to the university sector.

Today nursing is hardly recognisable as the same profession although nursing theory is still reflective of human caring (Watson, 1979; 1999) and unitary humanism (Parse, 1992; Rogers, 1980). Politically, unions, including the Australian Nurses Federation have been undermined by the government of the day in favour of workplace agreements. Today's collective bargaining requires nurses to consider all aspects of nursing that the profession can agree on as an acceptable remuneration package. Many

have part time employment, while others work double shifts, are overworked and feeling stressed because of increasing hospital bed turnover with decreasing staff ratio. Some nurses may be immobilised by the extent of choice while others may relish it. Some nurses have chosen not to advance in their practice. This may be associated with the recurring shortage of nurses (McMillan, 1999), so that a nurse might choose not to continue with his/her education in a specialty because employers do not have enough general nurses let alone specialist nurses.

The nurse of today could well be mystified by the choices s/he has to work in areas of specialised practice. For those nurses who choose to advance, there is a proliferation of courses they can study provided they are prepared to pay for the privilege. Directly associated with the commodities of education and health care is the booming need for the credentialling of advanced nurse specialists (Pelletier & O'Donoghue, 1998). The education choices include the choice of university or institution, mode of study, duration of course, and cost of course. The choice is difficult when one course may be considered better than another in a free market economy.

With so many issues are at stake, nurses and those involved in planning future directions in nursing need to make sense of what is happening to the profession in relation to ANS in particular. It is this issue that provides a starting point from which this investigation begins.

Background to ANS and Education

It is problematic for the nursing profession that the shaping of disparate specialised areas of practice has not been systematically planned. Advanced nurse practice (ANP) roles evolved after the turn of the 20th century when graduate courses for nurses were offered by hospitals (Bigbee, 1996). The four main roles that emerged during this era included nurse anaesthetists, nurse midwives, clinical nurse specialists

(Hamric, Spross, & Hanson, 1996) and, more recently in Australia, nurse practitioners (Chiarella, 1998). The 1970s and 80s saw a plethora of ANP specialisations such as stomal therapy, critical care, rural and gerontological nursing emerge, and more recently, the informatics specialist (O'Brien, 2001). It is also problematic that there has been a lack of clarity with the use of the term, *advanced nurse practice*. The term relates to a number of advanced practice roles such as clinical nurse, clinical nurse consultant, clinical nurse specialist, or nurse practitioner (Attrill, 1988; Ball, 1999; Chiarella, 1998; Dunn, 1997; Woods, 1997). It is possible that this confusion is associated with the role of the nurse as the advancing specialist relevant to this study.

Confusion has also arisen because education and health care are increasingly viewed from a political perspective, as commodities (McMillan, 1999), and that health care professionals, including nurses, are expected to embrace the ideology of consummerism (Parker, 1999). Furthermore, because of the rapid pace of societal change, health care critics advocate the need to debate and re-examine the tensions surrounding ANP and education (Bethune & Wellard, 1997; Hamric et al., 1996; Parker, 1999; Russell, Gething, & Convery, 1997; Scott, 1998). Educational programs are significant to the profession because courses designed for nurses in the workplace empower nurses to bring about needed changes in the way that they provide care (Mason, Costello-Nickitas, Scanlan & Magnuson, 1991). However, research on the deterrents and motivational factors that impact on nurses who participate in continuing education is necessary because of the fragmentation of generalist to specialist nurse practice (Fairweather & Gardner, 2000) and the lack of clarity in whose interests the need for participation in education lies (Kristjanson & Scanlan, 1989). These tensions have an impact on the growth and direction that nurses and the profession desire to take.

The aim of this study is to question how nurses deal with the confusion surrounding the ever-changing nexus between nurse specialisation and education. More significantly, I wish to examine the impact of ANS on the nursing profession in general and the specialising nurse in particular. Whilst the literature argues for an increasing need for specialist nurses, only two studies were found on the topic of ANS. Fairweather and Gardner (2000) examined the delineation of roles of specialists and generalist nurses working in the critical care setting and Ball (1999) examined the experiences of the advanced practicing nurse who also worked in the critical care setting. However, neither study explored the education issues surrounding ANS. Nor did the authors explore the issues of specialist roles and practice from other specialist groups of nurses. It is the endeavour of this study therefore, to examine all aspects of ANS and education so that an overall picture of the current phenomenon can be ascertained. This includes the social, political, economic and philosophical, as well as the educational issues that contextualise the modern nurse's experiences.

Notwithstanding the growth of consumer education, the development of nursing specialties is a paradoxical phenomenon within health care institutions across Australia and internationally. Continuing education and refresher courses for nurses for example, have in the past been considered necessary to ensure nurses keep abreast of current practice and skills. Currently however, there is a move toward seamless credentialling with registration of nurses across Australia between the States and Territories, but also the development of nursing professional groups and organisations to credential its own practitioners (Hamric et al., 1996; RCNA, 1996).

There is also a perception from both the nursing profession and society of the need for increasing specialisation (Sheehy & McCarthy, 1998) owing to the ongoing changes primarily set by budget driven governments and increasing health care

demands set by a knowledgeable society. As an outcome, the nursing profession has embraced an improved clinical career path (Attrill, 1988) for nurses in Australia. This is not only because of the development of nursing knowledge and research over the last 50 years world wide, but because of the consumer's more recent demands for equitable health care (Sheehy & McCarthy). This is significant to nursing.

There is no doubt therefore, that the increasing number of health courses including those for nurses to specialise at the post-registration or postgraduate level (Richardson, 2000, September 13, p. 36) is multi-factorial and that the ideological and changing political events influencing ANS and education requires constant critical review in order to make sense of what is appropriate for the nursing profession. Like the evolution of society, nursing too is evolutionary and brings with it a rich tapestry of tradition.

Problem Statement and Key Research Question(s)

In 1993, the Royal College of Nursing, Australia (RCNA newsletter, 1998) claimed nurse specialisation would significantly influence the future of nursing. The implication is that the pursuit of specialised nurse practice would enhance the credibility and status of nurses as professional health care practitioners. Since then, there has been an enormous increase in certificate and diploma awards offered by universities (Bethune & Wellard, 1997), hospitals and professional organisations. In this thesis, I term these institutions as education providers.

I believe that it is important that we understand the experiences of nurses who undertake advanced nursing studies because their stories will inform people of some of the predicaments that the advance specialists experience, and offer insights into the nature of this phenomenon. The key question for me became: What is to be made of the concern by me, nurses and nurse stakeholders, who sense problems associated with the demand for advanced nurse specialists? My position as a coordinator of advanced

specialist programs over a number of years in the university sector triggered this concern because I have had many discussions with nurses and stakeholders who confirm my views that there are anxieties and problems surrounding ANS. To answer this, the initial research question posed to RNs who were advancing in a specialisation became: What is *your* lived experience of being an advancing specialist who is undertaking advanced nursing studies?

However, this question is asked in the context of the ongoing need for recognition and legitimisation of nursing practice (Scott, 1998) and the political and professional enhancement of advanced practice (Chiarella, 1998; Hamric et al., 1996; Russell et al., 1997), and this needs to be addressed in this research. Moreover, the commodification of knowledge (Stewart, 2000), health services, and tertiary education has required health care professionals, including nurses, to adjust to the ideology of consumerism (Parker, 1999) in order to care for an increasingly complex patient population (Pelletier & Donoghue, 1998).

It is evident therefore, that the issues surrounding consumer health care for nurses is problematic because there are many interests to be served in the delivery of specialist nurse programs. It became clear to me that the research question to the RNs who were advancing in their practice would not clarify all of the above issues. Therefore, a second research question asked nurse stakeholders including executive managers, clinicians, researchers and educators about their understanding and experience of ANS and education. This question became: "What are *your* expectations of the work practices of nurses who have enrolled or undertaken an advanced specialty course of study?

Purpose of This Study

The purpose of this study was to identify the issues associated with ANS and education. Identification of these issues could explain the impact of ANS and education on the individual nurse, as well as the nursing profession. A deconstruction of the interviews from those who lived the experience of concern, including myself as the researcher (Fontana & Frey, 2000), enabled a reconstruction of advanced nurse practice that related to the transforming (Watson, 1999) and multiple realities of ANS and education. By using this approach, I attempted to re-contextualise and re-define the modern era of nursing that is embedded in reductionism, history and tradition (Hendricks-Thomas & Patterson, 1995).

Part A of this study focused on the conversations with RNs who had direct participation in and knowledge of nurse education programs. Part B of this study focused on the conversation with a group of nurse executives as stakeholders, who albeit indirectly, were politically and economically involved with the RNs who had undertaken ANS and education. They themselves had undertaken specialist practice in the past. Their experiences added to the analysis of the data. Both parts offered a reconstruction of ANS that emerged from the social theorising of ideology (Creswell, 1998).

Phenomenology was used in Part A and Part B to describe the lived world of advancing nurse specialists' and stakeholders' experiences, views and attitudes about ANS and education. From their experiences it was possible to deconstruct and reconstruct the issues surrounding the phenomenon. This was inclusive of researcher biases and humanism (Fontana & Frey, 2000), which in turn provided a deep analysis (Denzin & Lincoln, 2000) rather than mere description of the phenomena associated with ANS and education. The data in Part B, while discursive, added to the

reconstruction of the phenomenon where there were multiple realities (Denzin & Lincoln).

Aims

1. Undertake a deconstruction of the microstructure (individual perceptions) of advancing nurse specialists and stakeholders using phenomenology.
2. Undertake a reconstruction of the macrostructure of ANS and education through reflection and hermeneutic circling (Agger, 1991, 1998; Crotty, 1998).

Objectives

1. Reveal the experiences and interpret the meanings of ANS and education through the life-world of those nurses who experience the phenomenon of interest,
2. Explore the tensions, confusions, conflicts and contradictions of ANS and education experienced by specialist nurses and stakeholders,
3. Triangulate qualitative data to construct a view for nurses and stakeholders of nurse specialisation and education.

Significance of This Study

Arguably, the issues surrounding advanced study and specialisation based on the individual's circumstances and experiences are numerous and complex, but this is why ANS and education needs to be investigated; it will enable the profession to take a more defined approach. In these times of increasing community suspicion about the validity of the plethora of university level courses as well as in other tertiary sectors, there are more reasons than ever to conduct an authentic and reasoned argument for and against the pursuit of ANS and education in Australia. The reasons why a nurse chooses to undertake a graduate specialist course and the way in which s/he experiences the phenomenon is essential.

The reality in the current Australian context is that there is an abundance of courses offered nationally for nurses who wish to undertake specialist studies. The profession is fundamentally supportive of the direction taken to address the need for advanced practicing nurses across a myriad of specialties. The national review and evaluation of specialist nurse education in Australia (Russell, et al., 1997) was recently commissioned by the Department of Employment, Education, Training and Youth Affairs (DEETYA), currently the Department of Education and Youth Affairs (DETYA). This review lists the existence of at least 65 broad band nurse specialties and subspecialties (p. 14). The assumptions here are that all course offerings are equal in structure and quality, desired by all specialty and professional interest groups, improve the delivery of health care provided by nurses, and raise the profile and career opportunities of nurses. However, the reality is that there are many inconsistencies such as entry requirements, recognition of prior learning, standards and duplication of courses, and choices of specialties (Clinton, 1997). Dozens of private providers of postgraduate study, such as the NSW College of Nursing Education and the National Institute of Health Sciences in Canberra have entered the education market, many using distance education to make courses available to any nurse, anywhere. This has several potentially detrimental effects. Many formal and informal graduate courses throughout Australia are being converted from the Higher Education Contribution Scheme (HECS) to payment of up front fees. Differences in the capacity of students to pay, and education providers to charge fees raise concerns about equity and about the viability of many postgraduate courses.

Arguably higher education graduate programs are a means to increase career opportunities and rewards, but they are happening through formal and informal pathways so that no one system can readily assess the performance of nurse graduates

from such a wide range of courses. Furthermore, the needs of stakeholders (such as nurse educators, managers, clinicians and researchers) are potentially conflicting (Andrews, Gidman & Humphries, 1998). The irony is that enrolment in postgraduate nursing courses since 1995 to 1999 have seen a negative growth rate of -9.0% (Richardson, 2000, p. 36). The question needs to be asked. Why are we immersed in such rapid course development if nurses are not enrolling in them?

Issues revealed by those nurses who experience advanced practice are not widely researched and articulated within the Australian context. Therefore, the information that emerges from the data that are reflective of the current tensions of ANS and education will influence debate, research and practice across disciplines (Fox & Prilleltensky, 1997). Furthermore, an exploration is required in order to understand in whose interests ANS and education serves. More specifically, this study benefits all nurses because generalist nurses are commonly required to position themselves in advanced practice to ensure a fitting career path (Russell, et al., 1997). The RN is likely to benefit by considering his/her options in light of consumer knowledge, and trends in the health and education sectors.

The wider community will benefit from the research because specialist education and practice by health care professionals such as nurses, impacts on the delivery and quality of health care. There is an expectation that nurses should provide advanced practice in order to care for patients with complex health problems, as well as provide community health care access to rural, minority and high risk populations (Hanson, 1996). Apart from this, members of the community often expect specialist advice when they seek knowledge related to their health, take ill or are hospitalised (Joel, 1998). Such specialist advice will include that from the advancing practice nurse even if his/her education may be flawed.

The collection of multiple sources of data is significant to this study because it is a strategy to achieve meaning, understanding and critique in the form of discourse (Crotty, 1998) about the social phenomenon of interest. Advocates of data triangulation (Denzin, 1989; Janesick, 1994; Silverman, 1993; Streubert & Carpenter, 1995) suggest that a range of data from fieldwork add validity and reliability to qualitative research because participants and researchers can ensure more meaningful problem solving. This being the case, it is expected that this study will enable the separation of any emotional expressive facts from the advancing nurse specialists and nurse stakeholders to result in an enlightened account of any conflicting issues (Habermas, 1984, 1985, 1987) surrounding ANS and education.

The interpretations from advancing nurse specialists and stakeholders will illustrate the social issues involved and, therefore social significance of this phenomenon to the nursing profession. Therefore, in terms of the personal, social, economic and political factors, this study will be able to identify the conflicts of interest and contradictions that nurses regularly face. This sociological phenomenological analysis will distinguish the micro and macro social issues (Dines, 1995) consistent with the characteristics and current demand for advanced specialist nurses, thereby clarifying any potential practical benefits to the future advancing nurse and stakeholder.

Definition of Terms

Advanced Nurse Specialisation Programs. For this research ANS programs include clinically based programs that are offered to Registered Nurses (RNs) or Registered Mental Health Nurses (RMHNs). These courses may be conducted in the internal or external mode of delivery and be available to nurses with a Hospital Based Diploma (HBD), Bachelor of Nursing (BN) or equivalent degree. Graduate courses that are conducted within the hospital setting and enable the nurse to gain advanced standing

with a university program are inclusive of the criteria. This is because it is possible for some participants to have sought advanced standing to undertake a university program based on their recognition of prior learning (RPL). The criteria for RPL requires a nurse to have a minimum of 10 years experience in a relevant field of nurse specialisation, to be working at a senior level (Level 1.8 or higher) of nursing practice, to have made a significant contribution to the relevant professional nursing organisation, or able to prove his/her ability to undertake graduate studies.

Advanced Nurse Practice/Specialisation. Advanced nurse practice/specialisation refers to any nominated area of nursing practice that provides care for a specific patient population such as acute, community health, critical care, emergency, gerontology, high dependency, mental health, midwifery, oncology, orthopaedic, paediatric, palliative care, perioperative, and rural/remote nursing, for example.

An Advanced Practice Nurse. An advanced practice nurse is a RN (with a BN or equivalent) who has a minimum of one year's experience as a graduate nurse and is enrolled in an advanced nurse specialisation program. This nurse is employed as a Level 1, 2 or 3 nurse, and practices within any health care setting in Australia. An advanced practice nurse is inclusive of a RN (with a HBD) who is considered an expert in the area of specialisation by virtue of his/her RPL. Furthermore, for the purposes of this study, the use of the term advanced practice nurse (APN) is synonymous with the advanced specialist nurse (ASN), which is defined by the National Review of Nurse Education (Russell, et al., 1997, p. xiii) as one who is "...prepared beyond the level of a nurse generalist and authorised to practice as a specialist with advanced expertise in a branch of the nursing field".

Stakeholder: Executive Nurse Educator. The nurse educator, as an executive stakeholder, is an expert nurse who is employed as a RN, and is a coordinator of staff

development of a teaching hospital (or equivalent), or is employed as a university lecturer within a faculty, department or school of nursing in Australia. This nurse is usually involved in the hiring or promotion of RNs within the clinical settings.

Stakeholder: Executive Nurse Manager. The nurse manager, as an executive stakeholder, is a nurse who is employed as a RN, and is an Executive Officer/ Director of Nursing, or Nurse Researcher, or Clinical Nurse Consultant/Manager (or equivalent) of any teaching hospital in Australia. This nurse manager is usually involved in the hiring or promotion of RNs within the clinical settings.

Thesis Structure

This thesis comprises eight chapters, with an additional list of appendices (A-Z) that support my reflexivity, audit trail and findings of this study. Chapter two discusses the rationale for undertaking a triangulated qualitative approach, crystallisation of the method of choice relevant to the interview data for Part A and Part B, and the methodology used for both parts of the study. Chapter three describes the ontological approach to this qualitative inquiry and the rigour pertinent to the methods for data collection. Chapter four discusses the recruitment and characteristics of the participants in Part A of this study, followed by the core thematic findings. Chapter five describes three of the five sub-thematic analyses associated with the core theme. Chapter six describes the remaining two sub-thematic analyses associated with the core theme. Chapter seven discusses Part B of the study including the recruitment of and characteristics of the stakeholders, strategy of the focus group interview, and the thematic analysis. Chapter eight outlines the limitations of the study, recommendations, and integrative notes relevant to both parts of the study.

CHAPTER TWO

The Rationale for Undertaking a Triangulated Qualitative Approach

Introduction

This research utilises a *"new generation research approach"* (Streubert & Carpenter, 1995, p. 242) where different methods are triangulated. These comprise an "...unorganised group of research methods that share common beliefs about the goals and purposes of scientific investigation" (p. 242). In this study, two interview methods were triangulated: the interview data gained from advancing nursing specialists (Part A) with the interview data gained from nurse stakeholders (Part B). Both data sets (the repeated face-to-face interviews with advancing specialists, and the focus group interview with stakeholders) were analysed using Crotty's (1996, 1998), Husserl's (1948, 1960, 1970) and Moustakas's (1994) intentional and critical phenomenology (Appendix A) as a theoretical and methodological framework, which enables understanding by conscious reflection and critical phenomenology.

The purpose of this chapter is to describe the process by which the methods and methodology applied in this study were adopted. This includes an overview of the problems associated with using a single method for data collection and a discussion of the strengths different methods of data collection bring to a phenomenological analysis. The final part of this chapter describes how two methods were triangulated to arrive at a critical approach to complex phenomena associated with ANS and education.

The New Generation Research Applied to This Study

A qualitative but mixed methods approach was undertaken to interpret the essences (consciousness) and discourses surrounding ANS and education because no single method met the requirements of the researcher, which were to explore multiple truths surrounding ANS and education. Such an ontological approach enabled the

discovery of new knowledge surrounding the advancement of specialist nurse practice and education.

From a theoretical perspective, the research data related to Part A were guided by the Husserlian scientific philosophy of intentionality (Crotty, 1998; Habermas, 1987; Husserl, 1948, 1960, 1970, 1999; Kim, 1999; Levinas, 1973; Moustakas, 1994; van Manen, 1990). This required a commitment to reflexivity and self-insight on the part of the researcher so that the taken-for-granted experiences relevant to the phenomenon could be examined and re-examined (Koch, 1995). However, I soon found that this approach was limited for the topic I had chosen because I could not fully capture the political and economic constraints experienced by individuals living in a postmodern world (Foucault, 1965).

The second analysis (Part B) addressed this problem by using Crotty's (1998) version of social research that examines phenomena from a critical phenomenological perspective that is discursive. This is based on Habermas' intersubjective and practical understandings (Appendix B) about a social issue (Crotty, 1998; Habermas, 1981, 1984, 1985, 1987, 1999; Habermas & Seidman, 1989; McTaggart, 1991; Outhwaite, 1994; Watson, 1999; Wells, 1995; White, 1995) whereby the participants are subjected to critique, and the problem "...is characterised by mutuality of expectations rather than one-sided norms" (Crotty, 1998, p. 143). This discursive approach enables people's viewpoints about specific phenomena to be mutually understood and is emancipatory in intent. Furthermore, this form of communication forces a better argument about a problem that is resolved by common agreement (Crotty).

Limitations of Using a Single Method

Arguable, there is no one correct methodology that is able to satisfy a specific scientific inquiry (Habermas, 1984; Morse, 1989; Streubert & Carpenter, 1995). It was

reasoned, therefore, that the study of phenomena that are complex, where multiple realities are inevitable, and where multiple truths may present, required a combination of data generation methods and analysis to reveal the comprehensive nature of the phenomenon of concern.

From my point of view it was difficult to examine multivaried factors including human and non-human factors while using a single methodological approach such as hermeneutic intentional phenomenology. Therefore, an interpretative description of what was discursive for nurses facing advancing specialisation was considered necessary. However, the simple interpretation of the phenomenon would be limited because interpretation could not on its own, provide an overall picture of all possible factors that impacted on these nurses. The examination of human factors such as those involving nurses, patients, and other health care professionals along with non-human factors such as the physical environment (including clinical or educational institutions in which nurses, patients and other health care professionals exist), therefore, required a fresh, multi-faceted approach.

Intentionality in Husserl's transcendental phenomenology is important in the examination of phenomena such as ANS and education. Knowledge of the subjective world is based on human experiences that are conveyed through language and are in all consciousness. It is the understanding of the conscious experiences undertaken by nurses as individuals (Jasper, 1994) in this study that provided the subjective understandings of ANS and education. However, there remained one significant problem with this single phenomenological approach. Whilst the phenomenon could be explored using this consciously subjective approach, it was conceivable that other factors from outside the individual's experiences that s/he may not have contemplated or felt, was possible. To overcome this dilemma therefore, I turned to the development

of postmodern notions that were pervading the range of interpretive methodological approaches (Lowenberg, 1993). I concluded that the phenomenon of concern could equally be explained using a postmodern approach whereby the social world, in which nurses live and work, could be examined. In short, a postmodern critically discursive approach was triangulated with the phenomenological study.

In this study, triangulation was undertaken to more fully explore the single phenomenon of ANS and education. This exploration encompassed the human factors of two disparate groups of nurses; advancing nurse specialists and senior nurse executives, as well as the non-human factors such as technological advancements that are assumed evident in nursing.

Triangulation Applied in This Study

The issue of triangulation has been an exciting development in qualitative research since the 1970s when Norman Denzin first identified the four basic types of triangulation. These included data triangulation, investigator triangulation, theory triangulation and methodological triangulation (Janesick, 1994; 2000). Kimchi, Polivka and Stevenson (1991) also make mention of two other forms of triangulation, namely, multiple triangulation where more than two types of triangulation are used and, analysis triangulation where the same data is analysed using two or more analytical approaches for the purposes of validation. Janesick (1994) recently added a further type of triangulation to the list, referring this to "interdisciplinary triangulation" (p. 215) so that other disciplines such as education could lift out from under the influence and dominance of psychology which was often seen as the only means of understanding human lived experiences.

More recently, however, Richardson (1994), Stake (2000), and Janesick (2000) described triangulation as a crystallisation process. This process offers an alternative

description about the nature of modern qualitative inquiry because various disciplines are incorporated as a part of multifaceted qualitative research designs (Janesick). The significance of crystallisation is that it is viewed as a research design that is inclusive of many disciplines such as sociology, art, music, anthropology, psychology, nursing and education. Similarly, Watson (1999) suggests that the discipline of nursing is "becoming transdisciplinary" (p. 22) rather than being displaced by the dominance of a medical hierarchy. In doing so, nursing is reconstructing itself by creating a new view of nursing care and healing that is crystallising as a future model of practice that will be imbued by all health care practitioners.

Description of the Crystallisation Process Relevant to This Study

Phenomenology that included an intersubjective critique from nurse stakeholders comprised the two methods of choice to investigate the complex phenomenon of ANS and education. Methodologically this may have created a problematic framework for me because using multiple paradigms could have distorted the findings. However, Morse (1996) posits that it is the prerogative of the researcher to decide which method triangulated or otherwise, is essential for a study, or whether it is possible that the end product from a single methodological approach can be taken a step further.

Therefore, I chose to embark on triangulated, qualitative methods to examine multiple perceptions of reality. In doing so, I was able to create a new generation research (Streubert & Carpenter, 1995) study using a combination of interpretative, contextual and socially critical theoretical frameworks.

Part A: Phenomenology as a Method

Modern Philosophy, Qualitative Methods and Phenomenology

The 1800s and 1900s have seen a continued diversification of the philosophical and scientific approaches to understanding and knowledge attainment. Philosophical

movements comprised a new form of modern logic and the term phenomenology was first coined by an 18th Century German mathematician J.H. Lambert to describe the science of appearances (Scruton, 1995). This in a way was the beginning of what was considered knowledge that was subjective in nature. However, as a psychologist rather than a philosopher, it was Brentano (1838-1917) who pursued true subject matter. Brentano purported his understanding of matter that was subjective, to be empirical rather than interpretative in nature. Even though this was reflective of the positivist scientific paradigm, Scruton indicates that this was the first time that subjective knowledge began with the individual case: this being the first person knowledge.

This earlier development of modern philosophy is arguably the foundation of what is now well established as inductive or interpretive approaches to qualitative research. However, Morse (1998), van Manen (1990) and Denzin and Lincoln (1994) suggest that the field of qualitative research does not "...have a distinct set of methods that are entirely its own" (p. 3). The latter authors support the way that qualitative researchers that are from the human disciplines, use a variety of approaches, methods and techniques, including phenomenology and discursive analysis. This being the case, it is reasonable to suggest that phenomenology in particular and qualitative research methods in general, are always evolving. Therefore, there is not necessarily one right way to conduct qualitative research. What is agreed however, is that a method that is qualitative in nature is able to provide new knowledge and insights about a problem (Creswell, 1998).

Phenomenology had its origins in the European philosophical tradition, emerging from the philosophy of a late 19th century German philosopher and mathematician, Edmund Husserl. It was thought that the description of phenomena by the objects of experience would provide philosophic knowledge of what constitutes the reality of lived existence in the world (Creswell, 1998; Crotty, 1996; Lowenberg, 1993). This reality

was embedded in what Husserl termed 'intentionality'. His search for the foundations of knowledge per se was based on the assumption that beings had a conscious awareness of experiences that afforded structure in being and accounted for the description of what is reality. As Levinas (1973, p. 40) stated, "intentionality is for Husserl, a genuine act of transcendence". It is the act of intentionality that is the very essence of consciousness and knowledge. "Intentionality is what makes up the very subjectivity of subjects" (p. 41).

Contemporary Phenomenology

The term phenomenology has been used widely in research. However, confusion prevails as to the use of phenomenology as a movement, as a philosophy or method that can be used for research purposes. In one of van Manen's (1990) earlier writings, he indicated that phenomenology was not really a method but "more a reflective grounding in a deep sense, to provide for the possibility of the phenomenon of concern" (p. 173). By 1997 however, his re-examination of phenomenology as a form of inquiry tells a different story; that phenomenology is a method that proceeds from "epistemology to application"... [and] "from method to meaning" (van Manen, 1997, p. 350). Furthermore, he tells us that "phenomenological human science is discovery oriented. It wants to find out what a certain phenomenon means and how it is experienced" (p. 29). In other words, during phenomenological writing, lived experiences that are often concealed and invisible, become transparent and visible through language.

However, despite what van Manen (1990) defines as phenomenology, he indicates how phenomenology is a kind of questioning by an author that permits a rigourous interrogation of a phenomenon. This interrogation includes that:

- various levels of questioning are required;
- there is a re-writing or re-thinking about something that is not well understood;
- the construction of meanings has depth that creates a sense of the whole;

- certain truths are laid bare; a search for the ontological differences in human experience is captured;
- phenomenology demonstrates the capabilities of an author to see and show phenomena in a way that s/he is oriented;
- new understandings that belong to being are permitted to be gathered and viewed in the end as collective thinking.

This description remains comprehensive and readily justifies phenomenology as a method chosen for this study, as well as providing a methodological framework.

Phenomenology in Nursing

In nursing, there has been recent criticism about the way researchers have conducted phenomenological research that has supposedly evolved from the traditional European interpretation into a North American perspective (Caelli, 2000; Crotty, 1996). Crotty questions researchers who have radically adapted phenomenology to their own ends because the common core of European phenomenology is overlooked. What Crotty implies about nurse researchers in particular is that "they have avidly embraced a form of phenomenology which developed around them and which appears to serve their purposes well" (p. 24). They are, therefore, unable to justify phenomenology from its original intent, which was to describe both the object *and* subject of a phenomenon. As is evidenced in this study, I have taken heed of this criticism and embraced the Husserlian tenants of phenomenology that has its origins in European philosophy.

Caelli (2000) agrees with Crotty's (1996) analysis but indicates that a clear delineation exists between the North American and traditional European philosophies and styles of phenomenology. She explains that the pre-reflective experiences of individuals and the universal meanings of individual experiences are not sought by the North American phenomenologist. Rather, the North American philosophical approach has been to focus on participants' lived experience that is evident within a culture, such

as nursing, and not within the context of the universal external conditions. She points out that there have been at least three levels of phenomenological European approaches most often used by researchers. These may be described as consciousness that is intentional (Husserl, 1948, 1973), on being that is existential and founded on the pre-reflective accounts of life-world phenomena (Crotty, 1997; Heidegger, 1954, 1962) and thirdly, on the primacy of perception (Merleau-Ponty, 1964) where perceptual rather than intentional consciousness is the foundational mode of experience. Much of Merleau-Ponty's philosophy is similar in intent to Husserlian phenomenology; the difference in essences lie in Husserl's interpretations that are affiliated with language of knowledge while Merleau-Ponty's perceptual forms of expression is affiliated with painting (McTaggart, 1991).

Researchers have not only adapted the above approaches, but also approaches from other prominent French philosophers such as Michel Foucault and Jean-Paul Sartre. These European philosophers also advanced slight variations that have non-discrete interpretations of what constitutes phenomenology. The slight variations are considered postmodern and existential in nature respectively (van Manen, 1990).

Whilst the North American approach is culturally embedded and therefore different in approach, it is no less valuable and meaningful and has been particularly appropriate for the health sciences (Caelli, 2000) because it provides an interpretation of phenomena that is reflective of North American culture. The same could be said in defence of Crotty's (1996) criticisms that nurse researchers have adapted phenomenology as a hybrid research method within the Australian context.

This study of ANS and education has been developed in light of Crotty's criticism that nursing fails to acknowledge universal truths that describe not only the what (the object) that is experienced, but the way (the subject) phenomena are experienced. This is the fundamental reason why I chose to undertake a larger part of this study using the

traditional European approach. At the same time I do not wish to negate the validity and worth of North American and Australian qualitative researchers who use variants of phenomenology as a research method per se.

A Focus on Husserlian Transcendental Phenomenology

This study has embraced the traditional European philosophy of Husserlian (1931, 1948, 1960, 1970, 1973, 1999) phenomenology. The reason why I decided to go back to the earlier traditions of phenomenological research, and in particular, Husserlian intentionality was because of the assumption that participants recruited in this study were consciously aware of their intent to advance in a chosen area of nurse specialisation. In addition, they made a conscious decision to choose an education program that was reflective of their specialisation. Thus intentionality is a major theoretical framework for analysis specific to this study.

Whilst the information about ANS and education was gleaned from the nurses who were the respondents of this study, the way (the subject) they experienced the phenomenon was based on their social, moral, political and economic conditions of existence. The choice of Husserlian phenomenology was made in order to bring to consciousness the experiences of the nurse that is in primordial original form. Husserl's approach emphasises a systematic and disciplined methodology that uses data based on the conscious reflections of the participant's subjective acts and their objective comparisons (Moustakas, 1994). This included both the contextualisation of the object and the subject of the participants' life-world existence.

This was the first of two quite disparate qualitative methods used for this study. Fundamentally, the goal of qualitative research is to interpret and understand the different worlds of others. The phenomenological approach in Part A was the initial approach used for this study. These findings were collated and expressed in some semblance of order using thematic analysis. The second approach in Part B enabled me

to further review the phenomenon of concern from a postmodern perspective, using a phenomenological but discursive analytical approach. This form of analysis is relatively new territory.

Part B: A Postmodern Critical Phenomenological Method

Introduction to Postmodernism

In the light of this study, ANS and education may be seen as an ideal and not as a pathway that is of real benefit to the individual, profession and society as a whole. A postmodern approach was adopted for the second phase of this study to question this ideal. Postmodernism is an extension of the modern period in history that takes the critical approach to an ideology or understanding about phenomena that no longer seem transparent (Irvine, 1998). The approach attempts to re-contextualise and re-define the modern era that is embedded in reductionism, history and tradition. Nurse education for one, remains embedded in tradition and has been institutionalised by accrediting government bodies (Hendricks-Thomas & Patterson, 1995).

From a critical perspective people worldwide find no realistic reason to vest hope in a world that is good or getting better (Lemert, 1997). As Lemert suggests, postmodernism is about the researcher questioning the inevitable changes experienced by society and with it, the global realities of modern culture which may not always be for the better. He therefore asks, "what is to be made of the world-concern that preoccupies people outside the cloisters of privilege who believe the world is not what it used to be?" (p. xiii). In light of this study, a similar postmodern question could be asked. For example, what is to be made of the concern by me as a researcher, nurses and nurse stakeholders alike, who sense problems associated with the demand for advanced nurse specialists?

Postmodernism covers many disciplines and emerged in the 1980s as a complicated term that has been pursued mainly in academic circles (Klages, 1997).

Even so, postmodernism since the 1970s began as a set of ideas or an enlightened reaction, or critique of the conditions of the world that has multiple meanings (Creswell, 1998). Creswell further suggests that although it was a period of universal enlightenment, the primordial intent was to highlight the negative conditions that prevailed since the latter parts of the 19th Century and to show the imbalances of power and struggles often felt by individuals. Learning to understand these conditions allows open discussion and possible discourse from those people or groups who may have considered themselves marginalised or from those who continue to work and live with contradictions such as nurses, doctors or any other health care practitioner.

By using intentional phenomenology and critical phenomenology, I was permitted another means to crystallise the deconstruction (Fontana & Frey, 2000) and reconstruction (Denzin & Lincoln, 2000; Outhwaite, 1994; Watson, 1999) of the phenomenon of concern. In other words, intentional phenomenology provided an understanding of people who invested in nurse specialisation while postmodern discourses evident in critical phenomenology offered insights of people such as nurses who felt marginalised, sceptical and critical of ANS and education. The freedom to write about a phenomenon that is critically and socially motivated enhances the phenomenological approach that may be interpreted by some critics as merely descriptive in analysis.

From another critical perspective, postmodernism that is qualitatively discursive in nature may reveal a move away from obsolete roles which do not reflect the specialisation, sophistication and autonomy of modern nursing (Watson, 1999). Watson is passionate about a redefining and reconstructing of nursing that provides a delivery of health care that is harmonious with other health professions such as medicine. However, she appears to have an idealised view here because she emphasises an "emerging order in the midst of chaos, for all nurse practitioners" (p. 104). This

suggests that the negative conditions experienced by nurses may not necessarily be interpreted as destructive, but observed as a paradigm shift that is enlightening. Research needs to be carried out to see if the paradigm shift to an "emerging order" is as positive as Watson believes it will be.

The triangulated approach used in this study, therefore, provided me with the added capacity to undertake a sociological critique of the phenomenon of interest. Both negative and positive issues are examined and discussed in the thematic findings of this study.

Postmodernism and Critical Analyses

The critical approach to philosophical thinking, writing and research had its beginnings from the Frankfurt school in Germany after World War 1 (Stevens, 1989). Critical theorists during this time provided discourse analyses on the development of capitalist societies where the taken-for-granted conditions and traditions of democracy, bureaucracies and employee-employer relationships required exploration with an open and critical mind (Murray & Ozanne, 1991). Discourse analysis involves an examination and exposure of the current sociocultural, political and economic condition of modern society that can be extremely oppressive (Fiske, 1994; Wells, 1995).

Researchers who embrace this methodological approach are interested in critiquing forms of domination and oppression that may be experienced by silenced and marginalised groups in society. This may include the changing of activities and relationships of learners as consumers or clients of education, or courses as packages (Fairclough, 1992) that are sold to clients. Other examples include changing relationships between doctors and patients (clients), politicians and the public, and health care professionals, employers and employees. Fairclough suggests that changing relationships are discursively constructed. In this study, I decided to undertake a hermeneutic (interpretive) discourse that concerns the relationship of ANS to nurse

education. The outcome of undertaking triangulation of data in this study resulted in a search for an appropriate discursive methodological approach that could illuminate the nexus between ANS and education. A decision was made to use Crotty's (1998) critical phenomenology to guide Part B of this study. Crotty based this on Habermasian discursive communicative competence.

Part B: Crotty's Phenomenology and Habermas's Discourse

Habermas's interpretation of knowledge is one that is "never pure, [and] always founded in universal human interests" (Lemert, 1993, p. 414). Habermas speaks about different human interests such as technical, practical and emancipatory. According to Ulrich (1983), emancipation is fundamental to interpretation and understanding because it is possible to interpret historical events "as processes of individual growth and social evolution" (p. 65). In this way it may be possible to re-interpret nursing's recent transition from the apprenticeship model of education to the tertiary model.

On one hand, the move to a tertiary model of education that fosters theoretical, professional and interdisciplinary knowledge, is a result of social evolution. On the other hand, it is the result of individual growth from the time when nursing was historically embedded in the care for the ill and insane, and necessitated a degree of personal humility, suffering and subservience to all professions of the day. However, whether the change to university education was through social evolution or personal growth, both processes are founded on universal human interests.

This study of intersubjective experience and knowledge is also based on the premise that meaning enables people to empower themselves (Street, 1990). In relation to nursing, Street argues that scholars perpetually write about nurses as being disempowered because they do not value the development of oral skills as opposed to written practices that are embedded in language. She adds that nurse scholars in particular continue to claim that nurses resist the development of nursing as a culture

based on written practices. It is possible therefore, that nurse scholars may have miscalculated nursing's communicative practices because Street, and a decade later, Rolfe (2000) and Walker (2000) claim that "...nursing *is* an oral culture" (Rolfe, p. 83). Therefore, it is vital that these assumptions be re-explored and that nurses further examine and expose these scholarly views by "constructing telling arguments or critiques through conversation" (Street, 1990, p. 5) with a range of health care clinicians, including nurses.

Even though nursing is an oral culture, the scientific culture however, fails to embrace the narrative voice of daily conversation as empirical knowledge (Rolfe, 2000; Walker, 2000). To overcome this discourse, the authors and Street (1990) suggest that sociologists should challenge this status quo by affirming story telling as a research method that is able to express cultural knowledge embedded in nursing. As a result, I decided to use Crotty's (1998) version of critical phenomenology based on Habermas' communicative discourse in this study because it was one way of engaging in story telling via the oral knowledge from nurse stakeholders.

Crotty believes that the adoption of language as a research strategy has an affinity to Habermas' critical theory. That is, humankind is competent in the use of language that is based on a shared understanding (Brand, 1990). What is common to phenomenology and central to communicative discourse is that shared meanings are competently expressed in language or conversation, and not exclusively on the written word. The extension of Habermas' theory however, is that communicative action is motivated by the individuals' ability to reason (Brand). This presents as an analysis of rationalisation from a social perspective that focuses on "...the intersubjective achievement of shared understanding" (p. 14).

Overall, the tenets of Habermas' social theory and more specifically communicative competence (Brand, 1990; McCarthy, 1990) are based on a scientific

inquiry that is socially critical and emancipatory. Even so, White (1995) suggests there have been many modifications to Habermas' theory because there is no single concept that remains straightforward. Habermas's conceptual framework is made plausible however, because the concepts are interrelated and generate "...more conceptual, moral, and empirical insight than alternative approaches" (White, p. 7).

A triangulated phenomenological approach therefore, provided a deconstruction and reconstruction of the phenomenon of concern. This permitted me to uncover any distortions and constraints that may impede individuals (Stevens, 1989) or groups in their work and lifestyles. Habermas (1987) himself refers to his communicative action as that which advances Husserl's phenomeno-logical analysis. This communicative action refers to a collective consciousness that is identified by the narrative of historical events and social circumstances. The collective consciousness in this study is in Part B, the focus group of nurse stakeholders.

Summary and Rationale for a Qualitative Approach

The desire to make sense of ANS and education requires a qualitative inductive approach to analysis because little is understood of this phenomenon from those who have lived the phenomenon of concern. Intentional phenomenology that is interpretive (hermeneutic) and critical phenomenology that is discursively communicative and intersubjective, are appropriate to this study because of the rapidity of change. These changes including the technological revolution, demands for finite health care resources, and the corporate world of education have arguably led to a situation where people may find themselves in transition or in a tenuous situation.

I have endeavoured to understand and interpret both the affect and effect of ANS and education on individuals and groups. It is important that the endeavour of this study is not the identification of the specific social changes per se, but the lived

experiences of advancing specialists and stakeholders who live and work within a world that is socially contextual and changing.

The tensions of ANS in particular, are distorted by the consistency of societal change, educational marketing, enterprise work agreements, and technological advancements that add uncertainty to all health care professionals (Parker, 1999) and particularly, the career options for nurses. These latter issues constitute the contextual nature of ANS and education as a nursing phenomenon. Therefore, a deconstruction where the participants' and researcher's social biases are laid bare (Fontana & Frey, 2000) and a reconstruction, where the historical material values (Denzin & Lincoln, 2000; Outhwaite, 1994) relevant to advanced practice, were undertaken to understand the nature of this phenomenon.

Chapter three will extend this discussion further by relating the methodological choices to the research design appropriate for this study. In addition, a discussion of the audit trail in order to maintain the rigour required for a qualitative study is provided.

CHAPTER THREE

The Theoretical Underpinning and Methodological Approach to This Study

Introduction

My input as a researcher intimately involved in a phenomenological postmodern study required methodological explication and reflexivity so that authenticity and validity was assured as much as possible. The outcome of my methodological approach demonstrates how and why I adopted a particular ontological approach, methodologies and methods of data collection. The purpose of this chapter therefore, is to discuss the theoretical perspective relevant to this study, methodology, and the rigour primarily associated with Part A of this qualitative inquiry.

Phenomenology as a Postmodern Theoretical Perspective

Knowledge that is interpreted varies in clarity from individual to individual (Tucker, 1998). According to van Manen (1990) phenomenology is sometimes used "...when the descriptive function is emphasised, [and] 'hermeneutics' when the emphasis is on the interpretation" (p. 26). Even so, whilst the theoretical perspective concerning description and interpretation may differ, both are founded on the epistemological framework that is based on subjectivism (Crotty, 1996). Neither the concept of phenomenology nor of hermeneutics call things into question nor predict outcomes, but simply present things as they are (Crotty, personal communication, 4th December, 1996). This study about nurses who undertake advanced practice is oriented to a human science that uses phenomenology to present *what* a certain phenomenon means and *the way* (emphasis added) it is experienced (Crotty, 1996; Moustakas, 1994; van Manen, 1990). According to Crotty phenomenological nursing research has had an over emphasis of phenomena that is solely based on the individual self as object. Crotty

believes that the endeavour of authentic phenomenological inquiry is to seek "...an intentional analysis that embraces *both* object and subject ....i.e. on their being-in-the-world and their being-with-others" (p. 125). This view mirrors Moustakas' (1994) view that being-in-the-world as the "object" is considered textural in content rather than contextualised, and is described as a phenomenon that stands alone. The "subject" on the other hand, provides structural content that is contextual, and refers to their being-with-others.

I chose to take this theoretical perspective because this study is in keeping with Crotty's emphasis. That is, there are two main phenomenological foci. The first is that of the "object" in this study, which relates to the experiences of individual advancing nurse specialists and stakeholders on their being-in-the-world that provides an interpretation of ANS and education. The second phenomenological focus, the "subject", relates to the way that nurses experience ANS and education within the context of the social, moral, political, economic and personal conditions of the day.

In carrying out such a phenomenological approach, I am convinced that Moustakas (1994) and Crotty (1996, 1998) have similar theoretical perspectives of what constitute genuine phenomenological studies. These reflect my own perspective. There is in general, agreement that human understanding and meanings are an outcome of human experience and that the object and the subject are studied so that phenomena can be viewed in their entirety. To take this view a step further, it is argued that the separation of subject and object in qualitative research actually weakens the results because a researcher is limited in constructing theory that is relevant to a phenomenon (Minichiello, Sullivan, Greenwood, & Axford, 1999). In this study for example, a study of the experiences of nurses that ignores the subject or contextual issues surrounding ANS and education; such as the way that nurses experience work place agreements, education programs, and the health care system in which they function, would offer

limited depth of analysis to this study. This is because the way nurses may reflect on being-with-others, would not be analysed.

Similar to Crotty's views, Moustakas (1994) describes one's being-in-the-world as noema and one's being-with-others as noesis. In my view, both are central to understanding the theoretical perspective of Husserlian (1948, 1973) transcendental phenomenology. Moustakas' explication of what is noematic and what is noetic assures me that I am able to glean the evidence of perceptual meanings that constitute reality. The noema is that which the RN in this study experiences, that is, what s/he "sees, touches, thinks, or feels" (p. 69) and the noesis is the way in which the what is experienced, that is, how s/he thinks, reflects, feels, remembers and judges. My argument therefore, is that Moustakas and Crotty imbue noeses as those experiences that are able to "...bring into being the consciousness of something" (Moustakas, p. 69) and ultimately, provide the telling experience from participants that is intentional and able to support meanings that are real in relation to the participants in this study. I therefore contend that to study the noema (the object) alone would only provide a partial textural view of the phenomenon. It is ultimately the noetic influences shared by the RNs that would describe the social, contextual, and therefore, structural experiences of ANS and education.

Together, the object that is noema and the subject that is noesis afford the intentionality of consciousness to which Crotty (1996, 1998) and much earlier, Franz Brentano (1838-1917) and Brentano's pupil, Edmund Husserl (1859-1938), espouse. That is, every mental act constructs meaning and is essentially intentional whereby the world is made intelligible (Levinas, 1973; Scruton, 1995). I believed that the nurses in this study would be able to consciously reflect on both the object and the subject because they were currently living and experiencing the phenomena surrounding ANS and education.

The issues of object and subject were aligned with my assumptions (Appendix C). As I was personally involved with the interviews and data gathering, the explication of my assumptions was carried out to clarify my personal value systems and to acknowledge areas of personal power, biases and degree of subjectivity that I felt required periodic review during both parts of my study. At least 12 basic assumptions relevant to my study were considered. Some were adapted from Kincheloe and McLaren (1994). The explication of my personal beliefs above reflected the Husserlian, Crotty and Moustakas object/subject phenomena. Each statement incorporated the object that is textural experience and is then contextualised to include the subject, that is the human experiences with others in society. My assumptions acknowledge what I believed was the significance of the object/subject nexus that is intentional reality. Furthermore, the explication and periodic referral to my assumptions from the onset of identifying the problem statement was necessary in order to maintain focus on the research problem statement and how I would reflect on my developing thematic analyses (Appendix D).

One of van Manen's (1990) approaches to analysis was incorporated as an additional guide to the undertaking of this study. Keeping cognisance of the Husserl/Crotty/Moustakas framework where both object and subject were contextualised, the 'analyzing approach' suggested by van Manen (1990) and adapted from Streubert & Carpenter (1995), resulted in the following four steps as a guide for analysing the data;

1. Turn to the nature of lived experience by orienting to the phenomenon, i.e., keeping focused on the question and explicating all assumptions listed.
2. Explore the phenomenon by generating data using personal experience, consulting phenomenological literature and searching the existentialism (nuances) and descriptions from the participants.

3. Reflect on the data in order to isolate and glean thematic statements that are linguistic descriptions of events.
4. Write up the findings by varying the examples, writing and rewriting.

Therefore, in undertaking what may have appeared to some to be an eclectic approach to this study, I believe that a theoretical perspective that is noematic and noetic in analysis, provided a critical interpretation of the phenomenon of ANS and education.

Method of Data Gathering and Analysis: The Interviews

Questioning from an interpretive paradigm is open-ended. This allowed me to utilise my listening skills during the interview process (Creswell, 1998; Denzin, 1989). During the conversational interviews (Gubrium & Holstein, 2000) with each RN in Part A of my study, I anticipated a series of probing questions that could be drawn from the responses from one single open-ended question. This single question was posed at the beginning of the first of two rounds of face-to-face interviews with each participant. No specific prompts were orchestrated and the conversation with each RN followed spontaneously. Further inquiry on my part included non verbal cues such as a nod or by saying, "tell me more." This line of inquiry continued with the conversational flow and progressed, based on what the participant wished to say.

In short, additional prompt questions drawn from the first round of interviews with each RN was not planned because I wanted the conversations to evolve naturally (Eggins & Slade, 1997). However, what evolved, as a result of the preliminary analysis of the first round of interviews was a list of review questions (Appendix E). Therefore, prior to commencement of the second round of interviews, each RN was informed that I had a list of questions that were drawn from his/her first interview with me.

The opening question to each RN for the second round of interviews some six months later was similar to the first. However, it was slightly altered to reflect the RNs' progress in their studies. The opening question asked of each RN therefore became, "now that you are nearer completion of your studies, tell me about your experiences and decision to engage in this program of study, and how this has impacted on you." I then introduced the list of review questions as the conversation permitted during the interview.

The list of review questions ranged between 10-20 questions specific to each participant. These questions proved to be advantageous because they were trajectory in intent (Sandelowski, 1999), participant sensitive and afforded further reflection, clarification and expansion on issues raised in the first interview. As a result, I was more confident that I had gleaned as best I could from what each RN believed was worthy of discussion. It is this level of questioning that adds rigour to a qualitative study (Beck, 1994; Sandelowski, 1993; Silverman, 1993; Thorne, Kirkham & MacDonald-Emes, 1997).

One part of the rigour required in qualitative research pertains to an iterative approach during data gathering and analysis (Grbich, 1999; Thompson, Locander & Pollio, 1990; Thorne et al., 1997). I considered that the scheduling of a second interview with the same RN six months later would allow me to review and compare each participant's transcript for any variance that was considered either unreliable or acceptable evidence. The reason for doing so was fourfold; a) to capture any "experience-distant perspectives" (Benner, 1985, p. 9), for example, when participants were offered or gained a promotion between the time of their first and second interviews, b) to capture any "phenomenological variation" (Sandelowski, 1995, p. 181) over time, for example, when a participant reviewed her progress in her studies and decided to defer her enrolment, c) to capture a change of status position between the

interviewee and interviewer (Silverman, 1993), for example, me being an unknown researcher to a participant to me becoming a participant's mentor, or d) to capture a change of life-style circumstances, for example when a participant moved house or had to deal with the death of a family member during her advancement.

The six months spacing between the first and second interviews with the participants in my study was also undertaken because phenomenological data is inherently retrospective (Sandelowski, 1999, van Manen, 1990). The authors suggest that individuals cannot reflect on an experience that they are currently experiencing. Mindful of this, and knowing that the RNs in my study were currently experiencing the phenomenon of interest, I undertook the longitudinal approach. This strategy allowed for the possibility that some participants would complete their chosen program of study by the time of their follow-up interview, and therefore, able to reflect on their advancement retrospectively. In effect, three of the 13 participants did complete their study program on or prior to the time of their second interview. In all, each RN and I had the opportunity to reflect on our first interview (by reviewing the transcript together) and to draw on this interview prior to and during our second conversation.

As the sole interviewer in both parts of this study, my role as a listener was considered essential to ensure neutrality (Ahern, 1999). Maintaining a relaxed and non-threatening approach during the interviews, particularly if and when a RN wished to confide in issues that were sensitive in nature to them supported the notion of neutrality. This enabled me to gain the confidence and desired trust between the interviewer and interviewee. Furthermore, any anxiety I experienced focussed on 'being-at-ease' and accepting of statements that a participant felt was queer or unusual. The imperative was to ensure non-dominance over any participant. This latter perception was most likely related to the fact that six of the 13 participants in Part A and all stakeholders in Part B had had prior contact with me from a professional perspective. The concern here was

the participant's possible discomfort in sharing stories that may be secret in nature or too sensitive to reveal to an already known identity. However, my initial concerns proved to be ill founded on the basis that the participants volunteered to participate knowing that a prior relationship had already existed between the parties. This in fact proved to be an additional and positive icebreaker.

It is possible that from the participants' perspective, the intimacy of face-to-face interviews may cause some feelings of discomfort or self-doubt, particularly if the nature of the phenomenon is sensitive to them. However, van Manen (1990) suggests that increased awareness, moral stimulation, thoughtfulness, and a sense of liberation are positive outcomes as a result of participant involvement in interviews of a phenomenological nature. This proved to be the case with every participant in this study. Each voiced their appreciation and opportunity to be heard and understood, and most of all valued for their contribution as likely co-authors of the study.

In a second example of neutrality, I was concerned that one participant advancing specialist did not feel obligated to undertake her planned second face-to-face interview with me. Her interview was scheduled on the same day following a rigourous seminar presentation she gave to nurse colleagues. Whilst the seminar bore no relationship to this study, I was concerned that she might have felt an inordinate amount of anxiety that related to her seminar presentation. I offered this participant a deferment of our interview but she was happy to proceed.

Maintaining a Phenomenological Audit Trail

To ensure continued rigour in qualitative analyses and check for any potential for bias, co-coding[1] with a panel of experts (Janesick, 2000; Streubert & Carpenter, 1995)

[1] Co-coding: Thank you to my colleagues Drs Adrian Morgan and Yvonne Hauck for their support as co-coders in my study. Both are experienced qualitative researchers.

proved fruitful. Two nurse colleagues with expertise in qualitative research were given a week to separately enter their coding of two of my RN interviews. These were sent to each as hard copies. My coding of these segments were not revealed to either colleague at this stage. A meeting over a luncheon with my colleagues was convened a week later to verify and discuss our coding. As a panel, we confirmed my reasoning and interpretations with randomly selected code words from two participant excerpts. Consensus was achieved, for example, with code words including "public profiling" and "critical reflection". Each colleague had created "collaboration with others" and "collaborative relationship" based on the same participant segment. These code words were similar in meaning to what I had coded to be "public profiling". In another segment my code word "critical reflection" was interpreted by my colleagues as "reflection: critical appraisal" and "reflective practice" respectively. Whilst there is no claim to an exact match of word use during this part of my audit trail, the language and meanings nevertheless were considered by each of us to be similar in context.

To ensure validity of qualitative data that is truly reflective, collected and analysed, it was necessary to demonstrate an open and systematic approach to my interview data as no one method can be used for all types of qualitative data (Burnard, 1991). A journal (Janesick, 2000; Rodgers & Cowles, 1993; Streubert & Carpenter, 1995; van Manen, 1990) that incorporates a diarised chronological log of events and personal observations (Appendix F) enabled me to reflect on the events and execute my research strategies for the duration of the study. At the same time, this assisted me in generating an audit trail of events that minimised the potential for bias (Ahern, 1999; Morse & Field, 1995) such as favouritism for one RN over another. For example, I was aware that I might have favoured a RN working and studying in the perioperative setting because of my interest in this area of specialisation. Keeping an audit trail of my reflections maintained my awareness of this potential for bias.

Included in the audit trail was the cancellation of the second interview and withdrawal of data from the first interview with a participant, namely "Isabelle". The data was excluded from the study because Isabelle revealed prior to scheduling of a second interview that she was not currently enrolled in a course of study, but had completed advanced specialist studies some years ago. One of the inclusion criteria as a participant in Part A of this study was that s/he must be currently enrolled in a specialist nurse education program. A second interview with Isabelle, therefore, was not conducted and the participant withdrawn from the study.

Each participant was posted a personal letter of thanks for their participation (Appendix G) at the completion of the first round of interviews. At the same time a typed copy of the first interview transcript was either posted or handed to each participant prior to the scheduled second interview. This gave each RN a minimum of two weeks or more to read, prepare for, and offer any feedback, such as lack of authenticity, inaccuracy of interpretation, sensitivity of information given, typing errors, and offer any additional comment if so desired. All 13 participants returned verbal feedback to confirm for accuracy of their first transcript (Appendix H). Five of the 13

RNs, namely "Brenda", "Carla", "Fiona", "Helen" and "Olive" highlighted typing errors while Carla and Olive communicated their sensitivity of revealing their partner's enrolment in a specific university or naming her own place of specialist experience respectively. Olive drew my attention to a segment of our conversation that was sensitive in nature, and indicated that I should exclude it from the data. Also, Olive corrected two words that I had transcribed to read 'instability' rather than 'invincibility' and 'change', rather than 'chance'. These transcribing errors on my part may seem minor, but without a member check, can distort meanings and, therefore, interpretations that are truthful.

A third visit or postal contact followed with a copy of the second interview transcript given to each Part A participant. Once again, a personal letter of thanks and a written invitation to provide feedback or to voice any concerns they may have had was forwarded to each (Appendix G). This was done to undertake a member check for framing of the interpretations (Beck, 1993; Janesick, 2000; Lincoln & Guba, 1985). Written feedback that required correction of typing errors from the second interview transcripts was gained from two of the 13 participants only, namely Olive and Fiona. Six RNs personally communicated to me that the transcriptions were accurate in interpretation and offered no further written feedback. The remaining five RNs offered no confirmatory feedback following receipt of their second transcript. As with all participants, each was pleased to keep both transcriptions for their own personal reference. All RNs expressed that they were pleased to share their accounts and valued their contribution to the study. None felt it a threatening or arduous experience, but that the experience gave them the opportunity to talk with a colleague and to tease out issues that they may not have always considered worthy of discussion.

More significantly, it was discovered after the second interview with Olive that the second side of the taped conversation failed to be recorded. There was no cause for alarm however, as I was able to refer to the list of prompt questions that I had prepared prior to my second interview with Olive. The keeping of a hand written log of prepared review questions (Appendix E) that emerged from the first interviews with each participant proved to be not only systematic, but in this case, fortuitous. This action also enhanced my ability to link content from the first interview at the time of the second interview. I was able by process of elimination, to check for the content of the conversation that I had unwittingly not taped with Olive. It was uncanny that the last of all my taped 28 interviews partially failed because of operator error. This totalled some 19 minutes of unrecorded conversation. On discovery of this incident, I communicated

to Olive what had happened and sent a hard copy transcript of what had been successfully tape-recorded (45 minutes of conversation), with the addition of a briefly written outline of the issues I noted that we had discussed. Olive returned by post, an extensive written account of her perceptions based on the prompts and what she recalled that she had said at the time of the interview. Her written narratives were added to the final transcription and subsequently included in the data analysis.

Preliminary Analysis of the Interviews

During my preliminary analysis of the second round of interviews with the advancing specialists, I noted that some information from the first round of interviews was not necessarily addressed in the second round. This is because it was not relevant, already exhausted in description, or not considered an issue with the participant as a whole. However, what I did differently at the end of the second interview with each RN was to ask three set but open questions. The first two questions may not have been of interest to the participants but it was possible that asking about, a) their experiences of the accreditation process of health care organisations, and b) their thoughts about nurse credentialling, would reveal a common understanding about issues relevant to nurse specialisation. The third and closing question allowed each participant to share his/her future plans in nursing and to add any other comments that they desired. On completion of the second round of interviews, each RN was given a copy of his/her second transcript to analyse and provide feedback before I undertook the final data analysis.

Apart from a review of my data by my co-coders, I went back to the participants at least twice (each with a copy of his/her first and second transcriptions) and to four participants a third time to share in a review of my thematic analysis. Beck (1994b) refers to this as a member check. Two participants only were interested in reviewing my thematic analysis. This may account for the greater interest the RNs had in the

concrete descriptions of their own experiences rather than the synthesis of my overall thematic analysis (Sandelowski, 1993).

Coding of the Data

Coding of the interview data and thematic analysis shifted from my manual entry into a small code book to the electronic medium once all interviews were completed. A more detailed and expanded interpretation of each code word and theme as they emerged, was entered into The Ethnograph v5.0 (Seidel, 1998) computer program and listed under 'memos'. A detailed description of my interpretations with significant synonyms and antonyms that were deemed to be useful at the time of writing up of the results of the study was entered progressively. Besides, a visualisation of the changing 'family tree' of code words and themes viewed in The Ethnograph could be retrieved as, and when, required. I was able to view, reflect on, and check for sequencing and best fit. The computerised 'code book' was automatically dated and updated as the data was scanned for new or changed code words. At the same time, each code was linked to the relevant participant identifier. For example, 'A 1' for Andrew's first interview, or 'O 2' for Olive's second interview. This action allowed me to create, redefine, recreate or merge code words with a degree of clarifying confidence during the whole analysis until the resting family tree with core themes, categories and sub-themes finally evolved.

Further rigour was undertaken by seeking discussion and review of my thematic analysis and coding. The aim was to confirm authenticity of the data analysis (Beck, 1993, 1994; Streubert & Carpenter, 1995). This additional member check was conducted over the telephone soon after completion of the second round of interviews with two participants, namely Andrew and Helen. Both agreed to offer constructive criticism of my thematic analysis. This was undertaken by telephone at their request. A meeting with Helen was improbable as she lived some 400 kilometers away. We

discussed some of my coding and confirmed that code words such as 'being collectively invisible' and 'being rejected' were not what she would have imagined but plausible nonetheless. Much discussion took place concerning how she compared with the other participants. It was necessary to clarify with Helen that from a phenomenological perspective, the study was not based on comparisons with others but of life experiences that was relevant to each. However, the code words that I discussed with her were deemed plausible and relevant amongst all participants.

I requested that Andrew verbally critique my interpretation of the dialogue from our interviews. In doing so, I suggested that he tell me if and when he felt that some of my code words, themes and supportive narratives were plausible to him. During the process, Andrew listened and made response to my interpretations of at least 50 of the 73 code words that had emerged from the data. Andrew was positive and somewhat elated with the interpretations and indicated that credibility was evident. He stated that "it really provides me with an understanding of what I do" and felt a detailed sense of the whole.

In conclusion, a consensus about the authenticity and accuracy of all first round and second round interviews was reached. Further validation of themes and code words that emerged during my data analyses by participants that volunteered to undertake a member check, was achieved.

Validity/Trustworthiness/Inter-Rater Reliability

In qualitative inquiry, the explanation of trustworthiness as against validity and reliability is documented (Beck, 1992; Carr, 1995; Lincoln & Guba, 1985; Morse, 1998; Sandelowski, 1993; Streubert & Carpenter, 1995; Whittemore, Chase, & Mandle, 2001). Creditability or the truth-value of the data gathered from the interviews in this study was achieved when each RN was able to confirm his/her transcript as an accurate account of

the conversational interviews that took place. The interpretations in the form of transcripts and written or oral feedback were believable, recognisable and the participants were able to relive the experience.

Auditability is achieved by the listing of themes and codes that are subsumed by the meanings derived from the data. In addition, an extensive audit trail of my decision-making comprising my personal reflections, journal and logs in the form of field notes was maintained as an audit trail of why, what, how and when themes emerged (Appendices D, E, F, & H). Transferability or fittingness is afforded when a reader or others from the same or similar disciplines accept the narratives as plausible accounts of the phenomena under examination. Moreover, the narratives can be applied to the real world or the findings fit into another context. The use of co-coders for example demonstrates this.

Lastly, confirmability is gained when the reviewers of this thesis are convinced that auditability, creditability, and fittingness are achieved and that the data is fundamentally free from bias even though it is considered value-laden. My explication of how I maintained bracketing and the setting aside of my assumptions during the study provides evidence to substantiate my assertions of confirmability.

Saturation of the Data

Reaching saturation of the data is yet another issue that I took into account: that I had undertaken an exhaustive account of the phenomenon under investigation (Talbot, 1995). Indication of saturation in this study was evident after review of the first round of phenomenological interviews and before scheduling of the second round of interviews. No further code words were being created. In effect I had reached the stage when my search for further code words resulted in the collapse and integration of code words that had already been defined and the creation of significant themes. For

example, when the participants urged that they should maintain 'credibility' of practice or when they 'fantasised' about advanced practice, or when they believed others were 'hypocritical' about nursing, or described 'paradoxes' that were incongruent to their understanding about ANS or education, the codes were collapsed to link with my original code of 'idealism'. The code 'idealism' emerged in each interview, whilst the four codes mentioned above were scattered disproportionately throughout all 13 interviews.

This may also be viewed as a process of clarifying code words, segments or meaning units (Colazzi, 1978; Denzin, 1989; Diekelmann, 1992; Giorgi cited in Moustakas, 1994; van Kaam, 1966; van Manen, 1997) which is a common style. Furthermore, the process equipped me with the flexibility and freedom to be creative during coding of the data and to conceptualise themes that were effectively more concise in the number of codes, without loosing meaning.

The frequency with which the codes and themes occurred in successive interviews and until no further information could be found, provided further evidence of saturation of the data (Streubert & Carpenter, 1995). The Ethnograph program was useful in this endeavour as the numerical frequency and sorting in alphabetical sequence of codes and themes were automatically archived and retrieved in an easily interpreted spreadsheet (Appendix I). Furthermore, the number of segments that related to each theme, sub-themes and code were easily calculated. This provided me with a sense of confidence that there were many supporting narratives from which I could select and at the same time, demonstrate saturation of the phenomena.

Using Critical Reflection

Maintaining a critical perspective prior to proposal writing, during the data analysis and finally during the writing and rewriting of this study enabled reflexive

bracketing. This critical process enabled a continual and evolving review, return and ultimately final revelation of all possible facets of the phenomenon of interest. It also enabled me to maintain rigour in further probing of issues to conceive as best possible, individual conversations during the data analysis. For example, I maintained a log of weekly readings in the national newspapers for the duration of the study. These newspaper articles, journalistic reports and reflections were read and gathered from 'The Australian' and 'Weekend Australian' newspapers and the clippings logged on a weekly basis into an exercise book for periodical reflection. The articles comprised a mix of philosophical issues relevant to the current political, sociological and life-style issues of the day. These included, but were not exclusive to, issues on medical infallibility of health care services, family law issues, university education and learning, globalisation in the work environment, technological advancement, and matters pertaining to the nursing shortage. This log of articles heightened my awareness of current national sociological, political, economic and psychological issues that may have impacted on any of the participants during the data collection.

It was important that I did not work within a vacuum, but ultimately be aware of any issue that may have had relevance in terms of the contextual nature of the phenomenon under investigation. Not only was I more aware of what was known or said publicly, but more observing of the subject that is contextualised. Whilst this may be seen by some to negate the act of bracketing that is phenomenological reduction (Scruton, 1995, p. 253), "[a]ll reference to what is susceptible to doubt or mediated by reflection...was...excluded from the description of every mental state" (p. 253) at the time of coding each phenomenological interview. In other words, my critical approach was placed in abeyance at the time of interview with each of the 13 RNs and focus group of stakeholders. Any genuine interaction with a participant during a taped

conversational interview required entry into his or her subjective world rather than maintaining a personal critique of what was being said.

Reflection in Action

Reflecting on myself as well as others during the data collection and even more so in the analysis, enabled me to gain useful knowledge and insight that I might not have otherwise thought possible. I was able to mobilise and focus my attention on what Hirschhorn (1991) describes as common "triggers" such as "...anomalies, contradictions, and metaphors" (p.122) when carrying out the interviews. The sharing of other's experiences relating to advanced nurse practice and education proved to be a source of learning for me.

What became evident during the data analysis in particular, was the consistent manner in which I reflected on and interpreted the RNs' conversations. This in turn led me to consistently check the meaning of each code word as it emerged. As a result, I developed a protocol for quick review of ongoing analysis. While doing so, I kept a number of memos to reference my thoughts and why I arrived at a code word. A small hand-held memo book of code words that listed each new word in alphabetical order and under each participant's name became my chief reference source. I also gave each participant a pseudonym for purposes of privacy. In doing so, I sequenced the pseudonyms in alphabetical order in the memo book that also reflected the timing of the first to last interviews in chronological order. Such a systematic process enabled me to quickly view all documents or files subsequently entered and stored in electronic form or in hard copy. As for the memo book, I was able to easily skim through the memos and check for recurring and developing themes that included a brief extended meaning of each code word. I used this memo book to maintain accuracy and consistency of my entire data analysis.

Lastly, a hand-drawn mind-map of each code word and ultimately, themes, were sketched at poignant stages on a white board during the data analysis in order to make comparisons with previous mind-maps. Maintaining a mind-map as I changed code words, metaphors, or themes provided a schema of where I had come from and what had changed. This further enhanced the elarification process and audit trail of events until finally I had reached the findings to Part A that formed into a thematic reconstruction (Appendix J) that was fitting.

Reframing of the Methodological Approach

I made a significant change in the process of analysis soon after transcribing the focus group interview with nurse executives. I initially intended that the data from the focus group interview with the senior nurse executives would be combined with the face-to-face interviews with the 13 participant advancing nurse specialists. However, soon after transcribing the focus group interview I sensed a dissonance in meanings of the data. For example, the nurse executives focussed their conversation on ways of recruiting, educating and retaining advancing specialists, rather than on how RNs in the workplace experienced ANS and education. While the noematic (object) understanding about the phenomena of interest was the participants' focus in both parts of my study, it was the noetic (subject) textural understanding that differed. It felt wrong that both forms of interview data could be collectively collapsed into respective themes that shared fittingness.

The phenomenological method shared by Husserl, Crotty and Moustakas was in keeping with the individual interviews in Part A of this study, as the one opening broad question allowed participants to speak for themselves and not be influenced by others' discussions. In so doing, they were able to reveal that which was their experience and to describe the noetic way it was experienced in the world. This reconciled with the

object/subject framework that is based on phenomenology as a research method. My interaction between individuals in the focus group interview on the other hand, resulted in a more structured and consequently more formal response compared to the individual interviews. It remained open in nature, but more concrete in responses, perhaps because of the use of a semi-structured interview guide (Appendix K). This resulted in a more concise and collective view of issues that predominantly focused on the executive nurses' concerns about the compromises in the work place and the problems associated with staffing of nurses undergoing ANS and education. The economics of time was also a significant factor to consider for the focus group, and the meeting was rightly scheduled to a rigid timeframe compared to the individual interviews with the advancing specialists. It was at this stage when I reasoned that the focus group interview could not be conceptually integrated with the individual interviews.

At this stage of the data collection I decided to place the focus group data in abeyance until after I had completed all scheduled second round interviews six months later with each of the nurse specialists. This also necessitated consultation with my research supervisors to negotiate an appropriate rethink and possible change of strategy. I indicated that since the rereading and reviewing of the transcripts, I believed that the data from the 13 nurses participating in advanced study and practice was in keeping with the method of Husserlian intentionality (Husserl, 1948, 1973; Levinas, 1973; van Manen, 1990) as initially intended. However, I was perplexed by the focus group interview data. This data bore little resemblance thematically to the RNs' interview data, but lent best to the critical edge of professional nurse practice and health care policy. The focus group data from the stakeholders was indicative of Crotty's (1998) phenomenology that is aligned to Habermas's (1987) intersubjective communicative action. Therefore, the decision to use two parts to this study was made. In short, I used the focus group data for Part B of the study rather than combine it with Part A.

Change of Writing Style

Prior to the writing up of this thesis, I believed that to keep true to my mission of maintaining a critical phenomenological approach, it was best to write in the third person. However, on reflection, I was convinced that the phenomenological data during the post analysis period should be written in first person because of my closeness to the data. It felt natural to write in first person because of the shared interaction with participants and connectedness to the topic that was context dependent and value-laden. As Seidman and Wagner (1992) reason, truth and knowledge from a postmodernist perspective is not universal but context dependent. From this viewpoint, the power for the participants to speak as they see it, and for me to listen and interpret the phenomena of concern was made plausible by writing in first person, rather than writing in third person. Moreover, the writing in third person has traditionally been considered an empirical approach whereby objectivity rather than subjectivity, is valued.

CHAPTER FOUR

The Textural Core Findings of ANS and Education

Introduction

This chapter illustrates the textural core findings of 'moving toward ANS and education'. These findings emerged from the participants involved in Part A of this study, which described the object of a phenomenon that is continually changing. Therefore, the RNs sensed the feeling of moving as they advanced. Explanation of the data collection, recruitment and description of participants, the interview characteristics, the ethical considerations involved and the method of transcribing of interviews precede the discussion of these findings.

Recruitment of Part A Participants: The Advancing Specialist RNs

A stratified purposeful sample (Llewellyn, Sullivan & Minichiello, 1999) of advancing specialist nurses currently enrolled in a graduate program was sought. These nurses were recruited from areas of specialty practice. Thirteen RNs (two men and 11 women) were recruited as participants. Each RN volunteered to partake in the study because s/he responded to two staggered newspaper advertisements, one with a feature article (Appendix L). All were invited to talk about their experiences because they met the selection criteria; they were currently working as a RN, enrolled in a program of study relevant to ANS, and volunteered to articulate their recent experiences as an advancing specialist. In addition to the two newspaper advertisements, displays of fliers on metropolitan hospital and university notice boards (Appendix L), and the snowball sampling technique (Llewellyn et al.) were used. Five RNs were recruited from the 'West Australian', four from the 'Sunday Times', one from a hospital or university flier, and four from the snowball effect.

Each RN made initial contact with me by phone. Confirmation of currency of enrolment in a study program that reflected an area of ANS in which they were already practicing was obtained. Nine nurses volunteered from the metropolitan area of Perth and four from the regional area of Western Australia (W.A.). Contact details were exchanged and a consent form (Appendix M) and demographic questionnaire (Appendix N) posted to each. In the case of one regional participant, the forms were sent via e-mail. The scheduling of the first interview was tentatively confirmed at this stage.

The aim and purpose of the study, along with the interview process and information that would protect their privacy was detailed by telephone and outlined in the consent form. The maintenance of anonymity and confidentiality and the right as participants to withdraw from the study at any time were communicated. The participants kept a copy of the consent form and returned a signed second copy of the form to me, along with the completed demographic questionnaire with agreed pseudonym. Both forms were received personally or by post and filed under alphabetical order and corresponding pseudonym. For example, the first round of interviews was filed A1 (first interview with Andrew), B1 and so on, to O1. The second round of interviews was filed A2 (second interview with Andrew), B2 and so on, to O2.

Staging of Part A Interviews

The collection of data involved first and second round face-to-face or telephone interviews with 13 RNs. These appointments were staged over a five-month period. The first commenced in August 1999 and the last with Olive was completed by November 1999 (Appendix H). One RN (Nola) failed on two occasions to turn up to a mutually scheduled interview. I decided not to pursue this participant any further and to simply let things be, even though Nola initially contacted me in response to a hospital

flier. This resulted in 14 interviews being conducted and audio-taped. At this stage of the data collection I had received five additional responses to the newspaper advertisements, the majority from RNs working in the regional areas of W.A. However, none of these respondents met the inclusion criteria.

At the conclusion of the first round of interviews, all but one of the 14 participants confirmed that they would be available for a second interview in six months time. Isabelle was not sure when her family would take a job transfer from regional north to a south-west town in regional W.A. It was agreed therefore, that she, rather than I, would make contact again in approximately May, 2000. By August 2000, Isabelle contacted me. She revealed that she did not meet the inclusion criteria as a participant. Even though she had completed a graduate diploma in child health, she was not *currently* enrolled in an ANS program. I was glad to hear from her and we both confirmed that our first conversation would be omitted from the data analysis.

The second round of interviews commenced in March 2000 and completed three months later in June 2000. The undertaking of the first and second round of interviews resulted in a total of 27 interviews (13 repeat and one single), totaling a little more than 27 hours of taped and later transcribed conversations. The average time frame between the scheduling of the first and second interview with each participant was six and a half months.

Interview Characteristics

The first round of interviews included two telephone and 11 face-to-face interviews with participants. Of the 11 face-to-face interviews, six were conducted in the participant's home or place of work and five in my work office at the participant's request. The average length of time taken during the first round of interviews was 64 minutes. The duration of the interviews ranged from 41 to 90 minutes. The average

length of time taken for the second round of interviews was 58 minutes. This was slightly less in time frame compared to the first round of interviews. The duration of the interviews ranged from 30 to 70 minutes. Of the second round of interviews, three were conducted over the telephone, and 10 face-to-face. Two of the 10 face-to-face interviews were conducted in the participant's home; three in the participant's work office, and five in my work office, once again at the participant's request.

The time frames mentioned above take into account the recorded times of the conversations only. Time taken in the recording time plus the additional discussion time with each participant averaged one hour and 36 minutes for the first round of interviews and one hour and 28 minutes for the second round of interviews. This is mentioned because the warm up times and interview closures often prompted extended interactive discussions that were relevant to the ease at which the participants and I were placed.

Ethical Considerations

Consent to undertake the study was sought from the Edith Cowan University (ECU) Committee for the Conduct of Ethical Research. Permission to gain access and invite voluntary participants to discuss their experiences relevant to the phenomena was subsequently obtained from the Head of School of Nursing at Curtin University of Technology in Bentley, W.A. (Appendix O). This was considered necessary because part of the recruitment strategy was to display fliers on the School's postgraduate notice board to recruit likely participants. However, to ensure against inadvertent bias or conflict of interest it was decided *not* to recruit participants from ECU and make contact with the Head of School of Nursing and Public Health at ECU because of my affiliation with the university as a staff member. Potential participants from ECU or otherwise, on the other hand, were recruited through the newspaper advertisements. Permission to

display fliers of the advertisement in a variety of hospitals was also sought from the executive nurse educators of four metropolitan, and one regional hospital, namely, Sir Charles Gairdner Hospital, Hollywood Private Hospital, Mount Hospital, Fremantle Hospital, and Geraldton Regional Hospital (Appendix O).

Participants were reassured that their involvement in the study was voluntary and that they could withdraw at any time without penalty. Security of all data including audio-tapes, transcriptions, field notes, computer diskettes and hardware was maintained. My personal computer remained password protected and kept in my private residence. The remaining data were secured in a locked filing cabinet next to the computer. The audio-tapes will be kept for five years after completion of this study for audit purposes and if any participant wishes to review his/her conversations with me. After this time has elapsed, the audio-tapes will be erased.

Transcribing the Interviews: Using The Ethnograph

Use of The Ethnograph v5.0 (Seidel, 1998) is a software program that provided for a thorough analysis of complex data because of its powerful search and retrieval abilities (Russell & Gregory, 1993). It enhanced my ability to confidently collate, store, code, retrieve and statistically review the frequency of data when and as required. In addition, memos were stored and retrieved via The Ethnograph based on the date of entry. All code words could be sorted relevant to their frequency, alphabetically, or both. These functions and more were beneficial in handling the large quantities of data.

Description of the Participants

The demographic data indicated Carla and Judith had less than five years but more than two years of nursing experience. Of the remaining 11 RNs, Linda and Olive had five to 10 years, Helen had 10-15 years, Eric, Fiona, Karen and Megan had 15-20 years each, and Andrew, Brenda, Diedre and Gail had greater than 20 years experience

as a RN. Diedre had a master degree in nursing, nine had a minimum of a bachelor degree or postgraduate diploma relevant to nursing, and three a hospital based diploma award. Of the advancing nurse specialists, five were undertaking a master degree, four a postgraduate diploma, three a continuing education program, and one, a bachelor degree. All except Olive were studying part time. The range of specialties in which the RNs worked, studied or both, included men's health (Eric & Andrew), women's health (Diedre), learning disabilities (Brenda), intellectual/physical disabilities (Gail), midwifery (Carla), community nursing (Diedre), rural/remote area nursing (Helen), complementary health (Gail), mental health (Olive), oncology (Eric), critical care (Fiona, Karen & Linda), health service management (Andrew), emergency (Andrew & Fiona) and perioperative nursing (Judith & Megan).

At the time of the scheduled interviews and between the first and second interviews, all participants remained in nursing work. Some gained a promotion and others changed enrolment status in their field of study. Andrew was the first to be interviewed. He was enrolled in a graduate diploma in men's health and by the time of his second interview, was enrolled in a master degree in health service management while working as a Level 1 (first of five incremental levels of nurse employment in W.A). He also accepted a promotion as a Level 2 nurse in the emergency department (ED) of a metropolitan hospital. Andrew was in the early stages of his coursework studies through a Perth university.

Brenda was the second RN to be interviewed. She worked as a nurse consultant in special education while undertaking a master degree relevant to the education needs of children with learning disabilities. Brenda focused on individuals with attentional disorders such as attention deficit disorder (ADD) or attention deficit hyperactive disorder (ADHD). She was at the proposal stage of her research studies through a Perth

university. Carla was enrolled in a postgraduate diploma in midwifery through a Perth university. She worked in a regional hospital as a Level 1 nurse. By the time of her second interview, Carla had withdrawn from her studies even though she had completed half of her program. In the meantime Carla accepted a promotion (in management) as a Level 2 nurse in the same hospital.

Diedre was enrolled in a mental health course run in the distance education mode by the Health Department of W.A. She worked in dual nursing roles. The first as a part time consultant in the rural/regional sector as a woman's health private practitioner, the second as a Level 2 nurse coordinator in a regional hospital. By the time of her second interview, Diedre had accepted a promotional position as a community health nurse manager (equivalent to a Level 4), being responsible for the delivery of health care within a regional health service of W.A. She had also completed her continuing education course relevant to mental health. Eric worked as a Level 3 clinical nurse specialist in the oncology department of a metropolitan hospital while enrolled in a master degree program relevant to men's health and oncology. He was at the proposal stage of his research studies conducted through a Perth university. Fiona worked in a regional hospital as a Level 1 nurse while enrolled in a master program in emergency/critical care nursing. She was near completion of her master by coursework studies through a Perth university.

Gail was enrolled in an instructor's course in healing touch. This course was run in the Australian State of Victoria where a private education provider of complementary therapies was situated. The course catered for members of the Holistic Nurses Association and required up to two years full time study or equivalent to complete. Enrollees were required to attend part of their studies on campus at the Victorian centre. Gail had already undertaken prior studies specific to complementary health and wished

to practice as a complementary therapist on completion of her current instructor's course. She otherwise worked as the community nurse (equivalent to a Level 3 nurse) in a metropolitan centre of Perth that catered for individuals who had a severe physical and/or mental disability such as muscular dystrophy or spina bifida. Helen worked as a remote area nurse (equivalent to Level 2) in the north west of W.A. She was enrolled in an advanced health assessment, short education course offered by the Silver Chain Nursing Association. She completed her course by the time we had our second interview.

Judith was enrolled in a postgraduate diploma in perioperative nursing and initially worked as a perioperative nurse in the regional area of W.A. as a Level 2 nurse, and later in the metropolitan area as a Level 1 nurse. By the time of her second interview Judith had accepted the lower level of employment in order to gain varying experience in a large metropolitan theatre suite. She was near to completion of her course through a Perth university. Karen and Linda were both enrolled in a master program relevant to critical care nursing through a Perth university. Linda worked in the intensive care unit of a metropolitan hospital as a Level 1 nurse. By the time of her second interview, she gained a promotion as a Level 2 clinician in the intensive care unit (ICU). Linda was at the proposal stage of her research studies undertaken through a Perth university. On the other hand, Karen, who had vast clinical experience in the ICU had gained employment as a research nurse (Level 3) in the same hospital. By the time of her second interview, Karen was in the beginning stages of her research study.

Megan worked as a senior level (equivalent to Level 3) perioperative nurse in a metropolitan hospital and was enrolled in a bachelor program, majoring in health promotion through a Perth university. By the time of her second interview, she was near to completion of her degree course. Olive was the last RN to be interviewed. She

studied full time for a postgraduate diploma in mental health nursing through a Perth university. She did this while working as an agency nurse in the general medical surgical settings of different metropolitan hospitals. By the time of her second interview, Olive had completed all requirements to successfully graduate from her course.

It should be noted that four of the participants had dual specialist roles. Eric specialised in oncology with a focus on men's health while Andrew worked as an emergency nurse with a converging interest in men's health. Diedre continued work as a community nurse while consulting in her own practice, providing a service that was oriented to women's health. And lastly, Gail worked as a community clinical specialist, caring for people with physical and intellectual disabilities while advancing her knowledge, practice and expertise in complementary therapies. Such examples of dual roles and expertise did not affect the data analysis but demonstrated the contextuality of the phenomena surrounding ANS and education.

The Thematic Findings

Overview of Core and Sub-Themes

The core theme 'moving toward ANS and education' with subsequent sub-themes emerged from the RNs' critical reflections about the phenomenon of interest. These reflections (see sample in Appendix P) were embedded in all themes. It was through these reflections via the interviews that a de-construction (Fontana & Frey, 2000) of the RNs' lived experiences was realised. In the final analysis, 73 code words pertaining to the pattern and levels of core and sub-themes emerged (Appendix Q; R; S). All code words were based on the taken-for-granted knowledges of others that I inductively interpreted and understood as the RNs' everyday interactions (Crotty, 1998; Tucker, 1998). Based on the themes, a reconstruction of the phenomenon was made possible.

The collation and analysis of the themes contained an overlapping of 'nested segments' for many code words. This was because I viewed the narratives and subsequent meanings as contextual and not always recognised as discrete categories.

Moving Toward ANS and Education: The Competing Forces

The external competing forces that the RNs in this study faced included the nature of specialist nursing work within a bureaucracy. The internal competing forces they experienced were related to management decisions that the RNs faced while working in their area of specialisation, and when working with other health care professionals. Both forces impacted on them being an advancing specialist, and more specifically, on them being able to acknowledge and influence the delivery of a standard of health care that was acceptable to them. The external forces comprised for example, the state and federal health care systems, tertiary education system and the organisational changes taking place relating to federal and state industrial policy. The RNs in this study felt an obligation to respond to these issues as they presented in their work. The internal forces comprised the everyday contacts, management decisions, and exchanges that they faced while advancing, either in their place of work or in their home. For example, staffing restructure by nurse management or decisions relating to home and family issues, were detrimental to their advancement.

External Competing Forces

The recently implemented enterprise bargaining agreement (EBA, 1998) for public health sector nurses at the time of the interviews was revealed by the RNs as an external competing force. The EBA embodied the terms of reference under which the nursing profession's state industrial award was negotiated. As a result, the RNs in this study felt that they needed to be mindful of the impact of their requests for incremental salaries that were associated with the rising health care costs that the community was

required to sustain. For example, advanced specialist nurses needed to be mindful of nursing's ongoing industrial demands that in turn, impacted on the constant balancing of resources in terms of costs that their managers were expected to deal with.

Similarly there was a requirement for regional nurses to negotiate an award relevant to the nature of their work. It was important that remote area nurses should be involved in issues that concerned the nurses' industrial award because health service managers wished to spend as little as possible, including accommodating the rising salaries for nurses:

> *There's individual agreements registered for individual health services across the state now. And yes we [the nurses working in Albany] have different needs than perhaps to say, Geraldton. Geraldton has different requirements. And it's a step in the right direction but you da need to have strong people to negotiate. Because the health services managers want ta spend as little as passible [Fiona 2].*

At the same time another exter. l competing force emerged when the RNs thought that they might be able to deliver an acceptable standard of care to the individual that was cost effective. The suggestion was that the advancing specialist should think of new ways of delivering care that was cost effective. Ensuring care that was cost effective was a competing force that was constantly on their minds. While 11 of the participants had had previous management experience relevant to their clinical practice, one RN admitted that he was unable to relinquish his "bean counting" skills now that he was working as a clinician:

> *Well we were assuming that we were thinking as managers should think.... Clinicians should think of the most efficient way of delivering or the safest way of delivering their patient care...But at what sort of level of priority you put it I am not quite sure. I still do have same management, you know, some bureaucratic thoughts on health care and some very strong beliefs in what should and should not be allowable through the public health care system [Andrew 1].*

A further competing force was society's demand for health care based on a medical model of care. It was well understood what effect the role of the Australian Medical Association (AMA) played in thwarting nursing's professional aspirations (McCoppin & Gardner, 1994). Even though the nursing profession was gaining some respect by the public, a biomedical model was not always in keeping with how nurse specialists in the emergency department (ED) for example, could focus on a preventive model of health care, even if they wished to:

> *...of course the medical model still rules. It seems that society wants it that way. You listen to the current debate about the health care and the funding of other projects around the metropolitan area. Though the community says I don't want this (community projects), we want more hospitals, we want more of this medical model of care. But they don't know this. They don't realise what they are saying. It's a place for people with tobacco and alcohol related disorders to come in, have their problem fixed so they can return to their nasty behaviour that they were doing before! [Andrew 1].*

The health care system also presented as a competing force when the RNs cared for individuals who had private health insurance. The RNs felt an inequity within the bureaucracy because people accessed health care based on who could afford to pay for private health. As a result, at least four of the RNs felt that they were required to accede to what they had relatively little influence over, particularly when a patient accessed private health care based on a priori of convenience. From Andrew's perspective, the private patient was more concerned about the convenience factor of choosing when and where s/he could receive elective treatment; not on how well the nursing or medical staff of a particular hospital provided care. Privatised health care was considered a competing force because the public did not acknowledge the care that nurses gave. That is, it was felt that the public neither understood nor appreciated the mix of nursing staff that worked in a chosen hospital, let alone value the advanced specialist RNs who were employed by the hospital.

Carla also revealed how private health care services impacted on the nature of her work. She viewed this as a competing force because midwives as specialists had little influence over the nature of their work because of the small number of privately insured midwifery patients that lived in the outer Perth regions where she worked. The hospital had a bed allocation of 20 private midwifery beds and a complement of midwifery staff to meet that demand. However, there was often an imbalance when midwives working in the facility wished to utilise their dedicated midwifery skills. This was the norm when the majority of hospital beds was more often than not, occupied by non-maternity patients. As Carla saw it, this scenario occurred often because there were very few privately insured pregnant women residing within the hospital's region, thereby creating an under utilisation of the allocated 20 midwifery beds:

> *It gets me a bit cross because we don't always have maternity patients on our ward. We've got 20 beds, two birth suites, and some times the need for private maternity in the X region, isn't very high. The need for private insurance type patients, I think X hospital has the lowest number of in private health insurance in WA. And WA has the lowest number of private health participants in the whole of Australia. I guess you could say it has the lowest catchment. Sometimes we might have only five patients on the award out of 20, and four will be medical-surgical patients. And so the midwives have to work looking after those patients [Carla 1].*

Brenda's experiences of external competing forces were external to the hospital setting. She felt the tensions between health care professionals like herself and politicians at the state and national parliamentary levels. Brenda believed that it was necessary to determine the terms of reference from which all health professionals could pursue treatment modalities that were acceptable to parents of children with ADHD, to all health professionals, and to the community at large. Fundamentally, the competing forces between health care professionals and politicians were divided between a pharmaceutically or sociologically based treatment modality for children who had a

learning disability. Brenda believed that if a medical model of disease failed to acknowledge the social issues relevant to the management of children, the variations in behaviour found with an individual with ADHD could have massive ramifications on the health status of the individual. Furthermore, the labelling of such conditions could lead to an inappropriate diagnosis that failed to acknowledge an "intentional inhibition dysregulation" (Brenda) in preference to labelling a child with a set of symptoms that could be grouped as indicators of ADHD:

> *I know that Senator Chris [pseudonym], when he was the minister for education said to me that this is the single biggest public health issue facing Australia today. It will be for the next 30 years. And the problem is they [members of the steering committee] actually have no policies. And what I find fascinating is, and I'm actually running a petition through the constitutional committee of the West Australian government, they were gob-smacked to find out that back in 1995, the Commonwealth Disabilities Services, this is their calendar from the Commonwealth, this September, it was considered a disability in 1995! [Brenda 1].*

Once again, the competing forces were apparent because nurses like Brenda felt that she had little input or influence over an area of health care, in this case, mental health services, that was of increasing concern to society. As an advancing specialist in the field, Brenda was disturbed not only by the increasing incidence of mental illness in society, but also by the increasing incidence of youth suicide that could be linked to children suffering with ADHD, therefore, her interest in researching the topic. At the same time, she was aware of the heightened interest and growth of public expenditure in complementary health therapies for individuals with a learning disability. This may explain the move by parents with children with ADHD to seek an alternative model of health care. All in all, Brenda questioned the adequacy of a health service that was unable to satisfy the current demand for mental health care in general. However, even though Brenda expressed her opinions at the parliamentary level, to have influence, she

needed the support from all nurses to support her on the issue. She felt that this was not forthcoming.

Diedre also was fraught with external issues of control over patient care that was deemed competing in nature. For example, her practice included the taking of pap smears from women who requested women's health services in preference to the general medical practitioner. She was limited in her practice and found this a souree of frustration because of the perceived "ownership" of medical skills by the physician that were universally (medicare) funded. "We are forbidden to have provider numbers for our pap smears to go to the laboratories, beeause again, it's being blocked by a very strong force, and again for fear that we might take away the patients" [Deidre 1].

Not withstanding such an injustice, Diedre explained how her taking of pap smears had to be checked and ratified by external forces that generated competition for services rendered to women in the community:

> *They involve people like me [community nurses] who live in rural areas, and I mean, also perhaps those who are in the metro area. Anyhow, it just gives the patient a choice [when a woman consults a nurse or a doctor on women's health issues]. Getting back to the pap smears, we are now allowed to apply for our credentiols in taking of pap smears, providing we have the training and expertise. And providing that the laboratory that our pop smears go to, does quality control on us, ond we get the results back to make sure that we have endo-cervical cells on our pap smears. That's what it all boils down to really [Diedre 1].*

The nature of these competing forces also undermined Helen's practice as a rural/remote area specialist RN. Her nurse managers and subsequently, the members of her community expected her to provide a service that emulated a voluntary component of care. Helen had to compete for a fee for patient service given that there was a town doctor who visited from another town to her town for appointments and used her office as a consulting room, one day each week. Helen was annoyed and felt it an intrusion of

her privacy, not only as the sole full time health professional of the town, but also as a community member. However, she agreed to routinely relinquish her office space that was also a room in her home that she and her husband shared. Her office combined as a clinic room for a negotiated fee when the doctor visited each week on a Wednesday. This practise however, was unfair because the visiting doctor was able to claim a medicare rebate for services rendered while Helen was denied a rebate even though she provided similar treatment to the community members in the doctor's absence.

This system of medicare rebate for service by differing levels of health care practitioner placed Helen in a vulnerable situation over which she had little or no control. Any community member who received treatment by her was not required to pay the medicare schedule fee or any fee at all if she as the remote area nurse rendered the treatment. It was on a voluntary basis that the town folk were forthcoming with a fee for her service.

> *I think that they're (the community) very aware because they just don't give me any money, or they give me very limited...like I syringed a guy's ears the other day. Like he hadn't been for you know 100 years, and he was a farmer and was just at full harvesting, he had to get it done. And it took me ages because although he put some oil into his ears to soften the wax, it only softened the first couple of millimeters, so it was still quite hard. So it took me a good hour and I think he could have walked out with his shirt quite drenched because he also had a bit of a neck injury from the day before. So he couldn't bend his neck very well, but they were willing to give me like $50! You know like another lady came in, and I am lucky if I get $5 from her and I would really expect more from her [Helen 2].*

Another external competing force included the diversity of postgraduate courses available to nurses though the tertiary education system. The range and types of courses seemed competitive to the RNs because they needed to spend much time and energy in selecting a course that was best suited to their area of specialisation. For example, Linda was surprised by the reaction by her colleagues in the ICU. They were not

astounded that she was completing a master degree, but astounded that she was completing it in nursing. On the other hand, it was equally astounding to Linda to learn that her ICU colleagues were undertaking graduate studies in disciplines other than in nursing:

> *The majority of people have their nursing degree and I think it's about 50% have got their certificate or graduate diploma...I think there's about four or five of us that are doing masters but I am the only one that's doing it in nursing. Everyone else is doing it in health management and health science... [Linda 2].*

Linda reconciled however, that the nursing profession not only had to compete with other traditionally feminine occupations such as teaching and social work, but with other wide ranging career choices that were open to university entrants. These included for example, policing, commerce, mass communications and the Defence Force Academy, to name a few.

Karen also raised the issue about postgraduate programs specific to the ICU nurse. From her long experience in the field, she was doubtful of the rigour of some postgraduate specialist qualifications that indicated a nurse was able to practice as a specialist in the ICU. In her opinion, some could not function as a specialist even though they had a specialist qualification. This was a competing force because a nurse that was employed as a clinically advanced ICU nurse based on a qualification that was supposedly endorsed and recognised by the profession, was thought to be a competent advanced specialist in the ICU:

> *But we've got people who have said 'oh yeah I've got a postgrad dip in ICU'. But when you ask them to do something or take the most basic patient and they can't cope with it but they do have that qualification [Karen 2].*

This problem was compounded because current nursing staff in the ICU where Karen worked did not have a postgraduate clinical qualification in critical care nursing. Both issues emerged as competing forces and resulted in jealousies amongst the staff:

Oh other people who are jealous of them, the staff who don't have [postgrad qualification]...I mean they may have been in clinical positions for years but they haven't done the academic training and they can't see the overall picture. I mean they can't see the benefits of it at all, which is a bit sad [Karen 2].

Internal Competing Forces

Internal competing forces emerged because of nurse management decisions or patient care decisions that the RNs experienced in the workplace while delivering care. These forces were internal in nature because they were daily decisions made by managers and clinicians in the workplace. The RNs had regular experience and insight into these forces. For example, Linda revealed that ICU nurses were requested by management to undertake higher duties in the ICU if they had a postgraduate degree relevant to ICU nursing. She believed that some nurses refused to undertake advanced studies in critical care just to avoid having to undertake higher duties. In other words, to guarantee that they were not required to undertake higher duties by nursing management, Linda perceived that some nurses made a conscious decision not to do further studies as an advanced specialist in critical care nursing.

Linda felt that a reason why some nurses, unlike her, might have steered away from ever contemplating advanced studies in their field of work was because of unfair management decisions that the advanced specialist should undertake higher duties. To her, it was a reasonable expectation that a nurse should engage in additional professional qualities such as departmental leadership or participation in hospital teaching seminars once s/he had gained a higher qualification. However, the additional responsibilities added to the pressures to what was already perceived as a heavy clinical workload:

And you get this in any job, you know some people do more educational, more higher duties than others. Like I think in the medical realm if you don't publish a paper every so often or whatever, then you loose your position [Linda 2].

Equally disconcerting to all RNs in this study was the competing force between nurse managers and nurse clinicians in general. The RNs perceived that management was unsympathetic to the ongoing work of the advancing specialists and the resultant resignation of nurses in general from their jobs. For example, Carla vacillated between the positive and negative impact that management decisions had on the nursing staff of the day. She was bewildered by her management's changes of direction such as staffing mix. The ramifications created nurse redundancies, two of which were Carla's senior colleagues. However, in the end, Carla reconciled that the nursing management's decision to restructure was beneficial. Her colleagues benefited from the competing force. "We had an issue where basically they were told that the campus needs come first, the ward needs come second and individual needs come last" [Carla 2].

In another example, it was annoying when the RN worked closely with another health worker such as the doctor, but was required to compete with team members to adhere to an adopted standard of care. Judith experienced competing forces in the perioperative setting. She was responsible for the perioperative management of surgical patients in a major regional hospital in W.A. and was appalled at a particular surgeon's demands to pursue elective surgical procedures without waiting for a routine patient safety check. Judith felt that she needed to confront the surgeon's raised verbal demands. He failed to acknowledge her concerns for an adequate patient safety check, documentation and operating room processing that was in accordance with established hospital protocol. In her position, Judith managed visiting surgeons from Perth who came monthly to provide specialist services for the town's community such as gynaecological and plastic surgery. There was one general medical practitioner who was the sole surgeon, but it was one or two of the visiting surgeons who displayed communicative requests that were unreasonable and therefore a competing force:

I just told them to leave my office. I mean, it's not as if you have to get into a screaming match with them, that's not the point. I believe that if you are going to become the advocate to your patient, you need to cover all your bases... So if that surgeon comes screaming out to you, you can go, 'hang on a minute, your next patient is here. I will just sort out this issue for you and the patient will follow on' [Judith 1].

Examples of other internal forces experienced by the RNs included time management and their motivation to undertake ANS and education. These forces, for example, emerged while Fiona worked as an ED nurse in a large regional hospital. She was studying as an external student. Her time management skills and motivation to keep focus on her studies and work impacted on her ability to function as an advancing specialist. This pressure was a competing force that readily impacted on her motivation and therefore ability to pursue advanced practice:

It's dreadful! ...I find the biggest problems with external study no matter at what level, is time management and motivation. It's very difficult. I mean I have a lot of other issues that go on with my life. I work full time. We have a farming property and I have two children who are 11 and 13 currently [Fiona 1].

From a family perspective, Fiona's home situation worsened some six months later during the time of her second interview. She was dealing with her father's death, as well as the building of a new family home. She spoke of these personal internal competing forces that affected her progress even though she was mindful of her ability to prioritise:

Not [coping with non-work related issues] very well. You have to allow in the last couple of months I've had some extremely difficult personal issues to deal with. I've had the prolonged illness and death of my Father and other external issues to deal with, also building a house. You know priorities as I think I mentioned in the past are different when you are studying externally. I made a decision very early on in the semester that I would shift the focus off what I was doing until I had got time to do it [Fiona 2].

Other participants experienced competing forces, which also related to close family members. Helen was serving as the one and only nurse in the rural area. Her family did not fully understand and appreciate the additional management role she undertook as a rural/remote area nurse. During the first interview, Helen revealed that her management role was far greater than her actual clinical nursing role. Not withstanding this, even more insidious internal competitive matters were evident when she first began as a remote area nurse:

> *The way I did things and how I felt things should be done. And there was great opposition. Terrible things happened the first three months. Very, very, terrible things happened. But it was just the settling period. The Beansmill [pseudonym] community wasn't very supportive either. And even with my family funnily enough. My Father and my husband were very unsupportive and the two main people in my life, well they felt that I didn't do anything all day because they saw it as, I didn't see many clients, and therefore I didn't do much. And they couldn't understand what I did [Helen 1].*

The competing forces were most felt because her home interfaced as her office, and consulting room. Her clients often called for her services out of normal day hours and felt that her husband lacked any understanding about this!

> *I have had a few calls and I had one guy who was palliative. I was seeing him quite regularly for only a few days. You know much to my husband's absolute disgust. He can't understand how anyone can ring me up in the middle of the night for an ear ache, but how can I explain it? It's like that all the time. All the drunks even annoyed him but how can you explain that you have it all of the time when you are working in a busy emergency department [Helen 1].*

Competing forces about other family matters from 10 of the participants were also evident. For example, while Karen was advancing as a specialist in critical care; very little had changed now that she was undertaking her master studies:

> *That was really difficult actually. When I first started back studying I would say to the kids and Doug (husband, pseudonym) that there is something that I wanted to do for me. And I realised that the kids are getting older and doing their own thing and therefore there would be times that they would*

have to help. Of course it never happens (wry chuckle). So it was very hard, trying to work, trying to study, trying to manage a family. And they still expect you to be the same as we were before. Especially with my elder son who was also studying here at the time and his attitude was, 'you think your studies are more important than mine because you're doing the higher qualification.' Which wasn't the case at all [Karen 1].

In summary, the competing forces that the specialist nurse faced were both externally and internally situated. These forces caused them duress, impacting on their advancement. The internal forces included other health care professionals such as the nurse manager and doctor. The external forces comprised official governmental systems such as medicare and industrial organisations, and the plethora of postgraduate programs. These were perceived as the larger part of the bureaucracy in which the specialist worked. A competing force may have impeded a RN's degree of success but was interpreted in this study as collective forces that arose from the everyday situations in which the advancing specialists found themselves. These forces were socially embedded and describe the textural object that is interpreted as ANS and education.

Idealism: ANS and Education as the Ideal

All but one of the participants had an ideal view of what shaped ANS and education. To them, it would be an ideal to the profession and society if all nurses pursued continuing or postgraduate education in advanced practice. All nurses who currently gained a university education as a RN were ideally able to care for patients with health problems surrounding chronic illnesses. Furthermore, it was possible that all nurses had the opportunity to advance and research issues that impacted on the community. As a consultant, Brenda for example, was passionate about her area of specialisation and shared an ideal view about nurse education:

...I would say to nurses that want to get ahead, that this (ADHD and mental health) will be the public health issue for the next 30 years. And if anybody wants to get up the ladder, this is an area that I would concentrate on. Because anybody whose going to have an impact on chronic life-style

problems and an impact on the draining of the public health care system, if you have an answer to it, then you are going to be in demand [Brenda 1].

Similarly, Diedre viewed that the professionalisation of nursing through education would see nurses taking graduate and specialist education of their own volition:

...the biggest change that we can see and that one of the good things about having nurses with degrees [is that] they start out with education as very much part and parcel of their profession. And they continue through hopefully looking at education as essential. And that could be written into JDFs and it will be in the future, you know the academic qualification, so that's a good thing about them starting out their profession...[Diedre 2].

Karen's ideal in terms of specialist nurse education was that nurses in general were more aware of issues and therefore, aware of change in their practices because of nursing research outcomes. Nurses were happier to decide on issues that required change in practice. Ideally, all staff in the ICU for example, was willing to change from being unhappy about the shift work, to being happy about working 12-hour shifts rather than the usual rotational eight-hour shifts. Nurses who changed practice that was founded on research and based on results conducted in their hospital and clinical setting were happier to make changes. From her perspective "we (ICU nurses) generally are very very unhappy, [but] I think that by doing things like research into 12-hour shifts and various things we can hope to improve that" [Karen 1].

Megan shared an ideal that nurses like her could be competitive when negotiating a salary that reflected their level of skill. She understood that this was not always achievable but nevertheless, an ideal she practised because it was in the best interests of the professional nurse, particularly in her specialism of perioperative nursing:

I think to get well remunerated you have to go separately because there's no organisation, to get well remunerated you can't have it across the board. Because some places just say financially that they cannot afford to pay nurses at a reasonable base level. Ideally we should be in enterprise bargaining across the board and everybody in line with the options of going above that for private negotiations. It's like practice nurses, they negotiate their own employment package with their doctor and I think some work places actually. Instead of just saying "oh it's not the award, you can't do it." That's archaic, I think if you want to keep that nurse for whatever

reason because they're very good at such and such, or you know, whatever the reason, you should be able to negotiate and say "this is what we will offer you as a confidential bargaining tool" [Megan 2].

Fantasising

Most participants fantasised about what ANS and education could be. Under the rubric of idealism, four code words including 'fantasising', 'being credible', 'living with hypocrisy' and living with 'paradoxes as they arise' emerged as issues that the advancing specialists dealt with. These issues added to the textural understanding and meaning of ANS and education. Fantasising about what ANS should be, or what a nurse did in order to practice at an advanced level, was a thought process that went beyond the ideal. Examples included having a private practice, mentoring others, reversing the stigma attached to nursing as a lowly profession, doing a Ph.D, keeping a clinical focus as a specialist, having a clinical role model, having staff who embraced change as a positive value, or patients being grateful for the most basic of offerings that a nurse provided:

If I do my teaching with human touch next year, there's not a big market in that as yet in Australia. But there is a market for me to travel and teach at another place. Not possibly all the time but five times a year, do weekends or something like that. So I see myself as being a human touch instructor and running workshop groups and things over here around healing touch and complementary therapies. I would like a private practice. I would like to have us all go more to a health-orientated area than the sickness model. I really would. God I would. Energy work I think is great for health professionals [Gail 2].

I love teaching...to share my knowledge with people and teach them. And not just teach them because 'oh God it's my job!' It's basically for them to be able to walk oway and say that I did learn something. I remember reading one of my assignments. I read somewhere where it says, as a preceptor or as a teacher, it is the most honourable thing to be asked to actually teach someone in the nursing profession. And whatever you teach them, they've actually taken a part of you with them always [Judith 1].

Credibility as a Specialist

Being credible as a specialist was a quality that the RNs adhered to as a RN. For example, seven RNs believed it was important that any clinical research should be done

by clinicians such as the advanced specialists, and not by the Level 3s and 4s (Karen) who were usually placed in senior management positions of a hospital. Similarly, if an advancing specialist in the ICU took the position of a Clinical Nurse Specialist (equivalent to a Level 3 RN) then they must maintain a clinical focus and be a mentor for the staff. Furthermore, they must provide bedside care rather than undertake management issues that removed them from the bedside (Linda). Linda was adamant that a nurse employed as a CNS should be primarily available to staff for his/her clinical advancement in the department and not working elsewhere to attend meetings or doing other more administrative and managerial duties:

> *And what I want to do is study in the clinical arena. And although I think there are a lot of very good Level 3s out there, I don't think they're very good on the clinical front. And they never seem to be in clinical.....They are always, well which is not necessarily their fault, but their title is Clinical Nurse Specialist and so if you ask them o question, they should at least be able to tell you where to get the answer. And I found that they are not able to do that [Linda 1].*

Maintaining their credibility as an advancing specialist was also assured by being professionally responsible, that is, by undertaking further education that would advance them in their area of specialisation. This was the case for all participants in this study. Furthermore, having a foundational degree as well as a higher qualification that was reflective of a specialty, and that the qualification was rigourously assessed (Judith) was considered best. Similarly, Megan discussed credibility in terms of voluntary continuing education for all nurses. In her mind, a nurse was not credible if his/her knowledge was not updated:

> *I think it [continuing education] should be linked to registration because a lot of nurses will not undertake it, because they don't have to. And they just want to go to work, earn their money and come home. But you cannot be up to date if you're not up to date. I mean you've got basic nursing skills but the way of drugs, techniques and things change over the time, you really should be up to date.....the difficulty is actually classifying it. Whether you*

are actually reading a few journal articles like if you actually read your ANJ when you get it once a month or whether a lot of people just put it in the pile and that's about it! And you wonder how many people actually read it! It's substantiation of that. You can have a conversation and pick up bits of information from a colleague but one, is it correct? And two, did you hear them correctly? And like in a lot of the American magazines they do have CE points linked to registration of practice and you have a questionnaire that you fill out and send off. Just the act of these simple questionnaires, they take five minutes, but the fact that you have read it, done the questionnaire and sent it off, you get two phases of your learning to go into your brain and it might actually stay there [Megan 2].

Living with Hypocrisy and Being an Advancing Specialist

Hypocrisy in the work place was an emotive issue that impacted on the credibility of the advancing specialist and the profession. All of the participants prided themselves of being non-hypocritical and not wanting to work who they believed were deceptive about nursing practice. All wanted to maintain an ethical code of practice and that any management decisions that affected all nurses should be just. For example, 11 RNs were critical of an organisation or a hospital, while one RN was also critical of him for having adopted management practices in the past that he felt was hypocritical. For example, Andrew was critical of how insensitive and therefore, deceptive he was toward his clinical counterparts who were over-stretched, particularly when as a nurse manager, he reflected on how he made decisions about the staffing mix and their working hours:

And I was caught up in due process and on reflection, probably not very happy about the way I dealt with things..... Well, I joined a club of bean counting I guess, and number crunching, and I probably took it on with a bit of fervour and divorced myself from the clinical arena. So therefore, professionally, I probably did a bit of a disservice to nursing. I know it was something that I still believed in, but perhaps I went into a few things that were heartless [Andrew 1].

Furthermore, the RNs in this study felt that their judgement to take on a particular specialty or course was right for the profession and right for them. If for any reason that the organisation in which they worked did not agree with their decision, then it was the

hypocrisy of the responsible person or the organisation that was problematic, not them. For example, Diedre was scathing of her departmental senior manager's miscalculation about her advanced continuing education course in mental health in which she elected to enrol. It was deceiving that her line manager viewed mental health care was outside the realm of nursing and therefore out of the realm of her practice as a community nurse. Her manager questioned the need for her to undertake advanced studies in mental health. As a result, Diedre was offered no support by her manager such as partial funding to undertake the course or time off from work to attend a two-day teaching session:

> *Yes I did [enrol]. But they [Manager, Regional Health Authority] weren't sure that this course I was studying had much to do with my job (chuckles). And that's not funny. 'What's it got to do with nursing they said? So I persevered anyhow. I knew it had a lot to do with nursing [Diedre 1].*

In another example, Judith was aghast at the hypocrisy of some nurse colleagues who claimed to be professional perioperative nurses but failed to follow the standards of practice in the operating theatres:

> *...there's also things like they [perioperative nurses] don't even follow their own policy really, like counts. "You don't have to count that because it's not a big enough incision. You don't need to count that, you only need to count this, you only need to count that." I have a problem with counts. If something goes missing, how are you going to justify it? "Oh you only need to count 5 arteries, you don't need to count the other 15." But too bad if you need 8 or 10 arteries to come out [Judith 2].*

Living with Paradoxes as they Arise

Paradoxes arose when the RNs experienced inconsistencies in nurse practice or a conflict of interest while advancing. The many variations in nurses' attitudes that generated conflict impacted on how nurses, including the advanced specialist, should act or what nurses should value. This was particularly relevant in the hospital settings and felt to be too fluid to be easily reconciled. Nevertheless, some RNs described some of the inconsistencies they faced by revealing how nurses working in the clinical areas

often remained sceptical of any management decisions that had a direct impact on their clinical practice. These decisions included the employment of a credentialled nurse compared to a non-credentialled nurse, the need to be multiskilled as an advancing specialist, the discrepancy in pay compared to other professionals, and the implementation of a nursing research study that investigated current nursing practice:

> *So many people were against it. We have taken on 60% of the staff who can do 12-hour shifts and the remainder could continue with their other options. But we've gone from having not being able to get any staff to work in ICU to now we have a waiting list of over a year .....That is definitely a draw card .....there would be a lot of very very angry people if it's not brought in. Because they love them because you see the people that are against them, the short shift people say that they are too tired, they haven't really got the time. They're too tired to be working 12 hour shifts. How could they deliver safe and good quality patient care? But the 12 hour shift people say, but we are less tired, working a late/early you know, I'm not so exhausted. You know we get all these days off. We come to work, we are enthusiastic you know we are bright and we had a good rest and all the things that were identified, all the issues like late before days off, early after days off, three or four consecutive nights, late/early shift. They've all gone with 12-hour shifts! The people that work these shifts all these things that they have hated have disappeared now. So it's really interesting [Karen 2].*

Each RN was overwhelmingly supportive of multi-skilling in their practice. All believed that the skills they continually gained as a nurse and as an advancing specialist placed them in a better position to advance in a specialisation:

> *I have a background in child health and definitely in the community, and worked in family planning as a family nurse practitioner, I guess I have to say that I prefer women's health. And probably why I call myself a nurse specialist in women's health as well, because I can combine child health, women's general health, health promotion, as well as sexual and family health [Diedre 1].*

However, some perceived that the movement from general to specialist nursing would actually narrow their skills. In the oncology setting, Eric lived with the paradox associated with being multiskilled. Expanding his knowledge and skills in oncology nursing, men's health, as well as nurse management and research left him in a quandary as to how he was placed with his clinical colleagues on the ward:

...But again I think that the best core worker in that area [oncology] is the nurse. And I do believe that we need multiskilled nurses in this area. And I feel that my worst part of my skills, is I feel I'm too multiskilled and at the same time, it can come over as though he doesn't know what he's talking about because he's in too many areas. And in a way I understand this...I just think I feel it's something I'm interested in, and that's the opportunities that I had. It was more of a clinical nurse consultant role, you know, there was some counselling, there was some supporting, there was some patient care. There was some clinical teaching. So this whole mixed bag of stuff. And that's what I really like to do.....I do believe that we need multiskilled nurses in this area, [however]...I feel that is my worst part of my skills, is I feel I'm too multiskilled...[Eric 1].

Meanwhile, other RNs said that it was more employable being multi-skilled and that having experienced greater diversity and flexibility enhanced their confidence to pursue their goals. From Judith's perspective, perioperative nursing as a specialty included an extension rather than a narrowing of knowledge and skills. "It's a marvelous profession for diversity, I mean what other job can you get the diversity that you can in nursing" [Karen 1]. In addition they felt that they were more versatile and therefore more desirable if they sought employment as a specialist, especially in the rural areas. Even so, Gail felt doubtful in an earlier stage of her career about being a multiskilled specialist because the paradox remained:

It used to worry me back in the old days, the fact that I wasn't encapsulated in something. It did use to worry me. I thought I was too diffuse and whatever, but not any more. No, I'm really happy with that. That's probably something that's come out with all the education that I have done. That is I will pick what I want from each one and if I can't be put into a box, I can't be put into a box [Gail 1].

In another example of living with a paradox as it arises, Fiona identified the remuneration for nurses and the inequity between nurses' pay scales compared to other trades people or when nurses gained a promotion. The paradox was that while she was advancing as a master prepared critical care nurse working in the ED in regional W.A., the possibility of a promotion or remuneration to reflect her advanced practice would not be achieved:

...we have got an anomaly in that if someone goes to a level 3 position, they tend to take on a management role or clinical manager and they actually lose money because they go back to day time hours. And they could be getting paid less than what you know.....It doesn't seem to be going anywhere. They have tried. The health department is very resistant to pay out any more money because we do form such a large part of the wage you know the health budget. They have addressed it in terms of offering salary packaging across the board now that gives you some financial gain to those that need it, but it still doesn't address the bose-line issue that an electrician will get paid $30 an hour and a Registered Nurse will get paid $19. That to me is inequitable. And it's difficult to justify maintaining skill levels and committing yourself to lots of extra work [Fiona 2].

In summary having an ideal view enabled the RNs to illustrate any further phenomena surrounding ANS and education. Some were passionate about their area of specialisation, so much so, that they felt that their education and practice would be of benefit to the profession, the patient, and to themselves. As a result, they fantasised about the nature of ANS that in turn allowed them to visualise what they believed they would be doing in the near future as an advanced specialist. For them, this included the key issue surrounding ANS and education, however, it entailed that they must maintain credibility as a specialist and professional nurse. In so doing, their shared fantasies revealed the hypocrisy and many paradoxes between the ideal and the reality that they encountered.

Links to ANS and Education

The links that made it possible for the RNs to move toward advanced practice related to best practice initiatives, how each was able to implement health preventive measures, and the requirement for research to be undertaken relevant to their specialism. Furthermore, the manner in which the RNs established their long-term goals was a significant link that enabled them to move toward ANS and education. Having set personal goals was relevant to their chosen career pathway.

Best Practice as a Link to ANS and Education

Best practice in this study was described by the participants as those "delivering better care because you are questioning what you are doing and why you are doing it" (Andrew). The fostering of best practice initiatives included the motivation that a nurse exhibited to achieve higher standards of care, such as nurse credentialling, the undertaking of research that reflected the need for change to nursing interventions, the wide experience a nurse had as a community nurse, and when the advancing specialist questioned their's and other's practices. Megan, for example, believed the implementation of voluntary credentialling could be an effective method for the advancing specialist to validate their skills, and at the same time enable him or her to question their own and other's practices:

> *...they [nurses] practice and some people I think are questionable in their practice. But other people pick up the pieces or the slack and they've never committed a bad practice that they are questioned. But they too are not maintaining good practice. And I think credentialling will be a voluntary thing. So it won't pick up these people anyway because they won't voluntarily ask to be credentialled. But I think it will go ahead and I think it will be a tool to say "look, I am credentialled, this is how good I am." It will be some evidence to show you how good you are, when an paper...people look identical, but one's credentialled and one's not. You can actually say this is why I am so good [Megan 2].*

Health Prevention as a Link to ANS and Education

Issues raised in relation to health prevention and health promotion emerged from six RNs whose specialty focused on community nursing. I acknowledge that the participants in this study represented at least 12 different specialty areas of nurse practice, nevertheless it was coincidental that the remaining non-community advancing specialists in this study did not allude to health preventive practices. At least four RNs (Brenda, Diedre, Gail and Helen) highlighted the importance of health promotion as part of their every day practice:

I think where I come from with my nursing is a wellness aspect and a health promotion aspect. And that's one of things that Ricky Bay had in their ad was that it was geared toward promoting and supporting independence and the concept of wellness as opposed to a disease base. That's where I see complementary therapies as making a big difference [Gail 1].

I do feel sometimes that there's more management in this job than there is nursing. But what is community nursing? I've spent a good part of today stressing out over a word processor project, a stress article to put in the Minnitup Matters [pseudonym] because I feel stress is a very big issue in our community. And because I have got some really good information but its not displayed very well. I'm spending a lot of time actually doing it up really neatly and making it look good and I am planning to put in one every week [Helen 2].

Nursing Research as a Link to ANS and Education

ANS and education was unequivocally linked to the undertaking of nursing research and incorporated into nursing practice. As one RN indicated, "the research you conduct will in the long-term help nurses and help the patients in these areas. So that is really moving on into the future" [Karen 1]. All but two RNs found that the use of nursing research enabled them to synthesize their current nursing practice, specialist and research aspirations. For example, Olive indicated that there was a need for further exploration of issues relating to young girls in particular, who became anorexic, while Brenda felt that she needed to collaboratively research the learning difficulties of a population that suffered from a drug dependency. Andrew and Eric pursued research into men's health in the ED and oncology respectively.

Well only the current research that I've got at Swells [pseudonym], which is looking at aggression. The two areas are qualitative and quantitative. So looking at the quantity of aggression coming through the department and reasons why it might be developing. And the effect it will be having on the staff out there [Andrew 1].

Furthermore, because Eric and Olive felt passionate about research specific to their areas of specialty, they thought it was necessary to make changes to their practice:

I like change, as long as the change is for the better, but I think also with evidence based practice all of those sorts of things, you need to test theory in practice and you need to look at the best results and the best evidence for

your practice. And if you don't look at trialling and hypothesising I don't think you know you are going to find what's most appropriate as an intervention in different areas. I think you have got to try as long as it is not harmful to patients in the process...I think that nurses have a big place in research. I think that the liaison between academics, clinicians and administrators is important [Olive 2].

In another example, even though Fiona was not quite ready to tackle a research proposal at this stage of her master by coursework studies, she nevertheless identified a project that she had in mind. This was linked to critical care nursing in the ED:

Oh I've got one in mind. I'm going to do something with the telephone advice down here, telephone trials, and I want to do an evaluation or something on that, yeah...a mother who rings from a hundred kilometres away and says "I've got an asthmatic child, what can I do?" [Fiona 1] .....because at that stage the hospital had turned its focus onto allowing clinical nurses some non-clinical time to facilitate quality management projects, research. You know minor research activities and I thought I could do something with that [Fiona 2].

Carla however, had a quite different view about research in nursing. Carla was in her second semester of midwifery studies. She felt that she was struggling with the relevance of research, in particular, learning about qualitative research methods as a tool and sensed a division between midwifery practice and research that was reflective of her specialisation. Rather than a connection to research, she felt it was fragmented and not relevant to maternity care in the hospital. It was possible that the nature of her chosen program was not what she first envisaged:

I mean, I've done three years of research already, one unit per year as an undergraduate. And a lot of that was covered there. And you actually do use problem solving. It just doesn't seem the same.....Hmm, helping someone whose got a problem with breast feeding, while it's useful to know the ins and outs, the alternatives, the new research on breast feeding, I can't see how learning about qualitative research helps you help that woman [Carla 1].

Long-Term Goals and Links to ANS and Education

Setting long-term goals was important because each RN was able to anticipate the outcomes of their research interests or educational pursuits as they moved toward ANS

and education. As one RN told me about being a generalist nurse compared to an advanced specialist caring for patients, "...their physical needs were the needs met and for me, that wasn't enough. I needed to expand my care. I needed to expand in the way that I needed to provide for more of a holistic approach" [Olive 1]. Knowing this and identifying their projections, the RNs alluded to the gains they made in their chosen career pathway. At the same time, all but one RN identified their area of specialisation as a career pathway for them. Moreover, the majority of RNs were partisan to research in nursing. The undertaking of a research project was an integral part of their goal. They had either found their niche or were able to visualise fruition of their identified clinical research problems, provided they had the collaborative support from other research experts:

> *...one thing made me think about research, you know, was why are we doing this. And the other thing was my alternate goal, where I want to go in nursing, is I really want to be a Clinical Nurse Specialist or Consultant, whatever you call it in ICU. And the criteria for that is a masters [Linda 1].*

In summary, the establishment of long-term goals enabled the RNs to reflect on their progress. Even so, not all experiences of advancement for them were predictable. However, being mindful of where their studies in advanced practice would lead them, offered those RNs who had set long-term goals, a sense of personal harmony.

Reflecting, Rationalising, Balancing and Negotiating Options

The RNs reflected on experiences that empowered them to continually rationalise, and negotiate their studies, work, and careers in order to balance their lifestyles. They sought the options available in order to specialise and make a decision to continue to pursue ANS and education. Carla however, withdrew from her studies because the balancing of her lifestyle became too difficult. She rationalised that her course fees to undertake her university midwifery program was burdensome for her and her partner. They were planning on getting married soon. Even though she acquired a small

scholarship to assist her in her studies, it only provided a quarter of the total amount payable.

Other RNs shared common experiences. The main concerns the RNs had when rationalising and balancing career options related to family matters. These included; a) division of family responsibilities; b) exclusion of recreational interests; c) management of finances to pay for a course; d) minimisation of shift work to undertake studies; e) the need to stop night duty; f) deferment of studies when changing jobs; and, g) balancing time taken to travel to classes, work or clinical sessions. The latter was because of the required attendance at clinical practicums or seminars, and was particularly true for the rural counterpart because of the greater distances travelled. This often necessitated accommodation arrangements and separation from family, as well as the appointment of a relief nurse to continue expected work commitments.

All but one RN chose to study part time as opposed to full time so that family responsibilities were manageable. Olive was the one exception. She studied full time and worked agency shifts as and when she required additional money, supplementing her income with an 'Austudy' allowance. However, Olive told me that she had no financial overheads and had already paid a substantial amount toward her mortgage. Therefore, she felt financially secure before deciding to embark onto postgraduate studies. Furthermore, she felt better able to study full time compared to other advancing specialists she knew of because she did not have the added responsibility for the care of children. In short, the biggest obstacle for a number of RNs was the constancy of having to prioritise and negotiate study over child rearing, family activities, as well as the pursuit of personal interests and activities for those who did not have any children.

Four RNs who were undertaking master studies as an advancing specialist had one or more preschool child or children of primary school age. Brenda told me how she was

financially well healed, nevertheless, as a consultant working from her home, she cared for her three teenage children who were in need of her continual supervision owing to their specialist care needs. As her husband said to her, "well, you know, you have always been interested in that sort of thing, and as long as you do it part time and it doesn't interfere with the children" [Brenda 1]. Diedre on the other hand, continued to rationalise her travel between home and workplace because of the hundreds of kilometres she would otherwise have to travel on a daily basis:

> *No I don't [drive home each night]. I come up (from Angel to Bussel) Monday and go home on Thursday. It's too far and over 100 kilometers and it's the wrong time of the day. It (travel) just adds two hours to my day! .....I needed to keep some time for my extra commitment, that was negotiated too!.....I would have mentioned it in my letter of application. And so in the interview it came up, so I was able to negotiate that. And the position wasn't exactly full time. In fact it was negotiable as well. I don't think I would have applied for it if I wasn't aware that I could discuss these options with my employer [Diedre 2].*

At the same time when balaneing family matters, each RN rationalised not only what course best suited them, but were also prepared to negotiate with their employer, their work options. Ten of the RNs either applied or thought of applying for assistanee from their employer to undertake advanced practice and study. "Well really there's plenty of money out there if you are prepared to you know, just apply and forward your CV" [Karen 1]. In addition, they were prepared to negotiate a position and salary that they believed they were able to fulfil:

> *The clinical nurse position. Normally when you get promoted you start off with the lower increment so I have gone to the boss and said, "well what are you going to pay me then?" And she said, "well what do you mean?" And I said, "well you know, you could pay me 1, 2,3 or 4." And she said, "well I would normally pay you one." But I'm saying, "yeah well I'm open to negotiation." So I wrote out a few pages of why I thought I should be paid a little higher. And I dropped it in so I am waiting for a reply [Andrew 2].*

As another example, Helen negotiated employment and funding for a relief nurse because she wished to take time to attend four study days:

A typical example is that I've got field assessment study days coming up in November over at Y country hospital and it's for four days. And we are looking at getting relief. Well to get a relief at a nursing post is probably four hundred dollars a day if you are looking at relievers coming in. And you have still got to take on board their travel time and where they are coming from and how many days you can actually afford on my budget. Now my budget was $700 in surplus and we could afford to have someone for virtually two days or one and a half days because it was about half a day on a Friday [Helen 1].

In summary, the movement toward ANS and education meant that the RNs rationalised and balanced their family concerns as well as their work and study options. They were able to rationalise why other nursing staff that they worked with, were under duress; perhaps because of the excessive work-load or loss of life on the oncology ward for example. Furthermore, they were motivated to view their work positively and were keen to undertake further study and research.

Succeeding and Moving Toward ANS and Education

Succeeding in ANS and education provided both tangible and non-tangible gains. For example, seven RNs thought that a non-tangible gain included being successful owing to their enhanced theoretical knowledge. On the other hand, six RNs thought that a tangible gain included the offer of a promotion.

In the main, the non-tangible conceptualisation of 'succeeding' and what these RNs perceived as success were the most occurring events. For example, four RNs' perceived that success included being challenged and empowered by the additional responsibilities that being an advancing specialist afforded them. Furthermore seven RNs succeeded because they negotiated employer support for undertaking additional studies. Similarly, Eric felt "nourished" as an advancing specialist, and both Andrew and Eric felt that they had succeeded because they achieved their progressive educational goals to integrate men's health issues into their respective specialty areas.

Other non-tangible evidence of success was revealed when eight RNs talked about communicating at the same level as their lecturers or managers or when five participants were invited to participate as an executive member of their special interest group. Succeeding also entailed the undertaking of research in their area of interest or when seven RNs told about doing research that was specific to the profession and community. Eric also felt success when he was able to work in a multicultural environment. This ensured that his language skills could be utilised.

Nursing work away from the constraints of a medical model of care and/or maintaining a wellness aspect to their care proved to be successful and rewarding for six of the RNs. Brenda, Eric and Karen felt that they succeeded when they effected change in management styles or improved working relationships with medical practitioners. More importantly, being acknowledged and thanked by other staff in their department for effecting change that staff were initially resistant to but now embraced was encapsulated as success by Andrew, Eric and Karen. Success was about being able to gain the trust of community members in the rural areas as well as the acute setting, being confident with the use of technology in the ICU, or confident with the need for data storage and communication purposes while working in the regional and community nurse settings:

> *As I started off, I get a lot of personal satisfaction out of achieving and passing at the end of the day...I enjoy the achievement factor and one day I guess I would like to have a Masters, and...a PhD. That would be a wonderful thing to have. Why nurses don't go off and do it?.....But I am a believer in gaining knowledge, and I enjoy the achievement factor; the success, the successful feeling of passing I guess and achieving.....I see my lecturers a lot more differently.....and I feel there is much more of a wellness on a level plane. It's more than lecturer/student, it could even be like father/son, or mentor [Andrew 1].*

> *...the most satisfying thing is to meet someone at the door that is critically ill, to be able to stabilise them with my own efforts before the doctor arrives. To be able to support the family in that process as well and then to send them off to the ward knowing that I have done everything I possibly could to*

help them along their way. Now, that doesn't always happen, but certainly, that to me is the best thing. You know the baby that's got a chest infection and mum's beside herself. You know to that level, you know that they will be fine, and that's good. And that's why I stay nursing because of its interest [Fiona 1].

Yeah, I feel working in intensive care, I'm a lot more confident. I feel I know what I am doing, which I could manage before. I could look after a patient very well, but now that greater understanding there is a bit to be able to communicate intelligently with the medical staff and far more teaching of medical staff and junior staff. Everything just seemed to fall into place, my understanding of what was going on, how drugs worked. I gained an awful lot really.....it's just that when the consultants ask and the registrars ask about the effects of drugs and you are answering it and the registrar doesn't know the answer. I mean it's very good...the way they look at you, with respect, it's very satisfying inside as well [Koren 1].

Being Rejected, Gaining Rewards and Limitation of Rewards

To illustrate the textural understanding of success, three further codes emerged, that is, 'being rejected' and being offered a 'reward', or conversely the 'limited rewards' gained as an advancing specialist. Rejection was identified when a RN for example, was unable to negotiate her work-load and specialist experience with management to undertake extra visits to other departments of the hospital. As a part of her educational experience as a perioperative nurse, Judith felt rejected when she negotiated to seek additional competencies relevant to her specialism without success:

In day surgery I actually asked to spend a day doing day surgery once a fortnight to just keep up my scope work for endoscopies and colonoscopies and got shot down because they needed the theatre nurses upstairs because they are very short. I don't understand that... [Judith 2].

Four RNs felt rejected when their application for interview or promotion was not approved by an employer or when they were refused a CN position even though they had more than fulfilled the job description compared to other CNs they worked with in their setting or department. Feelings of rejection were also evident when the RN experienced conflict with senior management or when Eric, Judith and Megan

witnessed and attempted to deal with poor staff communication. Furthermore, when senior management required them to implement specialist skills to meet service needs before they had actually graduated from their course, two RNs felt used and rejected because it was not recognised or rewarded in an additional payment. Less tangible feelings of rejection was felt when five RNs reported that their nursing colleagues were disinterested in them for specialising. Furthermore, when other nursing staff were disinterested in attending conferences, were not professionally oriented, or failed to provide them with their personal support and encouragement, they felt rejected. In all, their colleagues did not outwardly acknowledge their struggles or progress toward ANS.

In terms of rewards for undertaking ANS and education, these were few. Other than when Karen obtained funding to attend a conference, the benefits the RNs gained were limited to non-tangible rewards. For example, Gail felt rewarded when she gained additional secretarial support to compile her community nurse documentation. Fiona felt rewarded when she was able to find work easily because of completion of her emergency nursing course, and Megan felt somewhat rewarded when management of another hospital approached her because she had the perioperative expertise that the hospital desired. Other non-tangible rewards resulted when Karen obtained a research secondment within her hospital while advancing in her master studies. This added to Karen's enjoyment of nurse specialisation that she felt offered enormous diversity within nursing practice that no other job could offer.

The limitation of rewards remained an issue with the RNs in this study because at least two participants believed that nursing in general was a demanding job with little prestige. More significantly, any tangible rewards such as elevation of their salary for the extra studies and work undertaken, was not forthcoming for Andrew and Fiona. Moreover, three RNs in this study felt that they were spending significant amounts of

money to undertake study for little reward. There was a need to "give up everything" (Carla) to work and pay for advanced nursing study, and "you are never rewarded for all the overtime a nurse does, just promises that you can get off early another day" (Carla).

At least five RNs however, identified the burden of cost to nurses in general if they undertook ANS and education, but made little mention of the extra financial burden to them. These RNs either took the opportunity to seek scholarship funding or chose a course that was competitively more affordable for them. Three others meanwhile, negotiated employer support such as leave with pay while Fiona negotiated paid travel and accommodation expenses related to her ANS and education. These initiatives assisted them financially to undertake advanced studies specific to their area of specialism, offering them some reward, be that it was limited.

One RN thought that gaining a master in nursing was the most that could be expected of an advanced clinical specialist because it would give a nurse the authorisation to negotiate a work place agreement. However, based on the cyclical high demand for nurses by hospitals, both Andrew and Fiona questioned the reality of having a clinical master degree even though the profession desired the master prepared specialist nurse. Fiona in particular felt ambivalent about the need for a clinical master degree in critical care because there was no incentive or reward. There was little support or encouragement from her work colleagues in the rural area. Even her Director of Nursing of the hospital was unaware and did not acknowledge that she was undertaking external studies in advanced practice. Furthermore, she was undertaking studies in her own time while working full time, caring for her family and actively contributing to her special interest groups such as the Australian Nursing Federation (ANF) and the Australian College of Critical Care Nurses (ACCCN).

Fiona was also critical of a Perth teaching hospital in which she undertook a 12-month contract to complete the hospital's critical care course before continuing with her master studies. She was required to accept a lower rate of pay for the duration of the course. Notwithstanding the above issues, she was also convinced that there would be no promotion to a Level 2 position available for her in the country, once she had completed her master of critical care nursing in the ED:

> *So the issues of living weren't too bad but I did feel quite resentful about that because you know the requirements before you could be accepted were a minimum of a Level 1/5 or 1/6. And I know it was a trade off to go back, you know, that all that study would be done as a 1/3 level. But we are part of the calculated FTE and in my course particularly, there were several people who worked in the intensive care unit of the hospital concerned and there were other people that had been nursing for (a long time). I was probably the oldest that had been nursing far some time, but certainly there were well-qualified people that if you know, who would deserve clinical positions if they had come up. So their expertise was being obtained very cheaply. And I find that that's another frustrating thing about postgraduate education and that it's probably another little one of my soap boxes is that there is no incentive for people to do the extra work. You don't get monetary benefit.....I'm ambivalent, but I don't know whether masters level clinical nursing at masters level is ever going to take off in a big way...but there is no incentive at all to do higher education especially like people in my situation where I am, for want of a better word, stuck in the rural arena for quite some time. Our positions for promotion are limited by percentage basis, you know, numbers of clinical nurses to number of RNs. Once they're filled, that's it. So I will be a masters qualified level 1 RN if a clinical nurse job doesn't come up in my field. And that needs to be addressed I think.....It is hard work, let me tell you, it's bloody hard work to try and study here without much support, without much encouragement. You know, people say "oh look, you are doing your masters!" And the first question is "why?" And their second question is, "well you know, what are you going to do with it at the end?" But there's nothing from the other end saying "well, if you get your masters, you could look into these jobs", there's nothing like that [Fiona 1].*

In summary, succeeding as an advancing specialist came with its rewards, limited or otherwise. The rewards however, were non-tangible in the main, but nevertheless, personally satisfying. The tangible rewards of success while advancing were considered to be difficult to realise.

Exercising Tolerance While Moving Toward ANS and Education

RN experiences that were contradictory in nature were ubiquitous. Similar to other health care professionals, the RNs in this study lived with contradictions every day of their parental, working, studious and recreational lives. Nevertheless, the noematic descriptions of the RNs' experiences were significant to them because they impacted on their advancement. For instance, three RNs felt that they needed to exercise tolerance toward their employment as an advancing specialist at the lowest level (Level 1) of nursing practice because it was simply a means to an end to becoming an advanced specialist. They could not always expect a higher incremental level of employment. At the same time, other RNs felt that they needed to be tolerant of the alterations and changes in the workplace that were related to the nurse's career structure and subsequent levels of employment. In their wait, they welcomed the recognition by the profession at last, of clinical practice compared to education or management positions for nurses. As a result, the RNs had shown tolerance because they had waited for the opportunity to take a higher level as a specialist RN when the opportunity prevailed.

Furthermore, the RNs believed it was necessary for them to be aware and tolerant of the changes taking place in relation to the widespread demand for advanced specialists. From the RNs' perspective, these included the demand for midwives and emergency nurses, expertise required by RNs in business management, the need for a focus on gender health issues such as men's health, and the necessity for evidence based practice, particularly in the critical care setting. They believed their awareness of current demands for expertise would ensure the most appropriate course of study for them was undertaken. The RNs continually re-examined the relevance of what they were doing and at the same time were mindful of the downsizing of the nursing

workforce owing to the increasing health budget. As a result they were understanding and showed tolerance of management decisions made by executive nurses, and able to consider the balance of funding issues relating to nursing staff undertaking continuing education courses or ANS and education.

Three RNs also exercised tolerance toward nurses who did not wish to embrace change. After all, "there are leaders and followers" [Eric 1] in nursing. Each RN in this study aspired to being a leader in nursing. Their aspiration as a leader required them to show tolerance toward other colleagues during their movement toward ANS and education. They were cognisant of the fact that for a variety of reasons, not all nurses wanted to advance in an area of specialisation like them.

Further specific examples of many other contradictions the RNs faced revealed their degree of tolerance. Being tolerant of other nurses who labelled indigenous people as too difficult or problematic to care for called for additional tolerance because it was contradictory in terms of nursing care that was supposedly holistic and culturally sensitive. In this example, Brenda's tolerance prevailed because other nurses had a limited understanding of indigenous people:

> *How does the nurse who doesn't understand ADD understand the difficulties that mother has in going and buying the groceries, getting them home, getting the meat and the vegetables, coordinating them at the same time, getting the children to the table because at the end of the day, those children's nutrition is going to be enhanced or it's going to be destroyed. So a nurse is trying to get good nutrition and the mother's more than likely to say here's 20 dollars, go and get some KFC, but if the nurse understands the difficulties in the organisation and the timing and everything, she can spend some time [Brenda 2].*

From the rural and remote area specialist perspective, the RNs were tolerant of other health care professional issues while working in a multidisciplinary setting. On the one hand, Diedre was intolerant of the medical doctor who made little effort to contribute to the decision making of a multidisciplinary health care team. On the other

hand, she exercised tolerance toward rural doctors who gave little of their time to attend multidisciplinary meetings because as private practitioners, they were busy health care professionals and were not paid for their time. Similarly, Helen was intolerant of community people who paid little or nothing in a fee for her services. However, she was welcoming and tolerant of members of her rural community when they used her home to take a shower or borrow some clothes because people believed that the rural/remote area nurse should have an open house and surgery:

> *...it was an MVA, and he came in at night. He showered in my shower which is very typical...And I gave him a pair of my husband's socks to put on because one of them had disappeared. He somehow lost his shoe on the way. No he put his sock around one of the bloke's arm or something, to stop the bleeding or something, so he got a pair of my husband's socks which I got back three months later I think. And I don't know if it's via the community or something else, but this is sort of the very colloquialism type of things that go on. And my house is often used for breast-feeding. You know I'm a breast-feeding clinic anyway and as an ante-natal clinic. I often do that in my room, you know we usually do that when the doctor's here because I've got time out [Helen I].*

Furthermore, as a community nurse working in the metropolitan area, Gail was tolerant of the volunteer disability 'carers' who worked along side her non-professional health carers. She treated them as colleagues. However, she was intolerant of the attitude of nurse colleagues who dismissed them as being unprofessional. The carers required much support from her as the professional health carer, and she was appreciative of volunteers because they readily cared for people who suffered significant disabilities. In addition, Gail supported the cultural shift from nursing work in the hospital setting to her work with volunteer work as a specialist in the community. These circumstances identified Gail's and Helen's acceptance and tolerance of other helpers who were not always familiar with work in a professional environment.

Exercising tolerance toward the beginner learner in a specialist area of nursing practice was also a contentious issue amongst 10 of the RNs in this study. For example,

Megan suggested that many staff working in the operating theatres were unable to accurately predict the rate at which a nurse learned while working in the operating rooms. Some RNs in this and other areas of specialisation were intolerant of beginners who did not learn specialist skills quickly. As an advancing specialist herself, Megan was mindful of dealing with the many strong and conflicting personalities within her specialism. She exercised tolerance toward the new perioperative nurse because she had a greater awareness of the global issues such as educational advancement that included an understanding of health care policy and change management. As a result, an advancing specialist was able to see the bigger picture and be motivated to implement new learning strategies that enhanced perioperative nurse advancement.

Similarly, Olive exercised tolerance over the uptake of her student role as a registered nurse, and postgraduate nursing student working in the mental health care setting. She believed that a degree of tolerance was required to deal with any conflict that arose in the work place, such as the attitude of some staff that was ambivalent toward students like her. Exercising this tolerance, pursuing staff who provided her with the learning that she felt that she needed, and being pro-active by dealing with personality conflicts that arose between staff members and her in the work place, was necessary. Doing so enabled her to negotiate learning opportunities with staff in her new learning environment:

> *As a student to me it was a little bit strange initially because I felt that I was back in a role that was unfamiliar to me or that a role that I hadn't been in for so many years. Working as a student was, I wasn't sure how I should perform that role, how much I should do. Whether I should sort of push into the registered nurse role because I am a registered nurse but I wasn't a registered mental health nurse. So I just tried to take any opportunity I could to do what I could without being too pushy [Olive 1].*

Tolerating Contradictions and Making Changes

Almost all of the participants not only exercised tolerance, but also realised that being involved in change in the work place was mutually beneficial. They were supportive of change even though they and their senior nursing staff experienced daily contradictions in the workplace. To get ahead in critical care nursing for example, Linda and Karen needed to embrace change. Furthermore, Olive believed that change in mental health practices from a custodial framework to a primary care approach was appropriate and the pursuit of evidence based practice in the specialism supported the need for change.

One RN considered his role was being a "change agent" [Eric] who took additional personal risks to actually effect change that was considered unnecessary by many of his working colleagues. For example, Eric questioned his line management of inadequate communication to staff on the ward and the perceived collusion by some senior ward staff members with the oncologist about patient treatments. This practice was to the detriment of all staff in being able to share information about the multidisciplinary care of the patient who had cancer.

To take this a step further, Eric indicated that he too had changed as a result of his advancing practice. During his second interview, he was able to reflect on how he had changed since his first interview. He recalled the state of flux he was in at the time of his first conversation and how disjointed he felt working in his new appointment as a clinical nurse specialist. The changes over the ensuing six months as a specialist had resulted in the diminishing of his clinical role. He was satisfied that the multidisciplinary sharing of information had improved since he instigated change to the patterns of communication between nurses and doctors on the oncology ward. He was

subsequently able to focus on nursing research in oncology as well as the nurturing of staff in the oncology department:

> *And I feel that that role is slowly being eroded, the one of the safe, care and nourish role. Not only the patient, but the care givers are my other concern in my particular role. It is the impact of all this stress on the employees...and in the week there have been two or three very traumatic deaths. There are two other imminent deaths on the ward. Now the sickness rate (of nurses) has risen again. There is a lot more bitchiness on the ward. There are some angers that are being thrown round by some staff blaming others for the way they have been practicing. The staff has been working two or three hours longer that they normally should do, and they are not going to get paid for it. So all in all, the stressors are on. We are no longer thriving in this environment. It's like trying to survive, and I feel, that fluctuation is a direct result of health care is unable to cope with sickness around them, and I really want to kind of promote more of this well being. Being able to help yourself before you can help others [Eric 1].*

Interestingly, all but one RN in Part A of this study expressed a desire to improve the channels of communication between all health care professionals within their specialties.

The need to change their course of study midway through their specialty studies was identified as another significant factor that related to the phenomenon of interest. Undertaking a specialist program in nursing had given some RNs heightened awareness of where they were heading and therefore, re-examine the direction they had taken, and therefore, make changes. Two RNs, namely Andrew and Fiona, decided that a change of course of study such as business management or emergency nursing as opposed to critical care nursing was possible for them. Similarly, Gail identified that taking a different direction in her nursing from a pure community nursing perspective to including complementary health studies was an appropriate change to make. For 12 RNs, the change they made in including studies that had an increased focus on management issues such as health service management and strategic planning as opposed to undertaking a purely clinical role was enlightening. This added to their goals and ideals of ANS and education. Brenda was the one exception. Her

conversations focused on her collaborative research project and not on any studies that included health management issues. Brenda's goal was to keep focus on her research.

Six RNs (Andrew, Carla, Diedre, Eric, Fiona and Gail) supported agreed changes to departmental policies. For example, a change of procedure manuals away from the list of nursing tasks to a compilation of principles such as occupational health and safety or environmental factors was a change for the better. Change that embraced the review of departmental strategies and policies, as well as discussion of issues that would improve interdisciplinary health care practices such as workplace priorities and effective people skills, were supported by the participants even when not by other nurses working in the same specialty:

> *But people don't see that and they don't like change. They don't realise the benefits of change and I just can't understand. I really can't .....Oh it's just a movement forward, I mean people don't undertake change unless they are going to benefit from it...So there are tremendous benefits and I think that you have got to keep an open mind about change and not, 'this is the trouble with 12 hour shifts,' You know older staff are going, 'oh too bigger change.' They can't see that it's got enormous potential, it's got enormous benefits, and I think that again it comes down to tunnel vision I think [Karen 2].*

> *Changing patterns. I think it is a challenge for health professionals to embrace change but I think with increasing knowledge and increasing evidence based practice it would be good to embrace some of the new strategies and therapies that are being seen to be effective in treating people. So I think that's important. I think that in X Hospital with one of the areas that I worked in they were looking more at primary care and moving away from the custodial care in one of the wards. And I thought that was good [Olive 2].*

Conclusion

In conclusion, the core theme of moving toward ANS and education described a phenomenon that was socially textural. The participant RNs who shared their lived experiences, revealed insights that identified many external and internal competing forces, the latter being encountered on a regular basis.

Ideally, each participant would have liked to focus on being credible as an advanced specialist practitioner, even though they had to do this while living with hypocrisy and paradoxes that made them feel a greater awareness of the struggles that they had to endure while advancing. Overall, ANS and education was viewed as a form of best practice whereby the RNs set long term goals in order to achieve advanced status. As advancing specialists, they reflected, rationalised, balanced and negotiated their work and learning options, maintained the will to succeed even though they often felt rejected by peers, and gained limited rewards that were mostly intangible in benefit. Ultimately, these RNs exercised tolerance about the many contradictions that they faced while advancing. They embraced change in the work place, particularly if change improved the communication patterns and sharing of knowledge between all health carers.

CHAPTER FIVE

Sub-Thematic Findings: The Way Through the Labyrinth

Freedom of Choice, Experiential Knowing and Maintaining Interdependence

Introduction

This chapter outlines three of the five sub-themes that emerged from Part A of this study. Collectively, the five sub-themes describe the subject of ANS and education; the way that the RNs structurally advance as specialists. This is metaphorically described as 'the way through the labyrinth of ANS and education'. The three sub-themes discussed in this chapter reveal how the RNs in this study continue to advance in their specialisation, ascertaining their *freedom of choice* when undertaking advanced practice, their way of *knowing through experiential learning*, and the way that they *maintain interdependence* while advancing. The sub-themes illustrate the contextual nature of ANS and education, adding structural meaning and understanding to the textural (object) interpretation of ANS and education described earlier in Chapter Four.

Freedom to Choose ANS and Education

How the RNs exercised the freedom of choice in undertaking a course of study was varied in context. Whilst all the RNs in Part A of this study made a conscious decision to practice and study in an area of specialism that reflected their identified expertise and interests, their choices were sometimes limited. On the one hand, Diedre, Fiona and Helen chose to study and work based on their geographical location. This was because of the inordinate distances required to travel to attend an on-campus course. On the other hand, three RNs preferred to undertake a short course, no more that an academic semester in length, in order to add to their skills as specialists. Helen for example, did not necessarily want to do a course by distance learning. She preferred

the face-to-face learning style and therefore, sought a short course that offered such a medium rather than a distance education package that was generally longer in duration. Similarly, Fiona preferred the on-campus style of learning but conceded that a distance package was workable considering the distances she would need to travel, that was over 800 km to Perth and return. Conversely, Linda chose a distance learning package because she was able to schedule her own work and study program from the convenience of her home, and at the same time, study at a time that suited her.

Secondly, six RNs classified the professional or global recognition of a university based course as important to them because they were likely to be universally acknowledged and therefore, in a better position to seek professional employment overseas in their area of specialisation. However, even though Carla chose to enrol in a university-based course in midwifery based on the same premise, she felt "battered" by her colleagues. Her colleagues indicated that she should enrol in a hospital-based midwifery program even though the only Perth hospital running a midwifery program was taking its last intake of students. Unconvinced, Carla enrolled into a university midwifery course to commence studies in 2000. She believed that she was better off professionally if she did a university course, but at the same time, relieved that she could retort to her colleagues that she no longer had a choice but to enrol in a university based program.

Andrew thought that providing nurses with the choice to undertake higher education was because the profession wished all health care workers including nurses like him, to "gain more knowledge and be up to date". Furthermore, Carla felt that she also "needed to have a degree in business and economics, as well as clinical knowledge" because of the requirement to not only manage patients, but to manage staff within a health care system or hospital that was a corporate business. Karen also viewed that the introduction of management skills in addition to clinical advancement

within the program for ANS was advantageous for her. There were wider choices in course content that included management and communication theory relevant to Karen's critical care nursing course. Furthermore, Karen felt that because there was such a diversity of nursing specialty courses altogether, she had many choices open to her as an advancing specialist nurse.

Similarly, Megan chose a health related undergraduate course rather than a generic nursing course. She decided against undertaking a nursing degree because she felt that the partial "Americanisation" of the content in the nursing undergraduate conversion degree was not for her. Parts of the course content, particularly that relating to nurse theorists, failed to equate to Australian clinical nursing practice. Instead, Megan chose to study a non-nursing degree in health promotion while working as a perioperative nurse. Her horizons and choice of employment relevant to surgical knowledge that she accumulated over the years, together with a degree, would enhance her choices and therefore, scope of work in the immediate future. In addition, she had "the choice to quit and the confidence to go elsewhere" because her expertise made her readily employable. Megan also indicated that choosing an advanced specialist course rather than remaining a generalist nurse, was preferable to staying in mainstream nursing. This was despite the fact that a nurses' specialist knowledge and experience were narrowed by doing so:

> *And I see that that's the way it should go to encourage more nurses to actually remain in nursing. I think you sub-specialise and whether you sub-specialise even further is debatable if it's too narrow or whatever. But it's like when you start going into your nurse practitioners or advanced practice nurses now they're even becoming more specialised, more specific and to me that's the way it should be...[Megan 2].*

Thirdly, three RNs (Fiona, Judith & Olive) chose to enrol in the same university in which they had undertaken previous undergraduate nursing studies. Having known

the academic staff, that the institution was viable, and that the university was situated in their home state was beneficial to them. For example, Judith sought distance education perioperative courses from universities on the Eastern seaboard of Australia such as Deakin and Queensland universities, but was pleased when she discovered that the university she graduated from in Perth had a new postgraduate perioperative course available. She dispensed with her earlier options and enrolled in the latter to undertake her postgraduate diploma course relevant to ANS and education. Judith perceived a greater freedom of choice, provided the choice of university offered an advanced perioperative program.

Fourthly, the choice of nurse program for Diedre and Linda was associated with the affordability of a course. Linda chose to take a HECS (Higher Education Contribution Scheme) funded course as opposed to an up front fee-paying course because it was "cheaper". Linda made this choice because she was not required to pay a large sum at the start of her course. She had previously experienced the hardship of paying up front fees when she undertook her advanced diploma in critical care nursing in Canberra. Meanwhile, Diedre was pleased to find a course that suited her needs. However, as a community rural nurse, Diedre was taken by surprise but at the same time delighted when she discovered that the fees for her course would be fully funded by the Health Department of W.A. In contrast, the remaining participants did not allude to the cost of their course(s) as an overarching factor that compromised their choice to undertake ANS and education. They were aware of the cost of self-education and the added value to them as specialists.

The choice of ANS and education was also the result of an indirect cost benefit analysis. Three participants felt that the costs were significant. For example Diedre had to secure leave to do a course, Carla had to reduce shifts so that she could study and at the same time earn an income, while Fiona had to cease shift work all together. When

Fiona was enrolled in her hospital-based critical care course, she was required her to work and study full time. The undertaking of this course resulted in Fiona being separated from her husband and children for 12 months because she had to work in a city hospital. She was also required to make additional payment for accommodation in the hospital in which she worked. This was a considerable sacrifice, which she made because the postgraduate diploma course that she had recently completed now articulated with a critical care master program that was offered by distance learning. This suited her because she lived and worked in a rural town of W.A. Furthermore, Fiona could now choose to undertake her master studies in critical care nursing as a part time student.

Karen, like Fiona, also regretted having to make the choice to work and study full time to undertake a postgraduate diploma course in critical care. Both felt guilty for choosing advanced studies to the detriment of continued rearing of their children. By the time they had completed their diploma studies and advanced onto their master studies however, both felt compelled to continue studies part time and work full time because they felt a strong commitment to ANS. Both were now progressing part time in their master studies. Therefore, at this stage of their master degree, they felt a greater freedom to choose when and how they advanced.

Brenda had the freedom to choose a master by research rather than upgrade her study to a Ph.D. She was adamant that the purpose of her master by research studies was to gain an understanding of the research outcomes in terms of the participants involved, and not as a means to gaining a higher award. Conversely Carla felt little freedom of choice in her program because students in the only course available locally to her, were required to pass a research unit before advancement into the practical components of their midwifery program. Carla cared little for the research component of her course but looked forward to the practice components on successful completion

of the research unit. It was more an obstacle because if she failed in the research unit, her progress would be delayed. Furthermore, she would be place in an untenable position because she would have to pay the same amount again to repeat the unit.

Finally, Linda was offered a choice of activity by her employer because she was undertaking master studies in critical care. Rather than attend the usual monthly study day for staff in her department, Linda was given a choice of activity such as data collecting or an activity that would facilitate her studies toward her master thesis. The freedom to choose an activity that better suited her studies was beneficial. The indirect result was that she felt that she gained personal support from her employer.

Reasoning as a Way of Choosing

Within the tensions often felt by the RNs who chose a course of study or work or both, the participants reasoned why they chose a particular course. Their inclination toward *reasoning* illustrates the ways that the RNs justified the choices that they made in pursuing ANS and education. These choices were aligned to what they perceived as being the current role of the nurse, the enjoyment of being a specialist, and conversely the difficulties of being an advancing specialist.

The role of the nurse. Seven RNs believed that if the profession did not expand the role of the nurse into the nurse practitioner role for example, then the advanced specialist nurse would continue to practice within a medical model rather than within a preventive health model of care. For example, as a nurse working in the ED, and with a keen interest in researching men's health issues, Andrew was concerned that the management of men's issues would not be suited to the current model of health care. This was because men often did not seek health care until the onset of disease had occurred. Andrew felt that he could expand on his knowledge of the patient's health, illness and disease processes because he could provide a greater educational role by

relinquishing his purely clinical focus as a clinical specialist in the ED. Andrew reasoned that took every opportunity to assess the male patient in the ED for lifestyle behaviours, thereby informing the patient of appropriate preventive strategies.

Eric and Diedre shared similar sentiments. Both focused on their role in the preventive health of men and families and women and families respectively. Eric felt that he had matured since our first interview and saw opportunities opening for him and to position himself better as a specialist in men's health and cancer care. He was setting himself up to move laterally to his preferred educational role as a specialist men's health practitioner. In so doing, he reasoned how he could create a therapeutic framework for men who suffered from cancer by being a more effective listener for example. Similarly, Diedre delivered a service to women in the rural south of W.A. Being a mature female, qualified in women's health, Diedre provided women an alternative practitioner to consult with other than the traditional male doctor. She felt that the doctor in whose practice she worked, had a vested interest in working with a community nurse consultant like herself because the doctor's patients preferred to consult her on matters relating to women's health such as child health. In her role, she functioned interdependently as a consultant, therefore, the joint practice agreement with the doctor was opportune for Diedre. However, her role as a nurse was compromised because her practice was dependent on the establishment of a medical doctor's practice that permitted a practice based on the current medicare rebate system.

In addition, Brenda and Gail reasoned why nurses in general could and should embrace a greater preventive health role. In their role as specialists working in the community, they needed to adequately assess child development so that awareness of future chronic learning problems could be described to patients and parents, and that complementary therapies for older people in aged care facilities in particular could be utilised. For example, both RNs pushed for more preventive care relating to nutritional

therapy or aromatherapy because health professionals in hospitals for example, practiced little preventive health care. Brenda believed that the sociological care of the individual was the "soothing of the soul of the patients that helped their neurobiology". Furthermore, a nurse in her position could "drive the bus" when it came to health education. During her management of children with a learning disability, Brenda was able to make an impact on a person's health because she had both the physiological knowledge and the developmental knowledge surrounding child development.

Conflict relevant to their role as advancing specialists prevailed. From the RNs' experience they reasoned that preventive health measures were a significant role that they practiced, but difficult to implement fully:

> *...some come to a female practitioner as I am. It's advertised that I am a registered nurse, that I'm trained in sexual, family planning, and health. And I practice out of a doctor's surgery. In actual fact I'm employed by the doctor. And they are there for a pap smear. But that's what they are booked in for, but most of the time, they're there not just for that. They have other issues. They have come for discussions with a person who is a listener and perhaps non-male. And perhaps being a woman as I am, and a little bit more mature than others...[Diedre 1].*

> *It's the credible qualifications (having a master degree), because I really feel the role I want to develop is a mens' health educator role. It's not actually available at the moment, so I think I need to get the information and then push for it to be developed, preferably within the public health service...And I feel this is the area that I can be of some real benefit. Because I do believe that when I provide education to a man around his health, together with 10 years of his own attempt to develop that knowledge, it's far more successful than him having his heart attack, coming into hospital, and then we try a treat him [Eric 1].*

> *I wanted somewhere that identified complementary therapies as an effective tool as well...Whereas what I found with the registered nurses in aged care and a lot of other places I have worked, it is a real closed off attitude...well someone told me I was a witch if I was going to do that sort of thing. And that's a very personal statement that I didn't like. Closed-minded and a lack of objectivity as far as I could see [Gail 2].*

The enjoyment of being an advancing specialist. Nurse specialisation offered many benefits to the RNs. The freedom to practice as a specialist, especially as a

rural/remote area nurse was one. Helen not only enjoyed the social involvement with the community, but was able to make contact by direct telephone link to an area doctor whenever necessary. She considered herself fortunate compared to many other remote area nurses who did not even have a landline telephone let alone a mobile phone at their disposal. However, she felt that she was not a "true" remote area nurse because she was not totally isolated. When she felt any doubt about a client, she was able to consult the area doctor from the next town some 120 kilometres away by phone. The irony was that while she admitted that she sometimes contacted the doctor for advice unnecessarily, she preferred the choice because she had backup if anything was to go wrong with a client, such as a complicated delivery of a newborn. Overall, Helen enjoyed the autonomy of practice but within the safety net of a team approach that was mutual and included the contact with a medical doctor.

Similarly, the role of the nurse in the ICU was enjoyable on completion of a postgraduate course in critical care nursing. For example, Karen reported that her course fostered greater personal knowledge and therefore, confidence to be able to communicate with doctors more intelligibly. The outcome was heightened mutual respect of the two health professions working in the ICU. In addition, Linda enjoyed work in the ICU because the nurse had the power of "control" over the patient and patient events. Furthermore, her joy as an advancing specialist was not solely based on having control over the patient but more so on the challenge of actually predicting patient outcomes.

The enjoyment of the advanced role as specialist related to the increased level of autonomy as well as to the increased respect with the medical team and with it, the increased confidence to nurse patients:

Yeah, I feel working in intensive care, I'm a lot more confident. I feel I know what I am doing, which I could manage before. I could look after a patient very well, but now that greater understanding there is a bit to be

able to communicate intelligently with the medical staff and far more teaching of medical staff and junior staff. Everything just seemed to fall into place, my understanding of what was going on, how drugs worked. I gained an awful lot really [Karen 1].

Difficulties of being an advancing specialist. Most RNs described difficulties in their work and application to study. Whilst 10 RNs stated that they enjoyed the challenge of study and appreciated the added responsibility that came with that challenge, they also experienced frustration and disappointment. Most RNs for example, felt that a course was worthwhile doing, but only if the theoretical content of the program was applicable to the area of specialism and reflected their specialty practice, and that the benefits of completing the course justified the fees payable to undertake the course. For example, there was a difficulty of paying large sums of money in fees when Carla found that she could not maintain full time work and study. During our first interview Carla indicated that the course required her to reduce her days of paid work in order to gain supernumerary midwifery practice of at least two days per week over two semesters.

For seven participants, the difficulty was not in finding extra funding by gaining a scholarship, but through having to continue the regular payment of life style necessities such as mortgage payments. Carla was the most recent graduate of all the participants, and found it particularly difficult. At the time of our second interview Carla had withdrawn from her midwifery studies. She had already paid approximately $3000 of the $8000 course with no likely outcome of practising as a midwife. On withdrawal from her course, Carla returned the $2,500 scholarship that she gained from the health department to enable her to undertake her midwifery program.

Other difficulties arose when some RNs discussed how some nurses did or did not survive work in the operating theatres. Megan felt that non-advanced specialist nurses "can be their own worst enemies" and often failed to support each other. For example a

diathermy plate dislodgment from the patient or contamination of a sterile field by a nurse had lead to difficulties in collegial relationships. In Megan's experience, instead of solving incidents such as this, as a group, some nurses relinquished details of an untoward event to a visiting anaesthetist or surgeon, with the intent to discredit a colleague. As an advancing specialist in the operating theatres, Megan felt that this type of behaviour was unwarranted, and therefore, always mediated as a group's mentor whenever collegial relationships become tenuous. She knew that there were better ways of rectifying conflicts within the department.

Megan revealed other difficulties when working in the private health care sector, particularly when and how the nurse treated the visiting surgeon differently compared to the public hospital counterpart. Megan felt that when working in the private sector she had a closer relationship with the consultant surgeon. This afforded a greater teamwork approach on decisions that were made during surgery when she and the surgeon worked for example on an elective case such as a hip replacement. Megan was cognisant and tolerant of the private surgeon's request for a "no-teaching" environment whereby nursing or medical students were often not permitted into the operating theatre. Megan felt that this practice however, severely limited advancing experience as a perioperative nurse in her hospital. The circumstances were the opposite in the public sector where teaching per se was an expectation. The difficulty arose when a perioperative nurse, unlike Megan, was not adaptive to this role in the private health care sector:

> *In the private sector it is very limited. There is no medical teaching and you could do some nursing teaching but some surgeons don't like it because they say, "I have enough of that in the public sector. I don't want learning during these cases thank you very much." So you've actually got to be very careful about how you teach and how much support you get. If you support them well and things like that they don't have a problem. But if you just left (the surgeon or anaesthetist) floundering, they get that in the public sector all the time and they will just not put up with it in the private. And because they're part of our customer as well as the patient, you sort of have to listen to them to some degree [Megan 1].*

Comparing, Global Reasoning and Rationalising Organisational Activities

All the RNs compared the relationship between health care practices and education to illustrate reasons why they chose to pursue specialist practice. On the one hand, two RNs referred to global reasoning when they responded to policies and issues that reflected their understanding of the bigger picture of health care practices. On the other hand, eight RNs rationalised their organisational policies and activities in order to justify their daily work as advancing specialists.

Comparing

The choice to undertake advanced specialisation made some RNs feel that they were not accorded professional respect in comparison to other health care professionals. For example, one RN believed that nursing notes remained invisible compared to medical notes when patient documentation during triage in the ED was carried out. As a result there was little evidence that identified nursing activities such as when a nurse checked or monitored a patient, provided nourishment, or simply offered support while the patient was waiting for test results:

> *...but you know in 2 weeks time, there is a letter coming back and they would say well I was left alone in the cubicle for 2 hours in pain and that. And so you pull the notes and there's the triage bit. The doctor's written all their bits but there is no nursing documentation to show what the nurse is doing to the patient regularly or you know, shown that they have provided food and drink to the patient or whatever [Andrew 2].*

Similarly, the comparison was made between nurses who provided care based on a medical model of care with those who delivered the more "nourishing" (Eric) psychological care to patients. For example, Eric described how alarmed he felt that nurses he worked with in the oncology setting felt at ease when they provided the physiological care to the patient. His nursing colleagues had adopted a model of care that they thought most appropriate because it was "more technical, had parameters, was measurable and tangible" (Eric), therefore, safer to apply, compared to the

nourishing and psychological model of care that the nurse could give. The nourishing role was not quantifiable therefore not easily recognised or assigned. This resulted in his staff moving away from the provision of nourishing care in the form of greater emotional support for the patient:

> *What I do feel working in this particular area is an acute oncology / haematology area, we have a lot of clinical expertise (physiological medical knowledge) which we feel safe with, because it's very safe. The blood count is this, we're going to now do that. In the areas that we kind of moved away from is the stable support, nourishing role, when the answers are not there [Eric 1].*

In contrast however, the medical model of care was not such an issue to those working in the community. For example, Diedre described how she was able to maintain a community focus in her area of specialty compared to the medical model of care:

> *...community health doesn't run in our medical model, it goes on the primary health care principles so we adhere to those strictly, even down to the team meetings that we make sure that we are adhering to the primary health care principles. And it's you know, second to everything that we do. So we are very much <u>not</u> in the medical model [Diedre 2].*

Comparing one critical care course over another was detailed. For example, as an advancing ED nurse, Fiona had undertaked a critical care course that included coronary care, intensive care and ED. Fiona described how pleased she was to be able to readily respond to a patient who had a cardiac arrest while she was learning and working in the coronary care unit. On sighting a patient in cardiac arrest in the coronary care unit, Fiona was able to apply her specialist ED skills with acumen. She was experienced in advanced resuscitation methods and therefore realised that she was able to apply her skills no matter what critical care department she worked in. She was happy as an outcome of the comparison:

Another participant RN compared her area of advancing specialisation in mental health to that when she practiced as a general surgical nurse in a major teaching

hospital. She described how she was able to provide holistic care where before, this was not possible. She pondered why she remained a surgical nurse for five years and subsequently realised that she needed more autonomy, less routine and greater flexibility in her work as a nurse:

> *I've actually started a postgraduate diploma in nursing and in mental health and I'm really enjoying it. I find it very interesting. Prior to that I have worked in the surgical environment, particularly colorectal surgery. And I found that it was very busy, at times inflexible and I felt that I was developing a routine and that I needed to have more autonomy and more flexibility in my practice.....I know it's very cliched to say I like people and I like to talk with people, I like to learn about people, but to a certain extent in general nursing, where I mean there isn't sufficient time to communicate with people in any detail. Consider attribution factors such as limited time and inadequate staffing, these are factors that impede holistic care, I really believe that. In the word that I worked in it was extremely busy. There was very little time to actually communicate with patients and to get to know those patients as people and help them in ways that they really needed help. So it was like their physical needs were the needs met and for me, that wasn't enough. I needed to expand my care. I needed to expand in the way that I needed to provide for a more of a holistic approach [Olive 1].*

Global Reasoning: The Ability to Gauge the Bigger Picture and Choose ANS

Global reasons for choosing ANS emerged as a) the professional snobbery within the health care sector that nurses must embrace further tertiary education, b) the community's expectation that a focus on a medical care can repair the health status of the individual rather than people adopt to a preventive model of health, and c) the economic changes in society such as work place agreements that are based on productivity and outcomes that "keep driving people" (Andrew). Furthermore, five RNs reasoned that the government of the day failed to address the high incidence of suicide relevant to mental health and men's health. Three of these RNs felt that the government's view of suicide as mainstream health rather than as a key health issue was seen as an international embarrassment.

Six RNs reasoned that they were aware of change in societal values that had impacted on the way that they provided care. For example, consumer choice between public and private health services was unstable. Furthermore, the distrust by level 1 and 2 nurses in general of hospital managers and tertiary academics, that one was unable to see the "bigger picture" were indicative of the participants' reasoning that were globally oriented:

> *...it is because they (nurses in general) don't understand what people in higher levels are doing. They don't understand what's going on out there. They don't like academics, they don't believe that they're in touch with what's going on in the clinical area. They don't believe that the level 3s and 4s know what's going on in the clinical areas. Therefore there's a reduction in faith and it's not until you get out of the clinical areas, the lower positions that you are forced to look at the bigger picture and you become aware of what's going on [Karen 2].*

> *The only thing I would say is the most confounding factor is society because 20 years ago...You know there was a place for everybody in society. Now what's happening is, we've got neon signs, we've got mass marketing, we've got buy, buy, buy, we've got output, output, output, we've got tougher time frames, we've got incredible conformity levels and that is impacting on the vulnerability within a particular group of people. And it's going to get worse, because we actually have taken the human-ness out of life. Everything is to do with time. Time is money, and the individual, there's nothing left [Brenda 1].*

Rationalising Organisational Activities

Choosing ANS and education resulted in the RNs rationalising their activities specific to their area of specialisation. They understood compromises and accepted a need for change in nursing practices and the implementation of new standards of care. For example, as an ED nurse, Andrew believed that an on-going review of practices and standards in departments of a hospital was necessary. Furthermore, external auditors through the accreditation process should conduct these because internal audits were not necessarily adequately accomplished or reflected the common expectations of health care standards nationally. Similarly, Helen thought that there was a need for the rural and remote area nurse to generate, adopt, and apply comprehensive documentation of

patient care to ensure safe practice. Even though nurses often described the amount of documentation as loathsome, it was necessary in view of the greater transparency of health care practices and therefore, accountability of all health care workers.

Overall, Eric thought it was necessary to maintain nursing within a bureaucracy because it was complex as an organisation. Even though work for him in a bureaucracy as an oncology specialist was sometimes frustrating and limiting, it was within a bureaucracy that excellence of health care to the consumer could be monitored and therefore, maintained.

In the ICU and elsewhere, Karen felt that there was a need to identify clinical indicators that were reflective of a department's care by nursing and medical staff. The negative media portrayal of a principle hospital in Western Australia recently, had major ramifications on the credibility of its staff. The political involvement and grief that was felt by the staff of this facility was overwhelming. Therefore, clinical indicators were a requisite to ensure viability of a public health care service.

From an individual perspective, Linda rationalised that gaining a promotion and taking on a coordinator role in the ICU required many non-nursing decisions to be made that were important for the overall running of the department. She realised how much non-nursing work she must do as a coordinator to ensure the smooth running of her department. For example, she was required to ensure the plumbing was functioning properly and deal with the engineers when the system failed in her department. She must ensure a reduction in cross infection in her department. Similarly, Megan thought that there was need for a staff mix of 'independent' nurses and 'co-dependent' nurses to work in the operating theatres. Even though she worked independently as an advancing specialist, she compromised that a successful operating suite worked better if all staff worked co-dependently as a team.

Being co-dependent would be quite conducive to OR nurses because you've got to work as a team if you need them. Technically, I mean theoretically you should actually work more cohesively as a team. If you've got too many independent workers working together it's a lot harder to get them to work together. But the independent workers are often more up front, more questioning and are more of a leader type in a team. So you really need a blend of those types [Megan 2].

Reflexive Action, Problem Solving and Interview Reflections

The process by which the RNs chose their work and studies as advancing specialists was evident in the way that they acted upon their decisions to achieve their goals. Their decisions and subsequent actions were based on what the RNs considered reasonable and therefore, the best course of action for them to take. Their decisions were not interpreted by me as the Heideggarian pre-reflective or being in the world, but interpreted from the Husserlian perspective of conscious thought that is intentionally reflective rather than pre-reflective. Being reflexive and taking action in this study related to the RNs' thoughts and actions as opposed to any actions that were based on fiction or even forced upon them. Their reflexivity was accentuated by their problem-solving approach to issues as they arose while advancing, and by their review and change of thoughts and actions between their first and subsequent interviews with me.

Reflexive Action

The RNs were reflexive in their actions because they analysed and reviewed their advancement, during and between interviews, so that they could add structure and meaning to their practice (Gubrium & Holstein, 1997). Three RNs were reflexive as active members of an organisation while four RNs approached specific organisations to maintain an awareness of health issues that were of particular concern to them. For example, even though Andrew claimed he was a "cheque-book" member of a number of professional organisations such as the Emergency Nurses Association and the Royal

College of Nursing, Australia, he reflected on how little, members of the nursing profession had communicated to the public on health care issues. The public needed to be aware of what the nursing profession had to say about health issues. Therefore, he spoke with a reporter to ensure current professional issues such as maternal outcomes and midwifery education were discussed and reported in the media. Similarly, Brenda was passionate about adults who suffered from ADHD. She reflected on how little nurses and the public knew about the problem. Therefore, she did "door-knocks" and visited nursing management staff in a large hospital. Her action was to share information about a disability that was most likely to be encountered by health professionals working in the hospital. She wanted to ensure that all health care workers, particularly nurses, were aware of the prevalence of the condition so that they could intervene or inform patients of the problems associated with the condition and advise people of the resources available if patients with ADHD required assistance. Furthermore, she lobbied the AMA, the judiciary and the Institute of Sport for example, about the enormity of the social problems related to people with ADHD. As an outcome, she was invited to write a program on the internet for those who desired reliable information about the condition. This she undertook.

Other RNs reflected and took action based on their concerns about public mental health issues, or on their choice of action as a nurse, or as a student. For example, Diedre pondered on the increasing incidence of women she attended to who had postnatal depression or stress. Her response was to seek a short mental health course of study that would enhance her knowledge and skills to deal with this growing health problem. From a counselling perspective Helen reflected on how she sought advice after she counselled a teenage female client that manifested a personal conflict of interest:

It's the Council for Remote Area Nursing Association. I've got a 1800 hot line, you know counselling line which you can ring...It's a crisis line for the remote area nursing nurses. And I only rang it the other day because one of the counselling I did, this was probably my worst case. It was the fact that I had a 14 year old girl who was actually in my netball club who had come up because she was on the pill and...it was all very awkward you know this girl was my peer in my netball club and she was also a client and a junior. And I just found it, it wasn't a role I was used to and I felt...I didn't know if I had done the right thing. But I felt very stressed by it all [Helen 1].

From a student's perspective, Judith found that she was in need of a sound foundation to her new work as a perioperative nurse. She reflected on how she had few suitable role models working with her. Her action therefore was to seek a self-directed learning package to ensure appropriate beginner progress and achievement of standards before she enrolled into a postgraduate program in her specialty. She also revealed that she learnt mostly by reflecting on her practice at regular intervals. This activity was taught to her during her undergraduate days. She now incorporated reflective practice as an effective means of critiquing and changing her practices as an advancing perioperative nurse because it improved her work behaviours.

Problem-Solving and Making a Choice

Three RNs, namely Brenda, Eric and Megan referred to how they instigated a problem-solving approach to their nursing care. They believed that health care workers including general nurses did not embrace a problem-solving approach in the broadest community sense. According to Brenda, this may explain why other health care workers other than the nurse were dealing with the increasing chronic lifestyle problems such as mental illness, learning difficulties and diabetes related to poor nutrition. Megan felt that the ability to problem-solve was a prised specialist skill:

You have to assess people on a different wave in that some people are organised, they have the problem-solving skills, they have deductive problem-solving and they are inquisitive. Those people survive very well in the operating room. If they don't have those skills, they can struggle for up

to 12 months and they're never really happy unless they move into an area which is like more ward orientated [Megan 2].

Interview Reflections

During the data collection for Part A of this study, I undertook a trajectory of interviews with each RN in order to identify any possible change in the RNs' thoughts and subsequent actions, given the six month time frame. The change in thoughts was revealed by the RNs' own admission to their change of heart or mind. They referred to their transcripts and on what they thought and said during the first interview and how their thoughts had changed at the time of the subsequent interview. For example Carla reflected on how negatively she spoke about the attitudes of hospitalised private patients. She believed that they were unreasonably demanding of her time, care and attention. In the subsequent interview, Carla indicated that she lacked understanding of the private patient. She described how both she and the private patient were bereft of information that was kept secret and not assessed or worse still, withheld from hospital notes. She understood that the demands set by the private patient was not necessarily the patient's fault. She needed to explore her involvement in a system that required her to review her practice.

Similarly, Eric reflected on his first interview and indicated how unsettled he was in his new job and settling with his family in a new city. He felt that he had had poor guidance career wise and that he was in a state of flux. Six months later however, he was much more focused on his research studies and was better settled in his job:

Ah since we last met and reading the transcript prior to this interview I can actually see how much I have changed and how much circumstances have changed. Things seemed to have calmed down but at the time I do recall that I was in a lot of flux, very poor guidance, very poor advice. And still attempting to settle into the culture at work here and also settling in Perth and a lot of settling in process, family wise, work wise and socially. And I can see how it came out in the conversation. That's why I said earlier it (work) was disjointed [Eric 2].

In another example, a RN told of the need to increase practicums so that students like herself could gain sufficient exposure and experience while working as a student in the mental health sector. At the time of the subsequent interview however, Olive had changed her view because the amount of exposure and with it experience, proved to be substantial. "I suppose maybe towards the end of the course I feel that I've had a substantial amount of practical experience. Perhaps that's because I feel more familiar with the area now than I did then" [Olive 2].

The Reality of ANS and Education

The reality of ANS and education emerged when the RNs considered an ideal practice in nursing and the impact of the nursing shortage on their career aspirations. The reality of nursing practice that was ideal concerned them. The RNs' felt that they needed to be pragmatic about the world of nursing in which they worked as advancing specialists. Their pragmatism reflected their approach to their work that enabled them to continue in their specialisation. One RN even identified survival techniques that enabled her to pursue specialist practice and studies.

The Reality

The RNs had to face multiple realities including remuneration, staffing and workloads. To most of the RNs, the reality felt was that the majority of nurses, along with other health carers, such as the physiotherapist, would not be able to negotiate a fair work place agreement as specialists, if they had to. More specifically, the nurses' EBA at the time of the first interview was topical and had widespread media coverage in W.A. Therefore, during the data analysis four of the RNs referred to the EBA process. These RNs believed that they were astute enough to derive an individual work place agreement between them and their employer, but in reality, they felt that the bulk

of nurses generally would be disadvantaged. Andrew, Fiona and Megan favoured a work place agreement. Two had been successful in negotiating such an agreement. However, all three RNs suggested an EBA was the best means of industrial bargaining as it was achieved on a collective basis, thereby protecting the interests of all RNs.

In relation to nurse specialisation, the reality was that there were not enough midwives "to run a roster to provide adequate cover in an eight bed maternity ward" (Diedre) in the rural area of W.A. Nor would a rural/remote area nurse like Helen have a problem in gaining work as a nurse, even if she did not have a degree in nursing. For example, Helen's RN registration from a hospital-based diploma sufficed because there were so few nurses who were attracted to work in the rural areas.

Furthermore, the reality of health care for Andrew for example, was that the ED catered for patients who were reactive to a major illness such as a heart attack or renal failure. Similarly, Linda felt that in reality, the ICU catered for much sicker patients that a nurse must have expert qualifications to be able to look after them. In addition, Diedre believed that people in the rural community did not get their needs met even though the statistics demonstrated high rates of "co-morbids" when compared to city statistics. For example, vehicle accidents were higher, the suicide rate was higher and young families failed to seek preventive health care because of the longer distances travelled to access the relevant health care professional. Similarly, Brenda felt that the rising number of co-morbids was evident within the community and needed to be addressed and could be addressed by the nurse.

Eric felt that the reality of acute hospital resources were finite but insufficient. The insufficiency was problematic for nurses when in reality there was an on-going need to orient new nurses to the oncology area for example. There were simply not enough resources in terms of experienced staff like himself, who were already over-stretched to orient a new nurse. The reality of resources available for the rural nurse

was also finite. For example, Helen was unable to draw on her remote area health budget to fund repairs to her surgery precinct, bearing in mind that the surgery was the only medical centre in town that serviced the community. The parking area in front of the surgery was in a state of disrepair that it was hazardous for patient parking.

The Nursing Shortage

All but one RN was concerned about the reality of the nursing shortage. So desperate was the situation in the ICU, nurses were being recruited from England. In addition, because of the shortage of midwives in the rural areas, the remote areas, and nurses in the operating rooms, the opportunity for the participant RNs to gain work was easy. However, there were not enough nurses like them to provide advanced specialist nursing care that the population needed. In reality, the shortage precluded one RN from being able to obtain any leave from work as a rural/remote area nurse. Olive felt that the current working conditions, the shortage of nurses, and the health care system together were considered to increase the stress on the young nurse:

> *I am also very concerned about the nursing shortage or the so-called shortage. And I believe it is real for us now and in my previous management job I did see another government document that crossed my desk, and which predicted a nursing shortage of 15 hundred, this is statewide, by the year 2000, and I saw this document 5 years ago. And it predicted a 15 thousand shortage by the year 2020 [Andrew 1].*

Pragmatism and Survival

The RNs' pragmatism enabled them to keep a balanced view about the realities that they faced as advancing specialists. For example, during their advancing careers as a specialist nurse they were pragmatic about the need to "not get too worked up about the feelings of urgency" (Andew) when a priority one patient entered the ED. Some nurses showed undue anxiety that had a negative impact on others in the department. For Diedre, the practicality of employing casual staff in order to constantly balance the

number of staff let alone the mix of staff required in the regional hospital was a second example. Thirdly, two RNs felt that like all consumers of education they should pay to complete their studies even though it was expensive. Furthermore, if one was serious about it, money was not an option when it came to extending one's career as an advanced specialist.

While Helen indicated that she survived with what she had in terms of limited equipment in her surgery and advertising materials relevant to health promotion and public health issues for her community, Fiona voiced how she had to come to terms with working full time. She told of how she survived to reduce her level of guilt associated with not being able to attend social activities for example with her two young pre-school children because of her full time shift work commitments. Even so, Fiona was pragmatic about the need to prioritise her studies. Nothing had changed since the first interview with Fiona because she indicated that fitting in study for her masters was simply but pragmatically, one of the list of things that she would do:

> *I would like to be able to spend more time with my children.....I regret having to go back to full time work and I do say I had to go back to full time work when my son was 14 months old, and I have worked full time ever since. I've missed out on a lot of the, what I consider, reasonably important milestones in their lives. I still feel guilt when I can't get to things that are important for them or events that happen and I can't organise to take them to, because I am not available. That's something that I will have to come to terms with myself. I understand fully [Fiona I].*

Sub-Theme 2: Knowing; Experiential Learning While Advancing

For the majority of RNs, gaining knowledge by virtue of their practice and formal education were the methods by which they felt that they learned and subsequently practiced as advancing specialists. Each RN's learning experiences and therefore, knowing, was professionally focused. Furthermore, their continuing education was an integral part of their educational and professional development and therefore, learning.

This professional development was derived in relation to the RNs' time of life or style of life or both. The majority of RNs valued experiential learning because their new knowledge was able to validate their credibility as an advanced practitioner. Their stories included the uptake of new, changing, different or unexpected knowledge.

All the RNs believed that continuing education was implicit, and that all should continue in their learning as a RN. As consumers of education, they felt the necessity for nurse credentialling, the limitations associated with nurse education at the undergraduate level, and the increase in technology as being complimentary to their advancement. Even though there was a cost to their advanced professional education, the RNs felt enlightened that their knowing had increased because of their experiential learning. On the one hand however, there was a perceived prior knowing that the RNs brought with them as an advancing specialist, but on the other, there was a paucity of knowledge sharing between practitioners and in particular by non specialist nurses. This had a detrimental impact on their learning with non-specialist nurses.

The RNs gained knowledge via the different educational processes that each RN experienced included, a) a formal university course that was more than 12 months in duration, b) a continuing education or short course where the duration of course varied from a few days to weeks, and, c) any specialised vocational work where the nurse gained skills and knowledge that were applied in the work place or area of advanced practice while delivering patient care.

Helen was certain however, that the best way to achieve experiential learning and knowledge was through practice alone. Similarly, Andrew suggested that a formal university program relevant to a specialisation that a nurse had previously practiced for two or more years was not absolutely necessary because he was able to adequately provide patient care in the ED. Andrew's experiential learning and knowing was based on his vocational experience alone that was gained while working at the bedside. Other

RNs however, told of additional perceptions concerning their experiential learning and knowing. They preferred the formal theoretical and clinical education available.

The undertaking of a formal critical care course meant that Fiona became more assertive with the medical staff because she was comfortable with all the lines and patient "plumbing". Being enrolled in a critical care course enabled her to gain not only formal knowledge, but also experiential knowing in the ICU and coronary care units, as well as in the ED. Similarly, studying with a group of nurses who were enrolled in the same course and concurrently working in the ICU, Karen experienced joint learning and knowing while studying with others. Studying jointly rather than in isolation was perceived better in terms of problem-solving issues as they arose and with the security of others. Moreover, Olive believed it was necessary that at lest two years experiential learning should be gained prior to advancement into an area of specialisation. This entailed experiential learning and knowing as a generalist nurse following initial RN registration.

Advancement in an area of specialty such as mental health required a degree of practical experience as a RN because if Olive wished to advance, she would need to consider her research interests. In addition, a minimum of six months in a specialty such as the ICU was necessary so that Linda was able to "look after the sicker patient" (while undertaking postgraduate studies in critical care. From Fiona's perspective, learning and understanding had advanced following completion of her formal critical care nursing program, and even before continuation into her master clinical studies:

> *I found myself, I was a lot more assertive with medical staff that you know what I wanted to have done and a lot more comfortable with the patient and a lot more confident about the patient [Fiona 1].*

Professional Education

Each RN realised at an early point of their nursing careers that they needed to know more about what they were doing while practicing as a clinician. They regarded professional education as a continual and experiential process of learning and knowing. This educational process in turn was recognition of their attainment of specialist knowledge. In other words, the RNs prized self-education as a natural process that was a means of advancement in their chosen specialist area(s) of practice.

In essence, professional education was primarily a personal belief in the building of their nursing knowledge. Secondly, their studies were simply a way of putting an academic level to their acquired knowledge. Fundamentally, tertiary study expanded one's critical thinking. Furthermore, it "is a way out of feeling in a flux or being dysfunctional...[as a clinical nurse]...and it also enables you to get a job" (Eric). Eric's perception related to the attainment of a master degree. The majority of RNs thought that a degree at master level would give them the credibility to practice as a professional nurse while Eric believed that undertaking "research is the next step to true professionalism."

Karen felt that undertaking a postgraduate diploma or master in a specialty was more acceptable than worrying about being credentialled because of the ongoing need to update the assessments of ever changing skills. Conversely, Carla sensed that some research components of her diploma course that articulated with a master by research program, would not benefit her because studying as a "participant observer" in research for example, bore little resemblance to the immediate antenatal, delivery and postnatal care of mother and baby. All the RNs concurred that the education program they selected should bear relevance to their area of specialised practice and that "there is nothing better than theory and practice to make a good mix" (Fiona).

Different models of education undoubtedly resulted in their professional development. For example, since registration as a nurse Gail had undertaken various graduate courses that were not necessarily related to nursing but nevertheless, considered experiential. Prior to this study and since registration as a RN, Gail did horticultural studies and culturally specific aboriginal education through Tertiary and Further Education (TAFE). In addition, she did a conversion degree in nursing, postgraduate gerontological nursing studies and specialist complementary health studies that were generic to any professional health care worker. Gail added that if she "does not fit into a box then it's not an issue". That is, she believed it unnecessary to be "encapsulated" into a traditional nursing specialty such as gerontology nursing or disabilities nursing. Besides, three RNs believed the undertaking of short courses was an effective method of learning once a generic professional degree was attained. Gail perceived nursing education as being "conventionalised" and interpreted education to be "bigger than any big box". Gail's eclectic approach to professional education broadened her experiential knowledge relevant to ANS and education.

In contrast, advancing and studying in a specialty, two RNs felt that they needed to seek the most appropriate course and program that would suit them. More significantly, the remaining RNs believed it important to study in a specialty that was of interest to them. Once a program was selected by a RN, eight believed that they should manage to pay for his/her education while five RNs felt that they should complete their studies in their own time Even so, nine RNs told of how they received financial or work related support to assist them in their advancement. With the culmination of the above factors, the greatest satisfaction Judith felt on completion of a program was directly proportional to the amount of effort that she put into a program that she was capable of doing. Furthermore, when working in a busy department or clinical setting such as the operating theatres, Judith believed that she needed to be self-disciplined, while Fiona

and Helen felt that they were continuously well motivated to undertake their chosen program. Otherwise, "it would be very hard to do" (Fiona).

From the rural perspective, the lack of a suitable supervisor to undertake a master degree in research or the rearing of a young family in Fiona's case was of concern. As a community nurse Diedre also had educational concerns as a lone practitioner. She needed to schedule and attend annual updates through the family planning clinic in Perth. She also needed to gain greater knowledge about diagnoses doctors and other practitioners made in relation to people with a mental illness. She had no time to undertake another university course because she could not afford the time from work to undertake a lengthy university program relevant to mental health. Therefore, she looked for a suitable short course and distance learning package that was offered through the health department. She took her annual leave to undertake study time and used her accrued additional days off (ADOs) to attend the week's practicum of the course that she had selected.

Similarly, Helen described how self-directed learning packages such as the nurse practitioner program could place pressure on rural nurses because she was busy when working as the sole practitioner in rural W.A. These courses were lengthy and required greater continued commitment. Therefore, she found advanced professional education in the form of a self-learning package served as an alternative learning tool. Even if a course was not accredited, Helen found that the information was of value and more importantly kept her updated. Furthermore, because she believed that there was a need to do at least one course per year, Helen undertook short courses rather than a degree. The short courses such as life support or health assessments provided her with current update of skills that she believed she needed to review.

Four RNs claimed professional education was a challenge to them. If Olive continuously challenged herself, she felt that she was learning. All indicated that either

formal or informal professional education of some nature should be undertaken by advancing clinical nurses, even though nine RNs indicated that some nurses unfortunately, would always see it as a waste of time. Megan always questioned the validity of a nurse's skills and knowledge in this changing world without any professional education. She suggested that continuing professional education should be linked to nurse registration because many nurses refused to undertake continuing education of any sort. The majority however, indicated that professional education through a formal university course was for them because of the greater acceptance internationally.

After having done a critical care course and with the relevant clinical experience, Linda believed that she took a short time to be able to independently care for an intensive care patient that for example, had a ventricular assist device. She had never had the opportunity to manage such a patient before. Furthermore, once eight of the RNs had taken the opportunity to enrol in a course they believed that they had learned so much that they would never look back.

In summary, professional education was viewed as experiential learning and knowing that was on a continuum for these advancing specialists. Their continued studies was the way that the advancing specialists pursued their professional development. As Brenda claimed, "nursing education needed to be redefined because the physical side of nursing has never gained respect." Furthermore, the outcome of continual professional education in general and of tertiary education in particular, "we will see quality nurses emerge":

> *Well I think it has to come to that because it's a developmental learning curve for everybody. Nurses are no different from everybody else. You can't take the practicalness out of it and you can't take the intellectual out of it. The problem is that they never really gave, and I have done both things (HBD and tertiary nurse education), enough credit or respect to the physical of it. So now it's being redefined in a sense. And I think with that, you'll start to get back the quality of nurses that have that more nurturing*

than the technical, which is another problem too. There is a place for both. But I think it should be valid and allowed that people can be both and be equally qualified [Brenda 1].

Consumer Education

Consumer education was felt by the RNs to be well entrenched as a product of society even though it came at a cost. As a consumer of education, 10 RNs equated themselves to being a customer, client or a purchaser of intellectual property that included educational programs or materials or both. In addition, as consumers of education by postgraduate students in Australia generally, and by nursing students in particular, the RNs felt that they were considered equal partners to their lecturers/tutors in the learning process compared to when they were first a nursing or undergraduate student. As consumers of ANS and education, three RNs preferred programs that enabled them to learn within a group environment because they were immediately able to "bounce off" (Fiona) colleagues' ideas and solutions:

And you know their input is always valuable because they may see exactly the same situation but view it in a different way. And you think "well I haven't thought of it quite like that" and that gives you more room to grow I think. Or to follow the tangency and yes, I think externally because even though you can make opportunities if the same people are doing the same topic within your own area, that's very difficult to organise [Fiona 2].

As evidenced by the choices they had in educational programs, eight other RNs however, did not raise the issue about programs that provided a group learning environment. All but two RNs pursued part or all of their studies as independent learners, without classroom contact, but on an external basis. Apart from one participant, the RNs supported ANS education programs that encompassed interdisciplinary education relevant to nursing, such as management. Consumer education like a master of business administration (MBA) for example, was felt to dovetail with interdisciplinary education including ANS and education.

Enlightenment

Being enlightened or feeling enlightenment was an enjoyable outcome of the RNs' learning and educational experiences. They felt enlightened because studying as an advancing specialist broadened their interest in nurse specialisation beyond expectation. More significantly, their confidence increased because they discovered new ways of adapting and applying their field to health care and policy. As a result, they encouraged others to take on studies. For example, one RN actively urged other nurses to undertake ANS and education. At the same time he provided other nurses with contacts and continually shared information about educational opportunities as well as his personal library with colleagues who might be interested in advanced specialist studies per se. A second RN sensed enlightened when he was ready to forego trying to do everything as a clinical nurse specialist. He discovered that he could narrow his studies relevant to men's health. Eric and Brenda in particular felt enlightened by their passion for studies in their respective fields of advanced practice that was research oriented.

Another RN, Megan, revealed how her studies had broadened her knowledge even further and where once she had little interest, if any in politics, she had now changed her attitude. Megan's understanding about politics, health care issues, education and her work as a perioperative nurse were inextricably linked and she felt enlightened by her expanding knowledge relevant to her area of specialisation.

Credentialling

Credentialling in nursing was an issue under investigation by nurses in Australia at the time of data collection. The majority of RNs believed that credentialling was one means of developing and introducing a tool that was able to validate advanced practice skills. Owing to their advancement in specialised practice it was possible that the RNs would encounter nurse credentialling in their respective fields of practice. Six of the 13

RNs favoured the introduction of nurse credentialling. Diedre was already involved in the credentialling process on a biannual basis because she had a provider number in conjunction with an accredited pathology department to obtain pap smears.

Andrew, Karen and Linda however, thought nurse credentialling was unnecessary because the acquisition of an academic qualification over a specialist skills based qualification was desirable and better accepted internationally. "And I would rather say to them (colleagues), look just go to uni and don't worry about the credentialling. I mean, what you gain from uni would be more accepted on a world-wide basis" [Karen 2]. Furthermore, another RN noted that Australian nurses were not required to become credentialled to be a professional nurse.

However, Eric, Megan, Fiona and Judith believed that specialist skills needed to be credentialled but not enforced. Fiona admitted that she was not fully conversant with the credentialling of nurses but would encourage the practice of updating of specialist skills for those who volunteered to undertake specialist credentialling. After all, Fiona believed that forcing nurses to undertake credentialling would "cause resentment, therefore, more nurses will leave the profession". Similarly, Judith felt that other nurses might leave their area of specialisation because they would feel threatened by not being able to meet the required standards for credentialling.

This group of advancing specialists as participants was somewhat partial to nurse credentialling, and expressed issues that needed to be seriously considered before they or the profession decided to embrace the concept. Two opposing narratives were telling about nurse credentialling as a possible tool for the validation of skills pertinent to the advanced specialist nurse:

> *I think recognised skills need to be credentialled and I think advanced skills need to be credentialled for the protection of the nurse. And also to identify that a nurse has got these skills but as far as compelling nurses to get these credentials I think we do a disservice to nursing by demanding it [Eric 2].*

I agree with it in principle because that way you can turn around and say I maintain this standard of practice and you can say I am a better employee because I am accredited because I have a) reached the standard and b) I have maintained that. But the question is, it will take time, it's at a cost. And is there going to be any discrimination? And the question is how many?.....I think it is a necessary process because not everybody will maintain a standard. And to maintain a standard of acceptable practice you have to have an external body assess it. Technically we should be accredited for our practice, no one comes and you know assesses our practice! Perhaps that's where credentialling comes in [Megan 2].

Limited Nurse Education

Four RNs voiced concern over the inadequacy of nursing specific health care issues during their undergraduate nurse programs. For example, Brenda remained concerned about the lack of focus on chronic life-style problems in undergraduate programs. Even though chronic illness was a significant social issue, nurse education still focussed on acute illness that accompanied medical intervention and orientation to health care. Brenda felt that the nurse could address chronic, social issues with added focus as an area of specialisation that warranted teaching and learning interventions as well as collaborative research. Similarly, Olive had limited experience and knowledge concerning mental health during her undergraduate program as a nursing student. She felt inadequate with such a limitation of learning experiences specific to mental health nursing. To overcome this limitation, she chose to undertake a course and specialty in mental health at the postgraduate level in the pursuit of in-depth knowledge and practice.

Megan indicated how difficult it was to encourage nurses to attend continuing education days at her hospital. The nature of education offered was limited in duration because staff would not attend unless they were paid to attend or that attendance was during work time. She found this attitude by some colleagues frustrating because there was no enthusiasm to participate let alone attend a session that she had prepared for them. As a result, Megan felt that nurse education had its limitations.

Because of Helen's work in the remote areas, the many graduate or short courses available were not tailored to her specialty. The knowledge that she required in servicing the health care of her community needed to be broad but with an emergency focus, such as managing a severe road crash victim and more information on pharmacology. She needed to search for available courses that would suit her continuing education needs and at the same time be useful and relevant to her area of specialty.

Using Technology

The use of a personal computer and the use of medical technology emerged as tools that were described as being useful for eight participants during their practice or studies. The remaining five RNs made no reference to their use of either personal computer technology use such as the internet or medical technology such as implantation of surgical isotopes. However, this did not necessarily mean that these RNs found the use of technology to be abhorrent. Technology to the RNs was an excellent source of communication, particularly for the three RNs working in the regional areas. For the majority of RNs, it was convenient as a resource learning tool and saved time by being able to use email or to maintain a disk copy of documents compared to the arranging of typing and posting of client documentation and memos. Access to online medical seminars and the virtual conference for example, from Toowoomba in Queensland to regional W.A. was fascinatingly useful. However, teleconferencing for Fiona was not as effective for the purposes of professional meetings with the ANF for example. Some RNs felt that professional discussions between colleagues often required a face-to-face approach to be effectively considered.

Five RNs indicated that a large part of their research activity involved computer technology and that problems related to their research could be easily and quickly

communicated and resolved by communicating to their research supervisors by email for example. Eight RNs indicated that they had a home computer or a personal laptop or desk-top for work use. However, even though one RN could not live without a computer Diedre's experience as a clinical manager over non-specialist RNs and enrolled nurses was the opposite. Very few nurses were computer literate, particularly those in the hospital rural/regional settings where she partly worked as a community nurse. The nursing staff would "freak out" if they were required to use a computer in the hospital. Similarly, Judith described the circumstances in the operating theatres of a metropolitan hospital when computer technology was introduced for the purposes of procedural and patient data information. The nursing staff in the operating theatres in a large metropolitan hospital where she worked resisted the initial introduction of computers. Not all nurses in her department were computer literate, however, Judith conceded that the additional time required to enter patient data and surgical details at the time of the actual surgical procedure was problematic for all nursing staff, including herself. Furthermore, the resistance to the introduction of new computer technology in the operating rooms was not necessarily related to a lack of understanding of computer technology, but more to a change in practice. This would take time to resolve. Even so, there was frustration associated with computer technology when the system failed to function completely or was slow to respond at the time of the patients' surgery:

> *I mean I can honestly say that I don't have the time sometimes to be sitting on a computer and you know jotting in numbers. Sometimes you can't even turn on the computer because it won't turn on. The screen won't work and you know you can't log on and you can't do this, and then when you do, it takes forever and you just haven't got time really. I mean you could be connecting the diathermy and the suction and have that all ready by the time that thing starts to go [Judith 2].*

In summary, the theme of knowing; experiential learning while advancing identified the way that the advancing specialist nurses actively gained knowledge

relevant to their chosen field of practice. They accepted consumer education as a responsible means of advancement. Some identified limitations in their generic education to enable them to proceed to an area of advanced specialisation. Fundamentally however, some RNs were enlightened by their continued pursuit of education. Education for them was a natural phenomenon that was also on a continuum. It required some to achieve better outcomes by engaging in learning before embarking on a course specific to their specialism, such as ICU nursing. It was pertinent for them to share knowledge between all nurses and between disciplines to ensure best practice. These insights therefore, provided a deconstruction and reconstruction of knowing as a result of the RNs' professional advancement relevant to ANS and education.

Sub-Theme 3: Maintaining Interdependence

Four categories emerged to describe how the RNs ensured an equitable level of advanced practice that was interdependent. Working interdependently as health professional did not undermine their self worth, but enhanced their ability to effectively communicate with other health care professionals, colleagues or community members. The RNs were able to maintain a level of interdependence while working and studying. This involved their connecting and expanding with others, the generation of enterprising activities that in turn created further personal or professional opportunities, and working in collaboration that generated a working level of interdependence between health care professionals. In addition their desire to maintain a sense of integrity while working in an interdisciplinary or multidisciplinary setting ensued as a constant personal need.

Further analysis of their level of interdependence identified how the RNs felt that there were lost opportunities when nursing colleagues either failed to pick up on an issue or drive an issue relevant to their practice. Furthermore, the RNs' desire to maintain their integrity was further highlighted by the subtle ways that each RN

managed this desire such as mutuality in the work place, mutuality in their home, or when they were simply acknowledged by other nurses and by the public for the work that they did.

Interdependence

The majority of RNs independently reviewed their course options and patterns of learning while some continually addressed their learning opportunities on a continuum. The interdependence of learning reflected their desire to undertake postgraduate courses that were empowering in nature. Learning about complementary therapies as a specialty such as meditation or healing touch for example were worth considering because these enabled the nurse to be empowered as a professional. A specialist like Gail was able to interdependently provide psychosocial care tailored for the patient.

Helen suggested that her interdependence gave her the opportunity to work with other rural nurses in a busier town on an annual basis. This was intellectually stimulating. She gained knowledge and shared skills with other health professionals including nurses and doctors. As an outcome she updated her nursing knowledge as well as skills. The preference for learning with a group of peers in the critical care course was a similar experience for Karen. Joint learning or learning interdependently within a group situation was lively and therefore, socially interactive. Two more RNs, Megan and Olive, related to their interdependent styles of learning by questioning the practices of other health carers or supervisors:

> *The biggest thing I had problems with were, I called doctors by their first name or if I don't understand something or, I say, "well why are you doing it like that?" I questioned their practice. And I don't have a problem in WA with all the doctors that I have worked with. But they had never come across anyone asking them, why were they doing that? Particularly a nurse, it was as though this hierarchical structure, nurses don't speak like that. They don't question. And I had an argument with one of the surgeons about, "yes you can use this" and he said "well why?" And I rattled off all the statistics why. And he sort of said he was under the impression he couldn't because he had been told no he couldn't. But it was the power*

drills and things, you know, locking of systems-in. And after that they actually started to treat me with a certain amount of respect. Because I actually had answers [Megan 1].

Lost Opportunities

Evidence of lost opportunities was prevalent but varied as the RNs told of their experiences as they advanced in their specialisation. Some lost opportunities were through no fault of others, but due to their lack of action. For example, at least two RNs failed to apply for a health department scholarship to which they were entitled, namely Carla and Olive. Both were disappointed in themselves for not investigating the opportunities for financial support to undertake studies and were disappointed in not applying for course funding in midwifery and mental health respectively prior to commencement of their studies. Subsequent to course enrolment, both RNs applied for funding during their studies and succeeded in gaining only partial funding for their studies. Unfortunately, their earlier semester studies could not be paid retrospectively because they had to make application for full funding on initial enrolment of their studies.

Another RN described a lost opportunity when she reflected how she should have undertaken nursing graduate studies years ago when in Edinburgh. Career advancement in clinical nurse education as opposed to management or education in the ICU was not recognised in the university at a time that Karen contemplated advanced practice. However, if Karen had the self-confidence to undertake research in nursing, she could have had a Ph.D by now. Instead, she delayed her studies. Nevertheless, she was keen to optimise on future lost opportunities in the critical care setting. She currently assisted critical care nurses to embark on exciting research because if they did not, someone else other than a nurse would come and take over the new clinical projects within the hospital.

A certain degree of negativity emerged during the interviews because nursing attitudes to caring for patients were distressing and therefore, a lost opportunity. For example, Karen and Olive believed that unlike themselves, nurses were unwilling or unable to adapt to change that improved on the way that nurses in the ICU or mental health setting could improve on nursing practice. These included their resistance to adopt clinical indicators in the critical care setting or the rejection of therapeutic interventions in preference to a custodial form of care in the mental health setting. As Olive indicated, change for the sake of change was not in the best interests of nursing, however, because some nurses were set in their ways, Brenda and Olive believed that other nurses missed out on more innovative ways to manage patients. Furthermore, their resistance stifled the RNs' drive to change practice because they did not have the support of other nurses in the department.

There was also a lost opportunity because of the diminishing nurses' role by psychologists and social workers, particularly in the mental health setting. Brenda felt that the nurse's role as the patient's advocate was lost because the mental health profile of patients was categorised under the principles of mental disease. What was most significant to Olive was that unlike her, many nurses did not see continuing professional education as important. This precluded any opportunism afforded them and the profession through further education.

Nurses' advocacy on behalf of the patient has been taken over by psychologists and social workers which are at arms length to this stuff that is important to the patient. And I personally think of psychologists as witch doctors because they don't include motivational stuff from a motor neuronal perspective in their training. Psychologists are not famous in this area of looking at what motivates the human spirit and so they have this role and then social workers take over the role of you know the nuts and bolts out there. And of course the nurse has been more focused because of the cuts on the bedpan, on the biology and everything, and in that process they have lost their role as the advocate. And they are the ones who are there 24 hours a day with the patient. Yeah so I would say that it's been severely eroded and of course that has also broken down their advocacy with the family in the ongoing treatment of the patient because the social worker has

taken on a lot of that role too. And they really don't actually have the training or the skills of understanding what motivates the human person to fill that gap appropriately [Brenda 2].

Connecting and Expanding

Connecting emerged as the way that the RNs related to other nurses and health care professionals while advancing in their area of specialism. This occurred when an issue pertinent to their practice was raised. Expanding related to how they used their connections in order to resolve common or isolating issues that they felt passionate about. The RNs endeavoured to associate with others rather than alienate themselves and therefore, isolate themselves in the work place. Their expanding approach enabled them to further extend their level of interdependence rather than risk curtailing their advancement through their education.

Connecting with other health care professionals including nurse colleagues emanated from 12 of the 13 RNs because this enhanced their socialisation with other nurses. Furthermore, their inclination to network with community services through the Silver Chain or community newspaper for example on the topic of suicide extended their health care initiatives to the community. Others like Andrew, Brenda, Diedre and Karen networked with a team of experienced nurse researchers within the university and metropolitan hospital sectors in order to initiate research projects or further develop their consultancy.

I just bounced the idea off a couple of people; off a senior nurse in the department, off the director or the consultant. And they said, yeah, it was a great idea. And so I then took it to the department, through the democratic process, wrote out a draft, you know, just a one pager, and put it in the communication book and got feedback [Andrew 1].

Furthermore, Diedre kept in touch with a nursing network because she could be informed about nursing issues and senior nursing positions that were to be created or

openly advertised. This worked extremely well when working in isolation, particularly in the rural sector.

Brenda had multiple connections owing to her involvement in the Liberal Party and representation on a community advisory committee to raise policy issues in relation to motivational disorders and impulsivity.

> *And part of the response of the petition...is the forming of a professional advisory body, which has, Aboriginal Health, University of Western Australia Graduate School of Education and Psychiatry, Paediatrics, Juvenile Health, PMH and Community Nursing. And I imagine that I will be on that professional advisory committee...So while I'm doing a Masters of Special Ed, it's really from a nurse's perspective that I would see my role..... What I am trying to say is I think there's got to be some forum where all nurses have to collaborate with each other. Because you see if they don't do it at a government department level, how does a nurse who's a specialist in ADD get across her stuff to a nurse who's in intensive care? How does being in intensive care help the patient get through the night when they are ADD? ...and so there has to be a point of collaboration between the disciplines within nursing because it takes on the whole life span [Brenda 2].*

Megan also told of how she was once encouraged to speak at professional forums by her tutor in her area of ANS and education, only to reveal that since that time she did far more work of an educational nature than she ever thought possible. Besides, the opportunity to participate in organisational activities as an advancing specialist increased. Each of these activities was resourcefully expanding for them and set up a level of interdependence that was manageable and realistic. Gail, meanwhile, was keen to use the expertise from other health care services or facilities such as colleagues from a variety of incontinence services so that she could direct her clients to an alternative service. Better still, Gail felt that she was able to gain information that she may not have at hand or was new to her.

The tangible concept of teamwork emerged because of the RNs' ability to connect and expand as health care professionals. Teamwork occurred when a RN worked as a specialist nurse within a larger health care team as opposed to when a RN cared for

patients on a ward. To the RNs, the team comprised varied health care professionals such as health service managers as health policy planners, physicians, surgeons, nurses and social workers. The nature of teamwork was the connection between health carers where joint planning and action actually expanded their practice. Six RNs indicated that teamwork in the form of team meetings, was an optimal part of their work. Furthermore, it was pleasurable for five of the RNs to work as a team member where expertise was shared, health care was cohesive, health care targets were achieved, primary health care services for the mentally ill better effected, and health care to patients overall was complete. Working as a team and being interdependent as a specialist however, was felt not to be the same as being dependent or independent:

> *Being codependent (interdependent) would be quite conducive to OR nurses because you've got to work as a team if you need them. Technically, I mean theoretically you should actually work more cohesively as a team. If you've got too many independent workers working together it's a lot harder to get them to work together. But the independent workers are often more up front, more questioning and are more of a leader type in a team. So you really need a blend of those types [Megan 2].*

Being Enterprising

Some RNs felt that they were enterprising because they dealt with common nursing or community social issues in creative ways that had a positive outcome. To enable them to be creative, they did not necessarily view themselves as being ambitious because of their advancement. It was more a case of being eager and spirited enough to pursue an issue interdependently but with a masterful degree of optimism and confidence as they advanced in their areas of specialisation. Some RNs were enterprising enough to negotiate a work place agreement like Andrew for example, that enabled them to balance their studies or negotiate funding with their employer for conference attendance. Diedre and Gail were prepared to either negotiate a balance between their consultancy and work schedule or negotiate a time-share roster with an

on-call facility to cover for a community service. Furthermore, Gail felt enterprising because she pursued her area of specialisation in human touch knowing that work in her area of specialisation was limited in a smaller Australian city such as Perth. She looked for opportunities that existed in other states of Australia with the possibility of beginning a practice in Perth. However, she first needed to pass the instructor's component of her course, which she was to complete at a later date.

Being enterprising also helped Helen to combine health care practices while shopping with community members that she otherwise may not have had the opportunity to communicate with, during her surgery hours, about life style issues. Karen felt creative in identifying ways that clinical nursing staff in the critical care areas could be able to focus on a research project that was combined with their work schedule rather than the staff having to undertake clinical research in their own time:

> *The budget is fairly strained but the best thing to get people in the clinical areas doing research to me is to allow them time, maybe one afternoon a week that they could focus on. I know it's not much but then the expectation is that they do some work in their own time and I think that if you are going to say to them, Gary (the Co-Director, Critical Care Division) could probably negotiate to get time off for them, certain staff members. I think it's an expectation for higher levels but I think level 1s and 2s, it might be good. I have suggested to Gary that the people doing 12-hour shifts maybe on a study day if they are interested, could pursue a research and that is an option that could come [Karen 2].*

Furthermore, another RN felt that she was enterprising because she openly confronted staff for mental health experiences that would present as a limited opportunity to access. Olive therefore, negotiated with the appropriate staff for specific community mental health experiences during her practicums. Otherwise, being less than enterprising, Olive felt that she would probably miss out on sufficient community mental health experience. On the other hand, one RN indicated that she was determined to openly demonstrate and be tested on her performance as an advanced perioperative nurse. According to Megan, it was an entrepreneurial way to say, "how good I am at

what I do" as an advancing specialist. Being open to a challenge and having the confidence to negotiate engendered a trait of character that was felt to be enterprising in nature. For example, Brenda attested to her enterprising ways as a consultant so that her message concerning ADHD was widely communicated:

> *...they (small business proprietors) kindly donated their services and I went into all the people that I shop with and that. 'I don't want your money, give me a box of stamps.' So I had boxes of stamps being thrown at me. And then I just got another guy to give me all the envelopes. So they were just mothers (with ADD children) doing this stuff. So I've got 1100 people (people to attend a seminar on ADD children with Christopher Green as guest speaker). They broke the fire regulations, and Christopher Green looked at me and said 'a few mothers!' and that's how it started. So we raised $17,000 [Brenda I].*

Maintaining Integrity

There was a strong personal desire by the RNs to constantly maintain a sense of personal integrity as a nurse in their area of specialisation. To enable this to occur it was important for the majority that they had the support of staff in their department or that an acceptable standard of practice was maintained. Three RNs told why they reduced part of their study load or why they withdrew totally in order to maintain their personal integrity. Fiona and Gail needed to review the emotional impact felt because of a death in the family and when Carla experienced an unexpected death of a patient, before either RN was able to pursue their studies.

The stressors of life or events in the work place for the RNs at times were overwhelming. They felt it was necessary to experience mutuality in the work place and with family members, and to be acknowledged for their efforts to provide nursing care while undertaking advanced studies. For example, work in the rural areas demanded update of skills and knowledge and the maintained respect with members of the community. Thus Helen adopted the practice of writing letters of thanks to key

community members for their support of the nursing and medical services. She also conveyed letters of thanks to the shire members in the local community news.

Another RN in the rural sector indicated that because she had a financial motivator in the form of a health department scholarship to complete her master studies in critical care nursing, she had a duty to the people that provided her with the assistance to study. Fiona, at the same time, maintained active membership of the ENA to ensure update of the latest skills and therefore, credibility as a critical care nurse.

More telling was the sustaining of patient confidentiality. This encompassed a RN's level of integrity that was readily challenged. For example, Helen was adamant that her immediate family members refrained from discussing clients who visited her surgery:

> *I don't talk to my family about it. They're disgusted actually, even my husband gets mad at me for not saying you know, 'who was it?' And I said 'you know if you really want to know you can go outside and have a look what car but you know I am not at liberty to give you that information.' He said 'it's only to take care' and then he stopped. 'And when do I know you are going to go down to the club when you have had a beer or so and just mention a name you know it's just not on!' And I know mum used to even say when I was living at home...she would soy 'for goodness sake stop being ridiculous!' But then again when we had people around and mum would say, 'oh yes she's very confidential you won't get anything out of her" [Helen 2].*

The RNs from the metropolitan perspective were equally desirous of maintaining their integrity. When Andrew discovered he had gained a promotion in his department for example, that was advertised externally, he canvassed the confidence of the staff in him as a clinician before he agreed to take the position. He learned later that his promotion actually lifted the moral of the department, mainly because the nursing staff learned that Andrew was successful in gaining a promotion as an internal applicant and not from outside of the hospital. As a result, Andrew was pleased that the other staff felt more confident about applying for a promotion as they were offered. Nevertheless, having consulted his colleagues, his integrity remained intact. Similarly, Brenda was

invited to publish an article in the United States of America. This particular article however, raised sensitive issues specific to Aboriginal health and learning disabilities in Australia. For example, from the Caucasian perspective, Brenda revealed that a claim was made that the majority of Aborigines suffered ADD. In respect of the Australian Aborigines, she refused to publish the article because to do so would be disrespectful to the indigenous population and of their way of life that differed from the Caucasian perspective. She felt that any disrespect for the Aborigines would undermine her integrity as a consultant and researcher.

Mutuality and Being Acknowledged

Mutuality in the workplace reflected the way that the RNs felt inclusive of other health care practitioners, including their peers. They considered other health care workers as partners so that they could share knowledge. This reciprocity was a sense of mutual reliance on information that was of joint interest. As a result, they felt acknowledged for their part of the exchange, which in turn provided them with a degree of job satisfaction. Similarly, the mutuality was extended to their lives at home with their partner and family members. That is, seven RNs believed that they gained a consensus from their partners when making decisions about their work or to proceed with their studies. They felt that there was no doubt that the time spent studying and working impacted on them as a family unit, therefore it was vital that they had the mutual acknowledgment to become an advanced specialist nurse.

One RN recalled the mutuality between himself and his lecturers during his postgraduate studies in men's health. This afforded him an ongoing mentorship that he desired. Besides, he was paying a large amount of money to be studying, so lecturers should not continue with the pedagogical style of teaching for advancing specialists. At the same time, he was considerate of the working relationship with his nurse colleagues.

For example, there was a need to maintain a sense of calm and be supportive of nurses working in the ED for example, owing to the level of patient acuity and intensity of work that the staff regularly experienced. Being an ED nurse, the RN had to deal with members of the public who were verbally or physically aggressive toward them because some patients presented to the ED with complex social problems such as alcohol abuse and domestic violence. Andrew felt that management staff in the ED had a primary responsibility therefore, to safeguard and support the clinicians. Furthermore, even though Andrew was happy to negotiate a work place agreement for himself, he claimed that the profession must protect the greater number of nurses who may not be able to negotiate a salary or conditions of service for them.

Mutuality was also linked to the way that some RNs believed that equal recognition of academic skills and clinical skills provided for a natural balance of staffing expertise in the clinical settings. The way that the balance was maintained was through open communication and the sharing of knowledge during the delivery of care. For example, Judith experienced work with surgeons who valued her opinion because they prescribed treatments based on her sharing of knowledge of patient events. Similarly, while in the operating theatres, the surgeon was accepting of information that Megan shared. Megan often guided the surgeon to select an orthopaedic implement that was deemed statistically better for the patient over another. On the other hand, another RN referred to the natural phenomenon of the number of leaders and followers in nursing. Eric felt that there were those who were enthusiastic to research, but it was a matter of creating a balance and mutual recognition for the work that the skills based nurses did:

> *There are various stages of people's experiences and skills and there are leaders and followers. And I think that that's maybe a huge outer bland statement but more specific to me I think there's an issue of we need to have visions to be following, people guiding that vision, people supporting that vision. And also a lot of grooming and developing going on. So I think that*

In its own way it causes hierarchies that are not designated. There are certain people that are naturally capable of being left to their own supervision who will enthusiastically research and study and be competent at all times [Eric 2].

Yet optimal mutuality was only achieved between like-minded people. For example, Gail felt that job sharing of her community nursing responsibilities with another colleague was beneficial, only because she and her colleague had similar work patterns. The similar practices of two nurses who were able to provide care that was equally acceptable to their long term clients was a point in question. Nevertheless, Karen believed that the doors opened for individuals who wished to pursue advanced practice if they were "prepared to give a bit of yourself." The decision to undertake advanced studies in critical care resulted in mutual recognition for Karen and Linda, for example, when employer support to attend lectures and gain appropriate experiences in the clinical setting was maximised. Furthermore, people were willing to help each other to care for patients in the ICU, and the continued teaching by all staff was felt to offer a far better environment in which to work. In addition, the arrangement of rosters between the nurse and manager offered an added sense of mutuality for seven of the RNs.

Similarly, Megan felt that the perioperative nurse who advanced in his/her area of specialty required management skills to negotiate differing experiences as a manager or clinician and therefore, opportunities to advance. She felt that this demonstrated mutual recognition by line management of her advancement. In the rural sectors, the doctor was open to a Helen's suggestions of health care management and services in the regional setting. In response, the doctor shared information and supplies of pharmaceutical agents for example, because he was aware of Helen's nursing boundaries regarding prescribing rights, or to Diedre's access to a health provider number for patient services.

Further mutuality was felt by actively seeking the rapport and therefore, respect, of children and teachers in the community when Helen provided voluntary health preventive sessions at the local school. Furthermore, Helen thought it best to advise farmers about their consumption of alcohol when she attended to them out of surgery hours to seek treatment for a wound. She was concerned about their general health status because they were inattentive to the adverse effects of alcohol consumption when taking antibiotics. She made it a mutual effort to treat the farmer at a time that suited him. She believed that the farmer was less likely to drink alcohol in conjunction with a prescribed antibiotic. Therefore, both client and nurse were able to maintain their overall integrity and mutual respect for each other:

> *..you know a lot of farmers will come in after hours to have dressings done or whatever and I feel well if I do that for them then I've got over them and they'll have to do something for me. And it might mean that they are less likely to drink with their antibiotics if I sort of put the hard word on them a bit...Oh well if I give them antibiotics, I've sort of done something for them maybe they can do something for me...(such as) reduce their alcohol intake over the weekend while taking the antibiotics. Or you know, stuff like this, you make it work for you...Yeah, well I don't think it's the intellect, I think it's just a mutual agreement you know, it's very much bush nursing [Helen 2].*

Being Acknowledged

Sustained mutuality in the workplace was conditional. The proviso was that other nurses acknowledged the RNs for the extra effort that they made to advance in their practice. The experience of mutuality was achieved if they were simply acknowledged by others, particularly their peers or managers and to a lesser extent, by their patients. As an outcome, Carla felt that she gained additional job satisfaction and was able to provide a more appropriate standard of care. For Andrew and Brenda, the outcome was that they felt greater involvement in the nursing profession because of their input into their area of specialisation. Acknowledgment was in the form of peer recognition and respect for nursing care rendered in the department or community, being seen as a

reliable source of information and invited to write an article for schools and publish, or being contacted by community leaders or lay people for advice. Being acknowledged by management with an offer of funding support for their studies and a negotiated roster to reduce their workload without undermining their current contract of service, were additional factors. Four RNs were pleased when offered a promotion by their employer, offered additional secretarial support, and when peers were genuinely interested in their research study.

Other RNs found it satisfying when for example, Fiona found that other health care professionals such as the social worker responded to her ideas as being useful, particularly for patient services related to triage. On the other hand, it was significant to one RN when she was not only invited by a university to continue with higher studies in a masters program, but also acknowledged by her peers for her excellent presentation style during hospital education sessions. Furthermore, the invitation to attend meetings and write in the hospital newsletter was another form of acknowledgment that realised mutuality in the work place and contributed to maintaining Karen's feelings of integrity and ultimately, her interdependence:

> *...and I find that doing the course, I've done a lot of lectures, lots of presentations in front of a variety of people but the thought of standing up in front of a microphone...Oh, I will get better, because I had to do it at uni and I used to be a nervous wreck. Whereas the last one I did it was on something to do with dialysis and it was an hour lecture or presentation, and I used powerpoint because I learned that. Of course nurses are always very impressed with that...and the girls who organised the study day came up and said, 'you've got marvelous presentation style, you're so relaxed and laid back when you talk.' Whereas before it was so damn hard whereas now I enjoy doing it and you do learn a lot from doing presentations [Karen 1].*

> *You know they go, 'how long have you been in ICU?' And I say, 'six years.' And they go 'oh?!' And I get you know the jaw drop...particularly with the promotion now. They've said, 'did you get that?' And they don't mean that as an insult, they just mean that they didn't realise the amount of experience that I had. Now that they're all getting to know me, yes, a lot more people are coming and asking me questions, seeking me out [Linda 2].*

Conclusion

This chapter discussed three of the five sub themes that emerged in Part A. The three sub themes identified the participants' choices in undertaking ANS and education, their ways of knowing and experiential learning that they accrued during their studies, work and personal life styles, and how they maintained interdependence of practice as they advanced in specialist practice. Chapter Six continues with the completed reconstruction of the remaining two sub-themes that metaphorically describe 'the way through the labyrinth'.

CHAPTER SIX

RN Profiling and Meeting the Crossroads

Introduction

This chapter explores the way that the RNs balance their professional and personal profiles, and how, while advancing, they meet a crossroad. These concluding sub-themes were revealed when the RNs' felt a fresh understanding about their advancing profile and resultant pathway that they took because of their change in direction. Arrival at a crossroad indicated the final direction of specialism that the RN embraced. These findings illustrate the concluding analysis of the movement toward ANS and education in its entirety, by the participants.

Sub-Theme Four. Profiling: Visualising and Situating Self

The RNs revealed how they needed to balance both their professional and personal profiles so that their professional and personal lives were workable and therefore, satisfying to them. By profiling, they visualised and situated themselves as advanced specialists. This allowed them to create opportunities to progress in their area of specialism, to persevere with their advancement while working in a bureaucracy, and for a few, to recognise a difference in experience between the delivery of health care for the private and public patient.

The RNs created a professional profile that emerged as a legitimate collective profile. In other words, the RNs believed that nurses, other health care professionals and members of the community visibly saw nursing as a profession only when collective profiling was evident. For example, when nurses from all fields rallied on health or industrial issues together, they gained media and public attention. Conversely, being collectively invisible to the public was abhorrent to the RNs. For example, an

individual nurse was rarely acknowledged in the media for his or work as a nurse. Their public invisibility made them feel collectively undervalued, especially owing to the enormous workload that all nurses endured. However, being collectively visible as a specialist nurse ensured the RNs with a nursing profile that was productive. In other words, the RNs' momentum to pursue advanced practice was warranted because they felt that they encountered public visibility as a professional group of nurses. Some RNs in this study however, felt ambivalent about nursing issues that were often problematic to other nurses and professions but not to them.

Creating Opportunities While Advancing

The RNs actively created and maintained an awareness of opportunities around them to add to their nursing profile. Five RNs examined new ways of implementing better practice while six responded to openings relevant to their area of specialism so that they could better position themselves for advanced employment. For example, Judith told of how she wanted to teach perioperative nursing. She constantly reflected on her prior practice and how she could do better by undertaking advanced perioperative nursing studies. She also took the opportunity to continue her studies while overseas and at the same time be with her husband because his business often necessitated periodic transfer of his work from one country to another. Examining ways to improve her chances of being a teacher in the operating theatres and taking the opportunity to transfer her studies while residing in a new country was a positive move:

> *This is a real challenge trying to do it this way (studying in the Philippines) so achieving my goal and finishing my postgrad studies are really good. My ultimate is basically to be able to teach. I'd like to teach clinical and theatre. If we actually go back to Port X, I look at things and say that what happened to me, I don't know what's happened to other people, so what could have I done better...and I thought okay this is what I want to do [Judith 1].*

Owing to the critical shortage of nurses and of advanced specialist nurses, it was opportune that all nurses seriously reviewed work place agreements and nurse education from the undergraduate level. According to Andrew, the situation with the nursing shortage was so bad, that it was timely that the nursing profession took the opportunity to consider a reversal of nurse education back to the apprenticeship model of practice:

> *...when it (work place agreement) was first introduced there was a lot of slack that could be brought up. But I don't believe that's the case anymore. It doesn't stop people from continually examining what they are doing which is probably what better practice is all about. You know stopping and looking at what you are doing which can mean reverting back to what you did 20 years ago because that model might now be the right one to operate with now [Andrew 2].*

At least six other RNs created opportunities while they were working to pursue their area of interest. For example, Eric looked for the opportunity to move sideways as an advancing specialist while waiting to progress his career in order to pursue his interests in men's health. Eric worked with male patients who were being treated for cancer. He waited for the opportunity when a role model or a sponsor for example would trigger his move sideways. Instead of caring for cancer patients in general, he waited for the opportunity to provide specialist care for men who fell ill with cancer. Being a nurse specialist in the hospital ward was one thing, but as a consultant, he believed that he could reach out to men in the community that generally resisted any preventive health care measures. It was too late if they had already contracted a disease such as cancer or coronary artery insufficiency. He wanted the opportunity to enable a change of male lifestyles so that they could combat chronic or acute ill health before the onset of a severe illness such as cancer:

> *I'm looking for the right way to go. But I don't think there is a right way. I think I need to remain open, look for the opportunity and perhaps you know, grow where I'm planted. I happen to be here (oncology ward) at the moment, so maybe this is where I need to develop and do the best I can. But I can see how doing the alcohol and drug misuse course, doing the men's health training. I can now start to see that well these are some of the areas*

that I can now move along. I don't necessarily move up. I just seem to be moving along [Eric 1].

Diedre valued her years of experience, expertise and qualifications to promote the health of individuals of the same gender as her. She found the opportunity to join with a male GP practice to provide a dedicated women's regional health service as a nurse consultant. "I'm a more mature lady, I've had the qualifications before I got here. So I just needed the opportunity to be there. Like women's health...I've always had that and done that, so I needed the places". Similarly, since Olive had undertaken her studies in mental health, she told how she took the opportunity to make a "positive change" to her career while Gail seized the opportunity to take on a consultant role to a wider community of persons who were disabled. Instead of following a reactive model to disease and illness relating to clients with spina bifida for example, she took the opportunity to be proactive. As a community nurse consultant, she created strategies to enable those with disabilities to live independently with community nursing backup. Gail stressed that she could visit patients rather than have them hospitalised. She could assist clients in their home to jointly solve problems before their anxiety levels peaked rather than allow them to be dependent upon medical assistance based within an institutionalised framework of care, such as a large teaching hospital or nursing home.

From another perspective, Karen took the opportunity to present a paper at a national conference with a view to publishing the paper as an article in a journal. Meanwhile, Fiona revealed that she did a specialist course of study because it was not only fitting with the nursing profession's desire to elevate the profile of ED nursing in the rural area, but would also be the best opportunity for a promotion.

Perseverance: A Way to Maintaining a Profile

Four RNs persevered with their specialised work and studies. They felt that having the perseverance to continue with work and studies would ensure them a professional profile that was not only public, but also meaningful to them. For example, Brenda wrote numerous letters to parliamentarians or departments to spread issues to the community and to other nurses surrounding her field of interest and practice. Her perseverance was remarkable because she continued to pursue communications within the public arena even though she received little formal response. The writing of numerous letters to organisations and parliamentarians resulted in just one supporting response from a civil servant. Furthermore, a senior nursing manager of a major hospital she visited, showed a negative response to her expressed concerns about people with ADHD. Brenda was concerned that nurses working in hospitals were not aware of ADHD. Nor were senior nurses interested in knowing about ADHD and the relevance to health care of individuals that were hospitalised.

Another RN was equally persistent. For example, Diedre decided she needed to advance her knowledge and undertake a distance education course in mental health because she was convinced that it was relevant to the current health of individuals in the rural community in which she worked. Her employer however, was sceptical about the relevance of a mental health course to nurses let alone, to community nursing. Therefore, Diedre was denied any employer support such as time release to attend an assessment related to the course, scheduled in the city some 250 kilometers away. Even so, the lack of employer support did not deter her from undertaking the course:

> *I did (apply for support), but they weren't sure that this course I was studying had much to do with my job. And that's not funny. 'What's it got to do with nursing?' they said. So I persevered anyhow. I new it had a lot to do with nursing [Didere 1].*

The RNs' perseverance to succeed as specialists was intrinsically motivated. Diedre, Fiona and Judith were three RNs in particular who viewed their advancing profiles as "intrinsically driven". Even though Fiona had a negative attitude because of her recent family setbacks that impeded her progress, she kept reminding herself that she needed to continue with her studies. She owed it to the profession, to the scholarship provider, and to herself. Similarly, Judith told of her perseverance from the perioperative nurse perspective. "You have to want to do it because nobody else is going to help you get there". This was an indictment of a specialisation that was bereft of specialist perioperative nurses. According to Judith, her colleagues and to a lesser degree, management offered no encouragement for the perioperative nurse to gain advanced practice. In spite of this fact, Judith's perseverance was indicative of her persistent profiling as an advancing specialist.

Nursing Care of the Private Patient

The profile of the advancing specialist was blemished or enhanced when the RNs compared the way that they delivered care for the patient in the private health sector. Carla, Megan and Olive experienced tenuous circumstances that could have hindered their advancement as a specialist while working in the private sector. For example, Carla felt despondent about working on the private ward of a co-located hospital because the expectations of the public and private patient varied significantly. However, Megan and Olive felt that work in the private sector allowed them to enhance their specialist profiles. As a perioperative specialist in the private sector Megan argued that "in the private sector you basically have to be able to do everything if necessary." This requirement ensured that the advancing perioperative nurse was able to apply multiple skills such as positioning the patient, circulating, scrubbing and assisting the surgeon, as well as helping the anaesthetist as required, rather than employing a

technician as an additional surgical team member. The down side to work in the private sector was that there was no team teaching between the surgeon and the perioperative nurse. Unlike perioperative work in the public sector, Megan was severely restricted in her teaching to new perioperative nurses during a surgical case because the "surgeons in the private sector did not like it." This minimised the learning opportunities available to the nurse working in the operating suite and the teaching profile of the perioperative nurse employed to care for the private patient.

Professional Profile

Professional profiling related to the manner in which the RNs shaped themselves as a member of the nursing profession and presented themselves as a leader in his/her workplace. They discussed issues that were pertinent to their specialty through their professional organisations and ensured that the community was aware of the work involved as a specialist nurse. Professional profiling that was public, was considered vital because without a nursing profile that was made public and effectively communicated to the public, information was often distorted in the workplace. Worse still the media and the public as a whole could easily misrepresent nursing as an unknown identity.

Ten RNs referred to postgraduate nursing qualifications or involvement in nursing research as the way to increase the profile of the specialism and the profession. It was helpful if an advanced specialist nurse had a master degree so that s/he could speak with other professionals on equal terms. Eight RNs urged the engagement of dialogue with colleagues and other professionals. The dialogue through professional or community organisations ensured that the public was made aware of health and nursing matters through the visual and printed media. Letting the public know about an issue that was of concern to nurses as a whole brought about professional credibility:

> *There's probably a lot of professional snobbery or whatever that goes on, and so by attending a tertiary institution, it brings on some professional credibility. To engage in dialogue with other professionals, is probably quite important. It's probably unfortunate that it has to be that way. But if you want to be able to speak on equal terms with a neuro-surgeon, if it helps you to have a masters after your name and it helps to deliver a better service, then you know, lets go for it [Andrew 1].*

Furthermore, Judith stated that "we need to believe in our top people who are trying to help the profession" and to do research because, as Karen said, if "we are academically inclined, it will be a better profession all round." Karen also indicated that "research was vital for the future of nursing and patient care". Any evidence of RN profiling in the public arena was made apparent by written publications and the tertiary qualification gained by nurses within a university:

> *Well I'm publishing, I'm researching, I'm still seeing clients on a private basis. I'm involved in writing a chapter in a book for Mary Smith on ADD and women and the special issues involved there. I have had a lot of recognition in the last 6 months for my work [Brenda 2].*

The majority of RNs indicated that being involved as a member of a professional organisation as they were, impacted on the way that they cared for patients as a specialist. This was because they could pass on clinical updates and other information to their workplace. The RNs from the rural or community perspectives were no less active in their professional profiling. Membership of professional groups for Diedre, Fiona and Helen, such as the Rural Reference Group, the Emergency Nurses Association, and representative of the Health Consumer's Council respectively enabled issues to be openly addressed within a public forum. For example, Helen was perturbed when she learned that members of her community were ill informed about a proposed change of health care service structure. The public resisted the change, but needed to be made aware of all the facts before they made a decision. She enhanced her professional profile when she spoke in a public forum:

> *It (the rural Council) meets quarterly. And I just sort of had a bit more information on MPSs (Multi-Purpose Service Centres) and how they work and are being set up throughout the State and you know, we (the people in the township) were going to be secure financially and we were going to be better off. And I saw at the end, like I got up and sort of pleaded with the community that you know, at this public meeting. I thought 'I can't believe I'm doing this, you know I can't believe I'm actually doing this! Where's this coming from?' I felt I'd sort of stepped out of myself and become this person that I never knew I actually was [Helen 1].*

Being Collectively Invisible

There was a downside to the way that the RNs procured a professional profile that was made public. The RNs referred to the undervaluing of nurses and of nursing in general as a profession. Not withstanding the arduous and sometime dangerous workloads that nurses overall were expected to bear, being collectively invisible and undervalued by the public or even by other nurses, dampened their professional profile as a specialist considerably. Being employed by another health care professional for example did little to enhance the visible profile of the nurse. There were very few specialist nurses like Diedre who was an accredited private practitioner:

> *There is no other nurse in Western Australia who does that except a nurse in Mandurah, whose husband is a GP. And the only other nurses doing pap smears are in remote areas, and they're employed by a health service. And the others, as I used to work in Perth, are employed by women's health centres or by family planning. So, most of these nurses who are doing what I do, are employed by somebody else [Diedre 1].*

At least nine RNs openly declared that they were invisible to the public as a nurse. While nurses were employed in schools for example, Brenda felt that the school nurse as a specialist did not use his/her child developmental assessment skills to identify and refer children with possible learning disabilities. From Brenda's experiences, it was the principal of a school who considered these skills outside the realm of nursing practice. The principal did not use the services of the school nurse, but devolved the

responsibility to the parents, school psychologist, or medical doctor if and when a teacher recognised child misbehaviour was linked to a learning disability.

Other forms of invisibility of the nurse were noted when no one in the community understood what a remote area nurse did or because there was no prominent political nurse leader who could act as a mentor for other nurses. Furthermore, a nurse was usually employed by someone else to enable him or her to treat individuals under the national medical rebate system, while every day nursing activities such as provision of comfort, were not visible in the ED because these were not documented while the patient waited for a medical diagnosis. The implications were critical to the profile of the advancing specialist:

> *And we have had a number of instances lately where people have written a letter with a concern regarding treatment so you pull the file out and look and we look and there's nothing there that shows what nursing care has been provided [Andrew 2].*

From the metropolitan community nurse perspective, individuals with a disability checked with their doctor rather than the community nurse. The judgment that was not considered by patients in the community however, was that the nurse might have been the best person to deal with these matters:

> *Oh God I think nursing needs its profile elevated. I really do. I see us, I see nurses as making such an amazing impact on the health system and getting no recognition and that's not even in a sad way. That's just the way it is. The nurses that I talk to that go to work and do what they do. And the people who say that the nurses are the best and really mean it, yet in the real sense out there in the real world, no it's not. [They will say], 'no I will go and check with my doctor' [Gail 2].*

Being Collectively Undervalued and the Demanding Workload

Nine RNs described nursing work overall as undervalued by the health bureaucracy in which they worked, by other professionals and by other nurses. For example, the RNs felt that nurses who were not specialists were not involved in the

running of a hospital. According to Diedre they did not understand the "bigger picture" concerning the health care system. After all, both Judith and Linda felt that many people still saw nursing as minimalist owing to the poor recognition of the skill level:

> *A lot of people see nursing, whenever I say it or tell someone that I am a nurse they think that all I do all day is hand out tablets and give people urinals or pans. And then if they find out that I work in intensive care, all they think I do is write down observations, whereas for me nursing is both of those with everything in the middle [Linda 2].*

From Fiona's perspective nurses were undervalued, particularly when advancing in a specialisation. For example, management obtained nursing expertise very cheaply when the experienced nurse was employed at a lower incremental level for the duration of a specialist graduate course. Furthermore, five RNs perceived themselves and nurses overall as undervalued in terms of remuneration for the workload they maintained. As Carla indicated, even a RN that studied and graduated as a midwife gained no extra remuneration over and above the generalist RN. Meanwhile, other RNs in this study identified the way that nurses undervalued other nurses. Three RNs believed that nurses abused one another or in Eric's experience, competed between themselves for recognition and authority by other health professionals, primarily the doctor. "One of the issues on the ward that was causing one of the most frustrations was individuals having a good rapport with the doctors, getting the information required and maintaining and using it against another member of staff" [Eric 2].

In terms of the nursing workloads, four RNs felt that the long hours of work and unpaid overtime were arduous, particularly for the advancing specialist who was studying. Furthermore, excessive periods of being "on call" for Judith and the long hours in balancing child rearing with full time work and study for Andrew, Fiona and Karen, were indicative of how these RNs managed a professional profile that needed

them to strike a balance and often undermined their advancement as a specialist. Apart from herself, Karen was concerned when she encouraged a colleague to undertake a research project, knowing that the nurse was expected to manage a busy workload:

> *Especially the girls in the burns unit are very very hard workers. And they do this (research project) on top of their work. And they are keen and whenever you ask them to produce something they always produce it, but God they have tried so hard. But I can see that this girl's carotid endarterectomy, she's a nurse manager on one of the wards and she's so stressed trying to do this research plus trying to maintain her managerial load as well [Karen 2].*

Legitimate Collective Profile

Some RNs supported the expansion of other specialists' roles and felt encouraged when their roles were extended beyond the generalist RN role. The extension of their roles added to the legitimacy of nursing that had a collective and cohesive profile. One example included the promotion of Andrew as an executive member of the ENA. Through the executive membership, an advancing specialist such as Andrew was encouraged to make public statements concerning nursing practice in general in the visual and written media. Other RNs like Fiona, Linda and Karen believed that their collective profiles emerged when a department was recognisable by its staffing profile. For example, the experience for Linda and others in the ICU was uplifting because other "nurses seek you out". This added to the visible success and collective profile of nurses who advanced in critical care nursing. And Fiona reported that the skill level of nurses in her ED was considered high because the majority of staff had recently attended and completed a trauma course. This added to the collective profile of the department:

> *I have done two internationally recognised trauma nursing courses within the last 12 months as well. One is the trauma nursing course from America run by the Emergency Nurses Association of America. And the other one is the paediatric trauma course and both of them, I'm now a certified practitioner in this. But yes that's things that we have been doing. There wasn't a lot of new information in those so perhaps we have got to the level*

where we are classed as (practitioners). And I say we because most of the people in my department are in the similar skill level and they have got to that level [Fiona 2].

Finally, the collective profile of the nurse was given credence if one was a postgraduate student. This may have been the reason why the majority of RNs felt it compelling to advance. Olive felt that "there is a lot more respect (by multidisciplinary health carers) as a postgraduate student." Meanwhile, two other RNs suggested that they procured a collective profile by being politically aware or worked with politically prominent figures such as the doctor in the Naltrexone Clinic. Six other RNs felt that their visibility and collective profiles as specialists was enhanced because they shared their knowledge with other nurses or included level 1 and 2 nurses in developing research projects specific to their clinical areas of practice.

Conversely, Olive was convinced that because nurses were the patients' advocates, they already had a legitimate collective profile. For example, as a patient advocate and as the principal liaison person working within a multidisciplinary mental health setting, the nurse was seen as a part of the team and therefore, visible and valued. Similarly, Karen and Judith respectively felt that medical staff in the ICU and the medical consultant in the operating theatre valued them because of their advancing practice and knowledge:

Oh I think that they know that they go to uni but I don't think that they realise that a lot of the staff actually go on further than that. And as they always say you know...it was 16 of us that were on secondment from ICU at one stage and the doctors' comments were 'well all of the best staff have gone and left the unit and go elsewhere' [Karen 2].

Personal Profile

Personal profiling was conceptually different to the way that the RNs maintained a professional profile. It was not about the RNs being ambitious, but more as establishing a profile that an advancing specialist could adopt. The way that the RNs sought a higher nursing position for example was interpreted as a personal achievement and therefore, a way of establishing a personal profile. Professional profiling on the other hand referred to the way that the RNs and others collectively viewed nursing in general and advanced practice in particular. The latter related to the visibility of nurses in the profession and the value placed on the nurse by society, health care professionals and nurse colleagues.

In developing a personal profile, seven of the RNs believed that they were a possible benchmark for colleagues with whom they worked. The RNs felt that being a role model or mentor actively encouraged others to advance in their practice or embrace change in practice. As an example, two RNs indicated that they would proceed to Ph.D studies in the future because other nurses had done so. Meanwhile, other RNs appreciated the acquisition of further responsibilities given to them as advancing specialists. Six RNs revealed that nursing management had suggested to them that they could apply for a higher position even before they had completed their specialist studies. Another RN's personal profile emerged when Eric waited for the opportunity to move into nursing administration so that he could appreciate the culture in which he worked and to understand the "bigger picture" surrounding hospital policy and health care services. After all, keeping their options open while working in a large institution and maintaining a skill mix enabled three of the RNs to take on an administrative or in Eric's case, a consultant role. More fundamentally, all but one RN described how updating

their skills and knowledge was a means to gaining a profile that was tailored to the specialist nurse:

> *I just feel that my impact would be far better in a different role. I'm not suggesting that I want to get away from patient interaction. I just think that for me it's not a case of I want to get out of nursing. I don't really see myself as a nurse anymore. I see myself more as an educator, counsellor, supporter, change agent and also most importantly somebody who nourishes people.....And the one above me, the Level 4, the Director of the Cancer Services, I think that is probably the best option to look at because of the greater networking that occurs. The opportunity to be involved in the politics of the hospital, the understanding of the actual culture of the area. So that's where my frustration is. It's the closing of being a clinician and accepting that role [Eric 1].*

A community nurse RN established a personal profile by accepting a position in an agency that philosophically matched her beliefs. That is, Gail sought employment in a service that supported a wellness orientation to care. Her area of specialism in complementary therapies could be integrated:

> *I principally do the healing touch, which is energy work. I also have reflexology and aromatherapy. I've done massage courses. I integrate them as such. I use a bit of massage for principally the energy work that I use.....I would love there to be a lot more demand for it! I think where I come from with my nursing is a wellness aspect and a health promotion aspect. And that's ...one of the things that Reed Bay (pseudonym) had in their ad was that it was geared toward promoting and supporting independence and the concept of wellness as opposed to a disease base. That's where I see complementary therapies as making a big difference [Gail 1].*

Pride and Maintaining a Personal Profile

Pride emerged when the RNs spoke proudly about their work as advancing specialist. Having a sense of pride as a specialist generated a personal profile that was covert but demonstrated as a common behaviour appropriate for an advancing specialist. Furthermore the way that they prided themselves was not always recognised by these participants and therefore, communicated the social complexity inherent of ANS and edueation.

More often than not, six of the RNs felt that pride, as a nurse was associated with the advocacy role of the nurse. For example, their moral goodwill to others and patients often demonstrated their benevolence that was considerate and rational toward others rather than being cruel, unfeeling or callous. Five of the RNs also prided themselves for being self-motivating in order to advance in their area of specialism. Being motivated mattered to them. It was not about what a nurse should do but about what kind of nurse he or she was motivated to being. None of the RNs wanted to work in a vocation or live in a society of ruthless go-getters where they would only help people if it helped them. Furthermore, they prided themselves on how they continued their studies even when family matters for example, took precedence:

> *I'm getting there, yes. Getting back to it [her studies]. This has only happened relatively recently so this has been within the last month. So it's getting back on track and it's self-motivation, it's self-discipline and self-motivation [Fiona 2].*

Seven RNs prided themselves because they not only motivated other nurses to continue in their studies but also searched for ways to improve their own practice. Megan also felt pride because she had the confidence as a perioperative nurse to leave her job for another if for example, no common resolution was achieved or if she was unable to collectively change undesirable practices such as poor staff morale in the perioperative setting. Other nurses who did not have the courage to openly discuss workplace conflicts with management like she did, could not consider themself as praiseworthy:

> *It's just that some and I'm very much an advocate [for the new perioperative nurse], if you are having trouble in my work place, I go somewhere else because different work places build on different relationships depending on who the manager is, who the key people in that area are. And a lot of people think, 'I can't just resign.' They have that insecurity to do that. They just won't walk out and do something new whereas I'm if something is not right, I just go, leave, start again [Megan 1].*

Many other examples of pride occurred in the workplace. For example, whenever some RNs assisted their clients to enhance their health and sense of well being, supported and shared knowledge with other nurses and patients, applied perioperative skills across a range of sub-specialties in the operating theatres, discussed relevant research data about surgical implants with the consultant surgeon, or gave the consultant doctor in the ICU the best answers to questions that related to patient treatments:

> *I mean it's just that when the consultants ask and the registrars ask about the effects of drugs and you are answering it and the registrar doesn't know the answer. I mean it's very good for your own [ego]. The way they look at you, with respect, it's very satisfying inside as well [Karen 1].*

Karen and Olive also felt pride because they were able to resolve conflicts in the home as well as in their workplace. This was because their study program as an advancing specialist in critical care and mental health nursing respectively for example provided them with the added specialist knowledge and expertise. Meanwhile, Linda experienced feelings of pride when "I was told when I got the level 2 and that was one of the areas that I beat everyone on because no one else (ICU nurse) was going for their masters" [Linda 2].

Ambivalence

As a researcher, I sensed times during the interviews that some of the participants seemed ambivalent about issues that were of importance to other RNs but not to them. This was in contrast to their affirmations of pride. For example, I was alerted when Brenda and Olive made little or no reference to the personal cost of their studies and advancement. Brenda in particular was so driven by her area of interest and advancement that she pursued her work regardless of any study related expenses such as consultancy expenses, course fees, travel to classes or meetings, or child care services. She lived an upper middle class existence and cared for three of her own children who

were diagnosed with ADHD. Such ambivalence about this RN's own incurred expenses however, was in contrast to her clients or people she knew in the community that suffered ADHD. Brenda was concerned about the parents of a child that was diagnosed with ADHD because some parents were unable to afford private health care or seek a private medical practitioner, particularly when no other alternative expertise could be found within the public health care sector. On the other hand, Brenda was ambivalent about the $2000 scholarship she received from the university she was enrolled in for undertaking her master of special education by research. It was "sweet" for Brenda, but not really necessary. Similarly, Olive was ambivalent but more astute about her career advancement expenses. She felt that the cost of undertaking full time studies for a year was of no financial consequence. Olive was sensible with money and planned her expenses accordingly. The remaining 11 RNs were aware of the costs surrounding ANS and education but were concerned about the financial burden to other nurses in general, to undertake ANS and education.

Another two RNs felt ambivalent about pursuing their master studies at all, one in critical care and the other in midwifery. This was because Fiona sensed that there was no chance of a promotion in her rural hospital after completion of her masters and because Carla progressively discovered that her midwifery course content was not what she had expected. These issues altered their perception concerning the profile of advanced practice and specialisation:

> *I'm ambivalent, but I don't know whether masters level clinical nursing at masters level is ever going to take off in a big way. While I won't say that we are stagnating, but there is no incentive at all to do higher education especially like people in my situation where I am, for want of a better word, stuck in the rural arena for quite some time. Our positions for promotion are limited by percentage basis, you know, numbers of clinical nurses to number of RNs. Once they're filled, that's it. So, yes, I will be a masters qualified level 1 RN if a clinical nurse job doesn't come up in my field. And that needs to be addressed [Fiona 1].*

And then this semester, it's been the research, and I don't know. I don't know how it's going to help me yet. I mean I'm more than half way through the semester, and I feel that it's more something that needs to be looked into later on in your career, if you want to go further and do your thesis [Carla 1].

Sub-Theme Five: Meeting the Crossroads

Introduction

The culmination of living the phenomenon of interest terminated when the RNs met a crossroads. A crossroad was not when they initially decided to undertake specialist studies, but when the RNs decided to either continue or not to continue in his or her area of specialisation. As they met the crossroad, two major issues emerged for them. Firstly, they revealed that they experienced feelings of being liberated, which actually contributed to their potential as advancing specialists, and secondly, they upheld openness about the challenges associated with their advancing practice. Owing to their openness during the interviews, the most positive attributes evident by this group of RNs unfolded. These attributes included the disclosure of their personal ambitions and intentions to be a specialist nurse. For example, they felt that being challenged in their practice and studies enabled them to clarify their status as a nurse and subsequent decision to take an appropriate course of action. It was at this stage that they acknowledged that they met a crossroad that was a turning point for them. The turning point occurred, when they felt that they had reached a plateau in the workplace or considered that it was time to move on, or both.

Their feelings of being liberated also reflected how the RNs gained increasing confidence about their current position within nursing. Being liberated while advancing gave them the urge to act as a catalyst to influence other nurses in their path or clients in

the community. This urge directly related to their aura of being liberated when they met their crossroad. Their descriptions of being liberated however, did not come easily for all. The reality was that some RNs felt vulnerable on many occasions during their quest to be challenged as an advanced specialist nurse. This was in contrast to being liberated. In essence, some RNs were either dispirited by their lack of potential for promotion for example or were embarrassed by their perceived lack of knowledge.

Being Liberated

The RNs desired to lead in his/her profession because they were liberated by what they experienced. Seven RNs affirmed their advancement in their specialism. Brenda for example, met with international experts who invested energy in researching and discussing controversial issues relating to ADHD during a conference. This inspired Brenda to start writing submissions to political organisations about the issues on her return to Australia from the overseas conference. At the same time she was exposed to such a volume of scientific literature on the subject than she never imagined, as a result, she envisaged other ways to expand her consultancy relating to learning and attentional disabilities. For example, rather than arrange seminars to present information to the public on ADHD issues, Brenda felt liberated enough to establish a book distribution company and called it 'ADDvanced Publications'.

> *...so in the end I thought 'well no, I can't go on with this.' So I left [Learning and Attentional Disorders (LADS) committee] and thought 'well, a way I could help them was to see what books were around.' Because I love books and that's where I had the contacts with people at this conference because they had a big display of the books, and from there I researched it all and that's how ADDvanced Publications started [Brenda 1].*

Eric felt it liberating when he realised that it was possible to deliver health prevention, promotion and wellness interventions for men who required a lifestyle change. He had experienced the aftermath of cancer treatments for his patients and

suggested that it was all too depressing for men once they seceded to an illness such as cancer. In addition, a lecturer who was a consultant and counsellor in men's health inspired Eric. Experiencing that inspiration was liberating. Being liberated, Eric believed that he was now ready to take the initiative in promoting wellness in general or wellness in men who were in the early stages of a disease such as cancer. As an advanced clinical specialist, he had come to terms with being his own role model. Furthermore, having a master degree would give him the tools to advance as a credible researcher in the field of men's health:

> *And I suppose really that's why, it's all kind of hand in glove now and realising that the Masters gives me the credibility. Of having a Masters it gives me the tools for having done researeh. I am already doing men's health and management as well. So really in a way it's all combining and all I need to now do is be patient, complete the course and the options, or like I say, are open. I didn't see it that way before.....[and] I think that's what I have realised that there is no role model. So I am going to have to start being my own role model [Eric 2].*

Other experiences of being liberated during their advancement emerged when Gail and Olive, for example, described how they enjoyed the flexibility to diversify their skills, when Helen felt autonomy of practice in the rural/remote area, and when Judith used reflective practice as a tool to assess her own practice. Furthermore, Karen felt liberated when she expanded on her research activities from a critical care focus to projects relevant to a range of patients that a specialist nurse cared for in the acute hospital setting. More specifically, having an eclectic and holistic framework of care to her nursing knowledge and approach was better for Gail than trying to be "encapsulated" in a mainstream specialism such as medical/surgical nursing or gerontological nursing. Gail's holistic approach to patient care was liberating because she was able to diversify her formal learning experiences to encompass complementary

health or education for not only the Caucasian population but also for the indigenous people of Australia.

Self-Assurance and Feeling Confident

There was no doubt that having the self-assurance and the confidence to continue in advanced practice added to the RNs' feelings of being liberated. All but Carla felt confident about their chosen area of specialised practice. A number of RNs felt confident that they would advance as long as they actively sought the motivation to continue with studies or undertook research relevant to their field even though it was new territory to them. In Linda's case, she had the self-assurance to work in the general ward even though her specialty practice was in the ICU. Moreover, as a perioperative specialist, Megan and Judith felt that they could confidently work in a variety of surgical sub specialties in the operating threatres.

Three other RNs felt self-assured because they could confidently care for a critically ill patient. Their confidence directly related to the advanced course that they were or had undertaken. For example, they understood the numerous vascular lines and medical treatments that the patient was going through and as a result, more assertive with the doctors and able to speak with the doctors more intelligibly. Their confidence had increased so much that they no longer felt the need to be subservient. All they needed was to take the opportunity when it arose to be a leader in their specialism:

> *I think that the new way and I think the old way was the "role follower", nurse at Nelly's knees, that's how I was told it was, and really maybe I have changed, I don't need to be looking for that kind of a person.....The biggest change for me is confidence that I am doing the right thing, demonstration and practice, the things that I have already mentioned, the things that have gone on here and my ability to get them done. Lots of enthusiasm, motivation and support by people in the research and teaching area to encourage me to carry on. Those things are probably, and also learning to be my own person and keeping not so much negative but accepting that some people will not change...[Eric 2].*

Yeah, I feel, working in intensive care, I'm a lot more confident. I feel I know what I am doing, which I could manage before. I could look after a patient very well, but naw that greater understanding there is a bit to be able to communicate intelligently with the medical staff and far more teaching of medical staff and junior staff. Everything just seemed to fall into place, my understanding of what was going on, how drugs worked. I gained an awful lot really [Karen 1].

Furthermore, four RNs indicated that they were more self-assured when they were competent to practice in their respective specialisms because their skills and knowledge were evaluated against the national specialist competencies. Clinical competence as an advanced specialist in the operating rooms for Judith and Megan, or in the critical care areas for Fiona and Linda for example, were measured according to professionally established criteria. These included the Australian College of Critical Care Nursing (ACCCN) and the Australian College of Operating Room Nursing (ACORN) competencies.

Being a Catalyst and Influencing Others

Being a catalyst and influential specialist was yet another way that the RNs purged any doubts that they may have had about their advancing practice. They influenced other nurses and clients in the community to uphold a standard of care that was an improvement on current practice. For instance, Brenda was a prime mover in enabling parents to gain information about their child's attentional disability. She acted as a catalyst to instigate an awareness and review of government policy in relation to children and adults with an attentional disorder:

...and they [the politicians] just looked at me as if I was a ding dong, and I said 'what do you want, is it money? What do you need?' And they said, money, and I said 'well money is fine, how much do you want, $5,000, $10,000, $15,000?' And (the health minister) said 'oh $15,000 would be nice.' So I said fine and I left the meeting [LADS, learning and Attentional Disorders Society]. So then what I did was I found out that their patron was Christopher Green, the fame from 'taming the toddler'...So in my normal, very lateral manner, I rang him up and I said, 'you know you're coming to

Perth for a meeting' which was something to do with someone else, and I said 'look, I've got a few mothers together [at the Hyatt], would you please come just for an hour and talk to some mums that have got some serious problems?' And he said 'well I really don't have time' but...[if I miss out on lunch] I'll talk to them between 12 and 1.' And I said 'well that will be fine'...So then all I did was I turned around to the LADS and said 'okay, I've got Christopher Green coming for lunch, we're on track.' So then we did up a (program) [Brenda I].

Other RNs like Megan, acted as a catalyst because she continued to influence other nurses to negotiate a salary in the private sector owing to their continuing education. Andrew informed other nurses by example that they could advance as a specialist by undertaking further study. Karen felt that she was influential over nursing staff in her hospital to because staff presented to her to discuss options for a potential thesis. She readily suggested to staff that they consider higher studies to advance in their practice.

Meanwhile, others enjoyed being a catalyst because they not only influenced other nurses but five RNs believed that they were a role model. This was because they had the confidence to question their own and other's practices, to intervene if practice was not to standard, and to resolve conflict in the workplace as required. Fiona felt that she influenced others and therefore acted as a catalyst because she shared the uniqueness of her rural/regional experiences with her metropolitan counterparts via teleconferencing. Judith felt influential as a role model when she sought the correct information from the literature when asked a question by a colleague that she could not readily answer. Furthermore, both Linda and Karen felt able to influence the doctor in the ICU over patient care while Diedre was able to act as a catalyst when she influenced the head of a university school of nursing to include community nursing in the undergraduate curriculum. At the same time, this was a liberating experience:

> *Well...that's how I got my job at X university in the first place. And when they put the initial ad in the paper for the clinical teachers, there was no community nurse in there! So I dialed the X university number, and I didn't know that I was talking to X (Head, School of Nursing at the time). She answered the phone, and I said, 'Oh I'm a community nurse and I see your ad in the paper, and you haven't got community in there.' And she said, 'well, I think you had better come and see me.' And the long and the short of it, I got a job. So, yes, I'm a bit passionate about community [Diedre 1].*

Feeling Vulnerable and Embarrassed

Feelings of vulnerability emerged as the antithesis to being liberated. If the RNs perceived a lack of knowledge or understanding about their specialism, they felt vulnerable. Being vulnerable was not only perceived as a personal embarrassment to some RNs but also left one feeling dispirited about her advancing practice all together. Feelings of vulnerability resulted from their reliance on managers with which they worked. Feeling vulnerable also occurred when they wanted feedback about their assignments or when they encountered a difficulty in their practice. Helen for example, felt embarrassed and therefore vulnerable because of her perceived lack of knowledge as a remote area nurse:

> *I remember, oh it was a patient, a two year-old who had broken her arm as her mother sort of helped her off her feet at school.....and her mother came in and said 'she had been screaming constantly for four days, like every half hour she'll scream. Sometimes she would scream for up to three hours.'...But I had rung the doctor and he had to ring me back. Sometimes he has to because he can't talk to me straight away, doing something else over there. And in the meantime, I sort of sent them down the street, and she woke and I was able to assess her properly when she got back. And when she did get back I did, but the doctor had rung and then told me, 'well, you know don't just think about the arm. Check her ear nose and throat...Sort of it's likely to be something else.' Sometimes you focus too much on the fracture...actually my concern was that it had been on for four weeks and the child was crying and it (the cast) already had been replaced once because it had become loose. And I thought maybe it was due to be changed again. But because it got changed earlier in the piece, they decided to leave it till six weeks. And I felt really stupid that I hadn't actually thought of that. Like I should have done a full assessment before ringing him [Helen 1].*

As a consultant, Brenda felt embarrassed at times because she also had a knowledge deficit about her subject. This was because she had insufficient understanding on the subject of learning disabilities because of the limited research into the problem. Similarly, other RNs felt vulnerable because they were required to achieve academic excellence as well as clinical excellence, did not have the pharmaceutical knowledge that enabled them to be a safe practitioner in the remote areas, or when they were viewed by colleagues as non-specialists because they were multiskilled. "I feel that is my worst part of my skills, is I feel I'm too multiskilled and at the same time, it can come over as though he doesn't know what he's talking about because he's in too many areas" [Eric 1].

As an advancing perioperative nurse Judith felt vulnerable when the nursing management in the operating suite for example, insisted that she organise and conduct a surgical procedure for which she had no prior experience. Judith stipulated that she needed to observe at least one laparoscopic cholesytectomy before she was able to recognise, assemble, and use the instruments appropriately. Judith had neither observed the operative procedure before, nor had any practical experience in this particular procedure. She nevertheless felt vulnerable as an advancing specialist because nurse management expected her to organise and carry out the procedure:

> *I walked into theatre one day and we were doing a laparoscopic cholecystectomy. I had never done one before, had never seen the instruments before...my preceptor was actually placed in recovery at the time and she asked to come in and assist me just for that one case and the Level 2 said 'no, you can stay out there.' And I got there and the other girl who was in the same position as me had only done one before and didn't have a clue. So I said to the Level 2, 'can you help me and tell me what I am doing here?' And she said, 'yeah, just put that there that there, that there.' (said rapidly). And I said, why? 'Because I said so and if you question me again, you're not going to do it'. That was putting it politely! [Judith 1].*

Work as a midwife in the remote areas often left the RN that was also registered as a midwife, feeling equally vulnerable. Carrying out a vaginal delivery in the home without medical backup such as a doctor or without standard maternity hospital facilities was very worrisome. For instance, Helen was concerned about the possibility of an infant mortality and the devastating effects this would have upon her as a midwife. Similarly, Carla felt vulnerable because she had insufficient clinical experience as an advancing specialist in midwifery. She had observed just two births in her first year of her two-year, part time midwifery course. Her feelings of vulnerability were compounded when other midwifery staff with whom she worked in the hospital undermined the value and relevance of her studies that included the understanding and application of research methodologies. The study into research methods was a part of her course. Carla felt even greater vulnerability and embarrassment as an advancing specialist because she was unable to explain the relevance of research to the midwives who worked in the same hospital as her. In the main however, the RNs' vulnerabilities dissipated with experience or on completion of their studies.

Feeling Dispirited

Fiona was one RN who became dispirited when she learned that she need not have undertaken an extra unit in research methods to complete her course. She had completed two research units of study, only to discover via the university administration centre on near completion of the second unit of study that she was not required to do two research units of study. There had been a university administrative error. Fiona need not have incurred the requisite course fees to do the second research unit, nor expend time and effort involved in completing the extra unit:

> *One of the problems that contributed to my loss of interest for a while earlier on this year was that I found out after that I had done it that I actually didn't have to do both.....And that was quite disconcerting and*

quite, and actually set my approach and my attitude back. I lost a lot of motivation after that because there would be no further credit for it. I did pass it but I didn't do it the justice that the unit deserved because I found that out about three weeks before the exam and so that made it very difficult because I thought well what's the point I have already done one. And I found that I was quite angry for a while because the commitment that I had put into it up until now and that.....Oh yeah I think probably, in actual fact my motivation was doing okay until I found about this extra unit that I had to do and that probably started the ball rolling [Fiona 2].

Not withstanding the above, Fiona was further dispirited because she felt that she was not valued for pursuing advanced studies in critical care nursing. No one else working in her hospital was undertaking studies relevant to advanced specialist practice and wondered why here efforts to advance her practice in the rural setting was not valued by colleagues:

I had to think about that. I feel valued for the work I do in that I believe I do a good job clinically. But I don't think anyone values the fact that I'm doing a masters. No, not at this stage, and as I said, whether that's because this is relatively unheard of, well it is unheard of. No one's doing any external masters down here [Fiona 1].

Judith felt dispirited because of the bullying she experienced as an advancing perioperative nurse. Early in her studies, she felt like leaving the operating theatres because of the daily verbal abuse in the form of swearing and dominance that she and others received by a senior nurse in the department. She believed that she would leave this hospital and go elsewhere. Prior to our subsequent interview, Judith had left the hospital:

And then we started the procedure (Operative Cholecystectomy), and I think I was flabbergasted by that stage and think I nearly contaminated the drapes, which then brought around the response of swearing at me and the surgeon in no uncertain terms. And the surgeon just had this attitude with her that we just looked at her and nodded. And just kept continuing which was good for me because he just looked at me and went 'don't worry'. So I was pretty happy about that. But this was a daily occurrence.....I'm a person who will actually confront someone and say, 'look, what's going on?' But for some particular reason I just withdrew and one of my friends said to me, 'you have become very submissive, it's not like you.' It just wasn't worth it. My life was miserable as it was at work anyway. I didn't want to make it worse by having to deal with this woman you know every single day! [Judith 1].

Openness and Meeting the Crossroads

Being open about their feelings during our conversations related to the way that the RNs' disclosed their personal ambitions to advance in their specialisation. They openly expressed the need to be challenged in order to achieve advanced practice. It was the challenges that these RNs faced that actually propelled them to continue in ANS and education. Furthermore, because they felt the challenges, they readily disclosed the nature of their personal ambitions, which in turn led them to meeting a crossroad. The crossroad was described as the RN reached a plateau that resulted in s/he making the decision to move on as an advanced specialist.

Ambition and Being Challenged While Advancing

Eleven of the 13 participant RNs mentioned that they were challenged, or needed a challenge, in order to continue advancing in their practice. All 13 RNs were driven by the challenges they experienced as a nurse. For example, Carla considered undertaking a course run by the Australian Institute of Management (AIM) within weeks of withdrawal from her midwifery course. Nursing management had offered her the AIM course because the hospital in which she worked required a nurse like herself with private nursing experience, to be a front line manager. This came with a promotion to an acting Level 2 position. Carla saw this as a challenge because she would be involved in administration and writing of hospital policies. Similarly, Diedre welcomed the challenge to develop and write new policies, for example, for the health authority in which she recently acquired a new promotional position as a regional coordinator.

The spirit in which the RNs insisted that they be challenged was also an example of their unrequited ambitions. For example Eric was ambitious to take on an administrative role within a large teaching hospital. During my first interview with Eric, he was frustrated in his position as a clinical nurse specialist and indicated that he

"seems to be moving along rather than moving up because he has not yet found the direction" in men's health. He was ambitious to advance but was either busy working or studying, or in between the two. He was over committed as a human being at times. On the one hand he realised that he needed to spend more time with his wife and two little children. On the other hand however, he suggested that if there was just one more hour in the day, he would be able to respond to all four challenges that included spending more time with his wife and children:

> *I always feel I should be doing more. I always feel that if only I had one hour to kind of finish this off because I've got little children. They don't want to hear about my masters or my thoughts. They want Daddy to go play with them.....[but] I think I need to remain open, look for the opportunity and perhaps you know, grow where I'm planted. I happen to be here at the moment, so maybe this is where I need to develop and do the best I can. But I can see how doing the alcohol and drug misuse course, doing the men's health training. I can now start to see that well these are some of the areas that I can now move along [Eric 1].*

Six months later during our subsequent interview, things were changing; he sensed his current role as a RN and specialist clinician in oncology was expanding:

> *I am starting to see that the word RN can be stretched as well. It can be like a base qualification to say, build onto something else. But yes I still see RN as a restricting title but I think if I keep going the way I am that where I want to go, it won't be an issue of an RN or not to be an RN it will be a case of something else will come along [Eric 2].*

Andrew and Karen desired to undertake a Ph.D at a later stage of their careers, that is, when their children were more independent. Both were advancing in a master degree in health management and nursing respectively. A third RN, Olive revealed that "a masters study would be a pleasant challenge" once she had completed her current postgraduate diploma in mental health. Olive already had in mind a research project associated with adolescent mental health. Meanwhile, Fiona described learning as a challenge and achieving a master in nursing was an added challenge because so few nurses in the rural sector actually had a master degree, particularly in emergency

nursing. In comparison to her metropolitan counterpart, Fiona believed that she already operated at the level of a nurse practitioner in the ED and would continue with her master studies as long as the study remained challenging:

> *The opportunities in this area are not high in terms of challenging practice, but let me clarify that. In the emergency arena here, we operate well and truly at the level of nurse practitioner. We don't have you know, on site medical support, we have doctors on call. But they're not there, they're not in the department all of the time. So that gives us a lot of opportunity to enhance our clinical skills our assessment skills and all that sort of thing. So that is very worthwhile. That is actually one of my big soap box issues you might say.....I think it will continue to be challenging for as long as I can keep motivated to find challenges within it [Fiona 1].*

Another RN was driven by work in a highly technological environment such as the ICU. To Linda, "the sicker the patient the greater the challenge". Meanwhile Gail identified her community work with the intellectually and physically disabled person as emotionally demanding, but immediately clarified her statement to "...challenging is a better word". Similarly Diedre's ambition was to be in private practice as a woman's health consultant. She had reached this challenge and was happy to consult part time.

The majority of RNs needed to maintain a challenge rather than be task oriented, bored, or dissatisfied "with the same routine day after day" (Megan). Megan not only enjoyed the challenge of total chaos of multiple traumas coming into the operating theatres, but also referred to the use of "people skills" in the OR as a challenge, particularly when the staff was negative about their workplace. Conversely, Helen had reservations about undertaking a project within a short course because there was an assessable component to the program. However, on completion of the project she was pleased with her achievement because the course challenged her to present information and feedback to her community based on her assessment of the community's needs. It was an enjoyable challenge because it was relevant to her work and she effectively

communicated her achievement by presenting her findings to the community she served via the community newsletter.

In summary, these RNs' ambitions together with their challenges ensured achievement of their goals and advancement in their specialisation for six of the RNs, continued drive to undertake private practice for three RNs, and the pursuit of research in their chosen area of interest for seven of the RNs. Even though Carla did not feel challenged by her midwifery studies, as indicated earlier, she had withdrawn from her midwifery program, but at the same time, revealed that she was stimulated and challenged by the idea of undertaking a front line management course suggested to her by her manager. The studies were relevant to nursing administration in the hospital in which she worked.

Arriving at a Plateau and Moving On

When Fiona, Megan and Olive actually met a crossroad they discovered that they had either reached a plateau in their nursing career or that they were ready to move on and out from their current workplace. That is, the prospect of moving into another area of nursing practice allowed them to broaden their skills or scope of practice as an advanced specialist. Similarly, Judith and Karen indicated that they must move on in their specialty because up and coming nurses wished to move into their positions and area of expertise. Therefore, they needed to consider undertaking further studies and to advance even further in their specialism. In contrast, Fiona knew that she was in a state of flux after almost two-thirds completion of her master studies in critical care/ED nursing. Fiona indicated that her opportunities as a clinician in the rural sector was not as high in terms of challenging practice because of the nature of care and level of patient acuity compared to ED nursing in the metropolitan area. Rural emergency nursing was broad and more fluid:

...even the most exciting work I think can become routine and I think you need to be able to look at it and say well maybe now I should go and do something else for a while and then come back and do this again [Fiona 1].

Furthermore, Fiona questioned if a clinical master program in ANS would ever "take off". She had reached a plateau because it was likely that the nurse practitioner role that had been recently introduced in two Australian States, namely Victoria and New South Wales, was what she really felt that she needed to adopt. However, the move to legislate the nurse practitioner role in W.A. was in its infancy. "I think I have said it, the nurse practitioner role, because it's becoming an actuality, it's not just a dream. I think that this is what I am waiting for" [Fiona 1].

Megan was also at a crossroad. As a perioperative nurse, she questioned where her next challenge lay. Was it work in a new OR facility, work as a medical representative, work as a manager or as a clinical educator in the OR, or something else altogether? Her plateau emerged because she could not see regular progress in her career being made after completion of her studies. Furthermore, Megan was unsure that there would be any further challenges for her in the operating theatres. There remained one challenge however. She challenged nurse colleagues who she felt had reached a plateau in their careers and did not identify their career aspirations:

I worked in the operating room with X Hospital 9 years. I left because I needed a challenge. You get to a point where you need to change something to challenge you. And I'm very much a person that I've reached a point, I need a challenge, I've got to do it. I enjoy a challenge and I'm not going to be just satisfied just doing the same routine day after day [Megan 1] .....But when I'm working with people you learn well for a while and then you plateau and then to consolidate that, and a lot of people get very frustrated because they think I'm not learning anything more, I'm not progressing. They can't see this regular progress again and you've got to say hang in there, you will begin shortly. And that's what I've noticed in learning anyway. And at that plateau stage I have quite a lot to do with people. I sort of say, 'well these are your strengths, this is how I see it. How do you feel about it? What could we offer you to help?' [Megan 2].

Moreover, Megan did not believe that she would be working in the perioperative setting for the rest of her career. She was optimistic about her options relating to perioperative nursing, such as nurse education.

Eight of the 13 RNs were proponents of moving on in their nursing careers. Each described moving on as either a necessary thing to do at the time of reaching a crossroad or simply a natural thing to do when a nurse continued in his or her specialism. The remaining five RNs were not as explicit, nevertheless, they would move on into an area of specialist practice rather than stay in nursing work that offered limited or no advancement. For example, Andrew, Brenda, Carla and Diedre enjoyed the challenge of moving-on. As a result they gained either a higher position at the time when the interviews were conducted or when Brenda increased her networking profile to pursue her research project.

The experience of moving on was an intentional and deliberate experience for the majority of the RNs. For example, whilst Eric enjoyed his job over the last 18 months, he anticipated that he would move on in his specialty after two or so years in the oncology ward as a clinical specialist. Not only did he see himself working in a large institution, but he could also see himself working in a much smaller but specialist area, relevant to men's health. Failing that he would take the challenge to move on and advance in a more administrative role as a director of services in oncology or cancer care. In short, he saw an expiry date to his current specialist job because he was able to do his job with minimal challenge:

> *It's the closing of being a clinician and accepting that role. And then having the courage to move on and have the more of an administrator role.....I do see myself moving on to more of a director of services though, or a manager of services [Eric 1].....*
> *Well clinically I'm realising now that.....I'm no longer a clinical expert and I identified that the day I came into this job because I am actually surrounded by a lot of experts who want leadership and support for their clinical practice. So rather than me being the hands on technical leader I*

> *am realising that I need to be the hands off supporter for others to be technically oriented. So I am realising it now that I can actually let go of it but still have a supporting role [Eric 2].*

Another RN also placed a time frame of four years in her current position as a community nurse. Gail had worked in her health facility for almost eight months, but knew at this early stage that there were other avenues open to her to expand her skills and broaden her scope of practice, particularly in complementary health. Other RNs were also quick to move on. As soon as Karen for example, had completed her postgraduate diploma in critical care nursing, she soon found it boring because she was confident of her knowledge and had already practiced in the ICU for more than 10 years. She simply wanted to accomplish more:

> *Well you see, not everybody is like me. I mean I don't know what drives me and it's that I want to achieve all the time. I want to learn and I want to know. And I guess a lot of people are quite happy to have the knowledge and stay where they are. But to me if you acquire greater knowledge, there's no reason why you can't move on and accomplish more and more [Karen 1].*

Karen and Linda moved on into the research pathway as specialist critical care nurses in the ICU because it was intriguing, important for nurses to do, and vital for the future to give some direction to the nursing profession:

> *I think actually doing the course, the postgrad dip did enhance my clinical skills, but once I obtained that knowledge, it was like, 'okay, I have achieved that now. Now what?' It was starting to become boring and I thought I have to move on [Karen 1].*

Summary: Profiling and Meeting the Crossroads

This chapter discusses the final sub-themes that resulted from a repeated process of deconstructing and reconstructing the interviews specific to the movement toward ANS and education. In essence, during the participants' profiling, the RNs generated both a professional and personal profile as advancing specialists. As they developed

such profiles, they alluded to the difficulties they faced as well as the challenges that they accrued. How they gathered a profile was similar to each RN testing the workplace in order to identify whether colleagues, managers and the community valued them as legitimate advanced practice nurses.

Once they established an acceptable profile, the RNs continued to advance in their specialisation until they met the crossroads. The RNs in this study arguably experienced a change of circumstances at this point of their careers. The change of circumstances culminated in their decision to move on as a specialist. Their decisions enabled them to expand on their scope of practice. It was not until they met this precipice that the majority continued to advance into a preferred area of specialism. Thus, being an advancing specialist was a shared experience that has been able to inform other nurses and the profession of what it is like to pursue advanced practice in the Australian context.

CHAPTER SEVEN

Part B Findings: Focus Group Stakeholders

Introduction and Overview

A second level of inquiry was triangulated in order to add further meaning and understanding of ANS and education. This chapter discusses the discursive findings surrounding ANS and education, revealed by a focus group of nurse executives who were the stakeholders in this study. The purpose was to deconstruct and reconstruct conversations about the phenomenon of interest. By analysing conversations from a group of nurse stakeholders who had a professional concern about ANS and education, it was possible for these nurses to provide another perspective about the phenomenon of interest. For all that, discussion of the findings that emerged from Part A of this study could be synthesised with Part B. To this end, it was possible to reconstruct ideational meanings about the world, interpersonal meanings about human roles, or human relationships (Eggins & Slade, 1997) that are a representation of a democratic reality. This critical phenomenological approach provided further textural (noematic) and structural (noetic) meanings surrounding ANS and education.

The reconstruction of the phenomena surrounding ANS and education was based on interview data gleaned from a group of nurse executives as stakeholders and not from a group of advancing nurse specialists. Furthermore, the interview data was not examined from an individual participant's perspective as it was in Part A of this study, but from a group perspective. Dialogue from this group of stakeholders is one way that meaning about a phenomenon can be constructed (Fairclough, 1992). To this end, the meanings were reflexively scrutinised (Patterson, 1997) and constructed by the stakeholders and interpreted by the researcher.

It should be noted that the data in this chapter is described in the third person. This is because the interview with the stakeholders was more structured and direct in style of questioning. Hence the data were sequentially and collectively derived compared to the interviews in Part A. This combination of events lent itself to a more formal approach in presentation style.

The stakeholders comprised a focus group of executive or senior level nurse managers, educators, clinicians and researchers. By virtue of their position within the nursing profession, these leaders were conversant with graduate nurses who advanced in a specialty area of practice, particularly as they were participants with a knowledge of advanced practice, and could therefore, justify his/her actions (Tucker, 1998). Therefore, the assumption was made that these participants were able to make critical judgments because they were obliged to structure sound and ethical standards of nursing management with advanced practice.

Overall, a discussion of phenomena surrounding ANS and education from a critical phenomenological perspective in this study provided an augmentation of the Husserlian, Crotty and Moustakas phenomenological framework discussed in chapter two. Therefore, it was from the 'ironist position' (Rolfe, 2000) that the researcher searched for multiple truths from two groups of participants involved in this study because each was committed to communicating their experiences with integrity and good faith (Rolfe).

The Discursive Dialogue

Crotty (1998) and Rolfe (2000) suggest that nurses who are motivated to challenge, defend and explain their beliefs, assess evidence and reasons for their beliefs, judge arguments, and come to a public and social consensus about phenomena, provide a critical approach and therefore, a discursive understanding about phenomena. It is

argued therefore, that the nurse stakeholders in this study provided a discursive analysis to ANS and education because they were required, as leaders, to be socially responsible for the development of advanced nurse practice. Their discussions during the focus group interview explained the life world from their perspective, but within the public domain. As the researcher was to discover, the interview data from the focus group was in many respects, different in meaning and often contradictory to the phenomenological data in Part A. For example, the stakeholders were empathetic toward RNs who undertook ANS and education, whereby the RNs in Part A felt that the stakeholders cared little about the way that they advanced.

Agger (1991) suggests that postmodern themes are driven by conservative political interests and are not indicative of the empirical social world. Rather they are representative of communicative public life that is embedded in dialogue, discourse and democracy. Therefore, an understanding of Habermas' theory of communicative action and using Crotty's critical phenomenology as a guide enabled the researcher to comprehend the stakeholders' discursive dialogue. This is because the stakeholders were a) oriented toward reaching a modern understanding (White, 1988) of ANS and education, and, b) communicated new forms of conflict or inequalities (Touraine, 1999; White, 1988) that nurses like themselves, experienced within the corporate world.

More to the point, postmodern research is fundamentally discursive and evolved in the 1930s in response to the impact on the human condition of the globalisation of capital and communications (Woods, Jeffrey, Troman & Boyle, 1997). More recently, postmodern research was described as a way to overcome oppression (Traynor, 1997) so that people could argue for change that was just and led to the betterment of society (Gibson, 1986). In brief, Crotty's critical phenomenology and Habermas'

communicative action provided an intersubjective social critique and therefore, discursive approach to the phenomenon of interest.

Notwithstanding the above, there is much similarity between phenomenology and critical discourse as two methods of inquiry. For example, both methods are interpretive in approach, the inquiry is value-bound and contextual, qualitatively inductive and deductive, and philosophically embedded in public life, social experience and human subjectivity. In addition, the aim of both methods is to subjectively understand the action of individuals (Rolfe, 2000) or groups.

From the nursing perspective, Watson (1995) suggests postmodernism and knowledge development in nursing is a discursive movement. To this end, Watson claims that change within nursing practice has moved from oppression to emancipation whereby the search for meaning is derived from personal experience as a form of truth. Furthermore, the social critique attempted in this study, is seen to be useful in liberating people (Stevens, 1989) such as nurses. Like many groups within a culture, nurses may be marginalised because of the global trend toward economic rationalism.

Description of Stakeholders

A purposive sample of 13 participant nurse executives was initially invited as RN stakeholders. This was because of their senior or executive positions (equivalent to Level 5 or Level 4) of employment within the nursing profession and within the Australian context. They had a vested interest and professional obligation to ensure the uptake of advanced practice by RNs. All shared the responsibility for the hiring of nursing staff. Each stakeholder was representative of a group of executive RN managers, clinicians, educators and researchers from the Perth metropolitan area, and from both the private and public health care sectors. The final number of stakeholders (10) included five directors of nursing or corporate clinical directors (four public and

one private sector representative), four corporate nurse educators (two private and two public sector representatives), and one research nurse (public sector representative) who had a joint appointment between a university and teaching hospital.

Table 1

Stakeholder Characteristics

Name: Pseudonym	Position	Specialisation	Public Sector	Private Sector
Annette	Corporate Director (Clinical Manager)	Midwifery/Neonatal Paediatric Health	✓	
Carol	Corporate Director (Clinical Manager)	Operating Theatre Suite	✓	
Cherrie	Corporate Educator	General/Mixed Specialisations		✓
Debra	DON, Director Clinical Services (Clinical Manager)	General/Mixed Specialisations	✓	
Gary	Corporate Clinical Director (Clinical Manager)	Intensive/Acute Care	✓	
Heidi	Corporate Educator	Hospice/Palliative Care		✓
Leisa	Corporate Educator	General/Mixed Specialisations	✓	
Martine	Executive Educator	General/Mixed Specialisations		✓
Pauline	DON, Executive Director (Manager)	General/Mixed Specialisations		✓
Sally	Corporate Researcher	Joint appointment: University/Hospital	✓	

Nine participants were female and one, male. As a matter of coincidence, this ratio represented the current proportional distribution of male to females based on the

nurse population in Australia. All participants were professionally acquainted with the researcher over the last 10 or more years but not necessarily with each other.

Focus Group Research Questions

Five questions were posed to the group of stakeholders in order to elicit a discussion concerning ANS and education. These questions were used as set prompts and introduced to the group as appropriate, during the focus group interview. Approximately 14 weeks later, the same five questions were again presented so that the stakeholders could offer any additional comments that they may have later considered. This time the questions were delivered via personal email to each stakeholder (Appendix T), along with a copy of the completed transcription of the focus group interview. This strategy enabled each participant to elicit written feedback if s/he felt so inclined.

Interview Lead-up and Process

The stakeholders were initially contacted either by telephone or face to face to establish an expression of interest to attend a focus group interview. They were briefed about the purpose and nature of the study, including likely attendees and schedule. All 13 stakeholders contacted responded favourably to attend the interview in a corporate meeting room within a university building. Each was formally invited by email some six to seven weeks prior to a nominated date, to participate (Appendix U). It was at this stage that each was provided written information of the proposed topic for discussion, the purpose of the discussion, the time, place and venue; that the interview would be sound recorded with their permission, and that refreshments would be served. The meeting was scheduled for a maximum of 90 minutes owing to ongoing stakeholder professional commitments. The researcher requested each to respond by phone or email

within two weeks of the formal email invitation. Eleven stakeholders responded in the affirmative.

On the appointed day, 10 of the 11 stakeholders attended the actual focus group meeting. The 11th stakeholder apologised on the day after the interview because she was indisposed on the day. The official meeting commenced at 1400 hours and ceased at 1530 hours. Each group member was introduced to one another as they arrived, offered refreshments, and handed a "letter of invitation and consent form" (Appendix V) by the researcher to read and sign. Two copies of the form were signed and dated by both the researcher and stakeholder prior to commencement of the interview. Each retained a copy for his/her own records.

Seating was arranged round a large oval table in a corporate meeting room. The researcher was seated adjacent to a standard desktop voice processor, which was centrally positioned. To ensure speech sensitisation, two additional small but flat microphones were extended to each end of the table. The researcher was also equipped with the focus group questions, and a pen and paper to take notes as required. However, note taking was kept to an absolute minimum so that the researcher could focus on the natural flow of conversation.

Prior to commencement of the tape, the researcher once again verbally ensured that any stakeholder was able to withdraw at any time without retribution, that the session would be taped, and that any sensitive information withdrawn at their request. Their name would be substituted with a pseudonym at the time when the researcher transcribed the tape and that their participation would remain confidential. Their participation as a stakeholder was to be informal and spontaneous, with minimal input or direction offered by the researcher. The first five questions were read out to the group (Appendix K). These were to be used to initiate the conversation and guide the

line of questioning. A sixth and final question spontaneously evolved in order to draw the interview to a close. The role of the researcher was to ensure that each participant was encouraged to offer an equitable and worthwhile contribution.

The taped interview commenced at 1415 hours and ceased at 1545 hours (Appendix H, Interview P). In summary, there was 90 minutes of taped conversation and 30 minutes of informality, comprising a 15-minute brief and a 15-minute debrief. The latter was undertaken informally with three to four members who were not pressed for time or desired further informal discussion. None of the stakeholders had any prior experience as a focus group research participant.

Focus Group Feedback and Follow Up

At approximately three weeks after the focus group interview, each stakeholder was posted a hand written personal letter of thanks (Appendix W). At three months after the focus group interview, a post interview memo (Appendix T) with an attached copy of the transcribed interview was sent via email to each focus group participant. Names were coded using the first two letters of each participant's pseudonym. The stakeholders were invited to check their conversations for accuracy of interpretation and for any data that they felt were too sensitive and therefore require omission from the original transcription. In addition, a copy of the six original focus group questions was listed at the end of each stakeholder's copy of the transcription. Each was asked to make further comments to these questions if they so desired.

All responded that their transcription was accurate apart from typos. Three of the 10 stakeholders offered additional feedback (Appendix X) via email in response to questions one and three. One stakeholder added further clarification to a statement and requested that the name of a hospital be omitted. All written feedback was added to the original focus group transcription in The Ethnograph software program by the

researcher for the purposes of data analysis. The data from the interview was explored to evoke ideational, interpersonal and textual meanings (Eggins & Slade, 1997) concerning ANS and education.

The Transcriptions

Transcribing of the interview data was not difficult mainly due to the quality of recording and selection of technological equipment. Even so, there were four occasions during the interview when the discussion was overly animated, resulting in muffled multiple comments or simultaneous laughter or both. However, reviews of the tape by the researcher enabled identification of the overlap of participants in three of the four animated vocalisations. This was because the researcher was not only close to the data, but was able to maintain recall owing to the relative short time frame between the meeting and transcribing of the interview. The use of quality recording equipment also enhanced the process.

Analysing the Interview Data

From the researcher's perspective, the data from this focus group interview were obtained by an interviewer who not only experienced similar interactional roles as the participants, but examined the data from a socially contextual perspective that encompassed critical reflections from a purposive group of RN executives as stakeholders. In support of using a focus group interview as a means of data collection, group interviews "...seem more appropriate when the researcher has specific topics to explore and is not interested in private aspects of people's lives" (Taylor & Bogdan, 1998, p. 115). With this in mind, the researcher attempted to pursue questioning from a group that was representative of the public domain of nursing. However, this did not eventuate because in order to come to a closure of the interview, the researcher asked each of the stakeholders about their personal experiences when advancing their practice.

While the questioning remained focused on the topic on hand, some stakeholders not only voiced the uncertainties that many nurses faced, but also their own emotional sensitivity surrounding the changing and sometimes arduous nature of nursing work and advancement through education. In recognition of this dialogue, the researcher felt reservedly confident at the time of the interview to ask each participant to respond to an additional sixth and concluding question mentioned earlier. This personalised questioning allowed for individual reflections within a group, based on his/her personal experiences as an advanced practice nurse. The results from this line of questioning is covered in the theme namely, 'personal philosophy' and is discussed later in this chapter.

Characteristics of the Focus Group Data

On final completion of the data analysis three themes and 27 code words (Appendix Y) emerged with a family tree (Appendix Z). This former appendix lists, categorises, and identifies the frequency of the code words. The discursive themes emerged as firstly, 'the debate', which describes the stakeholder and employer concerns about ANS; secondly, 'the solutions' that describe the desired pathways for ANS; and thirdly, 'the personal reflections' that outlines the personal philosophy that the stakeholders upheld about ANS and education. These themes provided a discursive understanding of ANS and education, which in turn provided a reconstruction of ANS and education.

Introduction

The data emerged as a discourse of the phenomenon of interest. These included:

a) issues that impact on nurses who undertake advanced specialisation,
b) solutions that describe a desirable pathway a nurse should take in order to pursue specialist practice, and,
c) experiences that were reflexive of the stakeholders' ANS and education.

Together, these three themes complemented the analysis that from a postmodern perspective, is considered a rational moral and political discourse (Outhwaite, 1994) about ANS and education.

The Debate: Stakeholder and Employer Concerns

Employer concerns and issues strongly supported two scenarios. The first was the understanding about gaining mutual responsibility between the executive nurse and the advancing specialist nurse. The second was the understanding of mutual responsibility between the clinical agencies and the education provider such as university schools of nursing.

> *I am saying if I give them (advancing nurses) a hospital course, then I have an obligation to submit it to your [the university] curriculum review and to every other university's curriculum review so that we do this in partnership.....(Debra).*

Within the scenarios, the stakeholders felt that the clinical agency or hospital should be responsible for the validation and recognition of the advancing specialist nurse clinical expertise as well as their knowledge. The university on the other hand should target the academic rigour necessary to undertake nursing research:

> *This is an ongoing debate.....Say for example, the critical care program or the emergency nursing program. Both of those in my mind provide a clinical specialty base where people can learn the advanced clinical skills and the theoretical knowledge specifically related to that clinical specialty. And they come out with a graduate certificate. For those who want to put that into the broader nursing context, and the broader professional context with more academic rigour and research, it articulates to allow them to go into the masters program with...advanced standing.... Also as a hospital we want to look at and actually try to establish those links with all universities (Debra).*

Whether an advancing specialist nurse working in a hospital should be involved in research or undertake a research project for example, remained a dilemma. The rhetoric continued throughout the interview about the undertaking of research and the

responsibility of the employer or the university to enable the RN to undertake a project. The majority of stakeholders was concerned about the added demand that the 'doing' of research placed upon a nurse while advancing as a specialist or once graduated. More significantly, the group acknowledged that there was a general but false perception that all nurses should undertake research. The majority of stakeholders deemed this an unnecessary requirement. It was suggested that only those nurses who wished to advance into a master by thesis program or Ph.D studies should undertake research.

Mutual Responsibility

All stakeholders indicated that they had a mutual obligation to the profession as a whole and to the advancing specialist nurse in particular, to ensure that s/he is offered a worthwhile clinical experience while studying. In order to maximise their effectiveness, they believed that hospitals or agencies needed to have the resources such as experienced specialist staff to support the advancing specialist (Sally).[2] Furthermore, both public and private employing hospitals should collaborate to open placements between all clinical facilities and interchange of students as negotiable (Pauline), particularly when only limited places are available for advancing specialists in palliative care for example (Heidi). In so doing, the stakeholder, as an employer, should be accommodating by allowing the advancing specialist to adjust his/her hours to fit with their studies (Debra).

Some stakeholders suggested that hospital advanced clinical programs were better able to support students because "they can pay them, making it much cheaper for the student than going through the university structure" (Debra). This enabled the nurse to

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[2] Letters in parenthesis are the names of each stakeholder's pseudonym. These include Annette; Carol; Cherrie; Debra; Gary; Heidi; Leisa; Martine; Pauline; and Sally.

work while studying. There were two parallels to this suggestion. The first was that a student may find it possible to earn an income nominating his/her own work schedule by working a choice of shifts with a nursing agency and study in an area of specialisation such as midwifery or mental health. This was evidenced in Part A when Olive did just that, to enable her to advance in mental health nursing. This choice however, was dependent on the chosen area of specialisation. As a service to the community, hospitals can only offer a course that reflects their services. Not all hospitals for example have an ED or large operating suite that services a number of sub-specialties such as plastic surgery or neurosurgery.

The second parallel was that the majority of postgraduate advanced specialist programs within an acute hospital such as emergency or critical care nursing were known to be undertaken in collaboration with many universities in Australia. The stakeholders felt that this directly related to enabling the advancing specialist to gain the appropriate clinical knowledge and competencies. However, other specialisations such as orthopaedic or gerontological nursing could not be considered a priority in a large hospital and therefore, not be offered as an area of specialisation. Therefore, it was felt that the prospective advancing specialist who chose a specialty needed to carefully check the difference in costs to him/her and that the area of specialty considered to be what s/he desired or how the program articulated with a higher award.

Furthermore, the stakeholders supported the notion that they had a mutual obligation to provide advanced education so that all agencies could benefit from employing a new specialist graduate. They felt that RNs, on completion of their course in a chosen specialty offered by a hospital or agency, were not obliged to work in the same agency in which the RN worked while advancing. In short, the mutual responsibility needed to be shared between agencies. Furthermore, there was no

requirement for the agency to place a bond on the RN such as the extension of employment for example, for the salary, support and experience that an agency or hospital offered an advancing specialist during his/her course of study. The nurse should only be required to enter into a joint contract for the expected duration of the course. It is therefore, up to the potential graduate of a clinical specialisation to investigate the quality and suitability of the clinical component of a course that they wished to undertake. The nurse who intended to advance in an area of specialisation offered by an institution should be prepared to negotiate and understand any contract that s/he may enter into for the purposes of advancing in an area of specialism.

Mutual responsibility or obligation from the advancing specialist perspective was not so tangible from the stakeholders' point of view. One stakeholder questioned what the RN could offer the hospital, university or profession in return? To overcome this dilemma, the stakeholders felt that the advanced specialist should take an "active role in leadership, [such as active membership of their professional organisation] mentoring and encourage evidence-based practice" (Sally) and "have the ability to recognise the need for change" (Annette).

> *I think with the reducing skill base of these nurses, that we do have to work in collaboration with each other to ensure that they get the appropriate practice experience and that they then have a worthwhile experience while they are studying. That when they come out that they can deliver good quality best practice service wherever they work. And we have to look at sharing those skill bases, whether it's public or private in which we do already. It's a very informal agreement but I think...It's made formal and [that] it's a great experience and staff will enjoy it (Pauline).*

Barriers that Impacted on the Moving Toward ANS

The rhetoric surrounding the 'doing of research' remained. Two stakeholders thought that nurses in general were unable to interpret the research literature. However, all agreed that the research skills gained by the advanced or advancing specialists were required to ensure the move toward evidence-based practice rather than continue with

practice that had no legitimacy in terms of empirical understanding. Nursing has had a long record of practice that is often embedded in ritualistic behaviours (McCoppin & Gardner (1994). The irony here was that even though there was a global move toward evidence-based practice, Debra felt that the resultant changes in practice were very slow because of the difficulty in specialists undertaking ongoing research.

Suffice to say this group was concerned about nurses' lack of research knowledge in general. However, as indicated earlier, the majority of stakeholders did not believe it necessary that all nurses including the advanced specialist should be expected to have expert knowledge about the research process. The elimination of research activities was seen on the one hand as a mutual obligation whereby the stakeholder could reduce the already high workload placed on the advancing specialist. On the other hand, the group required the advanced specialist to have an understanding of the research process and be able to critique the research literature so that the hospital could invoke evidence-based practice. The discourse remained contentious. All stakeholders were adamant that they could not foster genuine nursing research because the advancing specialist could not do research in order to contribute to evidence-based practice, until his/her workload in the hospital was redistributed to enable them to carry out research.

Other barriers to ANS were debated. For example, from Annette's and Heidi's perspective, even if a nurse wished to advance as a specialist in a hospital or agency that focused on palliative care or neonatal nursing, few clinical positions were available for them to negotiate the necessary experience, and therefore, gain the appropriate clinical expertise. This was further compounded when there were limited opportunities for the nurse once s/he had graduated and sought a promotion. In Part A of this study, Fiona also expressed concerns regarding her prospects of promotion in the rural setting, even as a potential master graduate in critical care nursing. She was not offered a promotion

in her hospital. She however, was in the minority. Five other RNs in Part A of this study gained a promotion, even before they completed their studies. Based on this study, the potential of promotion for the advancing specialist RN was opposite to what the majority of stakeholders thought.

According to one stakeholder in the palliative care setting however, there was very little in the way of promotion. As Heidi stated, "apart from retirement...I have asked that question in my area because of the setting being limited here and if I stay in the same specialty, there are very few positions that would even come up." The notion of promotion was more encouraging however, from the private sector stakeholders. For example, there was room for promotion of the graduate specialist because private hospitals were not bound by the public sector restriction of a ceiling placed on level 2 nurses:

> *They usually stay on in the area. We actually contract them to stay on in the area. Nothing's legal and nothing is definite about that...because they are so rewarded while they are doing our courses, what we call as clinical advancement programs. They're comprehensive in-service programs, two of which are articulating with X university, and several of those student learners have gone on to do [further] postgraduate studies. I think they get a tremendous amount of personal reward out of it. I think they do it from their own motivation and incentive and I think in time they will get promotion because of their increased...*
>
> *Interviewer: Do they get a promotion soon after they have completed their course at your hospital? Is there room for promotion?*
>
> *Yes there is (Martine & Pauline together). There is tremendous room for promotion in our hospital (Martine), (focus group mixed comments and laughter). We don't have a ceiling on clinical nurses like I believe you do in the public sector (Pauline).*

The most disturbing barrier to promotion was the lack of influence the stakeholders had and therefore the relative slow uptake by hospitals or agencies to support ANS and education (Debra). The stakeholders wished to offer advanced specialist courses for nurses to service their hospitals, but did not have the funding nor

the appropriate staff to develop let alone support a variety of programs. They were cognisant of the need to generate advanced programs but did not have the influence to gain the funds in order to make the required changes within the public health care sector. This undermined an otherwise exponential growth and support for ANS and education in W.A.:

> *Most people in leadership roles that is everyone in this room, that they will want to be leaders of change. They want to be involved in it. They want to start trying to shape the future. I think some of the frustration you are hearing today is more to do with the fact that unless you belong to the secret service club you actually have no influence. So you are working within a vacuum. And that gets frustrating after a while. I would say, I think most of us would (Debra).*

The situation was not the same within the private health care sector. In comparison, the private health care stakeholders believed that they enjoyed greater decision-making and the nursing executive was able to ensure governance over which areas of ANS and edueation that s/he wished to target (Pauline & Cherrie). The ramifications however, were probably not evident. Decision-making within the private hospital worked in tandem with the institution's competing forces, such as patient demand for a specialised service that was cost effective to the organisation. This may not have been in the interests of the advancing specialist nurse and advanced nurse education per se. On the one hand all stakeholders were supportive of the exchange of advancing specialist nurses between the private and public health care sectors for clinical experience, but on the other hand, the private stakeholder could readily decide to dispense with a specialisation based on the corporate economy of scale. As a consequence, the prospective advanced specialist nurse needed to be aware of the private hospital strategic planning before deciding on an advanced course that was either jointly or solely provided by the private health care sector:

> *[Change] is happening in both sectors, but I think the way it is delivered is perhaps very different. That perhaps you read about it in a memo or hear*

about it after. Whereas I think we [private sector stakeholders] are much more involved in that process and the decision-making (Pauline). (mixed comments by group).

But you know whether it's determined by shareholders or Federal government policy in terms of funding for health care, they have the powers where they [the private health sector] say, 'we're not going to do that anymore, we are not doing any heart surgery anymore because we are not going to get money for it' despite the fact that you [the public sector stakeholders] have spent the last 10 years developing a pool of specialist nurses in heart surgery (Gary).

In respect of the RNs in Part A of this study, the disempowerment by the stakeholders to provide sufficient expert staff and at the same time, to fund programs in ANS for the RNs could be seen as an equal source of frustration. Even though the majority of advancing specialists in this study rationalised their organisational activities and negotiated work and study options with their employers, the public sector stakeholder was restricted in negotiating a better work schedule or a lighter workload for the RN. Regardless, however, the stakeholder would overwhelmingly support ANS and education for all RNs if they had the appropriate funding. In regard to work in the private hospital sector however, of the two RNs in Part A, who worked in the private health care sectors, neither was concerned about any potential or actual lack of support for their clinical advancement. Moreover, they were prised by their employers for their advancement as specialists and in return, were praiseworthy of the respective agencies.

Positive Outcomes of ANS: Benefits to the Organisation

All stakeholders supported the work achieved by advancing specialists because these nurses invoked numerous benefits to their organisations. Specialists were an asset because they were enthusiastic (Cherrie) and motivated to bring greater knowledge to the workplace (Leisa & Sally), and actually searched for the evidence behind their practice (Cherrie). They learned skills quickly compared to the non-specialist nurse

working in the same area of specialty (Leisa). The majority agreed that the RNs' rapid uptake during learning required less intensive preceptorship by another staff member, saving the hospital time and money. For example, because of the advancing specialist's study program, they delivered hospital in-service programs based on mutual interests and were able to initiate and develop staff teaching packages. They were also of great benefit to the hospital because of their research base (Debra) and they often promoted best practice (Gary). Their knowledge and expertise impacted positively on the health care agency, the patient, the community and the profession.

> *...it's really a quality initiative as much as anything because people in those programs as was previously mentioned, really are involved in best practice. They are looking at what researchers are saying. They drive practice and you will often hear the anecdotal comment, you know there is a lot of difference between a unit with a course and a unit that doesn't have a course or an area that doesn't have a course (Gary).*

The fact was that a unit or department within a hospital that ran a specialist course was much better off in terms of attracting staff, profiling of clinical indicators and effecting best practice. The advancing specialist was also more flexible owing to their broader understanding of nursing management and strived to improve on what nurses did (Annette). Furthermore, if on completion of his/her studies the advanced specialist was happy with the support they received whilst studying, then the stakeholder would be fortunate enough to retain his/her services (Gary). Fundamentally the advancing specialists were the same as all other nurses with a few exceptions. They were considered to be the clinical leaders of tomorrow because they were "critical thinkers who display more confidence in articulating their views in a multidisciplinary setting when the issue is complex and difficult" (Debra). In addition:

> *They also have quite a wide network probably outside their work environment so that they have actually got a lot of resources available to them to learn more things and to bring that knowledge into the work place as well. But additionally too it might be that because they are motivated to learn that they learn more quickly because they are into that learning frame*

of mind. It may be that further down the track they don't have to be preceptored so closely so again the saving of time and money. There are cost savings because you can actually perhaps draw back your supervision of these people before you would normally do that (Leisa).

Negative Outcomes of ANS

Cost and lack of individual interest. The positive outcomes outstripped the negative outcomes concerning ANS and education. As discussed above, the advancing specialist was highly valued by all stakeholders. Even so, many stakeholders remained sceptical about the phenomenon under investigation. For the purposes of this study, their scepticism was interpreted as a search for enlightenment that surrounds common understandings and practices associated with education (Smith, 1993). As Smith asserts, such enlightenment that elevates the political consciousness of people that participate in professional growth and education decision-making is empowering. The interview process in this study opened and confronted issues specific to ANS and education that in reality, the stakeholders believed oppressive to those in the profession.

The stakeholders felt sceptical of the RNs as students, mainly for their motives to advance. This was because it was felt that some RNs were just seeking a "piece of paper...[because] it gives them an advantage in pursuing a career" (Cherrie). Similarly, hospitals had to gamble on whether to give a student study leave or not. A nurse was able to leave a hospital as soon as s/he has completed a program (Carol), leaving hospitals without a return investment. The question for stakeholders was how could this nil return on educational investment be dealt with? The antithesis to this question is that earlier, the stakeholders felt that the RN should not be obliged to continue in employment in the same agency on completion of their studies? The answer according to the majority of RNs in Part A of this study was that they at least expected non-tangible rewards for their advancement, such as recognition from their peers and from

senior management. As indicated earlier, at least five of the 13 RNs in Study A felt that they were neither acknowledged by their DON (Director of Nursing) for undertaking advanced studies, nor supported by their peers.

A return to hospital based courses was a solution where one stakeholder (Debra) mooted that the nurse earned a salary while studying. One Part A participant also suggested the same possibility owing to the shortage of skilled nurses in the hospital settings. This issue is significant because the majority who felt that the needs of the profession w vital overshadowed individual judgment in this study. This could have left some feeling disenchanted with the way that nursing education was headed. Even so, the group of stakeholders did not support this notion. It was considered a retrograde step and would undermine the advancement of nursing as a true profession. It was generally agreed that there should be a continuation of the merging of the universities and hospitals or agencies to provide advanced practice for prospective graduate nurses who wished to enter into a specialist area of nurse practice. The barrier to advancing practice was the global cost of education and its impact on individual nurses and other professions who wished to pursue advancement in his/her career:

> *And it goes back to this money thing again. You know we have talked about how costly our postgraduate education is and therefore specialisation if you are going through the university system, and if one looked at it in the wider community, one would say, 'well what's knew?' I mean it's expensive for anyone, not just in nursing (Sally).*

Promotional opportunities. No less significant was the scepticism surrounding promotion for nurses who undertook formal education in an advanced area of specialisation. Sally highlighted the rhetoric surrounding poor promotional opportunities for the new graduate in an advanced specialisation:

> *But the biggest problem I think is that at the end of it all, there's nothing extra for many of the nurses in terms of remuneration or even promotion.*

Because you know to stop the career structure and the flattening out of the salaries as people rise, so that they may spend a lot of money getting their qualifications and they take time off and drop salaries etc. And that would be fine if at the end of it they could see promotion or you know like other people they were even promoted while they were even studying, because of the value that the employer places on that. But they don't get that and in fact if they get a promotion, their salary often drops because they lose the shift allowances and things like that. You wonder about the incentives that there are towards specialisation ...in terms of [their] needs (Sally).

However, this was clearly not the case for Part A participants. Five of the 13 participants who advanced as specialists gained a promotion during their studies or on completion of their studies. A sixth RN was offered a promotional position even though she withdrew from her midwifery studies. This was a tangible reward because gaining a higher salary rewarded the six RNs. Nevertheless, promotion remained a contentious issue when another stakeholder revealed that nurses in her department who had recently completed a postgraduate program were purposefully held back from gaining a promotion because "they have got a little way to go" (Carol). In other words, Carol suggested that the nurse with a postgraduate award in the perioperative setting in particular had a false expectation that s/he should gain a promotion. Even though the stakeholder believed that these new specialists had a sound knowledge base, they required work experience at the more complex level of care before she would consider a promotion:

One thing that hasn't been discussed here is that you may have a postgraduate nurse whose successfully completed the course, but he or she may come back into the workforce, but doesn't mean that they are any more experienced. They may be broader in their knowledge and so forth, and that's something you have to consider. And we have got a few young nurses that have in fact done postgraduate but they have got a little way to go. You can see potential there and they are people who want to go ahead and will do something with it. But the expectation that they just step straight into a promotional role just because they have done it because in themselves we are not doing them a favour (Carol).

And often you will find that people will do that because they dearly want to

> *get into a specialty, but they can't because of lack of experience or knowledge and they will undertake this path to give them a lead in. And the other thing is that in some areas like theatre invariably in those programs you are introducing a novice more than you are an expert. So if you balance the two, you put the broader professional hat on, I think you should still support them in the same way that you support the one that is there (Debra).*

The issue of promotion or remuneration from another stakeholder's perspective indicated that a nurse was required to become more competitive and be up front to negotiate a salary based on his/her advancement. This again was evidenced in Part A. Andrew, Deidre, Judith and Megan supported similar beliefs about competing for a position. Any nurse with an advanced specialist qualification had the opportunity to compete for a higher negotiable salary in the private sector. However, there was limited opportunity for negotiation in the public sector because of the public sector award and EBA (1998) that was in line with the nursing career structure:

> *In the private sector you would have the ability if you wanted to, to put someone on a work place agreement to pay them more money. And that would be open to anybody and if they wanted to do it you know, I could do it with individual practitioners, if that's what we wanted to do (Cherrie).*

Furthermore, once the advanced specialist had completed his/her program, s/he had the upper hand if s/he wished to apply for a promotion in either the public or private health care setting:

> *I would just like to agree with Martine [private sector stakeholder] that a lot of people don't undertake postgraduate studies for promotion, they do it for their own self worth. And the issue is too that onee they have got a certificate or a postgraduate diploma whatever it is, that in itself lends it, that if they do apply for a position where it is essential criteria or desirable criteria, then that's the sort of thing that they have (Leisa).*

Stakeholder realities-choosing with uncertainty. With the nursing shortage and nurses choosing not to undertake ANS and education, the stakeholders faced a number of realities. Those working in the public hospitals for example not only worked and lived with the uncertainty of change related to health care policy, but as Debra

indicated, did not have enough nurses who wanted to do research because of the priority on service delivery and resultant workload. Furthermore, " I think that the metropolitan health service is going through a period of major rethinking, except no one knows what it is. Half of our memos say that they are going to announce something in a minute" (Debra). Furthermore, all stakeholders were required to compete between hospitals and agencies for specialist nurses (Cherrie). Such circumstances even influenced one stakeholder to include job descriptions for nurses in two Perth hospitals that could not stipulate the requirement for a nurse to have a postgraduate specialist award (Annette) to work in either hospital. So severe was the shortage of specialist nurses, that Annette could only request desirability of the relevant specialist qualification. The two hospitals in question were highly specialised hospitals that needed specialist nurses:

> *Well I don't think there's more chance of a promotion with a postgrad than there is with nothing. In the job descriptions I guess some of the essential criteria would be to grade for Level 3, that's a UG1. So that's it, where we are coming from in my two hospitals. But a postgraduate is probably desirable criteria rather than essential in any of the specialties including neonates...Because you can't discriminate.....To be a clinical nurse in my area we want a neonatal certificate, though that does not necessarily mean post grad (Annette).*

Patient acuity that aligns with a skilled work force. Other pressing stakeholder concerns centred on the need for a skilled work force that matched the increased level of patient acuity. The stakeholders were sceptical of maintaining standards of care to the patient because the demand for advancing specialists was far greater than the supply. It was disturbing that there were so few nurses, let alone advanced specialists to cover a 24-hour roster period. New knowledge and understanding about ANS and education that was enlightening, was almost always overshadowed whenever discussion about the shortage of specialist nurses was raised. This issue was common and problematic to all participants in both parts of this study. Ironically, some RNs in Part A for example, felt

that they were criticised by peers for being overly multiskilled as a specialist. They wished to diversify their skills because it was liberating for them. In contrast, the stakeholders focussed on the practical and technical advancement of specialist skills by advanced specialists owing to the nursing shortage. Having practically skilled specialists would alleviate the problem in the short term.

Equally as pressing, was that the stakeholder felt that the level of patient acuity within all hospitals was continually increasing. As a result, specialisation was defaulted to the novice nurse graduate:

> *All of us are sort of running under the ceilings of clinical nurses, which is on award base specialties it seems to be about 22%, and in the critical care areas and theatres, that sort of thing, it's around 30%. So whilst they have got the jobs now (general discussion and comments from focus group members), the acuity has changed a lot but the ceiling hasn't.....Seriously it's probably more, well these guys [other focus group stakeholders] might want to have a go at me but I think it's more of an issue in perhaps a tertiary/quarternary type of focus of your institution. Because I would say that each one of my wards is like a 12-months postgraduate specialisation in its own right.....Because of the mix of the specialties that you are putting in there...I mean it's fine if you're asking them to go to the general med ward or something. But even that now, and the way they manage them, (one comments, 'a bit scary'). I mean you sort of think that you have walked into a high dependency unit, not a general medical ward (Debra).*

> *I think that you are very right and I think that we specialise our nurses far too early. But we haven't got hospital paddocks out there of general general and surgical surgical, or medical medical that are so purist. Everyone of our graduates goes directly into a very highly specialised, high dependency, acute area (Martine).*

Summary

Employer concerns covered a wide spectrum of issues that were readily debated. In reality there was an excessive imbalance between the supply of nurses who wished to advance in both practice and education, and the demand for the specialist nurse Australia wide. So bad was the situation, a novice graduate who entered the acute care hospital for the first time as a RN was required to function as a specialist within a

specialty setting (unanimously agreed). This placed unrealistic expectations on the new graduate as well as on the stakeholder to deliver complex patient care. The reality was that "nurses [inexperienced new graduate nurses] had the jobs but hospitals needed advanced specialists to handle the increasing patient acuity" (Debra). Hospitals were simply not funded to deliver the number of courses that reflected the wide range of specialisms. Therefore, they did not have the resources to enhance nurse specialist skills let alone foster a culture that considered research knowledge and skills to be necessary for evidence-based practice. Worst of all, the stakeholders believed that they were unable to offer the advanced specialist remuneration or a promotion, particularly in the public sector.

With these concerns, the group of stakeholders was restricted by how little they could afford in the way of clinical advancement and educational support for the specialist nurse. However, they strove to provide mutual support for the individual advancing specialist. They continued to search for answers against all odds-they were willing to collaborate with universities and other hospitals to ensure quality education and negotiate individual support to prospective advancing nurses because nurses who had advanced in an area of specialisation were overwhelmingly beneficial to the organisation. The payback was that the advanced specialist nurse empowered an organisation to deliver quality care to the patient.

The Solutions: The Desired Pathways that Promote ANS

A discourse about ANS and education enabled a debate of stakeholder concerns about the phenomenon. The discussion not only identified the shared problems associated with advanced practice, but also stakeholder solutions to assist the nurse and stakeholder to gain advanced status that proved to be mutually beneficial. The researcher referred to the proposed solutions as "desired pathways" because the

stakeholders considered they were the best solutions that could be sought to promote advanced practice within the profession.

Hospital-Based Education

What was most evident was the rejuvenated discussion about hospital-based courses because of what the stakeholders considered was the high cost of university education. The irony was that the stakeholders viewed this would be a retrograde step to be taken by them or the profession. The stakeholders themselves had rendered enormous effort to lobby and engineer the transfer of nurse education into the tertiary sector since approximately the 1970s in Western Australia and Australia. The elevation of nurse education from the apprenticeship model of training that was embedded in the service needs of a hospital, to a tertiary-based model of education, had been a major achievement for the profession. All the RNs in Part A felt the same. Furthermore, the stakeholders remained supportive of the continuation of the pre-registration program for the nurse that was tertiary based and comprehensive in nature.

The change of heart however, reflected on how the advancing RN could progress in his or her area of specialisation. Such a statement raised the notion of automatic transfer to an area of specialism within 12 months of graduate nurse experience as a comprehensive but novice RN. Other questions were raised. For example, should all nurses pursue advanced specialisation? Is there no place left for mainstream general practice? Owing to the diversity of patients' needs in society, the diversity of multiskills desired by the RNs in Part A, and the stakeholders' concerns about the increasing level of acuity in the hospital sectors, nurse specialisation was considered a reality and essential for the provision of complex health care.

The group of stakeholders nonetheless, supported the individual choice by a RN to undertake advanced practice, but with the option to undertake a program either

through a hospital or university or both. To enable continued advancement within a specialisation to master level for example, articulation of a hospital-based program to a tertiary equivalent was necessary. Even so, the philosophy and quality of hospital programs was disputable. However, if a hospital had "QETO status" (Leisa) that is, was acknowledged as a Quality Endorsed Training Organisation (QETO), then this qualified a hospital to develop and deliver continual educational programs, including specialist programs for nurses:

> *And I know that (X Hospital) has just got QETO status and part of that is being a registered training provider with industry and (Y Hospital) has that. And I just think that more and more you are going to see that hospital type based programs coming back in because they are not going to cost people that amount of money. They are going to be more tailored to the needs for the nurse. I'm not putting university out. What I'm saying is that I think there have to be both. But I think that it's got to be acceptable to both I suppose too (Leisa).*

To this end, this group of stakeholders was alerted to the limited range of specialisations referred to within this group. Their concerns were representative of just 12 specialty areas (see Table 1), namely, emergency nursing (Debra, Gary & Leisa), critical care nursing including intensive care and coronary care (Cherrie, Debra, Gary, Leisa, Pauline & Martine), renal, neurology, and oncology nursing (Debra), paediatric, neonatal and midwifery nursing (Annette), palliative care (Heidi), and perioperative nursing (Carol, Debra, Gary, Leisa, Martine & Pauline). In the Australian context in 1997, seven broadband nursing specialties that subsumed some 58 subspecialties (Russell et al., 1997) was identified and categorised. The stakeholders understood that the list of specialties would continue to evolve. Even so, the areas of specialisation outlined were significant to this group of stakeholders and reflected the desperate need for these specialist nurses. The stakeholders wanted to gain qualified and advancing specialists to service hospitalised and community patients. They believed that specialised hospital departments should drive the development of specialist courses for

nursing staff. These hospital departments in turn should drive the articulation of these courses with the university.

Even so, some stakeholders felt that if such an approach was engineered, it was possible that a nurse that chose to undertake an active education profile relevant to his/her clinical skills, may be considered an advanced specialist even though s/he may not have any research skills (Debra) while undertaking a hospital-based course. Furthermore, those who proceeded to undertake nursing research rather than a clinically advanced specialisation through a university should consider that they were undertaking another specialisation:

> *I was faced in a situation where I had a very high percentage of novice nurses in my hospital and I needed to upgrade them quickly. And the only way that I could upgrade them quickly was to develop these hospital based courses for them. Because they got paid, they were taught, they were educated and also that we put some rigour into the curriculum so that several of the courses could articulate and that they could go on and get some credit for it. So I think we're developing programs out of the needs situation (Pauline).*

> *This is an ongoing debate amongst me and a couple of my colleagues at least...the critical care program or the emergency nursing program, both of those in my mind provide a clinical specialty base where people can learn the advanced clinical skills and the theoretical knowledge...For those who want to put that into the broader...professional context with more academic rigour and research, it comes and it articulates in to allow them to go into the masters program with [X] points of advanced standing.....It mixes together more effectively, the academic rigour and the research that you want from with the clinical experience, expertise, practice and knowledge. So I see it more as a better coming together (Debra).*

The stakeholders in this study subscribed to the joint pursuit of ANS and education by both public and private hospitals. They desired hospital or agency support for all nurses to advance in a specialisation even though some advancing specialist nurses would be set up to leave a particular hospital (Annette & Debra). Part of this support included a leadership structure that incorporated senior Level 1s at the ward level so that the hospital could have a complement of innovated staff with the

appropriate knowledge base (Debra). To enable this, four stakeholders felt that they must accommodate the nurses' hours to fit their studies for those going through either the university system or the hospital based system. Five of the RNs in Part A supported this. These individuals described how their employing hospital enabled flexible hours of work to fit with their study program commitments.

All stakeholders recognised that an agreement between the private and public hospitals and universities that was mutually beneficial was necessary because of the need to be increasingly budget conscious (Gary). They also indicated that the research ethic should be maintained, but done with a little more of a modest ambition, that is, less of an expectation that one nurse alone can undertake a project (Sally). Financial support was a must for a nurse to undertake research. Furthermore, any research problem should be identified by the advanced or advancing specialists working in the hospital (Cherrie), the stakeholders should stress and communicate the importance of nursing research to their staff (Cherrie & Sally), and that four stakeholders believed that research must be done in collaboration with the universities. To this end, the stakeholder must selectively channel those advancing or advanced specialists with research interests and prepare and support them at master and Ph.D level. It was considered that this approach would give the hospital and the individual nurse the desired leadership needed by the profession. "Ideally you would [be] co-located on the same campus where the interface between your academic staff, your research staff, your clinical staff, your undergraduate and your postgraduate programs...is one collective body that just generates a hum about it" (Debra).

Sharing of Strategic Goals

The second solution to undertaking a pathway toward ANS was considered imperative. The stakeholders as employers, should keep the staff informed of changes

taking place in both the private and public health care sectors. This was because health care policy and directions were continually in the balance because of changes within the health care bureaucracy. Therefore, if they did not effectively communicate the organisation's and profession's goals and strategies, half of the stakeholders felt that their nursing staff would otherwise read or hear rumours to the contrary. The outcome would be erroneous perceptions by RNs about management decisions. Therefore, as a stakeholder, they must continually filter information to their staff. These were similar sentiments expressed by the RNs in Part A.

From the public health care provider perspective, stakeholders had an obligation to the wider health community to prepare advanced specialists (Gary). This statement generated further discursive discussion owing to the perceived heightened responsibility and moral obligation the public sector had compared to the private sector to provide care to the community. The stakeholders from the private sector claimed that they were equally committed to an increase in the skill base of nurses and service to the community (Pauline). However the dilemmas prevailed, for example, one stakeholder from the public sector revealed how her department decided to halve the number of clinical nurse specialists in her perioperative department. There were too many chiefs and the role had become distorted and never clarified (Carol). This exemplified the dilemmas that these stakeholders were continually faced with. On this occasion however, the decision was not based on a cost-cutting exercise, but on a need for a leveling of leadership. In contrast, the stakeholders from the private sector claimed that they were certainly making an impact on the profession and the community at large by running courses that articulated with the university (Pauline). After all, it was to their good fortune that they were more involved compared to the public health counterpart in the decision-making process with the hospital's executives to create and fund advanced

courses for nurses. Furthermore, they were able to make room for promotion as desired because they did not have a ceiling on the number of Level 2s as did the public health sector:

> *The other side of it I guess in a tertiary or quarternary hospital is that you've got to look at your obligation to the wider health community in preparing people. And where that obligation stops is, is an interesting discussion point whether that extends to providing staff for the private sector, developing and providing staff for the private sector because the private sector often does rely on a well trained staff from the public sector (group rumblings, 'can I jump in here?', 'oh I would absolutely disagree with that,' blurred laughter and comments) (Gary).*

Summary

The desired pathways and solutions were primarily related to a merging of responsibilities to support the continuation of ANS and education for all nurses. Joint hospital-based courses (including both private and public health sectors) should drive the demand for specialist education and in so doing, should articulate their courses with university courses at the postgraduate level. There was the discourse however, as to which specialisation was more pressing and whether a limited number of specialisations should be created, particularly as members of this group of executives worked within the acute hospital environment. What of nurse specialisations that were serviced outside of the hospital sector? These were numerous and included primary health nursing, school nursing, family planning, men's health, women's health, adolescent health, mental health, education, occupational health and infection control (Russell et al., 1997), just to name a few. On review, five of the 13 nurses in Part A responded as participants from this milieu.

Personal Reflections: A Philosophy of ANS and Education

Introduction

From this theme it was evident that each stakeholder remained sensitive to the plight of nurses working in the hospital sector. This was in contrast to what the RNs in Part A thought. Firstly, the stakeholders believed that they could not accept the changes to a corporate style of education based on the user pays system of advanced education. Therefore, it was an expectation that the hospitals should provide continuing and experiential education for all advancing specialist nurses. Secondly, they were cognisant of and well prepared to work within the constraints of the health care bureaucracy and therefore, prepared to seek new ways of servicing the public and at the same time employ a complement of skilled and educated specialists in collaboration with universities or the like. Thirdly, they were morally bound and therefore accepting of how some groups of health care professions including nursing, were marginalised because of the work of caring that was undervalued or silenced by the hegemony of economics. Therefore, unless they or other nurses were not passionate about an area of specialisation, s/he would remain "miffed" by the pursuit of advanced practice and decide that advanced specialisation offered limited or no rewards for the effort required. The stakeholders were well versed in the politics of health care, the constraints that nurses and advanced specialists faced, but continued to strive for the promotion of ANS and education.

Personal Philosophy About Nurse Specialisation

Based on their own experiences, the stakeholders indicated that continued education in the form of postgraduate studies in nursing or a related discipline was extremely beneficial for a senior manager (Annette & Debra) or corporate educator

(Leisa & Martine) like themselves, for example. The pursuit of a clinically focused specialisation within a hospital such as midwifery (Pauline) was also considered beneficial if a nurse had a goal to become a DON in the rural setting. Overall, postgraduate studies were deemed pertinent to the nurse's potential (Martine) as an advanced specialist, and considered by the group as a worthwhile experience. The RNs in Part A felt the same; their professional profiles were heightened because of their advancement.

On review of Part A, nine of the advancing specialists were equally supportive of the inclusion of managerial knowledge and skills by either default or because of projected necessity as an advanced specialist. While working as a rural/remote area nurse, Helen for example indicated how she required management skills because of her remote practice. The particular skills she needed pertained to managing her budget as well as office filing and computer skills to ensure effective communication with the Council for Remote Area Nursing Association (CRANA) or to maintain patient documentation for the purposes of medical support and quality assurance. From the mental health nurse and critical care nurse perspective Olive and Karen were adamant that knowledge about managing conflict within a health care bureaucracy was essential for the advancing specialist. The nurse was able to see the bigger picture. That is, nurses were not only able to understand where they were situated as a health professional, but able to deliver non-judgmental care to the patient.

The continued discourse between management and clinical specialisation. What the stakeholders conceded to was the discourse surrounding ANS per se and the emphasis on management rather than pure clinical expertise. The group's sharing of personal philosophies about the efficacy of ANS and education indicated that because of the "academic rationalist argument" (Debra) within social health policy, there was a

priority to gain resources for the services that the advanced practice nurse provided. This required an advanced specialist to gain management expertise and such a priority undermined the need for a pure clinical focus for advanced specialisation:

> *Well I don't know whether it's just a trend or whether it's a permanent change, but I suspect the number crunching emphasis it will be permanent until we have another boom and there's a bit more money to throw around. In that environment you need to have the economic rationalist argument with them. You need to be able to look at the balance sheet and know what they are talking about, you need to look at the profit and loss statement and know what they are talking about. You need to be able to deal with all those issues and not just come out with a pure clinical focus to win what you need to win in terms of resources for the service you are trying to manage (Debra).*

Some stakeholders revealed that they changed their personal philosophy about their education soon after the nurses' career structure (Attrill, 1988) in W.A. was implemented. RNs that were already in the work place, including the most senior to the least experienced, perceived that they were forced to undertake a degree in nursing within a university before they could gain a promotion (Debra). A conversion degree for them and for current RNs was simply a means to an end (Debra & Pauline). Some felt at the time, that their work experience accounted for nothing. The irony however, was that their conversion studies and, since then, their continued studies, gave all stakeholders the discipline and confidence to present a stronger academic argument and to be on equal terms with other health care professionals. Furthermore, the entree to subsequent studies for five stakeholders, in a Master of Business Administration (MBA) or similar, for example, had augmented their management skills and board-room knowledge of finance. Furthermore, their accounting knowledge and the understanding of the language when they sought a senior management position such as a DON were enhanced. Similar sentiments were expressed by five of the stakeholders who focused on education or research as their preferred specialism within nursing.

In addition, undertaking a research study (particularly at Ph.D level) relevant to nursing enabled the nurse to investigate problems relevant to practice and to be able to articulate and critique an argument both orally and in writing (Gary & Sally). However, whilst the rewards of obtaining a Ph.D were personally gratifying, it was not absolutely necessary for a nurse such as Gary. He found that the personal cost in terms of family disharmony, financial outlay and continued stress of balancing executive work, study and family or social commitments, were enormous. Any tangible rewards such as a promotion or financial reward for example were not immediately evident. Gary had just in the last few months, obtained his Ph.D. It is significant to note that during the interview, two stakeholders revealed that they had obtained a doctoral award, both in the natural sciences, outside of a nursing faculty, but reflective of nursing as a discipline:

> *I am now sitting here with a PhD that may be of no direct use to me in the future. What it has taught me however, is how to inquire, all the points that Debra made about being articulate, being able to put a report together, how to write, how to critique things and that. So on balance I don't regret doing it but if you ask me what value I have got out of it, I can't say that in terms of career progression I needed to do it. I didn't need to do that (Gary).*

> *And I found that quite good, the different exposures to the different professional groups, that good grounding in what you need to argue in any board room or with any executive or senior executive about where you are coming at, using arguments that they can understand. Because increasingly you see them coming from finance, accounting, general management background so you have to understand the language, you have to know how to use it to your advantage (Debra).*

Empathising with the Advancing Specialist

The moment that a stakeholder discussed how a nurse could advance in his/her practice, empathy unfolded regarding the cost of postgraduate education a nurse must shoulder. Here empathy relates to the understanding of the term in its original technical sense as "*motor mimicry*" (Goleman, 1995, p. 98) of the stakeholder. For example,

empathy was felt when some stakeholders described the misery related to payment for their own education to advance in nursing. Such a reaction was similar to how the stakeholders perceived nurses of today must find it difficult to survive while trying to work and study, and in the majority of cases, care for a young family. The bottom line was that a nurse who pursued ANS and education must earn money. Furthermore, there was no incentive to undertake advanced study if nurses still desired "a life" (Carol) outside of their nursing work.

The stakeholders reflected on the hospital-based model of ANS and education where nurses not only had to take a drop in their level of pay, but in some cases, a drop in their hours of work to enable them to balance their work with study. Many of the focus group members shared similar experiences. In Part A of this study, one RN felt disenchanted when she had to take a drop in salary to advance her qualifications in critical care nursing. Fiona was particularly disenchanted because her experience, advanced skills, and continuing education in the ED were not recognised. When she recently completed her graduate diploma course before advancing onto her masters, all students who undertook a hospital-based critical care course, were employed on the lower pay scale by one agency, regardless of their current higher level of pay or position. Surprisingly to some stakeholders, the situation was felt to be no better now than it was 10-20 years ago, even though nurses had more flexible access to advanced specialist courses through the tertiary sector. The HECS fees and fee-paying courses per se were a "double-wammy" (Debra) because many nurses were required to reduce their hours of paid work. They had little choice but to take on part time work, mainly so that they can negotiate practice with another organisation that has the relevant clinical mix of specialist skills in order to meet their required professional competencies, such as palliative care or perioperative nursing competencies. They are required to trade off

permanent status, and in the process not only lose a career path and pay, but leave provisions including maternity leave and superannuation entitlements.

From the researcher's perspective, working casual work with an agency for example may have provided an answer for many nurses to gain control over their own working hours. But this also comes at a cost to some, particularly if a nurse did not gain a scholarship that at least covered the cost of course fees. One advancing specialist in Part A however, did just that. Olive for example successfully supplemented her scholarship income with agency work as desired, and enjoyed the flexibility and control over her extra work. Even so, the casualisation of nursing work did not emerge from the Part B focus group interview. This was likely because of the overriding shortage and need for specialist nurses at the time of the data collection.

Some stakeholders reflected on the times when hospitals were able to either plan for or rely on their workforce, by including health department funded programs for a nurse's ongoing clinical expertise. These programs provided them with a ready made competitive work force that was guaranteed, as long as nurses enjoyed acute care nursing or wanted to work in the ICU. Whilst the stakeholders conceded that large teaching hospitals in the main provided a limited range of specialisms, the demise of hospital-based funding programs for ANS gained wide criticism from a number of the stakeholders. That is, the employing hospitals of today were unable to guarantee staffing with advanced practice skills since the transfer of postgraduate programs (Cherrie & Debra) into the tertiary education sector. As a result, it had become harder for nurses in the work force to gain specialist skills.

Stakeholder Future Planning

Regardless of the resentment felt of being unable to obtain an ongoing supply of advanced specialist nurses because of the shortage of nurses and since the transfer of

nurse education into the tertiary sector, the majority of stakeholders supported advanced education for themselves as well as others. Even though they empathised with the advancing specialist nurse of today, they wanted to continue in their own studies and work. Some found recent middle management courses rigourous but fulfilling. Their ongoing studies would benefit them in their ongoing employment (Annette & Martine). The educational knowledge and people skills that they obtained would enhance any projects they were to undertake in private practice on their retirement from executive nursing. All had benefited from their ongoing advanced studies, as had the majority of RNs in Part A. All participants in both parts of this study were willing to undertake additional studies to enhance their professional development:

> *I am going to continue to do study when things settle down a bit. So I find it for me personally it's extremely beneficial (Annette).*
>
> *And I am currently enrolled in a company director's course at UWA so I like study, but certainly postgraduate study is something that I think as an individual, is pertinent to your own potential to be motivated and pursue your own career. I certainly enjoyed mine (Martine).*

Negative Experiences of ANS

Half of the stakeholders in this group described negative experiences relevant to their pursuit of advanced study. The negative experiences included the stress of working full time, the time involved in weekly travel between two major towns to attend university, the imposition of adding academic rigour in a nursing program in a relative short time frame, and the lack of recognition of prior learning (RPL) at the time of her studies. The RNs in Part A had the same negative experiences. Having to undertake a research project required enormous time and effort for one stakeholder, but not so for others. Even nurses of today simply cannot do all that, including research and look after a family and work (Debra). Literally nothing had changed since the stakeholders undertook their studies. Nurses are required to do everything on the run.

Another found her management studies pertinent but unable to really enjoy them because she was also commissioning a department of a hospital at the time (Carol). Another stakeholder raised the issues of stress in terms of reduced time with the family as well as being able to enjoy other recreational activities and skills in the home such as brick-laying (Gary). The cost was one of personal sacrifice and not quantifiable. The RNs in Part A felt the same.

Positive Experiences of ANS

Positive experiences far outweighed the negative experiences the stakeholders faced while undertaking ANS and education. The positive experiences for the RNs in Part A were also evident, but the rewards were mostly intangible. Similarly, all 10 stakeholders indicated that their experiences in advanced education was attributed to the stimulation (Sally & Heidi) they gained. This was accessed when they socially interacted and worked with other groups of researchers (Sally), when they could legitimately call study time as their time and no one else's (Heidi), or when their studies were enjoyable because the study was applicable to their work for example, as a corporate educator (Debra, Cherrie & Martine).

A MBA or postgraduate management course was good grounding when one needed to work as a senior manager (Debra) or be conversant with financial reports and budgets (Carol) or grapple with human resource management (Cherrie). One particular stakeholder enjoyed studies over a period of 10 years even though she was a widow and sole parent of her young children at the time. The qualifications she obtained made a big impact on her career. Another two stakeholders enjoyed their midwifery programs because they felt part of a cohesive group in a hospital-based program and were able to earn money at the same time (Leisa & Pauline). This was similar to Karen, Diedre and Helen, in Part A of this study. One stakeholder however, did not even use her new

midwifery qualification but nevertheless, recalled the experience as rewarding. In the main, postgraduate studies in education and curriculum building for example broadened their thinking and development as people and as professionals. Meanwhile, involvement in research at the Ph.D level was personally enriching even though it was not absolutely necessary to undertake. From all of this, the nexus remained. If a nurse chose to advance in his/her practice then it was the most positive experience but at the same time, the most stressful and therefore a negative experience. The nurse caught within this nexus needed to be able to balance the positives with the negatives:

> *My last experience wasn't such a long time ago. It was a human resource management and development course and that was not in nursing either. And I remember that as being a very positive experience because I was trying to teach myself through that, ways to getting information across to people and make it you know, fun and all that sort of stuff. So my memories of that have been very positive.....the group of people that we worked with in that course were from a wide variety of other groups and so it was very different from what I was used to. But I did do it because at that stage I was looking at a career more in staff development and it was going to add to my qualifications and my understanding of how to do the job I suppose (Cherrie).*

> *But I just loved the education (nurse education) and then that really got me thinking along the lines of education so I guess for me that really chose my pathway for me if you like. And I really enjoyed that. Then I went on and did postgraduate studies. But I only did postgraduate studies because I wanted to have the knowledge and I particularly chose all my topics when I did my postgrad and they were all on curriculum. So it was all curriculum process development, evaluation and the only reason I did that postgrad was to get that knowledge. But yes for me it had opened a lot of opportunity because I was able to apply for positions (Leisa).*

Projections for the Future of ANS

The stakeholder felt that no matter which field a nurse worked, their projection was that ANS would be a requirement in all areas of nursing. This did not come as a surprise, because even now, there are advanced medical/surgical or generalist programs available for the new comprehensive graduates, usually with a minimum of 12 months post registration experience. There was no real turning back the clock to nurse

education based on an apprenticeship model of training. What they expected was that advanced specialists would be the leaders and mentors of the future. As the RNs in Part A also felt, they not only had mentors, but now acted as a mentor, were actively involved in professional organisations, questioned their practice, sought best practice, and offered collegial support for others, owing to their advancement in an area of specialisation:

> *I would expect these nurses to take an active role in leadership, mentoring junior staff, encouraging evidence based practice by questioning existing practices, reading literature, involvement in policy and planning committees and where possible, research projects. They should be sharing knowledge through education sessions, and informally. They should take up active membership of professional organisations related to their specialty and make a cantribution to the activities of the organisations (Sally).*

Summary

Stakeholder sharing of their own experiences was enlightening because of their sensitivity to the plight of nurses in general and advancing specialists in particular. They reflected on the positive and negative experiences of ANS and education and continued to support ANS and education in all departments of the hospital clinical settings. They projected that ultimately nurse specialisation would be a requirement in all areas of nursing in the future. More importantly, the stakeholders viewed that a purist clinical advancement program that omitted an understanding of management principles for example would not adequately prepare the advanced specialist nurse of the future.

In conclusion, the deconstructing and reconstructing of ANS in this study highlight the desire of the advancing specialist to pursue advancement through education and at the same time the desire of the stakeholders to initiate, encourage and support the advancing specialist even though they were under great duress to do so. It is possible that it can be interpreted as a more positive version of their desire to foster

ANS and education. Their desire is, in reality, a part of the socially constructed existence of nursing practice that is always in a state of flux as opposed to maintaining an illusion of stability:

> *...because the whole structure in which you are supposedly leading and managing in this state at least, gets a major turn around about every 4 or 5 years. And they must have run out of ideas so they will go back to the beginning, but it's new for us because most of us don't live that long. Or in turbulent times like at the moment, it seems to be a weekly episode (Carol).*

Overall, the stakeholders had a global orientation and understanding about ANS and education; they saw the bigger picture. As a result, they felt that the advancing specialist should in reality, move beyond his or her crossroads as s/he advances through nurse specialisation and education:

> *I was just going to take up on from what Gary was saying. In our workplace I can think of people we have actively supported to study and advised them at the same time, 'look you're not going to get a position here. You actually have to go out into the big wide world and use the experience we have given you here.' And that's really part of our philosophy is that we are actively training people to do that (Heidi).*

This concept of 'moving on' was evidenced in Part A. This is described in the Part A thematic analysis when the advancing specialists reached a 'meeting of crossroads'.

CHAPTER EIGHT

The phenomenon of ANS and education is a nexus between nursing's body of work and nursing's body of knowledge; the object is texturally certain but the subject is structurally indefinite.

Limitations, Recommendations and Conclusion

Introduction

This study enabled the researcher to tease out the professional and sociological issues surrounding ANS and education and to identify the textural and structural nature of the phenomenon. Triangulation of two methods of data collection, namely Part A and Part B, made this possible. The findings identified that living and working, as an advancing specialist nurse was not a linear journey, but a transitional one. Furthermore, when the phenomenon was debated by the stakeholders, it seemed worse for them because they had to accept that his/her management decisions was inevitably compromised by the every day contradictions experienced within a bureaucracy, be it in the private or public health care sectors.

The study explored the various dilemmas and assumptions surrounding ANS and education. Being qualitatively experiential as well as discursive in meaning, the study permitted an emancipatory interpretation in order to reach an enlightened view of ANS and education. This was made possible by the circling of data triangulation of two disparate groups of nurses who had a vested interest in ANS. As Agger (1991, 1998) suggests, even though meaning is inherently elusive, hermeneutic circling in social research is vitally necessary in order to decipher social problems. The hermeneutic circling undertaken in this study was a "*methodological* device" (Schwandt, 1994, p. 121) in which the whole in relation to its parts and vice versa provided the means for human scientific inquiry. The researcher concluded that the circling within each part of

this study enabled the communication of truth embedded in the nested and overlapping narratives. This claim of truth may be either accepted or rejected by the reader. Nevertheless, an understanding of ANS and education was founded on the complex interface between the positive and negative experiences by the RNs. For example, they had the freedom to choose ANS, enjoyed the challenges pertinent to advancing practice, gained opportunities for promotion and achieved a liberating personal or public profile in the process, while conversely, they required perseverance to live with rejection and to deal with contradictions as they arose. The stakeholders were troubled about ANS and education. They desired to search for an answer to satisfy the educational needs of the advancing specialists so that they could meet the demand for a skilled work force and supply of future leaders like themselves. The interchange between the two studies provided an enlightened overview about ANS and education.

Limitations

Primarily, examining contextual social phenomena does not come with a straightforward set of solutions because living with ambiguity is a reality. The researcher did not arrive at one sound and all encompassing solution as an outcome of this study. There was no one best way to go about ANS and education in view of the disparate nature of nurse specialisations and education programs. It is the nature of the reality that was of interest to the social researcher. In the process, this study identified many situations and possibilities that were often compromising but nevertheless, a choice that a RN made.

Secondly, the study was not representative of the full range of participants that reflected the growing number of nursing specialties and subspecialties outlined in this thesis. The executive stakeholders in the focus group were representative of just 12 of the 58 or so established areas of nurse specialties. Nevertheless, they were

representative of the commonly known specialties such as critical care and oncology. Furthermore, all participants were cognisant of the range of specialty practice. Logistically, it was neither feasible nor was it the scope of this study to recruit and interview 58 specialist representatives for a focus group in Part B, nor conduct 116 repeated interviews with a purposive sample of advancing specialist nurses in Part A. This is useful if conducting a survey. The researcher was not questioning the viability or efficacy of different specialisations in nursing. Rather it was the experiences and impact on individuals, hospitals, the nursing community, and the profession that desire ANS and education.

Another limitation may be related to the timing of the advertised recruitment for advancing specialists in Part A of this study to participate. Some nurses responded to the advertisement but were excluded from invitation because they were not currently undertaking studies relevant to an area of specialisation. Others were excluded because they had recently completed a specialist course or were working as a specialist and intended enrolling in an advanced program. Many advancing specialists therefore, did not have the opportunity to tell their story even though some did wish to participate. Possible contributions from these specialists therefore, remained silent and therefore, a lost opportunity. These nurses could have had shared insights into the nature of ANS and education but were simply omitted from the study because they were not currently enrolled in an advanced specialist program on commencement of this study. Other possible lost opportunities may have resulted of reasons beyond the nurses' reach such as inability to fund their own studies, the casualisation of their work precluding them from specialist practice, and the need to diversify their responsibilities between family commitments and professional work.

In addition, the timing of the phenomenological interviews in relation to whether the participants had completed their studies or not may be considered another limitation.

The stories may have been presented differently if the participants had achieved their current educational goal. Not all participants had completed their advanced studies over the six-month interview period. In fact, the majority was continuing with their studies during the data collection. Therefore, the researcher did not confirm whether all participants had actually achieved what they initially set out to achieve. Three participants however, did complete their current study program close to the timing of their second interview and on completion of all interview data. This is considered incidental because the researcher's aim was to seek temporal experiences (van Manen, 1990) of the *advancing* specialist rather than narratives from nurses who had already qualified in an area of specialisation. The narratives therefore, were reflective of the phenomenon that was transforming rather than reflectively situated in past events.

Another limitation was that the study might have appeared to exclude the experience of ANS and education in other states of Australia or from other countries. Even so, this was not relevant because this study focussed on the Australian context of ANS and education because little was understood from the Australian perspective. Even so, at least seven of the RNs in Part A, namely Carla, Eric, Helen, Judith, Karen, Linda and Megan, said that they had either interstate or overseas experience in an area of specialisation.

Lastly, some research critics of this triangulated approach may consider the researcher should have engaged in a purist and socially constructed theory such as grounded theory that permits a fundamental generalisation and singular explanation of the emergent social processes (Strauss & Corbin, 1994) relevant to ANS and education. However, rather than construct a theory that would evolve according to human social patterns, the methods used in this study permitted a phenomenologically experiential and reasoned discourse of the ideology, experiences, and reality of social change as it is lived. These descriptions are communicated in language and are fitting of an oral

culture such as nursing. As a result, this study allowed for participants to identify and make change (Smith, 1993) when and if they choose to do so. The research therefore is believed to empower members of the profession to be able to consider their own directions and decide what is appropriate for them given the social framework, in which they live and work.

Recommendations and Implications for Nursing

There is much evidence in the literature concerning the need for specialist nurses. There is scant literature however, about the achievements by advancing nurse specialists who pursue graduate education. It is possible that there is a conspiracy of silence concerning nursing work, however, this study has added to the knowing about ANS and education and how the stakeholders and specialists themselves deal with sustaining such specialists in the workplace.

The participant narratives culminated into what Walker (2000, p. 90) describes as a "narrative rhythm." The common rhythm in this study included the costs of graduate education, the opportunities for promotion with appropriate remuneration, the need for management skills in combination with clinical knowledge and skills, and the utilisation of research at the masters and PhD levels to ensure nurse leaders for the future. An issue specific to Part B executive stakeholders was the creation of solutions that fostered the transfer of learning by advancing specialists between private and public agencies or hospitals as joint education providers. Therefore, it is recommended that a merger of all advanced clinical programs that are offered by a hospital or agency should be undertaken in collaboration with agencies and university schools of nursing. Both the private and public agencies that gain QETO status should support the exchange of clinical experiences for specialist RNs. Secondly, course fees should be detailed as an up front fee by an agency, as a quality endorsed education provider, for specialist nurse

programs, rather than subsumed in a contract of employment for the specialist work and education that a RN undertakes. To facilitate the process, each agency should set aside funding for the RNs' course fees in the form of a scholarship, based on a RN's application to work and undertake advanced specialisation in the agency in which the RN chooses to gain specialist practice. In the case of the consultant, rural, or outer metropolitan nurse, the RN should apply for external scholarships from his or her professional organisations such as the CRANA, ACCCN, the Nurses's Registering Authority, or State Health Department.

The notion of doing research was the most contentious or circular of all issues. Previous experiences of research undertaken by a minority of the stakeholders was not encouraging and provoked negative memories of how disadvantaged and pressured they were to conduct a clinical research project. In contrast, the advancing specialists who were undertaking research or embarking on a research project relevant to their field were enthusiastic and encouraged by the challenge. Six RNs in Part A who were advancing were already thrilled with undertaking a research project. However, the opportunity to carry out research by clinicians was in a sense, a dream because the stakeholders, such as the DON or clinical managers, needed the RNs for the hands-on care of the patient. The RNs' role was restricted because of the staffing demands and workloads to provide patient care over a 24-hour period.

In order for advancing specialists to undertake a research project and for the agency to realistically foster clinical specialist research and the delivery of care that is evidence based, a further recommendation is essential. The agency or hospital employer of RNs should be funded to employ additional relief or casual staff to supplement a reduced patient load for the advancing specialist. The patient load should be mutually agreed between employer and advancing RN. This should be for the period

that the RN is undertaking a research project specific to the specialisation, with the understanding that the project is part of the RN's study program.

The nursing implications are in the main, intersubjective. Whilst this study related to graduate RNs and executives who had an understanding of nursing practice and ANS, the progression, prospects and how these nurses are valued by other nurses and executives will impact on the recruitment of nurses into the profession in the first instance. In saying that, nurses who appreciate the implications of globalisation and who think as globalists are in a much better position to see the whole picture with its environment, social, economic, and political nuances and the impact of these in the health care system. Studying and advancing within this context, the RNs are better positioned to explore alternatives with the confidence to move on, or to redesign or create new integrated models of care, as well as to seek opportunities for themselves as competitive agents. The majority of RNs and all the stakeholders in this study understood that they worked in a system that was influenced by developments in a wider system. The RNs desired to make themselves visible to the community and therefore marketable. The stakeholders similarly desired greater visibility of the RN as a professional, but also needed an increased proportional distribution of say, and therefore, the health budget, in order to sustain ANS and education.

Recommendations and Implications for Nursing Education

The pace of change has made it difficult to prepare for the future. Yet studying what these RNs have experienced can allow for more rational decisions to be made on the sort of future that would be most desirable and the way that advancing specialists and stakeholders need to go about it to achieve the best outcome for RNs to pursue advanced education. The RNs in Part A described education as ongoing and necessary. They sensed a personal conviction that empowered them with the freedom of choice to

undertake advanced studies in nurse specialisation. They learned to compare, reason and rationalise organisational activities, such as those from employing hospitals, tertiary institutions and governmental bureaucracies that at times were restrictive or uncompromising.

However, this did not always deter the participants in Part A and B from pursuing advanced practice. Work experience and an understanding of conditions relevant to the workplace enabled the RN to view the reality of their experience as they attempted to advance in their practice. Their understanding fostered a freedom of choice to seek a program of study that they felt was relevant and would enhance their knowledge, skills and promotional opportunities. This was an important issue because having a choice of course that was suited or tailored to each participant, was considered better than working as a generalist which provided limited or no choice for advancement and promotion.

The reality was that advanced practice was gained through knowing and the experiential learning that resembled Burnard's (1989) model of experiential learning. This included the attainment of propositional, practical, and experiential knowledge. For example, the advancing specialist gained propositional knowledge through study of the literature referred to in his or her chosen program, practical knowledge through advanced clinical practice, and experiential knowledge through professional relationships with peers in professional organisations or with members of the community. As Burnard posits, the latter leads to the development of an individual's personal knowledge. In this study, personal knowledge accrued as the RNs maintained a level of interdependence, that in turn, ensured their personal integrity. Maintaining their integrity enabled them to pursue and enhance their personal and professional profiles. In doing so, they sought opportunities to advance, developed a legitimate profile, and persevered with their studies because they were concerned that nursing

should in terms of its education and practice, be legitimately recognised rather than continue to be unnoticed or concealed as a collectively invisible profession.

Almost all participants recognised that each had become a leader in their field. Through education, they had also become open to the competing forces such as the competition with other health care professionals or the need to be multiskilled, and the inevitability of change in the workplace. They no longer needed a role model, but utilised management skills or the results of research to be a credible specialist and provide best practice. Similarly, when the executive stakeholders reflected on their own past studies as advancing specialists, they too felt better equipped to discuss health issues with other disciplines owing to their choice of education programs, primarily through university education.

The stakeholders, however, were concerned for these RNs and for the recruitment of future advancing specialists. Consequently they desired the push to engage in collaborative education with the tertiary sector and private providers of education. However, they decidedly lacked the appropriate funding to support graduate nurse education, and had limited options to hire, retain and sustain the education and practice needed for these advancing RNs. Furthermore, life to them today is less stable than it was. Globalisation had created greater diversity in society, suggesting that some will embrace diversity while others will not because of the turmoil of contemporary life that is competitive, leaving many nurses feeling disenfranchised by change, and more specifically, by the commodification of health care and education.

I argue that it is not what education a nurse gets from an agency or what an agency gets from the specialist nurse, it is what an agency *expects* to get versus what the nurse actually does get, the ratio of hope to reality. And until very recently, hospitals and nurses hoped to manage with mainstream nurses rather than specialists. There is little doubt that ANS is beyond the scope of the mainstream generalist nurse and that all

agencies need specialists. Therefore, what RNs expect above the emotional and non-tangible rewards of ANS is the more tangible rewards such as improved remuneration.

Because of this, it is recommended that graduate nurses who wish to advance in an area of specialisation, should compete, validate, justify, and show performance that can be measured against monetary rewards. One way of doing this is by gaining national competency standards or credentialling through the advancing specialist's professional organisation such as the ACORN and Geriaction. In turn the hospital or agency should have an on-going review of specialist practice in departments of a hospital where external auditors, through the accreditation process, can adequately reflect on the common expectations of health care standards nationally.

In making such a recommendation, the outcome is that the human becoming (Daly & Watson, 1996; Parse, 1992) that nursing theory supports, has changed from a service that values a nurse's ability to care in an ontological way, to a service that supports the nurse's ability to be competitive and to fix a cost to the specialist care rendered, and at the same time, provide a model of care specific to the specialism and the consumer needs within that specialism. Nursing is now a business as all health care agencies are a business. In contrast, whilst Pearson (1990) suggested that contemporary nursing was responding to society's increasing value of holism and humanistic care, he nonetheless indicated that the design of new programs for nurses in the future should be balanced to enable students to confront the inconsistencies between nursing work and theory.

Implications Relevant to Methodology

Methodological pluralism is an awareness and respect for multiple methods. Research that is based on one method of qualitative research has only one view of life (Morse & Field, 1995). By attempting to study a phenomenon that included dialogue that was phenomenologically hermeneutic and critical in perspective, the findings

became not only richer in description but also added to the validity of the phenomenon under study. Furthermore, not only was a qualitative approach the best way to study the micro analysis of human thinking and activity, but provided insights into the experience of a culture such as nursing that continues to believe that it is the most disenfranchised of health care professionals. And having interviews spaced six months apart allowed the RNs in Part A to add reflections or add changes to the descriptions that they might have experienced. In that time, they had pieced together an event or described a flashback that provided further information.

The application of a second analysis was not a prescribed or established method for this study but combined authentic experiences relating to ANS and education to the "condition of doubt" (Patterson, 1997, p. 425). Patterson purports that the question of doubt is a reflexive analysis of phenomena that should be examined from the eyes and language of the researcher. The researcher therefore, took the analysis a step further and argued that it was possible that other analysts, vis-à-vis, nurse stakeholders, as well as the researcher could reflexively scrutinise the question of doubt embedded within the phenomenon of interest. Both the RNs and stakeholders in Part A and B lived in a socially constructed world. The reconstruction of such a world was presented from two views that revealed the structural difficulties or changes that any of the participants faced.

Furthermore, this study was undertaken with a good and moral sense where reality is in a state of flux and where the reports by the participants were taken at face value. The interviews were cathartic. The RNs in Part A, particularly reported that they received tremendous benefit in participating in the interviews. In sharing their thoughts, the effective communication of their world provided them with an understanding of the textural and structural context, in which they and other RNs live and work. This is of utility to nurses. The strategy of data triangulation therefore, has added to the

understanding of the postmodern world in which the advancing specialist lives. The researcher has told the story that was experientially discursive but emancipatory. Such blending of the data enables the reader to view the stories from both angles, providing a balanced and new view of the phenomenon. The advancing specialists and stakeholders were not polarised in their view of ANS and education. Both groups value nurse specialisation. Both have a vested interest because they believe that they are essential in order to provide a nursing service for the future. As one of the participants told it:

> *If everyone thought the same, there would be no change, if everyone perceived the same, there would be no diversity, if everyone was motivated the same, then there would be total conformity, if everyone felt the same there would be no conflict. It is those who think differently who ultimately effect change. It is those who perceive differently who provide diversity, it is those who are motivated differently, propel change and it is those who feel differently, experience conflict. And when you're looking at that, thinking differently comes from lateral versus linear, perceiving comes from creativity and sensitivity, motivation is lead to driveness and impulsivity, conflict has to do with struggle of the existence of two or more mutually antagonistic impulses which fuels motivation [Brenda 1].*

Conclusion

As a point of clarification, this study was *not* about the role of the CNS, but about the role of the nurse who undertakes advanced nurse specialisation. I highlight this issue in the conclusion of this chapter because the nurse in the CNS position may be seen to have a similar role to the advanced nurse specialist. In fact the CNS role evolved much earlier than did the advanced nurse specialist role-arguably in the late 1930s in North America (Hamric et al., 1996)-to orchestrate clinical leadership (Benner, Hooper-Kyriakidis & Stannard, 1999). In contrast, the advanced nurse specialist role evolved in the late 1970s to address the rise of specialisations in nursing (Hamric et al., 1996). Nevertheless, it is likely that the roles overlap.

In relation to the Australian context, the creation of the CNS role as a Level 3 nurse position was made to meet the challenges of the health care environment-primarily within the hospital sector-and to lead nurses by expanding their knowledge of

advanced nursing practice (Hamric et al., 1996). At the same time, it became desirable that the CNS would be prepared at the master level of nurse education (Sheehy & McCarthy, 1998). This was initially sanctioned and implemented in W.A. soon after the introduction of the W.A nurses career structure (Attrill, 1988). The debate continues however, over the blending of the advanced nurse specialist role and the CNS role and from the North American experience, the Advanced Practice Nurse (APN) that is also similar to the advanced specialist nurse. The only difference appears to be in the title. Nevertheless, the debate remains as to how these roles may be blended and may compliment one another in order to provide complex care to patient populations. The issue of blended roles was not strongly debated by the focus group, only to mention that four CNSs in one major operating room suite was downsized to one CNS owing to the confusion surrounding the poor delineation of the role at the time (Carol). What is the most common element of these two titles however, is that the advanced nurse specialist and the CNS are responsible for the direct care for specialty patient populations (Hamric, et al., 1996). The stakeholders were not confused by the differing titles.

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APPENDIX A

The Theoretical Framework Relevant to the Study

EPISTEMOLOGY:

Postmodern inquiry that is value-bound, contextual, and with researcher passion. Naturalist Paradigm-where there is new knowledge, new ways of thinking, and multiple realities.

ONTOLOGY:

The lived experience of ANS and Education comprising:
1."Object/Noema"-"the what" (textural/noematic) that includes individual perceptions of ANS and education, and,
2. "Subject/Noesis"-"the contextural way" (structural/noetic) that ANS & education is experienced.

THEORETICAL PERSPECTIVE:

Qualitative hermeneutics: An Interpretive approach.

METHODOLOGY:

Traditional phenomenology (European). A humanistic inquiry via hermeneutic and transcendental phenomenology: (Husserl/Crotty/Moustakas framework)- communication of understanding and meaning by conscious reflection and critical phenomenology about the phenomenon of interest.

METHOD(S):
Face-to-face & telephone repeat interviews
Focus group interview

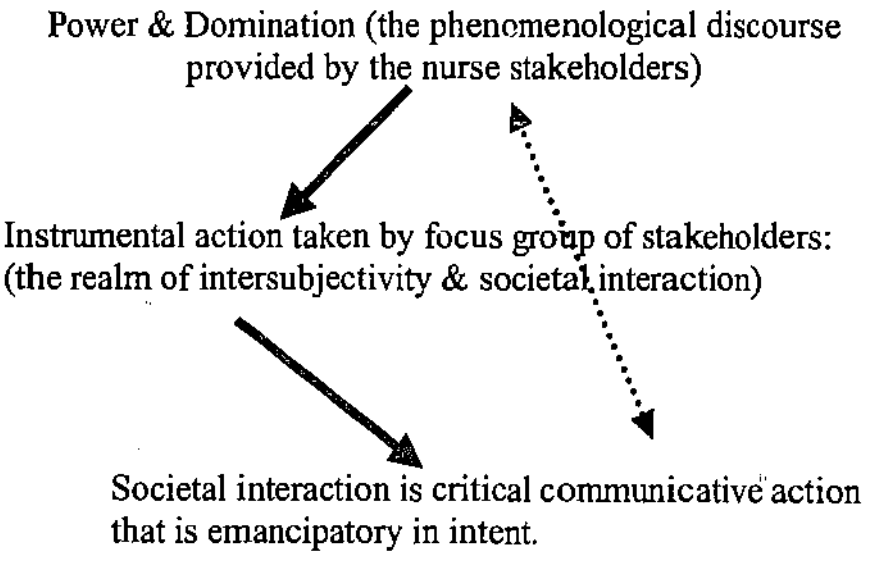
Audit trail and field notes: review of literature and social world that relates to ANS and education.

Adapted from Crotty, M. (1996). *Phenomenology and nursing research*. South Melbourne, Victoria: Churchill Livingstone.

APPENDIX B

Part B Conceptual Framework: Crotty's Adaptation of Critical Phenomenology and Habermasian Communicative Action

A Discursive Interpretation by Stakeholders



- The stakeholders are the RNs who constitute their experience as cognitive: The interest in predicting and guiding ANS and education as an objectified process.
- Mutual understanding in Part B of this study is achieved during the intersubjective understanding of the phenomenon of interest.
- Critical analyses intend to bring about emancipation in the context of language through communicative action

Adapted from Michael Crotty (1998). The foundation of social research. St Leonard's, Australia: Allen & Unwin.

APPENDIX C

List of Assumptions Relevant to The Study

List of Assumptions Relevant to Part A

1. I believe that the participants will indicate their desire to communicate about their roles as advancing specialists,
2. I accept that power relations are socially and historically constituted within nursing culture; viz, that there are competing interests and representations between specialist clinicians, educators, managers and researchers,
3. The interpretations from the participants are value-laden and cannot be isolated into facts,
4. The relationship between the phenomena and participants as speakers is never stable and is often dependent upon the moral, ethical, political, economical and social order of the time,
5. Language and intersubjectivity is the vehicle by which meaning is inferred,
6. Some groups in nursing, while accepting as inevitable, are privileged over others,
7. Oppression in nursing and health care is implicit and multivaried, and therefore may not be revealed in the data, and
8. Systems of class, race and gender may be implicated in the research.

List of Assumptions Relevant to Part B

1. That a critical analysis is able to influence debate, research and practice across disciplines (Fox & Prilleltensky, 1997),
2. That nursing's scope of practice remains ambiguous and overlapping of boundaries,
3. That the advancing specialists may indicate their marginalisation in order to fill a perceived gap in nursing skills at the advanced level, while managers and educators may relinquish their control (Porter & Ryan, 1996), and
4. That changing social conditions subsequently affect the participants' views of the social world (Staeuble, 1996).

APPENDIX D

Sample (Hand Copy Notebook) of Developing Code Words (Part A)
Thematic analysis with words categorised and arranged in alphabetical order and entered into The Ethnograph

H Hypocrisy(HYPOCISY)
-contradiction contrary to RN's character

I Interdependence(INTERDEPEN)
-working with other professionals

Idealism(IDEALISM)
-ideal/positive views about nursing

J/K No entries created

L Links to specialisation (LINKSPECI)
-links to specialism only

Links to practice (LINKP/S/R)
-links practice to specialism & research

Long term goals(LONGTERM)
-sets personal goals

Legitimate collective profiling (LEGCOLLPRO)
-calls for all RNs to contribute to the profile of the nursing profession

M Maintain integrity (MAIN INTEG)
-ensures integrity is intact

Mutuality at home (MUTUALITYH)
-desires harmony with family

Mutuality at work (MUTUALITY)
-desires harmony with working colleagues

N Negotiating options (NEG OPTION)
-negotiates with employer to undertake ANS

O Openness, being challenged (OPENESSB/C)
-frank about needing a challenge and undertaking specialist practice

P Public profiling(PUB PROFIL)
-positioning self who contributes to the profession

Paradox (PARADOX)
-incongruity & contradictions within nursing practice-may or may not be true

Q No entries created

R Reflexive action(REFLEX A)
-action/responses to problems identified within nursing

Reasoning(REASONING)
-seeks understanding of choices relating to nurse specialisation

Rationalising organisational activities(RATORGACTI)
-seeks understanding of workplace issues and constraints

Rationalising & balancing (RAT&BALANC)
-rationalises own finances with work commitments

Reflective Imagery (REFLEC IMA)
-Use metaphors to describe the versatilty as the nurse

Reflection on Interview (REFLEC/INT)
-reflection on first interview during the second interview & change of view

APPENDIX E

Sample Second Interview Review Questions (Second Interview with Eric)
Part A: List of Review Questions that Emerged Following the First Interview

(Note: The page numbers reflect the page number from which this part of the narrative was located in the participant's first interview transcript).

1. You mentioned that nursing was rather hierarchical (p. 4), similar to the military. Do you still feel the same? Can you expand on the nature of the hierarchical situations?
2. You mentioned you have communication skills (p. 6) that enable you to deal with not only men, but with those from different cultures. Are you able to use these skills effectively in Perth while working in the oncology setting? Do you get the opportunity?
3. You mentioned that you enjoy working as a team player (p. 7) with staff as well as patients to develop a supportive team approach. Is this still a passion of yours and how have you progressed since we last talked about this?
4. Are you enjoying your current job (p. 8) and have you lost or gained interest in your job?
5. Have nursing opportunities in W.A. opened up for you, or are the doors opening? (p. 9)
6. Do you still see men's health as your calling? (p. 9).
7. How is your diploma course in ADA (p. 10) coming along? Are you continuing with this?
8. Are you continuing with your other studies (p. 10) such as your masters and focussing on men's health?
9. You emphasised the caring role of the nurse and that we should embrace this (p. 12). Do you feel that this is still missing?
10. Is the staff still doing overtime and not being paid for it? (p. 13)
11. Are you winning the battle to help staff overcome the stressors of work? (p. 13)
12. Are you still in search of a nursing role model? (p. 14)
13. Is the sharing of knowledge or the lack of it between nurses an ongoing issue with you? (p. 15)
14. You indicated that you have a desire to promote a sense of wellness in the patient rather than full-on chemo or cure at all cost (p. 16). Is this still in your mind and that this view should be encouraged by the nurse?
15. Do you still feel as though you have had little time with your wife and children? (p. 17). Have you found a balance as yet?
16. Do you still feel a financial pressure with your lifestyle? (p. 17). What is most costly in terms of expenses for you now?
17. Are you still questioning your role as a RN? (p. 19). Is it still confining for you? Are you wanting to move into management per se?

The remaining three questions were the common questions asked of all participants at the end of their second interview.

1. What is your opinion of the accreditation process and the need for hospitals to be accredited?
2. Do you have any comment to make about nurse credentialling?
3. What has changed if anything since we had our first interview some six months ago?

APPENDIX F

Personal Diary and Log of Interviews

Date	Excerpt of log of events, actions, and reflections
20/3/00 InterA2 "Andrew" Posted 2nd transcript and letter of thanks 26/7/00	Rang "Andrew" @ 0815 to make appointment for interview. Unable to speak to him. Will ring back at lunch time on: xxxxxxx (h). Wife's name is xx. Rang "Andrew" at 12.50hrs. Made appointment for Tuesday 28th Mar, 2000 at 1000 at his home. First transcript posted to "Andrew" one and a half weeks prior to second interview. "Andrew" confirmed discussion and commented how the first conversation was filled with so many "hms". Confirmation and accuracy of conversation gained.
20/3/00 InterB2 "Brenda" Posted 2nd transcript and letter of thanks 26/7/00	Rang "Brenda" at 0820. Made appointment for interview at 10am Monday 27th Mar, 2000. Address xxx, Ph: xxx (h). First conversation /transcript posted to Brenda 2 weeks prior to interview. Transcript confirmed by Brenda as accurate.
20/3/00 InterC2 "Carla" Posted 2nd transcript & letter of thanks 26/7/00	Rang "Carla" for interview. Left message about making an appointment. I left my numbers and said that I would try her on her mobile, ph: xxx (h), ph: xxx(mob). Mobile not available when I rang. She returned message. I rang and confirmed booking for second interview on Friday 31st Mar, 2000 at 7.30pm via telephone. Must send transcript to xxx address. Sent 26th March, 2000. Carla rang me to highlight breach of confidentiality of her husband's name. First transcript confirmed as accurate. (Carla was tentative during second interview owing to being witness to an unexpected stillbirth at work, but still wished to continue with her follow up interview).
21/3/00 InterD2 "Diedre" Posted 2nd transcript & letter of thanks 27/7/00	Rang "Diedre" on ph:xxx. I left a message. She is now with the community health care service in xx. Diedre returned call on 22/3/00. Will do a telephone interview at 7.30pm 1st April(Saturday). ph:xxx (h). Need to send 1st transcript to address xxx. posted transcript 26/3/00 to Diedre in xx town. She confirmed authenticity of first conversation.
30/3/00 InterE2 "Eric" Posted 2nd transcript & personal thanks 2/8/00	Rang Eric. Will send out first transcript to his home address XXX, ph: xxx. Will meet for 2nd interview in Xward at X hospital at 9.30am on Mon 10th April, 2000. Sent copy of 1st transcript on 1st April. Eric confirmed the 1st conversation as authentic, but he felt he talked too much about the past.

APPENDIX G

Personal Letters of Thanks to Participants in Part A

Personal letters of thanks to participants after **first** interview

Dear XXXXX, Nov, 1999

I am nearing completion of my first round of interviews with 14 participants like yourself. This is in relation to my study about advancing nurse specialisation and education.

Five participants are from regional Western Australia and the remaining nine are from metropolitan Perth. The range of advancing practice nurses includes those from the community, oncology, midwifery, remote area, women's health, men's health, critical care, emergency, perioperative and mental health.

I look forward to making contact with you again for a second interview in the new year. At this time I will forward to you a copy of our first interview so that you may review it for trustworthiness and confidentiality. Please feel free to make any other comments that you wish.

Sincerely,
Miriam

rrrrrrrrrrrrrrrrrrrrrrrrrrrrrrrrr

Personal letters of thanks to participants after **second** interview

Dear XXXXX July 25, 2000

As discussed, here is a copy of our second interview/conversation from last (month when relevant interview took place). This is for your records and review.

If you have any comments to make please feel free to contact me. It is important for me and for you to know that our conversation was interpreted as a true and accurate record of events, thoughts and feelings.

Thank you so much for your valued input as a co-author.

Sincerely,

Miriam (a business card was also sent with this message and the transcript).

Note: Each letter of thanks was sent via a personally hand written pictorial letter paper.

APPENDIX H

Audit Trail of Interviews Data Collection Overview

NAME	Specialism, Region, Course & Institution	Length of interviews	Place of interviews	Transcript posted to participant with thank you	Member Check: response/ feedback/ +coding
'Andrew' **A1:12/8/99** **A2:28/3/00**	Emergency & Men's Health. Metro. PGDip/Curtin	50' + 70' Total tape=2hrs Total int=3hr5'	Face to face Face to face Home	Dec 99 Jul 00	Yes Yes +Coding
'Brenda' **B1:26/8/99** **B2:27/3/00**	Special Ed Consultant, Metro, Community. Masters/UWA	90' + 65' Total tape=2hr35' Total int =5hr30'	Face to face Face to face Home	Dec 99 Jul 00	Yes + No
'Carla' **C1:2/9/99** **C2:31/3/00**	Midwifery. Regional/Metro. PGDip/Curtin	60' + 58' Total tape=1hr58' Total int = 2hr25'	Face to face Phone Office/Home	Dec 99 Jul 00	Yes + Yes
'Diedre' **D1:9/9/99** **D2: 1/4/00**	Women's Hlth/ Community, Vasse-Leeuwin. Continuing Ed HDWA	75' + 53' Total tape =2hr8' Total int =3hr20'	Face to face Phone Work/Home	Dec 99 Jul 00	Yes Yes
'Eric' **E1:24/9/99** **E2:10/4/00**	Oncology CNS Men's Hlth, Metro Masters/ECU	78' + 30' Total tape=1hr48' Total int =2hr20'	Face to face Face to face Work/work	Dec 99 Aug 00	Yes No
'Fiona' **F1:5/10/99** **F2:8/6/00**	Critical Care/ED Regional, Albany. Masters/Curtin	40' + 55' Total tape=1h35' Total int=3hr40' Email	Phone Face to face Home/Office	Dec 99 Aug 00	Yes+ Yes+
'Gail' **G1:14/10/99** **G2:01/5/00**	Disabilities Metro, Community. Dip/Natural Therapy	75' + 45' Total tape=2hrs Total int=3hr10' +	Face to face Face to face Work/work	Dec 99 Aug 00	Yes No
'Helen' **H1:26/10/99** **H2:18/4/00**	Remote Area Community, Mingenew Continuing Ed, Silver Chain.	65' + 65' Total tape=2hr10' Total int=2hr15' + Letters/fax	Phone Phone Home/home	Dec 99 + *Apr 00 Aug 00	Yes + Yes +Coding

		Audit Trail Continued			
'Isabelle'[3] **I1:4/11/99**	Remote Area Comm-Narrogin Geron, Child/Fam PGDip/Curtin	64' Total tape = 64' + Letters/fax	Phone Home	Dec 00 Excluded from study	Yes N/A
'Judith' **J1:21/10/99** **J2:4/4/00**	Perioperative Metro. PGDip/ECU	60' + 70' Total tape=2hr10' Total int=3hr10'	Face to face Face to face Office/office	Dec 99 Aug 00	Yes Yes
'Karen' **K1:18/11/99** **K2:27/4/00**	Critical Care Metro. Masters/ECU	41' + 45' Total tape=1hr26' Total int = 1hr51'	Face to face Face to face Office/work	Dec 99 Aug 00	Yes No
'Linda' **L1:12/11/99** **L2:20/4/00**	Critical Care Metro. Masters/ECU	60' + 63' Total tape=2hr3' Total int=2hr23'	Face to face Face to face Office/office	Dec 99 Aug 00	Yes Yes
'Megan' **M1:24/11/99** **M2:17/5/00**	Perioperative Metro. BSc (Hlth Pro) ECU	70' + 69' Total tape=2hr19' Total int = 3hr14'	Face to face Face to face Office/office	Dec 99 Aug 00	Yes No
'Olive' **O1:26/11/99** **O2:28/6/00**	Mental Health Metro. PGDip/ECU	60' + 64' Total tape=2hr4' Total int=3hr42'	Face to face Face to face Home/office	Dec 99 Aug 00	Yes + Yes +
Focus Group Interview: **P: 21/01/00**	10 Participants: 2 DONs 3 Corporate Ds 4 Educators 1 Researcher	90' + 30' Total tape=90' Total int=2 hrs	Face to face, Corporate meeting Rm.	Thank you letters: 16.2.00. °Email of transcript 1 May 00	Yes × 3 1 DON: 29 May00 1 Corporate: 19 May00 1 Research: 19 May00

+ Additional feedback from participant such as typing error(s), reassurance of confidentiality, change of language to confirm accuracy of interpretation and meaning, and/or additional reflections.

[3] No follow up interview as participant revealed she was not undertaking any nursing studies: Data omitted from this study. The participant contacted the researcher on 29thAug 00 to validate the first interview transcription and schedule for follow up interview. Isabelle had transferred with her husband and daughter between interviews to resettle in south west Australia. She was actively seeking nursing work at the time she made contact.

APPENDIX I

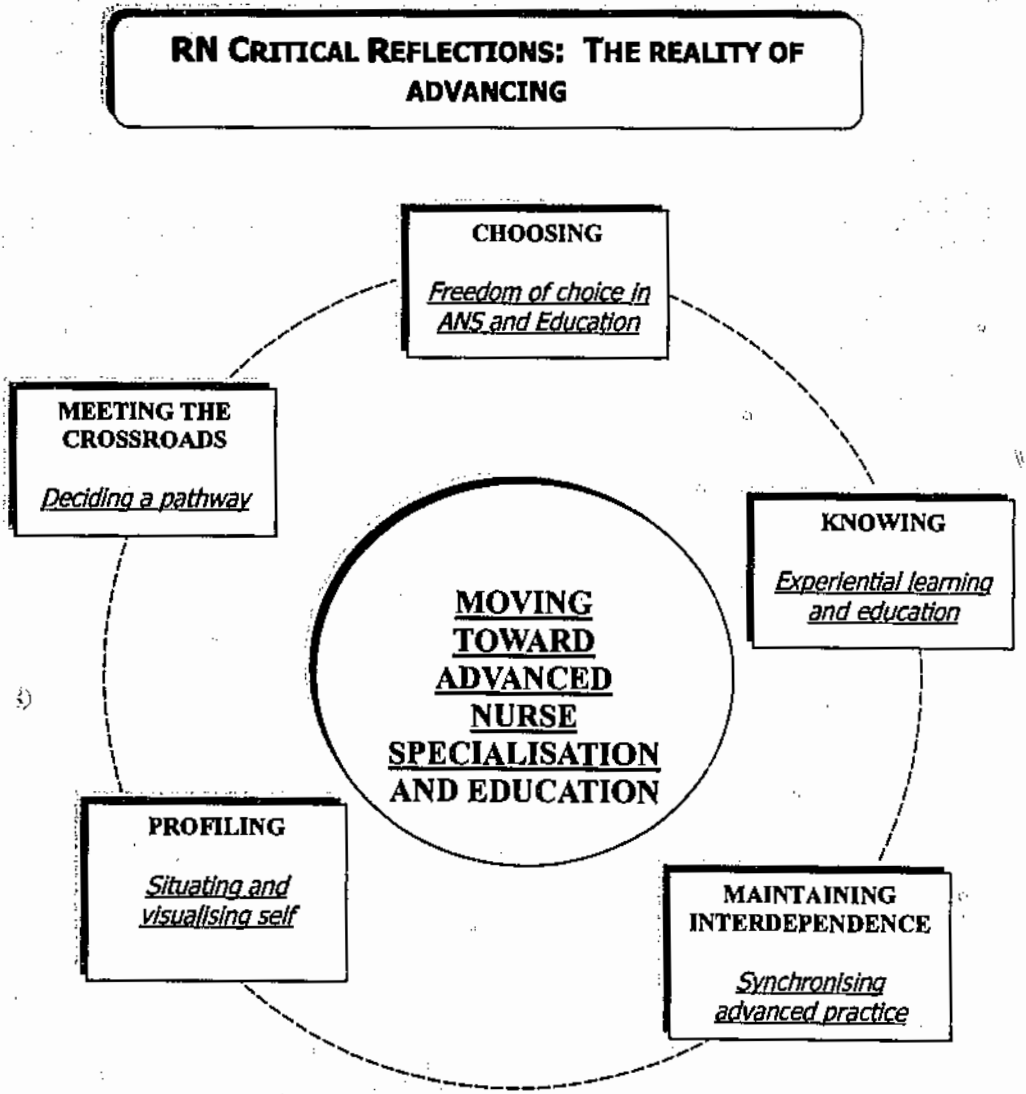
PART A: The Ethnograph List of All Codes and Frequency of Segments in Descending Order

Codes	Freq	Codes	Freq	Codes	Freq
Critical Reflections	488	Opportunism: Creating Opportunities	49	Enterprising	17
Succeeding	227	Balancing Options	46	Nursing Shortage	17
Comparing	210	Being Collectively Undervalued	41	Idealism	17
Reasoning	152	Ambivalence	38	Consumer/Professio -nal Education	16
Pride-Self Praising	147	Being Rejected	36	Hypocrisy	15
Reflexive Action	118	Pragmatism	35	Knowledge Sharing	15
Professional Education	111	Focus on Own Specialty	33	Being Credible	15
Being Challenged	107	Moving-On	32	Work Load	14
Public Profiling	103	Being Acknowledged	32	Perseverance	14
Feeling Vulnerable & Embarrassing	103	Limited Rewards	31	Versatile-Multiskilled	10
Reality	101	Negotiating Options	29	Problem-Solving	10
Self Profiling	100	Long Term Goals	29	Reflections on First Interview	10
Choosing	97	Global Reasoning	29	Openness	9
Mutuality at Work	97	Lost Opportunities	28	Enlightenment	8
Links to Specialisation	96	Knowing	26	Limited Nurse Education	8
Paradoxes as they Arise	93	Credentialling	25	Private Nursing	8
Tolerating Contradictions	87	Technology	24	Crossroads	7
Competing Forces	83	Tolerating Change	24	Reflecting on Options	7
Connecting & Expanding	82	Being Liberated	22	Best Practice	7
Self Assured Feeling Confident	81	Dispiriting	21	Health Prevention	6
Legitimate Collective Profile	74	Multiskilling	20	Prior Knowledge /Learning-Education	6
Competing Work Forces	73	Mutuality at Home	20	Ambition	5
Maintaining Integrity	64	Interdependence	20	Survival	2
Links to Practice, Specialisation & Research	59	Rewards	19	Plateau	2
Being a Catalyst & Influencing	54	Fantasising	18		
Rationalising Organisational Activities	52	Being Collectively Invisible	18		
Rationalising Options	52				

APPENDIX J

Part A Findings: The Way Through the Labyrinth

The Thematic Reconstruction of Moving Toward ANS and Education



APPENDIX K

Semi-structured Interview Guide

Part B Focus Group Interview Questions

Questions prepared for the focus group interview remained open and flexible in nature but included a more direct line of questioning followed by open discussion amongst the stakeholders.

1. What are your expectations of the work practices of nurses who have enrolled or undertaken an advanced specialty course of study?
2. What do you see as the advantages and disadvantages of having employed staff who are undertaking or have undertaken a course relevant to advanced nurse specialisation?
3. What impact if any, does a nurse with a tertiary or equivalent qualification have on the health care agency, the patient, the community and the nursing profession?
4. What in your experience are the issues nurses face when undertaking studies in advanced practice?
5. Are there any recommendations you would make in relation to advanced nurse specialisation and education? If so, what would these be?
6. What was it like for you when you undertook further studies while advancing in your career? Give an outline of your own experiences of nurse education and nurse employment.

APPENDIX L

Newspaper Advertisement, Article, and Agency/Hospital Flier

The Saturday "West Australian" and "Sunday Times" for Recruitment of Participants

ARE YOU A *Registered Nurse* WORKING and STUDYING IN AN ADVANCED CLINICAL SPECIALTY COURSE?

Your knowledge & experiences are of concern to the future of nursing!

Research into hospital and tertiary courses specific to the wide range of specialties practiced by nurses is being conducted. If you wish to have a say, then your experience and wisdom would be welcomed.

Contact Miriam Langridge on: [redacted] or [redacted] to make an appointment for a confidential interview.

Feature article: Sunday Times (Healthy Living Supplement)
26th September 1999-p. 18

Enthusiasm for postgraduate study in nursing appears to be thriving, but is it what practicing nurses really desire? Many RN clinicians see postgraduate nurse education as an avenue for career advancement via a clinical pathway. Other RNs view the challenge of advancing their knowledge in a chosen area of specialism as a legitimate means of increasing their knowledge and skills that ensure quality care to their patients. Even so, many RNs do not find specialization and postgraduate education so agreeable.

The personal cost of undertaking fee paying postgraduate studies is an onerous one. The requirement to juggle work patterns that are both physically and mentally demanding, the time required to commit oneself to a study programme, and more often than not, the need to balance parenting or family responsibilities, are just the tip of the iceberg. Many other factors may unfold from the investigation of nurses who are undertaking specialist practice and education. Therefore, RNs who meet the criteria above/below are invited to participate in this study. Your experiences will help to explore and identify aspects of nurse specialization and education that are based on the social, political, and personal conditions surrounding specialist nurses and stakeholders, such as hospitals and community agencies. It is easy to underestimate the impact of nurse specialization and education in today's commodity driven society, therefore, the findings of this inquiry will provide a genuine account of nurses' position and choices in their work.

Miriam Langridge RN

Agency/Hospital Flier

ARE YOU A *Registered Nurse* WORKING and STUDYING IN AN ADVANCED CLINICAL SPECIALTY COURSE?

Your knowledge & experiences are of concern to the future of nursing!

Research into hospital and tertiary courses specific to the range of specialty areas of nursing is to be conducted. If you wish to have a say then your voluntary participation is welcomed. Contact **Miriam Langridge** on [redacted] or [redacted] to make an appointment for a confidential interview.

APPENDIX M

Part A Consent Form (advancing specialists)

Project Title: **A deconstruction and reconstruction of advanced nurse specialisation and education.**

Investigator: Miriam Langridge RN. Phone: (08)9447 1375 (h)
(08)9273 8558 (w)

Confidential

Dear Colleague,

Thank you for your expression of interest and eligibility to participate as a volunteer in a study specific to nurse edueation and advanced practice. As a Doctoral candidate at Edith Cowan University, School of Nursing & Public Health, I am keen to invite you to share your experiences with me during at least two informal interviews.

The aim of this study is to investigate the nature of advanced nurse specialisation and education in Australia.

The purpose of your involvement is to add understanding of the nature of your professional work and studies within today's changing social environment.

The first interview will take place on or near to the commencement of your course. The second interview will be conducted nearer to the end or on completion of your course. Each interview will be audio-taped with your permission, and take no more than two hours of your time. The place and time of the interviews will be scheduled by mutual arrangement.

In order to safeguard your interests, please acknowledge the following and sign below:

- I understand that there will be no risk to my career or position in the hospital/agency or as a student as a result of my participation in this study.
- I give permission to be interviewed and for this interview to be audio-taped. I understand that on completion of the study, all tapes will be erased.
- I understand that information collected will be coded and secured by the researcher, safeguarding my anonymity and confidentiality.
- I understand that pseedonyms will be used and that my name will not be identified.
- I understand that I am free not to answer questions asked by the researcher during the interview and am free to withdraw my consent and terminate my participation at any time, without penalty.

I _____ agree to participate in the above named study.
(Please print your name)

_____ _____
(Participant) (Researcher)
Date: **Date:**

APPENDIX N

Part A Demographic Questionnaire: Confidential

The following few questions relate to your work as a nurse. Please tick ✔ the appropriate box(s) in questions 1 and 4.

Q1: How many years have you worked as a RN since graduation?

- ☐ 20 yrs or more
- ☐ 15-20 yrs
- ☐ 10-15 yrs
- ☐ 5-10 yrs
- ☐ 2-5 yrs
- ☐ 2 yrs or less
- ☐ Mostly casual/part time

Q2: In what specialty area of nursing are you currently employed and studying?

_____

Q3: What level/position are you currently employed?

_____

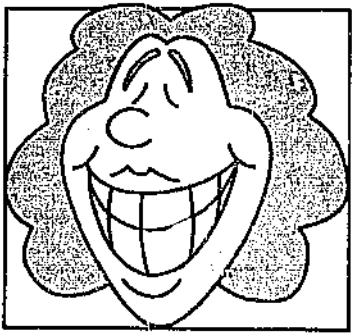
Q4: What qualifications do you have?

- ☐ HBD
- ☐ Specialist certificate/diploma
- ☐ BN or equivalent
- ☐ PG Diploma of Nursing
- ☐ MN or equivalent
- ☐ Other

Q5: What qualification are you currently aiming toward?

_____

Thank you for your responses



Pseudonym:

APPENDIX O

Email Seeking Permission from Head of School and Agency Executive Educators

To Head, School of Nursing, Curtin University of Technology

From:	Self
To:	hazelton@nursing.curtin.edu.au
Subject:	PhD studies
Send reply to:	m.langridge@cowan.edu.au
Date sent:	Wed, 4 Aug 1999 12:16:53 + 0800

Dear A/Professor Hazelton,

I wish to introduce myself to you as Miriam Langridge. I am a RN and lecturer at Edith Cowan University, School of Nursing and Public Health, as well as a PhD candidate at ECU.

To enable me to seek interested and applicable participants for my study, I wish to obtain your permission to place an advertisement on your School of Nursing PG notice board.

The advertisement is a simple A4 ad inviting an interview with PG nurses who are concurrently working and studying in an advanced clinical specialty.

The same ad (much small of course) was recently published in the Saturday West Australian, 31st July, 1999.

The title of my study is "A deconstruction and reconstruction of advanced nurse specialization and education".

I would welcome your response to my request. If you require a meeting, I am able to make an appointment to see you and discuss my study with you. My best day for an appointment is on a Thursday.

Yours sincerely,
Miriam Langridge RN, MSc (Curtin), PhD Candidate (ECU).
ph: 9273 8558 (w)
ph: 9447 1375 (h)
fax: 9273 8699
email: m.langridge@cowan.edu.au

REPLY

From:	"Mike Hazelton" <Hazelton@nursing.curtin.edu.au>
Organization:	Curtin University of Technology
To:	m.langridge@cowan.edu.au
Date sent:	Fri, 6 Aug 1999 17:04:28 WST+8
Subject:	Re: PhD studies
Send reply to:	hazelton@nursing.curtin.edu.au
Priority: normal	

Hi Miriam,

Yes, I am happy for you to post an advert on the notice board in the School of Nursing. You could either bring it over in person, or mail copies to me (or send by email). Let me know if I can assist in any other way.

Warm regards, Mike Hazelton

A similar letter above was sent to the corporate nurse educators of the following hospitals:

- Mount Hospital (Metropolitan private hospital)
- Hollywood Private Hospital (Metropolitan)
- Fremantle Hospital (Metropolitan public hospital)
- Sir Charles Gairdner Hospital (Metropolitan public hospital)
- Geraldton Hospital (Regional public hospital)

APPENDIX P

Part A: Sample RN nested *Critical Reflections* Relevant to ANS and Education

- "Feeling vulnerable" and therefore unable to "meet the crossroads"-limited practical experience as a midwifery student.

"This year, this is my first year, and I'm doing it part time, there's actually no practical at all, which concerned me, because I have only seen two deliveries in my entire career so far, and that was from a long way back, you know, just as an observer. But next year I will be required to do four days a fortnight practical for most of the term and then I think for the two weeks out of each term or semester, have, like a full time block" (Carla 1).

- "Comparing" rural and urban services and identifying the lack of "freedom of choice" to provide holistic patient care.

"If I suspect she has an infection for instance, I can't prescribe (as a woman's health practitioner). That's part of the deal of course. I then have to refer the patient to the GP. So there's this cumbersome thing about the patient having to go back to the GP. It's different in family planning where I have worked. The doctors are in the next room or are further down the corridor, so you put the patient's notes in the doctor's box and they get seen on the same visit. But this may not be so for people here. For instance, for women coming to the XX clinic in the morning, I get booked out. And there's no doctor on sight. I'm just there on my own" (Diedre 1).

- "Paradox and Reality" and understanding the difficulties associated with the "freedom of choice".

"It's difficult to say really. It's very difficult to say. I mean the patient realistically is unconscious and they wouldn't know the difference of whether this one nurse is being operating all day long. I find it has an impact on colleagues more so than anything else. It may have an impact a little bit later on when you have no choice in utilising somebody who may not be competent in recovery but you have no choice. In which case you find that you think, for crying out loud, you should have looked ahead and saw that maybe this might have happened and not just staying in your little comfort zone which a lot of people do" (Judith 1).

APPENDIX Q

Part A: The Schematic Cluster of Core and Sub-Themes

Codes	Codes	Codes
Core Theme: Moving Toward ANS & Education (Textural) ▼	*RN Critical Reflections*	***Sub-Theme 4: Profiling, Visualising and Situating Self (Structural)*** ▼
Competing Forces	***Sub-Theme 2: Experiential Knowing, Learning & Education*** ▼ ***(Structural)***	Opportunism/Creating Opportunities
Competing Internal Forces	Professional Education	Perseverance
Idealism	Consumer Education	Private Nursing Care
Fantasising	Costs	Professional/Public Profiling
Credibility as a Specialist	Credentialling	Being Collectively Invisible
Hypocrisy	Technology	Being Collectively Undervalued
Paradoxes as they Arise	Enlightenment	Work Load
Links to Specialisation	Limited Nurse Education	Legitimate Collective Profile
Best Practice		Personal Profiling
Health Prevention		Pride/Self Praising
Links to Specialisation & Research		Ambivalence
Long Term Goals		
Reflecting: Rationalising, Balancing & Negotiating Options		***Sub-Theme 5: Meeting the Crossroads*** ▼ ***(Structural)***
Succeeding		Being Challenged
Being Rejected	***Sub-Theme 3: Maintaining Interdependence*** ▼ ***(Structural)***	Feeling Vulnerable & Embarrassing
Gaining Rewards	Being Acknowledged	Openness
Limited Rewards	Enterprising	Self Assured: Feeling Confident
Tolerating Contradictions	Mutuality at Work	Being a Catalyst & Influencing
Focal Point: Own Specialty	Connecting & Expanding	
Tolerating Change	Maintaining Integrity	Being Liberated
Sub-Theme 1: Freedom of Choice (Structural) ▼	Interdependence	Dispiriting
Choosing	Mutuality at Home	Crossroads
Comparing	Lost Opportunities	Ambition
Reality		Plateau
Reasoning		Moving On
Rationalising Organisational Activities		
Pragmatism/Survival		
Global Reasoning		
Nursing Shortage		
Problem-Solving		
Reflexive Action		
Reflections on First Interview		

= CORE THEME: Moving Toward ANS and Education
= Sub-Theme 1: Choice: The Freedom of Choosing ANS & Education
= Sub-Theme 2: Knowing: Experiential Learning and Advancement
= Sub Theme 3: Maintaining Interdependence: Synchronising ANS
= Sub-Theme 4: Profiling: Visualising & Situating Self
= Sub-Theme 5: Meeting the Crossroads and Moving on

Codes: Words grouped by symbols to identify patterns and clusters of core and sub-themes.

APPENDIX R

Part A Core Theme: The Ethnograph Code Book and Family Tree

The Core Theme: The Textural/Noematic Movement Toward ANS and Education

		The Ethnograph Code Book		
Core Theme: Parent Code Word	Family Tree Code Word: Level 1	Family Tree Code Word: Level 2	Family Tree Code Word: Level 3	Family Tree Code Word: Level 4
Specialisation & Education	Competing Forces	Competing work forces		
	Idealism	Credible		
		Fantasy		
		Hypocrisy		
		Paradox		
	Links to Specialisation	Best Practice		
		Health prevention		
		Links to practice, specialty & research		
		Long term goals		
	Rationalising & Balancing	Negotiating options	Rationalising options	Reflective imagery
	Succeeding	Being rejected		
		Rewards	Limited rewards	
	Tolerating Contradictions	Tolerating Change		
Advanced Specialisations	Community Nurse			
	Complementary Health Nurse			
	Consultant: Learning Disabilities Nurse			
	Critical Care Nurse			
	Emergency Dept Nurse			
	Mens Health Nurse			
	Mental Health Nurse			
	Midwifery Nurse			
	Oncology Nurse			
	Perioperative Nurse			
	Remote Area Nurse			
	Women's Health Nurse Consultant			

APPENDIX S

Part A Sub-Themes: The Ethnograph Code Book and Family Tree

Sub Themes: The Structural & Contextual/Noetic Way Through the Labyrinth

		The Ethnograph Code Book		
Sub-Theme 1: Parent Code Word	Family Tree Code Word: Level 1	Family Tree Code Word: Level 2	Family Tree Code Word: Level 3	Family Tree Code Word: Level 4
The Freedom of Choice	Choosing	Reasoning	Comparing	
			Global reasoning	
			Rationalising organisational activities	
		Reflective action	Problem-solving	
			Reflection on first interview	
	Reality	Nursing Shortage		
		Pragmatism		
		Survival		
Sub-Theme 2: Parent Code Word				
Knowing: Experiential Learning & Education	Professional education	Consumer education	Costs	Enlightenment
	Credentialling			
	Limited Nurse Education			
	Technology			
Sub-Theme 3: Parent Code Word				
Maintaining Interdependence	Connecting & expanding			
	Enterprising			
	Interdependence	Lost Opportunities		
	Maintaining Integrity	Mutuality at work	Being Acknowledged	
			Mutuality at home	
Sub-Theme 4: Parent Code Word				
Profiling: Visualising & situating self	Creating opportunities			
	Perseverance			
	Private Nursing			
	Professional profile	Being collectively invisible	Being collectively undervalued	Workloads
		Being collectively visible	Legitimate collective profile	
	Personal profile	Pride	Ambivalence	
Sub-Theme 5: Parent Code Word				
Meeting the Crossroads	Being liberated	Self-assured	Feeling confident	Being a catalyst/influential
	Feeling vulnerable: Embarrassed	Dispirited		
	Openness	Being challenged	Ambition	
	Crossroads	Plateau	Moving on	

APPENDIX T

Email Memo: Follow-up Questions to Part B Stakeholders Post Focus Interview

From: Miriam Langridge
To: Individual focus group member
Subject: The focus group interview
Send reply to: m.langridge@.....
Date sent: Tue, 2 May 2000 14:27:47 +0800
Dear Co-Authors,
Do you recall when you joined as a focus group last January?
If so your memory serves you well.

I have as an attachment, a transcribed copy of the interview (some 40+ pages) conducted as part of my study on advanced nurse practice and education. You as stakeholders are not identifiable by your actual name. You do/will know who each member and speaker is by the letter codes I have given each of you. Members of this focus group and myself are the only persons to read this transcript. (I alone transcribed the taped interview: PHEW, but it was worth it!).

Could I ask you to do the following:

THIS WON'T BE DIFFICULT!

1. Review what you have said and confirm for accuracy of the intended conversation. (You should be able to work out the coded letters that belong to your voice or what you said!).
2. If you really care to, you might like to enjoy reading the whole transcription to indulge in the comments made not only by yourself but by all the other co-authors (focus group members). ANY COMMENTS ARE WELCOMED!

THIS REQUIRES SOME SCHOLARLY THOUGHT

3. If you feel so inclined, your offer of any constructive criticism that you feel is necessary would be welcomed. This will assist in the validity of this qualitative data.
4. You will find on the last page of the transcript, a list of 6 questions. Question 1 and 3 are in bold. I would welcome any further comments that you may like to make in relation to these two questions. (the remaining 4 questions as it so happens, have been covered extremely well during the conversation).

At this point I am nearing the closure of all stages of the longitudinal data collection and anticipate data analysis while on LSL this August. I don't plan to resurface in a hurry for fear of coming to "an early closure" which to some qualitative researchers/advisers is a sin beyond redemption.

Jokes aside, I remain very grateful for your time and challenging personal contributions. You names will be in my book one day?!
NOTE: If anyone is concerned about the naming of their hospital(s), please let me know if you would like them to be eliminated from the transcript. I will not be identifying them in any published materials other than to mention issues that reflect the public or private health sectors.

Cheers and many thanks, Miriam.
Attachments: interp.doc

APPENDIX U

Part B Sample Email Invitation to Focus Group and Response by Nurse Executives
(Invitation to attend a meeting/interview)

From: Miriam Langridge[SMTP:mlangrid@possum.fhhs.ac.cowan.edu.au]
Reply To: m.langridge@cowan.edu.au
Sent: Wednesday, 1 December 1999 12:36
To: "Leisa"@health.wa.gov.au
Subject: Focus Group Interview

Dear "Leisa",

You may recall when I asked if you would like to participate in a "focus group" interview with other person's (senior nurses from the metro area of Perth) like yourself. This is part of my Ph.D data collection concerning advanced nurse specialization and education. Please note that this interview will be tape recorded with your permission of course! I have now set a date and time for the new millenium.

Date: FRIDAY 21 JANUARY 2000
Time: 2pm-3.30pm
Venue: Room tba (Edith Cowan University, Churchlands Campus)

*A refreshing afternoon tea will be provided. You are one of the special people to be invited to participate, so please RSVP by 17th December ,1999.

Cheers Miriam
Miriam Langridge
Coordinator, Postgraduate Diploma of Clinical Nursing
Edith Cowan University
Pearson Street, Churchlands, 6018
Western Australia
Ph: 61 8 9273 8558
Fax: 61 8 9273 8699
Email: m.langridge@cowan.edu.au

RESPONSE

From: "Leisa"@health.wa.gov.au>
To: "'m.langridge@cowan.edu.au'" <m.langridge@cowan.edu.au>
Subject: RE: Focus Group Interview
Date sent: Wed, 1 Dec 1999 12:29:50 +0800

It is in my NEW diary.
thank's

"leisa"

Coordinator Corporate Staff Development
Fremantle Hospital and Health Service
PO Box 480
Fremantle, Western Australia 6959

APPENDIX V

Part B Letter of Invitation and Consent Form

Project Title: **A deconstruction and reconstruction of advanced nurse specialisation and education.**

Investigator: Miriam Langridge RN, Phone: [redacted]

Confidential

Dear Colleague,

Thank you for your expression of interest to voluntarily participate in a focus group interview. You are invited to join me with 7-10 other senior nursing colleagues like yourself, to share your knowledge and experiences relevant to advanced specialist practice and education. Your contribution via dialogue and discussion on this one occasion will add to the field data that is being gathered from nurses currently undertaking advanced specialist programs. The study is specifically related to the nature of nurse education and advanced practice. As a Doctoral candidate at Edith Cowan University, School of Nursing & Public Health, I am keen to invite you to share your experiences over an informal finger lunch at a time and venue that is to be tabled at Edith Cowan University in a conference room.

The aim of this study is to investigate the nature of advanced nurse specialisation and education in Australia.
The purpose of your involvement is to add understanding of the nature of advanced nurse specialisation and education within today's changing social environment.

The focus group interview will be tape-recorded and convened, as an informal meeting for no more than two hours duration. The place and time of the interview will be scheduled by mutual arrangement and communicated to you once a date is confirmed.

In order to safeguard your interests, please acknowledge the following and sign below:

- I understand that there will be no risk to my career or position in the hospital/agency as a result of my participation in this study.
- I give permission to be interviewed and for this interview to be audio-taped. I understand that on completion of the study, all tapes will be erased.
- I understand that information collected will be coded and secured by the researcher, safeguarding my anonymity and confidentiality.
- I understand that pseudonyms will be used and that my name will not be identified.
- I understand that I am free not to answer questions asked by the researcher during the interview and am free to withdraw my consent and terminate my participation at any time, without duress.

I _____ agree to participate in the above named study.
(Please print your name)

_____ _____
(Participant) (Researcher)
Date: Date:

APPENDIX W

Part B Sample Letter of Thanks to Focus Group Participants

Dear (Name), 16/2/00

I wish to take this opportunity to thank you kindly for participating as a focus group member for my study concerning advanced nurse specialization and education.

The group's reflections will add a balance to the reflections of those nurse specialists who are also participating in the study.

I appreciate your contribution and for having made time to attend the focus group interview.

Yours sincerely,

Miriam Langridge, Ph.D Candidate, ECU.

APPENDIX X

Part B Sample Email Feedback From Focus Group Stakeholder

From:	"Sally" (pseudonym)
Organization:	Edith Cowan University
To:	m.langridge@cowan.edu.au
Date sent:	Fri, 19 May 2000 15:33:11 +0800
Subject:	feedback
Send reply to:	"Sally" @....
Priority:	normal

Hi Miriam,
Sorry this has taken so long. Here is my response to your request - I'm afraid I can't offer much in the way of constructive criticism about the process, because I don't have experience with focus groups in the research process. However, from a naive participant's perspective, I think the session was conducted in a very professional and effective manner. A lot of effort went into the organisation, making people feel comfortable, well fed and watered etc and prepared for what was required of them. I found the questions fairly complex, and I'm not sure that there was enough time to address them all in sufficient depth, particularly when so many people were willing to talk and sometimes went off on other tangents. However, I guess this is not an isolated problem and I hope you were able to get useful information.

Review of what I said:
It looks quite accurate to me (but what a shock to hear how one rambles...)

Thoughts on question 1.
I would expect these nurses to take an active role in leadership, mentoring junior staff, encouraging evidence based practice by questioning existing practices, reading literature, involvement in policy and planning committees and where possible, research projects. They should be sharing knowledge through education sessions, and informally. They should take up active membership of professional organisations related to their specialty and make a contribution to the activities of the organisations.

Question 3.
The potential impact of these nurses on stakeholders: Ultimately, the quality of care should be increased and there should be a positive contribution to the knowledge and reputation of the profession and the functioning of the health care agency. This should be achieved through the acquisition of improved problem solving skills, an increased knowledge base, better knowledge of personal/professional networks and library resources as a means of continued learning as well as application of skills. There should be an increased awareness of issues related to the continuum of care across hospital/community, educational needs (personal and patient/family), psychosocial issues - from both a theoretical and practical perspective. This may be at some cost to the health care agency and profession in that these nurses need to be supported, with adequate resources to maximise their effectiveness in their clinical roles, and they will need financial support for research, library resources, conference attendance, computers, etc.

Hope this helps, Miriam. good luck,
"Sally"

APPENDIX Y

Part B Themes and Frequency of Code Words/Segments

(The Focus Group Interview with Stakeholders)

Code Words	Seg	Code Words	Seg	Code Words	Seg
The Debate		*The Solutions*		*The Personal Discourse*	
Employer Concerns	38	Desired Pathways	10	Own Philosophy	7
Benefits to the Organisation	21	Action	21	Empathy	9
Barriers	9	Action/Private Health Services	8	Own Future Planning	5
Realistic	13	Action/Public Health Services	4	Own Positive Experiences	19
Positive Outcomes	20	Collaborative Education	3	Own Negative Experiences	12
Negative Outcomes	16	Merger	1	Projections	6
Mutual Responsibility	9				
Making Comparisons	3				
Agent Validation	3				
Skilled Work Force	7				
Researcher	9				
Acuity	5				

= The Debate: Stakeholder and Employer Concerns
= The Solutions: Desired Pathways for ANS
= The Personal Reflections: Personal Philosophy of Nurse Education

Code Words: Words grouped by symbols to identify cluster of themes.
Seg: Frequency of segments/narratives.

APPENDIX Z

Part B: The Ethnograph Code Book and Family Tree

The Themes: The Stakeholder Textural/Noematic Movement Toward ANS and Education

		The Ethnograph Code Book	
Parent Code Word	Family Tree Code Word: Level 1	Family Tree Code Word: Level 2	Family Tree Code Word: Level 3
The Debate: Stakeholder & Employer Concerns	Agency validity		
	Mutual responsibilities	Barriers	
		Benefits to the organisation	Hospital based programs
		Negotiating support	
		Negative outcomes	Positive outcomes
	Realities of the workplace	Making compromises	
	Recruiting		
	Remuneration	Flexibility	Transportability
	Researching		
	Skilled work force	Acute/Complex level of care	
The Solutions: Desired Pathways for ANS	Actions to take	Action by private sector	Action by public sector
	Hospital-based Education		
	Collaborative education/Sharing of strategic goals		
Personal Reflections: A Philosophy of Nurse Education	Empathy with advancing specialists		
	Own future	Own positive experiences	Own negative experiences
	Projections for ANS & Education		