UNDERSTANDING THE MEANING OF NURSE PRACTITIONER AUTONOMOUS PRACTICE IN OKLAHOMA: A GADAMERIAN APPROACH

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SANDRA A. WEILAND

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DEDICATION

To my husband Ralph Weiland,
to my parents, Bruce and Gloria Page, and
to the nurse practitioners who made this study possible.

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ABSTRACT

SANDRA A. WEILAND

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Despite more than 45 years of nurse practitioner (NP) history, the ability of NPs to practice autonomously as primary care providers continues to be influenced by cultural, socioeconomic, and political factors. Relatively little attention, however, has been given to the NP's own understanding of what autonomy means within the context of daily practice. The purpose of this qualitative study was to elicit an understanding of the meaning of autonomy as interpreted by NPs through the lived experiences of their everyday practice in primary health care.

This was a Gadamerian hermeneutic study that also incorporated Gilligan's feminist perspective. Purposive and network sampling were used to ensure that a broad swath of NPs from diverse primary health care practice settings was achieved. Data were collected from nine NPs during individual, face-to-face interviews of one to two hours duration. Each interview was audio-taped and transcribed by the author or a transcriptionist.

Interpretive analysis incorporated Gadamer's hermeneutic model of the hermeneutic circle and development of understanding through the fusion of horizons. Gilligan's theory that the development of one's identity is defined through relationships of responsibility and care molded the context of hermeneutic interpretation. Findings revealed that "Having Genuine NP Practice" was the major theme, reflecting the participant's own overall meaning of his or her autonomy. Practicing *independently* and *alone* (in the room) *with the patient* provided the context within which participants shaped the meaning of Having Genuine NP Practice, including its four sub-themes: (a) relationships, (b) self-reliance, (c) self-empowerment, and (d) defending the NP role.

The participant NPs perceived their practice as autonomous despite a restrictive practice environment. Understanding how NPs in this study shaped Having Genuine NP Practice provided insight into their daily practice, their professional self, the integral part that relationships occupy in the everyday life of being an NP, and daily struggles. This study highlighted the impact of a traditional, hierarchical culture and the social impediments to achieving full autonomy. New knowledge of what Having Genuine NP Practice means enables the NP profession to influence health care reform better.

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The noblest pleasure is the joy of understanding.

Leonardo da Vinci (Davincibio.org, 2011)

CHAPTER I

INTRODUCTION

Focus of Inquiry

Autonomy is a cornerstone of nurse practitioner (NP) practice and is essential to understanding the professional role of NPs in providing primary health care services. It is also central to the ultimate success of the professional role of the NP as well as advancing the nursing profession. Despite more than 45 years of NP practice, the ability of NPs to practice autonomously as primary care providers continues to be inhibited by cultural, socioeconomic, and political factors (Weiland, 2008). Indeed, such everyday terms as *midlevel provider* and *physician extender* are used interchangeably with the title NP, further encouraging the perception of the NP as dependent and less than competent as opposed to an independent provider of primary health care. It is little wonder that no consensus has appeared among State Boards of Nursing, policy makers, physicians, third-party payers, society, and NPs themselves about what autonomy in NP practice really means. As a result, the unique NP role is undervalued and misunderstood, and the legitimacy and authority to practice autonomously is fragmented among the 50 different states and United States territories in which NPs are licensed to practice (Pearson, 2010). Even more critical and more poorly understood is the fact that not all NPs practice autonomously even when they have the legal authority to do so, while other NPs work

around state practice restrictions to achieve autonomous practice (Kaplan & Brown, 2004; Weiland, 2008; Whelan, 2000).

The concept of autonomy has been explored extensively for the following purposes: (a) conceptualizing and clarifying a poorly understood concept, (b) determining the pros and cons of autonomous NP practice, (c) determining the impact of state restrictions on NP practice patterns, (d) quantifying the levels of NP autonomy in practice, and (e) exploring the relationship between nurse characteristics and professional autonomy (Aveyard, 2000; Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Dachelet & Sullivan, 1979; Johnson, 2005; Keenan, 1999; MacDonald, 2002; Shutzenhofer & Musser, 1994; Wade, 1999; Wade, 2003; Weiland, 2008; Whelan, 2000). Conspicuously absent are studies that attempt to reach a deeper understanding of the meaning of autonomy and how NPs understand and interpret this meaning in their everyday practice environments. Furthermore, no known studies have specifically addressed how NPs understand the meaning of autonomy in an environment in which it is inconsistently defined. Practice in Oklahoma demonstrates this inconsistency.

Oklahoma grants the NP the legal authority to practice autonomously as a primary care provider, but at the same time requires physician supervision of prescriptive authority (Oklahoma Board of Nursing, 2003). The inconsistency of Oklahoma's NP practice regulations of being independent on the one hand, yet dependent on the other, is an exemplary practice environment in which to explore the NP's meaning of autonomy. In fact, NPs may themselves be confused about the meaning of autonomy and not

practice to the full extent to which they are legally authorized. If NPs are to be seen as members of a profession by themselves and others, and to be key participants in the health care environment as independent, autonomous practitioners,[1] it is important to understand what autonomy means to NPs in their everyday practice. The focus of this research is to explore the meaning of autonomy as it is interpreted by NPs who practice primary health care in Oklahoma.

Statement of Purpose

The purpose of this hermeneutic qualitative study is to understand the meaning of autonomy as it is interpreted by NPs through their lived experiences of their everyday practice. The research question that guided this study was: What is the meaning of autonomy as it is interpreted by NPs in Oklahoma through the lived experiences of their everyday practice in primary care?

Background of the Study

The background of the study is presented by organizing a discussion of these defining terms: (a) professional and profession, (b) autonomy and professional autonomy, (c) nurse practitioner as an advanced practice nurse, (d) NP scope of practice, and (e) NP role. Clarifying how terms are defined within this dissertation provides insight and promotes understanding of the NP as an autonomous professional.

[1] As defined by the National Council of State Boards of Nursing, the American Academy of Nurse Practitioners, the American Nurses Credentialing Center, and the Advanced Practice Registered Nurse Joint Dialogue Group (2008)

Professional and Profession

A professional is a member of a self-regulating occupational group that is legislatively granted the exclusive right to practice in a specific field. Professionals, therefore, believe they have earned the right to work autonomously because they have acquired the special knowledge base and been given the authority to do so (Blanchfield & Biordi, 1996). The occupational groups to which professionals belong are called professions. Examples of professions include the following: (a) medicine, (b) nursing, (c) clergy, (d) law, and (e) engineering (Catalano, 2009).

Each profession is given the freedom to set its own standards—both technical and ethical (MacDonald, 2002). Just like other professions, nursing has its own set of professional standards, which implies not only a right and wrong way of doing things, but also the responsibility to act according to those standards (Catalano, 2009; MacDonald, 2002). According to MacDonald, "no physician order has sufficient moral weight to override those [standards]" (p. 196). In other words, a characteristic hallmark of a profession is freedom from the control of another group in its division of labor (Dachelet & Sullivan, 1979). The term freedom from control implies self-governance and power, and self-governance implies autonomy; hence, autonomy distinguishes professions from occupational groups and is central to achieving professional status. Clearly, professional status and autonomy are closely linked as are power and control (Keenan, 1999).

Autonomy and Professional Autonomy

Although it may appear that the definition of autonomy is fairly straightforward, in reality it is complex and difficult to define (Dworkin, 1997). Indeed, Dworkin contended that autonomy can only be characterized by "how things are viewed through the reasons, values, and desires of the individual and how those elements are shaped and formed" (p. 10). For example, the *Merriam-Webster Online Dictionary* (2010) defined "autonomy" using language such as the right of self-government, self-directing freedom, moral independence, and self-governing. Implied within this definition are individual rights and the notions of respect and self-determination because autonomy functions "as a moral, political, and social ideal" (Dworkin, 1997, p. 10). In Western culture, autonomy is highly valued because individuality is valued (Yanay, 1994), but limits are set for individual autonomy and professional autonomy when values conflict.

The concept of autonomy that values individuality comes into conflict when ideals such as self-directing freedom or individual rights conflict with professional values such as responsibility, the obligation to do good, healing, and caring (Dworkin, 1997; McDonald, 2002; Pellegrino & Thomasma, 2007). Indeed, in its purest sense, individual autonomy disregards the complex personal and institutional relationships that make possible, or sometimes hamper, making real choices (Dworkin, 1997; MacDonald, 2002; Wade, 2003). For example, nursing is a helping profession that is guided by a code of ethics. The obligation to do good (beneficence) and to do no harm (malfeasance) guides nursing practice and is at the center of the therapeutic relationship (American Nurses

Association (ANA), 2001; Pellegrino & Thomasma, 2007). Professional autonomy in nursing, then, does not mean having total control; rather, it is simply the freedom to choose when and whether control is given up or retained (Keenan, 1999). Professional autonomy can also be implied to mean freedom of action and at the same time being fully accountable and responsible (Laperrière, 2008).

Physician autonomy, on the other hand, has been defined as self-governing; medicine is referred to as a "sovereign profession" (Culbertson & Lee, 1996). Physician autonomy is also defined by economic dimensions. Consequently, the medical profession enjoys economic independence and dominion over all knowledge and skills related to the profession. To this end, physician autonomy has traditionally trumped that of all other professionals in health care because by definition, physician autonomy has a supervisory monopoly over all medical work (Culbertson & Lee, 1996). Understanding physician autonomy socioeconomically as a "sovereign profession" partially explains the traditional hierarchical structure of the health care system and the close attention paid by the American Medical Association (AMA) to expansion of the NP scope of practice. It is no surprise, then, that physicians continue to push for collaboration and supervision at the legislative level under the guise of protection of public health (AMA, 2009) because protection through supervision secures their "social and economic prerogatives" (Fairman, 2003, p. 59).

Nurse Practitioner as an Advanced Practice Nurse

NPs are a sub-group of the advanced practice registered nurse group. The American Academy of Nurse Practitioners (AANP) described NPs as:

> Licensed independent practitioners who provide primary and/or specialty nursing and medical care in ambulatory, acute and long term care settings. They are registered nurses with specialized advanced education and clinical competency to provide health and medical care for diverse populations in a variety of primary care, acute and long term care settings. Master's, post master's or doctoral preparation is required for entry level practice. (AANP, 2007, p. 1)

Other advanced practice registered nurses include: Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM), and Clinical Nurse Specialist (CNS) (ANA, 2006). Philosophically, most advanced practice registered nurses share the belief that nursing is a holistic, caring discipline that considers the human response to illness and includes the client, the family, and society. The focus of their practice is health promotion and disease prevention; however, in order to meet society's health needs more fully, it was necessary that NPs expand their scope of practice to incorporate medicine's philosophical perspective—which is a lateral illness model of diagnosis and treatment (Ford, 1997; Hamric, Spross, & Hanson, 1996).

NP Scope of Practice

The NP scope of practice is legally defined by a state's Nurse Practice Act and enacted by the respective state boards of nursing. The scope of practice is the framework

that guides NP practice and is used by a jury to determine breach of professional standards (Klein, 2005). Each state independently regulates the practice of nursing, and because NPs have achieved legislative changes to the scope of practice at varying times, state practice acts vary in the definition of NP autonomy (Klein, 2005; Lazarus & Downing, 2003). Most states define autonomy by what it is not, rather than by what it is. For example, the *Oklahoma Nursing Practice Act* §567.3a (Oklahoma Board of Nursing, 2003) authorizes NPs to perform a history and physical examination; to diagnose, treat, order, and interpret diagnostic tests; develop a plan of care; and evaluate the plan of care without the requirement for supervision or collaboration. In contrast, §567.4a of the *Oklahoma Nursing Practice Act* mandates physician supervision in order to prescribe legend drugs. An NP's prescribing of scheduled drugs is limited to schedule III-V for 30 days. Philosophically, requiring physician supervision for any part of NP practice implies that autonomous NP practice is unsafe and that NPs are responsible to, and dependent upon, the physician because they lack the requisite knowledge, skills, and competency to act autonomously.

NP Role

Conceptually, Meleis (1975) defined *role* as a "sociopsychological construct" that is not merely "a set of behaviors or expected behaviors, but a sentiment or goal which provides unity to a set of potential actions" (p. 264). As a concept, role can be useful in the interpretation of personal behavior towards another and the context in which the behavior occurs; hence, role is the result of a complex interaction between the self and

society. A role can be determined by the actions and expectations of individual members within society (Meleis, 1975). Thus, roles chosen by the NP are validated through acceptance by significant others, such as patients, society at large, physicians, other health care workers, educators, and legislators. Essentially, the motivation to continue in a role is stimulated by the rewards and losses encountered through validation and acceptance. Hamric et al. (1996) contended that role development is a complex process that evolves over time, and emerges and evolves through validation.

The definition of role was operationalized by the AANP (2002) role position statement: "Nurse practitioners assess and manage medical and nursing problems. Their practice emphasizes health promotion and maintenance, disease prevention and the diagnosis and management of acute and chronic diseases" (p. 1). To achieve this, NPs take histories, conduct physical exams, order and interpret diagnostic tests, write prescriptions, and manage the conditions that are diagnosed.

Rationale for the Study

Historical Context of Autonomous NP Practice

According to Loretta Ford (1997), cofounder of the nurse practitioner movement and role, incorporating both a nursing and a medical model of practice was necessary to advance the autonomous nursing role and provide cost-effective primary health care services. Indeed, the pioneer NPs eagerly sought out physicians, and physicians responded in kind to the NPs' needs for collaboration and mentoring to achieve success in this newly developing advanced nursing role (Fairman, 2003).

In a historical study, Fairman (2002) traced the history of pioneer NPs' experiences with physician partners during the early years of establishing the autonomous NP role. Key to establishing a collaborative relationship was the ability of the NP to demonstrate competency, knowledge, and skill in order to gain the right to autonomous practice. For example, one participant reported: "In the beginning he was really gentle in letting me do things. Don't even make a referral without him. Don't do this. Don't do that. But soon he [knew] you well enough . . ." (p. 164). Yet another NP described how gaining trust and negotiating the boundaries of her practice through relationships ultimately helped her to gain autonomy: "I wanted them to feel comfortable with how I did things and then slowly showed them that I knew how to do some other things . . . . pretty soon, it was just—'Oh you didn't need to call, just go ahead and do that'" (p. 166).

Interestingly, Fairman (2002) made the observation that the collaborative relationship in those early days between the NP and the physician was not mandated by the edicts of national organizations such as the AMA and the ANA or by educational institutions. Rather, the relationship was "influenced more by the social environment and individual personality than by explicit directives to 'collaborate'" (p. 169). These stories pointed out that the relationship between the NP and the physician in their everyday work environment was an individual construction of collaboration where trust and respect were forged. It also showed that developing trust and mutual understanding of the practice boundaries between the NP and the physician was the fulcrum for successful collaboration. Relationships such as those described in the study cannot be legislated.

Moreover, the significance and value to the present study is that it reflects the NP's clarity of purpose, value, readiness, and verve to take on an autonomous role as well as the physician's acceptance of the NP as shown by their willingness and cooperation to share the daily practice environment. Just as important, the interrelatedness between nursing and medicine and the indistinct boundaries between the two professions is recognized by both NPs and physicians.

Unfortunately, neither all NPs nor physicians enter into a collegial, cooperative relationship. Physicians often view the advanced nursing role of the NP in a hierarchical model of care in which NPs function as dependent collaborators to, of, and with, the physician (Cairo, 1996; Campbell-Heider & Pollock, 1987; McLain, 1988).

Nurse Practitioner Autonomy

Anthropological Context of Autonomous NP Practice

The deeply rooted structure of hierarchy between nursing and medicine is culturally and socially constructed (Campbell-Heider & Pollock, 1987). As such, the ideology of hierarchy is a fundamental barrier to NP practice autonomy. Within the context of this study, cultural and social construction of relationships cannot be ignored because they are powerful factors that shape the NP's meaning of autonomy in everyday practice.

In a phenomenological study of nine NP and physician dyads to "critically analyze the essence" of the joint practice relationship between NPs and physicians, McLain's (1988) findings suggested that overall, "the language, values and behaviors of

the nurses continued to support, to varying degrees, the authoritarian and dominant position of the physicians" (p. 35). Only one physician in the study expressed an understanding that the traditionally dominant position of physicians limits the legitimacy of the NP as a health care provider. For example, the physician said, "I will use the term 'medical education' and 'medical care' which nurse practitioners have informed me makes them feel left out . . . now I say 'health care' and 'health providers'" (p. 34). This physician's understanding resulted from clear communication from the NP who challenged the traditional assumption that as a nurse, she had less authority. Other physicians, however, expressed an inability to view the NP as a nurse because "I don't think she's viewed herself as a nurse in a long time!" (p. 34). Further, ". . . nursing has a different kind of approach, or views this mission and what they do in a completely different light to that, and I would like to know what that light is" (p. 34). Misunderstanding by both NPs and physicians of what nursing is in the NP role may be a result of NPs' choosing a dominant medical model of practice because that is what is expected, or perhaps NPs are unable to espouse the values of nursing.

The findings of McLain's (1988) study further revealed that NPs continued to promote physician authority. For example, one NP said, "I'm not sure about this, and there's a physician here who I'd like to have come in. . . . Then it's the *doctor* going into the room, and if the *doctor* says it's okay then it must be okay" (p. 34). Most NPs in this study felt as though they did not have the legitimate right to step forward; instead, they "tended towards cooperation and accommodation" (p. 34). Although McLain's study

was a phenomenological study and therefore results cannot be generalized, similar results were found by Fulton (1997) in a qualitative study to explore nurses' views of empowerment in practice. Nevertheless, McLain's (1988) study is significant because it brings to light the influence of an overreaching hierarchical ideology that supports dependence of nurses, but independence of physicians. It also supports the critical importance of determining the meaning of autonomy as it is interpreted by NPs because if NPs are uncomfortable with increased authority or do not have value for NP autonomy, the professional role will not be successful, regardless of legislation to advance the scope of practice. Campbell-Heider and Pollock (1987) further contended that any changes in legislation to legitimize NP practice "will probably not alter hierarchical relationships until physicians and nurses recognize that these relationships can actually limit the options of *both* [emphasis added] groups" (p. 423). However, other factors intrinsic to the NPs themselves and to their readiness to become fully autonomous are also considerations.

In a descriptive study, Kaplan and Brown (2008) surveyed NPs ($N = 560$) in Washington State. As part of their survey, these researchers sought to determine factors that influenced the choice to have or not to have the authority to prescribe controlled substances (CS) II-V (joint practice agreement required). Contextually, Washington State had hitherto been a plenary state with NP authority to prescribe CS III-V (joint practice agreement *not* required). To gain the authority to prescribe CS II-V, however, a joint practice agreement (JPA) with physicians was mandated by new legislation. That

only 16% of all NPs in this study felt very, or extremely, well-prepared to prescribe CS may also be a factor in 23% of the study participants not seeking the joint practice agreement required for prescriptive authority. Just as striking were the attitudes and values expressed by some NPs. For example, some revealed fears and concerns for disciplinary action, lack of understanding about the meaning of addiction, and limiting prescription of CS to "limit my exposure to patients with drug-seeking behavior, high tolerance to opiates, or chronic pain requiring complex care" (p. 49). Despite this finding, 93% of all NP participants experienced either moderate or a great deal of autonomy regardless of whether they had prescriptive authority for CS. The findings of this study are significant because they emphasized the importance of determining the meaning of autonomy as it is interpreted by NPs. Although changes in legislation may legitimize NP practice, having the legitimate right may not change how NPs practice if they perceive they are already autonomous.

As a cultural and social construct, gender and social image may also influence how NPs define autonomy. NPs belong to a predominantly female profession whose gender and social image dictate certain behaviors in a health care system that is traditionally male-dominated (Baer, 2003; Hamric et al., 1996). For example, as females, nurses are seen as occupying a lower social status and, as such, having less power and authority than physicians. As females, nurses are cast in the emotional, caring role as opposed to the scientific, curing role (Baer, 2003). Therefore, as nurturers, nurses have, by and large, been perceived as dependent upon physicians, thus possessing less authority

(Baer, 2003; Catalano, 2009). The fact that physicians have traditionally held that they have *greater* authority than nursing because they possess superior knowledge and expertise, perpetuates the stereotypical image of women and physician dominance (Baer, 2003; Hamric et al., 1996).

In a longitudinal study that spanned 10 years, Carol Gilligan (1993) studied women's psychological development. Identity formation in women, Gilligan stated, occurs in the context of relationships and is "judged by a standard of responsibility and care [. . .] morality is seen by these women as arising from the experience of connection and conceived as a problem of inclusion rather than of balancing claims" (p. 160). Women, then, experience life differently from men. Where men's fear is intimacy, women's fear is separation. Gilligan's findings suggest that the social reality of autonomy—as a construct of morality—is contingent upon relationship, attachment, responsibility, and caring. Dworkin (1997) agreed and added that as a social construct, autonomy is a function of attitudes and beliefs which are affected by social class, the mass media, and economic institutions. NPs as women are caught in a health care culture that perhaps devalues the feminine interpretation of autonomy. Moreover, inequality of social power between nurses and physicians perhaps explains why nurses and NPs remain subordinate to physicians. The habit of one class group giving another the right to have the final word, as well as nurses' deep-seated feeling of vulnerability are, according to Fulton (1997), working class characteristics.

Organizational Culture and NP Autonomy

Organizational culture is a crucial factor in facilitating and restricting NP autonomy (Jones, 2005; Rashotte, 2002). For example, Jones (2005) contended that some physicians want to extend the NP role "as a panacea to the immediate needs of their respective institutions" (p. 204). Rashotte (2002) concurred, maintaining that NPs are little more than workers. Obviously, organizational culture is a factor that must be considered as having a significant influence on the way NPs construe autonomy in the work setting.

Cajulis and Fitzpatrick (2007) carried out a descriptive study to determine the level of autonomy among NPs ($N = 86$) providing care to an adult patient population in a large academic acute-care setting. Using the Dempster Practice Behavior Scale (DPBS), autonomy was operationally defined as the total score obtained on the DPBS[2]. Results showed that NPs with national board certification had a higher mean total score ($M = 118.64$, $SD = 15.15$) than those without certification ($M = 114.58$, $SD = 13.36$); however, the difference was statistically insignificant ($r = 0.13$, $p = 0.354$). There was no significant correlation between DPBS score totals and demographic variables such as age, years worked as an RN, years worked as an NP, basic nursing preparation, or length of employment in the current position. Interestingly, Cajulis and Fitzpatrick found that NPs in this study had very high levels of autonomy, but lower levels of empowerment. For

[2] The DPBS consists of a 30-item Likert-type survey with five possible responses for each item ranging from 1 = *not at all true* to 5 = *extremely true*. The total score ranges from 30-150, and the higher the score, the greater the autonomy. Reliability analysis revealed a Cronbach's alpha of $r = 0.95$ for this study (Cajulis & Fitzpatrick, 2007).

example, the Actualization subscale results indicated 44% of NPs showed very high decision making, responsibility, and accountability, with 43.2% having extremely high, 10.6% having moderate, and 2% having slight levels. On the Empowerment subscale, however, only 28% reported empowerment to be *very high* and 27% *extremely high*. These results may indicate that although the NPs perceived themselves to be highly competent, they may not have felt empowered, i.e., they lacked authority.

Perhaps the NPS in the study (Cajulis & Fitzpatrick, 2007) believed they lacked authority because (a) they were employees and, as employees, were limited in their authority, and (b) their practice was restricted by having no admitting privileges, no reimbursement, and the mandate to have a collaborative practice agreement. Potential bias in this study is the academic environment in which this study was conducted. An academic working environment is not the usual practice environment for NPs. In fact, the organizational culture of such an environment is more apt to favor the promotion of equality and unity between physicians and NPs, suggesting that NP practice autonomy is inversely related to the restrictiveness of the practice environment.

In their study to determine the level of autonomy of NPs providing care in a primary care setting, Bahadori and Fitzpatrick (2009) supported Cajulis and Fitzpatrick's (2007) findings. For example, Bahadori and Fitzpatrick also found the NPs in their study had very high levels of autonomy as measured on the DPBS. Similarly, Empowerment scores were low ($M = 25.08$, $SD = 4.23$); however, potential bias and threats may have had an impact on the results of this study. These may have included the following: (a) a

small sample size ($N = 48$), (b) convenience sample of NPs recruited at a national conference, and (c) reliability of the subscales—Actualization, Empowerment, and Valuation were all low with a Cronbach's alpha of 0.66, 0.44, and 0.57, respectively. Nevertheless, both studies support the notion that organizational cultural influences NPs' perception of practice autonomy. Unfortunately, neither study really captured the way in which autonomy is interpreted or understood within the practice environment. Without this knowledge, knowing that NPs have very high levels of autonomy is perhaps a hollow conclusion because NPs' high levels of autonomy may be as "workers" rather than as autonomous practitioners.

According to Dworkin (1997), there is a "natural extension to persons as being autonomous when their decisions and actions are their own; when they are self-determining." (p. 13). Thus, autonomy for some NPs may be closely linked to overreaching professional goals, such as achieving beneficence through patient advocacy. This may explain why some NPs make the choice to work around practice restrictions.

Working Around the Obstacles

Catalano (2009) contended that nurses are an eclectic, flexible group who work around obstacles in their practice environment to achieve their professional goal of beneficence. Although working around obstacles could be construed as manipulating the system to get what you want (Fulton, 1997), it could also be construed as NPs achieving autonomy despite constraints in order simply to function. It also highlights the illogicality of unreasoned practice restrictions in practical terms.

In a descriptive quantitative dissertation study to determine the impact of practice environments on NP practice, where NPs worked and how they worked, Whelan's (2000) findings suggested that state restrictions did not *change* how NPs practiced, but the type of practice setting did. Indeed, the more restrictive the prescriptive authority, the more likely NPs were to practice in health provider shortage areas (HPSA[3]). NPs who worked in HPSAs were more apt to work around state restrictions and usually *in consort with physicians*. For example, NPs prescribed with physician co-signature (most common), prescribed with physician consult, and called into the pharmacy. Prescribing without a physician consult was not uncommon. Of interest, Whelan found that 51% of NPs reported a physician on-site in those states requiring physician supervision, compared to 49% in those states that did not require supervision. Whelan's finding is supported by Hooker and Berlin (2002) who found that NPs and PAs working in rural areas "may be the sole medical clinicians in their locale for the majority of the week" (p. 175). A restrictive practice environment may not necessarily alter practice patterns with NPs practicing to their full extent even in underserved areas, with or without supervision.

Kaplan and Brown (2004) reported similar findings in their study to describe consequences of regulation in Washington State that requires a joint practice agreement (JPA) with physicians in order to prescribe CS. For example, 25% of NPs used pre-signed prescription pads, and 10% prescribed without physician involvement. Findings of this study also suggests that some NPs consider physician oversight a threat to their

[3] HPSAs are defined by total number of physicians working in a defined rural region—not total number of health providers (i.e., physicians, NPs, or PAs).

autonomous practice, and this threat to autonomy takes precedence over patient beneficence. For example, 46% of the NP participants prescribed a legend drug rather than the preferred schedule drug to treat patient pain.

Because they are able to enact their role despite obstacles to practice, NPs may well perceive themselves as autonomous providers. This further supports the notion that in an everyday practical sense, NPs and sometimes physicians develop strategies to work around obstacles to providing patient care. Whelan's (2000) study also illustrates that state practice regulations really serve little purpose other than to perpetuate confusion about what NP autonomous practice really means—at the individual NP level, there is no difference in practice patterns, i.e., what NPs do and how they do it.

Autonomy is clearly a complex concept, affected not only by legal sanctions and institutional rules and regulations, but also by sanctions that are either self-imposed or imposed by political, cultural and social ideologies, beliefs, and values (Dworkin, 1997). The question that drove the present dissertation study remains unanswered: What is the meaning of autonomy as it is interpreted by NPs in Oklahoma through the lived experiences of their everyday practice in primary care?

Significance to Nursing Practice

New knowledge gained from this study advances the NP role by clarifying and delineating the internal boundaries that are formed from personal meanings of autonomy and which ultimately determine how NPs practice. Moreover, understanding the personal meaning attached to NP autonomy can advance the nursing profession by integrating this

new knowledge into graduate school curricula, educating NPs to understand the legal and political issues to articulate and influence health care reform better. Understanding the meaning of NP autonomy may lead to reëvaluating how student NPs and new graduates are currently socialized to the autonomous role. Additionally, this research provides groundwork data for future research in development of an instrument to quantify the autonomy of practice that is specific to the NP and a model for autonomous NP practice.

Significance to the Participant

Knowledge from this study has value to the participants as they reflect on the concept of autonomy in their own practice. It also has potential value for NPs to understand better their current level of autonomy. In this sense, it brings to the forefront professional self-awareness, self-reflection, and ultimately personal and professional growth because this study gives the individual participant a voice.

Significance to Society

The cost to society of misunderstanding and undervaluing the autonomous NP role in the provision of primary health care services is approximately $9 billion annually (American Association of Colleges of Nursing, n.d.). In addition, physician supervision of NP prescriptive authority in Oklahoma is insidious because it engenders the belief that NPs do not have the authority to practice autonomously. Knowledge gained from the study helps to inform the medical profession, policy makers, and the public of the value and worth of the NP provider. Recognition of the NP as an autonomous provider has implications for (a) increasing access to care, (b) promoting health and disease

prevention, (c) decreasing health care cost, and (d) effecting change to present health care regulation that currently denies the NP full recognition and a place in discussions about Oklahoma's social health care policy.

Researcher's Relationship to the Topic

As a researcher, my interest in this topic stems from my own background as a Registered Nurse (RN) and as a Family Nurse Practitioner (FNP). The passion for better understanding autonomy really dates back to experiences as a student nurse in Australia 30 years ago.

Although daring to question authority is often seen as rebellious, my questioning has always come from a strong notion of who I am as a nurse, how I visualize myself as a person, and the place I occupy amid the intricate and complicated social scaffolding of the health care system. When I reflect on my experiences, it seems to me I have always actively sought to understand the ritualistic behaviors that supported a system that could not function otherwise. Indeed, it seemed the microcosm of health care was the condensed essence of the cultural beliefs and values with which I grew up.

Well do I remember working as a nursing student in Australia at the Princess Alexandra Hospital: the austere buildings, the flurry of starched uniforms, flowing veils, the smells of the ward, the silencing sounds of the suffering, and the militarism that was the glue that made it all work and function like a well-oiled clock with everything on a rigid schedule. Despite the rigidity, it was an exciting atmosphere full of expectation and surprise. The education was delivered by the experts—nursing instructors and

physicians—but I always wanted to know more. I dared to learn the art of taking a history and performing a physical, not because I was formally taught to do those things, but because doing so allowed me to take care of the patient better.

Wanting to know more than most was an attribute recognized by the Sisters on the wards: "Nurse Weiland, you are suited for intensive care." Consequently, the intensive care unit (ICU) became my home away from home. It was an environment in which boredom was interjected with moments of sheer chaos in those early days, but more important, it was the environment in which I flourished. It was the environment in which I grew up. The more I came to know my work, the more I came to know myself. Autonomy became more than making decisions; it was promoting the welfare of the patient and engaging in meaningful discussions with others, including physicians. The progression to advanced nursing practice was natural.

As an FNP, I am the sole proprietor of my own clinic in rural Oklahoma. I am also the secretary and a member of the Executive Board for the Oklahoma Nurse Practitioner Association. Additionally, I teach student NPs in a graduate nursing-school program. Running my own clinic, I have learned that autonomy also means taking a leadership role, being humble, and respecting myself as well as my patients. More importantly, what I know is that I really have a lot more to learn. My aim is not to take on the AMA by exploring NP autonomy; my aim is to help them and others see NPs as valid, legitimate, autonomous providers to be respected. There is a place, an acceptable place, for NPs in the provision of health care.

My position about state restrictions and physician supervision of NP practice is fairly straightforward: If someone who has the education and competency to carry out a role is denied responsibility, how can accountability be expected? Patient safety is no more or less of concern for NPs than it is for physicians. Practicing safely means *knowing* and embracing the standard of care. If the NP has been educated to know and practice this standard, why does he or she need to be told what to do and how to do it? Perhaps being told what and how to practice dampens thinking and maintains an outdated hierarchy. Autonomy requires a person to think and act independently.

Underlying Assumptions

The following assumptions guided this study:

1. The NP is a competent primary health care provider with a place in fulfilling a social obligation to society's health care.
2. NPs are professional autonomous providers of primary health care.
3. Oppression stifles autonomy.
4. No profession should have power over any other profession.
5. Power and control are closely linked.
6. Language is more than just words: It is historical, it is contextual, and it is how people come to know what they know.
7. The meaning of NP autonomy can be found in dialogue with NPs because they bring history and language about their practice into the dialogue.

Philosophical Framework

The philosophical framework that guided the underlying assumptions of this study was Gadamerian hermeneutics. It is an appropriate philosophical framework because the purpose of the proposed research was to gain a deeper understanding of the meaning of autonomy as it is interpreted by NPs through the lived experiences of their everyday practice. This is consistent with the ontological question posed by Gadamer (1967) which seeks subjective understanding of how the individual makes meaning of being-in-the-world by asking, "How is understanding possible?"

The principle of hermeneutics as philosophized by Gadamer (1967) is to "try to understand everything than can be understood" (p. 31). Language is, according to Gadamer (1966), "the fundamental mode of operation of our being-in-the-world" (p. 3) and is produced socially and historically—truth lies in one's connection with the past (Gadamer, 1985). Therefore, I investigated how the language NPs used to describe their lived experiences in everyday practice influenced and determined the meaning they gave to autonomy.

Hermeneutics Defined

Hermeneutics is the ". . . art or technique of understanding and interpretation . . ." (Gadamer, 2006, p. 175). Hermeneutics is an encounter with one's being-in-the world through language and raises questions as to the relationship of language to understanding, history, existence, and reality. Hermeneutics is an ancient discipline and in more modern times has emerged as a methodological foundation for the human sciences (Allen &

Jensen, 1990). As a human science, the purpose of hermeneutics is not to establish causation and facts, but rather to recover lost, obscure meanings and to *get clear*, or interpret, what is meant when something is said. It is not about what the speaker means, but rather is about what something means when it is spoken (Benner, 1985; Gadamer, 1985). In other words, interpreting meaning does not pertain to understanding the inner life of the speaker by evoking empathy—that would be speculative—rather, it is in the language spoken that enables interpretation of "the meaning of truth at play in understanding" (Gadamer, 1985, p. 483).

Hermeneutics has historically focused on interpretation of *theological* text; however, Gadamer (2006) extends the meaning of text to include works of art and the spoken word. From this perspective, Gadamer embraces the interview. The interview provides a venue for researcher and study participant to engage in dialogue. The purpose of the hermeneutic interview is not merely to reconstruct what was said, but to understand the meaning of the experience to be understood as revealed through the dialogue of the interview (Binding & Tapp, 2008).

Theoretical Framework

A feminist theoretical perspective was used in this dissertation study because nursing and NP autonomy involve questions related to gender and marginalization (Creswell, 2009). Furthermore, taking a feminist perspective was appropriate because the scope of qualitative research provides for a broad explanation of feminist issues (Creswell, 2009); additionally, the feminist perspective was consistent with the

philosophy of nursing which seeks to maintain a sense of the whole person (Benner, 1985). The theoretical argument that the fusion of identity and intimacy formation is defined through relationships proposed by feminist philosopher and theorist Carol Gilligan (1993) further guided understanding and interpretation of the significance of the meaning of NP autonomy. Finally, the goal of this guiding feminist perspective was to make women visible; hence, feminism precipitates questions of dualistic thinking and approaches knowledge development from the belief that there is no single correct approach (Campbell & Bunting, 1991). From this viewpoint, feminist theory not only provided the lens through which to understand and interpret the meaning of NP autonomy, but also broadened the scope of the hermeneutic interpretation when overlaid with Gadamer's hermeneutics (2006). (See Appendix A for feminist theoretical assumptions that guided this study.)

Summary

The complexity of autonomy in NP practice has yet to be clarified. A critical factor that has been overlooked in the literature needs to be explored, namely, the meaning NPs themselves give to autonomy in their everyday practice. This must be investigated and clarified because how each NP understands the meaning of autonomy guides their clinical practice (McDonald, 2002; Wade, 2003). In effect, this study took a fundamentally pragmatic approach towards elucidating, through the richness of language, how NPs in Oklahoma constructed the meaning of autonomy in a very practical, real-life sense. In an era of social change and health care reform, the study findings have the

potential to increase the autonomous role of NPs. In a consensus report, *The Future of Nursing: Leading Change, Advancing Health*, the Robert Wood Johnson Foundation in conjunction with the Institute of Medicine (2010) have called for advanced practice nurses to practice to the full extent of their education and training and to become partners with physicians in transforming health care. Further, the 2010 Affordable Care Act is poised to ensure health insurance coverage for approximately 30 million U.S. citizens, and NPs, as part of the health workforce, must be ready to meet the demand for the increase in access to care (Alliance for Health Reform, 2010). Only by clearly articulating the autonomous nature of their practice can NPs advance the profession and take their place as leaders and legitimate primary care providers.

CHAPTER II

REFLECTIONS ON INDEPENDENCE IN NURSE PRACTITIONER PRACTICE

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Abstract

Purpose

To examine factors that influence the ability of nurse practitioners (NPs) to practice as independent primary care providers.

Data Sources

Extensive literature search on CINAHL, OVID, MEDLINE, Internet journal sources, and professional association Web sites.

Conclusions

The authority for NPs to practice independently is recognized; however, the ability to put that authority into practice is undermined by the historical failure of political, professional, and social entities to recognize NPs as providers capable of providing primary care autonomously. Non-recognition is responsible for complex reimbursement policies (both federal and state) that economically and professionally restrain the NP role; hence, NPs remain in a financially dependent relationship despite 40 years of proven safe practice. NPs must articulate their independence as practitioners

more vociferously in order to meet society's health care requirements, as well as to attain professional fulfillment and forge collegial relationships.

Implications for Practice

NPs will never be seen as members of a profession by either themselves or others without the practicality of independence and autonomy. Although legal independence is a fact, real practice independence in the pragmatic sense is contingent upon reimbursement. Without fiscal sustainability, practice independence is an impossibility. And, without professional autonomy, NPs will have only an employee's voice in the dynamic health care system in which they are key players in providing health care services to the poor and underserved populations.

Key Words

Authority; independence; physician extender; professional competition; health care policy; reimbursement.

Introduction

Practice independence is central to the Nurse Practitioner's (NP) professional role (Baer, 2003; Fagin, 2003). However, over time cultural, social, and political factors have come to dominate how the NP practices as a health care provider (Rashotte, 2005). In the context of this discussion, *independence* and *autonomy* are use synonymously to refer not just to the legal authority, but to the practical ability to provide primary health care and exercise independent judgment and self-governance within the NP scope of practice.

The factors of physician dominance, reimbursement, and state rules and regulations have created practice environments that are detrimental to full recognition of NPs as autonomous providers, hence, to their full utilization (Bureau of Health Professions, n.d.; Hoffman, 1994; Phillips, 2005). The social and economic outcomes of non-recognition and under utilization of NPs include (a) denial of primary provider status, (b) decreased patient access to care, and (c) increased health care costs (Hoffman). Under utilization of NPs has been estimated to cost society approximately $9 billion annually (American Association of Colleges of Nursing, n.d.). Indeed, the social burden of health care spending nears $1.9 trillion (Kaiser Family Foundation, 2006a). Medicare alone spent up to $256.8 billion in 2003 (Kulesher, 2005). Additionally, a physician shortage of 200,000 is projected by 2020 (Cooper, 2004), and 46.6 million people are currently without health insurance (Herrick, 2006). The impact is that society is paying for non-recognition of this resource, not just financially but by a serious lack of access to care. The role of NPs can be carried out only with full professional recognition as independent providers.

The American Academy of Nurse Practitioners (AANP) (2000) voices the readiness of NPs to participate in a health care environment that itself is poised for major re-engineering: "With a changing health care system, Nurse Practitioners are in a prime position to deliver appropriate, acceptable, and cost effective health care as independent providers." However, a corollary to successfully using NPs is removal of constraints to

practice, without which the NP cannot achieve the real autonomy characteristic of a professional independent provider.

The purpose of this article is to examine factors that influence the ability of NPs to practice as an independent primary care providers. A retrospective overview of NP practice is presented, and the way NPs evolved within the physician extender role is discussed. Factors such as professional competition, health care policy, and obstacles to reimbursement are presented to show how they interface to perpetuate a *dependent* role that is secondary to the physician provider. While it is recognized that state nurse practice acts and scope of practice are directly correlated with restrictive practice environments, these will be addressed only insofar as their impact on eligibility for reimbursement. The author believes that NPs must articulate their independence as practitioners in order to attain fulfillment as professionals.

Historical Background

Primary Care—The Focus of NP Practice

It has been postulated that primary care is not *a* focus of nursing, but *the* focus (Fagin, 2003). And, because primary care is nursing's focus, nursing has historically responded to the social, political, and economic landscape of health care by expanding professional practice to fulfill the primary care role (AANP, 2002a; Baer, 2003; Fagin; Ford, 1997). For example, the advanced practice nursing role first proposed in 1965 by Dr. Loretta Ford, a registered nurse, and Dr. Henry Silver, a physician, was a natural progression from "visiting nurses who worked in expanded roles, [. . .] visiting nurses

serving the poor in urban tenements, [and] the public health nurse visiting an isolated rural family" (Fairman, 2003, p. 54), all of whom were acting to some extent in independent roles as primary care providers.

According to Dr. Ford (1997), the original NP role as a pediatric NP evolved during a time of change—the chaos of civil rights, the Vietnam War, rising health care costs, and health disparity among the poor and underprivileged. The time was ready for nurses to advance their profession. It was *not*, Ford insists, to relieve the physician shortage that had emerged in rural regions. Physician shortages were largely the result of medical schools graduating more specialists and subspecialists with highly technical skills and fewer generalist physicians with primary care skills.

The essence of the pioneer days of NP practice has been captured by Brown and Draye (2003) in a descriptive study highlighting the struggles and rewards of this profession. Fueled by professional desires to move beyond their traditional role, and rewarded by the positive feedback from their patients, these early pioneers' objective was to achieve autonomy of practice. This became central to the resilience of the pioneer NP who faced cultural, social, and political obstacles. For example, much frustration was reported by study participants because of society's cultural values adhering to well-defined physician-nurse roles; they were accused of "no longer being nurses [. . .]" (p. 394). Others encountered much resistance from physicians, other nurses, insurance carriers, and pharmacists. One pioneer recalled legislative testimony that perhaps best exemplifies the fear of change that existed at that time: "Nurse practitioners will become

like Scotch broom, first introduced to beautify the highway system in the state of Washington, but now a weed" (p. 394). Posturing and positions of power marginalized the NP role and undermined their authority: "I always felt like I was on trial or always being questioned about my expertise" (p. 394). According to Brown and Draye, this cohort of NPs went into advanced practice with a clear understanding of who they were and why they were embracing advanced practice; they wanted to make a difference, they wanted more than the traditional role of nurse, they wanted autonomy! However, the conceptual framework of advanced practice nursing that Dr. Ford had envisioned for the NP role, and to which these pioneers aspired, was recast by the economic emphasis of the *political* discourse of the day (Rashotte, 2005) and because opportunities to practice were limited (Brown & Draye). The NP was soon to be seen as a cost effective means to provide primary health care to the poor—to do this, NPs had to expand their role (Ford, cited by Fondiller, 1995; Rashotte).

Expanding Nursing Practice

Expanding the nursing role to that of primary care provider and assuming more medical tasks were evolutionary responses not only to societal and professional needs (Brown & Draye, 2003) but also to technical advances in medicine as well. Historically as medical practitioners have become increasingly skilled as a consequence of biomedical advances, many tasks once the sole responsibility of medicine have become the responsibility of the registered nurse (RN). For example, tasks such as measuring vital signs used to be the practice exclusively of doctors—today, they are measured by nurses.

In the same way, a host of medical tasks and the concomitant legal authority and responsibility to perform them now fall within the scope of NP practice.

The AANP (2002a) *Scope of Practice for Nurse Practitioners* defines primary care within the role of the NP as follows: "Nurse practitioners are primary care providers [. . .]. Nurse practitioners practice autonomously and in collaboration with health care professionals and other individuals to diagnose, treat and manage the patient's health problems." Philosophically, what sets the NP apart from the physician provider in primary care is what Dr. Ford described as *holistically oriented goals for self-care* which include patient and family education, facilitation of patient self-care, and promotion of health (AANP, 2002b).

The NP as a Physician Substitute

Politically, the NP role as a physician substitute had been identified as a solution, at least in part, to two burgeoning socioeconomic problems: improving access to care for the poor and constraining Medicare health care spending (Aiken, 2003; Hoffman, 1994; Kulesher, 2005). Organized medicine, in consort with the polity of the day, was in favor of physician substitution by *supervised* NPs because of its agenda to control the division of labor (Aiken). It is useful to understand that prior to the Rural Health Clinic Services Act of 1977, NPs in the employ of physicians provided services exclusively under the *incident-to* provision of the Medicare payment policy (Hoffman; Sullivan-Marx & Keepnews, 2003).

As physician extenders, and under the supervision of physicians, NPs improved physician productivity and income because billing incident-to realized 100% reimbursement, and NPs were used as low-cost labor (Hoffman, 1994; Rashotte, 2005). In order to demonstrate quantifiably the authority and validity of the role and to guarantee political support, NPs turned to research (Rashotte). Studies of process, patient satisfaction, and patient outcomes were by and large measured against the physician as the gold standard (Horrocks, Anderson, & Salisbury, 2002; Lenz, Mundinger, Hopkins, & Lin, 2003). Measuring NP competency this way provided a basis to lobby and to promote and market the NP (Rashotte). However, this comparison with physicians also detracted from legitimizing the *nurse* in the NP role as a primary care provider and instead emphasized the *medical* role of the NP as a physician substitute. This is an unfortunate mistake because the philosophical approach of the NP is quite distinct from that of the MD—the former emphasizes health promotion while the latter focuses on disease treatment, at least in North America. Their roles are simultaneously similar but quite distinct from each other and, therefore, there is no reason for one group to be independent and the other to be dependent. Measuring NP performance against the physician (or any other group) as the gold standard is inappropriate because the philosophical approach of the NP is singular. NPs are not physician substitutes—they are independent providers with a unique approach to health care.

The Arise of Professional Competition

It has been said that a fundamental fact of professionalism is inter-professional competition, "whereby movement in any one direction by a particular profession inevitably affects other professions" (Ameringer, 2002, p. 310). So, although the primary argument for expanding NP scopes of practice was to increase access to care for the poor (Aiken, 2003; Hoffman, 1994; Hooker, 2006), in effect, expanding these prerogatives posed a threat to the medical profession by encroaching on both its scope of practice and its market share (Christensen, Bohmer, & Kenagy, 2000; Ford, reported by Pearson, 2005; Grumbach & Coffman, 1998). An important consideration is that family practice was a fledgling specialty whose core competencies and values of care paralleled those of nursing, specifically those of the NP. In 1996, the Institute of Medicine updated their 1978 definition of family practice to reflect the family practice model of care; however, the definition and values espoused remained clearly connected with nursing's values. The definition is:

> . . . the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (cited in Graham et al., 2002, p. 1098)

It is perhaps not surprising that confrontation and competition with physicians ensued when nursing too had asserted its claim to be rooted in the biomedical as well as the social, sciences (Baer, 2003). In one sense, NP practice entered the primary-health

care realm at the right time for expanding the NP role, but NPs lost their place as key players when medicine developed family practice as a specialty because this role is exactly where NPs fit and it was claimed by physicians.

Evolution of Physician Perspectives

To maintain the medical profession's dominance as well as the exclusivity of their role as primary care providers, organized medicine has been a stalwart in discrediting NPs as competent providers (Aiken, 2003; Ford reported by Pearson, 2005). Dr. Ford recalls a time when the American Medical Association depicted "NPs as ducks (symbolizing 'quacks') . . ." (p. 31). Despite four decades of collegial collaboration and numerous compelling studies that demonstrate NPs are competent, that is, quality of care is no different from that of physicians (Horrocks et al., 2002; Lenz et al., 2003), physicians continue to express concerns that NPs lack the training necessary to provide comparable care (American Academy of Family Physicians, 2006; Committee on Pediatric Workforce, 2003; Grumbach & Coffman, 1998).

As an example, the Committee on Pediatric Workforce (2003) purports that studies validating NP competency and comparability of care are spurious because the ability to "manage all levels and complexity of care independently has not been addressed" (p. 427). Therefore, the Committee is opposed to independent NP practice, prescriptive authority, and reimbursement parity, and it supports legislated collaboration with other members of organized medicine at the state legislative level to prevent further expansion of NP scope of practice. Physicians, they state, are "optimally suited to serve

as leaders of the pediatric health care team because of their unique ability to manage, coordinate, and supervise the entire spectrum of pediatric care" (p. 427).

Similarly, the American Academy of Family Physicians (2006) believes that physician supervision is important to ensure quality of care because to do otherwise would "establish a second-class system of health care" (p. 2). Reimbursement, they contend, should only be afforded if the NP is supervised.

Findings of researchers Druss, Marcus, Olfson, Tanielian, and Pincus (2003) further suggest that overlapping scopes of practice is a major concern of physicians. In their descriptive study to determine longitudinal trends in outpatient care provided both by physicians and by non-physicians (inclusive of NPs and Physician Assistants), they found that not only had there been an increase in the relative use of non-physician practitioners from 30.7% to 36.1% between 1987 and 1997, but collaboration, defined as a physician and a non-physician working at the same site, also increased from 14.3% to 41.1%. These authors stated that their "findings supported previous research suggesting that physicians are increasingly enlisting non-physician clinicians to extend their coverage capabilities [. . .]" (p. 136). However, results of the survey further indicated that non-physician practitioners were providing the *same kind* of care, rather than complementary care. The researchers speculated that physician unease was really a result of a health care system that is market driven, is a finite resource, is highly regulated, and depends on reimbursement; in short, it is a direct result of competition being inherent in

the health care system itself. It may be inferred that physician perspectives are driven to a large extent by the economics of health care.

It is true that patients who have Medicare *and* supplementary health insurance are more likely to see a physician, while those with only Medicare or Medicaid are more likely to see a NP (Grumbach, Hart, Mertz, Coffman, & Palazzo, 2003; Hooker, Cipher, & Sekscenski, 2005). However, that NP penetration into the privately-insured population is the medical profession's *real* concern is made abundantly clear by statements such as: NPs do not seem satisfied "to provide care only for populations abandoned by physicians [but] *appear* to practice in the same socio-economically advantaged communities that are saturated with physicians" (Grumbach & Coffman, 1998, p. 825, emphasis added). Clearly, such statements are a misinterpretation of the statistics. Studies commonly report that only 20% to 25% of NPs practice in rural or physician-shortage areas (AANP, 2004; Grumbach et al., 2003; Hooker & Berlin, 2002), inferring that 75% to 80% practice in advantaged communities. However, the majority of this 75% to 80% practice occurs as supervised physician extenders in physician-run clinics in these advantaged communities because restrictive state rules and regulations dictate that they practice this way (Aiken, 2003; Bureau of Health Professions, n.d.; Whelan, 2000). Additionally, it is to the financial advantage of the clinics and their physician owners. Clearly, physician dominance, state rules and regulations, and reimbursement restrictions designed to protect the physician's market share have had a serious impact on the practicality of NP

practice independence, forcing the vast majority of NPs to practice as physician extenders.

NP Practice and Health Care Policy

In 1977, the Rural Health Clinic Services Act was passed to ensure access to care for poor and low income families residing in rural areas. To achieve this, the Act also provided for direct reimbursement to pediatric and family NPs for services to beneficiaries (Hoffman, 1994). It was "the first federal policy to separate non-physician practitioner coverage from employment in a physician's practice" (Hoffman, p. 142). Although it was suggested in 1971 (Committee of the Secretary of Health, Education and Welfare, 1971) that nurses ought to assume increased responsibility for primary health care delivery, the Rural Health Clinic Services Act provided the first recognition of NPs as a professional group deserving reimbursement as primary care providers. But how NPs were to be reimbursed was to become a contentious issue leading to a patchwork of federal policies that could be implemented even partially only by the passing of new complex state legislation and significant amendments to state nurse practice acts (Hoffman).

In her analysis of the 1992 Physician Payment Review Commission (PPRC) survey, Catherine Hoffman (1994), a senior analyst with the PPRC in Washington, DC, surmised that the culmination of competing federal and state political forces to improve access to care and achieve economic balance had resulted in no health care cost savings because the Medicaid reimbursement policy and payment differentials that had evolved

were more of an incentive for the NP to remain an employee. For example, although federal law clearly provides that "Medicaid will cover the services of pediatric NPs and family NPs, whether or not the NP is employed by or supervised by a physician" (Buppert, 1999, p. 129), not all states agreed with this federal law, and many still required on-site physician supervision of NPs. The requirement for on-site supervision in some states, Hoffman contended, "affects access to basic primary care by limiting the number of Medicaid patients who can be seen and the number of sites where services can be offered" (p. 148). However, many states did adopt non-restrictive policies so NPs would be eligible for direct billing.

According to Hoffman, payment differentials varied with state policy too. Some states reimbursed 70% of the physician fee, while others reimbursed 100%. The differential was based upon the Medicaid-to-Medicare physician fee ratio. The Medicaid-to-Medicare physician fee ratio was calculated by multiplying the Medicaid-to-Medicare fee ratios for each service by Medicaid expenditure weights, and the ratio across all services was computed by combining the fees based on these same expenditure weights (Norton, 1999). The overall ratio is a single value indicator of how Medicaid and Medicare fees compare.

In those states with below-average ratios, the NP was more likely to be reimbursed 100% of physician fee; whereas in states with above-average ratios, the NP was less likely to be paid the same physician fee. To this day, these same payment differentials exist (Phillips, 2005). And because states are striving to cut health care costs

further, they are contracting with Managed Care Organizations (MCOs) to administer Medicaid (Buppert, 1999). The important fact here is that only 60% of MCOs who administer Medicaid also credential NPs—this means that 40% of NPs do not have access to payment for services to Medicaid beneficiaries (Hansen-Turton, Ritter, Rothman, & Valdez, 2006) so this avenue for independent practice is denied.

Passage of the Balanced Budget Act (BBA) in 1997 increased the ability to practice independently by enabling direct reimbursement for *all* NPs (Buppert, 1999). Ostensibly, the BBA fulfilled the Federal Government's sociopolitical agenda to increase provider supply and at the same time to contain costs which had risen from 1% to 12% between 1967 and 1997 (Aiken, 2003; Kulesher, 2005). OBRA '89 was the first legislation to provide direct payment to family nurse practitioners (FNPs) for service to Medicaid patients; however, the FNPs had to work in rural areas to qualify. With the passage of the BBA, because it was a model for reimbursement practices, the potential for reimbursement from *other* third-party payers was created—NPs had entered the health care payer's market (Lindeke & Chesney, 1999; Sullivan-Marx & Keepnews, 2003).

Reimbursement

Ineligibility for reimbursement and non-recognition as a primary care provider have been cited by NPs as major barriers to providing health care services (AANP, 2004; Lindeke, Grabau, & Jukkala, 2004). Underpinning non-recognition as primary care providers are state Nurse Practice Acts that are either vague, or restrictive, or both. For

example, NPs acting under vague nurse practice acts are not empanelled because "it cannot be assumed that a non-physician provider cannot [*sic*] provide that service" (Frakes & Evans, 2006, p. 63). NPs working in those states with restrictive practice acts requiring supervision for prescriptive authority, or which do not allow prescriptive authority at all, are ineligible for credentialing too (Hansen-Turton et al., 2006). In fact, in their study to determine reimbursement barriers and NP practice, Hansen-Turton et al. found that in those states requiring supervision, only 19% of private insurers credential primary care NPs. Additionally, insurance carriers are regulated state by state; that is, there is no national insurance regulation, so that in one state, an insurance carrier may credential NPs but not in another (Hansen-Turton et al.). Inability to acquire hospital privileges has also been cited as a barrier (Lindeke & Chesney, 1999). But perhaps the most enduring and profound obstacle to practice independence is incident-to rather than direct billing (Hoffman, 1994; Lindeke & Chesney; Medicare Payment Advisory Commission [Medpac], 2002).

Approximately 58% of NPs who provide services for Medicare beneficiaries bill incident-to and, even if the NP has been contracted with Medicare as a provider, the majority of NPs continue to bill this way (Nurse Practitioner Alternatives, Inc., 2004). Although this method of billing has maximized physician income with Medicare paying physicians $369.7 billion in 2003 (Kulesher, 2005), it *hides* any contribution the NP makes to the practice from outside agencies such as Medicare and third-party insurers (Lindeke & Chesney, 1999; Medpac, 2002). Indeed, in a report to Congress in June

2002, the Medicare Payment Advisory Committee stated, "Because physicians also may bill (under their own provider number) for services provided by NPPs [non-physician providers] in their offices, information on the total number of services provided by NPPs is limited" (p. 5). Without supporting data to determine the complexity of the care delivered by NPs, the reimbursement rate of 85% was not recommended for change.

Lindeke and Chesney (1999) carried out a study to determine NP reimbursement patterns and found that even in a state where NPs enjoyed third-party reimbursement, billing under the physician's name was commonplace. Similarly, Schaffner and Vogt (2004) found in their study to determine NP practice patterns and compensation patterns that 72.2% of pediatric NPs billed under the physician's name. Forty-two percent had a Medicare identifying number and 29% a Medicare pin number. Only 10.5% had been individually empanelled with a private insurer, and only 16% were aware of reimbursement rates or how much revenue they generated for the practice.

Why do NPs who have the legal mandate and are recognized as primary-care providers continue to bill under the physicians' name? Reasons cited include: (a) not receiving information regarding reimbursement from the MCO even though they are a credentialed provider, (b) practice's or employer's desire for full reimbursement (MCOs reimburse at 85% physician fee if billed directly by the NP), (c) NPs practice without a provider number (either the practice had not applied for NP credentialing, or they have applied but the process of credentialing is slow), and (d) lack of NP knowledge and

inability, or lack of interest, to keep up with the changes in reimbursement policy (Lindeke & Chesney, 1999; Shaffner & Vogt, 2004).

Reimbursement is central to independent practice. When federal or third-party insurers require physician supervision, regardless of state nurse practice acts, or pay at reduced rates, or deny NPs because they do not recognize NPs as primary care providers, or just do not understand the difference between an RN and an NP, in effect, the NP is denied two things. The first is full reimbursement parity with physician providers and the second is full access to a potential market of 163 million people who are enrolled with commercial insurers, 42 million Medicare beneficiaries, and 55 million Medicaid beneficiaries (Hansen-Turton et al., 2006; Kaiser Family Foundation, 2006b; Kulesher, 2005). However, the community is also denied two things: health care parity and health care access to a provider of choice.

The outcome of reimbursement policy and current reimbursement practices is that 95% of NPs function within an employee role, and only 2% to 4% of NPs practice in an independently operated NP clinic (Nurse Practitioner Alternatives, Inc., 2004; Tumolo & Rollet, 2006). Because NPs continue to bill either incident-to or under the physician's name, data on the type of patient services provided and complexity of care are still missing. Thus, the full value that NPs provide in primary care remains unknown and unmeasured and, consequently, the practice of reimbursing NPs at a reduced rate continues (Medpac, 2002).

State regulation also impacts reimbursement and can be discriminatory (Hansen-Turton et al., 2006). For example, only 23 states have an "Any Willing Provider" (AWP) law while 27 states do not. AWP laws mandate that insurers must contract with any willing health care provider who meets the insurer's terms and conditions (Hansen-Turton et al.; Phillips, 2005), and one might think that such laws would automatically improve the NP's access to the patient pool. However, even an AWP law does not guarantee provider credentialing because the laws do not prohibit the MCOs from creating exclusive provider networks (and in some states, MCOs even administer Medicaid). But they do "forbid insurers to discriminate against a particular class of providers based on their training or licensure" (Levy, cited in Hansen-Turton et al., p. 207), so in that sense, they certainly must be viewed positively for NPs working in AWP states.

Discussion

Rashotte (2005) believes that NPs have been "presented in the discourse as physical object and activity within the overarching framework of business" (p. 54). Perhaps this is true. On reflection, each incremental expansion of NP practice has been amid a crisis whose driving force was economics. If we consider access to care as a financial concept, and if we consider NPs as a financial concept, an instrument, or object that is both cost-effective and productive, then using such an available resource makes good business sense. Those external forces such as professional competition, health care policy, reimbursement, and state rules and regulations determine where we work, the type

of patients we see, and where our practice of care extends (Bureau of Health Professions, n.d.; Frakes & Evans, 2006; Hansen-Turton et al., 2006; Whelan, 2000). Practice independence in this overall environment is next to impossible. But the biggest stumbling block is surely economic because economics drives policy, and policy, in turn, can have unintended economic consequences, especially for NPs.

A component of fulfilling health care needs of any population group is availability of providers who can provide the appropriate level and type of services needed (Higgs, Bayne, & Murphy, 2001). There are over 141,000 NPs in the United States who can provide 80% of primary and preventive health care services that were once the sole purview of medicine (American Nurses Association, 2006). NPs are educated to manage *independently* uncomplicated acute and stable chronic illnesses (AANP, 2002a; American Nurses Association), leading one to infer that NPs are capable of managing a higher percentage of common health problems than the touted 80%. For this reason, Christensen et al. (2000) have proposed using NPs to improve access by meeting the patient's needs because "Our major health care institutions—medical schools, groups of specialist physicians, general hospitals, research organizations—have together overshot the level of care actually needed or used by the vast majority of patients" (p. 2). These same authors further contend that disrupting the status quo will *transform* the current inefficiencies of using highly specialized professionals to provide lower level care. Clearly, NPs are capable of fulfilling this level of health care, but obstacles such as physician dominance, restrictions on reimbursement, and state rules and regulations

remain a barrier to the independence necessary to provide needed health care. Additionally, NPs themselves must recognize and use the independence they already have.

According to Hansen-Turton et al. (2006), NP independence is directly correlated with state law where "managed care companies become much more likely to credential NPs as primary care providers" (p. 211). However, to take full advantage of the recognition of the authority and independence of practice, there are internal barriers that have yet to be overcome (Lindeke & Chesney, 1999; Schaffner & Vogt, 2004). The question is: Are we ready?

Conclusion

Driven by the need to achieve professional autonomy, as nurses expanded their practice into primary care "they were seen as pushing the perimeter between the professions of medicine and nursing" (Baer, 2003, p. 43) because *nursing's* role has always been seen by others as necessary, but *dependent* on medicine. Therefore, to become key players in today's changing health care environment, NPs must first change the perceptions of others by clearly articulating who they are and what they do. Second, unless they use the legal authority and independence they already have, NPs will have only an employee's voice in a health care system in which they are in fact key players in providing services, especially to the poor and to underserved populations.

Physician dominance, restrictions on reimbursement, and various state rules and regulations have created practice environments that are detrimental to full recognition of

NPs as independent providers and to their full utilization. Just as the NP pioneers entered new territory, so are we today entering more new and complex territories. NPs have a professional obligation to practice independently in providing health care services. The NP role was never envisioned as a physician extender, and the physician extender role certainly has no place in NP practice independence.

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CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

A research design "is a definitive and complete statement of how the inquiry will be conducted" (Lincoln & Guba, 1985, p. 222). Methodology has been described by van Manen (2006) as "the theory behind the method, including the study of what method one should follow and why" (pp. 27-28). This chapter provides a complete statement of how the original inquiry was conducted as well as a description of Gadamerian hermeneutics as the most appropriate approach for this study. The reason for choosing Gadamerian hermeneutics is discussed first, followed by an overview of Gadamerian hermeneutics as a methodology. Finally, the plan for implementing the inquiry is discussed, including solicitation of participants, data collection, data analysis, and the procedures taken to ensure trustworthiness and rigor.

The Choice of Hermeneutics and Its Applicability to Nursing

This study's research question was: "What is the meaning of autonomy as it is interpreted by NPs in Oklahoma through the lived experiences of their everyday practice in primary care?" The decision to employ Gadamerian hermeneutics was based on the conceptual foundation of the question and its parallel to the principle of hermeneutics, which is to understand the hermeneutical experience and its meaning by understanding everything that can be understood (Gadamer, 2006). From this perspective, hermeneutics is a holistic strategy that seeks to study the person in the "situation rather than isolating

person variables and situation variables and then trying to put them back together" (Benner, 1985, p. 303). As such, hermeneutics is a humanistic science and is a good fit with nursing research, the practice of professional nursing, and the purpose of this dissertation because all three are concerned with understanding the *whole* human experience and developing practice knowledge. The fundamental mode of understanding is through conversation or language (Gadamer, 2006).

It could be said that nursing is an interpretive discipline in which nurses have always practiced within an environment that has emphasized the importance of oral and written language (Allen, 1994). Those entering the profession learn to speak the historical text they inherit, and through participation in the language, the nurse reproduces and changes this linguistic inheritance. The nurse, however, does not own or have sole claim to the language or give meaning to *it*, rather *it* gives meaning to the lifeworld of being a nurse because the language of nursing is collective—not individualistic. As Gadamer (2006) put it: "Language speaks us." For example, over time nurses have changed the clinical tradition of power imbalance between nurse and patient and between physician and the nurse from one of paternalism to one of advocacy (Allen, 1994). Through participation in the conversation of illness and suffering with patients, nurses have gained a deeper understanding of the centrality of the patient and the patient-nurse relationship to the nursing role rather than the traditional centrality of the physician and the physician-nurse relationship to the nursing role. Interpretation of the nursing role, then, is within the context of patient care and not as a physician's helper.

Consequently, the language of paternalism has been supplanted by the language of patient advocacy which has, over time, also become a metaphor for the advocacy of the profession of nursing because advocacy counterbalances paternalism and the imbalance of power.

The systematic interpretation of language—the language that shapes the experience—is essential to fulfilling this study's research purpose and answering this study's research question because language *is* at the very heart of interpreting the meaning of NP autonomy in everyday practice. Language, however, is more than just words: It is historical, contextual, and it is how we come to know what we know.

Finally, because my own personal philosophy as a nurse practitioner and as a woman is grounded in a feminist perspective, and because this nursing research inquiry evokes feminist ideals that nurses are—no matter what their gender—socially constructed (Chinn, 1999), I sought to incorporate a feminist perspective to enhance interpretation of the text. Although Gadamer (2006) did not address gender *per se*, his characterization of hermeneutics as the universality of experience of being human complements feminism insofar as both feminism and Gadamerian hermeneutics view the perception of experience as making sense of how one sees the world.

Hermeneutics as a Methodology

In his treatise *Truth and Method*, Gadamer (2006) asked the ontological question: "How is understanding itself possible?" He proposed that understanding is an historical, dialectic, and linguistic event, and in doing so, he rejected the notion of the subject-object. In rejecting the subject-object, Gadamer split from the traditional Cartesian concept of modern science and argued that understanding is not a subjective act; rather, the basis for understanding is a way of being in the world. The concept of the world is the lifeworld, the world in which we live and are immersed as participants. To be human, then, is to participate in an historical, cultural, and social context (Pascoe, 1996). Hence, the lifeworld is communal, yet it is also personal and symbolizes the sum of a person's experience and, as such, it represents the "whole in which we live as historical creatures" (Gadamer, 2006, p. 239). Therefore, in order to understand another's experience, "we must understand the whole in terms of the detail and the detail in terms of the whole" (Gadamer, 2006, p. 291). That is to say, we must understand the historical context (past and present) in order to understand the individual's meaning. But how does understanding happen?

Gadamer (1966) proposed that "Language is the fundamental mode of operation of our being-in-the-world and the all-embracing form of the constitution of the world." (p. 3). Language is a shared endeavor and is created by the world in which we live and is "not only an object in our hands, it is the reservoir of tradition and the medium in and through which we exist and perceive our world" (Gadamer, 1967, p. 29). Language,

then, is historically situated in time and space. It is there before we are born, it is traditional, and it is central to the concept of understanding. Thus, language is a major tenet of Gadamerian hermeneutic philosophy, and as such, it provides a framework for a Gadamerian hermeneutic inquiry (Gadamer, 2006).

Gadamer (2006) contended that we can never come to the end of hermeneutic inquiry because the question takes precedence over any answer we may conclude. Although one may question the suitability of employing a hermeneutic methodology, if indeed it is indeterminate, Gadamer's viewpoint does not negate reaching a conclusion or an answer *per se*. Rather, Gadamer took the stance that the researcher literally opens up the topic by continuously questioning interpretations to reveal new possibilities and new horizons. This implies that the possibility of truth remains unsettled (Gadamer, 2006). Gadamer's position can be illustrated by considering that in any research, whether it is quantitative or qualitative, the research process starts with a genuine question. Answers, or conclusions, are reached based upon analysis of the information at that time, that is, information from statistical facts or data obtained through interview. If significant new questions are asked, or new material comes to light in the future, the research process is repeated and new conclusions are formed. From this simplistic perspective, an hermeneutic method of inquiry shares similarities with *all* research insofar as it is an iterative process of analysis with convergence, or saturation, of answers to questions until no new interpretations, or understandings, are forthcoming *at that time*. Ultimately, the goal is to answer the research question, not to find an absolute solution. Hence, genuine

research questions sparked by scholarly imagination or *Phantasie* open up possibilities to new truths, new levels of understanding; therefore, inquiry can never be closed off by an answer (Gadamer, 2006). Conclusions are reached in an hermeneutic inquiry and are no less valid than conclusions reached by a natural science methodology.

Unique to hermeneutic inquiry is that there is no predetermined or fixed method of investigative procedures; rather, what is required is sensitive scholarship to the everyday world of the participant and familiarity with the human sciences (Gadamer, 2006; van Manen, 2006). Gadamer has provided some guidance by presenting a framework of ontological concepts such as hermeneutic consciousness, fusion of horizons, and hermeneutic circularity. These key constructs were further explored with respect to how they provide a model for the present hermeneutic study.

Hermeneutic Consciousness

Openness and the ability to question what is familiar is the essence or "real power of hermeneutic consciousness" (Gadamer, 1966, p. 13). To question the familiar is to question one's prejudices or pre-understandings. Prejudgments are, according to Gadamer, more than judgments; they are our historical tradition and represent the whole of our experience, our being-in-the-world. Prejudice is one of the major tenets of Gadamerian hermeneutics and is integral to interpreting and understanding the meaning of the text. Prejudice should not be bracketed out by hermeneutic inquirers. Rather, prejudice should be recognized as one's linguistic constitution of the world and examined for its legitimacy and bias, that is, the origin and the validity of pre-understandings or

truths. Hence, a researcher trying to understand a text will not rely on his or her own accidental fore-meanings; "rather, a person trying to understand a text is prepared for it to tell him something" (Gadamer, 2006, p. 271) so that the text "can present itself in all its otherness and thus assert its own truth against [the researcher's] own fore-meanings" (p. 272). Without hermeneutic consciousness, there is the danger of closing off interpretation before reaching a clear understanding of the text.

Fusion of Horizons

Gadamer (2006) used the metaphor *fusion of horizons* to describe the process of understanding, a process that is forever open, never closed, and always in motion. *Fusion* is the coming together of different vantage points (Koch, 1996). *Horizon* is "the range of vision that includes everything that can be seen from a particular vantage point" (Gadamer, 2006, p. 301). Horizons from different vantage points are continually fused as people self-reflect or interpret the text and conversely are interpreted by others. Fusion of these horizons leads to a new horizon with new understanding (Binding & Tapp, 2008). Every horizon is historical and includes "the context in terms of which the object of attention is understood" (Gadamer, 2006, p. 157). It is the willingness to be open, to question one's own historical horizon and truly to listen to another that opens up the dialogical process for understanding.

According to Koch (1996), the task of the hermeneutic researcher is to demonstrate how the fusion of horizons leads to understanding. Fusion of horizons can be shown through writing and explicating how the researcher participates in *making* data.

Examples are portrayal of the participant's voice; illumination of the social, cultural, and political contexts of both the researcher and participant; and how the researcher's and participant's horizons are fused. Hence, the historical horizon that the participant NP brings to the text and the researcher's historical horizon as the interpreter are fused to form a new and different understanding. Consequently, the new horizon could lead to increased understanding of what autonomy means to NPs as well as new understanding of autonomy as it relates to the participant NPs' everyday practice reality. When the dissertation is read by others and their horizon fuses with the texts, a new and different understanding will be reached. The horizon is unending, but the real work of understanding leads us inexorably into the hermeneutic circle to clarify the "conditions in which understanding takes place" (Gadamer, 2006, p. 295).

Hermeneutic Circle

The hermeneutic circle has its genesis in the hermeneutical rule "that we must understand the whole in terms of the detail and the detail in terms of the whole" (Gadamer, 2006, p. 291). This circular relationship is best described by Gadamer himself when he states, "We learn that we must 'construe' a sentence before we attempt to understand the linguistic meaning of the individual parts of the sentence" (p. 291). In other words, initial meaning of the text emerges when the interpreter projects an expectation, or pre-understanding, of meaning for the text as a whole. When part(s) of the text do not fit the expectation, the expectation is adjusted or changed, and the text then *unifies* its meaning around another expectation (Gadamer, 2006). The interpreter is

open to the belief that the text is indeed true and that the text has something to say because *it* is the authority on the subject (Binding & Tapp, 2008). Hence, the interpreter is constantly seeking to unify the text as a whole and consequently strengthen the intelligibility and truth of the other's argument. As a unified whole, the text functions to keep the interpreter focused on the subject itself, not on interpretations derived from one's own prior conceptions. Through this lens, the ontological position Gadamer took when he asked, "How is understanding possible?" becomes clearer. Language is at the center of hermeneutic philosophy and methodology, for each person enters the hermeneutic circle with a linguistic background, a linguistic history of tradition of their everyday world.

In this study, the centrality of focus was to reveal the meaning of NP autonomy. As an NP, I have developed a schema of what NP autonomy means based upon my experiences as a professional nurse and more recently as a practicing NP. Commonality of language and tradition made possible the back and forth movement of understanding and interpretation because together this common background created the shared space in the hermeneutic circle (Koch, 1996). My professional and personal values influenced my pre-understanding. During the course of textual analysis as I moved between understanding portions of the text against the background or context of the text as a whole, I came face-to-face with these prejudices—some I explored *before* analysis of the text, while others became evident *during* analysis of the text. I have made no attempt to hide my prejudices. Rather, those prejudices that have not already been revealed in the

process of developing hermeneutic consciousness were written down in a daily reflexive journal as the analysis of interview text proceeded. According to Koch (1996), a reflexive journal "is essential in recording the way in which my horizon is working" (p. 178), and serves not only to get into the hermeneutic circle properly, but also demonstrates how I am a partner in the interpretative process. Additionally, Koch contended that keeping a reflexive journal increases credibility.

To sum up, understanding the dialogical meaning of another requires that the hermeneutic inquirer situates "the other meaning in relation to the whole of our own meanings or ourselves in relation to it" (Gadamer, 2006, p. 271). The prerequisite or condition to approach another's meaning as an hermeneutic inquirer is (a) *intellectual* openness to self and questioning the legitimacy of prejudice and recognizing bias so that the text can truly present itself in all its *otherness* and assert its own truth, and (b) truly listening to the other in genuine conversation (Gadamer, 2006). The thread that weaves the fabric of interpretation and understanding is language. Language is historical, cultural, and social. It does not belong to us; we belong to language. Hence, "The anticipation of meaning that governs our understanding of a text is not an act of subjectivity, but proceeds from the commonality that binds us to the tradition" (Gadamer, 2006, p. 293). With this contention, Gadamer at once situated hermeneutics as a valid method of inquiry and explicated the universality of hermeneutics through language.

Research Plan

Setting

The setting for this study was the State of Oklahoma. The State of Oklahoma was chosen because the Oklahoma Practice Act for advanced practice nurses implies autonomy in the Scope of Practice. Yet, in order to attain the authority to prescribe both schedule drugs III-V and formulary drugs, the NP is required to have physician supervision. In addition, the ability to obtain credentialing with Medicaid, Medicare, and third-party insurers in Oklahoma as an autonomous primary care provider is restricted because Medicaid, Medicare, and third-party insurers contractually require a supervising physician. The context of this practice setting is that if NPs require a physician to supervise prescriptive authority, they also require supervision to become credentialed. Oklahoma, then, provided an ideal context in which to study the phenomenon of interest.

Participants

Participants in this study were recruited using purposive sampling from the 940 NPs practicing in Oklahoma. Purposive sampling was the sampling method of choice because a focus of hermeneutic inquiry generally, as well as this inquiry in particular, is the individual and understanding the full complexity of each individual's experience (Bailey, cited by Rudestam & Newton, 2007). Purposive sampling was also in keeping with both Gadamerian hermeneutics and the feminist notion that the participant is the expert. To ensure maximum variation of the NP sample and richness of data, network sampling was also used to recruit NPs. This was accomplished by (a) asking early

participants for referrals to other NPs, and (b) directly contacting NPs who were members of my social network and asking them for referrals. In this way, a broad swath of NPs from the diversity of primary health care practice settings was achieved. Each NP participant selected for the study met the following criteria: (a) registered in Oklahoma with a valid unrestricted license to practice as an advanced registered nurse practitioner, (b) registered in Oklahoma with valid prescriptive authority, and (c) practicing in a primary health care setting (e.g., primary care, specialty practice, government institutions such as state health departments and federally sponsored community clinics).

The rationale for being inclusive of Oklahoma NPs with prescriptive authority was justified on the grounds that prescriptive authority has historically been viewed as one of the fundamental measures of NP autonomous practice. Moreover, because this research could lead to political action and legislative changes to the rules and regulations that currently govern NP practice, NPs without prescriptive authority were excluded in the basic belief that this specific population of NPs was more likely to function in a nursing role as opposed to the NP role which incorporates both nursing and medical models of care. Prescriptive authority is an indicator, or measure, of NP autonomous practice, and to include NPs who practice without this practice dimension would detract from the focus of this study.

Protection of Human Participants

Permission to conduct this research was obtained from the Texas Woman's University Institutional Review Board (IRB). The IRB approval letter is located in

Appendix B. Participants were informed of their rights, which included the right to withdraw at any time during the course of the study. Prior to beginning face-to-face interviews, informed consent was obtained from the participant (Appendix C). In that consent, my identity as well as an explanation of the purpose of the research and an explanation of the research method was clearly set forth.

The study was designed to maintain confidentiality; hence, only I knew the true identity of each participant. Code names were chosen by each participant, and only those code names were used when reporting data. Participants were informed that in the event data were published or presented, all identifying data would be withheld. If the participant gave names of cities, clinics, hospitals, other health care workers, those names were deleted, and vague descriptions were used instead. All recorded tapes were kept securely locked. Only the researcher and the transcriptionist, who had completed the *Human Participants Protection and Education for Research Teams* online training course sponsored by the National Institutes of Health, were privy to the recorded tapes. A peer reviewer also was privy to the transcribed text for the purpose of validating themes. All texts were kept securely locked, and only I had access.

Data Collection Procedures

Recruitment of study participants began after the study was approved by the Texas Woman's University IRB. Participants were recruited via the official Oklahoma Nurse Practitioner (ONP) Website (Appendix D) where a recruitment notice was posted announcing the title of the study, the study purpose, information about the researcher,

details about the interview process (e.g., projected length of time of the interview and use of tape recorder), and contact information for the researcher (see Appendix E).

After establishing participant contact and determining whether the potential participant met the inclusion criteria, a mutually convenient time and place to meet was established. At the first meeting, the consent process was explained and two copies of the consent form were given to the participant for signature. Once the consent form was secured, the interview was conducted.

The Interview

The purpose of the hermeneutic interview was to gain new or different understanding by revealing the meaning of the experience through dialogue—not to grasp phenomenological insight into the participant's pure experience (Binding & Tapp, 2008). In this study, I focused on the meaning of NP autonomy as it was experienced in the participant's everyday practice. In order to achieve this purpose, the choice of semi-structured, face-to-face dialogue with participants was chosen to:

- ensure flexibility and encourage self-expression of thought and feeling (van Manen, 2006);
- encourage self-reflection (van Manen, 2006);
- observe non-verbal behavior, which can be interpreted as text (Fleming, Gaidys & Robb, 2003);
- provide a venue in order to raise hermeneutical consciousness and to getting clear the shared common meaning of autonomy as it was understood in every

day NP practice experiences through dialogical description (Gadamer, 2006); and,

- give voice to a community of nurses who have historically been voiceless.

Pivotal to any understanding and interpretation is asking the right question(s) because "Questioning opens up possibilities of meaning" (Gadamer, 2006, p. 368). Asking the *right* interview questions, therefore, was critical to the success of this hermeneutic inquiry (see Appendix F for the list of interview questions). Because I was seeking all of the possibilities and richness of meaning, the interview questions were a guide only, not a rigid set of questions followed verbatim for each participant's interview. Consequently, questions were also guided by the interview conversation.

Another factor that was essential to the success of this hermeneutic inquiry was conducting the interview within a hermeneutic atmosphere. Van Manen (2006) contends that the study participant should be given the opportunity to warm up and organize his or her thoughts. Van Manen further asserts that the art or skill required "of the researcher in the *hermeneutic interview* is to keep the question (of the meaning of the phenomenon) open, to keep himself or herself and the interviewee oriented to the substance of the thing being questioned" (p. 98). Therefore, at the outset of the interview, I (a) promoted a relaxed conversational atmosphere, (b) situated the interview within a collaborative or shared context, and (c) encouraged the participant to reflect on their experiences to make sense of their autonomous practice as they saw it. To accomplish this, I first collected demographic data, such as the participant's age, education, NP specialty, type of primary

care practice site, and whether or not he or she had credentialing and possessed a Drug Enforcement Agency (DEA) number for prescribing narcotics. I then led into a focused conversational atmosphere by describing who I am. For example, I revealed my name, my NP specialty, and where I practiced.

According to Binding and Tapp (2008) and others (Lincoln & Guba, 1985), in an hermeneutic inquiry, the researcher becomes the research tool for the purposes of data collection. Being a human tool requires much skill. For example, as both the researcher and a human tool, I had to be wary that the questions asked were driven by seeking to understand the meaning of NP autonomy and not by my own preconceptions of what NP autonomy means. Furthermore, Lincoln and Guba (1985) described the importance of pacing the interview so that questions become more and more specific, but at the same time the flow of the conversation is kept moving in an easy rhythm. As a research tool, I was also a source of data by my participation and observations (Lincoln & Guba, 1985). For example, I observed the participant's body language as well as emotions, which not only complemented or situated the text, but also allowed me to capture the meaning of autonomy as it is defined by NPs. Moreover, as the researcher, I became a co-investigator with the NP participant, because the participant and I self-reflected to interpret the meaning of NP autonomy (Geanellos, 1998; van Manen, 2006). Interviewing is the optimal way to collect data for an hermeneutic inquiry; however, my interviewing skills may have been a limitation.

Each interview was conducted and audio-taped by the researcher and lasted approximately one to two hours. At the conclusion of the interview, the participant was reminded that a follow-up meeting might be scheduled after analysis of the interview text. According to Fleming et al. (2003) and others (van Manen, 2006), at least two interviews should be conducted because the participant's and the researcher's understanding of the topic may change over time. However, from Gadamer's (2006) perspective and others (Debesay, Naden, & Slettebo, 2008), what is imperative is that the researcher become fully immersed and focused on the text so that the truth in the text breaks through. It is therefore not absolute that more than one meeting is critical to experiencing the hermeneutic circle because all dialogue—even if it was gained from one interview—was incorporated into the textual data as a unified whole for the purposes of the data analysis. Nevertheless, to ensure that the meaning of NP autonomy had been revealed through the dialogue of the interview and was not merely an account of the pure experience (Binding & Tapp, 2008), all participants were given the opportunity to reflect upon the transcribed text for completeness and to re-enter the dialogue of the interview to reach common agreement through re-questioning what NP autonomy means to them in their everyday practice.

Data Analysis

According to Gadamer (2006), there is no staged approach to analysis of text; however, there is an approach to analysis that is consistent with the theoretical foundations of hermeneutics. Hence, the analysis of this research inquiry followed the

method explicated by Gadamer and further clarified by Fleming et al. (2003). These nurse researchers identified gaining understanding (a) through dialogue with the participants, and (b) through dialogue with the text. Gaining understanding through dialogue with participants is interwoven with the text—they are not separate and distinct features of data analysis. Rather, as described by Fleming et al., data analysis is really a conceptualization of how the researcher *enters* into the hermeneutic circle through dialogue and becomes *immersed* in the circular movement of continual question and answer with the text. Finally, the research *gets clear* and understands differently within the fusion of horizons.

Gaining Understanding Through Dialogue With Participants

According to Fleming et al. (2003), gaining understanding through dialogue begins during the face-to-face interview, continues with analysis and interpretation of the interview text, and then turns back into subsequent discussion with the participant and text. Gaining understanding through dialogue, then, is not only verbal, but it is also textual.

Fundamental to Gadamer's (2006) position on how understanding occurs is recalling that each person brings with them into conversation those prejudices or pre-understandings that have evolved through tradition (i.e., culture, society, and linguistic interaction in their everyday lifeworld). It is through dialogue that pre-understandings are re-formed or changed into a new or different understanding. Conceptually, this process describes the hermeneutic circle wherein back and forth conversation from whole

to part and back again results in a new or different understanding and meaning with each dialogical encounter (Gadamer, 2006). Understanding then changes over time (Fleming et al., 2003) and is a shared endeavor—a fusion of both the researcher's and the participant's vantage points or horizons (Gadamer, 2006).

The starting point for gaining understanding through dialogue is necessarily situated in gaining entry into the hermeneutic circle by provoking prejudices that govern this researcher's understanding of NP autonomy because "the hermeneutic circle of understanding is not a random orbit of knowledge but an expression of the interpreter's fore structures" (Geanellos, 1998, p. 241). Bringing fore structures or prejudice into consciousness begins with questioning (Gadamer, 2006). The question: "What do I perceive the nature and meaning of NP autonomy to be in practice?" provoked self-reflection of the tradition underlying how I think—my beliefs and values. Because self-reflection is temporal and situated in the history of my past horizon (Gadamer, 2006), the language of NP autonomy was revealed to me in conversations with colleagues in phrases such as the following: (a) making decisions independently, (b) having professional integrity, (c) maintaining professional competency, (d) demonstrating loyalty, commitment, and moral obligation to the patient and the profession of nursing, (e) promoting the autonomy of the patient, (f) respecting others, (g) being fearful if I exert my legal right to be autonomous, (h) taking responsibility for my actions, and (i) being accountable.

This language embodies my personal assumptions and beliefs, but it is not all-inclusive or exhaustive. Neither is it a claim that these assumptions and beliefs represent true prejudices which facilitate understanding as opposed to false prejudices which hinder understanding. One can never know everything; therefore, self-reflection of prejudice must be ongoing throughout the interpretive process—and always with the self-effacing attitude that what is understood to be the truth may not be right. What this initial self-reflective exercise promoted was a beginning awareness and understanding of the context or hermeneutic situation. In this context as a hermeneutic inquirer, I found myself understanding the meaning of NP autonomy in all of its historicity from the vantage point, or horizon, both of my own as well as that of the NP participants in this study.

Gaining Understanding Through Dialogue With Text

Gaining understanding through dialogue with text is all about the interpreter trying to understand what the text is saying (Fleming et al., 2003). According to Debesay et al. (2008), the whole text must be defined as "that which is perceived to be an adequate framework within which one interprets" (p. 59). Therefore, to ensure an adequate framework within which to interpret, all textual elements such as nonverbal expressions, gestures, and researcher observations had to be included as text for analysis. In addition, "In order to facilitate the process of understanding, the first series of interviews should be analyzed before proceeding with the next sequence" (Fleming et al., 2003, p. 118). In this way, data analysis occurred simultaneously with subsequent data collection. Fleming

et al. (2003) suggested the following four steps which systematically organized analysis of the interview text:

1. As a first step to garner an overall meaning of the text, the entire interview text was read to discover an expression that reflected the essential meaning of the text. Understanding the meaning of the whole text was based upon the assumption that there was truth in what was being said. Only when the content of the text was incomplete, that is, the projected meaning and the meaning of the text failed to agree, the legitimacy of the anticipated or projected meaning was questioned. In this way, this researcher remained opened to what was being said in the text.
2. The next step involved detailed analysis of each sentence to discover those themes that exposed the linguistic meaning of that sentence. What followed was the circular movement of interpretation and understanding—as themes were identified, they were confronted by researcher expectation of what autonomous NP practice meant. In turn, expectation of meaning was challenged by the prevailing themes. According to Debesay et al. (2008), underlying the recursive adjustment of anticipated meaning are the questions: "What meaning?" and "Meaning for whom?" Clearly, these questions evoked in the researcher what Gadamer (2006) described as the "polarity of familiarity and strangeness" (p. 295). Ultimately, coming to understanding was somewhere between familiarity and strangeness,

producing a shared understanding. It would be easy to fall into the solipsistic trap and close off interpretation prematurely, but by keeping "one's gaze fixed on the thing throughout all the constant distractions that originate in the interpreter himself" (Gadamer, 2006, p. 269), Gadamer laid down the conditions in which understanding took place during this step, indeed during all phases of data analysis. Those themes identified in this step were validated with use of participant quotations and specific evidence in the text.

3. Themes identified through analysis of every sentence were related back to the meaning of the whole text previously identified. In the process of relating the part back to the whole, the meaning of the text was expanded as an outcome of shared meaning. In other words, the themes identified were essentially a product of both the researcher's pre-understanding and the participant's understanding of the meaning of NP autonomy. Although this step of the data analysis may seem to be clear cut and narrowly defined, it was not! What must be reiterated is that the hermeneutic task of understanding is in constant motion. Thus, the fluidity of the hermeneutic circle and the richness of the language produced a landscape of meaning that required returning many times to both the first and second steps as described in order to achieve harmony—that is, harmony of those themes identified as an expression of each

sentence with the whole text. Only then was there a correct understanding as text became expanded through the unity of the part with the whole. In the present study, shared understanding led to the fusion of both the researcher's and the NP participant's horizons.

4. In the final step, passages that were representative of shared understandings between researcher and participant were identified. Those passages selected and reported not only shed light on how shared meaning was determined in the process of data analysis, but also—and just as importantly—conveyed the element of truth and consequently trustworthiness in the study findings.

Ultimately, shared understanding through dialogue reorganized the old horizon of understanding to a new horizon of understanding. It is this co-created meaning or new version of NP autonomy that was interpreted as the study's findings. Although shared understanding brings into question the validity of interpretive findings, Gadamer was clear that researchers not attempt to put themselves into the other's position during interpretation. To do so would lead to subjectivism and ignore a necessary condition for understanding which is the confrontation of the researcher's historical horizon with the historical horizon of the text. Putting oneself in the other's position, then, is a limitation of hermeneutic inquiry because it invalidates the hermeneutic circle and any subsequent understanding through the fusion of horizons.

Methodological Rigor

Philosophically, the research perspective of a qualitative study varies dramatically from that of a quantitative study. Underpinning the difference is how knowledge is constructed and establishing *truth value* of that knowledge (Lincoln & Guba, 1985). According to Lincoln and Guba, in order to demonstrate the truth value of a qualitative study's findings, the researcher must adequately represent the multiplicity of constructed realities. To this end, methodological rigor was met through the trustworthiness criteria, which includes credibility, dependability, confirmability, transferability, and authenticity (Holloway & Wheeler, 2006; Lincoln & Guba, 1985; Polit & Beck, 2008).

Credibility and dependability were met by utilizing three strategies: (a) peer debriefing, (b) prolonged engagement, and (c) persistent observation. Confirmability was demonstrated by utilizing an audit trail. The criterion used to establish transferability was the use of purposive sampling and rich-thick description of the NP participant's context. Authenticity was demonstrated by reporting accurately the NP's thoughts and ideas (Holloway & Wheeler, 2006; Koch, 1996; Lincoln & Guba, 1985).

Credibility and Dependability

Peer debriefing enhances accuracy or validity of data analysis (Creswell, 2009); hence, it is a strategy to "keep the inquirer honest, exposing him or her to searching questions by an experienced protagonist doing his or her best to play the devil's advocate" (Lincoln & Guba, 1985, p. 308). There is no set strategy for peer debriefing; however, a doctoral candidate with qualitative research experience was solicited to act in

the role of protagonist. A draft copy of the data analysis was supplied to the peer to reanalyze in order to detect bias, subjectivity, and explanations that were not substantiated or did not fit with the interpretations. In addition, I sought personal debriefing—or catharsis—to ensure that subjectivity did not cloud sound judgment (Holloway & Wheeler, 2006; Lincoln & Guba, 1985).

Prolonged engagement was defined by Lincoln and Guba (1985) as "the investment of sufficient time to achieve certain purposes" (p. 303). The experience I have had as an NP also fits with the definition of prolonged engagement. The purpose of prolonged engagement in this study was to gain a deep understanding of NP autonomy as well as to build trust between researcher and reader, and researcher and NP participants. In order to gain a deep understanding, there was immersion into the data and related literature. For example, reading, rereading, and returning repeatedly to the textual data as well as literary sources gave sufficient time to minimize distortion of the data by inappropriate subjectivity (Lincoln & Guba, 1985; Polit & Beck, 2008). Believability of the text was enhanced by ensuring the research process was transparent and clearly written (Polit & Beck, 2008). A reflexive journal was kept to reflect the thought processes, to create a decision trail, and to justify decisions made during the research process (Koch, 1996). Establishing trust with the NP participants was assured by protecting confidentiality through use of a code name and obliterating all identifying data, being sensitive to personal stories, and during the interview, engendering an atmosphere wherein the participant was given the sense of affecting the inquiry outcome.

According to Lincoln and Guba (1985), the purpose of persistent observation is to "identify those characteristics and elements in the situation that are most relevant to the problem [. . .] and focusing on them in detail" (p. 304). Thus, persistent observation is salient to hermeneutic inquiry. It is a good fit because irrelevancies can be identified and described in detail during data analysis in a reflexive journal. Keeping a reflexive journal for this purpose dovetailed into prolonged engagement. Indeed, Lincoln and Guba (1985) described the process of persistent observation as adding depth to prolonged engagement.

Confirmability

Confirmability refers to objectivity or neutrality of the data and interpretations (Polit & Beck, 2008). Holloway and Wheeler (2006) proposed that the researcher keep an audit trail so that the researcher is able to show a "detailed record of the decisions made before and during the research and a description of the research process" (p. 262). Koch (1996) concurred and further added that the audit trail be made available to the reader in the detailed writing of the study and faithful representation of the text. In this study, confirmability was established by documenting (a) contextual data, including excerpts from field notes and interviewing, (b) methodological decision making and rationale for those decisions, (c) plans for analysis of text and interpretive framework, and (d) personal insight (for example, narratives that reveal personal and professional thoughts provide the reader with the context within which interpretation of the text occurred).

Transferability

Transferability is akin to generalizability, and according to Polit and Beck (2008), researchers can show transferability of the study's findings by providing "sufficient information to permit judgments about contextual similarity" (p. 550). Thick description is a term that when used in conjunction with transferability, refers to the thorough, vivid description of the context, the participants, and a multitude of perspectives that describe a theme (Creswell, 2009; Polit & Beck, 2008). Holloway and Wheeler (2006) believed that it may be feasible to generalize to others in the same or similar setting "a similar way of understanding" (p. 262). Consequently, thick description establishes a certain truth value as it relates to the study findings (Holloway & Wheeler, 2006; Koch, 1996). Transferability was achieved by conveying sufficient descriptive data of the study participants as well as showing how the interaction of the researcher as interpreter and the text achieved understanding.

Authenticity

According to Holloway and Wheeler (2006), authenticity is a term used to "demonstrate that the findings of a research project are representative of the participants' perspectives, that the study is fair and helps participants to understand their social world and improve it" (p. 284). In this study, two types of authenticity were incorporated: (a) ontological authenticity, and (b) catalytic authenticity.

Ontological authenticity was ensured by conveying multiple realities of the participants in such a way that both the reader and the participant were helped to understand the practice world of the NP. Catalytic authenticity was demonstrated through enhanced decision making by the individual participants as a consequence of the research.

Summary

Gadamerian hermeneutics is complex, being both a philosophy and a method. As a philosophy, it provided guidance to understanding the nature of being and the way understanding happens. As a method, it was used to further the understanding of NP autonomous practice by elucidating NPs' hermeneutic experience through the fusion of their history, culture, and language, and the circularity of the hermeneutic question-answer dialogue. For Gadamer (2006), there are no absolutes. Truth is multifaceted. From this point of view, Gadamerian hermeneutics encouraged freedom and openness to research and explore more comprehensively the landscape of interpretations and meanings of NP autonomy.

As a humanistic science, the aim of hermeneutics is to elucidate the essence of the hermeneutic experience (Gadamer, 2006). The experience of participation in everyday NP practice shaped understanding of that experience rather than the world shaping and explaining the experience. Experience, then, paralleled the phenomenological notion of *life-world* and *being-in-the-world* (Gadamer, 2006). NP practice was, therefore, a function of NPs' interpretation of their world and was irreducible to objectification and

facts. To understand the experience of NP autonomous practice and its ascribed meanings, the panorama of experience must be embraced because the human consciousness makes sense of the whole experience. Gadamerian hermeneutics enabled this researcher to gain a deeper, richer understanding of that experience and, in the process, define the meaning of NP autonomy.

CHAPTER IV

UNDERSTANDING NURSE PRACTITIONER AUTONOMY

A Paper Submitted for Publication in the

Journal of the American Academy of Nurse Practitioners

Sandra A. Weiland, APRN-CNP

Abstract

Purpose

This Gadamerian hermeneutic study was undertaken to understand the meaning of autonomy as interpreted by NPs through their lived experiences of everyday practice in primary health care.

Data Sources

A purposive sample of nine NPs practicing in primary health care was used. Network sampling achieved a broad swath of primary care NPs and practice settings. Data were collected by face-to-face interviews. Because NP autonomy is concerned with gender and marginalization, Gilligan's feminist perspective was utilized during interpretive analysis.

Conclusions

Having Genuine NP Practice was the major theme, reflecting the participants' overall meaning of their autonomy. Practicing *alone with the patient* provided the context within which participants shaped the meaning of having genuine NP practice. Having Genuine

NP Practice had four sub-themes: relationships, self-reliance, self-empowerment, and defending the NP role.

Implications for Practice

The understanding of Having Genuine NP Practice will enable NPs to articulate their autonomy clearly and better influence health care reform. Implications for advanced practice nursing education included curriculum revision and interdisciplinary education with medicine, to ensure socialization to the NP role and to reformulate health care's culture of physician-only-provider.

Key Words

Autonomy; NP practice; physician; healthcare system; hierarchy; collaboration; self-reliance; relationships; self-empowerment; defending the NP role.

Introduction

Autonomy is the cornerstone of Nurse Practitioner (NP) practice. It is an essential dimension required to achieve success as a primary care provider, and it is necessary for the ultimate success of the professional role of the NP, as well as for progressing the profession of nursing. Nevertheless, despite more than 45 years of NP practice, cultural, socioeconomic, and political factors continue to influence the ability of NPs to practice autonomously as primary care providers (Mullinix & Bucholtz, 2009; Weiland, 2008).

The Affordable Care Act of 2010 sought to increase the accessibility of 32 million U.S. citizens to health care. However, the number of primary care physicians is inadequate to meet this demand (Newhouse et al., 2011), yet physician opposition to NP

practice autonomy persists despite a long history of providing competent, safe, primary health care (American Medical Association (AMA), 2009; Institute of Medicine (IOM), 2010; Mullinix & Bucholtz, 2009; Newhouse et al., 2011; Safreit, 2010). Thus, NP autonomy remains a political issue deeply embedded in the culture of healthcare. For example, although *all* NPs are "expected to practice as licensed independent practitioners . . ." (National Council of State Boards of Nursing, 2008, p. 1), there is no consensus among state boards of nursing, legislators, third-party payers, hospital administrators, physicians, health care workers, and even NPs themselves about what autonomy in NP practice really means. As a result, the NP role is undervalued and misunderstood, and the legitimacy and authority to practice autonomously is fragmented nationally. Even though current U.S. NP autonomous practice is impeded by inconsistent legislation, NPs have gained recognition as capable primary health care providers and central contributors to the success of health care reform (IOM, 2010). Practice autonomy is essential for NPs to achieve their potential in health care.

The concept of autonomy and the external barriers to autonomous practice have been explored and reviewed elsewhere (Safreit, 2010; Weiland, 2008); however, relatively little attention has been given to the NPs' understanding of what autonomy means within the context of their daily practice. Indeed, no studies seem to exist that have taken a pragmatic, fundamental approach to elucidating personal meaning.

The purpose of this qualitative study was to elicit an understanding of the meaning of autonomy as interpreted by NPs through the lived experiences of their

everyday practice in primary health care. The research question that guided this study was: What is the meaning of autonomy as it is interpreted by NPs through the lived experiences of their everyday practice in primary care? Gaining such understanding is necessary to advance the profession and to enable *all* NPs to practice as licensed, independent practitioners, as health care reform demands.

Background and Literature Review

The literature to 2008 dealing with the impact on independent, autonomous NP practice of regulatory restrictions, which included prescriptive authority, reimbursement, and physician supervision, has been extensively reviewed by Weiland (2008) and others (IOM, 2010; Naylor &Kurtzman, 2010; Safreit, 2010). Although legislative barriers to NP autonomous practice are less restrictive than they once were, they nevertheless persist (Pearson, 2010). In part, this is because the NP role complements nursing with medical management.

The American Association of Nurse Practitioners (AANP) (2002) defined the NP role in the statement: "Nurse practitioners assess and manage medical and nursing problems. Their practice emphasizes health promotion and maintenance, disease prevention and the diagnosis and management of acute and chronic diseases" (p. 1). To fulfill this role, NPs take histories, conduct physical examinations, order and interpret diagnostic tests, write prescriptions, and manage the conditions that are diagnosed. Clearly, NPs embed a medical model into NP care. Philosophically, however, the nursing ideology of holistically-oriented goals for *self-care through health promotion and*

disease prevention dominate. In contrast, medicine's philosophical perspective is a lateral illness model of diagnosis and treatment (Hamric, Spross, & Hanson, 2009). The medical focus is curative. What is fundamental to understanding the NP role and clarifying the boundaries between medicine and nursing is that *tasks* do not define the NP; rather, the *role* defines the NP (Ford, 1997).

Historically, it was envisioned that the NP would function as an autonomous practitioner consistent with a nursing philosophy of self-care—*not* as a physician extender or substitute (Ford, 1997). This focus on the NP role defined NPs as *independent from*, not *dependent upon*, medicine. It also defined NPs professionally as autonomous advanced practice *nurses*. Nevertheless, the concept of NP autonomy became obscured amid fears from both medicine and nursing that NPs were crossing professional boundaries (Dempster, 1991). The confusion is captured by Brown and Draye (2003) in their study on pioneer NP experiences during those early days of intra- and inter-professional conflict. The historical account of physician support and mentoring of pioneer NPs to promote practice autonomy is well-documented by Fairman (2002). However, as a whole, neither medicine nor nursing supported the social, structural, and legislative changes needed to establish NP autonomy within the health care system (Campbell-Heider & Pollock, 1987).

Because autonomy is culturally constructed and closely linked to one's identity (Gilligan, 1993), it is important to determine how NPs perceive autonomy within the context of their relationship with physicians vis à vis a hierarchical structure. The

powerful influence of hierarchical ideologies is illuminated by McLain (1988) in a phenomenological study of nine NP-physician dyads. Findings suggested that overall, "the language, values and behaviors of the nurses continued to support, to varying degrees, the authorization and dominant position of the physicians" (p. 35). For example, one NP said, "I'm not sure about this, and there's a physician here who I'd like to have come in [. . .]. Then it's the *doctor* going into the room, and if the *doctor* says it's okay then it must be okay" (p. 34). Moreover, some NPs in McLain's study were unable to articulate clearly the nursing component of their role. This contributed to physician misunderstanding. In contrast, McLain also found other NPs' professional relationships with the physician were ones of respect and collegiality because these NPs were able to articulate clearly the NP role. These findings are supported by Burgess and Purkis (2010). However, their emphatic finding was that generally NPs developed a clear understanding of their role within a mutually respectful and trusting relationship, rather than bringing that understanding into the relationship. Nevertheless, studies have substantiated that NP-physician relationships continue to follow the traditional hierarchy (Martin, O'Brien, Heyworth, & Meyer, 2005; O'Brien, Martin, Heyworth, & Meyer, 2009; Street & Cossman, 2010), but none achieved insight into the ways in which NPs themselves contribute to this type of relationship.

Where some NPs find ways to achieve autonomous patient care, others do not practice to the full extent of their legal authority. Kaplan and Brown (2007) carried out a qualitative study consisting of 12 focus groups (approximately 100 NPs). Their study

described NP responses to legislative changes in prescriptive authority consisting of the choice to prescribe scheduled drugs under a joint practice agreement, or not to prescribe scheduled drugs at all. The authors found that having a choice to prescribe scheduled drugs did not mean NPs practiced to their sanctioned limits; neither did the choice determine the level of perceived autonomy. Clearly, the way NPs perceive autonomy in their practice is complex. The present study was designed to gain insight into this complex issue.

Method

The methodological framework for this study was Gadamerian hermeneutics. This was the selected methodology because the purpose of this research and the hermeneutic task are congruent—both seek to gain understanding through interpretation of language. Language is produced socially and historically. Who we are, our being in the world, is produced through language (Gadamer, 2006). Because NP autonomy concerns gender and marginalization (Creswell, 2009), a feminist perspective using Gilligan's (1993) theoretical argument that the fusion of identity- and intimacy-formation is defined through relationships, guided understanding and interpretation of the significance of the meaning of NP autonomy.

Setting, Sampling, and Participants' Rights

The setting was Oklahoma where physician supervision is required only for prescriptive authority for schedule III-V and formulary drugs. Recruitment of study participants began after the study was approved by Texas Woman's University's

Institutional Review Board. A purposive sample of NPs practicing in primary health care was obtained by posting a notice on the Oklahoma Nurse Practitioner Association Website. Network sampling was also used to recruit by asking early respondents for referrals and directly contacting NPs known to the author for referrals. Consequently, participants came from a broad swath of practice settings. Informed consent was explained and obtained from participants; and, to ensure confidentiality, each participant chose a code name known only to the participant and to the investigator.

Rigor was achieved through the trustworthiness criteria, which included credibility and dependability, confirmability, transferability, and authenticity (Holloway & Wheeler, 2006). The criteria of credibility and dependability were met by utilizing peer debriefing, prolonged engagement, and persistent observation. An audit trail was used to fulfill confirmability. Purposive sampling and rich-thick description of the participant's context were used to establish transferability. Authenticity was demonstrated by accurately reporting the participant's thoughts and ideas.

Data Collection

Data were collected via individual face-to-face interviews, each from one to two hours duration and were tape recorded. The recordings were subsequently transcribed by the author or by a transcriptionist. The author carried out all the interviews personally over a period of four weeks. Participants were unaware of who was in the study. Interview venues varied from participant to participant. At the conclusion of the analysis,

follow-up contact was made with participants via email to ensure that the findings still reflected their meaning of autonomy, and that the interpretation was accurate.

Analysis and Interpretation of Data

Saturation of data was reached with the seventh participant, but two further interviews were conducted for a total of nine interviews to ensure no further findings were discovered. Table 1 shows complete demographic data.

Table 1

Demographic Characteristics of the Participants (N = 9)

Characteristic	*N*
Gender	
Female	7
Male	2
Employment status	
Full-time	9
Part-time	0
Education level	
Master's NP	8
DNP	1
Type of advanced practice certification	
Family Nurse Practitioner	7
Adult Nurse Practitioner	1
Pediatric Nurse Practitioner	1
Professional membership	
Yes	8
No	1

(continued)

Characteristic	*N*
Clinical practice setting	
Independent practice	2
NP owned	1
Physician owned	3
Federal community health center	2
Indian Health Services	1
Years of advanced practice experience	
0-2	2
3-5	2
6-8	2
9-12	3
>12	0
DEA Number	
Yes	9
No	0
Third-party credentialing	
Yes	8
No	1

Data analysis followed the method explicated by Gadamer (2006) and further clarified by Fleming, Gaidys, and Robb (2003), which is about gaining understanding through dialogue with the participants and with the text. To facilitate data analysis, an extensive table was developed of recurring phrases and words, allowing circular movement through the text—first reading the whole, then the parts, and then back again. In this way, the author became immersed in the circular movement of continual question and answer with the text. Understanding took shape as the fusion of the author's pre-conception or understanding of autonomy merged with that of the participants.

The findings are presented in one major theme and four sub-themes as shown in Appendix G. The participants' overall meaning of autonomy was derived as Having Genuine NP Practice. Four individual parts or sub-themes were identified: (a) relationships, (b) self-reliance, (c) self-empowerment, and (d) defending the NP role. Thus, the four sub-themes when taken together comprised the overall meaning, as illustrated in Figure 1.

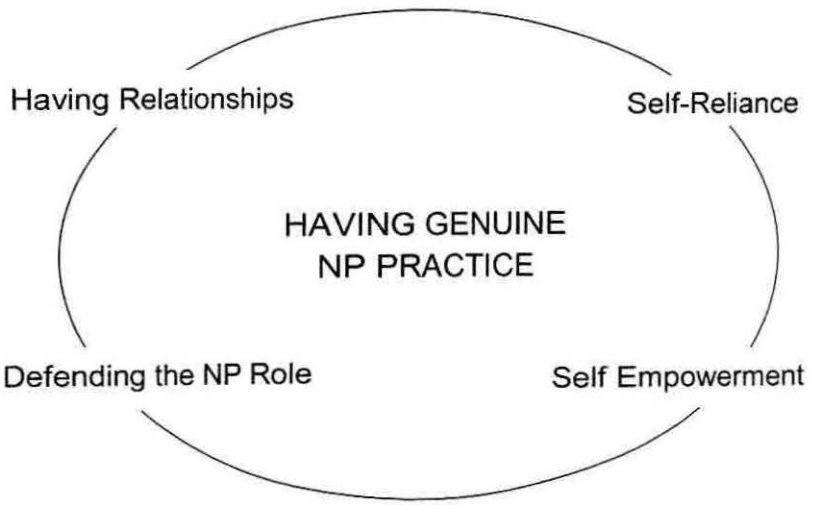

Figure 1. The meaning of autonomy: having genuine NP practice.

Major Theme: Overall Meaning

Having Genuine NP Practice

The commonality of how participants in this study understood the meaning of their autonomy was interpreted as Having Genuine NP Practice. This interpretation was achieved through the fusion of (a) the author's understanding and preconceptions of what autonomy means in practice (i.e., having freedom, using professional judgment with the

patient, and being responsible and accountable to the patient), and (b) the study participants' shared meaning of autonomy in their practice. The consensus meaning was that autonomy is genuine (real, true) when the NP practices *independently* and *alone* (in the exam room) with the patient. In this exclusive NP-patient relationship, the traditional physician-*nurse* relationship is supplanted by the NP-*patient* relationship. This is because the NP is responsible to and accountable to the patient and not to the physician. Having Genuine NP Practice, then, had meaning not only for the experience of autonomy, but also in simply being an NP. The overall understanding of what autonomy means is facilitated through the following answer in response to the question, "What does autonomy mean to you?"

> It means that I have the right to treat my patients the way that I feel they should be treated, which is holistically. It means that when I go down my hallway to my patients, that is my world, those are my patients, that is my area, and I can high-five them for a good A1C [. . .] I feel I am free to practice the way I want to practice within my scope, and I am free to care about my patients [and] I do, I emotionally connect with as many patients as I can [. . .] when I walk into the room, I don't let [anything else] affect me.

The meaning of autonomy for these nine NP participants is constructed from the individual parts, or sub-themes. At the root level, the participants framed their autonomy within the context of the NP-patient relationship and the practice environment.

Sub-Themes: Individual Parts

Relationships

The centrality of the NP-patient relationship to the meaning of autonomy was described as a reciprocal partnership in which "decisions are made together as partners in health," implying a relationship between equals. Embedded within this relationship of equality was the autonomy of the NP and the autonomy of the patient. Thus, the language used by participants further invited a view of their world through moral dimensions, obligation, and responsibility where the obligation to provide care in turn validated and shaped the meaning of autonomy. It also shaped the world of practice as one of both having and giving up control and provided the lens through which the professional and personal self were viewed. This interpretation was facilitated from the perspective proposed by Gilligan (1993) that the "activity of care enhances both self and others" (p. 74). For example, one participant commented, "I have patients that only want to see me when they come to the clinic, so they are my patients, and I am responsible for them, so that is autonomy." Other participants described the patient relationship as one of "listening carefully to patient problems" and "reciprocal trust."

Participants also described advocating for the patient. When asked, "What was the experience like as a patient advocate?" one participant responded, "Stronger, more confident that you're getting things done that the patient needs." For another, being a patient advocate meant doing what was right which not only validated, but also

reinforced autonomy through moral obligation: "I did what was right for that patient, and you know . . . [I feel] more confident about it, about being autonomous."

Collaborative relationships facilitate autonomy in the NP role (Burgess & Purkis, 2010; Fairman, 2002). Participants in this study also described the importance of relationships within the context of their autonomy; however, more than facilitating autonomy, autonomy was achieved through a web of connections which increased self-esteem and promoted professional growth through mutual learning. According to Gilligan (1993), conceptions of who you are and how one sees the world are built upon connection and affiliation, which ties one to the experience. Using this as a guide, interpretation of participant language led to further understanding that autonomy has meaning when relationships are built on mutual trust, respect, equality, and interdependency. Underpinning these types of relationships are social acceptance and power. For example, one participant said, "NPs here are highly respected; there is nobody who says, 'Oh, they are NPs'"; another stated, "Most of us are really close [. . .] the physician asks me a question, I will ask the physician a question."

Other participants understood collaboration as supervision when the relationship was legislated, so there was a sense of having less social acceptance and less power. For example, one participant said, "I think that full autonomy would be where you could collaborate with someone, but you are not required to do this." Participants in independent practice spoke of networking, which broadened the term collaboration to include the labyrinth of relationships in the healthcare system: "I have a large network of

providers I use [. . .] when I refer, they don't hesitate [. . .] they trust my judgment." Clearly, this participant's sense of self, or identity, showed through the voice of relationships.

Participants also worked with physicians in a contractual agreement in order to work around reimbursement barriers; this was described as a necessity. One participant understood workarounds as part of the traditional covert way in which nurses have achieved autonomy; however, within this context, workarounds were incongruent with professional identity at the advanced practice level:

> Hmm, and as nurses we're very good at that. It's kind of a circular continuum, you know, I think in the nursing profession, I mean, just [. . .] is it ever going to end, and with the advanced practice nurses, really, it should [. . .] workarounds, but it's not.

Relationships were not always experienced positively in the workplace. In the social context of risking loss of integrity, feeling dependent, and professionally powerless, the focus of the interaction was always to fulfill the responsibility to patient care. Yet at the same time, participants redefined the rules to maintain the relationship by shaping the experience of their autonomy as being the same as their physician coworkers and not a reflection on their competency. For example, one participant said, "I only collaborate with a physician if I am not quite sure of something, but yet I have seen the physicians act just the same way." Another participant described having "hurt feelings and hurt self-esteem" when, after asking about a medication, the physician coworker

complained to the administrator, "He [the physician] made such a big deal about it; he went to our medical director." The participant responded, "When you first put somebody on [a medication], did you question anybody or did you just do it? Because that's what I am doing. This is a learning moment." Even in retelling, the participant was upset.

Participants in this study also understood negative relationships as being part of the traditional, cultural background in which they practiced. Caught in a system in which they had little power or social authority, the daily act of ordering tests meant giving up sanctioned autonomy. "When I have a Medicaid patient or Medicare patient, and they are assigned to me [. . .] I am their PCP by state law, but when I try to call some places they want a physician's name to order an MRI, or an X-ray." Other narratives showed the interplay of class, gender, and inequality that effectively undermined the participant's legal authority as well as marginalized professional integrity. One participant said,

> There is a surgeon [. . .] he will say I don't want to talk to you, he wants to talk to the doctor [employer], and the doctor [employer] hasn't seen the patient, doesn't know the patient, didn't order the CT [. . .], and he [physician employer] said, 'If that ever occurs just call me and I will take care of it.'

In defending the participant, the physician employer took a paternal, protective position towards the NP.

Self-Reliance

The participants understood being alone as an attribute closely interwoven through the meaning of their autonomy. Being alone was interpreted as self-reliance

when fused with participant language such as, "I do it, I have no review, I do not ask for permission or report to anyone," and ". . . one person being responsible for their actions and not needing permission to carry out those actions." Being self-reliant opened up a deeper meaning such as having independence of action (i.e., control over their practice), self-confidence, and self-trust. According to Gilligan (1993), self-reliance from a traditional view of autonomy is understood as independence through separation; however, this traditional view is not consistent with participant language in this study.

Deeper interpretation of participant language revealed this is always a patient presence—at least implied. Hence, self-reliance was understood as being independent in the role, but connected to the patient. This meaning also prompted understanding of how participants shaped professional identity as an "expert" in an environment where barriers to practice run counter to the level of education and expertise of the NP. As one participant said:

> I do not call the supervising physician to consult about a medication I would use in primary care, but I may call a specialist about a medication I do not use in every day practice. . . . I've been trained to assess, evaluate, treat, and follow up and prevent with patients. And that's how I see autonomy.

Although self-reliance was also interpreted as liberating on the one hand, this understanding sharply contrasted with the language for physician supervision on the other. For example, when asked to quantify the level of their autonomy in everyday practice, most participants interpreted their autonomy as a "10 out of 10." This is

supported by other researchers who found that NPs perceived their autonomy levels to be high (Bahadori & Fitzpatrick; 2008; Cajulis & Fitzpatrick, 2007; Maylone, Ranieri, Griffin, McNulty, & Fitzpatrick, 2011). Within the restrictive Oklahoma supervisory environment, however, participants described autonomy as a "7 out of 10." How can the NP function as a "10" in a "7" environment? The answer lies in participant language: "It's a farce." "The supervising physicians are not supervising anything." "Day-to-day in the trenches, no one is watching what I'm doing." Out of view, autonomy is unrecognized by physicians and other health care workers.

Being alone was not interpreted as self-reliance for one participant—being alone meant isolation. This participant asserted,

> You are alone . . . you are not a nurse, and you are not a doctor, you are a nurse practitioner [. . .]. That isn't something that you learn in school and I wasn't prepared for, and that was, nurses don't really recognize you as one of them [. . .], you are sort of an island, you are a hybrid.

As a new NP, this participant was experiencing social and professional isolation.

Self-Empowerment

Being right was a focus of participant narratives about their best practice experience. Some participant stories wrapped around unraveling obscure patient diagnoses, while others also embodied the importance of being right as a function of the NP's care. Being right reinforced confidence in their competence, ability, and skills to do the job, and as well as the impact they had on patient outcome—it was also professionally

rewarding. For example, one participant said, "I hate being wrong with a passion, and I will argue to the death if I am certain I am not wrong, because I love to be right," and for another, having "those 'yes moments'" opened up the interpretive meaning of self-empowerment. Although the dialogue was also interpreted from the perspective that the participants were judging themselves as a function of their NP care (Gilligan, 1993), Boudrias (2004) described similar attributes as psychological empowerment where there is cyclical interplay between the work environment and personality. Nevertheless, the fusion of being right and fulfilling professional duty was a powerful reward—it cannot be taken away. One participant stated:

> So, three to four physicians this kid has seen and not one of them could diagnose her accurately, and the first time [. . .] she comes here and I diagnose her. We send her to nephrology and she is fine now, with no residual which is great with all the stuff she was on [. . .] but that was one of my greatest [experiences].

Another participant described self-empowerment from a different perspective:

> Generally, it is when I feel like that 'yes moment'. Someone comes in that first time, and I see they had a problem for a long time and maybe they saw somebody else, or didn't, and I am like, 'I know what your problem is and I can fix it,' and then they come back in couple of weeks and that is good. I always strive to get the 'yes moments' [because] it is not fun for them to come back, and come back, and keep saying 'no I am not better' [. . .] I know I am missing something here.

Understanding of narratives was further clarified when viewed from Gilligan's perspective that being right for the patient is also being right for the participant.

Defending the NP Role

Defending the NP role was interpreted from participant narratives of challenges they faced in the daily work environment. By defending their role, the study participants shaped the meaning of autonomy because they believed in themselves, and they envisioned themselves as professionals and autonomous primary care providers. One participant said, "I had to describe it [the NP role] to them, a pediatrician, and his wife was a nurse, and he asked me 'exactly what is this nurse practitioner thing?' [. . .] I had to explain it." Another defended the role by confronting conflict in the workplace, "I basically had to tell her one day, 'Look, you have two choices: One, you can go away and let me practice, or two, you can fire me. It is up to you,' and she didn't fire me."

Some participants understood the daily struggle to maintain professional identity as carving out the authentic self within the context of the traditional model of physician care. Interpretation through Gilligan's (1993) lens took on deeper meaning of being caught between the context of wanting to become disentangled from a culture that ignores the difference between physician and NP, and the context of being afraid to let the voice of difference be heard. For example, one NP commented, "We have to defend everything we do. We are held to that [physician] standard of care, not NP care [. . .] that is why we feel threatened by anybody questioning what we do [. . .] it is a social issue of a nurse and the physician."

Being reimbursed 85% of the allowable Medicare amount was interpreted as social denial of social parity for comparable services provided. Using Gilligan's (1993) perspective further increased understanding that participants not only had the need to be recognized for legitimate work done, but non-recognition was an ethical dilemma that undermined their responsibility and placed them outside the social sphere of acceptance. For example, one participant said, "I feel socially stigmatized. It's very offensive to be paid 85% for performing the same complexity of care, when I am the one down here with these kids managing cystic fibrosis to get paid 85%."

Refusing to be labeled or professionally defined by a hierarchical social system that misrepresents the real, or genuine, NP role, one participant summed up understanding the language 'midlevel provider' as, "I don't feel like I'm a midlevel provider; I feel like I'm a primary care provider as an NP, and I provide advanced practice nursing within the scope of my practice." One of the most disturbing challenges voiced by participants was defending their own role to other NPs who subscribed to a physician-dominated health care culture. For example, one participant defended the NP role, "I worked with a nurse practitioner who said, 'Well, if you had insurance, wouldn't you see a doctor rather than a nurse practitioner?' I said, 'Absolutely not. My primary care [for] my kids is a nurse practitioner.'"

Discussion

Having Genuine NP Practice was interpreted as being real and true, when the NP practices *independently* and *alone* (in the exam room) *with the patient.* Although the

understood meaning was cast within what appeared to be a stereotypical definition,[4] because a feminist perspective was incorporated into interpretation, a deeper meaning was achieved that expanded the definition through a different lens. Autonomy for the study participants had meaning not only experientially, but also existentially; autonomy is genuine because it has meaning in the everyday life of being a NP. On a scale of autonomy, the understanding of how autonomy *in practice* is achieved sits at one end as being what really happens (real), and the understanding of legal limitations sits at the other as being a farce. Unfortunately, NP autonomy is either hidden from view by the legal requirement of physician supervision, or it is obscured by cultural and social ideology in which NPs are themselves sometimes complicit.

Relationships were pivotal to the meaning of autonomy. In the meaning, the NP-patient relationship took center stage, and the stereotypical physician-nurse relationship was supplanted because, as found in this study, the participant was responsible and accountable to the patient, not to the physician. Collegial relationships with physicians and others were, however, pivotal to professional growth. Self-reliance was found to be an important underpinning because of the NPs' belief that they had direct control over their practice. Self-reliance further promoted understanding of how the NPs shaped their professional identity in a restrictive practice environment—an environment that is out of step with the level of education and expertise the NP has. Self-empowerment was a necessary ingredient because it reaffirmed the participants' competence and impact on

[4] Being alone or self-reliant, making decisions, and being responsible for actions are attributes which, according to Gilligan (1993), are stereotypically and historically associated with a *masculine* outlook.

patient care. Self-empowerment is intrinsic; it is something that the NPs confer on themselves, and it cannot be taken away. The fact that autonomy was so closely linked to the participants' identity of who they were as NPs was expressed as defending the NP role.

Limitations

Limitations of this study are that by their nature, qualitative findings are hard to generalize. Purposive sampling may also have caused bias. Moreover, although the sample size was small, saturation was reached after the seventh participant, and two further interviews were conducted to confirm saturation. NPs who agreed to be in the study may be different from those who did not; however, participants were selected from a broad spectrum of the NP population. Thus, this selection is unlikely to be confounding. The author's pre-understanding about NPs and NP autonomy may have caused findings to be overlooked; however, ensuring trustworthiness in data analysis and interpretation allowed for minimal distortion of the data.

Recommendations

This study led to the following recommendations:

- Further studies are recommended to develop an advanced practice model of autonomous practice.
- Analysis of participant narratives suggested that NPs may need to be more formally socialized to the role; thus, determining just exactly how NPs are socialized to their role at present would make a valuable study.

- A review of curricula and residency programs for the purpose of ensuring that student NPs receive formal education and socialization to the NP role could assist in providing more formal socialization to the role.

Formal instruction may be needed to inform physicians about the real NP role as well as to achieve a positive perception of the NP profession by physicians. This could be accomplished by bringing medical and NP students together for common instruction, even for one session, on the nature of each role.

The findings from this study could be used as talking points in order to inform legislators. As NPs move forward towards removing practice restrictions, research data are pivotal to enhancing professional credibility. Therefore, this study should be repeated in other states.

This study gave participants a voice they may not have had before and led them through the process of self-examination, including being introspective about the autonomous nature of their everyday practice. Other benefits included professional awareness, self-reflection, and, ultimately, personal and professional growth.

Conclusion

This study illuminated the meaning of autonomy as Having Genuine NP Practice. Having Genuine NP Practice has the potential to become a conceptualization of autonomy that has meaning for all NPs. Understanding how NPs in this study shaped the overall meaning of autonomy provided insight into daily practice, the professional self, and the integral part that relationships occupy in the everyday life of being an NP, along

with the daily struggles. This study showed that the power of social and cultural ideology continues to obscure NP autonomy socially, and the power of this ideology cannot be understated. Understanding social impediments to NP practice autonomy is the first step towards effecting cultural change.

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CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

This study focused on autonomy among NPs in Oklahoma. This chapter presents (a) an overview of the study, including an evaluation of the utility of Gadamerian hermeneutics and Gilligan's feminist perspective, (b) a summary of the study findings and literary context, and (c) implications of the study for advanced nursing practice, graduate nursing education, and nursing research.

Overview

The purpose of the study was to understand the meaning of autonomy as interpreted by NPs through their lived experiences of everyday practice in primary healthcare. Gadamerian (2006) hermeneutics as a philosophy and a method was the framework that guided the study. As a humanistic science, hermeneutics has the purpose to get clear, or interpret, what is meant when something is said. Hence, the major tenet put forth by Gadamer (1985) was that language is "the fundamental mode of operation of our being-in-the-world" (p. 3).

Language is produced socially and historically, and truth lies in one's connection with the past. Therefore, I interpreted how the language NPs used to describe their lived experiences in everyday practice influenced and determined the meaning they ascribed to autonomy. Additionally, a feminist perspective using Gilligan's (1993) theoretical argument was incorporated during interpretation because NP autonomy evokes questions

of gender and marginalization (Creswell, 2009). Data analysis followed the method explicated by Gadamer (2006) and further clarified by Fleming, Gaidys & Robb (2003).

Gadamerian Hermeneutics and Gilligan's Psychological Theory: An Evaluation

In this study, the driving force for developing meaning through interpretation came directly from Gadamer (2006) with every effort being made to adhere to hermeneutic interpretation. Unfortunately, Gadamer offered neither a set methodology nor guidelines for interpretive analysis. What Gadamer contributed was a model of dialogical circularity—the metaphoric hermeneutic circle that takes place between the text and the interpreter—and an insistence on adherence to traditional hermeneutics. Essentially, this amounts to being open and willing to listen to what the other is saying so that true interpretation emerges as *our,* rather than *my*, understanding. Therefore, distinct advantages of using Gadamer were ensuring true interpretation or at least avoiding false interpretation, and ultimately understanding and embracing his assertion that, as an interpreter, the author was not unlike a translator whose freedom to interpret was language-bound. From these perspectives, Gadamer's test of interpretation and trustworthiness can be demonstrated through the activity of feeding understood parts back into the overall interpretation to ensure that the application of those parts fits with the whole; in other words, ensuring true interpretation through connection and congruency. Pivotal to enhancing interpretation in this study was including during analysis Carol Gilligan's (1993) theory of moral development.

Incorporating Gilligan's (1993) feminist perspective complemented Gadamer's (2006) approach to hermeneutics because Gadamer and Gilligan share an underlying premise—the significance of language. For both authors, language revealed the world in which the speaker lived. Gilligan took this premise further and expanded language to include how people make *connections* through "different voices and the dialogues to which they give rise, in the way we listen to ourselves and to others, in the stories we tell about our lives" (p. 2). Gilligan's theory that the development of one's identity is defined through relationships of responsibility and care molded the context of hermeneutic interpretation in this study to include multiple ways of understanding how participants expressed their individual meaning of autonomy.

Although the same or similar interpretations may have been derived without incorporating Gilligan's perspectives, the meaning of autonomy may have been narrowed, resulting in prematurely closing off interpretation. The end result might have been misunderstanding and even under-representing the meaning of autonomy and, consequently, corrupting trustworthiness. As an example, when viewed through the traditional context of autonomy as the model of independence through separation, the following text, offered by one of the study participants, may have been understood as being independent, doing everything on one's own without connection to another:

> I see my patients, I take care of them. You know it [autonomy] is where you truly take care of your patients without going back to someone. I think I have been

pretty, you know, pretty autonomous because I have never had a physician right there all the time with me.

Viewing the same text from Gilligan's (1993) view of affiliation, responsibility, and care, however, showed that the traditional meaning of autonomy does not adequately portray what the language revealed. There was at once separation and connection—separation from the historical connection with the physician, but connection to the patient in the context of providing NP care alone. Although this is but a very small example of how Gilligan's theory complemented Gadamer's (2006) hermeneutic interpretation, it must be understood that the complexity of interpretation involving the hermeneutic circle and developing understanding through the fusion of horizons was by no means exposed fully in the above example. Nevertheless, this brief glance does provide some insight into the inspiration infused into interpretation using Gilligan's feminist view. Hence, Gadamer's model for interpreting the meaning of the words faithfully and applying Gilligan's feminist perspective to interpretation of the text, and to the present context of this study, were invaluable in answering this study's research question.

Summary of the Study Findings and Literary Context

Data analysis and interpretation revealed that the overall meaning of autonomy was contained in the phrase and major theme: Having Genuine NP Practice. It consisted of four individual parts or sub-themes: (a) relationships, (b) self-reliance, (c) self-empowerment, and (d) defending the NP role. The individual parts have separate meanings, but when pieced together, they actualize the overall meaning of autonomy.

Major Theme: Having Genuine NP Practice

Having Genuine NP Practice was identified as the major theme which reflected the participants' overall meaning of their autonomy in everyday practice. In their language, participants situated themselves in relationship to the daily practice experience of practicing *independently and alone* (in the exam room) *with the patient*. It was within this context that participants shaped the experience and the meaning of Having Genuine NP Practice, personally and professionally. Therefore, autonomy not only had meaning as the experience, but it also had meaning in the everyday life of being an NP. The reason is that the recurring reality of having the knowledge and skills to enact their role competently, alone, and independently evaluating and making decisions of care *was* real. It was genuine—irrespective of the practice restriction for prescriptive authority.

This research introduced a novel, yet fundamental approach to understanding the meaning of NP autonomy. No literature appeared to exist that directly related to the construct of Having Genuine NP Practice within which NPs understand their own autonomy. However, the individual sub-themes each hold part of the meaning of Having Genuine NP Practice so the literature associated with each of them was used to substantiate Having Genuine NP Practice as the overall theme, at least indirectly (Bahadori & Fitzpatrick, 2009; Boudrias, 2004; Burgess & Purkis, 2010; Cajulis & Fitzpatrick, 2007; Dworkin, 1997; Ells, Hunt, & Chamber-Evans, 2011; Fairman, 2002; Gilligan, 1993; Kaplan & Brown, 2007; Maylone, Ranieri, Griffin, McNulty & Fitzpatrick, 2011; Street & Cossman, 2010; Whelan, 2000; Yanay, 1994).

Sub-Themes

Relationships. Interpretation of the sub-theme, relationships, emerged as a pivotal element in the way in which participants ascribed meaning to their autonomy. Although all relationships in the immediate and wider practice environment occupied space in the participants' meaning of autonomy, the centrality of the patient relationship dominated both the language and the meaning of their autonomy. Within the context of patient relationships, participants found meaning and defined themselves as autonomous through the everyday activities of enacting the NP role and fulfilling the commitments they made out of professional responsibility and obligation to provide NP care to the patient.

Because of the NP-patient relationship, participants self-reflected upon their capability to provide NP care as being an expert or having competency to do the job. In addition, language such as patient loyalty or a patient following reinforced the genuineness or authenticity of NP care by giving the participant permission or social authority to provide that care.

The finding that the patient relationship was a central component in which the meaning of NP autonomy was constructed both professionally and personally is supported in the feminist literature as *relational autonomy* (Ells et al., 2011; Yanay, 1994). The finding is also supported in disciplines such as psychology (Gilligan, 1993) and philosophy (Dworkin, 1997) where the concept of relationships recasts the traditional meaning of autonomy from being *self*-centered to being *other*-centered. In this context,

relationships do not impede or limit autonomy; rather, relationships expand autonomy by considering the other's point of view and acting on promises and commitments to that other person. Moreover, the interpretive understanding of the interplay between autonomy and defining or shaping one's identify has been grounded in Gilligan's findings on female moral development. The nursing literature has yet to explicate through research, however, the central role of the patient and its relationship to professional identity development. Yet the centrality of the patient to nursing and NP practice is well-known by all professional nurses through tradition and the professional code of ethics. The latter is unquestionably a moral guideline that at once situates the patient centrally to all professional nursing care, and it is a moral compass for professional behavior in the provision of that care and could be interpreted as also shaping one's identity.

The finding that the participants' language excluded the immediacy of the physician from the NP-patient space had meaning inasmuch as NPs were responsible to and accountable to the patient. This meaning, however, did not exclude the spectrum of relationships (*albeit* outside of the exam room) in which Having Genuine NP Practice was constructed. The importance of having mutually respectful, trusting relationships with physicians and others in the practice environment broadened the genuineness or reality of their autonomy through social power. Within relationships that were not as mutually respectful or trusting, some participants in this study confronted professional inequality and social powerlessness by shaping the meaning of their autonomy as the

same as, or no less than, the observed physician coworker's autonomy. In this way, participants found validation and authority for their NP practice. While researchers have found that autonomy is corroborated within collaborative, collegial relationships (Burgess & Purkis, 2010; Fairman, 2002; Maylone, Ranieri, Griffin, McNulty, & Fitzpatrick, 2011), others (Martin, O'Brien, Heyworth, & Meyer, 2005) substantiated that "tensive issues" in the practice environment impeded NP-physician relationships and NP autonomy. Street and Cossman (2010) also found that physician familiarity with NPs did not necessarily breed respect because not all physicians perceived NPs as professional equals. Nevertheless, how NPs understood the meaning of their autonomy within the context of NP-physician relationships was substantiated at least indirectly.

The study finding that some participants gave up sanctioned autonomy when faced with cultural attitudes within the wider healthcare system has not been reported elsewhere. However, the enduring belief in hierarchical traditions in which the physicians have full authority has been reported (Martin, O'Brien, Heyworth, & Meyer, 2005; Street & Cossman, 2010). The American Medical Association (AMA) (2009) report further substantiated the cultural context within which participants in this study practice daily. In effect, the AMA report mirrored the social and cultural environment in which the study participants found themselves. It must be reiterated, however, that although some participants' autonomy was either given up, obscured, or hidden, the participants nevertheless understood themselves to be autonomous. Although Kaplan and Brown's (2007) study focused on NPs' experience after legislative changes, they, too,

found that NPs did not change the extent to they perceived their autonomy, suggesting NPs found ways to work around the system. Surprisingly, workarounds in the present study were referenced only by those participants in independent practice as a strategy to ensure reimbursement from payers who did not credential NPs. Working around was also viewed as incongruent with advanced practice nursing as a true profession.

Self-reliance. Interpretation of the sub-theme, self-reliance, came directly from participant language of being alone and their understanding of autonomy within the context of having control over their practice. Participants indicated a very strong feeling of autonomy, with most rating their self-perceived autonomy as 10/10. But, within the context of the Oklahoma scope-of-practice restriction for prescriptive authority, participants understood their autonomy as 7/10. Nevertheless, participants interpreted their meaning of autonomy in daily practice as unaffected because this practice restriction did not legally require the physician to be on site. Additionally, participants saw themselves as competent in prescribing those drugs that are common in their everyday practice. Practice restrictions, therefore, were termed "a farce." Other researchers have also found that NP participants in their studies reported high perceived levels of autonomy in their respective practice environments (Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007). More specifically, Whelan's (2000) findings that practice restrictions made no difference to how NPs practiced led to the conclusion that practice restrictions served no valid purpose.

Self-empowerment. As a powerful professional and personal reward, self-empowerment was an integral part of Having Genuine NP Practice. Interpreted through the language of participants' narratives of patient care, their stories reflected the fusion of "being right"—that is, being competent, having an impact on patient outcome, and fulfilling professional duty gave meaning to their autonomy. Self-empowerment was a professional reward, that was intrinsic. It was a function of participants' self-reflection on their care. Self-empowerment in this study was similar to the psychological empowerment described by Boudrias (2004).

Using the widely-used Dempster Practice Behavior Scale (DPBS), researchers have found that empowerment is an integral variable in autonomy (Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Maylone, Ranieri, Griffin, McNulty, & Fitzpatrick, 2011). However, the results of the empowerment scale could not be compared or used to validate this study's findings. Moreover, given the use of hermeneutics, the DPBS would have been an inappropriate measure for the present study.

Defending the NP role. The sub-theme, defending the NP role, was interpreted from participant narratives of challenges they faced in the work environment. By defending their role, these NPs shaped the meaning of autonomy because they believed in themselves as professionals and autonomous primary care providers—they believed they had Genuine NP Practice. Indeed, they felt like a primary care provider as opposed to a physician extender or mid-level provider. Faced with the dilemma of being held to the same standard as physicians, yet denied equal legal authority, was professionally

offensive. Being labeled a mid-level provider was understood by some participants as physician control—it was also understood as physician misunderstanding. That some NP coworkers did not have a mutual understanding of their role was a rebuke of the profession in favor of supporting the physician as the only primary care provider.

Similar challenges have been documented in the literature as persistent barriers to NP practice (Lindeke, Bly, & Wilcox, 2001; Lindeke, Jukkala, & Tanner, 2005; Street & Cossman, 2010; Safreit, 2010). That physicians continue to regard the NP as a physician extender is also captured in the literature by Street and Cossman who contended that physician resistance to NP autonomy stemmed from the need to retain professional sovereignty. In the present study, however, participants shaped their autonomy around their identity as professional NPs, a finding that must wind back to Gilligan (1993) and Dworkin (1997) who both support the finding that autonomy and how one's self-conception of who they are and the person they want to be, are closely linked.

Implications of the Study

Advanced Nursing Practice

This research highlighted the importance of understanding the meaning of NP autonomy and provided insight at the individual level of what autonomy means amid the professional rewards as well as daily struggles. New knowledge from this study advances the NP role by clarifying and delineating the meaning NPs ascribe to their understanding of autonomy. Knowing, therefore, informs the advanced practice profession through the understanding that having genuine NP practice situates the NP

professionally in a social sphere where healthcare reform demands the expansion of healthcare services for the U.S. public. Moreover, new knowledge and understanding of what Having Genuine NP Practice means will enable the NP clearly to articulate and better influence healthcare reform.

Findings from this study can also be incorporated into talking points to educate legislators and policy makers. NPs who participated in this study had increased insight into their then-current level of autonomy. Importantly, the study gave participants' a voice for other NPs to listen to, to question, and to raise their own self-awareness about the nature of their autonomy in their everyday practice.

Graduate Nursing Education

Faculty in graduate nursing programs are urged to integrate new knowledge gained from this study into their curricula at both the master's and doctoral levels. Doing so will enhance a deeper understanding and value for NP autonomy and Having Genuine NP Practice. Moreover, knowledge from this study can be integrated into courses to further the understanding of the social, cultural, and political issues NPs face daily. This study brought to light the importance of reëvaluating curriculum content to ensure student NPs and new graduates are socialized to the autonomous role. Faculty are further urged to push for interdisciplinary education between NPs and medicine to reshape and revise a culture of healthcare in which the concept of "physician-only-provider" is reëvaluated. This might be achieved by bringing medical and NP students together for common

instruction on the nature of each role. Health policy is another arena that could be jointly explored.

Nursing Research

Implications for future nursing research that have emerged from this study are extensive. Further research should be carried out to substantiate the concept of Having Genuine NP Practice. Additionally, this research provided groundwork data for future research in development of (a) an instrument to quantify the autonomy of practice that is specific to the NP, and (b) a model for *autonomous* NP practice. Little is documented in the literature on early socialization of new NPs to their role, and this would make an interesting and valuable study. It would also be both illuminating and instructive to carry out a study to determine whether NPs see their role as primarily medical or primarily nursing (health promotion and disease prevention). Although not within the scope of this study, the answers may be critical to the future of advanced practice nursing. Finally, McLain's (1988) study should be repeated because it provided an important perspective of barriers to NPs' having a collegial relationship that results from the attitudes of NPs themselves.

Summary

NP autonomy is a complex concept. Revealing how NPs understand the meaning of their autonomy in everyday practice led to the overall meaning as Having Genuine NP Practice. Understanding how NPs in this study shaped Having Genuine NP Practice provided insight into their daily practice, their professional self, the integral part that

relationships play in the everyday life of being an NP, and daily struggles. This study showed that the power of social and cultural ideology cannot be understated.

Understanding social impediments to NP practice autonomy is the first step to effecting change. One can change legislation to move forward with healthcare reform, but if social and cultural ideologies prevail as highlighted by participant narratives in this study, autonomy will continue to be given up and unrecognized, and it will remain hidden. If this occurs, NPs are likely to remain in the middle as mid-level providers.

The conversation about autonomy has not ended; indeed, it has only begun because from this study, new questions will be asked and new answers brought forth as NPs join the dialogue nationwide in the pursuit of becoming fully autonomous. The question, "Are we ready?" has been raised (Weiland, 2008). Findings from this study indicated that the answer to that question is 'yes'. However, both medicine and nursing as a whole must be ready for changes to the culture of healthcare that allow expanding and advancing the nation's healthcare services and that honors the distinctive contributions each profession makes to that advancement. Only then, will both medicine's and nursing's obligations to society be met.

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APPENDIX A

Feminist Theoretical Assumptions

Feminist Theoretical Assumptions

Issues of Gender and Diversity

1. Differences should be recognized and respected equally and perceived as valuable within and among genders and cultures.
2. Social behaviors that mute or silence the voices of nurses must be revealed and understood.
3. Ways of knowing are important.
4. The medical model is not congruent with the goals of nursing.
5. Knowledge is relational, interactive, and contextual.
6. Sharp distinctions between theory and practice are artificial.

Sources of Knowledge

1. Women's experiences are legitimate sources of knowledge.
2. Informants are experts on their own lives.
3. Narratives of participants were a means to achieve their active involvement in the construction of data about their lives (Campbell & Bunting, 1991).

APPENDIX B

IRB Approval

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Institutional Review Board
Office of Research and Sponsored Programs
PO Box 425619, Denton, TX 76204-5619
940-898-3378 FAX 940-898-4416
e-mail IRB@twu.edu

January 10, 2012

Ms. Sandra A. Weiland

Re: Understanding the Meaning of Nurse Practitioner Autonomous Practice in Oklahoma: A Gadamerian Approach (Protocol #: 15997)

The request for an extension of your IRB approval for the above referenced study has been reviewed by the TWU Institutional Review Board (IRB) and appears to meet our requirements for the protection of individuals' rights.

If applicable, agency approval letters must be submitted to the IRB upon receipt PRIOR to any data collection at that agency. A copy of all signed consent forms and an annual/final report must be filed with the Institutional Review Board at the completion of the study.

This extension is valid one year from January 27, 2012. Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any unanticipated incidents. If you have any questions, please contact the TWU IRB.

Sincerely,

APPENDIX C

Informed Consent

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: Understanding the Meaning of Nurse Practitioner Autonomous Practice in Oklahoma: A Gadamerian Approach

Investigator: Sandra Weiland
Advisor: Jane Grassley, PhD

Explanation and Purpose of the Research

You are being asked to participate in a research study for Ms. Weiland's dissertation at Texas Woman's University. The purpose of this study is to understand the meaning of autonomy as it is interpreted by Nurse Practitioners through the lived experiences of their everyday practice. You have been asked to participate in this study because you are a NP practicing in primary health care.

Description of Procedures

If you consent to participate you will be asked to spend one to two hours of your time in a face-to-face interview with the investigator. The investigator will ask you questions about autonomy and the meaning of autonomy in your every day practice. There will be follow-up contact after the interview to verify and clarify things that you have said during the interview. Follow up will be either a face-to-face meeting, telephone call, or email and will last approximately 30 minutes. The interview will be done at a private location agreed upon by you and the investigator. The interview will be audio taped and then written down so that the investigator can be accurate when studying your words and thoughts discussed in the interview and to assure the accuracy of the reporting of that information.

Potential Risks

Potential risks related to your participation in the study include fatigue or physical discomfort. If you experience fatigue or physical discomfort you may take breaks as needed. You may resume the interview when ready or choose to reschedule. You may stop the interview at any time. The investigator will try to prevent any problem that could happen because of this research. You should let the investigator know at once if there is a problem and they will help you. TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Potential risk may also include emotional discomfort. If at any time there is emotional discomfort regarding the interview questions, you may refuse to answer any question or

Participant Initials

stop the interview at any time. You can choose to resume the interview when ready, reschedule, or end the interview.

Another potential risk related to your participation in the study includes loss of confidentiality. Confidentiality will be protected to the extent that is allowed by law. You will be allocated a code name and the code name will be used on the audio tape and transcription. No one but the investigator will know your real name. Interviews will be conducted in a quiet, private location that will be determined by you and the investigator. Only the investigator, the advisor, and the professional transcriptionist will have access to the tapes. The tapes, hard copies of the transcriptions and the computer diskettes containing the transcription text files will be stored in a locked filing cabinet in the investigator's office. The consent form, with all identifying information, will be stored in a separate locked filing cabinet. Although there is the potential for loss of confidentiality in all email, downloading and internet transactions the computer will be password protected, firewalled, and virus protected. All data will be erased, shredded, or deleted within five years after the study is finished. It is anticipated that the results will be published in both the investigator's dissertation as well as other research publications but your name or any other identifying information will not be included in any publication.

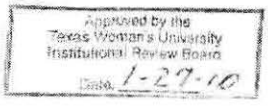
There is the potential risk for coercion because the investigator is a Board Member and a Regional Representative of the Oklahoma Nurse Practitioner Association. However, neither the investigator nor the Oklahoma Nurse Practitioner Association have any authority to influence your decision to join this study. Participation in this study is completely voluntary. If you decide not to join the study, or decide to withdraw at a later time this decision will in no way affect current, or future membership in the Oklahoma Nurse Practitioner Association.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time. At the completion of the study you will receive a $10 gift card from Target for your participation. If you wish to have a copy of the results of this study we will mail them to you. An indirect benefit from participation in the study may include a personal and professional sense of achievement by contributing knowledge to this study.

Questions Regarding the Study

If you have any questions about the research study you should ask the investigator and her advisor. Their phone numbers are at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu. You will be given a copy of this signed and dated consent form to keep.



Participant Initials

Participation in this study is completely voluntary and you may withdraw at any time without penalty.

_____ _____

Signature of Participant Date

*If you would like to know the results of this study tell us where you want them to be sent:

Email: _____
or
Address:

_____

_____

_____

APPENDIX D

Oklahoma Nurse Practitioners Website Permission

337 NE 8TH STREET
OKLAHOMA CITY, OKLAHOMA 73104

PHONE: 405-949-8738
FAX: 405-445-4864
INFO@NPOFOKLAHOMA.COM
WWW.NPOFOKLAHOMA.COM

July 12, 2009

Sandra Weiland, ARNP

Dear Ms. Weiland:

Please accept this letter as your authorization to utilize our website, **www.npofoklahoma.com**, for your research study. Your request was approved by the Executive Board of the ONP, July 11, 2009.

Please contact Susie Brown, Webmaster, ONP, for further instructions on how to get your request link on the website. You will be responsible for all charges related to this request, and will remit to ONP upon request.

Good luck on your research, and please let me know if we can be of further assistance in your endeavor.

Sincerely,

APPENDIX E

Recruitment Notice and Script

Recruitment Notice

Sandra Weiland, ARNP, is a Ph.D. student at Texas Woman's University and is seeking NPs to participate in a research study about NP autonomy in practice.

To participate you must:

- Possess an unrestricted license to practice in Oklahoma
- Possess prescriptive authority
- Practice in primary care
- Practice full-time (>36 hrs/week) or part-time (>24 hrs/week)

You will receive a $10.00 gift certificate from Target for participation. For information on participating in this study, call Sandra Weiland at 214-XXX-XXXX.

- **Location:** To be determined by the investigator and participant

- **Study Title:** Understanding the Meaning of Nurse Practitioner Autonomous Practice in Oklahoma: A Gadamerian Approach

- **Contact:** Sandra Weiland 214-XXX-XXXX (cell), or email

Recruitment Script

- Thank you for responding to the invitation to join the study.

- I would like to let you know that at any time during our conversation if you have any questions or concerns I want you to feel free to ask.

- Let me begin by telling you about myself and the study. My name is Sandra Weiland. I am a Family Nurse Practitioner. I am a Ph.D. student at Texas Woman's University. As part of the Ph.D. degree, I am conducting a dissertation study. The purpose of this study is to understand the meaning of autonomy as it is understood by you in your everyday practice.

- Would you be able to give 1-2 hours of your time for interviewing?

- The interviews will be conducted one-on-one and will be tape recorded.

- The interview will be carried out in a private area.

- There will be follow-up contact to verify and clarify what is said during the interview. Follow-up will take approximately 30 minutes.

- Do you have any questions at this time?

- When we meet and before we begin the interview, there will be a consent form for you to read and sign. After you've agreed to participate in the study and you are clear about your participation in the study, we will conduct the interview in a private, quiet, place.

- I would like to ask you some questions:

    - Do you have an active license to practice in Oklahoma?
    - Do you have prescriptive authority?
    - Where do you practice?
    - Are you still interested in being part of this study?
    - Where would you like to meet?
    - When would you like to meet?
    - What day and time?
    - Do you have any questions at this time?

APPENDIX F

List of Interview Questions

List of Interview Questions

1. Tell me about yourself:

    a. Your education and certification
    b. Belong to professional organizations
    c. How many years of practice
    d. The type of practice environment—e.g., NP-owned clinic, physician-owned clinic, State Health Department, Federal health clinic, etc.
    e. Are you credentialed with Medicare, Medicaid, third party insurers?
    f. How many patients on average do you see a day?
    g. Are these patient encounters billed under you?
    h. Do you have a DEA number?

2. In general, how would you characterize autonomous NP practice?

3. How do you define autonomous practice?

4. What does autonomy in your practice mean?

5. If you had to place your level of autonomous practice on a continuum, how would you describe it?—e.g., on a scale of 0-10, 0 = *none at all* to 10 = *full autonomy* based on the legal authority as described by the Oklahoma Nurse Practice Act.

6. Tell me about the organizational culture of your practice environment.

7. Whom do you work with?—e.g., Do you work with other NPs, PAs, physicians?

8. Tell me about your relationship with other medical practitioners.

    a. How often do you have contact with other providers?
    b. What rewards, frustrations, or even conflicts have you experienced related to autonomy in your practice environment? For example, if there was a difference of professional opinion regarding management of care for a patient whom you are managing, how would you handle that conflict?
    c. How does that influence how you practice?

9. Tell me a story about your best practice experiences.

    a. What did that experience feel like?
    b. How does that experience influence how you practice?

10. Tell me a story abut your worst practice experience.

    a. What did that experience feel like?
    b. How does that experience influence how you practice?

11. Is there anything else you would like to talk about?

APPENDIX G

Sub-Themes or Parts of the Overall Meaning of "Having Genuine NP Practice"

Sub-Themes or Parts of the Overall Meaning

of "Having Genuine NP Practice"

Sub-theme	Participants' comments
Relationships	"Patients like us; they like our care."
	"I just feel like I am able to guide patient's autonomy. This is where I am helping the maximum number of people change their lives. . . . I try to encourage [the patient]. I don't try to do blanket care; it is part of autonomy. I don't have a cookbook."
	"Certain physicians don't recognize the authority we have. They [physicians] do not recognize any [NP] autonomy at all."
	"I really enjoy learning with them [resident physicians] and being invited to things with them, and we teach each other."
	"We are seeing the patient together [in the hospital], but if I say I really think they need XYZ, he defers to me unless he really thinks I am just off the wall, then we will talk about it."
Self-reliance	"I do it, I have no review, I do not ask for permission or report to anyone."
	"Autonomy is where you have to stand on your own feet; it is your responsibility . . . it is also a privilege to do this care."
	"We have a sick population here. We are the second biggest immunizer besides the health department . . . so, yeah, autonomous, yeah, I feel like I am a '10' for what I do, but I am a '7' because they don't allow us to be fully autonomous . . . oh, it is huge."

(continued)

Sub-theme	Participants' comments
Self-reliance (continued)	"Every time I pick up a prescription pad to write a prescription and the supervising physician is my friend, so this is not directed to him, I appreciate him, but I think this [supervision] is a farce. This is what I generally think. None of this is reviewed, none of it is, and it is not because he [the physician] is not doing his job because all the state of Oklahoma requires is that their [physician] name is on the file and so I am making all the other decisions and I am intelligent enough to not treat a patient or write a prescription just because I can—I mean, I am not going to do that, you know. So when I make a decision to select a particular treatment, it is based on evidence; it is based on research in practice. I use the same guidelines every other primary care provider uses, and I probably use them more than a lot of physicians."
Being empowered	"I do what I do because I care, and I do what I want to do if I want to order that med, I will order that med. You know, I don't consider it as my physician wants me to do it." "It just swells your heart when you get these patients that are just so thankful. It encourages me; I am doing the right thing." "I know I have made a difference when I am there [in the clinic] so I think a lot of the reward is knowing I have done what I was supposed to do, and I help people. That is really the only reward I get." "I kind of think they're [the health care team] the spokes on the wheel because I am back here in the family practice setting with all the documentation. I am the keeper of the whole picture, even though I can't do all that alone—none of us can, but I am the one who can say 'ok this didn't work, this did work, this is great, and now we are all on the same page.'" "Family practice is not rocket science. I'm intelligent enough to not treat a patient or write a prescription just because I can. I mean, when I make a decision to select a particular treatment, it is based on evidence, on research."
Defending the NP role	"We need to push forward into what we are trained; we are not physicians, we are not trying to be physicians, or we should not be trying to be physicians, but there is definitely a place for a NP in the primary care arena as an autonomous provider. Period."

(continued)

Sub-theme	Participants' comments
Defending the NP role (continued)	"In the primary care arena, there's not a physician in my office, so therefore I am not a physician extender."
	"He [the physician] always told me, you are not a doctor, you will never be a doctor. I know I am not a physician. I don't want to be a physician."
	"I think it is social in the way that we are under the gun, so to speak, we are monitored."
	"The biggest hindrance to nurse performance really is NPs themselves, 'but I enjoy the security [when] somebody is there for me'—this is what they say. If you want to fall back on someone and not use the degree like it should be used, you should have stayed a registered nurse."
	"Globally, I think doctors don't understand the role of the NP. . . ."