**Title:** Exploring the relationship between nursing identity and advanced nursing practice: An ethnographic study

**Abstract**

Background

Advanced nursing practice continues to develop internationally. Previous studies suggest advanced practice may lack support within nursing, which may lead to underutilisation, retention and patient safety issues.However, the relationship between the wider nursing profession and advanced practice is poorly understood and the theory that professional identity creates cultural barriers to advanced practice has received little empirical attention.

Aims and Objectives

To consider the relationship between professional nursing identity and advanced practice by

exploring intra-professional relationships between advanced nurse practitioners and nursing colleagues.

Design and Methods

Ethnographic methodology was adopted. Fieldwork methods were participant observation and semi-structured interviews. Participants were advanced nurse practitioners (n=9) and nursing colleagues (n=5) across two primary care general practice organisations. Data were analysed thematically using framework analysis, underpinned a priori by professional identity theories**.** Reporting was guided by COREQ.

Results

Three themes were identified which indicated how intra-professional relationships were conducted: *Conciliating Nursing,* where advanced nurse practitioners took responsibility for developing positive relationships with other nurses; *Vertical Discounting,* where nursing colleagues were dismissive and undermined advanced nurse practitioners, who themselves behaved similarly towards other nurses; *Lateral Otherin*g, where advanced nurse practitioners undermined other advanced nurse practitioners. *Vertical Discounting* and *Lateral Othering* destabilised advanced practice.

Conclusion

Intra-professional relationships, and the broader nursing profession, shape advanced practice. We theorize this is underpinned by threats to professional identity, while weak professional identity among even established advanced practitioners exacerbates lack of support. Highlighting these issues allows space to develop alternative strategies to negotiate intra-professional relationships, informed by professional identity theories, which support rather than inhibit advanced practice.

Relevance to Clinical Practice

As advanced practice expands throughout primary and secondary care, and across allied health professions, the impact of professional identity and relationships on healthcare will likely increase and the importance of strong advanced practice identity will become increasingly relevant.

**Keywords**

* Advanced Nursing Practice
* Advanced Nurse Practitioners
* General practice
* Intra-professional
* Professional Identity
* Positioning Theory
* Primary Care
* Social Identity Theory

**Introduction**

Changing demographics, increased complexity of care and physician shortages have led to alternative methods of delivering healthcare internationally. One way of addressing these needs is to utilise nurses and other healthcare professionals in practice traditionally demarcated within a medical domain (Freund et al, 2015)). This is exemplified by advanced nurse practitioners (ANPs) working in primary care in the UK, many of whom share similar caseloads to general medical practitioners. However, the implications of this diversification, for the nursing profession more broadly and for advanced nurse practitioners specifically, and consequently for patient care, lack exploration and understanding.

**Background**

Within the UK and internationally, advanced practice is recognised as a level of practice rather than a specific role (International Council of Nurses, 2002; Health Education England, 2017). The ICN and HEE agree it is characterised by complex decision making, high level autonomy and masters level qualifications. In the UK, advanced practice encompasses four pillars: clinical practice, leadership, education and research (HEE, 2017). The HHE definition of advanced practice is set out in Figure 1.

Internationally, advanced nursing practice has developed on an ad hoc basis (Bryant-Lukosius et al., 2004). Standards of education are variable and titling inconsistent and there are significant legislative and regulatory differences between countries. (Freund et al., 2015). For example, USA, Australia, New Zealand and Canada have clear regulatory and legislative frameworks within which ANPs are required to practice (Freund et al., 2015; Marsden et al., 2011; Middleton et al., 2011). This contrasts with the UK where there is no title protection or current formal regulation beyond initial nursing registration (NMC, 2012).

Advanced nursing practice has been found to be safe and effective (Laurant et al, 2018). However, it may lack acceptability and understanding, leading to underutilisation (Andregård and Jangland, 2015). There is an emerging body of evidence indicating advanced nursing practice may be influenced by the broader nursing community (Bonsall and Cheater, 2008). Diversification of nursing roles and levels of practice may be unsupported by the nursing profession not only in terms of regulation and accreditation, but as a result of cultural conservativism (Currie, Finn and Martin, 2010). As a result, nurses working in non-traditional roles may be mistrusted and hindered by nursing colleagues, as well as sometimes subjected to open hostility (Powell and Davies, 2012). MacLellan, Levett-Jones and Higgins (2016) found newly qualified ANPs in Australia reported resistance by other nurses. This manifested in negative conduct ranging from dismissive and secretive behaviour to ‘turf wars’, with implications for patient safety, as well as ANP retention (MacLellan et al., 2016 p5). Furthermore, studies suggest ANPs differentiate themselves from other nurses by identifying themselves as elite and consider themselves to be held in higher regard than the broader nursing profession (Piil, Kolbaek, Ottmann and Rasmussen, 2012). However, the potential reasons for, and implications of, these intra-professional issues are poorly understood

Intra-professional differentiation may result in fragmentation of nursing identity as other nurses may feel undermined by advanced practice, where academic and technical elitism can be perceived to be valued above other aspects of nursing (Hart, 2004). In a study of practice nurses’ perceptions of advanced practice, Carr, Thorn and Rogers (2005) identified concerns that it challenged the status of traditional nursing, while devaluing experiential learning. However, the impact of these tensions on ANP practice and the role the wider profession of nursing plays in this, remains unclear. The theory that nursing as a profession has developed cultural barriers to ANP practice has received little empirical attention and is seen by some within nursing as unpalatable or taboo (Evans, Traynor and Glass, 2014; Lowe, Plummer and Boyd, 2013). Therefore, its explicit exploration warrants attention.

This paper reports findings concerning intra-professional issues relating to advanced practice, which was part of a broader study of inter and intra-professional working in relation to advanced practice in primary care and which was underpinned by a theoretical framework of professional identity.

Theoretical Framework

The study was positioned within a framework of professional identity which was informed by Social Identity Theory and Positioning Theory. Professional identity is a value and belief system which shapes and legitimises the behaviour of individuals within professional groups (Wilson, Cowin, Johnson and Young, 2013). It is underpinned by historical, social and political influences (Chulach and Gagnon, 2016). Professional identity is considered to be constructed through enculturation by participation in common workplace practices (Willetts and Clarke, 2014). One of its functions is to ensure individuals become, be and stay ‘one of our kind’ (Wackerhausen, 2009, p460). To be fully accepted as a member of a profession requires assimilation beyond formal learning to the embodiment of rules, beliefs and habits consistent with views and accepted values of the profession (Wackerhausen, 2009). Through this shared understanding, standards, behaviours and expectations are formed, the deviation from which is considered unacceptable (Wackerhausen, 2009). The influence of professional identity on behaviour makes its study of relevance to practice (Monrouxe, 2010). Therefore, it has utility in exploring how professionals work together to influence advanced practice.

Social Identity Theory (Tajfel and Turner, 1986) offers an explanation of how professional group identity is assimilated. It focuses on the individual as part of a collective, with group cohesion creating a sense of belonging (Willetts and Clarke 2014). This results in formation of group alliances, standardisation of group behaviour and development of individual and group self-worth (Burford, 2012). Group membership is seen as emotionally valuable (Hogg, 2006) and consequently self-worth is developed through perceived group status, while the individual’s status within the group creates self-esteem (Willetts and Clarke, 2014). However, as a consequence, groups see themselves as distinct from others and may use strategies to compete for prestige (Hogg, 2006). This results in privileging the values of the individual’s group above others and therefore provides an explanatory framework within which to explore group behaviours. It has particular resonance in explaining tensions between and within groups who are seen as competing to gain and maintain group status (Fiol, Pratt and Connor, 2009). In this way, professional identity influences how professional groups perceive and behave towards each other and its utility in understanding and influencing behaviours within and between professional groups is increasingly recognised (Currie et al., 2010; Monrouxe, 2010; Willetts and Clarke, 2014).

Fiol et al., (2009) argue that the perceived security of one’s own professional group predicts tolerance towards another group. Consequently, when a group’s identity is insecure, gaining security is predicated on the other group’s demise. Therefore, threats to professional identity may be triggered when group distinctiveness is perceived as vulnerable. (Fiol et al., 2009; McNeil, Mitchell and Parker 2013). McNeil et al., (2013) suggest that due to the nature of their practice, ANPs can be perceived to pose a threat to professional identity and have identified potential triggers, underpinned by the work of Chrobot-Mason, Ruderman, Weber and Ernst (2009) (Table 1).

Society holds enduring notions of what it means to be a nurse (Hart, 2004). Consequently, exploration of nursing identity cannot occur without setting it within a social, historical and political context, as this continues to influence how nurses view themselves and are viewed by others (Chulach and Gagnon, 2016; Wackerhausen, 2009). To this end Positioning Theory has utility.

In Positioning Theory (Davies and Harré, 1990), identity is understood as influenced by the individual’s relationships and interactions developed within wider social, historical, political and cultural contexts. It is underpinned by the concept that individuals and groups are positioned by themselves, by others and by wider society. Positions assigned to individuals and groups influence how they understand themselves, how they are perceived by others and how they behave (Georgakopoulou, 2013).

Positioning Theory regards identity as created through narratives (Harré, Moghaddam, Pilkerton Cairnie, Rothbart and Sabat, 2009). A key principle is that identity is created through the interaction between to the stories people tell themselves and others within local contexts (Garcia and Hardy 2010) and broader social, cultural, historical and political discourses, which have been termed ‘master-narratives’ (Georgakopoulou, 2013 p89). Examples of master-narratives would be societal level perceptions of what it is to be a mother or a teacher. Individuals draw on master-narratives to position themselves and others within storylines in order to claim rights and duties for themselves and to ascribe and challenge rights and duties to others (Georgakopoulou, 2013; Harré et al, 2009). Such master-narratives are often tacit and undisputed (Chulach and Gagnon, 2016). Therefore, their analysis raises them to a conscious level, allowing assumptions to be explored and contested.

Identity construction involves positioning one’s own group in relation to others, so narratives are not neutral but have specific identity aims (Garcia and Hardy, 2007). An analytical framework has been developed to interpret narratives in the context of wider social, political, historical and cultural identities (Table 2) (Bamberg, 1997; Bamberg and Georgakopoulou, 2008; Georgakopoulou, 2013).

Positioning Theory has utility in exploring professional identity because it surfaces tacit beliefs and behaviours situated within invisible social structures (Chulach and Gagnon, 2016). This is necessary to gain a clear understanding of how, why and in what ways identity may contribute to ANP practice.

Social Identity Theory and Positioning Theory highlight different aspects of identity formation. Structural and cultural positioning is explicitly embedded in Positioning Theory, while extending Social Identity Theory to consider identity threat allows a more nuanced understanding of interactional behaviours and their applicability to practice. Both frameworks were used to underpin this study. Specifically, professional identity constructs underpinned research aims and objectives and were used to frame observations and interview questions. They were also used as a framework to analyse data and explain findings.

**Methods**

Aim: To consider the relationship between professional nursing identity and advanced practice by exploring intra-professional relationships between advanced nurse practitioners and nursing colleagues within general practices

Ethnographic methodology was used to explore how ANP practice was negotiated within the culture of primary care. Critical ethnography examines hidden agendas and assumptions framed within social structures (Holloway, 2008). Therefore, it has particular utility in informing understanding of healthcare organisations. This study was underpinned by constructivist concepts, which explore not only what was happening, but how and why (Silverman, 2013). Reporting follows COREQ guidelines (supplementary file 1).

Quality in qualitative research centres on credibility and trustworthiness. For Hammersley (1990) this is assessed through establishing consistency between findings and wider knowledge, credibility (recognisability) of the account to readers, the extent to which findings are relevant to those in similar settings and reflexivity, which is a sensitivity and self-awareness of how both the researcher and the research process impacts on findings (Mays and Pope, 2006). Related to reflexivity is positionality. This is the understanding that the researcher’s position within the research process is linked to relevant aspects of their identity, political stance, cultural background, professional and socioeconomic status (Bourke, 2014), all of which may impact on research processes and outputs.

For Brunero, Jeon and Foster (2015) researchers who are also clinicians are never fully insiders or outsiders when studying professional environments. While this provides opportunities to gain access and enhance insight, it is necessary for the influence of the researcher to be reflexively considered and made transparent to ensure rigour. As lead researcher, my professional background as an ANP in primary care initially provided insight, and focused interest, in the phenomena studied. A priori concepts of identity had been developed from the literature, which informed the research process and raised awareness of my own nursing identity. Furthermore, my socialisation within nursing undoubtedly informed my views of the nature of nursing and its position within a wider healthcare context. As a consequence, it was necessary to reflexively and critically challenge these views and careful consideration was given to the context within which data were generated and analysed. This was achieved by looking for disconfirming cases and alternative explanations, by keeping a reflexive diary and making notes, alongside field notes, about practical impact and cultural, professional and ideological influences. Supervisory discussions provoked further reflection and questioning of analytical ideas.

**Study Design**

An ethnographic study was designed to gain in-depth information about cultures and behaviours influencing ANP practice within two general practice sites. Primary methods of fieldwork were participant observation and semi-structured interviews (Hammersley and Atkinson, 2007).

**Data Generation**

Data generation focused on how ANPs worked with colleagues within primary healthcare teams. This paper reports on intra-professional relationships between ANPs and other nursing colleagues and focuses on interview and observational data. The study was conducted by the lead author between September 2015 – March 2016. Ethics approval was gained from a University Department of Health Science Research Governance Committee and the study was funded by a PhD fellowship.

**Recruitment**

General Practices with ANPs in a region of England were identified through the NHS Choices website, which provides demographic information about general practices in England. Where practices were listed as having ANPs, ANPs were invited directly via email to participate.Two general practice case sites were chosen to achieve in-depth information: Oakcroft Alliance was a group of six general practices, while Moorfield Practice was a single practice (pseudonyms). These were selected for maximum variation in number and experience of ANPs, practice exposure to ANPs and differed in practice size, structure and organisation. Prior to starting the research, a presentation was made at each site’s primary healthcare team meeting to explain the study and provide study information leaflets.

The study followed a purposive sampling strategy (Holloway, 2008). Each study site had a ‘gatekeeper’ ANP who had initially agreed to take part in the study. They introduced ANP and practice nurse colleagues to the researcher. Participants were invited by the researcher to participate because they had a broad range of relevant experience and knowledge (Bowling, 2009), roles, gender and exposure to primary care. Some ANPs volunteered for the study before being formally asked as they were interested in the study and wanted to contribute to ANP research. All ANPs working at both sites (n=8) agreed to take part. A further ANP based at another practice was told about the study by a participating ANP and a volunteered to be interviewed. Because they had a wealth of knowledge and experience, and because qualitative research recognises such snowballing techniques as beneficial in gaining rich data, it was agreed this ANP would make a valuable contribution to the study. During the study, contact with other members of the nursing team led to purposive identification of key nursing informants. A total of 9 ANPs and 5 practice nurses were formally interviewed across both sites. All participants were informed they could decline participation at any point, and at any part, of the study. Study information packs were provided to all participants and informed consent obtained.

Interview duration for ANPs was on average 60 minutes while practice nurse interviews lasted between 20-60 minutes. ANPs ranged in experience, from one who was in training to one who had been a qualified ANP for >20 years. The others had worked as ANPs for between 3-15 years. Practice nurses ranged from newly qualified (within 2 years) to >20 years.

All ANPs working at the study sites were observed in multi-disciplinary team meetings, during supervision and during formal and informal discussions where professionals interact. Contextual sampling refers to different behaviours participants may display between different contextual settings, therefore observational fieldwork took place at different times of the day, different days of the working week and in different practice settings and contexts. While observing ANPs, interactions between team members relating to advanced practice were observed within each practice. This was made clear to primary healthcare team members before the research started and no members of the team declined to take part. Participants were informed in printed study information and reminded throughout the study that they could decline to take part. Observations were conducted overtly, with contemporaneous field note documentation carried out in full view of participants. Field notes documented interactions with and about ANPs relevant to the study only. In total 127 hours were spent observing ANPs across both sites. Sometimes more than one ANP was observed at one time (e.g. at meetings). Individual ANPs were observed between 2-13 times. Eleven multi-disciplinary team meetings were attended, as were two nurse team meetings and two full team learning meetings/events.

Interviews were informed by a topic guide developed iteratively using data generated during observations, as well as by literature including a priori theoretical concepts relating to professional identity. Focus was on how participants narrated and performed their role to make sense of their identity and the interviews were semi-structured in order to probe issues highlighted by participants. This allowed both exploration of theory and emergent themes.

**Data Analysis**

Data were analysed thematically by the lead author based on framework analysis (Pope, Ziebland and Mays, 2000), which is both grounded in raw data as well as being informed by a priori conceptualisations and study aims and objectives. Data from each study site were initially analysed separately, then cross-site analysis was then undertaken to compare and contrast findings.

Data analysed consisted of

* Transcripts from observational field notes
* Transcripts from audio-recorded qualitative interviews
* Researcher notes, memos and reflexive diary

Field notes and interviews were analysed separately initially, then compared and contrasted. Following Pope et al’s (2000) stages of analysis, familiarisation with all generated data was established by listening to recorded information and reading and re-reading written and transcribed data. All data were then analysed using a constant comparative approach, with data within each study site being collected and analysed concurrently to allow for development and testing of emergent themes and relationships. Data were then coded according to a priori concepts outlined in Social Identity Theory and Positioning Theory. Specifically, Bamberg’s (1997) three level positioning analysis (Table 2) allowed data to be coded at character, audience and societal levels, while Social Identity Theory considered data at individual, relational and group levels (Currie et al ,2010). However, the process was also iterative, allowing for emergent themes. Disconfirming cases and alternative explanations were sought. A reflexive approach was followed and a diary kept to support reflexivity and to create an audit trail of the analytical process. Supervisory meeting discussions between all three authors provoked further reflection and questioning of analytical ideas.

**Results**

Descriptive data for both sites are set out in Table 3. Oakcroft was a group of six practices led by one overarching practice, while Moorfield was a single practice.

In this section, study findings and some analytical discussion with reference to the literature are presented concurrently where appropriate. These are then related to the literature more thoroughly in the discussion section. This is because ethnographic practices are essentially non-linear. That is, exploring findings, analysing, drawing from other literature and writing are concurrent analytical processes which build detailed understanding of the culture explored (Hammersley and Atkinson, 2007),.

Three themes were identified from interview and observational data: *Conciliating Nursing, Vertical Discounting* and *Lateral Othering*. Each theme conceptualised an aspect of the negotiation of intra-professional relationships. Conciliating Nursing involved ANPs taking responsibility for developing positive relationships with other nurses. They did this with the awareness that other nurses may hold negative views of advanced practice, which may lead to negative behaviours. Indeed, such views and behaviours were identified and are termed here as Vertical Discounting, where other nurses undermined highly qualified and experienced ANPs who could be considered to be more powerful and of higher status within the professional healthcare hierarchy. However, ANPs also engaged in Vertical Discounting by similarly working to undermine other nurses. Moreover, individual ANPs also engaged in Lateral Othering. That is, they expressed negative views about other ANPs who would be considered their peers within the professional hierarchy, consequently positioning themselves as different to ANPs as a professional group and shoring up their individual position. Each theme will be explored in turn.

Conciliating Nursing

Findings indicated that superficially cordial relationships between ANPs and other nurses were evident. However a number of overt and covert negative practices and behaviours, along with perceived and anticipated intra-professional tensions underpinned by professional identity, influenced ANP practice. Consequently, ANPs spent time *Conciliating Nursing.*

ANPs drew on past events and master-narratives which informed their understanding that intra-professional relationships had to be carefully negotiated. ANPs anticipated other nurses might be unsupportive because they had experienced this previously.

*The team that I came from weren’t supportive and really quite negative and thought that I was, well in their words, ‘above my station’* **[ANP4 Interview, line 380]**

This attitude was reflected in a practice nurse interview.

*I worry about the blurring of roles I guess, you know, with people that might have ideas above their station or think that they could do things perhaps that they don’t have quite the skills and experience to be able to do.* **[Practice Nurse 5 Interview, line 522]**

As a consequence, one ANP was surprised when other nurses were accepting of the role.

*the nurses are great… I wouldn’t have been surprised if there’d been a bit of hostility thinking ‘well who do you think you are?’ but there’s none of that at all.* **[ANP8 Interview, line 373]**

The longest established ANP in this study positioned other nurses as accepting of advanced practice and saw her position as an expert resource as mediating these relationships. Such support was appreciated by other nurses. When ANPs had experienced difficulties in their professional relationships with other nurses, they considered it was their responsibility to overcome these.

*Like I said when I first came there were lots of suspicion from district nurses…Whereas, you know, over time it’s up to me to say what I do, to show them* **[ANP3 Interview, line 365]**

It may be assumed then, that intra-professional tensions may dissipate with time and interaction with ANPs. However, despite efforts of ANPs to conciliate nursing, this was not always the case, and ANPs experienced negative views and behaviours from other nurses. This is termed Vertical Discounting.

Vertical Discounting

Vertical discounting was experienced by ANPs in several ways. For example, when ANPs delegated work to other nurses, or where nurses felt ANPs had a supervisory role over them.

***ANP:*** *Erm. Hmm (long pause). I think some of them are fantastic and very accepting and I think I have had that, ‘Oh, are they just going to come in here and tell me what to do and step on my toes?’* **[ANP 6 Interview, line 368]**

It was recognised that while some colleagues positioned themselves as accepting of ANPs, this did not necessarily reflect underlying attitudes and beliefs. Such attitudes were more likely to be shared with others and not expressed to ANPs themselves.

*…people have always been very kind and very nice about what they’ve said about me. They’ve never been unpleasant. I know from sort of anecdotal gossip district nurses will say, ‘Oh asking us to go and do bloods, can’t she do it, she’s a nurse?’ and all this sort of stuff.* **[ANP2 Interview, line 322]**

There was also a perception that while superficially supporting advanced practice, some nurses displayed underlying behaviour contrary to this long after the role had become established.

*…but actually her behaviour is contrary to that. So there’s often a mismatch between what people say and their actual behaviour.* **[ANP2 Interview, line 313]**

However, other nurses were more overtly negative towards ANPs, something which caused some ANPs to reflect that this was perhaps intrinsic to the professional identity of nursing.

*I think sometimes in nursing some nurses are very supportive of those that want to develop and move on and some are not as supportive and it’s something I’ve never understood…they are still like that now…I bumped into a few of them the other day and they were very condescending I think is the word and very, ‘oh how’s it going being a doctor?’* **[ANP4 Interview, line 386]**

That nursing as a profession was culturally not always supportive of other nurses, both at an individual and a professional group level, was recognised by various participants. One ANP suggested, ‘sometimes nurses are a bit harder on each other, when sometimes maybe they don’t need to be’ **[ANP6 Interview, line 214],** while another was more blunt,

*a lot of that is just females and being together and being catty which is what a life time in nursing I’m fully aware what women are like together* **[ANP2 Interview, line 328]**.

Because some nurses appeared uncomfortable with ANP leadership and delegation, their narratives often positioned ANPs as nearer to doctors and separated ANPs from the wider nursing team.

*[Informal chat with practice nurse who said] ‘well no one here thinks of them as nurses, we think of them as GPs because that’s what they are. The practice nurses are separate from ANPs. I wouldn’t want to be one as I’ve got the perfect job for me.’* **[Observational Field Notes Moorfield, line 306]**

Martin and Hutchinson (1999) first highlighted that ANPs experienced discounting when trying to establish their position. Social psychological discounting included: undermining; ignoring; excluding; blaming; verbal abuse; stigmatisation, misidentification and being made invisible. This left ANPs marginalised. In this study, elements of discounting were evident in ANPs’ relationships with other nurses, despite the long establishment of ANPs at these sites. By positioning ANPs with GPs, other nurses discounted ANPs’ identity as nurses.

*They’ve no idea what on earth she’s on about. Was she a doctor? Was she not a doctor? Was she a nurse? Well if she’s a nurse why is she telling me to go and do this?* **[ANP4 Interview, line 527]**

Similarly, some nurses impliedthat taking on aspects of traditional medical roles removed the essence of nursing or was letting down nursing as a profession. As a consequence ANP practice was discounted as being inconsistent with nursing,‘I don’t see myself becoming an ANP…I really enjoy what I do nursing’.**[Practice Nurse 4 Interview, line 180]**

Furthermore, practice nurses framed their reluctance to deviate from defined parameters and reliance on GP oversight within a patient safety narrative, which they presented as a positive attribute specific to ‘good’ nurses. They positioned themselves as safe by working under the ultimate supervision and oversight of doctors. The implication being that by developing a broader, more critical perspective, ANPs were not conforming to this expectation of being a good nurse.

*the doctors know what we’re doing. They’re looking at what we’re doing and they know that we are working within our competencies within our roles and not, you know, putting anybody at risk.* **[Practice Nurse 5 Interview, line 368]**

Discounting was particularly evident in one nurse’s narrative of a conversation with a GP several years earlier about the introduction of an ANP to the practice. The nurse discounted the ANP role and indicated that the ANP’s appointment was irrelevant to her.

*Very interestingly Dr [Surname] pulled me before [ANP] started and said, was I nervous about her coming and joining the team and I thought it was a bit of an odd question to ask really and I said, ‘for what reason would I be nervous?’ Well he said, ‘well she’s an advanced nurse practitioner’ and I thought, ‘Well that still doesn’t answer my question. She’s not coming in as my boss’… my opinion of that has never changed* **[Practice Nurse 5 Interview, line 169]**

It was of note that the practice nurse stated her opinion of advanced practice had not changed, despite exposure to ANPs. There may be a pragmatic necessity for nurses to appear to overtly accept ANPs because of their subordinate positioning, while lack of formal contribution to decision-making within practices makes them unable to actively disagree. Consequently, the only way nurses can make their feelings known is through subversive behaviours such as discounting.

Advanced nursing practice was also discounted by some nurses who positioned it as unnecessary or ignored the contribution made by ANPs. One practice nurse did not acknowledge an ANP’s specialist role in the management of a long term condition, even though the ANP regularly carried out clinics at a similar level to GPs. Instead of considering the ANP as an expert source of support, the practice nurse positioned an inexperienced GP as providing support to practice nurses in this speciality.

 *[GP] who did [condition] left and now there is no one but me. I’ve told them I need support and one of the [GP] partners is now doing the [condition] diploma* **[Practice Nurse 1 Interview (not audio-recorded), line 75]**

It was not only primary healthcare team nursing colleagues who discounted ANPs. One ANP reported relationships with secondary care and specialist nursing colleagues could also be problematic, while another ANP **[ANP8]** was discounted because she was a specialist rather than generalist ANP.

*I think there is quite a lot of bitchiness amongst nursing, a lot of superiority particularly from the specialist area. I mentioned that I’d done the Master’s in [condition]. If I refer to a [specialist] nurse…I’ll get quite a snotty reply…it almost feels like they want to get one up on me in terms of that they are the specialist…you just get this feeling like, ‘who does she think she is referring me this?’* **[ANP2 Interview, line 678]**

In this study it was clear that discounting could take place in either direction; ANPs could also be seen to discount other nurses. Nurses were sometimes talked over by ANPs in meetings, positioned as lacking understanding and sometimes described on a similar level to healthcare assistants. Some expressed negative opinions about other nurses,‘Nurses embarrass and irritate me all the time’**[ANP2 Interview, line 676).**

*[In meeting] Practice nurse tried to talk, but was talked over by ANP. Practice nurse talked quietly, then faltered and stopped talking to the group* **[Observational Field Notes Oakcroft, line 359]**

*ANP said, ‘yeah, typical nurse, just says something but doesn’t think it through or know any rationale behind it’.* **[Observational Field Notes Moorfield, line 469]**

ANPs also positioned ANPs as different to other nurses. They utilised traditional perceptions of nursing identity to position themselves as more capable, competent and risk tolerant than other nurses.

*suddenly it’s your responsibility to come up with the problem, the solution, the diagnosis, the treatment, sign the prescription, it’s really scary stuff and its definitely not for everybody and it, you know, it’s not that you’re better than them it’s just that, you know, you’re wired differently and you’re willing to take that risk* **[ANP1 Interview, line 321]**

As a consequence, there was scepticism as to whether there was a critical mass of nurses with the potential, ability and motivation to develop as ANPs, strengthening the position of ANPs currently in practice.

*I think there’s a mismatch between sort of policy maker’s ideas and what nurses actually see as a position that they want to find themselves in. I spoke to the district nurse and the practice nurse, how they feel about upping their skills…and they just don’t want to know. So I’m not sure that that level of autonomy is what a lot of nurses want. I think they are quite comfortable with working within protocols and guidelines* **[ANP2 Interview, line 256]**

Vertical Discounting was used by both ANPs and other nurses to differentiate their professional space and, as framed by theories of professional identity, position the other professional group negatively in order to enhance their own position. However, as well as Vertical Discounting some ANPs could be seen to engage in negative views and behaviours towards other ANPs. As this was aimed at nurses within their own professional peer group, this is termed here as Lateral Othering

Lateral Othering

Lateral Othering is the negative positioning of both individual ANPs, and ANPs as a professional group, by ANPs themselves. Behaviours ranged from ambivalence, to discounting, through to individual ANPs positioning themselves as exceptional in relation to other ANPs. This was demonstrated in one ANP’s ambivalence, rather than positive support, of her practice employing a further ANP.

*They [GPs] all came to me and said ‘if we took on another nurse practitioner, how would you feel?’ I don’t feel anything as long as they can work as part of the team it doesn’t matter. It’s not threatening in anyway*. **[ANP9 Interview, line 377]**

That some ANPs were not always fully supportive of their ANP colleagues was also demonstrated in their comments about other ANPs, both as individuals and as a professional group. Some ANPs capitalised on perceived variability in the quality and standardisation of other ANPs, positioning themselves as different to other ANPs who may be less effective, less trustworthy or less competent. This was explicit in interview and also implicit in the way they presented themselves to others within the primary care team and to myself as an audience for their narratives. They utilised shared concerns within the practices (especially those of GPs and managers) to their advantage by positioning themselves as different to other ANPs, thereby shoring up their position in the practice.

*I know some nurse practitioners won’t see babies under 6 months, they won’t see pregnant women, they want 15 minute appointments and they won’t do on-calls and they won’t do visits....I just take on what feels comfortable and what I feel competent to be able to deliver as I’ve gone along with my role really and I think that maybe some of the reason why people say I’m not like an ordinary nurse is I probably do more when you compare me to those other nurse practitioners who aren’t as comfortable* **[ANP2 Interview, line 515]**

Of note, this self-positioning of individual ANPs as different to ANPs as a professional group appeared to be embedded within structures which privilege the biomedical model and consequently positions other (nursing) models subordinately. That is, biomedical knowledge is implicitly accepted as legitimate and individual ANPs aligned themselves with this, while simultaneously positioning ANPs as a group as failing to meet this standard. For Chulach and Gagnon (2015), such positioning is achieved through a process of “othering” (pg56) where *others* are negatively positioned as different to the ideal biomedical model. While Chulach and Gagnon (2015) theorise this at a group level, in this study lateral othering was observed as individual ANPs positioning themselves as different to ANPs as a professional group.

It was not only during formal conversations that ANPs expressed these views. It became clear that for some ANPs this was a narrative that threaded through informal conversations, while others used narrative stories to position themselves favourably in comparison to *other* ANPs.

*Walked to meeting room with ANP, she asked me what other ANPs at other practices in my study were like. I started to say ANPs I had encountered worked to a high standard, but she interrupted when I said ‘they are-’ and she said ‘very variable’. When I said, ‘no, I’ve found them to be very good’ she said ‘oh’, pulled a face and sounded surprised.* **[Observational Field Notes Oakcroft, line 286]**

The simultaneous positioning by ANPs as different to the majority of nurses and dissimilar to ANPs as a professional group, can be seen as a mechanism by which ANPs further protect their role and position within practices. Indeed there was some indication that ANPs did not actively support other nurses to develop by implying most nurses were unsuited to advanced practice and suggesting there was no practice requirement for further ANPs.

*there wouldn’t be another role for another nurse practitioner to be fair. There are 3 practice nurses, one of them has done her nurse prescribing…In my experience she doesn’t prescribe hardly ever, so she doesn’t appear to have a confidence around it...the other practice nurse who is keen to do her independent prescribing…that’s more of a personal desire than any sort of PDP [professional development plan] or anything which is identified that would be useful for her to do.* **[ANP2 Interview, line 341]**

In this way ANPs were positioned as individual, and exceptional, relative to both nurses and other ANPs. As a consequence of focusing on the individualism of ANPs, there was a lack of trust in ANPs as a professional group and ANPs were positioned as different to the majority of ANPs, for whom a large degree of suspicion persisted. For this reason, practices in this study preferred to employ ANPs they had experience of. Indeed, eight out of the nine ANPs in this study were previously known by, or recommended to, the practices where they worked.

While it is important to acknowledge that not all nurses behaved towards, and talked negatively about, ANPs and vice versa, intra-professional working relationships remained a core issue which may contribute to the success, or otherwise, of ANP practice. At both study sites, ANPs used various techniques to forge intra-professional relationships such as explaining their role, taking on overspill work and providing a source of experienced and expert nursing knowledge, as well as seeking advice from other nurses. While this was successful in conciliating nursing to an extent, perceptions of advanced practice appeared to remain relatively fixed and the dichotomy between ANPs and other nurses appeared to hold firm.

**Discussion**

This study identified that ANPs of all levels of experience faced undermining and negative views and behaviours from the wider nursing profession, despite working to ameliorate this. That even established ANPs continued to experience this contrasts with previous assumptions that time and exposure to ANPs would minimise such behaviours. This has implications for utilisation, recruitment and retention of ANPs as well as patient safety. However, ANPs themselves also engaged in similar behaviour by presenting an individual elite identity and positioning themselves as different to ANPs as a professional group and the wider nursing profession. As this study was underpinned a priori by professional identity theories, these will be used to frame subsequent discussion.

There is a small but growing body of evidence to suggest that the profession of nursing, and individuals within it, may be complicit in undermining and inhibiting advanced nursing practice. For example, studies of ANPs’ experiences of role transition have identified deliberate techniques to undermine individuals and roles by other nurses who withhold information, dismiss, demean and behave in a passive-aggressive way towards ANPs (Brown and Draye, 2003; MacLellan et al., 2016; Martin and Hutchinson, 1999). MacLellan et al., (2016) also identified that novice ANPs felt deliberately unsupported by other ANPs. While these previous studies focus on novice and ANPs in transition, findings reported in this study demonstrate that such behaviours are experienced in environments where ANPs, both as individuals and as a concept, are long embedded within study sites. While overt aggression described by McLellan et al., (2016) was not evident in this study, subtle undermining of ANPs was demonstrated by some nurses. They ignored ANP contributions, made negative comments, questioned competence and expressed dislike of carrying out work to support ANPs. This constitutes what Martin and Hutchinson (1999) term as discounting and, in this study, was usually covertly insinuated while portraying outward support for ANPs. This covert behaviour is potentially harmful as both ANPs and others may find it difficult to identify and define, consequently making it more difficult to address.

Behaviours such as Vertical Discounting are usually understood in the nursing literature as a downward trajectory where more influential nurses behave negatively towards new or inexperienced nurses (Daiski, 2004). However, in this study ANPs who were established at the practice sites and held senior positions, were still exposed to vertical discounting. From a Social Identity Theory perspective, this can be seen to be underpinned by group-level professional identity in a number of ways. A lack of a strong, coherent ANP identity made it easier for ANPs to be positioned as an out-group in comparison to others with stronger group identity. It was of note that other nurses in this study drew clear distinctions between ANPs and nurses, while some implied that advanced practice was not reconcilable with traditional nursing identity. By implication, ANPs were letting down the profession of nursing by pursuing what were seen by some as non-nursing agendas. It appeared that the historical, political and gendered context from which nursing originates (Davies, 1995) proved difficult to shake off and it remained that there was a dissonance between what ANPs and other nurses considered to be the core of nursing identity.

Jealously may play a part in relationships between ANPs and other members of the nursing profession (Lowe et al., 2013; MacLellan et al., 2016). Although there is little empirical evidence to pinpoint motivation for negative intra-professional behaviour, this may have some theoretical basis. Evans et al., (2014), argue that nursing provokes feelings of anxiety, envy and jealousy and suggests that jealousy is related to feeling that others are getting what you deserve and hence rivalry occurs. This can result in negative behaviour and ill-will aimed a spoiling what the other has. Evans et al., (2014) contend that nurses experience feelings of jealousy for privileges afforded to doctors, which has the potential to distract nurses from the main focus of service delivery with potentially harmful consequences for patient care. Furthermore, nurses’ jealousy of doctors is seen as taboo and therefore never raised to a conscious level or explored. Drawing on McNeil et al’s (2013) theory that negative behaviours occur when professional group identity is threated (Table 1), it is possible that Evans et al’s (2014) assertions can be extended to the suggestion that professional envy, jealously and rivalry may occur in relation to advanced practice, with ANPs seen as privileged above other nurses, while remaining less privileged than GPs. Contentious issues of status, power and pay may all contribute to perceptions of unfairness. Consequently, the perceived treatment and status differentials of ANPs relative to both GPs and other nurses may underpin professional relationships.

It is empirically difficult and methodologically problematic to demonstrate jealousy and envy (Miceli and Castelfranchi, 2007) because both are taboo, rarely admitted and consequently remain at an unconscious level. It can, though, be related to professional identity. McNeil et al., (2013) theorise that professional identity becomes more salient when it is perceived to come under threat, for example if one group of professionals are seen to be privileged over another (Table 1). This increases salience leads to fractures in relationships. In this study the primary healthcare teams appeared to work together effectively on a superficial level and there were no overt conflicts related to ANPs. Furthermore, advanced practice had been established for some time at both sites and, therefore, it may be assumed that threats to professional identity may be less salient. However, evidence of negative behaviour remained. It is suggested here that it is feasible that the weak professional group identity of ANPs may be enough to trigger professional identity threat and may contribute to the experiences of ANPs as they enact their roles in primary care.

This study also paid attention to the attitudes and behaviour of ANPs. There was a demonstration of low level negative, ambivalent and discounting attitudes and behaviours towards other nurses and ANPs from some ANPs through both narratives and actions. ANPs as individuals positioned themselves as different to other ANPs, and nurses more generally, as a mechanism to defend their position and this has been more widely observed (Piil et al., 2012; Woods, 2000). In this study, some ANPs positioned themselves as elite amongst other ANPs which influenced how others, including powerful decision-makers, perceived ANP practice more broadly. From a Positioning Theory perspective (Davies and Harre, 1990) ANPs used master-narratives of widely shared public discourses of what it is to be a nurse to position themselves as different. This has potential consequences for recruitment and utilisation of ANPs as, if individual ANPs are positioned as capable and competent in contrast to ANPs as a professional group, this limits the utilisation and employability of ANPs as a professional group. As ANPs are considered central to addressing workforce shortfalls, this is problematic for healthcare delivery more broadly.

The reasons why ANPs displayed Lateral Othering, in that they appeared ambivalent and sometimes negative towards other ANPs, requires exploration. That ANPs positioned themselves in an individualistic way can be seen as a consequence of a lack of a cohesive professional identity. Drawing on Social Identity Theory, the very variation and lack of clarity within advanced practice means there are few shared norms and beliefs to mediate the shaping of a shared ANP professional identity. As a consequence, ANPs as a group can be seen as unsuccessful in forging a strong internalised group identity while failing to develop a powerful public image of advanced nursing, thus minimising their strength as a professional group. So while an ANP’s personal credibility and value were promoted by individual ANPs positioning themselves as different, special or unique, ANPs as a profession were less successful in strengthening advanced practice at a professional group level.

Lack of a cohesive professional group level identity might create a threat of being compared to other ANPs, where there is no established framework for comparison. Because ANPs in England come from diverse backgrounds and there is currently no standardised level of education, regulation and no established professional group identity, ANPs may not have felt confident in their individual capabilities and this in itself may be enough to create identity threat. However, while the unclear status of ANPs in England may contribute to threats to professional identity, McLellan et al’s Australian study shared similar findings despite advanced practice being regulated and standardised (MacLellan et al., 2016). This implies these concerns transcend national boundaries and may be more closely related to the profession of nursing per se. It also indicates that moves to standardise advanced practice in the UK (Health Education England, 2017) may not be enough to alleviate identified cultural issues.

Chulach and Gagnon (2016) argue that advanced practice occupies a space between the cultures of nursing and medicine, which in itself creates instability and uncertainty, therefore, this too may increase identity threat. It may be that moving away from a nursing identity, for example by using the title advanced clinical practitioner which is now gaining prominence in England (HEE, 2017), some of these issues may be addressed. However, as Wacherhausen (2009) identifies, inculcation of professional identity requires retaining commitment to your professional group. Therefore, breaking away from a nursing identity may be problematic for ANPs.

Some study participants suggested that internecine discord is somehow intrinsically embedded within the professional identity of nursing. From a Social Identity Theory perspective, it is through developing and maintaining a robust group identity that professional groups are able to negotiate their roles more effectively from a position of strength (Fiol et al., 2009). However, nursing as a profession appears split. On one hand, nursing can be seen to be such a fragmented group that developing cohesive group identity is difficult. This is particularly relevant to advanced practice which can be seen to stray from core nursing identity. By contrast, as a professional group, nursing appears to hold a fixed identity of what it is to be a nurse to such an extent that deviation is seen as illegitimate, even when the idealised identity does not relate to the pragmatic needs for modern healthcare services.

Workplaces may also contribute to a culture of professional identity threat because other advanced roles such as advanced physiotherapists, pharmacists, paramedics and other allied health professionals, as well as the introduction of physician associates, may provoke an underlying threat even for established ANPs in relatively stable practice environments. Furthermore, primary care and advanced practice in England are in a significant state of flux and this too may exacerbate professional identity threat. While advanced practice may have been developed to meet workforce demands, it may not positively enhance the professional identity of nursing. Dissonance between the two may increase instability. Therefore, the nursing profession is required to consider these contentious issues and how they impact on future practice.

In this study, despite individual ANPs working to conciliate nursing and negotiate intra-professional relationships, it appeared that they were unable to fully overcome professional identity at a group or institutional level. They seemed ill equipped to develop novel strategies to address negative behaviours and attitudes of other nurses. It may be that ANPs concentrated their resources on those traditionally considered more powerful, such as GPs and managers, spending less time and effort engaging in relationships with other nurses who may be seen as less powerful and therefore less able to influence ANP practice. Consequently, negotiative resource was freed up to focus on powerful others. However, nursing holds its own form of subversive power (Hart, 2004), consequently, Lateral Othering and Vertical Discounting remained long after advanced practice had been officially established. Indeed, issues identified in older studies do not appear to have significantly changed over time or with the establishment of advanced practice. In order to support advanced practice moving forward, it is necessary to consider how nursing as a profession, and advanced nursing practice within, can work to address these key issues.

**Study Strengths and Limitations**

This study focuses on information-rich data with the aim of gaining deep understanding of complexity (Bowling, 2009). It involved close exploration of two general practices. While general applicability across contexts in a quantitative sense is not claimed, knowledge gained may be transferred to other situations (Holloway, 2008). Theoretical generalisability and transferability of findings to other contexts may be achieved through thick description, connecting results to current theory, comparing findings to existing work and allowing the reader to situate evidence within existing experiential knowledge (Holloway, 2008). While features of practices in this study, and the individuals within them, may not directly reflect other workforces, qualitative analysis allows identification of patterns of behaviours and attitudes which may resonate with other institutions, practices and ANPs.

This study highlights contentious issues related to advanced practice and the wider nursing profession and highlights some potential consequences. It does not suggest solutions, but rather serves to raise these issues to a conscious level and provide theoretical insight into why these issues may persist long after ANPs have become established, both as individuals and as a professional group. In doing this it seeks not to blame individuals, or the profession of nursing, but to highlight the structural underpinnings affecting professional relationships and ultimately the provision of patient care.

**Conclusion**

Intra-professional relationships within nursing play a significant, but underexplored, role in shaping ANP practice. Specifically, Vertical Discounting and Lateral Othering were identified as negatively influencing ANP practice. Although ANPs worked to address this through Conciliating Nursing, they also displayed their own disruptive behaviour. By raising this to a conscious level, alternative ways of negotiating professional relationships, underpinned by theories of professional identity, may be explored. This has the potential to develop, rather than inhibit, ANP practice. It is essential that the profession of nursing confronts unpalatable behaviours, rooted in professional identity, in order for advanced practice to develop effectively, to ensure utilisation, strengthen recruitment and support retention in order to enhance healthcare provision.

**Relevance to Clinical Practice**

As advanced practice develops exponentially across and between professions and throughout primary and secondary care, the impact of intra-professional relationships on healthcare delivery is likely to increase. The need to forge strong intra-professional relationships will become increasingly important and the professional identity of advance practice ever more significant.

**Impact Statement – What does this paper contribute to the wider global clinical community?**

* This study highlights advanced nursing practice can be negatively impacted by the nursing profession itself, with negative behaviours within the nursing profession undermining even established advanced practitioners. Furthermore, negative behaviours by advanced nurse practitioners towards other nurses were also identified. This Vertical Discounting creates tensions, undermines advanced practice, and may reduce recruitment, utilisation and retention.
* As a result of the weak professional identity of advanced practice, individual advanced nurse practitioners differentiate themselves from advanced nurse practitioners as a professional group to shore up their position. This Lateral Othering is important as it prevents ANPs developing a strong and cohesive group identity, which in turn limits utilisation and scope.
* This paper theorizes that professional identity threat coupled with the weak professional identity of advanced practitioners plays a part in undermining and destabilising advanced practice. This underpinned by invisible structures of professional identity and hierarchy. Raising these issues to a conscious level allows development of alternate strategies to negotiate advanced practice in order to enhance healthcare provision. In this way advanced practice can strengthen and thrive in order to further enhance patient care.

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**Tables**

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| --- |
| **Table 1: Potential Identity Threat Triggers (McNeil et al, 2013)** |
| 1. Differential treatment, when one (usually dominant) group receives preferential treatment.
 |
| 1. Differing values (e.g. biomedical/holistic models).
 |
| 1. Assimilation (where dominant group expects subordinate group to assimilate dominant culture)
 |
| 1. Insulting behaviours (where groups devalue each other)
 |
| 1. Simple contact (anxiety of working together triggers conflict)
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|  |

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| **Table 2: Bamberg’s (1997) three level positioning analysis explores:** |
| 1. The narrator as a character in relation to other characters in the narrative
2. How the narrator positions him/herself in relation to the audience they are telling their story to, as this reflects culturally embedded identity narratives
3. How the narrator positions him/herself in terms of past events and pre-existing master-narratives i.e. how narrative fits with wider societal discourses.
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| **Table 3: Site Characteristics** |  |  |  |
| **Site** | **Total Patient Population** | **Population Deprivation Decile†** | **Number of ANPs** | **Number of GPs** | **Number of Practice (Registered) Nurses** | **ANPs Interviewed and Observed** | **Practice Nurses Interviewed**  | **Practice Nurses Observed** |
| Oakcroft Alliance | 39,938 across 6 practices | 3-7 | 6 | 30 | 15 | 6 | 2 | 2 |
| Moorfield | 12,458 | 3 | 1 +1 in training | 9 | 3 | 2 | 3 | 3 |

**†**Public Health Profile Population Deprivation Decile: 1=highest deprivation, 10=lowest deprivation

**Figure 1**

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| **Health Education England Advanced Clinical Practice Definition (HEE,2017)** |
| Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master’s level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people’s experience and improve outcomes. |