AN OCCUPATIONAL STUDY: NURSE PRACTITIONER PRIMARY CARE PROVIDERS

by

JEFF SCOTT SHELTON

(Under the Direction of James E. Coverdill)

ABSTRACT

This dissertation explores and examines the factors that influence perceptions of nurse practitioners (NPs) toward their work and profession. This study uses both qualitative and quantitative data. This project relies on interviews with nurse practitioners who work in primary care non-hospital settings to explore their perceptions of their roles and professional identity. Additionally, these interviews are analyzed to understand the participant's perceptions of how autonomy and job satisfaction are created and conceptualized through their lived experiences. The second source of data, the National Survey of Primary Care Physicians and Nurse Practitioners 2012, is a cross-sectional data set of Physicians and Nurse Practitioner primary care providers in the United States. These data are used to examine further the factors that influence job satisfaction and autonomy.

The inductive analysis shows that NPs engage in dual-boundary work; that is, they maintain their nursing identity while carving out a unique provider role that is different from that of a physician. Additionally, interview data showed that NPs place a high value on the interactions in the clinical space. NPs shared narratives of social interactions with co-workers and patients that, in turn, create perceptions of satisfaction. Additionally, these data show

nuanced perceptions of autonomy, including unanticipated views on when and how and NP should gain autonomy from medical supervision.

Lastly, the quantitative analysis highlights two important influences. First, the amount of time spent on tasks does not influence feelings of satisfaction and that it is the perception of that time that matters most. That is, when nurse practitioners feel that the time, they spend is the right amount of time, this influences satisfaction, regardless of the quantity of time. Lastly, the computerization of medical records profoundly impacts perceptions of autonomy and job satisfaction. While computerization makes the work easier, it also reduces satisfaction and perceptions of autonomy.

INDEX WORDS: Nurse Practitioner, Job autonomy, Job satisfaction, Profession boundaries, Emergency Medical Records

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DEDICATION

I dedicate this work to two incredible souls. To Barbara, who was called from this plane of existence too soon and who shared with me the world of dreams and laughter. To Linda, for all your sacrifice, encouragement, love, and support. You are my mom and my best friend.

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The work of nurse practitioners and all those who work in the healthcare field is vital. As I write this, the Coronavirus 19 pandemic has the world in a deathly grip. Every day I read posts and comments from healthcare workers who are struggling with a lack of resources, sleep, constant stress, and concern for their patients, colleagues, and families. Their work is heroic, and it is time for all healthcare workers to be acknowledged, protected, and revered for what they contribute to society. This project is academic; however, it also has the purpose of educating others on who nurse practitioners are and what they bring to healthcare.

I want to offer my thanks and gratitude to Jim Coverdill. His humor, guidance, advice, and persistence helped me stay focused and drive through to the end. I will never forget our walks in the Georgia summer – in the middle of the day – and our conversations over a cup of coffee. You helped me to navigate the academy and inspired me to think deeper about my work. The dissertation and my education would not have been the same without you, and I thank you.

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CHAPTER 1

INTRODUCTION

Nurse practitioners (NPs) represent a relatively new and crucial occupational group. NPs hold two occupational locations, that of a registered nurse (RN) and that of a health care provider. Their position in the healthcare field makes the profession unique to study because they are neither just nurses nor are they physicians, yet they claim membership to the former and distance themselves from the latter. This dissertation explores NPs as a strategic profession that allows for an examination of boundaries, professional identities, and perceptions of work.

In recent decades, the division of labor in health care has increased, with new occupational groups emerging and providing care. The emergence of NPs is a prime example of this trend. Over the past 50 years, NPs emerged from the ranks of RNs to become a distinct occupation. As of 2018, there are an estimated 248,000 NPs licensed in the U.S.(AANP 2018). The United States Bureau of Labor and Statistics ranks NPs as the sixth fastest-growing occupation (BLS 2018) with a projected growth of 26% between 2018-2028 (BLS 2018b). In comparison, the average growth rate in the health care field is 18% (BLS 2018), with the overall growth estimated at 7.1%.

Today a little over 86% of NPs are certified in primary care, and 77.8% work in primary care (AANP 2018c). NPs have prescriptive authority in all 50 states; however, the breadth of that privilege varies between states. Of those prescribing medications, NPs write an average of 23 prescriptions a day according to the AANP sample survey for 2016 -- the most up to date information for this measure. The NP workforce in 2017 -- the most recent data available -- is

92% female, an average of 49 years old, predominately white, non-Hispanic with a little over 97% holding a graduate degree. The average salary for NPs, regardless of specialty and hours worked, is over $103,000 (AANP 2018a).

The expansion of the profession of NPs is situated in the growing need to supply health care services. According to the Association of American Medical Colleges, recent estimates of the shortage of primary care physicians range between 14,800 and 49,300 by 2030 (AAMC 2018). The lack of providers varies by the predicted growth of non-physician providers and the level of their utilization (AAMC 2018). The same AAMC report examines findings that suggest that the full use of non-physician providers could result in reducing the gap between the supply of health care providers and demand.

However, the implementation of NPs can vary depending on the professional culture and organizational policies (Reid-Ponte 2018). Furthermore, it is micro-interactions that operate between individuals that are crucial in creating the practice environment and the NP's role as a primary care provider (Poghosyan, Nannini, Smaldone, et al. 2013). The diffusion of the occupation of NPs is occurring at different speeds and to varying levels of implementation, making them a promising group to study.

Also, previous studies suggest that NPs have low levels of job satisfaction, and often feel constrained in their clinical activities (Bryant-Lukosius et al. 2007; Faris et al. 2010; Kacel, Miller, and Norris 2005; Ryan and Ebbert 2013; Schiestel 2007). However, those studies offer little insight into what activities or experiences facilitate or thwart perceptions of satisfaction or contentedness with their clinical work. As a profession situated between M.D.s and registered nurses, NPs represent an ideal group with which to explore classic issues regarding boundary work and perceptions of work such as job satisfaction and autonomy.

The sociology of work has long shown an interest in investigating one profession deeply to examine and explore relevant issues. For example, Lortie (1975) studied, among structural and historical factors, school teachers' attitudes toward work and specific tasks. Other examples include Haas and Shaffir's (1987) examination of the professionalization process of doctors, Rinehart's (1997) exploration of the influence of the adoption of lean production methods on workers in a Canadian car factory, and Finlay and Coverdill's study (2007) of the careers and work of headhunters, to name a few. What all of these have in common is the exploration of one occupation to understand patterns of socialization, work practice, and perceptions of work.

The current project focuses on nurse practitioners to study and analyze their perceptions of professional identity and work. That is, how do they perceive the boundaries of their profession, and how do they view their work within these bounds? In general, research on the creation and maintenance of work boundaries has helped to conceptualize how groups control work, clients, knowledge, and communication privileges (Abbott 1988; Gieryn 1983; Nancarrow and Borthwick 2005; Stein 1969). Traditionally, studies have invoked a one-versus-one model by which boundaries and relationships of a given profession are driven by the goal of complete dominance (Freidson 1970, 1988; Larson 1979).

In contrast, Abbott (1988) proposed a “system of professions” approach that highlighted the interdependence of professionals who vie for control over tasks and legitimacy (Abbot 1988; Abbott 2005; Lamont and Molnár 2002). Each contest and shift in one profession can influence others. Several works have used a systems approach along with historical analysis to illustrate the emergence and changing nature of professions at the macro-level (e.g., Goodrick and Reay 2011; Starr 1984; Abbott 1982; Fairman 2009). Analyses of historical and macro-level aspects of boundaries have been fruitful. However, they tend to reify boundaries as “clear-cut.” Several

scholars have argued that boundaries are much more flexible at the level of work itself (Allen 1997; Timmons and Tanner 2004) and that dominance and competition are not always the main goals of those who work in professions (Liu 2015).

A study of NPs holds the potential for understanding the work of these professionals and broader questions in the sociology of work and occupations. For example, the flexible nature of boundaries is negotiated in modern health care and how perceptions of work are created and maintained on the "shop-floor" for professionals in healthcare.

Dissertation Overview

Each chapter contains a brief literature review to situate the findings into the broader literature. In Chapter 2, I review the history of nurse practitioners, how they came to be formed, and the relevant issues concerning the profession. Chapter 3 discusses the methods and data used in this dissertation. Five chapters present the findings. Chapter 4 highlights how NPs discuss roles and professional identity. NPs work to maintain their nurse identity but also develop a position as a healthcare provider – which is beyond the role of a registered nurse. The goal to keep and create these roles presents what I refer to as a dual-boundary puzzle. This chapter discusses this issue and how NPs navigate and perceive these roles. In Chapter 5, the narratives of NPs are presented as they relate to job satisfaction. Building off the survey-based research that dominates the NPs literature, this person-oriented data explores how NPs perceive what makes for a good or bad day and emphasizes the importance of interpersonal interactions in the clinic. Chapter 6 explores perceptions of autonomy. Given the historical context of nurses being subordinate to physicians and the professional level conflicts over jurisdictions studying NPs perceptions of autonomy is logical. Far from a call for full independence, the stories and opinions of the participants put forward a nuanced view. While many feel complete freedom to

work within their training and education is necessary, how this is achieved and when in the NP career track varies. This chapter unpacks these nuances and builds a more elaborate explanation of what autonomy means.

The next two chapters report on the quantitative results from the analysis of the National Survey of Primary Care Physicians and Nurse Practitioners 2012, described in more detail in Chapter 3. The results of a quantitative analysis examining perceptions of job satisfaction are reported in Chapter 7. The literature and the qualitative findings presented in Chapter 5 highlighted the salience of time for NPs and motivated a deductive analysis to examine specific factors. The deductive analysis in this chapter unpacks perceptions of time spent across six task areas on feelings of job satisfaction. Two aspects of time are used, the weekly percent of time spent on each task and the perception of the time spent as being about the right amount. The results suggest that the opinion of the time being just right is the most critical factor influencing levels of job satisfaction and that the amount of time has no effect.

Chapter 8 offers the results of the analysis of how medical records systems and their computerization affect perceptions of autonomy and job satisfaction. Much has been written on how electronic medical records (EMR) have received resistance and on the attitudes of physicians toward EMR. Little research has examined how NPs perceive EMR or how these record systems influence the perception of work for NPs. Computerization and EMRs are a central feature of a healthcare professional's work and justify further study concerning job-related attitudes. Lastly, Chapter 9 highlights the main results of this project, contributions to the literature, limitations, and future research.

CHAPTER 2

ESTABLISHMENT OF NURSE PRACTITIONERS

This chapter starts with a description of the NP profession, including a brief history of their emergence, educational and licensing requirements, and variation in the legal status of NPs. The second section provides a review of scholarship that illustrates the importance of a study of nurse practitioners and will unfold in two main sections. Each of the proceeding findings chapters will include a review of the relevant body of research.

History of Emergence and the Merging of Nursing and Medicine

The complex history of nurse practitioners spans over 50 years. Given the time and space restrictions for this chapter, the information in this section will focus on the pertinent factors that contributed to the formation and expansion of the NP role. Several works, most notably Fairman (2008, 2009) and Fairman and D'Antonio (2008), provide comprehensive historical research on the NP occupation and are central sources for this chapter. While no single factor or a linear chain of events led to the emergence of NPs, two broad themes can be identified from the literature that have contributed and continue to drive the transformation of the occupation. The first theme is the increase in the public need for health care. The second theme is that legislative bodies, as well as many nursing and medical professionals, have recognized the need to increase the number and skill of health care workers to meet public needs. These two themes have allowed for opportunities that supported the expansion of the nursing role and the development of the NP occupation. The following section will describe these two themes and the significant events involved in the creation and continuing growth of the occupation.

In most accounts of the history of NPs, Loretta Ford, a pediatric nurse working in public health in Colorado, is considered to be a central figure and the founder of the NP role. Working to improve access and delivery of well-child examinations, Ford, in the early 1960s, advocated for expanding the role of public health nurses (Ford 1997). In 1965, Loretta Ford and Dr. Henry Silver started a program at the University of Colorado to train public health nurses in an expanded role (AANP 2018b). The goal was to train nurses in advanced techniques and knowledge, as well as to give M.D.s a highly trained clinical assistant and collaborator (Fairman and D'Antonio 2008), specifically to work in primary care settings (Fairman 2008).

The expansion of the role of public health nursing to meet the needs of children in the community was the principal goal (Ford 2015). As Loretta Ford recalled in an article in 2015, "[the physician] shortage did give us 'the opportunity' to demonstrate that public health nurses could be qualified to meet well-child health needs" (Ford 2015:295), but was not the primary driver. This program aligned with the goals of other nursing professionals, and in 1967, Boston College, established the first NP masters level program. By 1973 there were over 65 NP programs, and by 1980, 200 programs or tracks training NPs were available in the U.S. (AANP 2018a). Ford, like many other nurses in both academic and research settings, believed that nurses could be trained to expand their role beyond task-orientated skills and be more involved in the diagnosis and treatment of patients (Fairman and D'Antonio 2008). To this end, this goal meant that a new role needed to be forged.

The NP developed from two different role sets: that of the nurse and that of the physician. Nurses were trained in caring for patient's hygiene needs, doing basic tasks under doctors' orders, and consoling the patient (Bates 1975). The tasks of taking a patient's history, conducting an examination, developing a prognosis, and creating a treatment plan -- also understood as

clinical thinking -- were the domain of the physician (Fairman 2009). The expansion of the role proposed a sharing of the latter domain. However, on an informal level, nursing sharing the tasks of medicine was not entirely new. Bates (1975), as an M.D. and a co-director of nurse practitioner programs, observed that nurses were often called upon to take on tasks of physicians when there was a time constraint, such as late at night or when the M.D.s allowed it. However, the role expansion of nurses into that of an NP was a deliberate and explicit move into the domain of doctors.

Making a move from nurses occasionally working in the physician's domain to having those tasks be part of their role meant a change in training. Specifically, it meant a change in the knowledge needed to make a prognosis, diagnosis, and treatment plans based on knowledge and clinical experience—also understood as clinical thinking (Benner, Hughes, and Sutphen 2008; Fairman 2009). Ford, among others, advocated for clinical thinking as part of a nurse's training and thereby expanding the nursing role in providing care and meeting public health care needs. (Fairman 2009). The interest in expanding the nursing role was not new, and the nursing profession did not fully support such an expansion. However, the social, political, and professional changes of the 1960s and 1970s created an opportunity for the expansion of nursing into the domain of medicine (Fairman and D'Antonio 2008; Ford 2015).

The expansion of the nursing role and programs to train nurses in clinical thinking was taking place in a social environment where the organization of health care and the complexity of patients was also changing. During the 1960s and into the 1970s, the increase of medical students choosing to enter specialties over primary care created shortages in providers to care for public health care needs of the chronically ill, elderly, children, and those in need of preventive care services (Dunn 1997). At the same time, entitlement programs -- Medicare and Medicaid --

provided an increase in the number of patients who could access care and specifically gain access to acute and specialty care. In turn, this brought more complex patients to hospitals and clinics, which required a more specialized medical workforce (Dunn 1997; Fairman 2009).

Responding to this change in need, the surgeon general commissioned a study in 1963 into nursing (Fairman 2009). It was clear that the training of nurses needed to be examined and reviewed, considering the changing healthcare needs of the public and the demands put on nurses who delivered that care (Hassenplug 1963). Among their recommendations was to increase the training of nurses to include a bachelor's in nursing. Most nurses at the time held a nursing credential earned in a diploma program run by a hospital. These types of training programs resulted in a limited education as well as a limited familiarity with other healthcare settings such as clinics in the community providing primary care (Fairman 2009).

Following the publication of the report commissioned by the surgeon general, several changes were made to the funding for the development of four-year nursing programs. For example, The Nurse Training Act of 1964 (NTA) helped to fund the creation of baccalaureate programs for nursing as well as to support student loan programs (Fairman 2009). These four-year programs helped students develop the necessary training requirements to meet the increase in patient complexity. Notably, the creation of comprehensive nurse training also meant that more nurses would have the fundamental training needed to become NPs. While not the focus of the report, the support and reorganization of nursing education allowed for an opportunity to increase the potential pool of prospective NP students (Fairman 2009).

Other central legislative actions that assisted the growth of NPs included the passing of The Rural Health Clinic Act of 1977 that required that federally funded rural health clinics ensure that 50% of their services were provided by NPs, certified nurse-midwives and physician

assistants (O'Brien 2003). Another milestone legislation, the Balanced Budget Act of 1997, allowed for NPs to be recognized as providers and bill directly Medicare for their services (O'Brien 2003). In short, the late 1960s started an NP movement that brought attention to the promise of NPs to all levels of government and started the establishment of organizations and channels of support to expand the role of nurses and NPs.

Establishing a Foothold

While the expansion of the nursing role and the development of programs garnered broad support, it was not without conflict. For nursing, the first obstacle was to convince nursing faculty, administrators, and notably the American Nursing Association, that nurses could engage with clinical thinking and intellectual reasoning as part of their role (Fairman 2009). Central to the resistance was the tradition of nurses being taught to see M.D.'s as the source of direction and knowledge and that their role was to follow doctors' orders on a rule-based mentality that was not to be challenged (Bates 1975; Fairman 2009). The ANA was viewed as slow to advocate for advanced practice nurses and work to establish educational and credentialing standards. Inter-professional conflict slowed the process of establishing NPs as a separate occupation and, therefore, needed organization support for changes in education and licensing (Fairman 2009).

The 1970s and 1980s were a time of significant change and a time of organization for nursing. Some groups and social actors worked to develop cohesive and streamlined educational standards and certification processes. Several central events are of note. Staring in the late 1960s, advanced nurses began to create organizations based on their specialty. These organizations were local in nature and organizational structure (Fairman 2009). However, these groups did not have the power to establish national norms or standards. In 1973 the National Organization of Pediatric Nurse Practitioners was established, representing most NPs practicing at that time. The

formation of the professional organization was followed by the creation of the Council of Primary Care Nurse Practitioners by the ANA, giving a voice to primary care NPs. By 1985, the American Academy of Nurse Practitioners (AANP) -- currently known as the American Association of Nurse Practitioners -- was established and began a concerted effort to expand the role of NPs through state and federal legislative actions. The American College of Nurse Practitioners was formed in 1993, providing a professional organization to support the expansion of NPs by nursing faculty (O'Brien 2003). By the 1990s, both the practitioner and the faculty sides of the profession were represented by national organizations. The actions and initiatives of both organizations worked to strengthen the profession and standards of care.

The expansion of the nurse role allowed for more providers of care that were trained to treat the changing public health care needs. Equal in importance is the new social interactions between expanded role nurses and physicians that create new working relationships. Training programs opened an opportunity for nurses and physicians working in urban and rural areas outside of the hospital to develop clinical relationships and create professional boundaries that were not seen in other clinical settings. Focusing on the elderly, well population, and the chronically ill, nurses and physicians expanded the role of nurses as both clinical colleagues and on-site educators, sharing their knowledge and skillsets (Fairman 2009). In other words, the boundaries and hierarchical nature of the physician-centered model of health care became slightly more porous and open to alteration (Bates 1975).

Educational and Clinical Requirements

Nurse Practitioners (NPs) are Advanced Practice Nurses (APRNs) who have undertaken advanced clinical education and are trained to deliver care to a variety of population types and in different clinical settings. APRNs include certified registered nurse anesthetist (CRNA), certified

nurse-midwives (CNM), and clinical nurse specialists (CNS). (NCSBN n.d.). While this study focuses on NPs, it is important to note that NPs are one of the four recognized designations of advanced practice nurses. NPs are trained to diagnose, treat, and manage both acute and chronic health conditions (AANP 2018c). Also, NPs can order diagnostic tests and interpret the results depending on state laws. Educational pathways for NPs vary depending on the prior education of the aspiring NP. The typical path for a non-nurse to be trained as an NP is first to pass the RN licensure exam, gain one to two years' experience as an RN (this can vary by state and NP graduate schools), and then earn a graduate degree in nursing. A Master of Science in Nursing (MSN) is the minimum requirement for an NP, with some receiving a Doctor of Nursing (DNP). For RNs trained through an associate of nursing program or other diploma programs, there are hybrid graduate programs available (Nurse Journal 2014). Additionally, post-graduate degree programs are available for those who received a master's degree in another discipline.

While in graduate school, nurses choose a population focus, which includes family, adult-gerontology, neonatal, pediatrics psychiatric/mental health, and women's health. They also choose a specialty such as primary care, surgical, acute oncology, dermatology, and cardiology. Specializations can be changed, or new specialties acquired, any time after graduation by enrolling in a certification program for that specialty (Anon n.d.) After graduating with an MSN or DPN, the aspiring NP sits for the national exam. They must also comply with any state-specific requirements. For those NPs who will prescribe, they must apply for a DEA number (AANP 2018c).

In all, there are four steps to becoming an NP: become a licensed nurse; earn a graduate degree; pass a population-focused national certification exam; and meet state-specific qualifications for licensure (How Do Nurse Practitioners Become Certified? 2018). There are

five certification boards in the U.S. that give the NP national exam. Each board has similar requirements for those who wish to sit for the exam: an RN license; a graduate or post-graduate degree with a population focus from an accredited program; and transcripts showing that advanced courses have been passed in physiology, health assessment, and pharmacology (How Do Nurse Practitioners Become Certified? 2018). Except for the National Certification Corporation, all boards require a minimum of 500 supervised clinical hours in the chosen population focus. While the Institute of Medicine recommended residency programs to be part of the training for NPs, the standard currently used is that of supervised hours (Rugen et al. 2016).

Although an M.D. or AANP can supervise clinical hours, requirements vary by school. Also, supervised clinical hours are often left up to the NP student to arrange. While some graduate programs do have lists of preceptors that agree to oversee hours, many do not. After acquiring the national certification, licensure must be obtained in each state an NP seeks employment (How Do Nurse Practitioners Become Certified? 2018). A broad understanding of these variations is essential to conceptualize the position of the occupation of NPs.

Legal Status of Nurse Practitioners

There are considerable differences in scope of practice (SOP) regulations across states (Kilpatrick 2013; Poghosyan, Nannini, Smaldone, et al. 2013; Xue et al. 2016). While some states provide NPs with full SOP, others limit or restrict practice (Safriet 2002; Yee et al. 2013). According to the American Association of Nurse Practitioners, 22 states provide for full SOP, 16 give a reduced scope, and 12 provide for a restricted scope of practice (AANP 2018d). Yee et al. (2013) argue that restrictive SOP laws can limit the practice opportunities for NPs (such as working in a rural area), payer policies, and influence NPs perceptions of the work environment.

Given the variation in state-level SOP regulations, perceptions of autonomy and legitimacy of NPs must be explored within that macro-structure.

The AANP categorizes scope of practice laws into three categories (AANP 2018d); full practice, reduced practice, and restricted practice. Categorizations reflect variation in the levels of legal restriction on the practice of NPs. However, there exist differences in allowed scope within categories that must be accounted for in any typology. To unpack this issue, Kuo et al. (2013) utilized a classification dividing states into three groups based on allowing: independent practice and prescriptive authority, independent practice with some supervision for prescribing, and physician supervision over practice and writing prescriptions. Among their findings, they found a strong association between prescriptive authority and the number of patients Medicare patients seen by NPs. Similarly, Park et al. (2018) based their categorizations from Kuo et al. (2013) explored the association of independent prescriptive authority and perceptions of autonomy. Their findings suggested independent prescriptive authority as the central factor that contributed to higher perceptions of autonomy regardless of the level of general restriction over an NPs work.

Furthermore, while broad categorizations are useful, they cannot accurately depict the variation between and within states. Drawing from the 2017 American Medical Association state law chart on the legal status of prescriptive authority, two comparison examples illustrate this point (State Law Chart 2017). Both Georgia (GA) and California (CA) are considered restrictive states per AANP using the general broad categorization schema mentioned earlier. In Georgia, an NP is not permitted to prescribe schedule II-controlled substances while in California, they can prescribe these medications if they have taken some advanced coursework. Additionally, NPs in Georgia must complete an advanced course in pharmacology to have

prescriptive authority for schedule III-V, while in California, they are required to be supervised by an M.D. for six months and take a pharmacology course for the same levels.

Another example of variations within state categorization can be seen between Colorado and Nebraska, which are both considered full practice states. Colorado requires 1,000 hours of mentorship with an M.D. or an APRN for prescriptive authority. Also, NPs in Colorado need three semester hours or four-quarter hours of education in pathophysiology, pharmacology, and physical assessment. In contrast, for NPs to receive prescriptive authority in Nebraska, the state requires physician involvement for the first 2,000 hours. There are no additional educational requirements for prescriptive authority beyond the 30 hours of education in pharmacology for the general NP license. The examples offered above demonstrate a variation in practice environments. While this dissertation does not examine the influence of state-level practice laws, the above suggests variation in how NPs do their work and the emerging nature of the profession.

The role of the advanced nurse combines the caring skill set of the nurse and clinical thinking of the physician- albeit more limited due to educational differences. Nevertheless, the formalization of the role of NP illustrates that it is distinctly different from both the nurse and the physician roles, respectively. It also challenged the traditional model of health care delivery and the positions of those involved. It is beyond the goals of this dissertation to answer the question of how the scope of practice laws in states vary and how they may influence NPs. While the establishment of the occupation has taken great strides, the previous sections illustrate that the standardization of the occupation is changing. If a profession or occupation is a group that, at the most basic definitional level, engages in the same work, we would expect that the tasks and, therefore, the power of the group would be similar across the national context. This is not yet the

case with NPs. A detailed and chapter-relevant literature review is presented in each findings chapter. However, the following will briefly review the literature and will explore the variation in the experiences of NPs and illustrate a need to continue to study this emerging group.

Nurse Practitioners in the Literature

Much of the literature on NPs focuses on exploring and debating their clinical competence (Brown and Grimes 1995; Donald et al. 2013; Horrocks, Anderson, and Salisbury 2002; Kennedy et al. 2015; Landsperger et al. 2016). The research that examines NP competence and patient outcomes compared to that of M.D.'s helps to legitimize the idea that NPs can perform quality clinical work independently from physicians. Another central theme is regulation, commonly called "scope of practice" (SOP) that governs NPs clinical work and is set individually by each state. Despite the Institute of Medicine's recommendation that NPs work independently from physicians, tensions and resistance remain common (Poghosyan and Liu 2016)). While these are important issues, they are not the principal foci of the proposed project. The research reviewed here explores two key questions: first, how NPs perceive their work environment; and second, various structural factors that can constrain or facilitate the autonomy of NPs to practice to their full scope. These two bodies of research broadly situate this dissertation and illustrate the need for more research on the work experiences of NPs.

Perceptions of the Work Environment.

Survey-based studies, which dominate the literature, have provided information about the job satisfaction and autonomy of NPs and their patterns of workplace collaboration. Job satisfaction is commonly low across all facets of NP work (Bryant-Lukosius et al. 2007; Faris et al. 2010; Kacel et al. 2005; Pasarón 2013; Ryan and Ebbert 2013; Schiestel 2007). Lower levels of job satisfaction are related to lower perceptions of autonomy and more definite intentions to

leave a current position (Choi and De Gagne 2016; De Milt, Fitzpatrick, and McNulty 2011). High job satisfaction, in contrast, has been linked to favorable perceptions of relationships with colleagues (Maylone et al. 2011). In contrast, unfavorable opinions of colleague relationships are associated with the intentions of NPs to leave their current position (De Milt et al. 2011).

In a qualitative study, Weiland (2015) found that NPs described autonomy as being alone with their patient and having complete control over patient care. Control of that sort was understood as "Genuine NP Practice" (p. 99) and was seen as the goal of the full scope of practice. While limited in its aims and scope, Weiland's study suggests the value of a qualitative approach to the study of NP work. Autonomy, for example, is a term that needs to be unpacked, grounded in what NPs mean by it, and how it manifests – or does not – in their work. Likewise, global quantitative assessments of job satisfaction fail to reveal what does and does not bring joy and frustration regularly. The dissertation will thus attempt to develop further the sort of scholarship advanced by Weiland to understand better the meaning and sources of satisfaction and autonomy in the work of NPs.

Structural Factors and Autonomy of Practice

Previous studies suggest that structural factors constrain and enable the clinical practice of NPs and thus bear on autonomy. One line of inquiry focuses on the implementation of NPs in clinical settings and suggests that other members of the clinical practice must understand NP roles and responsibilities for NPs to function effectively (Clarin 2007; Schadewaldt et al. 2014). Also, factors such as communication, trust, and confidence in the competency of NPs facilitate the successful implementation of NPs (Hallas, Butz, and Gitterman 2004). Unsuccessful implementation of NPs can lead to underutilization (Kilpatrick et al. 2013), inappropriate utilization (Reay, Golden-Biddle, and Germann 2003; Elliott, Begley, and Higgins 2016;

Poghosyan, Boyd and Clarke 2016), dissatisfaction with collaborative relationships (Andregård and Jangland 2015; Hallas, Butz, and Gitterman 2004) as well as tensions between nurses, administrators, and NPs (Bahouth et al. 2013).

Structural factors at the organizational level also bear on NP autonomy. For example, Reay, Golden-Biddle, and Germann (2003) found that organizational policies sometimes blocked NPs from giving telephone orders, or from having a line on a prescription pad for an NP's signature. This research showed that greater autonomy for NPs was accomplished when management took on the role of NP advocate by acknowledging and supporting their clinical skills and the full scope of practice. Similarly, Bahouth et al. (2013) found that when management in six US hospitals implemented an NP leadership model that allowed for an organizational hierarchy that was separate from that of nursing and medicine, one result was a greater collaboration with colleagues.

While organizational policies and structure can influence how NPs experience autonomy and legitimacy in their work, state-level factors also play a central role. There are considerable differences in scope of practice (SOP) regulations across states (Kilpatrick 2013; Poghosyan, Nannini, Smaldone, et al. 2013; Xue et al. 2016). While some states provide NPs with full SOP, others limit or restrict practice (Safriet 2002; Yee et al. 2013). Yee and colleagues (2013) argue that restrictive SOP laws can restrict the practice opportunities for NPs, complicate payer policies, and influence NPs perceptions of the work environment. Poghosyan, Boyd, and Clarke (2016) argue that in some states, NPs are not allowed to complete worker's compensation forms, admit patients to hospitals, order needed tests, or order medical equipment. While this dissertation does not examine the direct influence of these laws, it is essential to recognize that these macro-level considerations may be salient when analyzing the narratives of NPs.

A review of previous research illustrates that there are conflicting perceptions of the roles of NPs and that these perceptions are heterogeneous across NP experiences. As argued by other scholars, more needs to be known to understand better NP autonomy and inter-professional relationships (Choi and De Gagne 2016; Weiland 2015). This dissertation unpacks the concepts of roles, job satisfaction, and autonomy. The next chapter will discuss the methods and data used in this project.

CHAPTER 3

METHODS AND DATA

This dissertation explores and examines the factors that influence perceptions of nurse practitioners toward their work and profession. This study uses both qualitative and quantitative data. The qualitative data for this study comes from interviews with primary care nurse practitioners working in Georgia. Using an inductive method of data analysis is appropriate for developing an in-depth exploration into how nurse practitioners perceive factors that constrain and facilitate their day-to-day work (Patton 1980; Strauss 1987). A qualitative method of analysis best aligns with the symbolic interactionist framework used to develop and analyze this part of the study (Boggis and Cornford 2007; Stryker 1980).

The second source, the National Survey of Primary Care Physicians and Nurse Practitioners 2012, is a cross-sectional data set of Physicians and Nurse Practitioner primary care providers in the United States. The year of data collection is the most recent data set of its kind. I use the data from the responses of NPs to examine the factors that influence job satisfaction. Specifically, I am interested in how specific tasks or groups of tasks, as well as factors of the work environment, affect perceptions of satisfaction. The analysis of this data helps to expand on the qualitative portion of the dissertation. The rationale and details of the design will be discussed in the proceeding section. Please note that the analysis of the survey data is currently on-going, and a general description of the survey data and the rationale for its inclusion are included in the proper sections. The two chapters that discuss the findings of these data will

include a brief methods section that will detail the construction of variables and the analytical strategy.

This chapter proceeds with a discussion of the research design, including the rationale of using both the qualitative and quantitative data highlighted in this dissertation. This is followed by a description of the criteria used to choose participants and recruitment procedures. A brief section will follow concerning the considerations of myself as the researcher and how this may have impacted the data collection and analysis. Next is a description of the interview guide proceeded by sample characteristics. Procedures for data analysis will close out the chapter.

Research Design

Past research has illustrated that the beliefs of NPs regarding autonomy, professional identity, and job satisfaction vary across contexts (Bae 2016; Choi and De Gagne 2016; Park et al. 2016). The core of this project is a case study of NPs working in non-hospital settings to explore familiar topics of study, such as boundary-making, autonomy, and job satisfaction, in a restrictive scope of practice state.

To further examine factors that influence job satisfaction, I used a national data set, which allows me to consider NPs who work in primary care clinics across the U.S. These analyses supplement the qualitative findings by allowing for an examination of issues that dovetail with those that emerged in interviews. The following will explain the rationale for choosing this approach and discuss the separate and combined contributions of both the qualitative core and the quantitative follow-up.

Morgan (2013:13) discusses the use of a qualitative core with a quantitative second phase as a Quantitative Follow-Up design. This method is used to expand on and complement the inductive results through a deductive approach that can examine NP perceptions across different

variables and contexts that go beyond the qualitative data (Morgan 2013; Small 2011). Specifically, the survey data used allows for an examination of how specific clinical actions with patients, as well as interactions with physicians, may influence the perceptions of NP job satisfaction. Furthermore, the use of a national data set allows for an efficient method to test assumptions across states with a differing scope of practice laws. The addition of the quantitative follow-up also serves to explore extensions of the current project and the creation of a future research agenda, both of which will be discussed in the conclusion chapter of this dissertation.

The core of the study uses both observations and interviews to explore the lived experiences of nurse practitioners practicing in a state that places restrictions on their work. Observations served to develop sensitizing concepts for the study, gain an understanding of how NPs framed professional barriers and facilitating factors, and gain access to potential participants. Observation data is not used directly in the analysis. However, the data served as information to formulate early memos and conceptual frameworks. Semi-structured interviews were conducted with participants to gain an understanding of their lived experiences as a nurse practitioner in Georgia. This type of interviewing technique is best for allowing for flexibility to explore those topics that are most pertinent to the individual. (Bamball and While 1994; Montgomery 2004).

The second data source is the National Survey of Primary Care Physicians and Nurse Practitioners 2012. Data was collected using a mailed survey that occurred from November 23, 2011, to April 9, 2012 (Donelan et al. 2013). A random sample was taken from The Nurse Practitioner Masterfile and the American Medical Association Masterfile provided by the Medical Marketing Service. The sample consisted of nurse practitioners and physicians who were trained in adolescent medicine, adult medicine, family medicine, general practice, geriatric

medicine, internal medicine, pediatrics, or women's health. The sample for the survey consisted of 957 each of nurse practitioners and physicians trained and working in primary care, totaling 1,914 providers. The reported response rate of 61.2% provided data from 972 providers, 505 physicians, and 467 nurse practitioners (Donelan et al. 2013).

For this dissertation, only the nurse practitioner sample was used. The focus of this study is on NPs working in primary care outpatient clinics. NPs who practiced in hospitals, care homes, veteran services, public health, or correctional facilities were dropped. This data set offers a unique opportunity to examine how perceptions of time across task areas and division of labor influence job satisfaction. Also, these data allow for an analysis of how computerization medical records are associated with feelings of autonomy and work satisfaction. The results of the quantitative analysis are presented in Chapters 7 and 8. Each chapter discusses the data and methods used for the analysis.

Site Selection and its Significance

The site for the recruitment of interview participants was the state of Georgia, which was chosen for two reasons. First, as a resident of the state, I could use my connections to the community to gain access. Second, a restrictive state allows for the exploration of work-related issues in an extreme case and one that is counter to how NPs have trained as well as the national agenda and lobbying efforts of the AANP. These circumstances make NPs in Georgia a promising group to explore perceptions of factors that both facilitate and constrain their practice. Furthermore, a qualitative case study design focusing on an extreme case allows for the fleshing out of common variations in an unusual case (Jahnukainen 2010).

Participants and recruitment.

Recruitment of participants started in the spring of 2017, with the last interviews being done in February of 2018. The target population for recruitment was nurse practitioners who lived and worked in the state of Georgia and worked as a primary care nurse practitioner in a non-hospital setting. I initially planned to interview NPs in various settings, including a large health facility, but was unable to make contacts to gain entry. I, therefore, focused on NPs working in outpatient clinics as primary care providers. To contact the targeted population and gain access to the professional community, I cast a wide net and employed several different recruitment tactics. (All recruitment material is provided in Appendix A-C. Recruitment and data collection were both aided by support from two separate research travel grants from the University of Georgia Graduate School, the Summer Research Travel Grant for Doctoral Students for the summers of 2017 and 2018.

The primary strategy for recruitment was the use of snowball sampling to gain access to NPs who worked in primary care in non-hospital settings. I began by contacting my physician, dissertation committee members, colleagues, and friends in Georgia. I provided a recruitment flyer when requested. The initial outreach resulted in the first three contacts. As with most of those that were referred, I sent an invitation to participate via email. Each invitation was similar with the addition of a change of name and who referred them. If the participant replied within a week, I sent them another email to arrange for a time to conduct an interview. I sent a follow-up email if there was not a reply within 7-10 days. In the rare case that I did not hear back after the second email, I dropped them from my list of possible participants. This occurred three times in the data collection phase.

A central source of potential participants came from gatekeepers I contacted and developed. The first gatekeeper was an NP who was referred to me by one of the first participants. After a few email exchanges, we spoke on the phone. He informed me that he thought that others in his clinic and their sister clinic in the same area might be interested in participating. He sent the recruitment flyer to the manager for both clinics, and the lead manager forwarded the call for participants to the NPs working in two sites and as well as a women's health clinic that operates on the same property as one of the general clinics. In total, six nurse practitioners agreed to participate. Through conversation with the gatekeeper for the clinics, I arranged a day for interviews. The lead manager for all three clinics arranged the work schedules of the NPs interested in participating. On the appointed day, I drove to the first clinic, and after a short tour, I conducted two interviews back to back. I then traveled to the second clinic and spoke with NPs between patients. Of the final two NPs, I interviewed, I spoke to one during her lunch break and the other right after her shift.

I also developed gatekeepers at the state-level professional organization. The first group of gatekeepers came from contacts made. At the same time, I attended and observed the state-level professional conference for nurse practitioners, partially through the support of the Summer Research Travel Grant for Doctoral Students from the University of Georgia Graduate School in 2017. While at the conference, I met professionals whom I would have otherwise not had been able to contact quickly. Also, I was invited to walk around the conference, observe, and talk with conference participants. As a result of the conference, I met several NPs in central leadership positions, spoke to several more NPs who practiced primary care, and passed out cards, and call for participants fliers. Additionally, I made contact with a state legislator whom I had a few conversations with throughout the data collection process. While these conversations were not

used directly in the analysis, the communications helped educate me on the history of legislation in the state concerning the full scope of practice for NPs.

From the contacts I made at the conference, I was invited to tour a school of nursing in the state. The tour was set up to coincide with a state legislative occupational study meeting on campus. The meeting was attended by several healthcare providers in the state, presenting what their clinics were doing to provide care as well as their utilization of NPs in their practices. During the tour and at the meeting, I was able to talk with two central gatekeepers, distribute my call for participants, and conduct one interview.

Through the contacts that I made on these trips, I secured the cooperation of three officers of three different groups to promote my study by sending out my recruit flier, which reached approximately 4,000 Nurse Practitioners in total. Emails were sent out by these contacts 3-4 times between September 2017 and January 2018. Also, an announcement of the study was posted on the Facebook page of the local NP chapter by a member, as well as several reminders of the study sent out via the list-serv for the state organization. The emailed call for participants resulted in a majority of my participants with the others being referred. Some NPs asked for and emailed the recruit flier to their friends or colleagues. Others, with the permission of their colleagues, gave emails to me to follow up.

Another source of information came from attending the American Association of Nurse Practitioners Annual Conference in Denver Co. from June 26th- July 1, 2018. While at the conference, I attended several sessions that focused on state and federal regulations for the profession. I also attended the southeast section meeting and learned of recent and upcoming legislative actions aimed at increasing the scope of Nurse Practitioners (NPs). Also, I was invited to attend a leadership luncheon was I met with the leadership for the Georgia chapter of Nurse

Practitioners as well as other states in the sector. These meetings allowed me to have several informal conversations that informed my conceptualization of my data and offered new avenues of inquiry. These conversations helped me to maintain contact with essential gatekeepers and meet the incoming leadership.

Additionally, during the week of the conference in Denver, I attended three main events, including a buffet dinner for all conference attendees. These events covered the year's legislative and promotional campaign success as well as laid out the plans for the upcoming year. At these events, I met and spoke with several NPs. These conversations helped me get a better perspective of how the role of the NP is viewed in different regions. Also, I met with the Director for Legislative Affairs for the national organization and learned of several issues salient for NPs practicing in various states and was able to fill in some of the gaps I had on the history of NPs in the U.S. As a result of my trip I met with several leaders of the professional associations of NPs both at the national and state level. These meetings and my observations assisted my analysis of the interviews, both confirming some of my conclusions as well as helping to frame further analysis by challenging some of my assumptions.

Self

My position as an outsider was an asset. At the beginning of the project, I was concerned that not being a nurse would be a barrier to access. On the contrary, it served to legitimate the process and project. Nurses themselves conduct a good amount of research that focuses on nursing in the U.S. Being from outside of the discipline of nursing or medicine was viewed as intriguing. However, being from a family of nurses also helped when I was asked why Nurse Practitioners became my dissertation topic. My status as an outsider was something that was brought up in almost every introduction that a nurse or nurse practitioner gave me. This type of

introduction almost always resulted in immediate interest and curiosity. After informing them that I was a sociology doctoral student and a bit about my project, the interest usually resulted in an exchange of emails and interest in my research. For example, at the national conference in 2018, a person I was speaking with exclaimed to the group we were with that she could not believe that I came to the conference, and I am not even a nurse. This was a common sentiment and served to give me access and gain legitimacy.

Description of the Interview Guide

Semi-structured interviews were used to explore the lived experiences of nurse practitioners. The interview guide was designed to explore how participants choose to become an NP, the perceptions of the work and work environment, views of the legal status of NPs in the state, and finally, their advice and thoughts for those who may be entering the profession. The following briefly discusses the guide. I first present a table with the main questions listed by grouping and then discuss the rationale and purpose of each group. Following the logic of a semi-structured interview, the wording and probes occasionally changed from participant to participant. A full list of the most common probes can be found at the end of this chapter, along with the associated questions.

Table 3-1 Interview Guide -Main Questions

Question Number	**Group Entering the profession and beginning of career perceptions**
1	I'd like to start by asking for a bit of your backstory. Could you describe to me how you became an NP?
2	Okay, so once you set your sights on being an NP, what did you expect that it would be like?
3	Could you give me a brief job history since you became an NP?
Perceptions of work relationships and influence	
4	Let's talk a little about your current job. What do you feel makes for a good day?
5	What makes for a bad day?
6	I now have a better sense of the sorts of things that make for good and bad days. Are there things that you do to help move your days one way or the other?
7	On a day-to-day basis, how would you describe your experiences with collaboration in your clinic?
Perceptions of organizational and state context	
8	Going beyond good days and bad days, I would like to get your thoughts as to how larger issues affect your work. Are there things outside of your direct control that you feel impacts your work?
9	There is a lot of talk about these, and one of the things I am interested in is how these laws affect the work of NPs. So, how do you feel SOP laws affect your work?
Wrap up questions	
10	Thinking about your initial expectations of the job of NP, how do they compare with now?
11	Do you have any advice for those considering becoming NPs?
12	What changes might be in order to help boost the stature of NPs and the attractiveness of being an NP?
13	Is there anything I have not asked about that you feel is important to ask?

The first group of questions (1-3) supplied data on how participants entered the profession and how they perceived the profession at the beginning of their career. Also, life histories gave insight to the RN to NP transition, including the reasons why they made the change, when, and the number of years they have worked in each separate role. The answers supplied assisted in the creation of probes for later questions.

The second group of questions (4-7) explore how NPs perceive their work relationships and how they create, negotiate, and maintain these relationships. The answers to these provided a better sense of how NPs work to maintain job satisfaction (what brings them joy and frustration on the job) as well as autonomy. The initial hope was that this section of questions would

provide data that showed how NPs act on a micro level to manage the "boundaries" of their profession and how they may act to resist or even recreate power structures in the clinic. While perceptions of boundaries and relationships were illuminated, details on the actions of NPs were lacking. However, the inclusion of a quantitative element was added to assist in providing more depth to complement the interview data.

Questions 8-9 are designed to gather data on how NPs perceive how organizational and state context may matter and how they deal with perceived constraints. These questions together aimed at uncovering perceptions about how lived day-to-day experiences of the NP were influenced by meso- and macro-level factors. Some NPs offered long narratives, while others were much briefer. Much of the rich data came from those who had held leadership positions at the national or state level. However, the contributions of narratives from NPs answering these questions and probes helped develop an understanding of experiences of professional boundaries and the development of a professional identity.

The last part of the guide is broken into four wrap-up questions. These questions gathered the perceptions of NPs about how their job expectations might have changed over time, their perceptions as to the future of NPs, the advice they would give to new NPs, and what they felt could be done to strengthen the stature and status of the profession. Depending on the career path, length, and experience in leadership, the answers varied in length and depth.

Many of the questions encouraged a narrative response. Some respondents' careers were longer than others, and their experience varied. Therefore, when an NP had considerable experience in a certain area or with a certain concept, I allowed them to talk in-depth about the experience. What this meant for the interviews was that not every NP addressed every question, and the time each NP spent answering each question varied.

The first and second group of questions was asked of each participant with some variation. The third and fourth sections varied in length. With some who had more leadership experience and tenure in the profession, the discussion of state laws and organizational policy took most of the interview. With others, their narrative of their career path took up a majority of the time, and the middle section of questions was given less time.

Sample Characteristics

To explore the lived experiences of NPs working in a state with the restrictive scope of practice laws, I conducted 36 semi-structured with NPs in Georgia. For purposes of this study, three interviews were dropped, one practicing Midwife, an NP working exclusively in a hospital setting, and an RN faculty member who teaches in an NP training program. This left thirty-three eligible participants. Of the thirty-three NPs in the study, thirty-two were working at the time of the interview, and one had retired in 2015. The latter NP is still active in local NP leadership, and in addition to her experiences as an NP, she also provided invaluable data on the history of the state's scope of practice laws and NPs in the state. The following reports the details of the thirty-three interviews that were done with Nurse Practitioners used in this dissertation. To aid the presentation of the data, I use several tables throughout the chapter. For easy access, tables are placed below the relevant text. I use a number to refer to each NP in this chapter and all proceeding chapters. The NP number will be presented in each table along with data specific for the table.

Thirty-three, in-depth interviews were conducted with nurse practitioners in the state of Georgia. Nine interviews were conducted in person in the NPs office or private space in the clinic. The other interviews were done by phone. Interviews lasted from 30 to 85 minutes, with the average interview running 56 minutes. Approximately 88% of nurse practitioners in the state

are female (Kaiser Family Foundation, 2018). This study reflects that distribution with four male and 29 female participants. Twenty-seven NPs have a Master of Science in Nursing only; seven also have a Doctor of Nursing (DNP), and 3 have a Ph.D.

Table 3-2: Sample Characteristics by Sex and Education

NP Number	Sex	Highest Education	NP Number	Sex	Highest Education	NP Number	Sex	Highest Education
1	Female	Master Level	12	Female	DNP	25	Female	Master Level
2	Female	Master Level	13	Female	Master Level	26	Female	Master Level
3	Female	Master Level	14	Male	PhD	27	Female	Master Level
4	Female	Master Level	15	Female	DNP	28	Female	PhD
5	Female	Master Level	16	Female	DNP	29	Female	Master Level
6	Male	Master Level	17	Female	Master Level	30	Female	Master Level
7	Female	Master Level	19	Female	Master Level	31	Male	Master Level
8	Female	Master Level	20	Female	Master Level	32	Female	DNP
9	Female	Master Level	21	Female	Master Level	33	Female	Master Level
10	Female	Master Level	22	Female	DNP	34	Male	DNP
11	Female	DNP	23	Female	Master Level	36	Female	Master Level

All thirty-three nurse practitioners in the study specialized and practiced in primary care. Ten of the NPs also held another specialty. Five of the thirty-two practicing NPs work in two different settings. For this study, NPs were asked questions about their work and experience in primary care. When an NP worked across more than one specialty or setting, I had them focus on their work as a primary care provider. While some also spoke about non-primary care provider experiences, these narratives were not used in the study.

Table 3-3: Sample Characteristics by Primary and Secondary Specialty

NP Number	Primary care specialty	Second specialty	NP Number	Primary care specialty	Second specialty	NP Number	Primary care specialty	Second specialty
1	Women's Health		12	Primary Care	Acute Care	25	Pediatric	
2	Primary Care		13	Primary Care		26	Primary Care	
3	Primary Care		14	Primary Care		27	Primary Care	Acute Care
4	Primary Care	Psych	15	Primary Care		28	Primary Care	Acute Care
5	Primary Care		16	Primary Care	Psych	29	Primary Care	
6	Primary Care		17	Primary Care		30	Primary Care	
7	Primary Care		19	Primary Care		31	Primary Care	Acute Care
8	Primary Care		20	Primary Care		32	Primary Care	
9	Primary Care		21	Primary Care		33	Primary Care	
10	Primary Care	Acute Care	22	Primary Care		34	Primary Care	
11	Primary Care		23	Primary Care		36	Primary Care	

As primary care providers, most of the NPs work in a private clinic run by an M.D. (13), while six work for a non-profit primary care clinic (Federally Qualified Health Center or FQHC), 3 for a retail clinic, 4 for a state-owned clinic, with 2 working for themselves or with other co-owners who are also NPs. Note, the specific type of state clinic is intentionally not mentioned to adhere to agreements for confidentiality and anonymity. Given the small size of the health care community, I was asked to avoid using specifics for site locations.

Table 3-4: Sample Characteristics by Primary Clinic Type and Location

NP	Primary Clinic	Location	NP	Primary Clinic	Location	NP	Primary Clinic	Location
1	State Clinic	Non-Rural	12	Community Health Clinic	Non-Rural	25	Private Clinic	Non-Rural
2	Private Clinic	Rural	13	Private NP run Clinic	Rural	26	Private Clinic	Non-Rural
3	Private Clinic	Non-Rural	14	Private Clinic	Non-Rural	27	Private Clinic	Non-Rural
4	Retail Clinic	Non-Rural	15	Private Clinic	Non-Rural	28	Private Clinic	No report
5	Community Health Clinic	Non-Rural	16	Community Health Clinic	Rural	29	State Clinic	Rural
6	FQHC	Rural	17	FQHC	Rural	30	Private Clinic	Non-Rural
7	FQHC	Rural	19	Private NP run Clinic	No report	31	Private Clinic	No report
8	FQHC	Rural	20	Private Clinic	Rural	32	Private Clinic	Non-Rural
9	FQHC	Rural	21	Private Clinic	Non-Rural	33	Private Clinic	Non-Rural
10	FQHC	Rural	22	Retail Clinic	Non-Rural	34	State Clinic	Non-Rural
11	State Clinic	Rural	23	Retail Clinic	Non-Rural	36	State Clinic-Retired	Non-Rural

Frequently mentioned in the literature is the potential for NPs in rural areas. Therefore, the sampling procedure tried to reach NPs who worked in both rural and non-rural settings within limits presented by the use of snowball technique to reach participants. Twelve NPs reported to work in rural areas, eighteen in non-rural, and three did not report. Of the twelve working in a rural area, six work for a not-for-profit clinic utilizing federal and state grants. All six work for the same employer across three clinics.

Years worked as a nurse, and as an NP was recorded for each participant. Eighteen NPs worked as a nurse for under ten years before becoming an NP, fifteen worked from 10-20 years as a nurse before becoming an NP, and four worked as a nurse for over 20 years before becoming an NP. Years as an NP were also calculated. Of the 33 NPs, sixteen worked for less than ten years, and 18 have worked as an NP for ten or more years.

Data Analysis

All interviews were recorded and transcribed. I transcribed the first 14 (approximately), and the rest were professionally transcribed. I used Express Scribe software and a foot pedal to control the speed of the audio and rewind as needed. Additionally, I used a professional service to review the transcripts I had previously done to clean up any errors.

Furthermore, each recording was listened to a minimum of three times to familiarize me with the data and emerging themes. Lastly, I limited the amount of editing done in order to try and keep the voice and intention of the participant by omitting non-lexical conversational sounds (e.g., hmm or uh). I left words such as “kinda,” “you know,” or “like” because I wanted to keep the original communication as intact as possible.

Interviewing, transcribing, and coding coincided. I developed the codes as I listened to interviews and reviewed memos and notes. As themes emerged from the data, I added codes as

well as broke down categories of codes into parent and child codes. To aid with coding, I used Dedoose, a cross-platform application developed to assist in keeping track of codes and quickly organizing data. As I coded more interviews, I was able to use word clouds provided in Dedoose as well as grids and counts to help me recognize general patterns. I also set up descriptor codes that captured general information about the NP, such as the setting they worked in as their primary place of employment, secondary place of employment, primary and secondary specialty, highest degree, years as an RN before becoming an NP, and years as an NP. The extra layer of descriptive codes allowed for checking for patterns across these characteristics.

After coding the first ten interviews and adding to the codebook, I restructured the codes and reviewed the coding as well as re-coded some of the interviews. As I continued coding the rest of the interviews, I added and removed codes as was needed. After all the interviews were conducted, transcribed, and coded, I reviewed each interview again, looking for redundant codes. When preparing to write up the results, I took a two-prong approach. I used the main themes that emerged in the data and re-examined the corresponding sections of the transcripts. I then went through each section and selected quotes most associated with the theme. As I did this, I used keywords in the quotes to search a clean file of all the transcripts. This additional layer of analysis helped to capture quotes that may have been missed with prior coding.

Additionally, all quotes and all transcripts were coded with the corresponding interview number. These were used as headers in word document files so I could efficiently see how many NPs were associated with any given theme helping me to notice trends or isolated experiences. I could then cross-check these with an excel file that gave me information about the typical characteristics mentioned above.

CHAPTER 4

HOW NURSE PRACTITIONERS DEVELOP PROFESSIONAL BOUNDARIES FROM A CONSTELLATION OF ROLES

When people ask me, I always introduce myself as a nurse practitioner. I never call myself a doctor. (NP 21)

Nurse practitioners (NPs) and physicians share many of the same tasks across a variety of clinical settings. Depending on state laws and organizational policies, NPs can run clinics, have their own set of patients, prescribe medications, and give medical advice. In short, NPs diagnose, determine prognosis, and prescribe treatment in many of the same clinical situations and specialties where M.D.s also practice (Poghosyan, Nannini, Smaldone, et al. 2013).

Additionally, the training that NPs receive allows them to deliver health care in their specialty (e.g., Primary Care), have their licensing boards, and the same authority over their patients in a way that is very similar to M.D.s. They also have power over health care team members, such as nurses and office staff. Looking at the work done, NPs can appear to be the same or similar to that of M.D.s. For example, both M.D.s and NPs conduct wellness exams, and the patient will likely receive the same outcome from either (Stanik-Hutt et al. 2013). From all appearances, they do the same work and produce the same results in a variety of clinical settings. As discussed in Chapter 2, part of the professional project of any group is to illustrate the unique nature of their work and set up a mandate. In the case of NPs, they create a mandate through a dialectic process involving two different domains, that of nursing and that of medicine.

NPs work in the realm of nursing as well as medicine. NPs must hold a license as a registered nurse and a nurse practitioner to practice. Discussed in the current chapter is how NPs identify closely with being a nurse while also performing tasks that are in the same domain as M.D.s. Pulling from both nursing and medicine creates a dual-boundary puzzle that involves defining and maintaining both an RN/NP boundary as well as an NP/M.D. boundary.

Through the synthesis of nursing and medicine, NPs develop a narrative of holistic care (or whole-person care) that allows for the conceptual space to build their own professional role identity. The merging of a nurse's role with the medical model of health care is the foundation of how NPs view their practice and, in so doing, NPs develop a unique professional identity that encompasses both roles and approaches to health care. The data in this chapter will show that NPs argue that the combination of nursing with medicine brings extra value to the provider role.

This chapter explores how NPs perceive their role in the clinical space and illustrates the complex nature of an NP's identity as a health care provider. NPs use narratives of difference and similarity in their approach to delivering health care to make the argument that they are unique and offer a different type of patient experience. The boundary work that NPs engage with creates a porous boundary between themselves and nursing while suggesting a more solid demarcation between themselves and M.D.s. That is, NPs work and identify as a nurse and keep this identity sacred (or "salient"?), and at the same time, demand for and maintain their privilege to do the work of a provider. In all of this, they do not aim to appear to be a physician or claim control over the domain of medicine. The chapter will begin with a brief overview of the relevant literature and theoretical frameworks. A presentation of the main themes will follow.

Boundaries in Theory and Practice

Sociologists often argue that professionals individually and collectively strive to create and keep professional boundaries. Studies of boundaries have shed light on the processes through which groups control work, clients, knowledge, and communication privileges (Abbott 1988; Gieryn 1983; Nancarrow and Borthwick 2005; Stein 1969). This research adopts either a macro or a micro approach.

The macro approach emphasizes relationships between professions and the state, the public, and other professions and occupations. Traditionally, studies have invoked a one-versus-one model where the goal of complete dominance drives boundary and relationship creation (Freidson 1970, 1988; Larson 1979). In contrast, Abbott (1988) proposed a system of professions approach that highlighted the interdependence of professionals who vie for control over tasks and legitimacy (Abbott 2005; Lamont and Molnár 2002). Each contest and shift in one profession can influence others. Several works have used a systems approach along with historical analysis to illustrate the emergence and changing nature of the professions at the macro-level (e.g., Goodrick and Reay 2011; Starr 1984; Abbott 1982; Fairman 2009).

Although analyses of historical and macro-level aspects of boundaries have been fruitful, they tend to reify boundaries as "clear cut" and of vital importance to those who work in professions. Several scholars have argued that boundaries are much more flexible at the level of work itself (Allen 1997; Timmons and Tanner 2004) and that dominance and competition are not always the main goals of those who work in professions (Liu 2015). Understanding the flexible nature of boundaries along with their meaning, importance, and how professionals maintain or challenge them requires an in-the-trenches or on-the-ground approach to studying the social world (e.g., Blumer 1954; Hughes 1958).

A critically understudied area is how professionals do boundary work across more than one boundary. Boundary work is often conceptualized as one group moving into another group's territory and taking over the area's tasks and functions. The identity of the group, however, stays the same in the eyes of the public and professionals. For example, physicians who take on a specialty in genetics have been met with resistance, but there is no discussion over their identity as physicians (Martin, Currie, and Finn 2009).

Several scholars have explored boundary work at the micro or individual level. A central aspect of this research has shed light on how social actors use language, also referred to as rhetorical devices, to secure or defend their occupational position and control over tasks and material resources (Allen 2001; Norris 2001). Research finds that "limitation rhetoric" is most commonly used to denote differences in expert knowledge between groups. For example, Sanders and Harrison (2008), in their study of nurses working with heart failure patients, found that the dominant profession of cardiology used the rhetoric of superior knowledge as the single means to both legitimize their claim and limit the claims of others. Martin, Currie, and Finn (2009) found that genetic specialists also deployed their ability in the field of genetics as the prime method of defending their jurisdiction against general practitioners who have a focus on genetics.

Similarly, Mizrachi, Shuval, and Gross (2005) observed interactions between physicians and alternative medicine practitioners to show how physicians used legitimation talk that recognized the utility of a subordinate profession without providing a formal acknowledgment. These studies illustrate how dominate groups assert control over work using language that confirms their claims and allows for the limited participation of other occupations.

The rhetorical device of "superior knowledge" is also used in relationships other than that of physicians with non-physicians. Allen (2000) showed that nurses used rhetoric denoting their superior knowledge when training Health Care Assistants (HCAs) to assert their dominant position in the unit hierarchy. Similarly, Timmons and Tanner (2004) demonstrated how operating department practitioners used rhetoric that demeaned the holistic perspective of nurses in an attempt to position their profession as a valid medical profession based on expert knowledge.

Newcomers can employ rhetoric, not just established groups. For example, according to Allen (2000), HCAs asserted that their knowledge-base and their holistic philosophy of care justified their claims of autonomy. This allowed them to resist being characterized as assistants or nurse-extenders. Similarly, Foley and Faircloth (2003) found that midwives highlighted their competence in staking claims to their task and workspace while at the same time using the language of medicine to describe their work. This last example illustrates a profession highlighting the difference, but at the same time, aligning themselves with, the dominant group to gain legitimacy.

The current study shows how NPs use rhetoric to keep a foothold in nursing while also claiming a legitimate stake in the role of a health care provider. The case of NPs is unique because they hold two distinct roles, that of nurse and that of the provider. They can and sometimes do enact both roles to accomplish their work. However, it is crucial to notice that from the narratives of NPs in this study, there are no clear intentions to gain domain over medicine; instead, they synthesize their role as a nurse with the knowledge gained from medicine to create a new identity. The dual-boundary nature of the NP makes the profession different from other studies of boundary work that focus on a sole role moving into the jurisdiction of another.

An exception to this is the work of Trotter (2019). Using ethnographic and interview data, Trotter illustrates how NP students work to keep their ties with nursing while assuring physician colleagues that they are not a professional threat. A logical extension of this work is an inquiry into how NPs working in private, physician-run clinics perceive their boundaries and roles.

Roles and Boundary Creation for NPs

In this section, I discuss five themes that illustrate how NPs work to create their role and differentiate themselves from registered nurses as well as from physicians, while often doing work that belongs to both fields. These themes are divided into external rhetoric and internal rhetoric. The first two themes show how external rhetoric, created outside the profession, works to define NPs boundaries and how NPs pursue a reframing of these labels. The last three themes address internal rhetoric or language that is created and used by NPs to define their professional space.

The first external theme involves labels such as "mid-level." Through an analysis of NPs' responses to these types of labels, I describe how they perceive their profession and its difference from medicine appear. The second theme begins to reveal NPs' close attachments to the nurse identity through narratives defending against the use of the nurse label for and by non-nurses. Together, these themes discuss how external rhetoric is used and perceived by NPs to work toward defining and defending their roles.

Internal rhetoric is discussed in three themes. The first of these illustrates how NPs delineate themselves from physicians by combining the identity of the nurse and the role of provider to create a rhetoric of difference to set up a boundary through deference and language of respect. For example, many NPs assert that they are not M.D.s, that they do not have the same education as M.D.s, and that they do not want to become an M.D. Some further this demarcation

by drawing the boundary based on roles and, for example, illustrating that the use of an NP is best suited for work with specific clients or cases. This theme is followed by a discussion of how NPs perceive their role as a synthesis of nursing and medicine and how they perceive their transition from that of the nurse to that of the provider.

Positioning the NP in the Field of Health Care.

Is an NP an RN with additive knowledge? Are they "mini-docs," or are they something completely different? This question has led others outside of the profession to create and use labels such as mid-level, physician extenders, or non-physician providers. These external labels use language to define the NP's boundaries. In each designation, the idea and title of "physician" function as the orienting concept. In general, the current schema used to organize the workforce of healthcare places the M.D. as the authoritative figure in terms of ability and knowledge. This organizing method allows for other occupations and professions to be placed in the flow of work. This schema creates the relational position of the NP.

Nurse practitioners are nurses with advanced education. However, their work resembles that of nurses and that of physicians. Therefore, since NPs are advanced nurses but not M.D.s, their placement in the schema is perceived to be in-between that of nurses and that of M.D.s. Hence, labels such as mid-level are not uncommon. This is not, however, how the professional organization of NPs views the relationship. This boundary is therefore contested and worth exploring further.

The designation of "mid-level providers" is a collective term that works to make the NP/M.D. boundary more robust and is thought to have gained its legitimacy as a label after Medicare adopted it for processing reimbursements. Subsequently, many other insurance companies have adopted the term. If using a vertical model of the professional hierarchy is based

on the amount of knowledge and skill as well as its application, then NPs are between RNs and M.D.s. However, NPs do not identify as mid-level and orient their position in health care as a provider. A question then emerges about why the resistance to this designation exists. Such a label would allow for a legitimate claim to an area of work. NPs instead consider their position to be at the highest level in nursing. They also perceive that both their knowledge and skill are equal to any other member of another profession performing the same task or duty. In rejecting the mid-level label, they open the boundary of NP/M.D. to a more porous definition and contradict their language of deference that will be discussed in further detail in later themes.

The purpose of this section is to explore how NPs position their professional identity and to illustrate the complex and social nature of the construct. Occupational titles can have cultural meaning, and NPs use these meanings as an attempt to create a new title. They combine the identity of a nurse with the identity of the provider. The creation of the field of NPs emerges from how these competing perspectives are negotiated and enacted.

While NPs perform several tasks that physicians also perform, for NPs, the meaning behind their title and position in the health care field is a combination of pushing back against medicine-based definitions and advocating for a new way of imaging a provider. NP 32 stressed the importance, to her, of nomenclature defining the NP role:

> So, let's start off with verbiage. Nurse practitioners have long been referred to as mid-level providers, okay? […] it's sort of like saying we're not full providers; we're just kind of in the middle because we're not physicians. […] at least in my practice, they refer to us as an advanced practice provider. My previous practice, they called us mid-level, […] You know, I couldn't change that. That was just their thinking. So yeah, even just verbiage makes a difference, how we're referred to.

As NP 32 points out, the use of labels is not consistent across clinics. As far as health care delivery is concerned, NPs' skill sets and knowledge are between that of and an RN and an M.D. The main point is that NPs are called upon to work as healthcare providers and, when doing so, are both expected and required to deliver care at the same level as a physician. NPs, therefore, view the subjective belief of status as equally crucial to the objective standard of care.

It is also possible that the acceptance of the mid-level label could help carve out an agreed-upon area of authority. However, this is not the strategy taken at the individual or the national level. Many of the narratives suggest the need for a different schema to organize their profession. Instead of a schema wherein medicine is the central reference point, there seems to be a perception of vertical parallel fields where each group (e.g., physicians and nurse practitioners) run parallel to each other, conferring and collaborating when needed, yet occupying and controlling their field. Micro-interactions between fields would logically require deference to one another, but the fields and professional positions would be considered separate and organized according to their related fields.

The professional project for NPs includes using a strategy to create a professional space where NPs are considered providers of health care and are not discussed in relation to physicians. In other words, they are advanced practice nurses who practice nursing and are also providers. NP 11 suggests this when she explains her thoughts around the label:

> Mid-level, I've heard that a lot [and] I do not like mid-level because honestly, as a nurse practitioner, I'm not mid-level. I'm at the top of my game. I have a doctorate degree in nursing practice. I am not mid-level. I am a "top level." […] - NP 11

The reference to being "at the top of [her] game" refers to the identity of being a nurse. She has reached the top level of nursing and does not use physicians as a reference point when

delineating her position in health care. She instead uses the field of nursing to describe her position in the hierarchy. NPs are trying to set up a place for nursing in the delivery of care as providers. The title Advanced Practice Nurse (APRN) suggests that the role is more than that of a nurse. There is little disagreement with this delineation from any quarter. It is when APRN's move into the realm of providers that professional boundaries are questioned and attempts to define the role and boundaries are made.

While the AMA, as well as the AANP, play essential roles in defining boundaries, they are not the only boundary makers. The state also plays a significant role and is behind legitimizing the designation of a mid-level provider. NP 11 has a doctorate in nursing and talks about the mid-level designation and how she perceives this term to contradict her actual role:

> I think that term came out of the actual Medicaid, Medicare terminology, and pay scale. […] If I do a head nose and throat [and] someone's got sinusitis or whatever, I'm going to get paid 75% of what a physician would get paid for that exam for that exact same visit, and this is straight out of funding from Washington. So we're not talking about a doctor's opinion, it's Federal laws that are being passed that are saying that my job and what I do for my patient isn't worth a hundred percent. But I did everything, and more than that physician would have done because I maybe talk to them about their depression because, like why do you keep crying, are you in pain what's happening to you or whatever other things it is.

While the creation of this term and the political process that took place in its creation is important, it is beyond the scope of this study. What this quote does offer is one way in which the NP/M.D. boundary is defined and how this sets the stage for confusion over the role. It also highlights what will become more of a focus of this analysis later, specifically how NPs try to

make a distinction of their work from others. They assert that they notice and treat problems that would not be caught by other provider types, especially those associated with medicine. The reasoning is that a whole person approach puts forth an argument that NPs supply something that no one else does and, therefore, are in a different occupational field using a different schema to organize and define their profession.

Contrary to the rhetoric of defense employed by many NPs, there also those NPs that use the term mid-level to describe themselves as a group. They may use this because it is what they are referred to by others and have been socialized to use. However, the use of the term "mid-level" suggests that resistance to the term does vary. A few in the current study used the term, some correcting themselves and others not. I heard this term used by NPs in my conversations with them as well as in casual conversations at conferences. While not common, it did occur. NP 16 comments on her own experience:

> You know, our education is not mid-level. We are not trying to take over anything. You want to work in partnership for the benefit of the patient, but you find a lot of PA's and NP's call themselves that and I will correct them very quickly, respectfully.

The response to this term varies. For many, it is considered to be a demeaning term. The AANP has issued comments explaining why this is the incorrect term. However, for some NPs, they do not perceive the term in the same way.

> Yeah I think [the physician] would say that we are mid-levels but it doesn't hurt my feelings […], but I know that that's a big thing even when I was in school I felt that way, and I don't, my personal opinion about that is I think that I don't think that that is a bad thing necessarily. NP 6

Terms such as mid-level are used to place NPs above nurses but below physicians. Contrary to this type of hierarchical conceptualization is one created by NPs that place their profession on a track that does not directly include M.D.s. It may include medicine but not physicians. Therefore, according to this organizational schema, they are part of the nursing field and at the top of the hierarchal structure. On the one hand, it is semantics, but for NPs, it is perceived as more than that, it is a way of conceptualizing their profession. NP 14 talks about the idea of where to place NPs.

> NPs don't like that word [mid-level]. (laughs), Yea it is a little degrading. There is that. And then there is, the reality is, you will find, I don't think you will find, I hope you don't find an NP that will ever say that their role […] is to be a physician or act [as] a physician. That is not what we do; it is not what we wanted to do. If we wanted to be a physician, we would have [gone] to medical school. They practice very, very differently, our goal, our thinking, our physical practice, our demeanor, our way of providing education, is very, very, different.

What this quote signifies is the conceptualization of nurse practitioners as a group that occupies a different field from that of medicine. Instead of a vertical relationship, they argue for a horizontal one. More than that, however, there is a suggestion that they are not on the same professional organizing board. They instead assert that they are separate from medicine and while they enter the same clinics, perform many of the same tasks, use many of the same tools, and wear the same coats, they are not the same. While the labeling of mid-level or non-physician providers aligns with NPs rhetoric that they are not physicians, it is not accepted as a way of defining their professional boundaries as a health care provider. While external rhetoric works to define the NP/M.D. boundary, outside actors and language also work to construct the RN/NP demarcation.

Drawing the Boundary of a Nurse.

Nurse practitioners hold a position in and outside of nursing. Therefore, they engage in boundary work on two fronts. NPs endeavor to support a relationship with both RNs and medicine while not being placed as solely belonging to either profession. Being able to cross professional boarders is how the NP occupation does their work, and maintaining friendly relations is useful and essential. The following is from a smaller set of data that highlights how NPs are also concerned with the role of the nurse and its maintenance regardless of the position of NPs as providers.

Nurse practitioners draw the boundary of a nurse by defending against the use of the title by others who are not trained as nurses. While it is illegal to wear identification that misrepresents oneself as a nurse, informal labeling is the topic of NPs observations and comments. Through telling stories of medical doctors calling their medical assistants (MAs) nurses and MAs taking the title for themselves, NPs illustrate their efforts to support and police the identity of the nurse. Medical assistants often engage in tasks that nurses also perform. However, doing the work or having the skill to do the job is not the point of contention. The challenge is focused on the use of the title of a nurse.

Through an over-generalization of skills and knowledge, licensure groups are confounded to create two groups: physicians and non-physicians. NPs suggested that this made the demarcation of the boundary of a nurse too porous or even invisible. Many NPs spoke about how in some working environments, all non-medical doctors who worked with patients were considered /called “nurses,” and this could include medical assistants as well as support staff. While there are state-level laws that mandate that all RNs must wear a name badge noting that they are an RN, there were several experiences where non-RNs would tell patients, “I am your

nurse." The acceptance of this labeling by physicians and others in the clinic works to obscure the licenses of RNs as well as NPs by labeling all non-M.D. personnel as the same. The boundary between nurses and MAs was perceived as something to defend, even if the NP was not working as an RN at the time. NP 26 shared that:

> A lot of the MAs will refer to themselves as nurses, so [for example] if I called my family practice and I left a message, they'll say [that] you can leave a message with so-and-so's nurse, and I'm like well, I know that you don't have any RNs at that office, they're all MAs. [….] it's just that whole general culture of just calling everybody a nurse.

Another NP experienced how the culture that NP 26 referred to also shaped the way a non-health care professional approached patients and how patients themselves were influenced:

> I remember one of the practices I was in we had a receptionist and she would get these calls, and she would get where she was telling patients what to do. I remember the doctor getting a callback and was told well your nurse told me to do this. She was not saying she was who she was exactly, and because she was female and giving advice, they were assuming that she was a nurse.

This quote illustrates the culture of assuming all non-physicians are female, as well as the assumptions the receptionist had that she could dispense information. NP 26 refers to this as a culture that acts to define jurisdictions and boundaries. Taking together the stories from NPs suggests that, while they work to manage and define the RN/NP boundary, they also actively work to defend the RN/MA boundary. The connection to being a nurse is a substantial part of their identity. NPs must also define and manage the NP/M.D. boundary. This boundary, and how NPs perceive the creation and maintenance of it, are discussed in the following section.

NP NOT M.D. The Use of Subjective Definitions and Objective Experiences

When going to a health clinic, people expect that a nurse will take their vitals, write down some necessary information, and then tell them that the doctor will be right with them. Furthermore, the provider is assumed to be a physician who holds an M.D., even if the term "doctor" is not used. The standard expectation is that a doctor will see the patient. With the emergence of nurse practitioners as well as physicians' assistants, the person one sees may not hold an M.D. Furthermore, the details of the visit may vary. The following section unpacks how NPs use a holistic perspective of health care to frame their profession as different from that of medicine to redefine the clinical space to include their profession as a separate and independent provider.

The expectation of who holds the position of health care provider is an integral part of the creation of the professional boundary. NP 15 holds a Doctor of Nursing degree. She shared a story that illustrates the symbolic nature of the word "doctor." While, technically, anyone with a doctorate can use the title of "Doctor," in healthcare, it is more complicated due to the power of the term as well as the cultural/public understanding of the title.

> I was asked to do a talk on inter-professional education and collaboration […], and it was to a group of medical students, and you know, there were other professions there, […], pharmacy, nursing, medicine and ours. The objective was for the students to understand the education and the training [of] each of the professions and what our role really was. So, after I had – and I kind of went through my spiel […], and they opened the floor for questions. Well, one of the questions to me from one of the students was, so when you're in the hospital, are you going to make us call you, doctor? You know, I was kind of flabbergasted by that, and I was like well, you know, I think that's – it gets confusing. So

> no, I'm a nurse practitioner. I am not a medical doctor. I'm very clear about that. I don't have a problem not being called doctor, because I think it gets confusing. But I'm really interested in, you know, why you would ask that question. You know, have you had a bad experience? And he was just like no, you know, there's just been – you know, that's a topic of conversation. But I was a little bit surprised that – that came from somewhere. And it probably came from my medical colleagues that are educating them. So, you know, that perception I feel like is a little bit out of my control. I can't control […] necessarily what people think. I can influence it, and you know, again, that just – that just takes time.

This quote illustrates how professional identity can be created through others' perceptions of the profession. NP 15's story suggests concerns over the title of doctor for both herself and the medical student. The surprise over the question was that the student did not ask about training concerns or competencies but instead voiced concerns over the label. The medical student's response could be partially connected to the lack of symbolic power of the term "provider" as compared with that of "nurse" or "doctor." Regardless, the concern is one that NPs work to negotiate by crafting a professional identity that does not imply being like a physician, even though they are doing the same exams and procedures as part of their clinical duties. The rhetoric used to define and defend their boundaries is couched in a cultural understanding of who delivers healthcare. Instead of a direct attack against medicine, NPs work to carve out a niche that is defined by a difference in approach and experience.

NPs are providers, but they are not M.D.s. This distinction is one that is asserted by NPs to help create a difference and reassure others that they are not claiming to be any more than they their training allows. Even though they are claiming tasks and clinical situations that are also

shared by medicine at the same time, NPs declare that they hold a skill set and knowledge that is solely theirs, and this offers a different product than what other providers offer. This difference is claimed to come from their experience and theoretical grounding in nursing. For example, NP 14 has worked as a nurse practitioner for over 20 years and has been involved with the training of NPs as faculty. When talking about the difference between physicians and NPs, he stresses the nursing model as central.

> I'm always a nurse; I always practice nursing. I'm not trained in medicine. It would be inappropriate for me to say that [I am]. A good example of that is if you have a plumber working on your house, does that make him a carpenter, and the answer is no, he is just using a tool that belongs to somebody else or another profession. When we write prescriptions when we do diagnostics, when we sew somebody up with the sutures, when we do something like that, we're using tools that are typically medical tools, but nurses use them too.

This narrative suggests that the professional project for NPs includes making the symbolic meaning of tools, such as using sutures or a stethoscope, transferable to their role and identity as a provider while making sure not to claim the status of an M.D.

While NP 14 talks about specific tools, others framed their difference more broadly and abstractly to distinguish the NP brand of patient-provider interaction. NP 12 illustrates that the NP/M.D. difference is bound in the type of approach that nurse practitioners use to treat their patients.

> So, there's so much, it's so multifaceted, and I feel like as a nurse, and a nurse practitioner [we] are very holistic with our patients, we don't just treat your body we treat your mind we treat your spiritual self, we treat everything.

By treating “everything,” the description leaves the boundary vague and contrasts the more specific image of the work of an M.D. In the subjective nature of the description, a new identity is created.

NPs use rhetoric that positions their role as a provider as something different and subjective. The framing of the role of the NP provider builds on this subjective nature to create and legitimize their role. NP 14 describes how NPs pull from both nursing and medicine.

> So, when you go to a nurse practitioner, and you're talking to him about your sore throat or your headaches or whatever they're going to be looking at the whole picture they're not going to just try to focus in on the disease process that might be causing the problem. [However, they] would be aware of it because that's the other thing you need to understand is that nurse practitioners work in the overlap, and what I mean by that is if you draw a big circle and you say everything in medicine falls [in this circle]. And you draw [another] big circle and say everything in nursing falls into that circle. Because of what we do and whom we work with, they overlap [creating a] big Venn diagram […], and nurse practitioners primarily work in that overlap. We also work out of that at [sometimes] as far as a nurse, but [the] nurse practitioner role is primarily in the overlap. […] Even though I use some medical tools, I never practice medicine, I never look at it that way.

Therefore “doing healthcare” is redefined, leaving open the possibility for a new conceptualization of what makes for a provider. Vagueness may not, at first, seem like a strong strategy. However, NPs frame their difference with physicians by using language that conveys an image of a provider who is more flexible in exploring what the patient needs beyond the reason for the visit. While medicine also works to include the whole person, and physicians may also

work to connect with their patients, NPs use rhetoric of contrast to highlight a provider identity separate from that of a physician.

NPs frame their work in a way that highlights what they can do but also what they cannot, thereby pointing out that they must know their limits and when to refer a patient out or contact a collaborating physician in the clinic. Using NP 14s Venn diagram example, NPs try to keep the RN-NP relationship porous while supporting perceptions of a more solid NP-M.D. boundary. While NPs are making a foothold into the authority of medicine, they are limiting any shared territory that would expand beyond their core nurse identity. However, what would be the reason to stop?

As NPs gain more legislative victories, their scope of practice begins to expand as well as their options to work as independent providers. NPs are not the only group that has pushed into territory occupied by medicine and specifically that of M.D.s. However, nurse practitioners have so far not been acquired as a subordinate member in the same way that physician assistant (PA's) or Doctor of Osteopathic Medicine (D.O.s) have, with the former being created by medicine (Fairman 2009) and the latter becoming accepted by and arguably absorbed by medicine. NPs try to keep a boundary that simultaneously allows them to work in the clinical space as a provider while holding onto nursing. This strategy suggests a need to buffer themselves from attempts by outside groups to absorb their profession.

The holistic care rhetoric of NPs builds an image of a provider that is different from M.D.s and therefore warrants a distinct identity. NP 12 explains this when she describes how being multifaceted is what makes being an NP valuable to her.

> […], that to me, is why I am glad I am a nurse and a nurse practitioner, and I say I'm a nurse because that's the basis. I'm a nurse because that is what I am even though I'm an

> advanced practice nurse. I am a nurse. I feel like sometimes when you have doctors and Physicians assistants who may not have that previous experience of sitting with a patient for 12 hours and a bedside or just doctors and PA's don't come in with that background that nurses do, but I feel like that's what makes those practitioners amazing providers because we have that holistic view of patients.

This quote links the NP role with that of the RN and suggests that the RN role is an essential part of their work and is a practice that M.D.s do not engage in. Of course, not all RN experiences are the same, and not all NPs work for several years as a bedside nurse before taking the NP role. Furthermore, M.D.s could have this experience, depending on their residency and expertise. The claim NPs use is that years of experience and a viewpoint of care allows them to make judgments as to whether they should inquire further when a patient shows various behaviors.

However, this training could be part of medical school, and it is increasingly expected that M.D.s communicate with their patients and serve the whole person. M.D.s can and do practice the provider role much like an NP. The negotiations of boundaries are, of course, different but illustrate how NPs must shroud their claims. They must find a way to legitimate their move into a provider role by distancing themselves from the identity of an M.D. but simultaneously illustrate their competence as a provider. Important to the subject of boundary work is that it is the NP who uses this skill and subjective language to create their professional space and jurisdiction.

Building on language that suggests a collaborative nature, NPs draw a boundary around their role by pointing out how doing their role frees physicians up to work on more complicated patient issues. This is a type of deference that illustrates a boundary that supplies NPs cover from

accusations of encroachment and creates an image of cooperation and aid. For example, NP 26 talks about how doing her job helps define the division of labor.

> And then so the sicker people can see a physician when they need to see a physician. And they're not tied up, you know, with, you know, things like doing well exams or trying to – like a lot of the routine things.

NPs view their place in the division of labor as potentially helping M.D.s with their role. This again justifies a space for NPs and works to illustrate a cooperative strategy of claiming an authority. Similarity NP 14 expresses that

> I want them to be the very best cardiologists they can be or endocrinologist they can be or whatever; I want him to focus on that.

The above two quotes show how NPs justify their role as a provider by advocating for a reorganization of the division of labor. The argument is that M.D.s have a rightful place as specialists who can manage complex cases. Using the rhetoric of difference and deference, NPs confirm the stature of M.D.s and highlight the ways NPs can fit into the delivery of health care. NPs are defining their boundary by use of subjective language such as holistic care as well as redefining the boundary of M.D.s. Both strategies work to try to redistribute the workload and division of labor to make a case for their claims to jurisdiction.

I am Nurse but Not a Nurse: Making the Transition

The role of NP is predicated on the integration of the role of nursing with the role of medicine. This boundary is suggested when NPs share moments when they knew they had crossed over from the role of a nurse to that of an NP. This transition was marked by recognizing the adoption of clinical thinking that moved beyond that of nursing. Through this process, the identity of the nurse is expanded with the addition of ways of thinking about care and the patient.

The framework used is not a case of one perspective substituting for the other, nor is it an instance of addition. Instead, it is a case of synthesizing two roles to create a new one. This dialectic process indicates an intriguing boundary that changes by expanding the nurse boundary into the realm of the provider. Practicing NPs perceive their boundary as originating from a theoretical perspective of a nurse combined with that of medicine. These narratives illustrate when NPs become aware of this merge. This cognitive change illustrates a role transition and creation of a dual boundary – RN/NP and NP/M.D.

Nurse practitioners discussed the transition from nurse to the provider as something that happens over time, during their formal training as well as at the beginning of their NP career. Learning a new role encompasses a distinct set of skills as well as different perspectives than that of a nurse. Making that transition involves a change in thinking as well as developing new clinical skills. NP 12 is a practicing nurse practitioner and a faculty member who trains NP students. She discussed the RN to NP transition as starting in the classroom.

> When you come into [a] nurse practitioner program from being a nurse, there's a change [in] how you look at patients. We look at [the] patient's one way [as a] nurse, and then we kind of […] have to flip the way we look at patients.

This “flip” is a significant step to crossing the boundary between nursing and medicine. She goes on to explain what she means by this.

> When you're looking at the patient from a nurse, you're thinking how this medicine is going to affect them and what they are doing [at] this moment. Whereas, [when] we are looking at it from a, as a nurse practitioner [we are] looking at them [more on a] medical basis and you're saying okay what about this patient makes me think about a certain diagnosis. You're thinking more diagnostic; it is a medical diagnosis that we’re going

> [for]. So, you're not just thinking about how this medicine or how this therapy is going to affect this patient as you do as a nurse. You're thinking about 'what am I going to do to make this diagnosis?'

Developing clinical thinking moves the nurse into the realm of medicine. It brings to the role of the nurse a unique perspective and one that may appear subtle but is profound for the expansion of their occupational boundary.

When an NP starts to work at an advanced role, they encounter the common issue of ambiguity, much like physicians do when they start their training (Haas and Shaffir 1987; Kim and Lee 2018). This similar perception, experienced by NPs, indicates a central transition point. NP 23 discusses this when she talks about what surprised her the most about the NP role.

> Well, I think for me, there's a really big step from [the] staff nurse level. […] The biggest surprise for me was that I had to learn how to live with ambiguity a lot more than I did as a staff nurse […]. You know, as a nurse practitioner, when you diagnose, often you just are not 100% sure. You're pretty sure, and you treat the most likely, you rule out that it's not anything life-threatening and really serious that could cause long-term damage, and then you just really diagnose and just go with the most likely. And I think that's the thing that was the most surprising to me, that there [were] a lot more uncertainty and a lot more ambiguity in that role versus the staff nurse.

Ambiguity in medicine is not new, and the comments of NPs experiencing this illustrates a commonality with medical students. This is not something that NPs comment on as coming from their nursing training; it comes from moving into the world of medicine and suggests a role change.

Integrating clinical thinking into their work is not a smooth boundary to cross, and some NPs can struggle with its development. There is a different feeling when the patient is now your patient, and you feel responsible for the care plan. NP 34 shares that she was "scared to death […] of killing someone". She shared that when she tells her students that, she feels that "everybody nods because everybody feels – most people feel the same way." The perspective change was a standard view and one that marked a transition not only from nurse to nurse practitioner but also from nursing to medicine. The move is not smooth and can take time. NP 20 shared that:

> P: It was really rough. Let me tell you.
>
> I: Tell me.
>
> P: I had about – I had about I'd say between three and six months, I'm not sure how long it was, but even before I graduated, like I could see my mindset shifting from a well, they didn't order it, so I'm not even going to ask about it, you know, like to – to your – you know, your peers and you're like well no, I do need to ask about that because this is our patient too, you know? So, it's just a different mindset where you can't pass that buck on because you're the nurse. I don't know how to explain it. It's just a mindset, and it shifts, and you just accept more responsibility, and you realize that there's no one else that's going to deal with it; I'm going to deal with its kind of thing. And I guess as an RN, you do that as well, but there's even more of it now. Just more of indebtedness to that person because you've taken them on as a patient kind of thing. […] There's a commitment, I guess. […] It's just a mind shift that happens.

While this mind shift starts in school, it continues after graduation, and for some, the shift intensifies. The role change from RN to NP is pronounced and brings with it the need to

negotiate ambiguity and unknowns. This also brings with it the need to rely on theoretical groundings that go beyond that of nursing.

An NP is an RN with advanced training. An essential part of the training is the ability to use theory and not rely on procedures alone. As NP 34 mentions below, this can be a hard lesson to learn.

> As a clinician, it's not as "science-y" as you would think it would be. Nurses – and students are oftentimes frustrated because they want to know the answer. And you can't protocolize health care. It requires this human sort of interaction. […] Most of the time, the things that bring people to – for a health encounter, they're self-limiting. They're going to get better on their own […], And then there's a few times where it's really important to get it right. But a lot of the time, you know, you just go 'let's just watch this for a while, and you call me' – and then it gets better. But people don't like that. When you're in school, and I felt the same way, you want to know what can I do? I've got this pharmacopeia, I've got these things that I can call upon, I've got these tests I can order. What do I do? And sometimes nothing is the best thing to do, but that's harder to learn. And you're also afraid to miss something. So you know, I think about a year in – and I don't know if you've heard this already, but it's a common – one of these tired tropes that you hear in the nursing profession, that you learn more in the first six months on the job than you did in the entire nursing school. And the same thing is true when you graduate from an APRN program. You learn more on the job because you're immersed in it, you're having to do it, and you're doing it every day, and you learn so much more than you ever did when you were a student. You learn more about what the job really is because you think you know, and it turns out [that you] really don't.

This quote shows how NPs begin to realize the boundaries of their role and how clinical thinking is fluid. Also, this type of thinking is crucial and helps to pave the way to becoming an NP.

While some NPs spoke of the RN to NP role as a more linear movement from one to another, other NPs spoke of moving back to the RN role as they made that shift. For the latter group of NPs, the transition was hard because, as they took on the hat of the provider, they did not quickly drop the hat of a nurse. NP 5 had worked as an ER nurse as well as an Acute NP and Primary Care NP. When she first made the transition over to NP, she shared that:

> They actually kind of had to tell me to stop doing it. I would do a lot of stuff that the nurses technically could be doing or should in quotation marks because you had to do it just seems like it was easier for me to do it when I was in there like when I would put stitches in. I would go get all the stuff and put a dressing [on] and clean the patient and put the dressing on wrap them up and then tell them what was going on. And they're like no, no, no; you need to let the nurses do that. You could spend your time seeing the patient and learning and delegating.

This quote illustrates that another aspect of a provider's responsibility is being able to delegate and give orders to others in the clinical space. This skill set is not as strongly linked to the RN role, and, while NP 5 can perform the RN work, it is not her role in this setting. This transition includes an expansion of technical skill and responsibility to the patient, but it also involves an increase in the power and authority over other health care workers. This tension is amplified in discussions over debates on how much RN work experience should be required before one gets their NP license.

RN to NP: The RN Role Influence

Making the transition from RN to NP can be hindered as well as supported by experience as an RN. The shift from one role to another involves the crossing of an internal boundary that is navigated differently within the ranks of NPs. A current debate concerning NPs is the number of years an RN should work before they apply to and train as an NP. This is an intriguing matter in that, for some states and NP programs, the expected years of training are set through regulations. In some states, the regulation is ambiguous, with many programs moving a student from RN to NP with the only nurse experience being acquired in NP school. Whether it is established through a specific law, policy, or social norm, this issue links the NP role with the RN role and illustrates a different kind of boundary that must be negotiated. For some, the process is essential to train a new NP on the nursing side of their provider model. For others, it is a way to stay connected to the tradition of nursing. Another argument, less mentioned but relevant to note, is that by not working as an RN for an extended period, a nurse does not get socialized into a mindset that can be antithetical to the NP role.

NP 15 comments on the advantages and disadvantages of working as an RN before taking on the role of NP as she has seen it.

> [There are] disadvantages to each one. So, I think that for me, what I've seen of the students that are going straight through, it might be a little bit easier for them because they aren't – you know, when you start working in a role, it's hard to transition to another role. And you just don't have the role of bedside nurse incoming – of course, they've got their nursing education, but it's not ingrained in them yet. So, it might be a little bit easier for them to make that, you know, transition in that way. But on the other hand, nurses

with a lot of experience, have a lot of experience and that sometimes shows in, you know, how quickly they'll grasp a lot of the concepts that we're trying to teach them.

For a subset of NPs, there was a sense that working as a nurse before taking on the NP role was beneficial but that working too long could cause problems with the transition. Working as a nurse for an extended period was, by some, looked at as a barrier. NP 26 shared that, when it comes to making a diagnosis, experience as an RN can create a barrier.

And some people are – some nurse practitioners I have mentored seem to be like well, what if – you know, they're very hesitant to make that – to do that. I find that more so if the student has been a nurse for a long time, you know, like 15, 20 plus years, and they're going to NP school. I find that they have a harder time making that transition than somebody that's only been an RN for, you know, five – two, three, five years.

NP 26 connects this with having worked in a secondary role to a physician or other provider and therefore being more familiar with falling back to the core role of a nurse when confronted with having to make a diagnosis and take on the core responsibility for the patient.

They've not had to – you know, that – that hasn't been their responsibility to have to do that. So – but it's – as I said, you feel like, you know, you're walking a balance because, you know, you're there to help out people, but at the same time, you have to know when it's out of your realm, so –

I: When to refer it to someone else?

P: Yes.

This quote illustrates the move from one level of responsibility to another, but it also reveals that there are limits to the responsibility. There is a point where an NP needs to refer to someone else. This is another boundary, and it involves knowing when to pass the patient on to another.

Knowing when to pass authority over to another provider is part of the clinical thinking toolbox, but how much of this is learned by working as an RN before the role of NP is the central question. For NP 32, RN experience is useful but more for exposing her to health care in general and less in terms of teaching clinical thinking skills.

> I think too there is some – and this is just kind of my take on it, I think it would be helpful, although not completely necessary, to have some experience as a nurse before you become a nurse practitioner, because at least when you're a nurse, you have some clinical background to bring to the table. Like I can't imagine these young women that are, you know, just going straight through nursing – getting a nursing degree and going straight through to become a nurse practitioner without any experience. I don't agree with that. But, on the flip side, having 30 years' experience has not particularly helped me in my transition from nurse to nurse practitioner. But what did help me was my experience, the things I had seen, you know what I mean? So that's what I mean when I say it's kind of a mixed bag to kind of – to say it should be this way or this way.

When she talks about the experience, she refers to the general process of health care. Overall, the RN experience "didn't really help with the transition into the new role, you know, because the role itself is completely different from being a nurse." NP 32 makes a distinction here that is worth noting. Gaining familiarity with the process that people go through when ill, whether a specific illness, disease, or something more general, is helpful. Learning the role of NP, however, is its own challenge, and that learning process only occurs through the process of training and working as an NP.

While some NPs focus on the experience as it relates to caring for the patient, others spoke about how working as an NP holds symbolic or subjective importance. These narratives

presented the boundaries of NP being built and constrained by a tradition of holding the position of RN before moving to NP. For example, when talking with NP 27 about the requirement or norm of having worked a specific number of years as an RN, she shared something that corresponded to the comments of others.

> The people that are becoming nurse practitioners now are skipping nursing altogether, and what I mean by that is they're going four years through a baccalaureate program, they're going right into NP school, and they're coming out as nurse practitioners, skipping even working as an RN. I initially -- when I first started seeing this, I thought how dare […] you have to have passion. There has to be a deep-rooted reason why you've come into this field, and I was kind of like I don't like this.

This quote reflects a common view among the NP community. As mentioned above, some say it is to learn the nursing model, and others say it is the experience of seeing sick people and seeing the process, and others hint at it as being a tradition. NP 27 illustrates this in how she connects having a passion for being a nurse and that, by doing so, you prove that you are committed to the profession. However, throughout her career, she changed her perspective.

> I don't like how you know; […] people are coming out of NP school, and they've never worked as a nurse, but they also think differently. Whereas my generation of nursing kind of how we came up through the ranks, we came up in a very oppressed environment. Doctor was the boss, and we did what the doctor said. But that's not the new nurse practitioner. I'm telling you. They are coming out of NP school, and they're not held, bound by that environment that the rest of us worked in, and I've seen it more, and more, and more, and I bet you that this generation moving forward that they're going to be more of a fighter than my generation was because we just kind of sit back and say yes, sir, we'll

> do that, and then when he walks away we'll talk amongst ourselves, 'he was so mean.'[…] But we weren't willing to get up and do anything about it, but I don't see that in this new generation, and so now kind of changing my opinion, maybe you don't have to work 15 years, turning patients, cleaning bedpans, walking patients, to know what's going on. Maybe you don't. Maybe by bypassing that, we might actually start to see change happen because I don't think this generation coming out would put up for a second what I have put up coming through the years with.

Several ideas can be taken from this quote. First, she adds to the earlier discussions that the role of a nurse is a role that is under the control of a physician and that, in this role, following orders is a vital part of the job. She also reinforces the idea that moving from RN to NP offers a challenge in having to change a mindset. It is important to remember that nurse practitioners do not drop the RN license or role and, thus, negotiating the dual boundary can make the RN/NP boundary stable. Second, working as a nurse can provide symbolic meanings and experiences that help with the RN/NP transition. She argues that NPs not getting used to being in a subordinate role to physicians could help to bring about change in the boundaries of NPs due to changed expectations. Her narrative speaks to the tension of role switching from RN to NP and the nuanced ways that the transition can be influenced.

The length of time spent as both an RN and an NP is vital to the role transition and boundary creation between the two. It is also worth considering how historical context could be another issue. The NPs interviewed for this project all work in a state that restricts what they can do as compared to other states. For many NPs, such as NP 27, the need to expand the scope of practice for the profession is essential, and as seen in her narrative, it is something that she thinks may be influenced by the amount of time and ways in which an NP has experienced the RN role.

While some have argued that NPs work to negotiate their role with that of nursing in a way to stay true to the nursing role (Trotter 2019), there could also be a different type of boundary work that recognizes the core identity of a nurse while maintaining a provider role. While an NP works as a provider, they rely on the mindset of a nurse to build an understanding of the patient's condition. A question for further study is how, as NP 27 points out, the career path taken by many new NPs to bypass working as an RN in any significant way may change the NP's professional boundary. One line of inquiry is to ask: Will the sentiment of "I am always a nurse" change, and how does this sentiment vary across types of entry pathways to the role of NP?

Working as an RN is part of the pathway to becoming an NP. It could be argued that it allows for the development of the nursing model as part of being a provider. However, it also links the NP role to the role of a nurse. While there are debates that the word nurse is problematic and some have called for a change of the title, the reality is that being a nurse is perceived as the core of what it means to be an NP. While NPs do work as providers, they are also firmly in the jurisdiction of a nurse. As mentioned earlier by NP 14, the shared space between nursing and medicine is where an NP is found. This means that two different boundaries are defined and defended, that of the RN/NP and that of the NP/M.D. Often, one boundary can influence the creation and maintenance of the other. Furthermore, the boundaries that define this space are flexible and can vary in how easily they are crossed or supported.

While state laws and organizational policies can establish the types of work professionals can perform, the workplace itself is an essential site for defining and defending boundaries (Abbott 1988; Hughes 1958). It is on the ground or the "shop floor" where crucial negotiations of boundaries occur. These negations include how social actors perceive themselves and others.

This chapter offered examples of how NPs create professional boundaries and identities by negotiating a dual-boundary role. This is accomplished by maintaining their nurse identity and by building a prover role that is differentiated from physicians. The next chapter explores how perceptions of the work are created on the ground, in the clinic. Specifically, how is job satisfaction perceived and developed?

CHAPTER 5

CREATING JOB SATISFACTION

This chapter explores how professionals working in restricted work conditions find joy in their work. While changing the conditions to allow NPs to work more autonomously is perceived by many in this study as essential to their professional lives, it was not directly mentioned as part of what makes for a good or bad day. Instead, NPs focused on factors that align with their professional values of care at the clinic level, and unlike state practice laws can be controlled to a greater or lesser degree from their position in the clinic. The narratives highlighted in this chapter show how the appointment time, helpful support staff, and gratitude from patients bring joy to NPs and contribute to an ethos of care that reflects their ideas of professional responsibility. The narratives suggest that it is the perception of a culture that aligns with the practice values of NPs that drive satisfaction. Viewing job satisfaction as a construct involving several factors that are loosely connected allows for a robust way to understand variations in individual work satisfaction.

Exploring lived experiences through narratives can help to unpack the complexity and nuance of job satisfaction (Brown, Charlwood, and Spencer 2012). For NPs, the day-to-day interactions that are important to understanding what makes for a good or bad day occur in the clinical space. The concept of clinical space is most commonly used to refer to the physical aspects of the delivery of health care services, such as the arrangement of equipment or the design and arrangement of exam rooms (Gunn et al. 2015). I expand this definition to include how NPs perceive their interactions with social actors in the clinic. For this analysis, the

individuals involved include the NP, the non-provider support staff (i.e., nurses and medical assistants), the office support staff, and the patient. Interactions between social actors in the clinical space contribute to perceptions of satisfaction and indicate a shared cultural understanding of what is valued in the workplace. This agreement is conceptualized in this study as an ethos of care. NPs identified four factors as contributing to job satisfaction: schedules, the importance of support staff, the patient-provider interaction, and receiving gratitude. The organization of this article starts with a brief literature review followed by the findings and concludes with a discussion of the contributions of this analysis to the literature and theory.

Job Satisfaction in the Literature

Many NPs work in states that restrict their scope of practice, which could influence perceptions of autonomy (Park et al. 2018) and job satisfaction (Choi and De Gagne 2016; De Milt et al. 2011). Issues of low work satisfaction and turnover threaten the potential of this group of providers, with several researchers reporting that job satisfaction is low across several areas of NP work (Bryant-Lukosius et al. 2007; Faris et al. 2010; Kacel et al. 2005; Pasarón 2013; Ryan and Ebbert 2013; Schiestel 2007). Furthermore, lower levels of job satisfaction are linked to perceptions of reduced autonomy and stronger intentions to leave a current position (Choi and De Gagne 2016; De Milt et al. 2011). Similar to research that examines how workers find satisfaction in low-quality jobs, this study broadly explores how NPs working under restrictive conditions experience job satisfaction. Why workers report satisfaction in jobs that are low quality is an area of interest that scholars have highlighted as an empirical problem appropriate for the work of sociologists (Brown et al. 2012.)

The most common approach to NP job satisfaction research is to utilize quantitative methods with a heavy reliance on univariate and multivariate analyses (Hoff, Carabetta, and

Collinson 2017). A recent example is provided by Poghosyan et al. (2017), who uses multilevel logistic regression models. A recent review of the literature notes that, with few exceptions, extant research does not fully utilize demographic or work context variables (Hoff et al. 2017). Some exceptions are Kacel, Miller, and Norris (2005), who found that NPs were most satisfied within their first year of becoming an NP, and Faris et al. (2010), who examined a national sample of NPs working in the Veterans Health Administration.

Additionally, and most relevant to the current study, Poghosyan et al. (2017) focused on primary care NPs working in Massachusetts, where NPs can practice independently from physician collaboration or oversite. The authors suggest that the scope of practice (SOP) set at the state level may influence perceptions of satisfaction, and they argue that intrinsic factors, such as autonomy in practice, are associated with high job satisfaction. While Poghosyan et al. (2017) focused on NPs working solely in a primary care setting in one state, other states with a different SOP may show different results, and they suggest that there is a need to explore these perceptions in different legal settings.

Some NP research examines how organizational policies and attitudes influence NPs and outcomes (Poghosyan, Nannini, and Clarke 2013). This framework utilizes an analysis of the organizational structure to examine working conditions and perceptions, also known as the organizational climate in the NP literature. Poghosyan, Nannini, and Clarke (2013: 135) define organizational climate for NPs in primary care as "[…] a set of organizational attributes, which emerge from the way the organization interacts with NPs and affect NP behaviors and outcomes." For example, Poghosyan, Nannini, Stone, et al. (2013: 346), using in-depth interviews, developed five areas related to organizational climate for NPs practicing in primary care. These are: "… (a) NP-physician relations, (b) independent practice and autonomy, (c)

organizational support and resources, (d) NP-administration relations, and (e) professional visibility." These areas highlight structural factors that can be addressed through policy changes and shed light on prominent issues that, if addressed, could expand the use of NPs in primary care.

In a recent review of research on job satisfaction of NPs as well as PAs, the authors suggested that role expansion for NPs may lead to higher satisfaction (Hoff, Carabetta, and Collinson 2017). However, they also highlight NPs frustration with extrinsic factors such as patient load and short appointment times. The overall picture of job satisfaction for NPs is complicated, and more research is needed that explores the day-to-day work and adaption of NP roles (Hoff et al. 2017; Park et al. 2018). Specifically, what is missing from these studies is how day-to-day interactions play a role in the creation of satisfaction. In both of the recent systematic reviews, Han et al. (2018) and Hoff et al. (2017), note the small number of studies examining job satisfaction and the lack of qualitative studies.

Similarly, Schiestel (2007) suggests that qualitative research be employed to flesh out what makes for job satisfaction. For example, while factors such as patient load and appointment times are linked with low satisfaction, what is driving these perceptions is unclear and begs the question as to what broader social constructs can help explain these self-reports. The current study frames the day-to-day work of NPs in perceptions of values and an ethos of care to help explain why objective factors highlighted in survey research elicit feelings of high or low satisfaction.

To the best of this author's knowledge, there has been little work that has explored this line of inquiry using qualitative methods. Understanding how job satisfaction is perceived and created regarding lived experiences is best done using an on-the-ground approach (Hughes

1958). The current study adds to the body of literature on NP job satisfaction by exploring perceptions of day-to-day work experiences through the narratives of NPs.

Contextualizing Job Satisfaction

The current study is situated in a large, broad body of literature that examines job satisfaction across several occupational domains (e.g., the Australian judiciary [Anlrue and Mack 2014], information professionals [Moniarou-Papaconstantious and Triantafyllou 2015], and care work [Hebson, Rubery, and Grimshaw 2015]). This line of inquiry has illustrated the connection between job satisfaction and life satisfaction, turnover, burnout, and organizational commitment (e.g., Dorenkamp and Ruhle 2019; Hoff et al. 2017; and Prosser et al. 1996).

Many scholars conceptualize job satisfaction as deriving from perceptions of meaningful work (Steger, Dik, and Duffy 2012). Exploring what makes for meaningful work is a pertinent question asked across academic fields and types of work (Rosso, Dekas, and Wrzesniewski 2010). Meaningful work holds importance for an individual and is viewed as a means of producing desirable and worthwhile outcomes (Lysova et al. 2018). In a review of the literature, Rosso et al. (2010) note that there are several ways researches have conceptualized the sources of meaning in work. One frequently used conceptualization is that of work values, or those outcomes that people feel should occur through their work (Lysova et al. 2018; Rosso et al. 2010). In the case of health care providers, values would logically involve helping people. These values, in turn, are part of a clinic or organizational culture that guides actions and interactions.

Exploring the cultural context of work is a staple of work and organization scholars. The development of an ethos or cultural understanding can be a stable driver for how a profession distinguishes itself from others and the tasks they perform (Fayard, Stigliani, and Bechky 2017; Reay et al. 2016). Organizational culture can manifest in feelings that the day-to-day activities or

policies of an organization are natural and have lasting authority. How organizations and corporations accomplish, that is a classic line of inquiry seen in watershed works such as Barley and Kunda (2006), Burawoy (1979), and Rinehart (1997). These lines of research establish how control over employees is manifested using ideologies that can result in individuals' goals matching those of the corporation.

Brown et al. (2012) suggest that qualitative methods of sociological research should go beyond reports of satisfaction. The authors argue that this line of inquiry will assist in getting beyond linking job satisfaction with job quality and provide a nuanced view of why workers find satisfaction in a variety of contexts. In line with this suggestion, Deery, Kolar, and Walsh (2019) explore job satisfaction in dirty work, illustrating how workers find joy in work that otherwise would be considered severe or unpleasant. Developing ways to deal with unpleasant work conditions or an organizational structure that is oppressive, manipulative, or unpleasant is a fruitful line of inquiry for ethnographic research.

Additionally, how workers have invented ways to manage repetitive work and menial tasks illustrate the creativeness that workers employ to bring a sense of joy or meaning to their work (e.g., Burawoy 1979; Edwards 1979; and Hodson 2001). Research exploring how workers maintain a sense of joy in their work illustrates the social nature of that accomplishment and how, in the face of low pay or reduced autonomy, workers develop other needs that, when fulfilled, influence satisfaction. This study highlights another context in which professionals find joy in their work through social interactions that allow for the fulfillment of their values as health care providers.

The current study uses a conceptualization of culture to explore how an ethos can serve the professional and thereby influence perceptions of job satisfaction. While not directly created

by the organization that manages the facility, a culture of care is maintained through the actions of those in the clinic and creates the clinical space wherein NPs can practice care that aligns with their professional values. The findings of this study shed light on links between individual perceptions of meaningful work and factors of organizational culture by exploring the dimensions of what creates joy and frustration for NPs in their day-to-day work. Such data has a promise to expand on previous research and offer consideration of essential variables to include in statistical models. Furthermore, given the focus on a need for more primary care providers, this study provides insights to develop policies and practices that can create and recreate work environments conducive to high satisfaction and, in turn, retention.

How do NPs Talk About Satisfaction?

In this section, perceptions of nurse practitioners illustrate how time and the efforts of non-providers in the clinic influence work satisfaction and how an ethos of care helps to explain the importance of these perceptions. This ethos helps to place each of these themes into a broader conceptualization of what NPs identify as crucial for the making of a good day or satisfaction with work. While each theme is individually relevant to understanding perceptions of job satisfaction, the overarching drive is the delivery of quality care. Examining more broadly what contributes to the delivery of quality care has the potential of discovering context-specific factors to change or maintain.

This section unfolds with a discussion of the importance of scheduling as means of setting up a provider-patient interaction, how this staging is linked to the enactment of valued roles, the importance of support staff in creating the clinical space that allows for NPs to do their best work and the contribution of patient gratitude to perceptions of job satisfaction.

Setting the Stage for Provider-Patient Interaction: Time Matters

Scheduling is important because it sets the time limits for provider-patient interaction. The ideal goal is maintaining the patient volume to meet financial requirements while also accomplishing the professional objectives of helping. However, several barriers must be overcome. Anyone who has had an appointment with a health care provider knows how scheduling can quickly go awry. This section explores NPs' perception of the importance of having adequate time to see a patient and deliver care that meets their ideal of professional obligation.

The issue of scheduling came up in most interviews, but the importance of this issue became clear to me when visiting two rural clinics. The manager of the clinic aided in setting up appointments for any NP who wanted to talk with me. On this day, I visited two clinics and spoke to 7 NPs. The pace of the work was fast, with patients moving in and out of the clinic. People arrived, ambulatory, in wheelchairs, on crutches, and presented several different issues. Walk-ins presented themselves at the reception area and were shuffled back to see a provider or were told that they would need to go to the urgent care clinic down the road. It was apparent that there was a high amount of change and variety at both clinics. One NP saw me between patients while another needed to stop and answer questions from the front office before the interview and one time needing to break so he could handle a question. While one site cannot be representative of all clinics, my conversations with NPs revealed one factor shared by most: scheduling of patients can make or break a day. Whether it was a good day or bad day, often hinged upon patient flow. The narratives of these NPs illustrate that schedules are a defining feature of how a day is perceived and are essential to the delivery of care.

When talking about what makes for a good day, NP 30 summed up what many NPs mentioned by saying that a good day consists of "[…] efficiency, productivity, patient satisfaction (laughs)." Explaining what efficiency means to her, she shares that:

> Efficiency – so I don't like my patients to wait. I like to be able to get them – you know, if they've got an appointment at 10:00 […], I'd like to see them within 15 minutes or so and get their treatment done or be able to go over the information with them. I also don't want to make them feel rushed and make sure that I'm able to answer all of their questions.

Time is an issue repeatedly shared in interviews. Adequate time is crucial because it means that NPs can perform the task and roles that they feel are needed for any given patient. Being able to get the necessary treatment done, collect information from the patient, and answer a patient's questions is essential.

NP 30 also highlights the importance of not wanting her patients to feel rushed. Adequate time allows for a more conducive space to perform their work. For example, NP 2 told me that:

> If you have a 15-minute slot, and somebody calls in 'oh my stomach hurts,' and they end up having who knows what, it takes way more than 15 minutes, and you end up feeling rushed, and it never fails that that person ends up coming in 11:30, at lunchtime, or at 4:30 in the afternoon and they are having some sort of adrenal crisis.

These types of situations create a clinical space that is not conducive to the level of care NPs desire to deliver, resulting in frustration.

In contrast to the above quote, NP26 described her bad days as mostly being connected to a hectic schedule where she is not able to get done what she is trying to achieve for the patient.

> I think being pulled in ten thousand different directions or you know, I have a complicated patient that I just feel like, you know, I can't – either I'm like oh, I'm trying to reach, you know, the physician I work with, I can't reach him […] [or] they're (the front office) yelling at me to go see the next patient, and I'm like oh my gosh. That would be a bad day.

Days such as the one that NP 26 describes can contribute to long days and overwork as NP 20 describes a bad day:

> chaos, not getting to call anybody back until I get home, because I have charts that I can access at home through a secure service. And so, if I get home, you know, and just get started on that, I could be – I could be doing that at 8:00 or 9:00 at night. […], If it's been a rough day in the office.

Both above quotes illustrate the connection between perceptions of good and bad days and the patient flow or schedule. These findings align with survey findings that link insufficient time with patients to low ratings of job satisfaction.

While most NPs shared their frustration with scheduling, for providers who work in rural settings, the issue can be more pronounced. For example, NP 6 worked in a rural clinic and shared a common perception of those who work in these settings.

> Some days we will see patients all day, and they just have one issue going on, and that is ideal. […] Some days, it's like every patient has five things, and you're just not set up; modern medicine's just not set up to address five things in 15 minutes. I don't feel good about that, makes me feel horrible [and it is] horrible for charting and care.

Providers who work in rural settings spoke of the type of patients that they see often have multiple health issues to address. These issues are often the result of infrequent visits for primary

care and low health literacy. What this means for providers is while the matter of time is valuable, it needed to be considered in the context of the patient's needs, both for treatment and education. When there is inadequate time allotted, the level of care can suffer. NP 6 illustrated her concerns on this topic:

> I just feel like [the care given is] skin deep, and sometimes you need to go deep, and I don't have time. It's spreading me out, and it makes me forget things to do. If I have five things to do, and I have these things on my mind, and these are the important things, I don't always feel that my priorities for their care are the same as their [received] care, and so I try and address the things that are pertinent to them but also explain to them that I know you feel good, but your blood pressure is through the roof. So, we need to address that too.

When the schedule is not conducive to an ethos of care as perceived by the NP, and according to the patient's needs, the day-to-day experience becomes frustrating. Juggling the issues of what care is needed within the time frame can result in feelings of frustration that thereby contribute to perceptions of satisfaction.

The influence of the schedule is not static because it is created through interactions with others in the clinical space. Schedules become fluid because humans present with different needs and issues. Walk-in patients, unexpected comorbidity presented by patients, accidental overbooking, and a myriad of other factors can challenge the workflow. The organization of work takes the combined effort of many to create efficient and smooth delivery of care, which in turn links with perceptions of a good day. The following illustrates what factors NPs perceive as necessary to creating a clinical space that fosters high satisfaction

One common way NPs describe a lack of time is being rushed. They know that they cannot possibly address the issues the patients present with when there is inadequate time, which creates frustration and a feeling of dissatisfaction. Not being able to provide care to the level they would prefer is something NPs shared as central to a successful patient-provider interaction and day. The narratives focused on the outcomes for patients. Rough encounters with the staff or other providers were not a theme brought up by NPs as part of a good or bad day.

It Takes an Office

While at first glance, issues of scheduling can be framed as a battle between those who schedule and the providers, this view inadequately describes how the schedule is created. While it was not a surprise that NPs mentioned time as an issue, it was intriguing how they spoke of what makes it work and how this contributes to perceptions of a good day. Per the narratives of NPs, a common theme is that support staff matters. One way this was made clear was through the story of an NP who works at an urban clinic housed in a retail store and who mostly works by herself. NP 4 compared her non-retail work setting to her current setting:

> So, nursing in general is, I would say, collegial. And we support each other tremendously; the most frustrating thing in this environment is that you are completely by yourself. And when I say by yourself, I mean by -- yourself, like if there is an IT problem that comes up you have to fix that if there is any computer issue, hardware, software, you have to fix that [or] if there is an environmental issue, you have to fix that. While you are actually trying to see patients. So that is the frustrating piece, but when you have support, you know they try to be. Like the area director and your clinic's manager, they are very, very, supportive, and that makes a huge difference. They are just not around.

This quote illustrates some of the non-patient factors that must be handled as part of the process of delivering care. She goes on to list some of the things she does, such as greet patients, schedule patients, and make follow up calls to patients. In short, NP 4 performs all the duties of a clinic by herself, for the most part. What NP 4's experience offers is an understanding of what can be taken for granted when thinking of health care delivery and provides an insight into the number of tasks that are needed to create a clinical space that allows for high-quality health care.

The opening of this section illustrates an extreme case to set up the narratives of how the support staff is viewed as a vital part of the clinical space. Working in a busy urban clinic, NP 1 commented on scheduling and shared that to make a good day "[…] support staff can make a huge difference" (word emphasized by NP). This was a common expression made by NPs. The flow of patients and the work can be influenced in many ways by the others. Support staff can include a variety of people with different duties. One position that is central to helping create a good day is assistants, whether they are nurses or medical assistants. NP 1 goes on to explain:

> So, if I have an assistant who is really organized and kind of knows the next step and can anticipate what we are going to need, it saves time, makes things flow better, patients are in and out quicker. But if I have an assistant, it is not a problem here, if I have an assistant that does the bare minimum and doesn't want to have an equal part in taking care of the patient [that is a problem].

Working with others to create the optimum clinical space presents a picture of how individual efforts contribute to the overall goal of patient care. One way this type of teamwork pays off is described by NP 2:

> […] right now, I have got a new medical assistant, she is really great, but she is really scattered … so if she is on task and we get everything done, it's more about getting it done and feeling like you are not rushed, that is the hardest thing, NP 2 (rural)

Assistants can add a way to manage time that can be spent with the patient.

Non-provider personnel play an essential role in creating the best scenario for productive NP-patient interaction. The importance of support staff working to develop an ethos of care allows for a clinical space that is conducive to the type of care the NP wants to deliver. Each member of the clinic plays a part in the delivery of care that, in turn, helps to create job satisfaction. NP 1 describes the actions that are taken by others in the clinic and how she perceives them as vital to her being able to do her work.

> […] I feel like the person who is at the check-in desk, [the person] who is at the checkout desk, [or…] the clinic assistant who brings the patient back, I think [they] are just as important if not more important than me in the whole role. Because if my patient comes in and they are not welcomed at the front in a kind and respected manner, they are already in defense mode, and the medical assistants or clinic assistant, they call them here. […] My assistant [often times] identifies things that need to be addressed by just talking to the patient and a lot of times patients will come in and unload on them and tell them everything and then they have already said it once, and they may not think to say it to me. So, like, these assistants are super good here, they pick up on things all the time and say [to me] 'you may want to talk to her about this' I think that is just so important for people to work together and everyone has such an important role. And the nurses here do a lot of our follow up; it saves us a lot of time. They call, after a procedure, they call the patient, 'how are you doing?'

This quote comes from a conversation about what helps to create a good day, which can also be equated with being able to provide quality care to her patients.

In addition to medical assistants and nurses, office administrators also play a significant role in creating an ethos of care. NP 8 works in a rural primary care setting. When talking about what makes for a good day, she laughed and stated that “The schedule works out correctly.” Talking more about this and who helps make a smooth schedule, she illustrates the importance of teamwork and support:

> […] for the most part, the administrators kind of set [the schedule] and they try to do it the best way possible, so it works with the way I practice and the way other people practice, so they're really good about working with us, but they still want you to try and get as many people in very time-efficient.

Talking with NP 8, it was clear that the care of the patient and working with her practice style was part of what made for a sense of job satisfaction. While past research has highlighted that tensions with the administration have been seen to be a source of dissatisfaction, administrators can also play a significant role in organizing the delivery of health care to support the ethos of care.

Support can also work behind the scenes, and this type of support is only noticed when an NP recognizes that there was no blowback or lousy news due to poor organization. NP 6 works in a rural clinic, and when asked what seems to be the most helpful to create a good day, she told me, “I don't know if I can answer that. I don't always know. I feel like things are closed loop.” She explains this as “people get back to you – that's a big thing – [what] we really try to focus on here is the order goes out [and] the order gets closed. […].” In this case, she is referring to the electronic records systems they use; she goes on to say, “And even just closed loop with people

in the office because people send me telephone and counters and things, I want to know, I never heard anything about this, but did it ever get taken care of?" The use of an electronic medical record system and office policy help to ensure that orders are complied with and that the providers get informed when they are completed. This leads to being able to complete the work and both physically and mentally check it off as done.

NP 15 works in an urban clinic and brings together the main themes of this section when talking about what factors help to create a good day:

> I think for me, it was probably just being able to give the patients – spending time with the patients that I needed to spend to really hear what they were trying to tell me to get, you know, to the correct diagnosis and the best treatment plans that I could. And also just to be honest, I mean, having everybody work together as a team and you know, have the physicians doing what they needed to do and me having my patient load and us all kind of working together to make sure that we took really good care of the patient and that we weren't, you know, rushing through things, or you know, […] somebody else's schedule that wasn't supposed to be there because – you know, I'm not supposed to see that patient, or you're not supposed to see that patient, and you know[…] what we figured out over the years is there were some things that the nurse practitioners handle better, and there were some that the physicians just needed to see. So, the physicians that I worked with were like wow, you know, when you're doing this with these patients, which needed to be done, you know, we can do this.

This quote illustrates an ideal scene where schedules and patients are managed in a way to maximize care. Organizing the delivery of care in this way allowed this clinic to offer the needed care to patients because "everybody is working as a team." When teamwork extends across

providers and support staff, it can contribute to the creation of satisfaction in the work because it allows for providers to fulfill their goals of helping patients.

A central part of the delivery of care and helping to make a good day is the work of support staff and the nursing or medical assistants. This is important for two reasons. First, the NP role can be facilitated or constrained by the support staff. Therefore, accounting for this is essential in understanding workplace satisfaction. Second, the support staff's perceptions of their work and job are also important to know since they are part of clinical space and can influence the job satisfaction of NPs directly or indirectly. While this study cannot get at this connection directly, it does suggest that the satisfaction of other personnel could influence the work and thereby influence the perceptions of the work environment of the NPs.

This section sheds light on how NPs view time and how an ethos of care is created through the interactions with support staff and the solo efforts of these staff. While time and time management are the two major themes discussed, together, they give part of the development of an ethos of care that is created and used to provide quality care. When NPs voice satisfaction with the day, they do so by highlighting how they, with the assistance of others in the clinic, can help a patient and deliver the care they needed. The next question is, what do NPs do with their time when they have it, and how does this highlight the importance of an ethos of care? While detailed accounts of NPs actions are beyond the scope of this work, NPs did share how scheduling and staff support work together to allow for the creation of a clinical space wherein NPs can enact specific roles. These roles align with their perceptions of professional obligation. In the following section, how NPs perceive the link between time and important clinical roles is discussed.

Roles and the Creation of Job Satisfaction

While scheduling is essential to allow for adequate time to spend with a patient, conceptualizing the roles taken during the patient-provider interaction helps to explore the ways NPs find joy in their work. NPs play distinct roles as part of their overarching status as a primary care provider, driven by the patients' needs and questions. These roles are associated with what makes for satisfaction, and the issue of time becomes a resource to correctly choose the actions that will lead to an optimum outcome for the patient and NP. Two main roles emerged from the data that I have termed educator and investigator. I will now discuss how NPs describe these roles and their connections to work satisfaction.

Educator

Educating patients emerged as a primary concern of NPs and part of what brought joy to their work. In addition to providing a prognosis, diagnosis, and treatment plan, many NPs work to ensure their patients' future health by empowering them to take control of their health. At the core of helping patients is instilling a sense that they can help themselves and manage their condition. Accomplishing this with patients is vital to building an ethos of care.

When discussing what made for a good day, NP 4 described how working in a clinic that is housed in a retail store offers a unique setting to educate patients, and this is important to her as to what makes for a successful day.

> It is a great setting to do a lot of preventive care. Talk to them about the annual things that are due that they don't know of, I would say education, and I am a very community-based person […]. They tend to come here because they say it is easier. The time is easier; it's a quick visit. Its, you know, we develop a relationship with people. In a short period of time, I don't follow people, but I have a lot of patients that would specifically

> come to me because I was there, and I know them, and I have watched their kids grow up, it's like a family setting.

What is alluded to in this quote is the perception of the clinical space and how it relates to the opportunity to practice and educate patients. The setting offers a chance to help her patients by educating them on their health conditions, provide ways to practice preventive care, and do so in a setting wherein the patients feel comfortable. In this case, the appointments are quick, but the patient's concerns and the NPs goals are conducive to this time frame. Having the time to educate patients is part of delivering optimal health care, a critical issue brought up by NPs. This does not equate to having long appointments in all cases. What it does suggest is that the time allotted is appropriate for the patient's concerns and condition.

In a more traditional setting, the role of the educator is also perceived as an essential role. NP 32 works in a private urban clinic and has been in the nursing field for close to 20 years. She spoke of her clinic as offering her time to enact the role of an NP fully and that a significant part is being able to educate her patients.

> The patients are complex, and I have time to kind of sort things out while keeping moving. And so yeah, I really enjoy that I have that time […] I mean, one of the things that I love most about my job is educating, educating patients. And I'm very good at it, and I do it in a way that they can understand.

The role of the educator is essential to how NPs conceptualize care and their role as a provider. It is not something that gets added on or something that is nice or is great to do if they have time, it is an essential part of their clinical toolkit and their perceptions of what defines their job as a provider. For NP 32, the types of cases she gets need more time, but she is allowed the time she needs to correctly diagnosis and also to educate patients.

While the role of the educator was shared by many as necessary, a few gave detailed examples of this role. For example, NP 16 works to provide care to a rural area, and her story of a home visit highlights the lived experience of the educator's role. As part of her provider responsibilities, she goes out into the community to do home care visits. When we talked about why she works as an NP, she commented that she enjoys "Just giving a different aspect, a different take of the medical side to the patients [and] just being able to explain to someone in layman's terms what the heck is going on." She shared an encounter with a patient she saw on one of her visits as an example of how she tries to bridge the gap between medical knowledge and her patients' understandings and needs. The patient smoked and had high blood pressure.

> […] he reminded me of a lot of my family members […] I remember my grandfather would go to work, working on cars from sunup to sundown, […] go to sleep to do the same thing over again, so there was no real emphasis on health or whatever. And I had asked [the patient] if he wanted to stop smoking and he said yeah, I thought about it, but you know. So, I was able to turn [relate] that his blood pressure and let him know how that related to smoking and how that related to his blood pressure and let him know how it relates to the cardiovascular disease. I told him basically that things may not be big now, but if you don't stop smoking, what's going to happen is, you're going to lose your leg, and then you're not going to be able to work. So that's sticks. I know it's really important to you to support your family, and that's great, and I commend you for that, but you also have to know that these are the choices that you are making, you know, and I'm just giving you the information.

Conveying information in a manner that garners buy-in gets at the core of what education means for many of these NPs. When the organization of their work aligns with this purpose, it can result

in a favorable outcome for the patient and create satisfaction in the work. She continues by illustrating how she makes her point using her experience and authority:

> […] But what's going to happen to in about 20 years, you're going to lose your leg so you're still making decisions now and he looked at me and right away they called the doctor and made an appointment. […] I'm just letting you know that based on what I have seen for over 20 years, this is going to be the end result. So, I think that he was able to hear me and [I] pray that he follows through.

The one-on-one conversations take time and skill to convey the needed information, and this type of conversation came up several times as part of what makes the NP role meaningful. While this was a home visit, the communication style and the patient-provider interaction illustrate the role of the educator in action.

For some NPs, being able to spend adequate time with the patient is ideal but does not always happen. NP 26 works in a private urban clinic. She discusses the importance of having time to help her patients and what a good day means to her.

> I guess where – this rarely happens, where I can spend adequate time with my patients and I felt like, you know, I've done my job and I've helped them and [moved them] into where they need to be. I mean, most of my patients, being in ambulatory care, you know, they're not like super sick or anything like that. I've obviously had to send some people to the ER, but usually, it's just helping to manage diabetes, high blood pressure, you know, that kind of thing, depression, or whatever.

Having adequate time is an issue, mentioned by many NPs. This links to what constitutes satisfaction with the day's work.

> So, I think my – a good day was when I really felt like again, [I] kind of done my job and helping these people and had them feel like they can help themselves, they have a sense of okay, I can do this, and I'm not going to let, you know, this run my life. I'm going to – you know, I'm going to manage it. And so that for me is a good day. But you know, unfortunately – and this is any provider I think, PA and NP, M.D., is that you don't get enough time to do that, a lot of times. (NP 26)

In this quote, the idea of education is further developed. Empowering patients to take control of their health program is viewed as central to learning. Far from giving a handout or talking for a few minutes about the pros and cons of a treatment plan or medication, this quote shows how education has a goal. This goal can be obtained, as noted above, in a short appointment or may need more time. Regardless, the goal is accomplished by relating to the patient at their level of understanding and spending the time necessary to communicate effectively.

Investigator

The second role that emerged from the narratives of NPs is the investigator. This role, like that of the educator, highlights the importance of having both time and conducive clinical space. The role of the investigator involves interacting with the patient and gathering information. Being able to enact the role of the investigator was linked to perceptions of a good day. For example, NP 11 described that for her picking up on a clue and digging in to see what may be going on is part and parcel to the role of an NP. She illustrates this with an example:

> If [a patient] comes in for something [like] birth control, but they seem sad. I'm not going to just blow off the fact that they seem sad because that's not today's appointment. I'm going to be like, 'hey, you seem really sad, what's going on?' Even though depression is part of that screening, for a nurse practitioner, for birth control, because some birth

> control aids do that. ‘So, tell me about that, how long you have felt sad.’ I've never seen a nurse practitioner let something like that go.

One barrier to this type of exploration is appointment length. By the nature of investigative work, the issues that arise are not always voiced by patients when they make the appointment.

The investigative role is critical for care because unknown or unmentioned problems can be dormant and hidden. Undiscovered health issues can result in further pain and, in some cases, mortality. NP 11 shared that after completing an examination of a patient with a physician colleague and while they were both walking out, she stopped and told the physicians that something did not seem right, and she wanted to talk with the patient more. She had noticed that the patient was very sad, and while the medication she was taking can cause sadness, the intensity of the patients’ symptoms promoted NP 11 to talk with her more.

> So, [I] went back in [and] I said you know we're getting your prescription for estrogen, but I notice that you seem really sad what's going on? Waterworks, tears, and suicidal [ideations]. […] The extra effort of doing that prevented a suicide, I believe, because they had a plan. […] So, we were like okay we need to get you in counseling and ended up with medication for the depression a little bit of a different prescription for estrogen and so counseling, medication, and the thing that the person came in for.

The flexibility of the clinic, the physician, and the investigation skills of the NP were all needed to give this patient the care they needed. The decision of what actions to take and when is couched in a culture that allows for the enactment of roles that align with an agreed-upon definition of care.

As in the above narrative, investigative actions can save a life. Working in a clinical space that facilities these actions is vital. NP 21, who works in a clinic in a non-rural area, shared

how having time with patients allows her to get to know her patients and discover areas of concern that a patient may not volunteer. One example NP 21 gave illustrates this role.

> […] that's one of the things that I'm really happy with the doctor, that we keep the practice small, we get lots of time with the patient. […] I get a chance to talk to the patient, and I know about them. And a day that I'm really proud of is the days that I catch something really big and save a life. Those are always really, really fun days. I did one last Friday. I was getting an EKG, and I predicted everything that would happen to this man based on the EKG, even though he was completely asymptomatic.

She sent the patient to the ER. The patient had surgery to put in a pacemaker, as she had predicted. Being able to take on an issue such as this and help the person – in this case, save a life – underlies the purpose of the work done. She further explains that:

> I'll sense someone is asking me a question or going through a certain thing, and I'll go into it further. So, then I'm able to treat more stuff. Like a lot of times, anxiety or depression, something like that, that you know, you've got a single mom who's got a kid, she's not suicidal […]. But she's just going through so much right now and she just – a lot of times, they just want to be heard. So, bringing that up or talking to them – they would never go to a doctor, counselor, or they don't realize how significant and what a big weight it is, something like that, and just being heard and letting them know what treatment options are out there for them.

These types of conversations take time and a willingness on the part of the provider. The patient coming in with one idea of what may be wrong and the NP, noticing something, exposes another issue of greater or equal importance. This takes time and, thereby, a schedule that is conducive to that type of care.

Positive Feedback: Receiving Gratitude

Once the patient is in the room with the NP, the work itself can be a source of satisfaction or frustration. While studies have indicated that patients rank their satisfaction with NPs as high (Agosta 2009), an area of research that has not been adequately covered is how the interaction with patients can bring a sense of satisfaction to NPs. While the measurable outcomes of the work can bring a sense of accomplishment, such as ratings gathered from patient satisfaction surveys, a group of NPs shared that a significant part of what makes for a good day is receiving confirmation that the work done has had a meaningful outcome. Patient feedback was not conveyed as something they strive for, first and foremost, as their goal is the delivery of the proper care. However, how expressions of gratitude were talked about by NPs made it clear that positive patient feedback contributed significantly to what makes the work meaningful.

Working in a rural clinic that serves a largely indigent population, NP 7 is no stranger to needing to connect her patients to resources outside of the clinic. The resources include access to food banks or being connected with programs that will help defray the costs of medications. When talking about what makes for a good day, she shared how connecting her patients with these resources was a central part of what brought meaning to her work. Also, she stressed that working with an administrator that fully supported these efforts was central. She told me the results seen in her patients' comments, and feedback significantly contributed to a sense of meaning and satisfaction.

> I feel good because the patient feels good. They are so demonstrative of their gratitude. I know somebody else could have done it. I know that, but it was me, and that's why I get up every morning, and I work. Not here [only here] but just wherever because there is

> usually one patient every day that's like [that]. That's why I'm here. All the others are important as well, but there's usually the one that sticks out.

The central part of these narratives of receiving gratitude is knowing that their actions made a difference. This validates the culture of care and the actions taken in the clinical space to deliver quality health care.

Receiving gratitude influenced more than just feelings of appreciation. When days are very hectic, and the pace of work is testing, positive feedback provides a sense of purpose and a boost to confidence. For example, NP 6 works at not for profit outpatient clinic in a rural town that sees a high volume of patients, many of which live below the poverty line. Several of the people cared for by NP 6 have multiple health issues and a limited amount of resources to manage their health. He shared that:

> I think the days I really value and the days that are the best days [are ones that] at the end of the day; I really feel like I made a difference. It could have been totally crazy madness even [and] sometimes one patient coming back and telling you 'I feel better to thank you, whatever we did it worked,' […] that's what I cherish, that's the best day. I feel like I made a difference. And I know I'm smart enough to know people aren't always going to tell you that you're never going to know sometimes, but that's always a great boost of confidence and makes for a good day when somebody says something like that.

Direct patient feedback validates the work, and for many NPs reinforces why they are in the occupation. Being able to have influence and help others is what drives their perceptions of who they are as providers and what makes for a pleasant work environment. The work of health care providers is multifaceted, and each case they see can present with different needs and have

different outcomes. However, the product is to help a patient get the care they need; getting feedback that this goal was reached is essential.

Sometimes patient gratitude comes as a result of a seemingly simple conversation. Some NPs shared that communicating and listening have a profound impact on patients and, in turn, provides an NP with a sense of meaning. NP 3 has worked in health care for over 20 years. She has worked in several different work settings. She spoke about how important knowing that you have influence can be for continuing with the occupation. “So again, it was always that for me, why are you wanting to take care of people? It was never what some employer was going to give me in terms of appreciation. It’s going to be what that patient gave me [….]”. The intrinsic value of the role is a crucial factor in defining the NP role beyond the scope of practice or technical expertise. NP 3 further explains this through recalling a time when she was doing her clinical hours for the NP credential, she shared:

> [For example,] I was in an STD clinic for clinical [and]; honestly, I was just, I was overwhelmed by the clinic I was in. It was a free clinic; it was an STD clinic. […] I got in there, and I was like what is going on with these people I don’t think that I can do this. I left that clinical that day after seeing a female that had repeatedly been going through the same motions, and I remember talking with her and having a conversation and talking about life and where she wanted to be and where she felt she was. I do this with everybody when I can. I didn’t go to clinical for two days and [when] I went back […] she was sitting in the lobby, and she said to me I [have been] waiting for you to come back because you made such an impression on me and I don’t want to be where I am. Now, who can pay like that, you cannot pay any price for what that was worth to me, and

> as I said I was about ready to walk away from this because this is not something I am capable of or even want to do.

For NP 3, the intrinsic value of patient gratitude provides the most fulfilling reward for her work. She also goes on to say that while, of course, she wants to be paid well, it is the patient outcome and the positive feedback that keeps her working in the role. This perception highlights the importance of feedback and, more importantly, results that are known and definite. NP 3 emphasized that:

> I don't want to say you can't pay me enough, [but] you can't put a price tag on it, is what I mean. […] you get beat up [and] you do feel like you want out, but then it's that one patient letter that was written to your boss about how you were and how nice you were or how you helped them or just one word that you may have shared with them […] at the right moment in their life or their situation that they needed to hear it and you were the one to give it to them. That feels good.

It became apparent, after hours of conversation with NPs, that clear positive outcomes drive NP satisfaction and are part of the development of an ethos of care. The conceptualization of what care is and what qualifies as positive outcomes help to define work satisfaction in a way that cannot easily be seen with surveys or frameworks that measure satisfaction as psychological variables.

These data show how the structure of the workplace, as demonstrated in NPs narratives of setting the stage for the provider-patient interaction, enactment of roles, and patient feedback operate within a broader social context. Brown et al. (2012) suggest that an objective model of job satisfaction includes norms and expectations that are socially constructed. In the current study, the perceptions of a good and bad day are situated through the social world of the clinic.

Central to setting the stage for the patient-provider interaction is having sufficient information on the patient's condition. This data is gathered by the support staff from the patient through conversations and using that information to approximate an adequate length of time for the appointment. This is important to the enactment of vital roles. If there is not enough time or information, the efforts of NPs to deliver care is attenuated. When the roles of educator and investigator are enacted, this helps to accomplish the goal of care and therefore adhere to the norms of NP professional practice. Being able to fulfill these roles produces joy and satisfaction with work and contribute to the organizational culture of the clinic.

Another essential psychological outcome for NPs and one that is important as well to studies of work is the perception of autonomy. In the next chapter, how NPs understand and perceive autonomy in the clinics they work in is explored.

CHAPTER 6

Autonomy and Constraints -- One Size Does Not Fit All

[…] we already have some autonomy, but [we could] have a lot more, and it depends on whom you work for. (NP 12)

Autonomy is a central concept explored by studies of professions and work. The adage that 'more is better' is implied in most discussions of control over the tasks and material resources of one's profession. The American Association of Nurse Practitioners presents a clear message for full autonomy for NPs. They use rhetoric that stresses independence and the ability to practice without the necessity of supervision by an M.D. What is less clear, however, is how individual members of the profession perceive this goal for themselves. It would be reasonable to expect, especially in a restricted scope state, to hear stories of frustration with the scope of practice that does not allow for full autonomy. While NPs talk about the need for a full scope of practice, many of the narratives also illustrate a desire for less than full autonomy and a need to rethink when an NP may be ready to practice at their full scope. Therefore, while autonomy is something that can be granted by the state or an organization, it is also a personal perception.

Laws governing practice have been linked to perceptions of autonomy (Poghosyan et al. 2016). However, investigations show that the work environment, among other factors, can influence autonomy (Hernandez and Anderson 2012; Poghosyan et al. 2017; Weiland 2015). The standard argument offered in the cited studies is that restrictive scope of practice laws and resistance to the NP role by physicians and administrators lowers autonomy, which in turn reduces job satisfaction and can result in turnover and burnout. The corollary is that by lifting

restrictions and creating a more NP friendly work environment, perceived autonomy and job satisfaction will increase. While studies have shown how these assumptions can be accurate (Choi and De Gagne 2016; Park et al. 2016; Wang-Romjue 2018), there is also variability in how autonomy is perceived, and this suggests that autonomy is a relational construct (Killackey et al. 2019). This chapter shows how professional perceptions and opinions can shape feelings of autonomy and are varied across lived experiences. The perceptions and experiences shared by NPs in this chapter are framed by interactions at the macro, meso, and micro levels. Exploring these narratives illustrates nuanced ways in which autonomy is perceived in a state that has a restrictive scope of practice. Also, the NP movement to increase autonomy can open the possibilities for those who want to expand their scope, but not all NPs feel the same about to whom or when certain levels of autonomy should be granted.

The chapter is divided into a brief literature review to situate the findings, three sections analyzing the data, and a discussion section. The findings section will unfold, first, with stories of autonomy that illustrate a variety of experiences within the area of primary care across several different clinical settings. Second, NPs differ in how they view autonomy. Far from a call for full autonomy, these narratives illustrate a nuanced opinion of what autonomy means as well as how and when it should be increased. The last findings section will explore how NPs perceive resistance at the micro-level, and its influence on autonomy will be explored. The chapter will conclude with a brief discussion.

Developing Autonomy: Literature Review and Framework

Exploring worker control has a long history in the study of occupations and professions. Nonetheless, this chapter briefly discusses relevant literature that explores autonomy for nurse practitioners, which has helped to frame the current study.

Increasing the scope of practice laws and the use of nurse practitioners has been called for by the Institute of Medicine (Fairman and Okoye 2011). The expansion of state laws to allow for NPs to practice to their fullest training has increased both the numbers of NPs as well as the number of patients receiving treatment by nurse practitioners (Kuo et al. 2013). Furthermore, states with the least restrictive scope of practice laws have shown to have a higher number of NPs practicing in areas with a shortage of primary care providers, including rural communities (Xue et al. 2018). Also, states with a full scope of practice are shown to have more favorable third-party payment policies, increasing the amount paid for visits to NPs (Yee et al. 2013). Overall the research suggests that an increase in the scope of practice provides for several positive outcomes for the profession as well as the public.

Concerns of autonomy at the micro-level are linked to keeping and increasing the workforce as well as increasing the quality of life for NPs. For example, a recent review of the literature showed that perceptions of autonomy have a strong relationship with job satisfaction, patient satisfaction, and positive collaboration with M.D.'s (Choi and De Gagne 2016). A review of qualitative studies exploring autonomy suggests "NPs' roles and responsibilities, practice relationships, and organizational work pressures" (Wang-Romjue 2018:148) as the main themes across the nine studies. These studies highlight how the scope of practice laws may interact with other factors only viable at the interactional level.

For example, Hernandez and Anderson (2012) showed constraints on the ability to practice using a nursing model of care as a factor in lower perceptions of autonomy. Likewise, Poghosyan et al. (2016) found that low comprehension of the role of NPs by administrators and physicians can lower perceived levels of autonomy. In interviews with nine NPs working in a restrictive scope of practice state, Weiland (2015) found that NPs linked high feelings of

autonomy with the ability to practice independently and without the presence of a physician. At the same time, positive relationships with physicians and strong collaborative arrangements built on respect and understanding of the NPs role contributed to autonomy.

Using quantitative analysis, Maylone et al. (2011) suggested that perceptions of collaboration and autonomy were high among NPs, but the two variables were not correlated, suggesting that working relationships may not directly influence autonomy. Furthermore, NPs, with over ten years of experience, reported higher levels of autonomy, suggesting that years of experience may have an influence. Similarly, in a recent review of the literature of primary care nurse practitioners, Choi and De Gagne (2015) found autonomy to be again linked with collaboration, job satisfaction, and personal autonomy. Some of the factors influencing low perceptions of autonomy were the scope of practice laws, lack of support, and lack of prescriptive authority.

Few studies have looked at autonomy across states with a different scope of practice laws. A recent exception is Park et al. (2016), who found that while SOP laws are important, prescriptive authority is most influential on day-to-day autonomy. Using a nationally representative sample of nurse practitioners, Park et al. (2016) found a variety of perceptions of autonomy within states, suggesting that SOP laws are not the only factor driving perceptions. Similarly, Poghosyan, Norful, and Laugesen (2018) interviewed 14 NPs and 12 physicians in the State of New York shortly after the passing of legislation lifting the need to have written practice agreements. The results showed that while the scope of practice laws had changed, the diffusion of the laws into the day-to-day work of NPs has been slow.

The literature suggests that interactions and the clinical environment play a key role in creating and maintaining perceptions of autonomy. However, autonomy is framed as a zero-sum

game in most of the literature. What is not explored is how NPs feel about different levels of autonomy. The following section explores experience-based perceptions of autonomy. Some NPs are satisfied with restrictions and little autonomy, while others are not. In these narratives, the factors that contribute to their professional opinions are revealed. A better understanding of how autonomy is defined and created at the micro-level can help to bring clarity to the issue of diffusion of state laws as well as help introduce new variables to be assessed.

Stories of Autonomy

This section illustrates variations in autonomy through the following narratives that highlight diverse perceptions across various clinical sites and experiences. Also, this section illustrates how autonomy and support are not mutually inclusive and how perceptions of autonomy do not always depend on being able to work within practice authority and are created relationally. The first set of narratives comes from one NP who compares her experiences across three clinics in which two concepts are highlighted. First, how each clinic defines and constructs autonomy, and second, how the NP perceives which types of control best suit her own professional needs. The experiences shared by this NP illustrate how variability in work autonomy can be influenced by the professional fit between the NP and the clinic as well as how policy and inter-professional relationships are essential to consider. The second subsection illustrates experiences from NPs who work in a retail clinic. These stories are selected to show variability in the experiences of those working as primary care NPs in a restrictive state. These data suggest that autonomy is not a static concept and that an NP's agency is part of how autonomy is defined. In other words, what one NP may consider constraining, another may not.

Three Site Perspective: A Vignette

This section discusses the work experiences of NP 1 across three different clinics. Each experience offers a brief account for comparison. Exploring one NP's interactions across three different sites helps to unpack possible variations of work autonomy in the state and set up the rest of the narratives explored in this chapter.

> Well, I have worked in two different types of situations -- one where I was not autonomous at all. [For example,] I worked with a group of six physicians, it was very stressful, because […] they each had their own way of doing things and I had to always stop and think, okay, this is such and such's assigned patient how would they handle this situation, and I would have to kind of, handle it that way. […] If I saw a patient that had to have any kind of procedure, she had to be scheduled with one of the physicians, there was no continuity of care.

The level of autonomy at this clinic was below her practice authority, as well as that of the level the state allowed. However, for a first job, she commented, "I learned a lot; it was a great first job." While her demeanor may frame this experience, the structure of the clinic, while constraining, was not absent of merit. What this suggests is that it is crucial to separate the issue of autonomy from other perceptions, such as support or learning.

Support can be provided in many ways. It is also idiosyncratic, and it is not exclusively linked with autonomy. It is important to note that the training track for NPs includes supervised clinical hours but not a residency with more clinical hours and types of experiences. However, NPs also mention the amount that they learn on the job in the first six months as particularly important to becoming a confident provider. Having support and opportunities to gain experience is viewed as paramount to developing their role.

Sometimes autonomy can be granted, resulting in benefits for practice, but the lack of support can be constraining. NP 1 also worked for a clinic that is federally funded in a rural area of the state. At this site, she was given much autonomy, in contrast to the privately-owned clinic. This experience came with benefits and obstacles. One advantage, also mentioned by others, linked the autonomy of NPs with positive health care delivery.

> I was completely autonomous; it was the opposite end of the spectrum. That had a lot of benefits because the continuity of care for the patients was better.

In other words, the delivery of care for the patient was not interrupted with the need to gain approval to wait for a consultation with an M.D. What this quote suggests is that levels of autonomy can drive variation of the workflow. She goes on to elaborate and compare this site with her past work in a private clinic.

> I kind of did things, I don't want to say my own way, but things were more evidence-based, because when I was in the group of six, a lot of them were older, so they were doing things just the way they have always been done, and they didn't want to hear [about] the latest research […]. So, I was able to do things more evidence-based, so that was good, and then the continuity of care, EB, one other thing… it was also a time-saver, because I didn't have to go with every single patient […] and say, this is the patient, this is the situation, [and the doctor saying] you should do this [and] this, you know. I was just doing it.

In this quote, autonomy is defined as the ability to do the job granted by her practice authority, something she was not able to do in the earlier private clinic. Consequently, she was able to supply care that matched her expectations and training. However, NP 1 also felt that she was on her own, and the level of support was less than ideal.

> I didn't like that because I needed that, I felt like I needed that support because there are situations that I think NPs shouldn't be independent and there were times that I felt I really needed that support that I could [go to someone] and say 'hey what do you think about this.

This quote is insightful for two reasons. First, more autonomy can supply a more continuous workflow and control of their immediate work environment. Second, this quote illustrates how autonomy needs to be separated from the concept of support and that the two are not mutually inclusive. It is important to remember that in this state, each NP has a collaborating physician that can be called to give advice or share a clinical experience. However, these relationships are often managed over a distance, with a variation on the amount of time it takes to receive feedback. Furthermore, as suggested above, the strength of these interactions can vary.

The latter narratives illustrated two ends of the autonomy spectrum. The current site in which NP 1 works highlights a level of autonomy that she described as "just right."

> And then now I am really autonomous in this situation. […], but I still have someone who reads my charts, and you know someone I can go to; I was working in rural medicine before here, and I didn't have anybody. […]
>
> I: [Regarding your current clinic], what seems to be the most helpful aspect of the job -- to keep your autonomy?
>
> P: Well, there are three physicians here. If I need someone, I can easily go to someone, and they do read each of our charts. So, I can; I know that if I do something that they believe may not be appropriate, they will let me know, not that that has happened. But I do kind of have that support behind me.

Support and autonomy in this clinic work together to supply the ideal work environment for NP 1. When asked what she felt contributed the most to creating this environment, she shared:

> So, we have very well written policies and procedures and good physician support. I would say those are they two things. [Allowing] me to practice under my scope, don't expect me to do anything out of scope, but don't hinder me from doing things that are in scope.

The career track of NP 1 is an excellent example of variation in autonomy and feelings toward each level. While there was variation in each clinic, there were also some other health care professionals in the same building who could offer support or consultation. Contrary to this is the experiences of those who work in some retail clinics. Exploring the experiences of NPs that work in clinics housed in a retail store paints another picture of autonomy in this state.

The Retail Clinic Experience

Retail clinics cater to acute health care needs and health issues that can be addressed in a brief period. Furthermore, the clinic space is often small, with minimal staff. Often, NPs work with their managers and collaborating physician off-site. This section focuses on data from NPs who are practicing in retail clinics. The data illustrates similarities and differences with other NPs and settings. In conversations with NP 4, who works in a retail clinic, she revealed her thoughts about autonomy.

> I: Does it have that feeling of being a sole practitioner. You are not, but kind of.
>
> P: No, you are by yourself, laughs, you are the sole practitioner. (laughs) In this system, I can do this, I have been practicing for a long time, and the autonomy is wonderful. I think that is one thing that we love, but at the same thing, it is kinda of a lonely environment,

and you don’t have that ability to bounce information off folks that in any [other] environments you would do so. That’s kinda of a piece in retail itself that is a downer.

There are two points that NP 4 makes that are important when considering autonomy. First, in this retail clinic, NP 4 works by herself. She shared that this means “by, your, self,” laughing, and pausing between each word to emphasize that she is genuinely in the clinic without anyone else. She comments that if there is a tech issue, she manages it herself; if there is a form to fill out, she does it; if there is a patient to call, that is part of her duties. NP4's comment about being by herself aligns with NP 1s experience of having much autonomy but little in the way of support or collegiality. In both cases, there is the technical side, wanting to be able to consult quickly over a case or clinical issue, as well as a personal side, having colleagues around to talk with regardless of the reason.

The retail clinic treatment policies are specific as to what the NP can and cannot do in the course of their treatment. Within the limited clinical boundaries, NP 4 feels that she has complete autonomy. This is an example of how autonomy is relative, and the views shared are framed by factors such as organizational policy and personal preference. NP 4 is not working within her practice authority, but within what she can do, she has autonomy. When questions of autonomy are asked in interviews and surveys, the relative nature of the answers can be overlooked. NP 4 describes how she feels working under limited protocols.

I: Does the retail clinic itself restrict [your scope] even further [than the state]

P: No, because we are fairly independent in that they try to allow as much as possible that we can do and they are always developing ways to expand your scope of practice so in that case, I mean, retail, like I said, is already limited because of the environment that you

> are in, you have to follow those guidelines, but I think in terms of being independent working pretty much by yourself- they try to allow for as much autonomy as possible.

As NP 4 mentions, the clinic is limited, but she feels like she has a good amount of day-to-day autonomy. What this also means is that she is not practicing to her full practice authority, but she is autonomous as far as the work she performs. Separating the concept of practice authority from autonomy is important in that it allows for a more nuanced view of potential work environments. In the case of NP 4, she practices with much autonomy, but due to the guidelines of what services she can offer, she is not practicing to the full level of her training (practice authority). As she describes: "Our scope is not that large."

While the retail clinic can be arranged in a way that the NP works independently and with a high level of autonomy, the same structure can limit the care given, and the types of patients treated. NP 33 also works in a retail clinic and adds some detail to the issues NP 4 brought up.

> I will manage some people's blood pressure; I will start people on, you know, cholesterol medicine. I'll do some minimal management of diabetics. But I'm very, very selective because I see, sometimes, in the wintertime, 20 patients a day myself, and make those phone calls back to patients, and we don't have good follow up on if I make someone go get labs somewhere. I could be off because we work 11 hours, you know, we have days that we're on, days that we're off. There is no nursing staff to grab abnormal labs. It just makes me nervous that things would hang out there on – you know, just not grabbed. So [I am] pretty selective on how far I go with people.

She also mentioned that at one time, she did have an RN who worked with her, but since the company let her go, "I've had to change scope a little bit." The experience NP 33 shares shows

how working by one's self with autonomy over the day-to-day work does not mean autonomy over clinical choices.

The organization of the work environment does not mean that there is no oversight or collaboration. Per Georgia law, the collaborating physician must review 10% of the charts of any NP with whom they have a collaboration agreement. NP 4 comments on this issue:

> So, what they do is evaluate 10% of our charting. […] I only had to call [my collaborating physician] one time, 2 ½ years ago, and I actually couldn't reach her, so I ended up calling the person's neurologists and ended up speaking to him. […] So that's how that worked out, so she evaluated 10% of our charts, and we get feedback from her through our electronic medical system.

Formally, the chart inspection and feedback system are set up for oversight purposes as well as a means for the NP to consult on a case if needed. However, the collaborating physician is only one source. As others also commented, immediate colleagues in the same clinic or system are often available to consult or discuss a case as well. As for the ability to get advice on a patient's treatment or health issue, NP 4 shared:

> If I do need a clinical consultation, she would be the first person that I would try. Well, [my collaborating physician] wouldn't be the first person. If it were something that I just wanted feedback on and some conversation, then I would probably call my clinic manager first, if she was available, if she's not available then I also have another nurse. […] We have a lot of resources we have our clinic manager, we have an educational NP, we have an area director, so right there is three NPs that you could collaborate with. If there is something that I feel I need to talk directly to a physician, then I would call her.

While NP 4 works alone and has a high level of autonomy, she also has a network to use in the course of fulling her obligations as a primary care provider. Being alone and autonomous does not mean being isolated from colleagues and sources of advice and experience. The professional networks NP 4 pulls from are part of the organizational system.

Another element that is different in a retail clinic involves the relationships that can be developed. Consider the distinct advantage for collaboration with a pharmacist that works near the NP's clinic.

> I do have; I do some medication collaboration with our pharmacist. Now that's a great thing about working in retail. The pharmacist is right there we have a good relationship with them, and it's a really good thing. We talk about medicine, a lot of [patients] in retail are so focused on the financial aspect of the medicine, so the pharmacist will help us with what most cost-effective [path]. **[…]** the clinic that I work in is pretty busy. […] The pharmacist and I can go up and talk to [the patient]. They always answer our calls, or they will call us and ask us a question, I think it's a good relationship.

This is a unique story to retail clinics and helps show a relationship with pharmacists that is often not developed. When NPs talk about conflict with people outside of the clinic, it is frequently with a pharmacy that is questioning the authority of the NP to order a specific medication While this tension is not the focus of this dissertation, it is important to mention, because it highlights the difference in autonomy due to an organizational structure and how the professional relationships matter.

Protocols that are written by the organization can structure the work and perceptions of autonomy. NP 23, who works in a different retail clinic than NP 4, described how the process

works and thus illustrates the potential for various levels of autonomy that are created at the clinic level.

> […] we have a guideline that spells out what type of medications we can prescribe for what condition. And it's – those guidelines are very comprehensive. Pretty much everything that I see – that I'm able to treat at [this] clinic is covered under the guidelines. If there's a case where I want to go outside of the guidelines, I actually have to call my collaborating physician and get the okay, [for example], 'can I order this medication?'

The clinic protocols determine the level of autonomy as well as the allowable work tasks. These protocols can align with practice authority or be set below the education and training level of the NP. As NP 23 illustrates:

> If I go outside of the guidelines and it's not included in that, which that's not – knowledge-wise, as a nurse practitioner, I know that I would not need to get the clearance from the M.D., but regulatory wise, I have to do that extra step. And I do understand from the M.D. [point of view], because actually the prescription is called in under their name, so they will want to be notified if I go outside of the agreed-upon guidelines.

This quote shows an example of the on-site practice authority that is developed with the collaborating/supervising physician. The agreement between the NP and the physician is termed the protocol agreement, and the level of practice, what the NP can do, may be different from what the state-level policy allows. It also highlights the potential for tension and dissatisfaction. As NP 23 points out if she wants to do something in the course of providing care that is within her practice authority but is not included in the protocol signed and agreed with the collaborating physician, she needs to contact and consult with the physician.

This section explored four diverse types of clinics, a private clinic, a rural federally funded clinic, a state-funded health home, and a retail clinic. Through exploring stories across different organizational types of primary clinics, this section illustrates variations in perceptions of autonomy and how the structure of the clinic may play a role. Two principal issues are highlighted by NPs narratives: first, how autonomy and support can operate separately; and second, that organizational structure and policies can operate separately from state scope of practice laws.

Far from a Clear-Cut Stance of "Give Us Autonomy Now"

Full professional autonomy for nurse practitioners is central to the platform of the national association (AANP). More specifically, the AANP argues that what an NP is trained to do (practice authority) should be reflected in laws that govern the level they can practice at (scope of practice laws), and NPs should have full autonomy for those related tasks. The intention to align practice authority, the scope of practice and autonomy is known to all NPs as central to the national level associations lobbying efforts. However, stories of autonomy reveal a variety of experiences and reflect various meanings of what ideal autonomy looks like at the individual level. Also, the narratives in this section show a variation of professional opinion as to whom and when on a person's career track an increase in autonomy should be granted. This chapter highlights the professional opinions of NPs regarding autonomy, allowing for a textured view of the issues and suggests possible areas of the structure that underlie contentions. The following section analyzes the stories, opinions, and perceptions of NPs as they relate to the scope of practice and autonomy.

As mentioned above, the central argument from NP leadership is to align SOP with practice authority. While many NPs agree with the expansion of the scope of practice laws, there

are variations in professional opinions. Some NPs suggest that alignment between state laws and practice authority can occur but must be moderated by years of experience. For example, NP 23 laid out these two factors when asked about her qualifications to work in her clinic.

> Training wise and experience wise [I am qualified]. Now, I do want to say one caveat to all of that, and I know that probably some of my nurse practitioner colleagues would be very upset if they heard me say that, but I know there is a lot of discussion about fully independent practice for nurse practitioners, especially in some of the Western states where they do not need any type of collaborating physician.[…] To be honest with you, I know there's a really big push for that, but I'm not sure I'm 100% for that, and I'll tell you why. It depends. If I'm […] an experienced nurse practitioner or if I have worked in a certain setting as a staff nurse, and then I transition into a nurse practitioner role, I would be qualified to do that. But if I'm, say, a nurse practitioner that worked in family practice and then I want a change and go in another specialty, I would just – I would either need a little bit more training, or I would really need that relationship with a specialist physician to teach me.

A few NPs prefaced their comments by saying that their thoughts about autonomy were in the minority opinion. However, a common comment was that an NP needs to have the training and proven experience in addition to formal education to be granted complete independence. These opinions suggest that while NPs are educated to their full scope of practice, the resulting confidence and perceived skill level does not raise the level of being able to work independently straight from school. Instead, the prevailing sentiment is that there needs to be a connection with a physician, at least for some time, before an NP gains more or full autonomy.

The NP/M.D. relationship can offer more than state-mandated supervision. For some NPs, the M.D. is perceived as someone with more experience, knowledge, and as a colleague that can help advise and mentor. NP 1 shared her thoughts about how the states SOP laws influenced her work; she said:

> I am probably in the minority with nurse practitioners. But I like the fact the somebody reads my charts- laughs. […] I feel that it covers. I feel like from a liability standpoint. I am covered. I like being held accountable. A lot of NPs find it offensive that their charts are read, but I just don't, I just don't, to me, it's just like well, I don't. There is always somebody there to say well we could do this differently or whatever. Part of me would love to have my own practice, independent practice. You can't do that in GA. But, the other side of me says, that's probably really not a good idea.

The professional views that are given by NP 23 and NP 1 were given with qualifiers that suggested that they do not believe that they are in the majority. However, in interviews and conversations with NPs, there is a sense that the training to becoming an NP, while strong, could be made stronger. For example, a residency program was mentioned by NPs and is also part of a national conversation. NPs in the state do need clinical hours. However, there is often difficulty in getting connected with a practice that can supply the needed training and education.

The combination of education and clinical experience, as discussed in earlier chapters, is vital to building confidence. An extensive literature exists that illustrates how education in medical training works to build confidence and a sense of competence**.** Completing medical training acts as a type of cultural capital that is viewed by others as valuable and deserving of trust (Haas and Shaffir 1987). This type of capital is missing with many NPs and is only gained or perceived to be procured after years of on-the-job training. However, the training received

while working is site-specific and dependent on the relationships and personalities of those involved.

For example, NP 22 commented on autonomy in her clinic and how the in-house physicians work to support her practice and delivery of care.

> We do still have a good bit of autonomy if you're working in a good work situation and the physicians I've been since 2003 […] they have been extremely supportive, and that's been very good. In fact, if I come and ask either of them […] whether it's my supervising or the other one, they'll just give me advice. I have to state if I'm really concerned about something, would you please come to look at this person's stomach, you know? I don't like what I see, because […] they trust me. They always – I always feel like if I consult with one of them and they tell me this is what I would do, that legally that's what I better do.

This quote echoes those in the previous section, but also adds another brief but essential element. NP 22 refers to legal obligations and that clinic advice equated with not only good health care delivery, but what is better from a legal viewpoint.

In addition to viewing clinic advice in a way that is linked to a legal view, NP 22 also shares that she feels obligated to take the advice.

> Because I've asked for the consult, I've gotten it, and I should abide by it, which is, you know, some part of an Uncle Tom sort of way of looking at it, but – and I always chart if I consult with one of the doctors, whom I consulted with and what they recommended I do.

This quote highlights two points. First, NP 22 felt an obligation to follow through with the clinical advice given, suggesting a power dynamic that is in contrast to practice authority

aligning with SOP. Second, the way she frames her decision is done in a way that suggests she feels she is betraying her profession. The tensions over the scope of practice laws are framed as a tension between nurse practitioners and physicians. However, professional opinions and needs vary within the nursing community.

While practice authority aligning with SOP is one issue, a related issue is that of NPs having an independent practice. This is similar but gives an NP the right to open their own practice without a physician involved in any way. While NPs work under their license regardless of SOP laws, independent practice is something some NPs commented on directly.

NP 1 shared her professional opinion on the issue of independent practice

> I don't know I just kinda feel like maybe I don't have the credentials, Well I don't have the credentials now to do it, but I don't know. I am kind of torn, I kinda feel like NPs probably need physician's backup. And I think I am very much in the minority. Laughs. Oh, man

She expanded on this and how education and experience are essential.

> Education and experience, you know think about it, they are in medical school for four years, and then they have to do a residency, NP we don't have to any work experience before you become an NP it's not required, and I think that is where you learn all of your, through work experience. I know I am in the minority; I am probably the only person that will answer the question that way. You are going to find that I am definitely in the minority.

She is not in the minority. Several states have passed or suggested a tiered approach to NP practice independence. When an NP should be able to work independently from a physician is

the main issue. The issue is not an either-or proposition. In the interviews for the current study, a variety of opinions were offered.

NPs feel that they gain a lot of needed experience and knowledge working on the job after graduation and certification. Regarding how qualified NPs are to open their independent clinical practice straight out of school, NP 10 said: Not straight out of school. I mean I think you have to be 15 years and I don't know that's a hard one for me because. […] really. I mean, I think you should always still be under an M.D. and have someone who is your collaborating physician so you can call them or text them for questions at any time.

NPs' perceptions of their profession's relationship with physicians varied. While some new NPs, such as NP 2 and NP 10, felt that they needed an M.D. to practice, others that had much experience also felt that there should be a connection with physicians and NPs. Often ten to fifteen years of experience was mentioned as a pre-requisite for complete independence.

However, no justification or reasoning was offered to support the number of years needed before an NP could open an independent practice. NP 19 did offer some clarity to the issue. She starts by talking about how, when she worked in oncology, the delivery of care was very team-based, and the physician was the head of the team and that it is an effective team model and how experience is needed for those who work in a specialty or primary care.

> I believe that in specialties […] it's not a bad idea […] it's a good thing that the doctor is there and he's helping and making the determination. He's got a lot of years of experience, which I can say that some nurse practitioners have a lot of experience too and probably, you know, once they have been there for 15 years or so, they may be able to have an equal – you know, I'm not even going to say that many years. [to build], you know, understanding of the specialty, it could be even less.

The argument is that NPs need to spend time learning outside of school. This was common among NPs, and many mentioned that a lot is learned within the first six months after graduating. The need-for-experience argument is often justified by comparing with the training of M.D.s:

> But knowing that doctors have that […] how can I say, they have the residency and more experience than the nurse practitioner who just comes out of school, you know, and learn as they go. Learn on the job. It's on the job training. So, you know, there's the difference right there. But so that means with that, the nurse practitioner would have to actually learn – you know, they would gain the knowledge that the doctor already has, but it's still good for somebody who's been specializing and has a lot of that experience in that specialty -NP 19

Professional opinions of NPs stress the importance of experience with the way the education and training tracks are set up. NP 8 comments on this as a part of the issue with the track.

> I feel like they would need more experience. I think you've got to have that because it's possible they could go from nursing school maybe work a year maybe go to practice

While state laws are viewed as essential and lobbying is needed to expand these laws, perceptions of NPs point to the need for a change in the training and education track for NPs to align with the goals of more autonomy and independent practice. Most often noticed is the lack of a standard residency program. The type and rigor of on-the-job training are idiosyncratic, and the number of years many NPs felt was needed far extends that of any medical residency. Lack of confidence and issues of feeling inexperienced highlight structural issues behind training and education tracks.

This chapter has explored perceptions of autonomy across different clinic types, illustrating the influence of structure and culture regarding proper levels of autonomy. Many of

the narratives offered thus far come from NPs commenting on their experiences in the state of Georgia. Each one has only worked in Georgia, and the SOP laws and policy environment are all that they have experienced. However, several narratives were collected from NPs who had worked in states with a higher level of autonomy than Georgia. The comments from these NPs gives further evidence for a cultural explanation for various level of autonomy and scope that can, in turn, help to explain different structural factors.

Narratives comparing the scope of practice granted by other states to Georgia came up several times. These quotes show how the variation in SOP across states work to frame the opinions and lived experiences of NPs. One explanation for various views on the scope is that the structure that allows for SOP creates a culture that drives and keeps in place views of the profession, both from within and from without. NP 12 shared that:

> I feel [that] Georgia is behind the times. You've got Colorado, California, New York, Alaska, and you have these […] states that are like basically -- they say you have this training go forth and help people. And not in a reckless way, you know, there's a, you can Google just look, and you know state breakdown of states. And then you look at Georgia, Alabama and you're like […] what's going on. It's really sad. It's really sad. Again I do think it depends on the person you work with or the group you work with because you can be given a lot of autonomy, but then there are also others I've talked to, nurse practitioners, whom they don't get to do anything. They're just a glorified nurse.

This quote highlights two perceptions. First, that structure in the form of state laws can influence perceptions of autonomy; and second, the importance of micro-level decisions that grow from interactions that develop a professional culture that leads to more autonomy.

NP 4 compares her experiences across states with different SOPs. Her quote highlights how working under an expanded scope does not exclude collaboration and how working independently can influence your professional views.

> I also worked in NH, where you can practice completely independently, and I have done that. […] It's an amazing feeling; it's like I tell ya the level of accord you have with your patients when you don't feel restricted. I mean, it's a phenomenal feeling, and you feel that you can do a lot for them, and you are able to spend the time with them.

Feelings of autonomy provide for a sense of fulfillment for NP 4, but these same feelings are also felt by NPs working within lower levels of scope.

However, working together with physicians without restrictions brings with it a different sense of professional autonomy and identity.

> The practice that I worked in did have a physician, […] you obviously do not need a collaborating physician. But just the feeling of autonomy and working together as a team and not having that oversight, not that I am saying that not having any oversight is a horrible or great thing, either way. I think that the ability to collaborate with people is essential; you always need someone to get feedback from and bounce a thought off of, which is essential in any environment. Particularly in medicine.

Similar to what other NPs have mentioned, the delivery of health care necessities communication and collaboration with other health professionals. While NP 4 is advocating for independent practice, she also perceives her role as a member of the team. The solo practitioner, completely on her own and detached from others, is not an image she promotes or sees for herself. The work and the treatment of patients are viewed as naturally collaborative to achieve the best outcomes for the patients. She goes on to unpack the meanings behind her beliefs.

> No one knows everything, so to have that is great, but there has to be a mutual level of collaboration, a mutual level of respect, a mutual level of being colleagues versus saying this is nice, supervising physicians because right then and there you are restricted, and I think that NPs are educated, smart, they are very well rounded, they can practice independently and do so and [can] do so much more if they didn't have that barrier. Now, are there some collaborating physicians or supervising physicians that allow to you to be just as autonomous as you want to be, which is great but then you have that oversight that is just so restrictive that you can't breathe and it doesn't make any sense, and it's kind of a damper on your role.

The quote highlights how the meaning behind independence or supervision has symbolic power as well as real consequences. The tension highlighted is between the actual skill of the NP and the ability to do the work and beliefs by others that doubt that ability. This quote also points out that the level of autonomy in restrictive or limited environments can resemble full scope, depending on the supervising physician. The latter observation creates a work environment, at the meso level, that is unpredictable and idiosyncratic.

Observations and experiences of the scope of practice laws in other states cannot be discounted as an influencing factor on perceptions of autonomy. Coming out of school in the earlier part of the twenty-first century one NP looked at other states and thought

> […] to find out [that] in other states, nurse practitioners have their own clinics, they – I mean, I was like wow, you know? I thought that was great. I think it's great, and it was like, you know, I might want to have my own clinic, you know? I could do my own clinic. I could be in, you know, rural Georgia, having my own clinic, taking care of patients, you know, who need routine, you know, diabetes or blood pressure or you

know, things like that. I thought opening my own clinic would be – that would be great. But then it was like no, you know, you need to have a physician. And then I think now you're not allowed to hire a physician. […] it was like oh my gosh.

The understanding of autonomy is illustrated in this quote as being formed by observation of other state practice environments against the actual practice environment in the state one works. This shows another set of factors that can influence perceptions of autonomy. It also suggests that professional opinions of autonomy are related to categories. That is, NPs can view their own level of autonomy by comparing their level of practice with others in a different state.

Similarly, knowing the scope of practice can be greater, and having worked in that scope can influence current perceptions. For example, NP 3 has worked in two different states for the same health care corporation. Her experience was unique in that while she worked for the same company. The scope of practice had to change when she moved due to state laws. Her feelings toward autonomy were that she was being "dumbed down." Staying in the job served a financial need but not a professional one.

Views of autonomy are not created in a vacuum. Narratives of NPs who have worked in states that have a higher scope of practice than Georgia evaluate their experiences in part if not in whole considering their past work experience. When the need for health care providers is considered, these data suggest a need to explore how training and working in states with low or high levels of scope impact the movement of these professionals across states. An in-depth analysis of this issue is beyond the scope of this study and one that was not foreseen at the beginning of the project. Examining the choices of NPs to move to a state based on the state's SOP laws may help to predict the workforce migration and numbers in states and areas in great need.

The Influence of Unfamiliarity on a Culture of Conflict

The previous sections highlighted how structural and cultural factors can influence perceptions of autonomy and that work experience varied across the participants. Some found their working relationships with physicians supportive, while others experienced tension, distrust, and constraints. Through these narratives, a complex picture of job autonomy appears formed by both structure and culture. These experiences can be explained through a cultural lens that considers history and personal attitudes. The positionality of NPs is often framed as a provider that is not an M.D. and in need of supervision by a physician. There is a concern among some in the medical community both locally and nationally over NP scope of practice. These debates and their corresponding attitudes can create a culture of work that many NPs must confront in their day-to-day work. Still, as will be illustrated later in this section, this is not uniform across work contexts or experiences. However, to paint a picture of the perceptions of autonomy, it is important to get a sense of the conflicts NPs shared and how conflicts are often grounded in cultural and personal factors.

A common theme was that of NPs needing to prove themselves or build trust when working with a new physician. While showing competence upon entrance to a new position is standard, NPs spoke of needing to negotiate suspicion or mistrust that is distinctly different. When talking with NP 17, she explained:

> So, on top of trying to practice, […we] have to prove that despite the study information that we provide equal or better care than physicians in primary care, on certain measures, [and] at least one of the measures is safe, competent care. […] we still tend to have to prove ourselves, whereas physicians don't.

This resistance acts in a way to invalidate and bring into question an NP's training and licensure and is often the first barrier an NP must overcome to establish their immediate scope.

The perception is further backed by the idea that NPs and M.D.s are at great odds with one another at the professional level. This tension helps to form NPs perceptions as to the resistance they receive at the micro-level. NP 17 explains: "So, it really is – it's a turf war, and it's sad because it should be about patient care. But it's really turning into kind of an ugly turf war."

It is logical to surmise that if NPs and M.D.s in a given clinic harbor mistrust or feelings of unease toward each other that tensions could arise. The result is a work environment driven by cultural factors that can influence levels of autonomy and collegiality.

One way by which cultural factors were perceived to influence the work of NPs is through over monitoring. NP 15 describes the clinic she works in as much more restrictive than where she worked prior. She explains that the physicians there take a micro-manage approach beyond what is required by law.

> I think physicians in our group want to monitor and have more say in what we do and want to get paid more for doing that role -- We have one physician in our group especially who wants to ride you on everything you do and have a say in everything you do and wants you to come to [them] for okay for doing, you know, simple little things, ordering simple little things.

The restriction or over monitoring can be linked to the attitudes toward NPs as not being able to fully operate as providers of care as well as a perception of needing to oversee the work of NPs. It also highlights an unfamiliarity to the role and supports previous findings.

Tension and fear over who sees the patients and the level of NP autonomy can cause NPs to be very cautious and aware of how an M.D. will react. For many, needing to be careful not to somehow step on toes is simply a part of the daily routine. These perceptions are rooted in experiences where the professional competence of NPs is challenged overtly. For example, NP 28 recalls that in one setting, an M.D. launched a campaign to educate patients as to what NPs can do as compared to himself.

> A physician that was my supervising physician in my last practice actually had this chart, and he would take [it] in and show his patients to show how much more education he had than us nurse practitioners […] You sometimes feel like you're walking on eggshells.

NP 28 also mentions that not all physicians resist NPs' full scope or try to lessen their role. This is important to highlight. As has been mentioned earlier in the chapter, many NPs experience positive relationships with physicians. However, when tensions exist, a culture that constrains autonomy can be created. These restrictions can go beyond that of the state's scope of practice.

One influential factor is that of experience working with NPs. NP14, who has worked in the role of an NP for over 20 years, shared with me his experience with the process of gaining acceptance from non-NPs:

> Those that don't know me or who don't work with me are hostile. Once they work with me a little, well, they're not hostile, and it's, and I don't think it's with me I think it's a familiarity with the role.

The first encounter an NP has with a physician can be one that questions the NP's role and intention. NP 30 describes her experience with this and how it can vary across providers.

> Some physicians […] don't want them [you] to treat their patients, you know, that kind of thing. And some of them – some of them love them. Some of them have been great educators for me, you know, kind of take you under their wing, and they show you stuff, and they teach you stuff, and you know, they're willing to answer questions. And some of them are just like don't bother me.

This quote highlights the variation that can be found in relationships with physicians and how this can influence autonomy in an idiosyncratic manner. Secondly, when an NP has worked with a set of physicians for some time, familiarity with the role occurs. This familiarity is not only with the NPs competence as a provider but also an understanding that NPs are not trying to take the M.D.s job or patients. This is an important distinction and parses out two issues. First, there is the question of competence, specifically, can this NP deliver the level of care they are claiming to be trained to perform? Second is the issue of role acceptance to perform these healthcare-related tasks. Where NPs experienced the first issue, they quickly overcame concerns; when they also encountered the second issue of role acceptance, resistance becomes slower to resolve and sometimes stayed constant.

Like the structural factors such as organizational treatment protocols, the cultural influence was not consistent across NPs lived experiences. Even those that experienced conflict over their role also had shared occurrences of supportive and collaborative relationships with physicians. Scope of practice laws, organizational policies, and attitudes of others toward NPs all play a role in the creation of perceptions of autonomy, and each can vary across clinical settings and NPs' experiences. The variation experienced by the participants illustrates how perceptions of autonomy can vary but also change when an NP moves to another clinic or works with a different group of medical professionals.

Chapters 5 and 6 explored the perceptions of the work of NPs through narratives and offered an inductive analysis of these data. The next two chapters build from these findings and utilize a national data set to explore questions that cannot be accessed by the qualitative data provided above. In Chapter 5, how NPs perceived a good and bad day was investigated, and the concept of time was central to the findings. The following chapter builds from these findings and asks how perceptions of job satisfaction are linked to time and specific tasks.

CHAPTER 7

THE GOLDILOCKS EFFECT OF JOB SATISFACTION: A VARIABLE ORIENTED EXAMINATION OF THE EFFECTS OF WORK CONTEXT ON JOB SATISFACTION

Nurse practitioners hold the promise of helping to meet the growing demand for health care services (Green, Savin, and Lu 2013). Therefore, a primary focus of research on NPs is to understand the factors associated with the wellbeing of nurse practitioners, notably turnover-intention (Hoff et al. 2017; Poghosyan et al. 2017) and job satisfaction (e.g., Faris et al. 2010; Misener and Cox 2001; Pasarón 2013). A crucial factor shown to influence turnover and exiting is job satisfaction (De Milt, Fitzpatrick, and McNulty 2011; Hoff et al. 2017), which has received a considerable amount of attention from researchers.

Chapter 5 used a person-oriented approach to explore the joy and frustrations of work on the clinic floor. In this chapter, I employ a variable-oriented approach to examine how aspects of the work of NPs shapes job satisfaction. Specifically, this chapter examines how job satisfaction may be influenced by the amount of time spent on various tasks, perceptions of that time, and the division of labor for several essential services provided by primary care providers.

Literature Review

People invest a significant amount of time and effort into their work-life, and therefore the area work is of great interest to sociologists among other social scientists. Examining the work itself has produced volumes of research that have shed light on numerous jobs, occupations, and professions (e.g., Barley and Kunda 2006; Becker et al. 1961; Becker and Carper 1956; Braverman 1974; Hodson 2001b). The underlying questions of these studies

primarily followed a person-oriented approach. That is, an approach grounded in qualitative methods and in the tradition of Everett Hughes that produced several watershed studies deeply exploring a single profession (Solomon 1968). These studies inevitably look at the connection between social actors and their work.

Another approach is to use quantitative methods to answer empirical questions related to work by identifying key variables and examining their relationship with each other and the central variable(s) of interest. In other words, a variable approach to how the work context influences outcomes for the individual, occupation, or the interests of the employer.

Job satisfaction is traditionally used as an indicator to examine the perceptions of the nurse practitioner's autonomy and intentions to leave (Choi and De Gagne 2016; De Milt et al. 2011). In short, if job satisfaction is high, then it is expected that NPs' autonomy will be high, and the intention to leave the job low. Research has utilized both quantitative and qualitative methods to explore job satisfaction of NPs, as discussed in Chapter 5. Survey research is commonly used in NP job satisfaction research (Hoff et al. 2017), and a large number of these projects use the Misener-Cox Nurse Practitioner Scale developed in 2001 (see Misener and Cox 2001 for details of the scales' development). The scale uses a 6-point Likert scale that ranges from very satisfied to very dissatisfied across 44 items. The construction of this scale measures two conceptualizations of job satisfaction: intrinsic and extrinsic values. The former is associated with aspects of the work, and the latter is often related to issues of the job, such as pay, hours, and opportunity for promotion (Misener and Cox 2001).

In the broader literature, job satisfaction is a measure of a subjective assessment of work experiences and is measured as an overall perception (Brown et al. 2012; Judge et al. 2017). The nature of a measure, such as job satisfaction, is that each person, even in the same job, can have a

different value for what makes for satisfaction either in the aggregate or concerning one dimension of the work (Brown et al. 2012; Kalleberg 1977). Therefore, job satisfaction can be hard to measure with any consistency since it can be related to both psychological and contextual factors. A single measure of job satisfaction risks overestimating or underestimating real satisfaction (Bozeman and Gaughan 2011:118). Rose (2003) argues that in approaching an examination of job satisfaction, attention should be given to separating the job from work. This clarification is operationalized as extrinsic aspects associated with "job," such as promotions, pay, opportunities for professional improvement, and intrinsic elements, such as work context and relationships with administration associated with "work."

All work consists of tasks, some of which may bring more satisfaction than others. Tasks can be tedious, repetitious, challenging, and have various degrees of alignment with what a person thinks they should be doing or wants to do. Therefore, is it the amount of time spent on a task or group of tasks that influence perceptions of global job satisfaction of a job, or is it that social actors perceive jobs and work tasks differently? In other words, is the perception of the task more important than the actual time involved in doing the task?

Organization of Work: The Division of Labor in the Clinic

In this analysis, the division of labor in the primary care clinic refers to who does what tasks relating to patient care. These include face to face care, education of the patient and family, record keeping, follow-ups, referrals, and issuing prescriptions. As discussed in detail in Chapter 2, the central focus of the nurse practitioner movement is to expand the role of NPs and achieve the passing of laws that allows NPs to practice to their full knowledge and training. However, research indicates that the state-sanctioned level of practice does not always reflect that of the clinic (Poghosyan et al. 2018), indicating that even when laws are passed to expand NPs roles,

diffusion happens in the clinic and through inter-professional interactions. That is, work environments matter and that support of the NP role is vital to job satisfaction (Dillon et al. 2016; Pasarón 2013). For example, Poghosyan, Nannini, and Clarke (2013:134) report that organizational climate consisting of "autonomy, NP-physician relations, and professional visibility" is vital in considering the perceptions of nurse practitioners of their work and profession. Together this line of research suggests that what NPs do in the clinic is essential; it also suggests that constraints on NP practice can lead to lower levels of satisfaction. That is, the division of labor -- who does what in the clinic -- would be expected to influence perceptions of the job and satisfaction.

Several studies have illustrated that intrinsic factors are drivers of high satisfaction. Some examples are autonomy (Kacel et al. 2005; Pasarón 2013; Ryan and Ebbert 2013), time for face-to-face patient care, challenge, variety in patients (Kacel et al. 2005; Misener and Cox 2001), and respect from doctors (Chattopadhyay, Zangaro, and White 2015; Faris et al. 2010). Also, in a study of advanced practice nurses (APN) in the Veterans Health Administration, Faris et al. (2010) found that having to perform a large amount of non-APN tasks was associated with a perceived barrier to their practice. Therefore, does the division of labor influence job satisfaction? Given the previous research, it would be expected to affect perceptions. For example, if NPs are relegated to duties, they are overqualified for, that should produce lower levels of perceived satisfaction.

Time Allocation on Tasks

To my knowledge, a consideration of the time spent on tasks in a primary care clinic by an NP has not been examined in the literature on NPs and job satisfaction. Why is this important? We know that NPs link elevated levels of job satisfaction to certain intrinsic items

such as treating patients that present a challenge, as discussed above. However, is it one patient a day with a complex issue, two, or more that bring an increase in satisfaction? The literature does not specify what is too much, too little, or the right amount, nor does the qualitative analysis presented thus far shed light on this issue. However, time could be important in understanding the relationship between what people do at work and psychological outcomes. Time is a common concept in work literature and often examines work and family balance. I suggest that task balance at work is a concept that allows for a more nuanced understanding of what occurs at the micro-level and how time spent across various aspects of work can influence the worker and their perceptions of the work and job.

Data and Methods

The focus of this chapter is to examine factors associated with job satisfaction for nurse practitioner primary care providers (NPPCPs). I use the National Survey of Primary Care Physicians and Nurse Practitioners 2012, a cross-sectional data set of Physicians and Nurse Practitioner primary care providers in the United States. A total of 313 NPs who work in a non-hospital office setting in both rural and urban clinics are included in the analysis.

Dependent Variable

The dependent variable for these analyses is dichotomous. As originally collected, investigators asked participants, "On the whole, how satisfied are you with your employment?" Respondents choose from four categories; very satisfied, somewhat satisfied, somewhat dissatisfied, dissatisfied. Over 51% (N=159) of the sample responded that they are very satisfied with their job as a nurse practitioner primary care provider at their current place of employment. To understand the factors associated with perceiving the highest satisfaction category, "very satisfied," a binary variable was created with very satisfied coded =1 and all other responses set

to 0. Subsequent reporting on this variable will refer to each response category as “very satisfied” and “less than very satisfied,” respectively. Constructing the variable in this way allows for an examination into what contributes to high satisfaction. It also permits the use of binary methods of analysis (logistic regression) that avoid the complexities associated with a highly skewed, four-category dependent variable.

Independent Variables.

Three sets of independent variables (IV) are used in these analyses: percentage of time spent on various tasks; perception of time spent on those tasks as "about right," "too much," or "too little;" and the division of labor among NPs and M.D.s for each task. A total of six task areas are considered: direct patient care, patent and family health education, patient documentation, patient-related calls, continuing education, and administrative work. The first measure for each task area indicates what percentage of their work time NPs spend on the task each week. The second measure examines the perceptions of the amount of time spent on each task as about right, too much, or too little, which provides subjective assessment rather than an objective measure of the amount of time spent. Lastly, I consider the division of labor between NPs and M.D.s. These measures assess the following services to patients: annual physicals, follow-up visits for chronic controlled conditions, visits for complex conditions, care for non-emergency acute illnesses, patient/family teaching, care coordination, and follow-up for abnormal results. The following will discuss each variable's importance and construction.

Task Time Allocation

As originally collected, respondents were asked to report the percent of the time that they spent over ten areas of work in an "average" week in 5% increments. The percentages were to sum to 100% across all areas. Two areas of work -- research and teaching in a clinical or

academic setting -- were dropped from the analysis because they were very uncommon among NPs. Additionally, continuing education was initially measured by two questions. One question asked for the percent of time each week spent on education for development and licensure; another asked about the time allocated to taking courses, reading journals, attending conferences, and continuing education. For this analysis, I combined both variables, making one continuing education measure, as the distinction between the two was not important for my purposes. Therefore, a total of six areas of work are used in this analysis.

Table 7-1: Percentage of Time Allocation Weekly Across Task Areas (n=303)

	Means	SD	Min	Max
Direct patient care	48.851	21.579	0	100
Patient/family teaching	12.762	12.577	0	100
Patient care notes/documentation	16.234	12.623	0	100
Patient related telephone calls	8.386	6.683	0	40
Continuing Education	7.376	7.701	0	40
Administration	4.214	10.41	0	80

Table 7-1 shows descriptive statistics for the percentage of time spent across the six task areas. The highest average amount of time spent per week is on direct patient care (mean=48.9; SD=21), which ranges from a minimum of 0 to a maximum of 100. The least amount of time is spent on administrative work (mean= 4.2, SD=10.4). Together, the means and standard deviation of each measure, as shown in Table 7-1, suggest a wide variety of experiences for the same position working in different clinics. This indicates that the allocation of time spent is not standard or predictable across NP primary care providers in this sample.

Perceptions of Time Spent

Time allocation as a percent of time spent on areas of work per week offers an objective measure of the labor of the NPs in this sample. However, another area of interest is how NPs feel about the time they allocate to different tasks. This question permits a consideration not only of objective time allocations, but of how NPs assess those allocations. The evidence suggests that there is a dominant pattern in that perceptions are either that the time spent is about the right amount or it is not, with most responses falling into either the "too little" category, for some tasks, or the "too much" category, for others.

For example, frequencies of perceptions of time spent on direct patient care (N=311) illustrate a pattern that time allocations are seen as about the right amount or not: Too much = 10, Too little = 78, About the right amount = 199 (with 24 cases having missing data). In the area of patient/family teaching, the pattern looks like this: Too much = 1, Too little = 115, About the right amount = 166 (with 29 cases having missing data). These results suggest that it is possible to simplify the assessments of NPs to indicate that the time allocated either matched or failed to match their sense that it was "about right." Therefore, I collapsed the three responses as originally collected into a dichotomous variable to measure perceptions of time spent as matching the NPs feelings of time spent being just right or mismatching: 0 = mismatch, 1 = match. Missing data are included in the mismatch category to preserve cases following a sensitivity analysis that suggested that doing so did not alter the results.

Table 7-2 below, reports the descriptive statistics for perceptions of time spent across the six task areas of work used in this chapter. The task that the largest number of NPs felt they did not spend the right amount of time on was patient notes, where 57% reported a mismatch between time allocated and the sense that they spent about the right amount of time on that task.

The fewest mismatches of time spent, and assessments of that time involved direct patient care, which had 36% indicating a mismatch.

Table 7-2: Perceptions of Weekly Time Allocation Across Task Areas (n=311)

	Mismatch		Match	
	Freq	Percent	Freq	Percent
Direct patient care	112	36.01	199	63.99
Patient/family teaching	145	46.62	166	53.38
Patient care notes/documentation	178	57.23	133	42.77
Patient related telephone call	125	40.19	186	59.81
Administration	149	47.91	162	52.09

To further examine the effect of perceptions of time on job satisfaction, I include a summary variable to determine the additive effect of matching perceptions in more than one task area on job satisfaction. In short, the single-task "matching" variable were summed up across task areas to form a composite that ranged from 0 to 6. Low values indicate few if any matches of time spent and perceptions of that time as "about right;" high values indicate many matches. In some analyses, this summary measure was collapsed to have three categories (0-1, 2-3, and 4-6), and two dummy variables were used that contrasted those with 2-3 matches and those with 4-6 matches against those with one or no matches. The dummy variables explore the question of how breakpoints may matter. It is possible that matching on 2-3 categories is enough, and no more influence can be created by having more matching work tasks. It is also possible that more is better and that having 4-6 matching categories maximizes the likelihood of high job satisfaction. These variables provide a nuanced analysis of how perceptions of time spent on task areas can influence job satisfaction.

Division of Labor

I include an independent variable measuring the division of labor between NPs and M.D.s in the clinic across seven services to examine whether and how it might bear on job satisfaction. NPs were asked to report whether a service was provided mostly by physicians, mostly NPs, both physicians and NPs, other specialties, or staff- not primary care, or not applicable. A dichotomous variable was created to contrast work done by both NPs and M.D.s with the task being conducted by either NPs or MDs. For each clinical area, the variables are coded 1 when both M.D.s and NPs perform the work and 0 when it is the province of one or the other group. The assessments are thus between "sharing" and "dividing" the work between NPs and M.D.s.

Analytic Strategy

Descriptive statistics and logistic regression are used to examine the relationship between the independent variables and NP job satisfaction. Logistic regression is appropriate because the dependent variable has two possible outcomes, feeling very satisfied with their employment and feeling less than very satisfied. STATA 14 is used to analyze the data.

Tables 7-3 through 7-12 report mean difference tests and crosstabulations conducted for each task area comparing the perceptions of time spent with the percent of time spent. Next, two-sample t-tests were conducted to evaluate the relationships with time spent on each task area with perceptions of being very satisfied or less than very satisfied with NP employment. Next, t-tests are conducted to examine the relationship between the division of labor with job satisfaction.

The results of the logistic regression analysis are presented in two tables. Each independent variable is run first with the dependent variable and then with the control variable.

For ease of presentation, all of the results for the regression models are reported in the same tables. The first table, 7-13, shows the results for the logistic regression of job satisfaction on perceptions of time spent across six areas of work. Model 1 presents the results for the baseline models. Model 2 shows the results, including the control variables. Table 7-14 presents the results of logistic regressions of job satisfaction on groupings of match categories. For ease of interpretation, the results in both tables are presented in odds ratios.

Results

The primary finding is that perception of time matter for job satisfaction, but actual allocations of time to various tasks do not. This section starts by exploring the results of NP's opinions of time allocation over the six task areas examined: direct patient care, patient and family health education, patient care documentation, patient-related phone calls, continuing education, and administrative work. First, t-tests and crosstabulations are presented. Then, the results of the logistic regressions are reported.

NPs who report that the amount of time on a task is about right are categorized in these analyses as a "match." Those NPs who believed the amount of time to be too much or too little are classified as "mismatch." I begin by testing the hypothesis that time matches and mismatches are associated with time allocation. Two-sample t-tests were performed for each task variable. I then performed cross-tabulations to examine the relationship between perceptions of time and job satisfaction.

Direct Patient Care

Table 7-3 below reports the results of a two-sample t-test conducted to evaluate the difference in means of the percent of time spent on direct patient care between the match and mismatch groups. This analysis contrasts NPs who feel their percent of time spent on direct

patient care is just right (the match group) against those who do not (the mismatch group). The mean time allocations for the mismatch group on direct patient care (N=109, M=43.98, SD=22.01) is less than the time allocations for the match group (N=194, M=51.58, SD=20.09). The results of the two-sample t-test indicate a statistically significant difference in means of time allocation between the mismatch and match groups (t (301) = -2.98, p=.003). That is, perceptions of time as mismatching or matching what the NPs desire is, in fact, associated with the percentage of time allocated to direct patient care. The amount of time spent matters for perceptions of that time. Specifically, as indicated by the results, NPs who mismatch on perceptions of time allocated devote less time to direct patient care than those who feel the time spent is about right.

Table 7-3: Two-Sample t-Test Comparing Perceptions of Time Spent on Direct Patient Care with Percent of Time Spent on Direct Patient Care

	Mismatch			Match					
	M	SD	n	M	SD	n	t-value	df	p-value
Percent of time spent, weekly	43.98	22.01	106	51.58	20.89	194	-2.98	301	.003

Next, I evaluate the relationship between perceptions of time spent on direct patient care and perceptions of job satisfaction. Table 7-4 shows the cross-tabulation of match and mismatch on perceptions of satisfaction. Of the mismatch group, 41.07% were very satisfied with their job. In the group of NPs who believe their time allocation on direct patient care is just right (match), 56.78% reported being very satisfied. That roughly 15 percentage point difference in reported satisfaction between the mismatch and match group is statistically significant (Pearson chi-square=7.08, p=.008). This analysis suggests that the perceptions of time spent on direct patient care influence perceptions of job satisfaction.

Table 7-4: Crosstabulation of Perceptions of Time Spent as Mismatch and Match with Job Satisfaction

Variable		Mismatch	Match	Total
Very Satisfied	n	46	113	159
	Freq	41.07	56.78	51.13
Less Satisfied	n	66	86	152
	Freq	58.93	43.22	48.87
Total		112	199	311
		100	100	100
Pearson chi2= 7.08		p=0.008		

Together, these inferential statistics can tell us much. First, the amount of time spent on direct patient care influences the perception of that time as being perceived as just the right amount of time or not. Second, the perception of the effort spent on direct patient care has a statistically significant effect on reports of job satisfaction.

Patient and Family Health Education

A two-sample t-test was conducted to compare the amount of time spent on patient and family health education for the NP group reporting a mismatched perception of time, M=10.07 (SD=8.93), and the NP group reporting a matched perception of time M=15.09, (SD=14.68). As seen in Table 7-5, there was a statistically significant difference between means of time allocation and the mismatch and match groups (t (301) -3.53, *p*=.000). This indicates that perceptions of time spent are associated with time allocation for the task area of patient and family education.

Table 7-5: Two-Sample t-Test Comparing Perceptions of Time Spent on Patient and Family Health Education with Percent of Time Spent

	Mismatch				Match					
	M	SD	n		M	SD	n	t-value	df	p-value
Percent of time spent, weekly	10.07	8.93	141		15.09	14.68	162	-3.53	301	.000

Table 7-6 below, shows the cross-tabulation of match and mismatch on perceptions of satisfaction. Of the group of NPs who perceive their time spent on patient and family health education as too much or too little (the mismatch group), 41.38% reported to be very satisfied with their job, a figure that is substantially lower than what is found for the matched group 59.64%. The difference in reported satisfaction between the mismatch and match group is statistically significant (Pearson chi-square=10.32, p=.001), indicating that perceptions of time spent on patient and family health education influence perceptions of job satisfaction.

Table 7-6: Crosstabulation of Perceptions of Time Spent on Patient and Family Education as Mismatch and Match with Job Satisfaction

Variable		Mismatch	Match	Total
Very Satisfied	n	60	99	159
	Freq	41.38	59.64	51.13
Less Satisfied	n	85	67	152
	Freq	58.62	40.36	48.87
Total		145	166	311
		100	100	100
Pearson chi2= 10.32		p=0.001		

Patient care documentation

The mismatch time group reported a mean of 18.39 percent of their time dedicated to patient care documentation. By comparison, the match time group for patient care documentation

was associated with a mean of 13.32. Table 7-7 shows the results of the two-sample t-test for perceptions of time spent on patient care documentation with time allocation indicated a statistically significant effect (*t* (301) 3.51, p=.000).

Table 7-7: Two-Sample t-Test Comparing Perceptions of Time Spent on Patient Care Documentation with Percent of Time Spent

	Mismatch				Match					
	M	SD	n		M	SD	n	t-value	df	p-value
Percent of time spent, weekly	18.39	13.00	174		13.32	11.51	129	3.51	301	0.000

Similar to the previous analyses of time spent on direct patient care and patient and family health education, perceptions of time spent on patient care documentation had a statistically significant relationship with the perceptions of effort as mismatched or matched.

In Table 7-8, the results of the cross-tabulation of match and mismatch on perceptions of satisfaction are shown. Of the group of NPs who perceive their time spent on patient care documentation and notes as mismatched, 44.94% claimed to be very satisfied with their job; the same figure for those who were matched rises to 59.4%. The difference in reported satisfaction between the mismatch and match group is statistically significant (Pearson chi-square=6.36, *p*=.012). This suggests that the perceptions of time spent on patient care documentation and notes influences perceptions of job satisfaction.

Table 7-8: Crosstabulation of Perceptions of Time Spent on Patient Care Documentation with Job Satisfaction

Variable		Mismatch	Match	Total
Very Satisfied	n	80	79	159
	Freq	44.94	59.40	51.13
Less Satisfied	n	98	54	152
	Freq	55.06	40.60	48.87
Total		178	133	311
		100	100	100
Pearson chi2= 6.36		p=0.012		

Patient-related calls

The mismatch time group for patient-related calls indicated that they spent, on average, about 9.18 percent of their time on that task, as seen in Table 7-9. In comparison, the match time group for patient-related calls spent 7.83 percent of their time, on average, on that task. The results of the two-sample t-test for perceptions of time spent on time allocated for direct patient care did not indicate a statistically significant effect (t (301) =1.72, p=.0847). In this case, there is thus no statistically significant difference in the time allocated to patient calls between those who mismatch on perceptions of time and those who match.

Table 7-9: Two-Sample T-Test Comparing Perceptions of Time Spent on Patient-Related Calls with Percent of Time Spent

	Mismatch				Match					
	M	SD	n		M	SD	n	t-value	df	p-value
Percent of time spent, weekly	9.18	8.30	123		7.83	5.25	180	1.72	301	0.084

Table 7-10 below, shows the cross-tabulation of match and mismatch groups on perceptions of satisfaction. As in previous analyses, the group of NPs who perceive their time spent on patient-

related calls as too much or too little (the mismatch group) are less likely to be highly satisfied than their matched peers (40% versus 58.6%). The difference in reported satisfaction between the mismatch and match group is statistically significant (Pearson chi-square=10.35, p=.001). While the weekly percentage of time spent on patient calls is not associated with perceptions of time spent, these perceptions do influence the levels of satisfaction. This pattern is strong evidence to suggest that time allocations, per se, are far less important for job satisfaction than the subjective assessments NPs make about those allocations as being about right, too little, or too much. In this case, the actual time allocations do not vary significantly across the match and mismatch groups, but that does not prevent the perception of match from shaping satisfaction. Perceptions, not actual time, matter is a sustained and significant manner.

Table 7-10: Crosstabulation of Perceptions of Time Spent on Patient-Related Calls as Mismatch and Match with Job Satisfaction

Variable		Mismatch	Match	Total
Very Satisfied	n	50	109	159
	Freq	40.00	58.60	51.13
Less Satisfied	n	75	77	152
	Freq	60.00	41.40	48.87
Total		125	186	311
		100	100	100
Pearson chi2= 10.35		p=0.001		

Continuing Education

A two-sample t-test was conducted to examine the relationship between perceptions of time and percentage of time spent on continuing education, suggesting that the mismatch time group for continuing education spent a smaller portion of time on that task when compared to the match group (5.92% versus 9.75 percent). The results in Table 7-11 of the two-sample t-test for perceptions of time spent on continuing education with the percent of time spent indicated a

statistically significant effect (t (301) = -4.32, p=.000). That is, opinions of time mismatching or matching with feelings of time spent on continuing education being just right are associated with the time allocated to direct patient care.

Table 7-11: Two-Sample T-Test Comparing Perceptions of Time Spent on Continuing Education with Percent of Time Spent

	Mismatch				Match					
	M	SD	n		M	SD	n	t-value	df	p-value
Percent of time spent, weekly	5.92	7.81	188		9.75	6.91	115	-4.32	301	0.0000

Table 7-12 shows the cross-tabulation of match and mismatch on perceptions of satisfaction. Of the group of NPs who perceive their time spent on continuing education as too much or too little (the mismatch group), 45.83% reported to be very satisfied with their job, a figure much lower than the 59.66% of those in the match group who indicated that they were very satisfied. The difference in reported satisfaction between the mismatch and match groups is statistically significant (Pearson chi-square=5.62, p=.018). This means that the perceptions of time spent on continuing education influences perceptions of job satisfaction.

Table 7-12: Crosstabulation of Perceptions of Time Spent on continuing education as Mismatch and Match with Job Satisfaction

Variable		Mismatch	Match	Total
Very Satisfied	n	88	71	159
	Freq	45.83	59.66	51.13
Less Satisfied	n	104	48	152
	Freq	54.17	40.34	48.87
Total		192	119	311
		100	100	100
Pearson chi2= 5.62		p=0.018		

Administration

The mismatch time group for administrative work has a mean time allocation of 4.23 percent, a figure that is remarkably close to the 4.19% reported by the match group. The results of the two-sample t-test for perceptions of time spent on time allocated for administrative work was not statistically significant (t (301) = .031, p=.974). That is, the perception of time spent on administrative work has no statistically significant effect on the perceptions of that time; the results are not presented here in a table.

A cross-tabulation was performed on job satisfaction and the perceptions of time spent on administrative work. Of the group of NPs who perceive their time spent on administrative work as too much or too little (the mismatch group), 45.64% reported being very satisfied. In contrast, 56.17% of the matched group reported being very satisfied. However, given the relatively small numbers of NPs in this analysis, the difference in reported satisfaction between the mismatch and match group does not quite reach conventional levels of statistical significance (Pearson chi-square=3.44, p=.063). This means that the perceptions of the percent of time spent on administrative work does not influence perceptions of job satisfaction.

Allocation of Time

I evaluated the relationships with time spent on each six task areas with perceptions of satisfaction with NP employment. Two sample t-tests were conducted for each of the six task areas. However, the results showed no statistically significant relationships for any of the task areas and job satisfaction. Additional analyses were conducted that permitted a parabolic pattern of association. For example, one would expect either unusually low or high allocations of time to be associated with dissatisfaction, thus rendering a certain time or interval of time as the proverbial "sweet spot" with respect to satisfaction. These more complex models, estimated in

logistic regression, consistently showed no association between actual time allocations and job satisfaction. I thus do not present them here. It is clear that the amount of time does not influence how an NP feels about their job for the sample in this study. Past research, as detailed above, has suggested that NPs want time to spend on specific areas of work, such as direct patient care. What these data illustrate is that the amount of time is not as relevant as the perception of that time.

Division of Labor

Much research on the scope of practice of nurse practitioners indicates that autonomy affects job satisfaction. That is, what NPs can and do perform in the clinic is thought to influence job satisfaction (Kacel et al. 2005; Park et al. 2016). I include a measure of the division of labor to examine further the relationship between what NPs do in the clinic and job satisfaction. Contrary to expectations, there was absolutely no support for the division of labor in the clinic having an effect on job satisfaction. It did not matter if NPs and M.D.s worked together or if they worked separately. This was the case across all seven services that respondents reported data.

Logistic Regression Results

Logistic regression was used to test the relationship between perceptions of time spent on each of the six areas of work and job satisfaction. This section first presents the results for perceptions of time for each of the six areas of work on job satisfaction. Each mismatch/match for task areas variable is analyzed in two models, first by stepping in only the match/mismatch indicator and then including all control variables. Results are put into one table, and odds ratios are reported with standard errors. Model 1 reports the odds ratio, p-value, and standard error for the baseline regressions. Model 2 shows the results for each regression run with a single area of work and the

control variables. Estimates for the control variables are not included in the table to simplify the table and the presentation.

Table 7-13: Logistic Regression of Job Satisfaction on Perceptions of Time Spent Across Six Areas of Work. (N=290)

	Model 1- baseline			Model 2		
	Odds Ratio		(SE)	Odds Ratio		(SE)
Perceptions of Time Spent- (Match Reference)						
Direct patient	2.00	**	0.13	2.00	**	0.51
Patient/Family teaching	1.95	**	0.47	2.06	**	0.51
Patient Care Documentation	1.67	*	0.40	1.62	*	0.40
Patient Related Telephone Calls	2.20	***	0.54	2.34	***	0.59
Continuing Education	1.65	*	0.40	1.67	*	0.41
Administration	1.39		0.33	1.43		0.35

†p<.1; *p<.05; **p<.01; ***p<.001

The left column presents the baseline or zero-order results. As expected, every odds ratio in that column is positive, which indicates that those who believe the time they spend on a particular task is about right have higher odds of being very satisfied. More specifically, the analysis suggests that the odds of being very satisfied with employment are two times higher for NPs whose perceptions of time spent on direct patient care matches feelings of just the right amount of time (OR=2.00; p<.01). Similarly, the odds of being very satisfied with employment is 1.95 times higher for those NPs whose perceptions of time spent on that task of patient and family health education are viewed as being just right (p<.01). The strongest association between perceptions of time allocation and being very satisfied is found for the task area of patient-related

telephone calls. The odds of being very satisfied with employment are 2.20 times higher for those NPs who feel their time allocated to patient-related telephone calls is about right compared to those that feel the time spent do not match ($p \leq .001$). Lastly, the analysis of perceptions of time spent on administration with job satisfaction showed no statistically significant effect.

These analyses corroborate the results of the two-sample t-tests and crosstabs presented earlier in this section. As reported earlier in this chapter, there is a wide range of time spent on each task area, and the amount of time spent does not affect the perceptions of job satisfaction. That is, what matters most for NPs concerning job satisfaction is their perception of time spent on tasks as matching their perceptions of the time being about right. To further investigate the influence of perceptions of time, I include three variables that measure the frequency of matches across the six task areas. The first is a simple count of the number of matches across the six task areas. The second and third break that count into a set of two dummy variables to explore the possibility of non-linearity.

Table 7-14: Logistic Regression of Job Satisfaction on Groupings of Match Categories

	Model 1-baseline			Model 2		
	Odds Ratio		(SE)	Odds Ratio		(SE)
Perceptions of Time Spent						
Cumulative match	1.27	**	.08	1.28	***	.086
2 -Category Match	1.4		.46	1.39		.47
3-Category Match	3.04	***	.92	3.17	***	.994

†p<.1; *p<.05; **p<.01; ***p<.001

Table 7-14 reports the results for the effect of matching on cumulative categories. The analysis suggested that for the "cumulative match," each additional match across the six areas

boosted the odds of being very satisfied by a factor of 1. 27. That effect, on a variable that ranges from 0 to 6, is both sizable and statistically significant. The set of dummy variables suggests a non-linear pattern, as the first contrast is not significant or sizable, but the second contrast is both. NPs who believe they are matched on 2 or 3 task areas are statistically indistinguishable from their peers who have matches in one or no task areas. However, NPs who match in four or more task areas are more than three times as likely to be very satisfied as their peers who have one or fewer such matches. The linear effect presented first is thus being driven, in large part, by a substantial difference in satisfaction between NPs who are the most and least matched.

In the right-hand column of the two tables, the results indicate the effect of matches once a set of control variables had been added to the model. The results are quite clear and easy to summarize. In short, the "net" or "independent" effects of matching once the control variables are taken into account remain nearly identical to the bivariate or "zero-order" effects presented in the left-hand columns. Quite clearly, the results are not being confounded by the control variables. In addition, analyses not presented here show that the inclusion of actual time allocations to the models (both the zero-order and net-effects models, presented here as models 1 and 2) do not alter the patterns described here. Time allocations continue to have no bearing on job satisfaction apart from their perception as being about right by NPs. That pattern holds up in simple models, without controls, and those that include control variables.

This chapter examined how time allocations on various tasks and perceptions of those time allocations influence job satisfaction. In addition, I explored how the division of labor in clinics between NPs and M.D.s might influence job satisfaction. The results highlight how perceptions of time are the central drivers of job satisfaction, not the amount of time. The division of labor between NPs and M.D.s in clinics does not appear to bear on job satisfaction.

Through an analysis that uses specific tasks, the results contribute a nuanced view of factors that influence work satisfaction. It also aligns with recent calls to include work context in work outcome studies on NPs perceptions of their job (Hoff et al. 2017).

CHAPTER 8

THE EFFECTS OF COMPUTERIZED MEDICAL RECORDS AND EASE ON NURSE PRACTITIONERS PERCEPTIONS OF INFLUENCE OVER WORK AND JOB SATISFACTION

This chapter examines how electronic medical records (EMR) and the ease of retrieval of data influence nurse practitioners' perceptions of autonomy and job satisfaction. Most research investigating the use of EMR has focused on the experience of physicians; very few projects have explored the opinions and experiences of other health care professionals. As the increase in the use of NPs in health care delivery continues, and in the face of a strong push for EMR systems, research that includes NPs as a primary focus of attention is needed. Furthermore, the use of EMR systems, also called information technology systems, in the broader literature on work, presents a classic puzzle in the sociology of work. That is, how does the introduction of technology influence work?

The use of Information Technology (IT) in the workplace is an evolving area of interest. Starting around 1971, with the invention of the microprocessor, computers and computerized systems have become an increasingly common part of everyday work life (Belanger 2006). Factors involved in the implementation of, and resistance to, information technology are the focus of much research across areas of work and industry (Bates 2002; Belanger 2006; Cenfetelli and Schwarz 2011; Kumar et al. 2019). Also known as health information technology, these computerized systems are used to store, share, analyze, and retrieve health information. These systems include electronic health records (EHR) used by health care professionals, personal

health records (PHR) that are used by the patients, and the use of electronic prescribing (HealthIT.gov n.d.). The term EMR encompasses all IT systems. However, EMR is often interchanged with EHR, and that is how it is used in this dissertation. The implementation of the EMR system is argued to be different from other IT systems and therefore in need of special consideration (Samhan and Joshi 2015)

Few studies explore how the use of EMRs affects perceptions of the workplace and job satisfaction. The central focus of research into the use of information technology in health care primarily focuses on the implementation of EMR with a concentration on resistance to the use of EMRs. Physician attitudes and use of EMRs have been the focus of most research, with very few studies examining EMRs and NPs or other healthcare professional's opinions as the primary focus of the research (Balestra 2017). To the best of the author's knowledge, none have used a national sample to examine the link between the computerization of medical records and the autonomy and job satisfaction of nurse practitioners.

This study examines two areas of interest: professional autonomy and job satisfaction of NPs, using two measures. The first is perceptions of the ease of gathering medical records; the second is a measure of whether the process is computerized. The purpose of the analysis is to ascertain the degree to which these factors affect the perception of workplace influence and job satisfaction. The results suggest that computerization is positively associated with perceptions of ease. However, computerization is also linked to lower levels of autonomy and job satisfaction.

The organization of this chapter is as follows. First, the current study is framed within the larger body of research examining work and technology. Next, a brief review of the literature is offered, covering how IT in healthcare has been considered. This is followed by a section discussing the methods and data used for this project, the results, and conclusions.

Links to the Sociology of Work

The introduction of technology into the process of work changed the way people did their jobs, the skills involved, and how organizations managed and controlled work and workers. The use of technology furthered the rationalization of work that emerged in the early twentieth century (Hodson 2001b). The definition of technology used today encompasses not only machinery that was often the focus of early studies, but also the use of software and hardware that are used to alter or design the processes of work and production (Belanger 2006). The introduction of machines and equipment into the operations of work led to automation. That is, machines and equipment are used to do work and move the products and elements of the work by automatic means. The most common conceptualization of this is the assembly line, where parts are run on a conveyor belt, and workers standing in one spot put together components that then move on to another area where workers add on more elements until the product is complete (Hodson 2001b). Automation is in contrast with the process of one worker or a team of workers putting together a product, such as a car, in one fixed location. The result of these processes is to produce in a manner that could not otherwise be done (Lee 2008).

Several studies have shown how the use of machines impacts the experiences of workers. For example, Hodson illustrated from a review of ethnographies exploring assembly workers that employees experienced reduced autonomy and opportunities for upskilling and were subjected to harsh working conditions, all resulting in high levels of exhaustion and alienation (Hodson 2001b). While the introduction of IT into the workplace presents similar concerns and empirical questions to the technology used in the factories and industry, Belanger (2006) argues that there are three main differences between automation and information technology. First, automation moved workers one step away from the production of the product into the role of overseeing the

production via a machine. Second, automation technology controlled the pace of work with little opportunity for workers to change the flow or organization of the work.

In contrast, information technology often allows workers to have more control over the pace and processes of the work. Additionally, information technology is part of the process of work, but it can also generate data as a new product (Belanger 2006:327). For example, employees making a list of prescriptions for a patient or a list of clients for a salesperson.

Additionally, the implementation of IT systems has both opportunities for an expanded sense of autonomy. It can, however, also create perceptions of less independence. Brey (1999) argues that IT has the potential to generate autonomy through the strengthening of communication potential, improving the dissemination of knowledge related to organizational policies, plans, and actions as well as offering opportunities to work off-site and thus contribute to work-life balance goals of the employees. Brey also includes three areas of technology that can threaten autonomy. These are enhanced monitoring potential, predefining tasks, and creating a dependence on others to ensure the IT is maintained, up to date, fixed when needed, or for help in operating the system.

In a review of research exploring technology and work, Burris (1998) observes that while some have argued that IT systems build in a promise for more autonomy and control over work, others side with a neo-Braverman view. That is, while management may not be as visible, computerization is another mechanism to control and monitor worker's progress. The use of IT may produce a more adaptive and less rigid organization of work that improves perceptions of autonomy; however, it can also restrict the decision-making options available to workers. For example, Burris (1998) argues that the use of computerized systems benefits management and

capitalist goals and is therefore not different from the use of non-digital technology. In this way, the use of IT is similar to all other technology use.

The use of IT starting in the early 1970s changed the way many managers and corporations organized work and designed production. Technology and work are a permanent fixture in modernity and are no less so in healthcare. The central focus of this chapter is the use of IT in health care and specifically by nurse practitioners and its influence on individual psychological outcomes. The following section will briefly discuss IT and healthcare and position the current study within the need to explore IT and nurse practitioners' perceptions of work.

Healthcare and Information Technology

Higher uses of EMR are associated with elevated levels of stress, feelings of burnout, and low job satisfaction for primary care physicians (Babbott et al. 2014). The time-consuming processes of data entry, as well as the resulting reduction in time for interacting with patients, is noted as a central factor contributing to adverse psychological outcomes for physicians (Friedberg et al. 2014). While physicians have voiced interest in the use of EMR, there is also concern over the reduction of productivity and adverse effects on their work (Holden 2010). Similarly, Wang et al. (2019) found that among internal medicine residents working at an academic hospital, a significant amount of time is spent inputting data into the electronic health record, especially at the start of the day shift. While variation was observed between residents, depending on their year and supervisory responsibilities, the authors argue that the time spent on examining digital records is an example of a change in the organization of work. They argue that instead of the traditional patient rounds at the start of a shift, physicians spend time reviewing records and notes of patients reducing face to face patient-physician interaction. Similarly, Hill,

Sears, and Melanson (2013) found that physicians working in one community emergency department spent more time entering data into the EMR (43%) than direct patient care (28%).

The level of success of the implementation of information technology, in general, is associated, in part, with collaboration with users (Dwivedi et al. 2015). In the healthcare industry, the choice of EMR systems and their implementation is not always done with consideration of the contextual factors relevant to physicians and other health care workers (Kumar et al. 2019). The perceived threats of the introduction of technology can be the perceived restrictions on decision making (Ngafeeson 2015). This is in direct conflict with the domain of medicine (Freidson 2001), and it is logical to assume there may be some resistance or mistrust.

In a recent literature review, Kumar et al. (2019) reported on research that investigated forms of resistance to health information technology systems. The authors showed that context could be a vital variable to consider. In some cases, the level of urgency could motivate the avoidance or misuse of technology. Kumar et al. (2019) point out that a negative attitude toward information technology may lead to resistant action.

Much of the focus on perceptions and use of EMRs has concentrated on physicians' views and experiences. Additionally, very little research on NPs' perceptions of EMRs has been conducted (Borycki et al. 2015). The following brief review will examine the research on EMRs and NPs. The overarching theme of all the research covered is that contextual factors matter, and this includes the use of EMRs in a way that aligns with the work goals of the healthcare professional and the needs of the patients. In these ways, the challenges and concerns with EMRs are not much different from those of physicians except for the needs of accessing distinct types of information.

There is some evidence that NPs and physicians use EMRs in a similar way (Li et al. 2012). Additionally, research suggests that NPs use different features of the EMR systems to facilitate holistic care when treating an individual patient as compared to a group of patients (Borycki et al. 2014). One primary area of difference between nursing trained providers and physicians is in the type of data needed. For example, Kannampallil et al. (2014) found that hospital residents and NPs used different strategies to locate patient data and suggested that different training may be the primary reason.

Likewise, examining EMRs and the work of NPs in Canada, Borycki et al. (2015) found that overall NPs report that EMRs helped with clinical decision making, improving quality of care, and communication between healthcare professionals in the clinic. However, the authors noted that many NPs felt the EMRs had no impact on preventive care or the treatment of chronic illness. This finding was noted as peculiar and surprising because a core part of NPs' philosophy and mission is preventive care and chronic disease management. The authors conclude that the creation and implementation of EMRs need to take into consideration the core goals of NPs to better integrate the system into their day-to-day work needs.

Research to date on the use of EMRs by healthcare professionals focuses on implementation and types of use. The larger body of literature engaging with computerized systems as part of work suggests that IT has influences on the perception of job autonomy. Furthermore, autonomy is shown to be linked with job satisfaction, as discussed earlier in this dissertation. It is, therefore, logical to inquire into how EMRs may affect NPs' perceptions of job autonomy and satisfaction. To the best of the author's knowledge, no studies examine the link between NP perceptions of autonomy and job satisfaction with the use of medical record

systems. This project looks at how the understanding of ease of gathering medical information and whether the system is computerized influences job satisfaction and perceptions of influence.

Data and Methods

This chapter examines how perceptions of the use of medical records and the computerization of the process impact two dependent variables: feelings of autonomy and perceptions of job satisfaction. The National Survey of Primary Care Physicians and Nurse Practitioners 2012, a cross-sectional data set of Physicians and Nurse Practitioner primary care providers in the United States, is used. The total number of cases varies across models, as is described in the results below. These NPs are those who work in a non-hospital office setting in both rural and urban clinics.

Dependent Variable: Perceptions of Influence

The dependent variable is an ordinal scale measuring the perception of professional influence in the clinic. This variable is created from combining two variables: influence over the organization and influence of patient care. NPs were asked how they felt about their opportunities to influence decisions about their workplace organization. They were also asked to rate their opportunities to influence decisions about patient care in practice. A five-point Likert scale measures perceptions ranging from excellent to poor for each question. Each variable was reverse coded to indicate perceptions from poor = 1 to excellent = 5. The two variables were combined by adding them. The resulting variable measures overall perceptions of influence in the clinic, ranges from 2 to 10, and is conceptualized as a perception of overall autonomy.

Dependent Variable: Job Satisfaction

The dependent variable for these analyses is dichotomous. As originally collected, investigators asked participants, "On the whole, how satisfied are you with your employment"?"

Respondents choose from four categories; very satisfied, somewhat satisfied, somewhat dissatisfied, dissatisfied. Over 51% (N=159) of the sample responded that they are very satisfied with their job as a nurse practitioner primary care provider at their current place of employment. To understand the factors associated with perceiving the highest satisfaction category, "very satisfied," a binary variable was created with very satisfied = 1 and all other responses set to 0. The rationale behind this is that somewhat satisfied leaves too much variation in how this is being considered. However, comparing the highest-ranking allows for an investigation into what contributes to this ranking compared to all the other choices.

Independent Variables

Participants were asked to assess the ease of doing ten tasks related to the medical records system in place in their clinic. They were asked: "With the patient medical records system in the practice in which you work, how easy would it be for you (or staff in your practice) to do the following? Is the process computerized"?".

Specific variables measure the ease of using medical records for specific data needs. These are measured on four-point scales from "cannot generate" to "easy." For each of those specific areas, the NP also notes whether that process is computerized (1 = yes; 0 = no). All missing data was deleted listwise.

Analytic Strategy

Ordinary Least Squares regression (OLS) are used to examine the relationship between the independent variables and NPs' perceptions of influence. Logistic regression is used to examine the relationship between independent variables and NPs perceptions of job satisfaction. STATA 14 is used to analyze the data.

The results of the OLS regression analyses are presented in two tables, one table for each dependent variable: perception of influence and then job satisfaction. The assessment of the ease of access for each task is first run as a simple regression with the dependent variable. Then the variable measuring whether the process for that task is computerized is examined using simple regression. Next, the ease of access and computerization variables are both included. Finally, the ease of access, computerization, and all control variables are stepped into the regression model. This process is used for each task to examine the relationships with perceptions with each dependent variable separately.

The first table, 8-1, shows the results for the OLS regression of the influence of the ease of generating reports and computerization on perceptions of influence. Model 1 presents the results for the baseline ease-of-access models. Model 2 shows the results of computerization on feelings of influence. In model 3, the ease-of-access and computerization variables are combined. Model 4 includes the control variables. Table 8-2 presents the logistic regression results for job satisfaction. The independent variable and procedures stated above are the same for this analysis. For ease of interpretation, the results in both tables are presented in odds ratios.

Results

The central findings are quite intriguing. Ease of access is enhanced when medical records are computerized. Ease of access is also positively related to perceptions of influence and satisfaction. However, computerization is negatively associated with job satisfaction across nearly all report tasks as well as with feelings of influence. These data suggest that while computerization makes the task of generating needed reports and data more manageable, it also influences perceptions of how professionals perceive their job and their influence. The relationships that are shown in this analysis add to an underdeveloped line of study in the

literature. Additionally, these exploratory results highlight the importance of further investigation as well as a reframing of how computerization is used as a variable in research examining perceptions of health professionals.

Ease of Access and Computerization: Do they Bear on Perceptions Influence?

To evaluate the relationships between computerization of records as well as perceptions of ease in generating reports with perceptions of professional influence, Ordinary Least Squares Regression analysis was conducted. Table 8-1 is organized by first naming the type of list or data being asked about, followed by the report of there being a computerized system available in the clinic for that particular report function. The list of ten tasks has been divided into three general groups. The first are reports related to care interventions. The second includes reports that summarize patient characteristics and treatments. The last group includes lists that help track and maintain appointments and referrals. The first two models in the left-most columns are easy to summarize. For all reporting issues, greater ease in generating reports is positively, although not significantly, associated with higher levels of influence. In a similar way, computerization has a consistently negative, albeit insignificant, bearing on levels of influence. Neither of those zero-order models, however, is particularly telling because these two variables exhibit a classic "suppressor effect" on each other. The reason is that they have opposite effects on influence but are quite strongly associated in a positive way with each other. The "true" negative effect of computerization on influence is masked (driven towards zero) when ease of access is not controlled; likewise, the "true" positive effect of ease of access on influence is masked (again driven towards zero) when computerization is not controlled. In effect, each variable's bearing on influence only emerges in model 3, when the two are entered in the model together.

Table 8-1: OLS Regression of Computerization of Records and Perceptions of Ease in Generating Reports with Perceptions of Professional Influence

	Baseline models				Without Controls		With Controls	
	Model 1	(SE)	Model 2	(SE)	Model 3	(SE)	Model 4	(SE)
Diagnosis	0.179	0.118			0.322 *	0.142	0.315 *	0.144
Computerized			-0.214	0.343	-0.737 t	0.412	-0.677	0.418
Lab Result	0.130	0.125			0.317 *	0.152	0.293 t	0.155
Computerized			-0.356	0.321	-0.830 *	0.392	-0.736 t	0.400
Overdue for tests or preventive care	0.303 *	0.127			0.533 *	0.152	0.527 *	0.154
Computerized			-0.275	0.328	-1.046 *	0.388	-0.976 *	0.397
Quality of care by the chronic condition	0.173	0.30			0.359 *	0.149	0.360 *	0.151
Computerized			-0.458	0.323	-0.914 *	0.371	-0.791 *	0.382
Demographics	0.034	0.118			0.236	0.149	0.233	0.152
Computerized			-0.534	0.343	-0.958 *	0.435	-0.819 t	0.447
Summary of visit for Patients	-0.118	0.126			0.150	0.170	0.143	0.174
Computerized			-0.770 *	0.326	-1.031 *	0.444	-0.908 *	0.459
Summary of clinical care measures to payers	0.066	0.123			0.302 *	0.145	0.281 t	0.147
Computerized			-0.693 *	0.323	-1.131 *	0.384	-1.004 *	0.397
Track missed appointments	0.218	0.141			0.373 *	0.155	0.364 *	0.159
Computerized			-0.495	0.360	-0.910 *	0.397	-0.766 t	0.417
Track referrals	0.147	0.147			0.318 *	0.154	0.292 t	0.160
Computerized			-0.415	0.324	-0.810 *	0.374	-0.694 t	0.389
Send patient reminders	0.164	0.128			0.287 *	0.139	0.270 t	0.143
Computerized			-0.468	0.320	-0.757 *	0.347	-0.638 t	0.362
Ease - sum 10-30	0.026	0.019			0.065 *	0.022	0.062 *	0.023
Computerized - sum 0-10			-0.068 t	0.041	-0.154 *	0.051	-0.136 *	0.053

t p<.1; *p<.05

Model 3, which includes ease of access and computerization, shows that one, the other, or both variables are significantly related to perceived influence for all ten issues explored. The analysis suggests that ease of report generation is associated with higher levels of influence at the .05 level with the exceptions of generating reports on demographics and providing a summary of the clinical visit for patients. That is, the easier it is for an NP to accomplish a task, the higher their perception of influence. These analyses suggest that for each level of ease of generating a list of diagnoses for a patient, there is a .322 rise in perceptions of influence ($P<.05$). In contrast, the computerization of the process for this report is associated with a .737 decrease in perceptions of influence ($p<.10$). Perceptions of ease related to creating a report of lab results are associated with a 0.317 increase in perceptions of influence ($p<.05$). However, the process being computerized is again associated with a loss of influence (-.830, $p<.05$). Other record-generation issues present similar patterns.

The final rows of the table present the results for two variables that represent sums. The first, "Ease – sum," is the simple sum of every ease-of-access indicator, and thus ranges from 10 to 40 (high values mean greater ease). The second, "Computerized – sum," is the sum of the ten "is the function computerized?" indicators, and thus ranges from 0 to 10 (high values mean more computerization). Models 1 and 2 present zero-order effects that are, once again, strongly hindered by suppressor effects. Model 3 shows the same pattern as in the individual indicator-models, namely that ease-of-access heightens perceptions of influence, whereas computerization has the opposite effect. Both effects are sizable and highly significant.

The results of model 4 represent an effort to take into account a roster of plausible control variables. The coefficients on those controls are not shown, as the focus here is on the ease-of-access and computerization variables. The results are easy to summarize. In most cases,

including the controls weakens but does not eliminate the sizable and significant effects of the two variables on influence. Without question, the control variables matter here, but the general pattern evident in the results for Model 3 remain strong and common.

This exploratory analysis is limited by the data and questions asked. For example, computerization is negatively associated with perceptions of influence across each task. However, the strength of the association varies. Perhaps there is something about certain tasks in which computerization is perceived as a barrier. While ease of generating a report is linked to feelings of influence, the utilization of a computerized medical record adversely affects NPs' opinions of their influence. Exploring how the rationalization of health care through computerization works to reduce professional autonomy is a critical area of exploration and in need of further examination.

Ease of Access and Computerization: Do they Bear on Job Satisfaction?

I now turn to the analysis of relationships between ease of report generation, computerization, and job satisfaction. The dependent variable is a dichotomous measure coded 1 when the NP reports being "very satisfied" (0 otherwise), making logistic regression appropriate. As in the results for influence, reported above, the single table has four models, and features the effects of the variables of primary interest. Results indicate the odds of being highly satisfied for every unit increase in the independent variables. The overall pattern across models shows that satisfaction is higher among NPs when report generation is easy, but lower when those reports are computerized. The results, therefore, tell essentially the same story as what we found when influence was the dependent variable.

Table 8-2: Logistic Regression - Ease and Computerization on Perceptions of Job Satisfaction

	Baseline models				Without Controls			With Controls		
	Model 1		(SE)	Model 2		(SE)	Model 3		(SE)	Model 4		(SE)
Diagnosis	1.244	*	0.130				1.379	*	0.178	1.389	*	0.181
Computerized				1.008		0.301	0.596		0.221	0.578		0.216
Lab Result	1.157		0.126				1.259	t	0.170	1.279	t	0.175
Computerized				0.976		0.271	0.69		0.239	0.633		0.233
Overdue for tests or preventive care	1.222	t	0.137				1.530	*	0.218	1.548	*	0.223
Computerized				0.702		0.201	0.374	*	0.136	0.356		0.131
Quality of care by the chronic condition	1.105		0.124				1.236		0.163	1.242	t	0.166
Computerized				0.763		0.213	0.582	t	0.191	0.554	t	0.187
Demographics	1.077		0.111				1.302	*	0.178	1.327	*	0.184
Computerized				0.676		0.203	0.416	*	0.165	0.375	*	0.153
Summary of visit for Patients	1.032		0.114				1.179		0.180	1.188		0.184
Computerized				0.804		0.232	0.600		0.239	0.569		0.233
Summary of clinical care measures to payers	1.07		0.114				1.292	t	0.173	1.308	*	0.176
Computerized				0.608	t	0.174	0.415	*	0.146	0.38	*	0.138
Track missed appointments	1.27	t	0.158				1.477	*	0.215	1.509	*	0.225
Computerized				0.69		0.217	0.438	*	0.161	0.396	*	0.151
Track referrals	1.216	t	0.142				1.433	*	0.203	1.483	*	0.219
Computerized				0.747	.	0.210	0.472	*	0.161	0.418	*	0.149
Send patient reminders	1.11		0.124				1.222		0.152	1.242	t	0.158
Computerized				0.694		0.194	0.564	t	0.176	0.521	*	0.169
Ease - sum 10-30	1.025		0.164				1.065	*	0.023	1.072	*	0.024
Computerized - sum 0-10				0.947		0.034	0.869	*	0.042	0.852	*	0.043

t p<.1; *p<.05

The results are found in Table 8-2. In a way that is logically identical to the analysis of influence, the results in models 1 and 2 are confounded by a strong suppressor effect. It is only when both variables enter the analysis in model 3 that the situation becomes clear. In model three, there are two main patterns. First, the odds ratios for ease-of-access are all above 1, and the ratios for computerization are all below 1. What that means is that ease of access boosts job satisfaction. Conversely, computerization, net of ease of access, lowers job satisfaction. This is exactly the same pattern that was found for influence. For example, the analysis suggests that for each unit increase in perceptions of ease of generating a report of diagnoses, the odds of being highly satisfied with the job increase by 37.9% (an odds ratio of 1.379), an effect that is statistically significant. Computerization of this task does not have a statistical relationship with perceptions of job satisfaction. Unlike the results for the influence dependent variable, the inclusion of the roster of control variables does little to diminish the effects of ease of access and computerization on job satisfaction.

The findings in this chapter illustrate the crucial need to examine further the use of IT in the healthcare field. While using computerized records makes work more manageable, it also produces uneasy feelings and perceptions of loss of influence and satisfaction. These exploratory analyses represent a contribution to the literature and a promising line of future research.

CHAPTER 9

CONCLUSION

This dissertation focused on nurse practitioners working as primary care providers in non-hospital settings. Situated in the tradition of studying one profession in-depth to examine and explore work experience (see Hughes [1971] and Hodson [2001b] for classic examples), this project investigated three areas: roles and boundary-making, perceptions of job satisfaction, and perceptions of autonomy. Both qualitative and quantitative methods of analysis provided the findings. First, using data from 33 interviews with NPs, this project explored how NPs see and maintain their role as providers, how job satisfaction is established and recognized as a social construct, and how NPs define and perceive autonomy. Using the National Survey of Primary Care Physicians and Nurse Practitioners 2012, this study examined the influence of task-related factors on job satisfaction and feelings of autonomy.

This chapter will discuss the findings and is organized into four main subject areas. First, the project has shed some light on how NPs perceive and develop their professional identity and boundaries. Second, the findings on job satisfaction will be discussed, synthesizing what the study highlighted using both inductive and deductive methods. Third, the results from the interviews and survey data will be considered as to how they relate to feelings of autonomy. And Fourth, a special note on the effect of computerization will be discussed. The findings of this exploratory analysis were unexpected. They offered insights on how IT may influence NPs' perceptions of work as well as the importance of considering the use of computerized medical records in studying job satisfaction and feelings of autonomy.

Dual Boundary Work

My study shows that NPs engage in dual-boundary work by defining and defending the RN/NP boundary, as well as the NP/M.D. boundary. Through a dialectic process involving these two different domains, NPs work to position themselves as nurses and as providers of health care. The RN/NP border is meant to be porous or fluid, meaning that NPs claim the area of nursing as part of their domain and can move quickly between the role of the nurse and the role of the nurse practitioner. NPs present the NP/M.D. border to be more solid, and they use rhetoric to show a difference between themselves as a provider and a physician's role as a health care provider. This is partly done to stave off fears from others that NPs are trying to take patients from M.D.s. However, they do see many of the same patients and use many of the same clinical tools. A way to establish themselves is to use language to frame their role as a health care provider as different and justify a distinct classification of NP providers.

The professional goal is to establish independent jurisdiction over an area of work. While NPs may take from medicine in terms of tools and theory, they also create their own. Through defending against external rhetoric and using their internal rhetoric, NPs work to set up a definition of health care provider that allows them to work as advanced nurses and not remain beholden to medicine or physicians.

While maintaining closure over the jurisdiction of nursing, NPs simultaneously seek a market shelter over their brand of a healthcare provider. Their professional project involves keeping a firm footing in nursing while reaching out to claim authority in the field of medicine as a primary care provider. They do this by defending against extreme rhetoric that places their role as subservient or secondary to medicine while also defending the boundary of nursing. Furthermore, NPs build for themselves a provider identity that pulls from both nursing and

medicine and, through the subjective nature of an integrated approach, try to prove themselves as different and separate from physicians. While NPs work to establish their difference from M.D.s, they also work to illustrate their connection to and difference from nursing. Therefore, NPs engage in dual-boundary work and demonstrate a unique case to be examined. While many instances of boundary creation and maintenance illustrate a linear movement from one area to another, NPs keep their authority in nursing while moving to establish a role that both challenges the physician's territory and works to carve out a new definition of the role of provider.

Influences on Job Satisfaction

The research highlighted in this dissertation explored NPs perceptions of job satisfaction through narratives of lived experiences as well as examining factors that may influence opinions through the use of a national survey. The interview data showed that NPs place a high value on the interactions in the clinical space. It is striking that NPs did not mention state licensing laws when speaking of what makes for a meaningful day. They instead shared narratives of social interactions with co-workers and patients that, in turn, created a good or bad day. NPs narratives showed perceptions of satisfaction could be linked to the broader social context of the workplace. Having information on the patient's condition, support staff gathering information from the patient through conversations and approximating an adequate length of time for the appointment all help to set the stage. If there is not enough time or information, the efforts of NPs to deliver care is attenuated. When the roles of educator and investigator are enacted, this helps to accomplish the goal of care and therefore adhere to the norms of NP professional practice. Being able to fulfill these roles produces joy and satisfaction with work and contribute to the organizational culture of the clinic.

This interconnection between NPs and support staff also brings to light the importance of taking an ecological view of the clinic and exploring how the support staff may influence NP satisfaction. These data suggest that adding in variables that measure attributes, perceptions, and attitudes of support staff and other providers may help to create a complete model of what contributes to job satisfaction in workplaces such as clinics. These factors are essential to creating an ethos of care. An intention and desire to deliver quality health care is an individual factor. What helps to make this a reality in the organization and commitment by others the NP works with and thereby creating an ethos of care that aligns with this intention. Looking at satisfaction from an ecological point of view and incorporating a lens that sensitizes the research toward organizational culture may help to build a complete picture.

NPs narratives illustrate a strong desire to live up to professional expectations of quality care, and a central concern for NPs is the time allotted to patient care. That "time matters" was a central theme developed from the stories of the NPs who were interviewed.

While the qualitative data highlighted the importance of relationships in the clinic and specific roles that were related to a good day, questions remained as to how individual work tasks and factors around these tasks may also influence perceptions. Researchers have shown that NPs report varying levels of satisfaction across areas of work, and it has been argued that the context of the work may explain the variation (De Milt et al. 2011; Hoff et al. 2017). To unpack how the work itself may impact perceptions, I analyzed a national data set of NP providers. The survey used to collect the data asked NPs about time allocation over six task areas. It also gathered reports of NPs perceptions of the amount of time they spent. These data help to answer the question of how time matters.

I started by examining the time allocation for each task on job satisfaction. Given the association past research had shown between these areas of work and satisfaction, I wanted to explore the relationship of time spent on each task area with overall satisfaction. Based on the importance NPs narratives place on face-to-face patient care and the education of patients and family members, I expected that the more time spent on these tasks would be associated with a rise in satisfaction. Also, tasks such as administrative work and documentation would have little effect or be associated with lower satisfaction. To explore these assumptions, I first examined the association between time spent on each task and satisfaction using two-sample mean difference tests. Furthermore, and contrary to expectations, the amount of time spent on each area of work is not associated with satisfaction. The objective measure of time spent is inadequate for assessing levels of satisfaction for NPs.

Next, I examined how the perception of time spent on each task is associated with overall satisfaction. The link between perceptions of time and job satisfaction indicates that the amount of time spent is not the salient factor; instead, how NPs feel about the time spent relative to their expectations and preferences is what matters. That is, when NPs feel that the time allocation is about right, they are more likely to report that they are very satisfied with their work. The subjective measure of perceptions of time spent as a driver of satisfaction, both enlightens and confounds. That is, knowing that the subjective nature of satisfaction is vital validates the need for more on-the-ground explorations of work. However, it is also further proof that measuring job satisfaction is not straight forward and needs to consider the subjective and interactional nature of work itself.

The analysis indicated that nurse practitioners are more satisfied when they believe that they are spending about the right amount of their time on various clinical tasks. To expand on

this discovery, I examined if the perception of matching is additive. That is, does the odds of being very satisfied with the job increase with each category that matches with perceptions of just right? The results suggest that there is a cumulative effect for perceiving that the time spent is about the right amount on job satisfaction. What this means is that there is not one task area that drives satisfaction and that it is a combination of the time spent over several areas of work being balanced that matters the most.

Furthermore, there is a great deal of literature and effort to expand the roles of NPs (Poghosyan et al. 2018; Safriet 2002; Xue et al. 2018; Yee et al. 2013). Inherent in these studies, as well as in messages from both nursing and medical professional groups, is tension and potential conflict over expanding the roles of NPs. It would be incorrect that this is the case for every person involved, but nevertheless, the tension exists. Therefore, it would be reasonable to expect that the division of labor for services performed in the clinic would influence job satisfaction. These data do not support the idea that the division of labor between NPs and M.D.s in the clinic affects job satisfaction. This does not mean that the expansion of the role is unimportant or unnecessary. An examination of such a claim is well beyond the scope of this project. However, it does suggest that the division of labor on the clinic floor is arranged in these clinics in a way that does not produce a negative impact on how NP's perceive their work.

Perceptions of Autonomy

Nurse practitioners in the current study illustrated a wide variation in perceptions of autonomy. Much of the data presented in Chapter 5 supports previous studies that have highlighted the importance of collaboration and familiarity with the NP role. Additionally, NPs narratives show that there is a variation of experiences based on where and whom they work with as well as the organizational policies.

A key finding of this chapter is the perceived difference between perceptions of autonomy and perceptions of support. These are two factors that are not mutually inclusive, and each separately can influence perceptions of job satisfaction and feelings of well-being. Connected to these perceptions is the finding that high levels of autonomy do not need to be associated with also having a full scope of practice. Being able to work independently within a restricted scope can provide elevated levels of autonomy and well-being, even though the NP is working below their level of practice authority.

Much of the professional literature and messaging promote the full scope of practice for NPs across all states. This is promoted to obtain legislation that allows NPs to practice within their practice authority (training and education). This chapter highlights the professional opinions of some NPs who are uncertain if the current path to full independence is adequate to allow for the full scope. These perceptions are from NPs working in a restricted scope state, and they highlight a need to compare their perceptions with those from full scope states. The influence of a culture of restriction cannot be ruled out as influencing perceptions.

Regardless of the impact of culture, the narratives also show how structure varies in the state and how a need for a more uniform system of training NPs after certification may be needed. Several NPs mentioned the need for a residency program. They mentioned this as a way for NPs to gain more experience across different specialties. However, it could also be a way to gain profession-wide familiarity with the role. Further research needs to be undertaken as to how other states and educational programs have approached this issue.

Computerization and Medical Records Systems

To further explore how work experiences might influence job satisfaction and autonomy, this study examined how the use of medical records and the computerization of these records

impacted the level of job satisfaction and perceptions of autonomy. Today, electronic medical records are dominant, and in 2012 when the data set used in this study was published, EMRs were very common but not at 100% implementation. This data set gives a unique opportunity to see how computerization may influence perceptions of work in a way that may not be possible today.

Information technology in the health care field is a permanent fixture. In the general body of literature examining the computerization of work, the implementation of IT influences physicians' feelings of autonomy (Holden 2010). The use of IT to monitor work, assist in the conducting of tasks, and record data will only continue to evolve. It is logical to predict that the ways technology is used in work will produce new and yet unknown interfaces and possibilities. Therefore, it is essential to understand how technology affects the worker and issues of dignity and autonomy.

While research has focused on the implementation of EMR and other healthcare-related technologies, few studies have examined the influence technology has on the healthcare professional and specifically nurse practitioners. This dissertation reviewed two elements of using a medical records system, namely the ease of generating specific reports and whether this process is computerized. The results illustrate that the ease of data retrieval is positively correlated with computerization. That is, NPs perceptions of ease rise with the computerization of the medical records. In addition, ease of data retrieval appears to boost autonomy and satisfaction. In contrast, computerization is associated with a decrease in both perceptions of autonomy and job satisfaction. These results are surprising and illustrate that while easy access to data is essential, there is something about the computerization of the system that reduces perceptions of autonomy and job satisfaction. The odds of having a reduced feeling of autonomy

or being dissatisfied with the job are quite large. These results suggest that more research needs to be conducted to understand these relationships and contexts in which this effect occurs.

Limitations

This project has a few limitations that need to be taken into consideration. The interviews were conducted with a group of NPs that all work in one state. Exploring issues such as the influence of state laws is not feasible with this sample. Additionally, while all of the NPs in the study work in primary care, it is difficult to make comparisons across different types of clinics due to the small sample size and sampling methods. However, these NPs do give a good picture of their lived experiences in non-hospital settings working as primary care providers. Additionally, the themes generated from these data show strong shared perceptions and experiences worthy of qualitative analysis.

One of the main limitations of the study is that of a small number of men in the sample. While the ratio of female to male NPs is similar to the national ratio, there is not enough data to confidently make comparisons across the sex category. Many of the NPs mentioned directly or hinted that women and men experience boundary-making differently. Based on the work and professions literature, there is a good chance that this is the case, but, unfortunately, these data cannot examine that issue.

As is the case with qualitative data collection, it is difficult to verify the validity of the narratives. That is, I cannot be sure if NPs shared data, they felt matched my expectations or if their recalls matched the reality of the events. However, this is an inherent limitation to qualitative research. However, I do feel confident that I was not intentionally led astray or that I purposefully led a participant to a particular answer. However, the stories told about their lived experiences seem like a relatively accurate account.

This project also uses quantitative data to examine perceptions of job satisfaction and autonomy. One limitation of these data is that it is from 2012, and changes in laws and education may influence different views if conducted today. However, these analyses limit the examination to relationships between variables that are unlikely to be different today due to the resilience of delivery structures and hierarchies. Also, the data offers a unique chance to examine computerization that would not likely be possible today, given that the use of computers is even more predominant than when these data were collected.

Additionally, while information on what states these NPs work in is variable, the distribution of NPs across the different categories of the scope of practice does not allow for quantitative analysis of the influence of these laws. While such an analysis is well suited for this type of data, it cannot be conducted with any level of certainty.

Future research

This project highlighted several factors that contribute to and influence boundary-making, job satisfaction, and perceptions of autonomy. Several new lines of inquiry emerged from this project. From the qualitative data, a primary extension is to increase the number of participants across different states as well as clinics to allow for a robust comparison of experiences. Such a project would allow for needed comparisons of perceptions and the ways NPs negotiate their roles. Crucial to this would be to collect data on the tasks of NPs and how they think about the task as well as how it is performed. In addition, a consideration of rural versus non-rural experiences could further an understanding of what drives NPs to choose rural clinics.

Additionally, a detailed account of the career paths of NPs could assist in understanding the career choices of NPs and perhaps build a typology of paths into and out of the profession.

This project would build on the existing literature of careers, but with a focus on a profession that is primarily comprised of women, it would allow for an investigation into how roles such as motherhood or non-motherhood influence the options and choices made.

An expected finding of this project was how computerization influenced perceptions of satisfaction and autonomy. There is much to explore in this area. The analysis of the current project suggests the influence of EMRs on NPs perceptions of autonomy when the medical records are computerized. However, there are also contextual factors that this analysis is unable to access. For example, does computerization itself have adverse effects on specific aspects of NPs practice such as face-to-face interaction with patients, and it is the effect on the patient-provider interaction that is creating the lower autonomy and satisfaction. On the other hand, the ease of gathering data is producing positive feelings. However, a limitation of these data is that specifics of the task are unknown, as well as detailed opinions about the EMR systems being used.

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APPENDIX A: INTERVIEW GUIDE

1. I would like to start by asking for a bit of your backstory. Could you describe to me how you became an NP?
    a. What was your career like before that?
    b. What made you want to move from being an RN to an NP?
    c. What do you feel is the difference is between working as an RN and as an NP?
    d. Did you ever consider other professions in the medical field? Which? Ask for details about the decision.
2. Okay, so once you set your sights on being an NP, what did you expect that it would be like?
3. Could you give me a brief job history since you became an NP?
    a. What made you choose Primary Care?
4. Let's talk a little about your current job. What do you feel makes for a good day?
    a. What seems to be the most helpful? Can you give me an example?
    b. Who is the most helpful? Probe: Admin staff, Nurses, Docs, Patients.
    c. How are they helpful?
5. What makes for a bad day? Can you give me an example?
    a. What is the most challenging? (Get a few examples)
        Probe: Admin staff, Nurses, Docs? Patients?
6. I now have a better sense of the sorts of things that make for good and bad days. Are there things that you do to help move your days one way or the other? Get a few examples from both a good day and a bad day.
7. On a day-to-day basis, how would you describe your experiences with collaboration in your clinic?
    a. What sort of things make for a positive collaborative relationship? (get 2-3 examples)
    b. Are there things you do to create these relationships?
    c. Probe: between you and the physician. You and RN's
    d. What sort of things makes for a negative collaborative relationship? (get 2-3 examples)
    e. How do you deal with interactions such as what you just shared with me?

f. If not mentioned, probe for relationships with RN's as well as Physicians.
g. Whom do you seem to collaborate with the most? Why?

8. Going beyond good days and bad days, I would like to get your thoughts as to how larger issues affect your work. Are there things outside of your direct control that you feel impacts your work? Get a mix of both those that are helpful and those that are challenging, and after each example ask:
    a. How so? (What makes this issue challenges? Or what makes about this makes it helpful?)
        a. Probe for relationships with managers or administrators.
    b. Are there things you do to deal with these situations?

9. So, can we talk a little about SOP laws? There is a lot of talk about these, and one of the things I am interested in is how these laws affect the work of NPs. So, how do you feel SOP laws affect your work? How so? / In what ways? Could you give me an example?
    a. Probe how these laws are helpful. Get 2-3 examples
    b. Probe for the ways these laws seem to present challenges. Get 2-3 examples.
        a. For challenges, ask what they do to deal with them.

10. We are near the end of the questions. I just have four wraps up questions for you.
    a. Thinking about your initial expectations of the job of NP, how do they compare with now?
    b. Do you have any advice for those considering becoming NPs?
        a. Knowing what you know now, what would you do differently?
    c. What changes might be in order to help boost the stature of NPs and the attractiveness of being an NP?
    d. Is there anything I have not asked about that you feel is important to ask?

Thank you for your time, it was very good meeting you.

APPENDIX B: CONSENT FORM

UNIVERSITY OF GEORGIA
CONSENT FORM
Occupational Case Study of Nurse Practitioners

Researcher's Statement

I am asking you to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. This form is designed to give you the information about the study so that you can decide whether to be in the study or not. Please take the time to read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information. When all your questions have been answered, you can decide if you want to be in the study or not. This process is called "informed consent." A copy of this form will be given to you.

Principal Investigator: Jim Coverdill

Sociology Department, UGA

jimcov@uga.edu

Purpose of the Study

This is a study about the profession of Nurse Practitioners (NPs) specializing in primary care. The purpose of this study is to understand the expectations that NPs hold when they begin their career, the lived experiences of NPs practicing in primary care, and what activities or experiences facilitate or thwart perceptions of satisfaction or contentedness with their work. I asked to interview you because I am interested in you and your experiences as a Nurse

Practitioner working in primary care. Only licensed Nurse Practitioners working in primary care at a non-hospital setting are eligible for this study.

Study Procedures

If you agree to participate, you will be asked to:

- Answer questions about how you entered the profession of Nurse Practitioners and why, your initial expectations of the profession, your experiences working as an NP, as well as your thoughts about the direction of the profession and ways it may strengthen its professional position in the health care field.
- The interview will be between 45 and 90 minutes. You will be interviewed once.
- We do not anticipate any risks from participating in this research.

Benefits

This study could potentially be of benefit in three ways. First, the findings of this study could help to strengthen retention of Nurse Practitioners by better understanding areas of Nurse Practitioners satisfaction and discontent with their work in primary care. This is important due to the scarcity of primary care providers, especially in predominately rural states such as Georgia. In addition, the findings of this study could potentially shed light on the career path of Nurse Practitioners, thereby increasing the knowledge needed to improve recruitment of Nurse Practitioners specializing in primary care. Lastly, the findings from these data could be used by health care organizations, physicians, primary care clinics, and health care clinic managers to create and strengthen policy aimed at retaining and hiring Nurse Practitioners.

Incentives for participation

There is no monetary incentive for participation.

Audio/Video Recording

Interviews are usually audio recorded, this allows for accurately keeping track of information. The recordings will be deleted once the project is completed. The transcriptions made from the interview will be archived until the paper is submitted.

Please provide initials below if you agree to have this interview audio recorded or not. You may still participate in this study even if you are not willing to have the interview recorded.

_____I do not want to have this interview recorded.

_____I am willing to have this interview recorded.

Privacy/Confidentiality

Your identity in this study will be kept confidential. A key code will be made which indirectly identifies you with your interview. The principal investigator and co-investigator will be the only parties with access to the individually identifiable information and key code. This information will be kept on a password protected computer until the end of the study, at which time it will be deleted. Researchers will not release identifiable results of the study to anyone other than individuals working on the project without your written consent unless required by law.

Taking part is voluntary

Your involvement in the study is voluntary, and you may choose not to participate or to stop at any time without penalty or loss of benefits to which you are otherwise entitled. If you decide to withdraw from the study, the information that can be identified as yours will be kept as part of the study and may continue to be analyzed, unless you make a written request to remove, return, or destroy the information.

If you have questions

The main researcher conducting this study is Jim Coverdill, a professor; Jeff Shelton, a doctoral student at the University of Georgia. Please ask any questions you have now. If you have questions later, you may contact Jim Coverdill at jimcov@uga.edu. If you have any questions or concerns regarding your rights as a research participant in this study, you may contact the Institutional Review Board (IRB) Chairperson at 706.542.3199 or irb@uga.edu.

Research Subject's Consent to Participate in Research:

To voluntarily agree to take part in this study, you must sign on the line below. Your signature below indicates that you have read or had read to you this entire consent form, and have had all of your questions answered.

_____	_____	_____
Name of Researcher	Signature	Date
_____	_____	_____
Name of Participant	Signature	Date

Please sign both copies, keep one and return one to the researcher.

APPENDIX C: PHONE CONSENT FORM

UNIVERSITY OF GEORGIA

PHONE CONSENT FORM

Occupational Case Study of Nurse Practitioners

Thank you for wanting to find out more about our research study. My name is Jeff Shelton, and I am a researcher at the University of Georgia's Department of Sociology, working under the guidance of Jim Coverdill, a professor and the primary investigator of the study.

This is a study about the profession of Nurse Practitioners specializing in primary care. Do you currently work in primary care?

{If No}: Thank you very much for your time. If you know of any NP's currently working in primary care that may be interested in participating in the study, please pass on the information for this study and my contact information.

{If Yes}: The purpose of this study is to understand the expectations that Nurse Practitioners hold when they begin their career, the lived experiences of Nurse Practitioners practicing in primary care, and what activities or experiences facilitate or thwart perceptions of satisfaction or contentedness with their work.

This study could potentially be of benefit for better understanding areas of Nurse Practitioners satisfaction and discontent with their work in primary care, shed light on the career path of Nurse Practitioners thereby increasing the knowledge needed to improve recruitment of Nurse Practitioners specializing in primary care. Lastly, the findings from these data could be used by

health care organizations, physicians, primary care clinics, and health care clinic managers to create and strengthen policy aimed at retaining and hiring Nurse Practitioners.

If you agree to participate, you will be asked to:

- Answer questions about how you entered the profession of Nurse Practitioners and why, your initial expectations of the profession, your experiences working as an NP, as well as your thoughts about the direction of the profession and ways it may strengthen its professional position in the health care field.
- The interview will be between 45 and 90 minutes. You will be interviewed once.
- We do not anticipate any risks from participating in this research.
- There is no monetary incentive for participation.

Do you think you might be interested in participating in that study?

{If No}: Thank you very much for your time. If you know of any NP's currently working in primary care that may be interested in participating in the study, please pass on the information for this study and my contact information.

{If Yes}: All information that I receive from you during this phone interview, including your name and any other information that can possibly identify you, will be strictly confidential and will be kept under lock and key. Remember, your participation is voluntary; you can refuse to answer any questions, or stop this phone interview at any time without penalty or loss of benefits to which you are otherwise entitled.

Interviews are usually audio recorded; this allows for accurately keeping track of information. The recordings will be deleted once the project is completed. The transcriptions made from the interview will be archived until the paper is submitted.

Is it okay with you if I audio record our conversation?

.**{If No}**: Thank you, I will not record the interview

{If Yes}: Thank you, I will now start the recorder when I we begin the interview.

Please ask any questions you have now. If you have questions later, you may contact Jim Coverdill at jimcov@uga.edu. If you have any questions or concerns regarding your rights as a research participant in this study, you may contact the Institutional Review Board (IRB) Chairperson at 706.542.3199 or irb@uga.edu.

Do I have your permission to ask you these questions?

If no- answer any questions or concerns and if/when the participant to ready to begin start the recorder and interview.

If yes- start the recorder and interview.