Negotiating the role of nurses in New Zealand general practice: A grounded theory study

A thesis presented in partial fulfilment of the requirements for the degree of

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Abstract

Nurses in general practice improve health outcomes by working with patients with chronic conditions, coordinating care for high-needs patients, promoting population health and undertaking advanced practice roles, such as prescribing. However, the primary care environment is complex, and whether or not such non-traditional activities are undertaken by nurses in general practice in Aotearoa New Zealand varies from place to place. Insofar as ways of working within individual organisations may encourage or stifle innovation in clinical practice, understanding the processes involved in negotiating the nursing role may be key to the improvement of services.

There is a significant evidence-base about the influence of context on nurses' role development. However, little is known about the process by which nurses negotiate their roles in New Zealand general practice. This thesis reports on research undertaken to address this evidence gap by asking "How are the roles of nurses in New Zealand general practice negotiated?"

A constructivist grounded theory design, informed by symbolic interactionism was used. Twenty-two participants from 17 New Zealand general practices contributed data, generated through semi-structured interviews conducted between December 2020 and January 2022. Through phases of concurrent data generation and analysis, using common grounded theory methods and constant comparison, the participants' main concern and prime mover of behaviour were identified, leading to the construction of an explanatory theory around a core category.

The resultant grounded theory of *creating place* provides a substantive explanation of how nurses' roles in general practice are negotiated as individuals progress from roles defined by the care-philosophies of others to those that incorporate their own professional ethos. Conditional upon their access to role models, scheduled dialogue with mentors and decision-makers, and support for safe practice, nurses can progress through stages of *occupying space*, *positioning to do differently*, and *leveraging opportunity*, to realize individual concepts of *need-responsive nursing practice*. Such concepts are themselves developed during negotiation; nurses' positive personal self-efficacy and strong organizational governance are enablers of effective negotiation.

The theory of *creating place* offers new insights into the process of nurses role negotiation in general practice. Informed by the extant theory of job crafting and the job demands – resources model, findings support strategies to enable nurses to better negotiate their professional roles and advocate for patient health needs.

Acknowledgements

The pursuit of any course of action occasions opportunity costs in respect of the paths not taken and collateral impacts on others. Therefore, firstly I acknowledge the privilege that has allowed me to conduct this research, at this time, in a space that may have been occupied by another.

I acknowledge the impact of my choosing this path on family and colleagues and for their gracious and generous support and understanding when I could not always be there for them.

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Paper 1. Statement of contribution doctorate with publications/manuscripts

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STATEMENT OF CONTRIBUTION DOCTORATE WITH PUBLICATIONS/MANUSCRIPTS

We, the student and the student's main supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the student's contribution as indicated below in the Statement of Originality.

Student name:	Sarah Louise Hewitt
Name and title of main supervisor:	Professsor Nicolette Sheridan
In which chapter is the manuscript/published work?	One

Describe the contribution that the student and members of the supervisory team have made to the manuscript/published work:[1]

Sarah Hewitt Wrote the paper and conceived and conducted the statistical analysis

Nicolette Sheridan - Reviewed it critically for important intellectual content and contextual relevance
Karen Hoare - Reviewed it critically for important intellectual content and contextual relevance
Jane Mills - Reviewed it critically for important intellectual content and contextual relevance

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Please provide the full reference of the research output:

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Chapter 1 Introduction and Overview

"Whilst acting according to habit is essential in our day-to-day work, we should take time to examine ... assumptions to make sure they are consistent and coherent according to reason and that they represent our true values." (Toon, 1994, p. 2)

1.1 Introduction

My interest in the question addressed in this thesis, 'How are the roles of nurses in New Zealand general practice negotiated?', arose from experience as a practice nurse and as a researcher in a national primary care research project. In this chapter I give a personal introduction, explaining my worldview and why I chose to conduct research. I provide an explanation of the derivation of the research topic and why it is important, and outline the methods used in the study. In each section, I highlight where in the following chapters detailed discussion of the points introduced may be found.

The opening quote is drawn from a paper entitled, "What is good general practice? A philosophical study of the concept of high quality medical [*sic*] care". The paper was written in response to the pressures and uncertainties then contemporary in British general practice, by an English doctor, on attachment to a New Zealand university. As I explain in what follows, this resonates with my personal, academic and professional experiences and its themes are relevant in Aotearoa New Zealand today. By asking how the general practice nursing role is negotiated, I sought to understand how new ways of practice, new *essential habits*, consistent with current societal and professional imperatives, could be created to realize high-quality *nursing* care within my own area of practice.

1.2 Personal introduction

In 2007, aged 43 and having retired from a 20-year career as an officer in the Royal Air Force, I moved to Aotearoa New Zealand from the United Kingdom. In 2010, I began studying nursing, and became a New Zealand registered nurse in August 2013. I had completed a BSc (Hons) Degree in 1985 and enjoyed the return to tertiary study. Therefore, after completing the 12-month Nurse Entry to Practice Programme, which included the completion of a post-graduate paper, I entered a Bachelor of Nursing Honours Programme in March 2015. This included taught elements regarding research methods and the completion of a research project; learning was enhanced by participation in a District

Health Board (DHB) nursing leadership development programme. In my dissertation, "The effectiveness of current practice in cardiovascular disease risk assessment in primary care: A comparative study of patient outcomes", I focused on organizing services for effective preventive care.

Since nursing registration, I have been continuously employed in a large, rural general practice, in Aotearoa New Zealand's North Island, within which, in 2016, I began a clinical coordination role with responsibility for audit and the preparation of written policies and procedures. Accordingly, I have acquired a range primary care skills and knowledge; notably, following completion of a DHB work-based education programme, in October 2017 I gained authorization as a Registered Nurse Prescriber in Community Health (RNPCH).

My decision to become a nurse was pragmatic; I had not intended to embark on a major second career. However, after three years in Aotearoa New Zealand, my children were settled in school, my husband was established in his work, and I began to consider my employment options. I felt I had transferable skills from past experience but was unsure as to how to market them; a professional qualification offered new challenges, security of employment and a pathway to success. I accompanied a friend to a nursing career information evening, and shortly afterwards enrolled in a Bachelor of Nursing Programme. Returning to academic study and embarking on a new career in middle-age, in a new country, challenged my beliefs, values and expectations. Indeed, as a student of nursing in Aotearoa New Zealand, I was introduced to the professional need to critically reflect on how my attitudes could impact on nursing care in relation to the cultural needs of health consumers. This included addressing my perception of the impacts and ongoing processes of colonization in the context of health determinants and socio-economic inequity in Aotearoa New Zealand.

Of course, my worldview is a product of my demographics and experience. I am a white-British, cis-gendered, heterosexual woman: a second child of four. I was brought up without hardship, by my married biological parents and received a traditional school education in the state sector in north-east England between 1969 and 1982. As a young undergraduate student of Environmental Sciences, studying both sociological and geo- and

bio-scientific topics, I was introduced to ideas about the nature and understanding of reality at individual and societal levels. My military career presented many challenges, reinforcing my resilience, self-efficacy and sense of duty by rewarding problem-solving behaviours. I learned about organizational matters, leadership and social responsibility and saw how interpersonal dynamics are influenced by differing levels of power and autonomy, including those arising from negative group normative attitudes about gender, sexual orientation and race. Through marriage and motherhood, I gained insight into the world's responses to those close to me and shared vicariously in their impacts. This enabled me to better recognize my own strengths, weaknesses and improved my ability to recognize these characteristics in others, raising my awareness of vulnerability and the pitfalls of my own enduring unconscious bias. Similarly, through close interactions with patients and colleagues, I have learned how others' lived experiences, frequently in stark contrast to my own position of privilege, shape their understanding of self, society and the natural world. Therefore, though initially schooled in the positivist paradigm, and the belief in objective truth, independent of human thought (DePoy & Gitlin, 2016), I have come to appreciate that reality can be subjective, or socially constructed. As such, and as described in the naturalistic paradigm (Tullis Owen, 2008), it is context dependant and pluralistic, differing from person to person in the light of individual experience.

Over time, I have learned to use a range of strategies to engage with the world. Now, I take a pluralist and pragmatic approach to research, wherein I am open to using all methods necessary to understand phenomena of interest. Accordingly, in my study of cardiovascular disease screening effectiveness, I used quantitative, hypothetico-deductive statistical methods to determine the effectiveness of a screening programme by auditing records, and proposed additional qualitative research with patients and health practitioners, to address the communication of key healthy lifestyle messages. The research reported here required study of human behaviours and social realities. These I believe to be the products of interaction between individuals whose differing conceptions of truth are both formed through and continually shaped by experience. Therefore, I took a social constructionist approach and sought to co-construct meaning in interaction with research participants. Further discussion of ontological and epistemological positionality is in Chapter Four.

Like many new graduate nurses, on entering practice I experienced the bewilderment caused by a mismatch between reality and expectation known as Transition Shock ™ (Mooney, 2007). I felt professionally ineffective and limited in my ability to follow my nursing creed, due to established practices which seemed to militate against continuity of care and perpetuate throughput of the acutely unwell. Over time, I have employed strategies to mitigate my misgivings and optimize my personal clinical practice. These include: establishing supportive relationships with colleagues; taking responsibility to improve my own understanding; and advocating for and demonstrating best practice. For example, as a new graduate, I was the practice cardiovascular disease screening programme champion. I found the screening to be a resource-intense activity and, wishing to understand its worth in terms of health outcomes, chose it as the topic of my honours research. My findings were used to promote opportunistic health prevention in my organization. However, it proved difficult to operationalize this approach due to funding, scheduling and staffing difficulties, factors that also limited the extent to which I have been able to use my prescribing skills. Despite ongoing attempts to resolve these matters, through collegial dialogue and consensus at practice level, they persisted. Therefore, I sought the opportunity to better understand the drivers of current ways of working by participation in primary care research, focusing on nursing in general practice.

1.3 Introduction to the research topic

In this section I introduce the research topic. I explain the background to the selection of the research question, provide a statement of the research problem and discuss its significance. I also introduce aspects of nursing in general practice in New Zealand in the published paper "Understanding the general practice nursing workforce in New Zealand: An overview of characteristics 2015 -2019" (Hewitt et al., 2021).

1.3.1 Background to selection of the research question

Shortly after commencing PhD candidature, during May 2019, I interviewed nurses within a national study jointly funded by the New Zealand Ministry of Health and the New Zealand Health Research Council (HRC Reference 18/788), "Evidence to Guide Investment in a Model of Primary Care for All", and began reviewing the New Zealand primary care research literature. Whilst doing so, I recognized that my experience of struggling to implement new ways of working was common among nurses across the sector

and that in the absence of a strong national voice for nurses in general practice, variation in roles is subject to local negotiation. Consequently, some are limited to the performance of closely controlled and largely delegated tasks and others have a high degree of autonomy regarding their own clinical practice. The literature relating to nursing roles in New Zealand general practice, showed, *inter alia*, that opportunities to negotiate nursing roles were mediated by individuals' interactions within organizations, as well as by the exigencies of the wider health system and this resonated with both the accounts of interviewees and my own experience. Therefore, I became interested the processes of role negotiation at practice level. Further discussion of the New Zealand general practice nursing literature is in Chapter Three and detail regarding the derivation of the research question may be found in the published paper "Grounded theory and symbolic interactionism: Freedom of conceptualization and the Importance of Context in Research" (Hewitt et al., 2022), included in Chapter Four.

1.3.2 Statement of the research problem and research question

Whilst health system and organizational factors are widely reported as barriers to and facilitators of expanded nursing practice in primary care, the processes by which nursing roles are negotiated in the context of such factors are not addressed substantively in the research literature. Addressing the research question, 'How are the roles of nurses in New Zealand general practice negotiated?', this study aimed to develop a theory to explain staff experiences of negotiating nursing roles in general practice in Aotearoa New Zealand and to identify implications of findings for the development of primary care nursing practice.

1.3.3 Background to and significance of the research topic

Globally, socioeconomic factors drive health inequity, causing levels of premature death and morbidity that can be reduced through primary health care (Barber et al., 2017). Primary health care is defined as universal health through social equity (World Health Organization, 2023b) and requires collective action across society, as well as the provision of appropriate health services which focus on health promotion and disease prevention (McMurray & Clendon, 2015). It includes, primary, or first contact, care (Martin, 2015), access to which is a determinant of health. In Aotearoa New Zealand, where such primary care is provided by general practices, the Indigenous Māori population bear a disproportionately high burden of preventable morbidity and mortality (Ministry of Health,

2015) and the diverse population of Pacific Peoples also endures significantly poorer health outcomes than the non-Māori, non-Pacific population (Minister of Health, 2023). The origin and character of these inequities are discussed in Chapter Two.

The 2001 New Zealand Primary Health Care Strategy called for health service providers to be population-health focused and to enhance nursing capability, which was regarded as pivotal to the improvement of health outcomes. However, the alignment of capability and need did not eventuate (Carryer, 2017), and the recent New Zealand Health and Disability System Review (Ministry of Health, 2020) highlighted ongoing concern about health inequity, citing obesity, poor nutrition, hypertension, and substance abuse as leading national causes of mortality (Ministry of Health, 2019). Nursing interventions can improve health outcomes in each of these areas and, for many primary care presentations, nurses achieve outcomes as good as or better than family doctors (Norful et al., 2017). However, New Zealand commentators cite factors such as restrictive funding models (Ministry of Health, 2009), challenges in finding new evidence-based models of care (New Zealand Nurses Organisation, 2014) and the effect of nurses' employment status, within businesses controlled by medical general practitioners, as having limited the pace and reach of nursing innovation within New Zealand Primary Care (Docherty et al., 2008; National Nursing Organisations Leaders Group, 2018). The Health and Disability System Review concluded:

> *"While there are examples of change that is making a substantive difference, there is little evidence that innovation is shared or scaled. Primary care funding mechanisms remain complex, and most incentivise(sic) throughput. The funding model provides little incentive to adopt more innovative approaches to primary care. The consensus is that change has been limited and slow* (2019, p. 124).

New Zealand general practices receive around half their income from public funds. However, most operate on a private business model with scope to tailor services to the needs of communities, including if they so choose, by the provision of nurse-led services. The often-stated view that greater use of nurses, working closely with communities, can cost-effectively address issues of inequity, both in Aotearoa New Zealand and around the world (All-Party Parliamentary Group on Global Health, 2016; New Zealand College of Primary Health Care Nurses, 2012; World Health Organization, 2021) remains current and

only partially addressed. Understanding, the processes by which nursing roles are negotiated within individual organizations may be key to improved primary care provision and better health outcomes.

1.3.4 Introduction to nursing in New Zealand general practice - Paper 1

The published paper "Understanding the general practice nursing workforce in New Zealand: An overview of characteristics 2015 -2019", reproduced in its entirety below introduces background regarding the structure and complexity of nursing in general practice in New Zealand, including levels of nursing registration, the history and use terminology used to describe nursing roles in primary care and the make-up of the general practice nursing workforce. Since its publication, complexity in the sector had been compounded by the COVID 19 pandemic and the total number of nurses practicing in New Zealand has risen to 65,419, including 612 nurse practitioners; seven per cent of nurses are Māori and four per cent are of Pacific Ethnicity (Nursing Council of New Zealand, 2022b). In addition, under health reforms arising from Health and Disability System Review, DHBs were disestablished on 1 July 2022. Further discussion of the New Zealand primary care sector and the impact of COVID 19 is provided in Chapter Two.

Understanding the general practice nursing workforce in New Zealand: An overview of characteristics 2015-19

Abstract

Limited knowledge about the nursing workforce in New Zealand general practice inhibits the optimal use of nurses in this increasingly complex setting. Using workforce survey data published biennially by the Nursing Council of New Zealand, this study describes the characteristics of nurses in general practice and contrasts them with the greater nursing workforce, including consideration of changes in the profiles between 2015 and 2019. The findings suggest the general practice nursing workforce is older, less diverse, more predominately New Zealand-trained and very much more likely to work part-time than other nurses. There is evidence that nurses in general practice are increasingly primary health care focused, as they take on expanded roles and responsibilities. However, ambiguity about terminology and the inability to track individuals in the data are limitations of the study. Therefore, it was not possible to identify and describe cohorts of nurses in general practice by important characteristics such as prescribing authority, regionality and rurality. A greater national focus on defining and tracking this pivotal workforce is called for, to overcome role-confusion and better facilitate use of nursing scopes of practice.

Introduction

Primary Care is increasingly complex due to: ageing populations and greater prevalence of long-term conditions (Norful et al., 2017); hospital admission policies (Murray-Parahi et al., 2016); vaccine-preventable and novel infectious-disease outbreaks (Fraser-bell, 2019; Wilson et al., 2020); and greater emphasis on health promotion (Freund et al., 2015). Consequently, task-sharing among health professionals has been necessitated (Sangaleti et al., 2017), and as in Australia, UK, USA, Canada, Finland and the Netherlands, nurses in PC in New Zealand (NZ) may provide services, traditionally limited to doctors, including assessment, diagnosis and treatment, medication-prescribing and referral to secondary care (Maier & Aiken, 2016). In NZ, it is general practice that is the mainstay of primary care.

Nurses employed in NZ general practice became known as Practice Nurses (PN) in 1969, with the Practice Nurse Subsidy Scheme and were then characterized as doctor's assistants

(Docherty et al., 2008). Currently, nurses at all three levels of registration (i.e. nurse practitioner (NP), registered nurse (RN) and enrolled nurse (EN)) practise in general practice, with levels of autonomy commensurate with their education and training (Table 1.1). The term 'PN', or 'general PN' is also applied to nurses employed by primary care physicians in UK and Australia (Hoare et al., 2012; While & Webley-Brown, 2017); whereas in the US this area of practice is termed 'office-based nursing' (Steppie & Kirchner, 2020). More recently, nurses working outside hospitals, may be termed 'primary health care nurses' (PHCN), and sometimes the terms 'community nurse' and 'primary care nurse' are used (Betony & Yarwood, 2013). However titled, there is no formal accreditation or validated role-specific competency standards for nurses in NZ general practice (Halcomb et al., 2016).

Table 1.1 Levels of professional nurse registration in Aotearoa New Zealand

Level of Registration	Education and qualifications	Scope of Practice
NP	The following conditions must be met to register as an NP: • current NZRN status • at least four years' experience • completion of an approved clinical master's degree and 300 hours of clinical supervision • be assessed as competent by a Nursing Council of New Zealand panel	Advanced scope of practice, including: • ability/authority to manage episodes of care as the lead provider • authorised prescriber status • may admit/discharge to/from secondary care • may issue standing orders • may issue death certificates • may access general medical, aged residential care and Accident Compensation Commission (ACC)[1] funding subsidies (Ministry of Health, 2023)[2]
RN	RNs commonly enter practice with a three-year bachelor's degree Graduate entry via an approved two-year master's degree has been introduced	Practice collaboratively and independently, performing a broad range of general nursing functions. Subject to further education, training and competence assessment, may take on expanded practice roles. Since 2016, (Ministry of Health, 2017) may qualify as prescribers, in one of two categories: • RN-prescribing in primary health and specialty teams – long-term condition focus • RN-prescribing in community health – common non-complex condition focus with a limited schedule of medications available (Nursing Council of New Zealand, n.d.)
EN	Trained to Level 5 (Diploma) of the NZ Qualifications Framework	Perform a broad range of general nursing functions under the supervision of an RN or NP (Nursing Council of New Zealand, n.d.)

1. ACC is a a levy-based government agency insurance programme that funds care following accidental injury (Gauld et al., 2019)
2. This reference has been updated since the publication of this paper, yet it provides the original data.

NZ's health system is largely government funded, with 20 regional District Health Boards and 31 Primary Health Organisations and most services are free (Gauld et al., 2019). However, general practices are publicly subsidized, mostly privately-owned, for-profit

businesses, which charge for services (Gauld, 2016). Several practices, including Māori and Pacific providers, servicing populations with high social and health needs offer low fees. They include practices operating under the Very Low Cost Access Scheme and 'third-sector' (non-government, not-for-profit) organizations (Gauld et al., 2019).

In 2001, the Primary Health Care Strategy (King, 2001), introduced Primary Health Organizations and recognized nursing as essential to achieving population health goals. By adoption of the Strategy and uptake of initiatives to fund nurse-led care, nurses' roles in general practice expanded (Finlayson et al., 2012). The first NZ NP was approved in 2001 (Jacobs & Boddy, 2008). Although there were initially few job opportunities (Carryer & Adams, 2017), with the simplification of the registration process and the removal of legislative barriers to practise (Adams & Carryer, 2019) numbers have increased (Nursing Council of New Zealand, 2020b).

Ambiguity around nursing titles in primary health care (PHC) is common internationally (Norful et al., 2017) and complicates role development and interprofessional collaboration (McInnes et al., 2015). In addition, the structure of NZ general practice, which limits national oversight (Downs, 2017), a lack of knowledge about NZ general practice nursing (Hoare et al., 2013) and gaps in workforce governance (Rees, 2019), have slowed innovation in team-based and expanded nursing practice, despite a favourable policy-environment for community-based services (Tenbensel et al., 2017). An understanding of the characteristics of nurses in NZ general practice will help prepare and sustain the future primary care workforce.

As mandated, under the Health Practitioners Competence Assurance Act 2003, NCNZ records the practising status of all members of the NZ nursing workforce. Using data collected by survey of applicants renewing Annual Practising Certificates (APC), the NCNZ publishes biennial workforce profiles. By analysing variables in these profiles, this study aimed to describe the characteristics of nurses in NZ general practice and to compare them to those of all NZ nurses.

Methods

This study uses NCNZ workforce profiles of NP, RN and EN cohorts active in the workforce at 31 March in 2015 and 2019. The two profiles enable analysis of variables by 'area of practice' and have equivalent and comparable datasets (Nursing Council of New Zealand, 2015, 2020b). As the terms PN and PHCN both describe nurses in general

practice, three populations were identified for analysis: (1) nurses nominating an area of practice as 'Practice Nursing' (APPN); (2) nurses selecting an area of practice 'Primary Health Care' (APPHC); and (3) 'all nurses' (AN). Age, sex, ethnicity, level of registration, region of qualification and hours-worked were analysed.

Chi-square tests assessed differences between the APPHC and APPN subgroups and AN in 2019, as well as changes in characteristics within populations between 2015 and 2019. Statistical analysis was conducted using SPSS 26 (IBM SPSS Statistics for Macintosh, Version 26.0; IBM Corp., Armonk, NY, USA); with significance set at $\alpha=0.05$. Because participants could choose up to two areas of practice, a number were represented in all three groups and the overlaps could not be removed. However, because the sizes of subgroups in each dataset were less than 10% of the whole, no special account was taken of the non-independent portions of the populations, save to note that results of tests of significance would be conservative (Hayes & Berry, 2006). Ethnicity data were not subject to significance-testing as many nurses identified with multiple ethnicities. Because the data used in this study were anonymous and in the public domain, ethics approval was not required.

Results

At 31 March 2019, 54,456 individuals were active on the NZ nursing register, across all levels of registration; 3018 (5.5%) were APPN. Although the total number of nurses trended upwards by 8.1% between 2015 and 2019, the number of APPN fell by 9.6%. Over the same period, the number of nurses choosing APPHC rose by 41.5%, to 4695 (8.6%) (Nursing Council of New Zealand 2015, 2020) (Table 1.2).

In 2019, both subgroups were less ethnically diverse, more predominately female and NZ-trained, and more likely to work part-time than the AN population. A significantly greater percentage of APPN than AN was aged 55 or more, with the percentage of nurses in this age range in the APPHC population more closely matching the AN distribution. Although there were relatively fewer nurses aged 34 or less in each of the subgroups than the total, this effect was less pronounced for APPHC. A similar pattern was observed for men in the workforce. The percentage of NPs in the APPHC sub-group was more than fourfold that in the other groups. European ethnicity was predominant in all three populations, more so in the subgroups. The percentage of Māori and Pacific nurses within the APPHC group was higher than for APPN and AN. The largest differences between the groups in

terms of ethnicity were in the percentages of Asian nurses. Of the 27% of all RNs who qualified overseas, most trained in the Philippines. Significantly smaller percentages of RNs in the subgroups were internationally qualified and, of these, most were from UK; for AN, the highest number were from the Philippines (Table 1.3).

The balance of full-time to part-time working did not change over time for either subgroup. The percentages of the youngest and two oldest age categories were higher for both subgroups in 2019 than in 2015, and there were lower percentages in the 35 to 54 range for each. Both subgroups showed a greater diversity of level of registration and region of qualification in 2019; the number of NPs identifying as APPN more than doubled and the number identifying as APPHC increased more than fourfold. The percentage of UK-trained nurses in each sub-group fell. An increase in the percentage of Asian nurses in all groups demonstrated increasing ethnic diversity, with the number of Asian nurses in the APPHC subgroup more than doubling. There were slight increases in the percentages of Māori and Pacific nurses in both subgroups (Table 1.2).

Over the same four-year period, there were statistically significant changes in all characteristics for AN, bar EN hours-worked. For AN, there were increased percentages in the two oldest and in the youngest age categories and a reduction for those aged 35-54. The percentage of men in the AN workforce increased and numbers of NP grew steadily, while numbers of EN fell. There were slight increases in the percentages of Māori and Pacific nurses. More nurses qualified in the Philippines and fewer in UK. A slightly greater percentage of RNs worked full-time (Table 1.2).

Attitudinal effects on survey responses, ambiguity around terminology and the inability to track individuals in the data limit the present analysis. Therefore, it was not possible to identify cohorts of nurses in general practice by prescribing authority, regionality, or rurality. Targeted analysis of NCNZ-held data including raw APC survey data and nurses' registration details, which were not available to the authors at the time of this study, could partially address this. However, the definition of rurality for NZ health purposes is problematic (Fearnley et al., 2016) and is currently being researched (Health Research Council New Zealand, 2019). Nursing Council of New Zealand (2020b) acknowledges that, in 2019 of 57% of nurses self-identifying as part of the rural workforce by 'Employment Setting', did not live in a rural area by postcode.

Table 1.2 Changes in characteristics of three populations of New Zealand nurses between 2015 and 2019, namely those stating area of practice nursing (APPN) or primary health care (APPHC) and all nurses (AN)

Unless indicated otherwise, data are given as *n* (%). *P*-values from Chi-squared tests refer to differences within groups over time. NA, not applicable

	AN			APPN[A]			APPHC[A]		
	2015 ($n = 50\,356$)	2019 ($n = 54\,456$)	*P*-value	2015 ($n = 3342$)	2019 ($n = 3018$)	*P*-value	2015 ($n = 3317$)	2019 ($n = 4695$)	*P*-value
Age (years)[B]									
≤34	12 444 (24.7)	15393 (28.3)	<0.0001	346 (10.4)	387 (12.8)	<0.0001	522 (15.7)	903 (19.2)	<0.0001
35–44	10 067 (20.0)	9720 (17.8)		623 (18.6)	440 (14.6)		700 (21.1)	865 (18.4)	
45–54	13 651 (27.1)	12 119 (22.3)		1087 (32.5)	776 (25.7)		1081 (32.6)	1268 (27.0)	
55–64	11 643 (23.1)	13 394 (24.6)		1010 (30.2)	1064 (35.3)		824 (24.8)	1302 (27.7)	
≥65	2551 (5.1)	3830 (7.0)		276 (8.3)	351 (11.6)		190 (5.7)	357 (7.6)	
Sex[B]									
Male	4211 (8.4)	4990 (9.2)	<0.0001	48 (1.4)	53 (1.8)	0.308	132 (4.0)	196 (4.2)	0.663
Female	46 145 (91.6)	49 459 (90.8)		3294 (98.6)	2965 (98.2)		3185 (96.0)	4498 (95.8)	
Level of registration[B]									
NP	142 (0.3)	365 (0.7)	<0.0001	6 (0.2)	15 (0.5)	0.016	30 (0.9)	137 (2.9)	<0.0001
RN	47 488 (94.3)	51700 (94.9)		3274 (98.0)	2927 (97.0)		3203 (96.6)	4428 (94.3)	
EN	2726 (5.4)	2391 (4.4)		62 (1.9)	76 (2.5)		84 (2.5)	130 (2.8)	
Ethnicity[C,F]									
European	39 953 (79.3)	39 398 (72.3)	NA[G]	3115 (93.2)	2636 (87.3)	NA[G]	2828 (85.3)	3775 (80.4)	NA[G]
Māori	3510 (7.0)	4206 (7.7)		213 (6.4)	220 (7.3)		420 (12.7)	603 (12.8)	
Asian	8648 (17.2)	12 239 (22.5)		189 (5.7)	266 (8.8)		255 (7.7)	554 (11.8)	
Pacific	1868 (3.7)	2355 (4.3)		120 (3.6)	136 (4.5)		186 (5.6)	268 (5.7)	
Other	2773 (5.5)	3016 (5.5)		114 (3.4)	148 (4.9)		139 (4.2)	233 (5.0)	
Region of qualification[D,F] (RN only)	$n = 47\,488$	$n = 51\,700$		$n = 3274$	$n = 2927$		$n = 3203$	$n = 4428$	
NZ	35 111 (73.9)	37 515 (72.6)	<0.0001	2805 (85.7)	2481 (84.8)	<0.0001	2671 (83.4)	3691 (83.4)	<0.0001
UK	4014 (8.5)	3614 (7.0)		249 (7.6)	191 (6.5)		245 (7.6)	274 (6.2)	
Pacific	558 (1.2)	513 (1.0)		47 (1.4)	44 (1.5)		55 (1.7)	58 (1.3)	
Australia	663 (1.4)	688 (1.3)		45 (1.4)	39 (1.3)		54 (1.7)	71 (1.6)	
Philippines	2991 (6.3)	4836 (9.4)		21 (0.6)	38 (1.3)		52 (1.6)	146 (3.3)	
India and Sri Lanka	2072 (4.4)	2577 (5.0)		13 (0.4)	37 (1.3)		25 (0.8)	66 (1.5)	
Other	2079 (4.4)	1957 (3.8)		94 (2.9)	97 (3.3)		101 (3.2)	122 (2.8)	
Hours worked[E,F]									
RN	$n = 42\,956$	$n = 47\,877$		$n = 2315$	$n = 1880$		$n = 1886$	$n = 2565$	
Part-time	20 471 (47.7)	22 114 (46.2)	<0.0001	1723 (74.4)	1394 (74.1)	0.837	1089 (57.7)	1421 (55.4)	0.120
Full-time	22 485 (52.3)	25 763 (53.8)		592 (25.6)	486 (25.9)		797 (42.3)	1144 (44.6)	
EN	$n = 2486$	$n = 2167$		$n = 42$	$n = 48$		$n = 66$	$n = 94$	
Part-time	1354 (54.5)	1121 (51.7)	0.062	21 (50.0)	24 (50.0)	1	31 (47.0)	48 (51.1)	0.610
Full-time	1132 (45.5)	1046 (48.3)		21 (50.0)	24 (50.0)		35 (53.0)	46 (48.9)	

[A]The areas of nursing practice available to respondents were: addiction services, assessment and rehabilitation, child health, continuing care, district nursing, emergency and trauma, family planning/sexual health, intellectually disabled, intensive care, medical, mental health (community), mental health (inpatient), nursing administration and management, nursing advice/policy, nursing education, nursing research, obstetrics/maternity, occupational health, oncology, palliative care, perioperative care, practice nursing, primary health care, public health, school health, surgical, youth health and other.

[B]Data for age, sex and scope reflect the entire practising nursing workforce, independent of survey response.

[C]Data for ethnicity reflect those nurses who answered the relevant survey question; up to three ethnicities could be identified and were not prioritised in reporting. 'European' includes NZ European/Pakeha and Other European. 'Pacific' includes Samoan, Cook Island Māori, Tongan, Niuean, Tokelauan, Fijian and Other Pacific Peoples. 'Asian' includes Filipino, Other South-east Asian, Chinese, Indian and Other Asian. 'Other' includes African, other and unstated ethnicity. The percentage unstated ethnicity was 0.1%.

[D]'Region of qualification' refers to that which first entitled entrance to the NCNZ register. In addition to those regions listed, other regions were Central and Eastern Europe, Central and South America, China, the Middle East, North America, other Africa, other Asia, other Western Europe, South Africa and Zimbabwe.

[E]Data for hours worked reflect those nurses who answered the relevant survey question. 'Part-time' denotes fewer than 35 h worked per week.

[F]Survey completion was voluntary, with a completion rate of between 95% and 100%.

[G]Chi-squared tests were not performed because 12% of nurses gave two or three ethnicities.

Table 1.3 Comparison of characteristics of nurses stating their area of practice as practice nursing (APPN) or primary health care (APPHC) with those of all nurses (AN, in 2019

P-values were calculated using Chi-squared tests and are for comparisons with AN. NA, not applicable

Characteristic	AN,	APPN[A]		APPHC[A]	
	n (%)	*n* (%)	*P*-value	*n* (%)	*P*-value
Age (years)[B]	*n* = 54 456	*n* = 3018		*n* = 4695	
≤34	15 393 (28.3)	387 (12.8)	<0.0001	903 (19.2)	<0.0001
35–44	9720 (17.8)	440 (14.6)		865 (18.4)	
45–54	12 119 (22.3)	776 (25.7)		1268 (27.0)	
55–64	13 394 (24.6)	1064 (35.3)		1302 (27.7)	
≥65	3830 (7.0)	351 (11.6)		357 (7.6)	
Sex[B]					
Male	4990 (9.2)	53 (1.8)	<0.0001	196 (4.2)	<0.0001
Female	49 459 (90.8)	2965 (98.2)		4498 (95.8)	
Level of registration[B]					
NP	365 (0.7)	15 (0.5)	<0.0001	137 (2.9)	<0.0001
RN	51 700 (94.9)	2927 (97.0)		4428 (94.3)	
EN	2391 (4.4)	76 (2.5)		130 (2.8)	
Ethnicity[C,F]					
European	39 398 (72.3)	2636 (87.3)	NA[G]	3775 (80.4)	NA[G]
Māori	4206 (7.7)	220 (7.3)		603 (12.8)	
Asian	12 239 (22.5)	266 (8.8)		554 (11.8)	
Pacific	2355 (4.3)	136 (4.5)		268 (5.7)	
Other	3016 (5.5)	148 (4.9)		233 (5.0)	
Region of qualification[D,F] (RN only)	*n* = 51 700	*n* = 2927		*n* = 4428	
NZ	37 515 (72.6)	2481 (84.8)	<0.0001	3691 (83.4)	<0.0001
UK	3614 (7.0)	191 (6.5)		274 (6.2)	
Pacific	513 (1.0)	44 (1.5)		58 (1.3)	
Australia	688 (1.3)	39 (1.3)		71 (1.6)	
Philippines	4836 (9.4)	38 (1.3)		146 (3.3)	
India and Sri Lanka	2577 (5.0)	37 (1.3)		66 (1.5)	
Other	1957 (3.8)	97 (3.3)		122 (2.8)	
Hours worked[E,F]					
RN	*n* = 47 877	*n* = 1880		*n* = 2565	
Part-time	22 114 (46.2)	1394 (74.1)	<0.0001	1421 (55.4)	<0.0001
Full-time	25 763 (53.8)	486 (25.9)		1144 (44.6)	
EN	*n* = 2167	*n* = 48		*n* = 94	
Part-time	1121 (51.7)	24 (50.0)	0.812	48 (51.1)	0.899
Full-time	1046 (48.3)	24 (50.0)		46 (48.9)	

[A]The areas of nursing practice available to respondents were: addiction services, assessment and rehabilitation, child health, continuing care, district nursing, emergency and trauma, family planning/sexual health, intellectually disabled, intensive care, medical, mental health (community), mental health (inpatient), nursing administration and management, nursing advice/policy, nursing education, nursing research, obstetrics/maternity, occupational health, oncology, palliative care, perioperative care, practice nursing, primary health care, public health, school health, surgical, youth health and other.
[B]Data for age, sex and scope reflect the entire practising nursing workforce, independent of survey response.
[C]Data for ethnicity reflect those nurses who answered the relevant survey question; up to three ethnicities could be identified and were not prioritised in reporting. 'European' includes NZ European/Pakeha and Other European. 'Pacific' includes Samoan, Cook Island Māori, Tongan, Niuean, Tokelauan, Fijian and Other Pacific Peoples. 'Asian' includes Filipino, Other South-east Asian, Chinese, Indian and Other Asian. 'Other' includes African, other and unstated ethnicity. The percentage unstated ethnicity was 0.1%.
[D]'Region of qualification' refers to that which first entitled entrance to the NCNZ register. In addition to those regions listed, other regions were Central and Eastern Europe, Central and South America, China, the Middle East, North America, other Africa, other Asia, other Western Europe, South Africa and Zimbabwe.
[E]Data for hours worked reflect those nurses who answered the relevant survey question. 'Part-time' denotes fewer than 35 h worked per week.
[F]Survey completion was voluntary, with a completion rate of between 95% and 100%.
[G]Chi-squared tests were not performed because 12% of nurses gave two or three ethnicities.

Because of the limitations described above, it is unclear how many nurses in the APPHC data were employed in general practice. However, this analysis suggests that the NZ general practice nursing workforce is older, less diverse, more predominately NZ trained and far more likely to work part-time than other NZ nurses.

The older age profile of APPN reflects a long-standing trend in primary care internationally. In Australia, in 2015, 60.1% of PN were aged over 45 (Heywood & Laurence, 2018) and in UK, one-third were near retirement age in 2017 (While & Webley-

Brown, 2017). In NZ, in 2009, 29% were reportedly between 50 and 60 years of age and only 3.6% were below 30 years (Ministry of Health, 2009). The relatively high percentage of nurses aged 34 and under in the APPHC data may reflect the greater acceptability of the PHC term to that demographic, insofar as it includes nurses working in general practice, and the attractiveness of other PHC roles to younger nurses. Historically, NZ nursing graduates, mean age 25 (Gilmour et al., 2017), mainly sought employment in hospitals (Wilkinson et al., 2016). However, since the Primary Health Care Strategy (King, 2001), undergraduate nursing programmes have offered greater PHC content (Betony & Yarwood, 2013) and since 2008 the Nurse Entry to Practice Scheme has supported graduates into PHC with post-graduate education, mentorship and financial incentives for employers (Haggerty et al., 2012; Hoare et al., 2013). In 2010, 26% of NZ new graduates entered community roles compared to 6% in 2005 (North et al., 2014). Despite improved opportunities, graduates report less professional support in PHC than in secondary care settings and that lower pay in PHC is problematic due to student debt (Wilkinson et al., 2016). The need to improve graduate transition to practice in PHC is a recognized global-phenomenon (Murray-Parahi et al., 2016).

The low numbers of men in nursing is well-documented and attributed to professional gender-stereotyping and the social status of nursing (Jamieson et al., 2019; Stanley et al., 2016). Across care settings, and national jurisdictions including UK, Australia and NZ, differing organizational, funding and care-philosophy characteristics affect nurses' employment conditions (Hoare et al., 2012; While & Webley-Brown, 2017). Hierarchical views of nursing specialisms exist, with higher-acuity settings attracting more graduates, particularly men (Wilkinson et al., 2016) seeking better pay, career stability, and the opportunity for advancement (Stanley et al., 2016). RNs working in NZ general practice have historically earned less than those in District Health Boards (Ministry of Health, 2009) and current estimates, place the differential at 10% ((New Zealand Nurses Organisation, 2020a). Nevertheless, in 2017, PNs reported relatively high levels of job satisfaction, attributed to flexibility of working conditions (New Zealand Nurses Organisation, 2017). This accords with the high prevalence of part-time work in the subgroups, which may be associated with the increased number working beyond retirement age. Parental responsibilities are the most often cited reason for nurses working part-time (Nursing Council of New Zealand, 2020b); this may include grandparenting.

Significant differences in the make-up of the workforce by levels of nursing registration, between groups and over time arise from increased numbers of NPs. In general practice, NPs perform most *tasks* undertaken by physicians. However, they may be limited when they are valued by employers only as 'replacement doctors', to meet acute demand (Officer et al., 2019) and not in accordance with their specific remit to improve population health outcomes (Nursing Council of New Zealand, n.d.-a). Third-sector organizations support advanced nursing roles, as single-low-fee policies, which prevent higher charges for physician consults, incentivize their use (Wilkinson, 2012). The large increase in the number and proportion of NPs among APPHC is in keeping with this and with the intent to use NPs to improve access to care, particularly in high-risk and rural communities (Officer et al., 2019). Acting a leaders and advocates for nursing and the populations they serve, NPs are also catalysts for broader health-system and nursing role development (Carryer et al., 2007).

The goal of demographic parity in nursing is yet to be achieved (Ministry of Health, 2018b). In 2018 the general population comprised 16.5% Māori and 8.1% Pacific Peoples (Stats NZ Tatauranga Aotearoa, 2019), proportions in excess of those observed in nursing. The data show only incremental increases in percentages of Pacific Peoples and Māori. However, for APPHC, the actual number of Māori has increased by 43%. Socioeconomic disadvantage for Pacific Peoples and Māori continues to negatively impact both health outcomes (Ministry of Health, 2015) and opportunities to enter the health professional workforce through culturally appropriate tertiary education (Wikaire et al., 2017). The higher percentage of both ethnicities in the APPHC data reflects the presence of community-based Māori and Pacific Providers (Nursing Council of New Zealand, 2020b). The higher percentage of Asian nurses in the AN population reflects targeted overseas recruitment by District Health Boards (Walker & Clendon, 2012). Filipino and British nurses made up 60% of internationally qualified RN in NZ, in 2019, with 44% of the Filipino nurses employed in Auckland (Nursing Council of New Zealand, 2020b). The relatively high proportion of UK-qualified nurses in the two subgroups may reflect the known similarity of PN and other community nursing roles in UK and NZ (Hoare et al., 2012). The predominance of NZ-trained nurses in both subgroups presents an opportunity to strengthen general practice nursing in NZ by continuing to improve domestic undergraduate programmes.

Recent sources provide context for understanding the reduction in numbers of APPN. A 2017 survey of New Zealand Nurses Organisation members reported 10.7% of respondents gave their job title as PN whilst 15.6% identified 'Primary Health/Practice Nursing' as their field of practise (New Zealand Nurses Organisation, 2017). A survey of NZ general practices reporting ratios of full-time equivalent (FTE) staff to patients (Phelan, 2019), together with the national patient-enrolment rate (Te Whatu Ora, 2023b)[1], indicates there were around 2604 FTE nurses in general practice in mid-2019. With a mean FTE of 0.6 for each subgroup in 2019 (Nursing Council of New Zealand, 2020b), this suggests the number of nurses in general practice then was approximately 4340. Extrapolating early findings from an ongoing national study suggests a figure of around 4084, in 2019 (N. Sheridan, personal communication, May 4, 2020). Therefore, it appears that there were over 4000 nurses in general practice in 2019, including all those identifying as PNs and a number identifying as PHCNs. Nursing identifies strongly with the patient-focused, social justice and preventive health goals of PHC (Ortiz, 2019). Therefore, the observed downturn in numbers of APPN is likely to reflect changes in how nurses in general practice define their professional identity, as they take on broader roles and responsibilities (Leitch et al., 2018) than were traditionally associated with the term 'PN' (Docherty et al., 2008).

Conclusion

This study suggests that in NZ, the general practice nursing workforce is older, less diverse, more predominately NZ-trained and very much more likely to work part-time than other NZ nurses. There is evidence that nurses increasingly favour the designation PHCN over PN. Data limitations prevented insights into key areas such as RN prescribing, regional variation and the rural workforce, and better data are required to facilitate workforce planning. With the broadening of the clinical scope of nurses' work in primary care and their embracing of PHC principles, it is important to support all efforts to optimize the use of nursing scopes of practice. Therefore, there should be greater focus at a national level to define and track this pivotal nursing workforce, to address issues of sustainability, to attract and retain younger nurses and increase diversity.

[1] This reference has been updated since the publication of this paper, yet it provides the 2019 data.

1.4 Introduction to research philosophy

In this section, I introduce the philosophical underpinning of the study, including the selection of the research methods and consideration of ethics. Concepts of knowledge and understanding arise from human attempts to make sense of the world and our existence in it and the study of such matters is called philosophy. Three divisions of philosophy are of particular relevance in the research context: ontology, the nature of reality or what there is that can be known, also termed metaphysics; epistemology, or how we gain knowledge and understanding (Berryman, 2019); and ethics, or the nature of right and wrong in human action (Jackson, 2014). To ensure that a study design is robust, the philosophical positions taken when conducting research, must be clearly articulated and must fit the research question and the methods used Tracy (2010).

1.4.1 Introduction to methods

In this study the research question is '*How are the roles of nurses in New Zealand Practice negotiated?'*. The term *negotiation* is used in a general sense and does not exclude non-consensual or non-participatory processes which may be at work. The term role refers to the professional tasks performed, and responsibilities discharged by nurses in daily practice. Since negotiation and role, are interactional in nature, grounded theory (GT), guided by symbolic interactionism (SI), was selected as an appropriate research design. Specifically, constructivist GT design was used to accommodate the researchers' knowledge of the situation of inquiry as clinicians and researchers. Note, a distinction is made between constructivism and constructionism. Both terms reflect a view that the reality experienced by humans is a subjective interpretation or conceptualization of the external world (Berger & Luckmann, 1971) and were used by Charmaz, the originator of constructivist GT (Chamberlain-Salaun et al., 2013) interchangeably. Further discussion of the distinction between the terms is is in Chapter Four (pp.76-77).

GT methodology is designed to identify basic social processes in their interactional context and has become a widely used methodology particularly, but not exclusively, for qualitative research, and in various fields, including medical education (Kennedy & Lingard), nursing (McCann & Polacsek, 2018) and the construction sector (Kulchartchai & Hadikusumo, 2010). In contrast with the hypothetico-deductive research paradigm, it involves the construction of substantive theories using inductive-abductive reasoning to systematically and iteratively conceptualize data and is an appropriate research design when the aim of a study is to provide

an explanation, or theory, of why things happen by identifying processes inherent to social phenomena about which little is known (Birks & Mills, 2023; McCann & Polacsek, 2018). SI is a paradigm within behaviourist sociology which draws on the philosophy of pragmatism and sees interaction as the key to human behaviour and the construction of society. Pragmatism focuses on human actions and holds that humans interpret their environment and create meaning and knowledge, according to its usefulness in any given situation. Therefore, SI sits within the constructivist paradigm and is congruent in terms of ontology and epistemology with GT (Aldiabat & Le Navenec, 2011). Further methodological discussion of GT and SI and their foundation in pragmatism is in Chapter Four (pp.81-82).

1.4.2 Introduction to ethical considerations

Normative ethics deal with matters of right and wrong and theories in this area of philosophy allow us to consider how human affairs should be conducted in practical situations (Cave, 2015). The Declaration of Helsinki (World Medical Association, 1964), developed in response to atrocities committed during the Second World War, was a major development in research ethics, making clear that research methods must protect the rights and wellbeing of those involved. Today, social research should, in addition, ensure participation in research: is voluntary and informed; does not involve deception; and is characterized by integrity and lawful conduct (Denscombe, 2014). Such considerations were addressed in the study design, and ethics approval was granted by the Massey University Human Ethics Northern Committee.

1.5 Chapter summary and thesis structure

This Chapter has provided an overall introduction to the thesis. Here and in the chapters which follow, where manuscripts are included, the text, figures and tables are as in the published or submitted form, save that, where necessary, the format has been amended to conform with the remainder of the thesis. References from manuscripts are included in the thesis bibliography. The text style is in accordance with the New Oxford Style Manual (2016) and the presentation of tables and figures follows Freeman, Walters and Campbell (2008); italics are used for emphasis and for specific terminology, including concepts arising from the analysis. Participants' quotes are in inverted commas, and APA 7 referencing is used in conjunction with Endnote™ X9.3.3.

Chapter Two introduces the situation of inquiry, including background regarding the organization of general practice within the New Zealand Health System, and the health status of the New Zealand population. Chapter Three analyses the research literature relevant to the question, 'What is known from the research literature about the negotiation of nursing roles in New Zealand general practice?'. Chapter Four discusses the research methodology and includes the published manuscript, "Grounded theory and symbolic interactionism: Freedom of conceptualization and the importance of context in research" . Chapter Five describes the research process and outcomes of analysis. In Chapter Six the grounded theory constructed from this research is presented, including the manuscript "The process of nurses' role negotiation in general practice: A grounded theory study" (Hewitt et al., 2023), and Chapter Seven situates the explanatory power of this new grounded theory by relating extant theories to the findings. Finally, Chapter Eight concludes the thesis, making recommendations and discussing their implications. Due to the iterative, recursive and reflexive nature of GT methods and the inclusion of published material some restating of ideas occurs across chapters.

Chapter 2 Background – The Situation of Inquiry

"The conditional elements of the situation need to be specified in the analysis of the situation itself as they are constitutive of it, not merely surrounding it or framing it or contributing to it. They are it." (Morse et al., 2016, p. 208)

2.1 Introduction

This chapter's opening quote reflects that from a constructivist position, contextual factors do not stand alone but combine intimately with human actors to produce the situation of inquiry. Therefore, in seeking to go beyond a simple description of the contextual background to my research, I have used situational analysis to identify and to consider, "…the major actors and actants, discourses and spaces, temporalities and organizations, and political–economic and social–cultural elements that come together in the situation of inquiry." (Friese et al., 2021). As further explained in Chapters Four and Five, that situation of inquiry is the New Zealand general practice negotiating environment.

Situational Analysis (SA) is a technique of diagramming and reflection wherein elements within situations of inquiry are identified. Three types of diagram are used: situational maps, messy, ordered and relational; positional; and social worlds and arenas (Clarke, 2019). In this chapter, three diagrams are presented and their core elements are discussed. As described in the paper "Grounded theory and symbolic interactionism: Freedom of conceptualization and the importance of context in research", which forms part of the methodological discussion in Chapter Four, three questions were used throughout the research process to facilitate engagement with the situation of inquiry. Reflecting the tenets of SI, the questions are 'Who and what are the actors in this situation?'; 'What is meaningful to the actors in this situation and why?'; and 'How do actors' individual lines of action interact in this situation over time?'. The answers to these questions provided the detail included in the diagrams, which were updated throughout the study in the light of engagement with the data. The ordered situational map, Table 2.1, gives an overview of the situational elements. The positional map, Figure 2.1, shows the range of issues relevant to general practice, apparent in contemporary discourse about nursing roles. Finally, the social worlds and arenas map, Figure 2.2, supports summarizing remarks about how the various elements combine.

Table 2.1 Ordered situational map of actors, elements, discourses and issues active in the New Zealand general practice negotiating environment

Individual human elements/actors[1]	**Collective human elements/ actors[1]**
Academics Allied Health Professionals Business Owners Doctors Enrolled Nurses Leaders Managers / Administrators Non-regulated Health Workers (Kaiāwhina) Nurse Practitioners Patients Policymakers Registered Nurses Researchers Student Nurses	Academia Business Business Associations Competitors Community Commerce Churches/Clubs Family/Whānau Marae NGOs/ Charities Public Services Schools Health System District Health Boards Health and Disability Commissioner Health NGOs Ministry of Health Primary Care Providers Primary Health Care Organisations Primary Health Care Nursing (PHCN) Professions College of Nursing Aotearoa (NZ) New Zealand Nurses Organisation New Zealand Medical Council Nursing Council of New Zealand Royal College of New Zealand General Practitioners
Implicated/silent actors	
Individual health needs	
Economic elements	
Accident Compensation Commission Public Funding - Private Business Model	
Nonhuman elements/actants	
Disease States	
Temporal elements[2]	**Related discourses[3]**
Business Ownership and Care Models COVID19 Pandemic Pay Bargaining	Medical Model Medicine-Nursing Dynamic (Power) Nursing Philosophy Patient Centred Care Pay Parity
Sociocultural/ symbolic elements	**Major contested issues[3]**
Determinants of Health Inequity Perception of Nursing Profile-Uniforms/Badges/Webpages Nursing Now™ Challenge Regulatory Bodies Treaty of Waitangi	Advanced Practice Autonomy Funding/ Pay/ Workload Primary Health Care Nursing Professional Development Task Substitution Workforce Development

1. See Social Worlds and Arenas Map
2. See section 2.6
3. See Positional Map

In Chapter One, I introduced the research topic, situating it within my sphere of experience and world view. Now, drawing on these maps, I locate the thesis in its societal milieu, providing

background to issues raised in the subsequent analysis and discussion. The core elements discussed are: the health status of the New Zealand population, including issues of health inequity; the organization and funding of general practice within the New Zealand health system; the general practice workforce; nursing autonomy and advanced nursing practice; and temporal issues affecting general practice during the period of study, February 2019 to June 2022, notably the response to the COVID 19 pandemic.

2.2 The New Zealand population and its health

Māori are the indigenous people of Aotearoa New Zealand. With increased European settlement in the early nineteenth century, Britain sought to exercise control over the growing number of British subjects in Aotearoa New Zealand and to protect trading interests within the region by averting possession of Aotearoa New Zealand by another European power. This led to the signing of the Treaty of Waitangi (February 6, 1840) by which the British Crown acquired rights to govern and represent Aotearoa New Zealand, and Māori received guarantees of cultural protection, rights to natural resources, and self-determination (Palmer, 2008). In 1840, there were about eighty thousand Māori and 2000 non-Māori, living in Aotearoa New Zealand (Moewaka Barnes & McCreanor, 2019). Thereafter, a predominately British colonial settler population grew rapidly, its ethnocentric institutions, "racialised beliefs, ideologies, structures, and discriminatory practices" (Cormack et al., 2018, p. 2) became established, and Māori were marginalized regarding access to socio-political and economic power, resource and freedom of expression, in favour of New Zealand Europeans (Pākehā). From the mid-1980s, New Zealand immigration focused on skill-recruitment to support economic growth and the ethnic diversity of the population increased (Spoonley, 2015). Now, Aotearoa New Zealand is a nation of five million people, in which the predominant ethnicities are European (70%), Māori (16%), Asian (15%) and Pacific Peoples (8%) (Stats NZ Tatauranga Aotearoa, 2019, 2020). The major challenge it faces is to overcome the legacy of colonialism by which the "vitality, aspirations and potentials", of Māori communities towards health and wellbeing have been and continue to be harmed (Moewaka Barnes & McCreanor, 2019, p. 19).

The Treaty of Waitangi has never had the force of domestic law but is considered the founding document of the modern nation of Aotearoa New Zealand and guides the relationship between the government and Māori. Understandings of its meaning vary, in part due to the conflating of the term *sovereignty* with *governance* and of the phrase *undisturbed possession of all*

properties with *full authority over all treasures*, between Treaty's original English draft and the Māori translation (Palmer, 2008). In 1975, the Treaty of Waitangi Act, established the Waitangi Tribunal to hear grievances arising from breaches of the Treaty and to adjudicate issues arising from differences between the English and Māori texts (Durie, 1989). During the early 1980s, at a time of deteriorating economic circumstances and in the context of a wider review of the socio-economic standards to be applied to public policy in Aotearoa New Zealand (Barnes & Harris, 2011; Royal Commission on Social Policy, 1988), the Treaty of Waitangi became central to the debate around Māori social development and health (Durie, 1989). Because of differences in interpretation of the Treaty texts, policy was informed by agreed Treaty Principles and, in the health sector, the *Three Ps* of *partnership, participation and protection*, became the mantra for understanding individual and collective obligations under the Treaty. Nevertheless, through forces of initial and ongoing colonization, health and social inequity has been endured by Māori for many decades.

Overall, life expectancy in Aotearoa New Zealand is about 83 years for women and 80 years for men (2017-2019 data) (Stats NZ Tatauranga Aotearoa, 2022a). Noncommunicable disease is the leading cause of morbidity and mortality, accounting for 88 per cent of health loss, that is loss of healthy life due to premature mortality and years of morbidity. In the same period (2017-2019), injuries accounted for eight per cent of health-loss, and infectious diseases, neonatal disorder and deficiencies of nutrition contributed four per cent (Long Term Conditions Advisory Group, 2017). However, for many health conditions and for disability and suicide, the burden is greater among Māori than others, with life expectancy for Māori falling approximately seven years below that for non-Māori (Ministry of Health, 2015). Moreover, for the diverse population of Pacific Peoples in Aotearoa New Zealand, comprising more than 17 different ethnicities, life expectancy is five-and-a-half years less than for Europeans (Minister of Health, 2023). Their burden of disease is also disproportionately high, with, for instance, a rate of diabetes diagnosis three times higher than the national norm (Te Whatu Ora, 2023h) and high rates of mental distress and suicide among Pacific youth (Kapeli et al., 2020). Around a quarter of the New Zealand population is estimated to suffer from depression and in areas of deprivation and among Māori and Pacific Peoples, rates of psychological distress are up to 30 per cent (Kulshrestha & Shahid, 2022). Since morbidity and mortality from noncommunicable disease including mental health issues, affect Māori and Pacific Peoples disproportionately, recent public policy in these areas has focused on reducing health inequity. However, the Māori and Pacific populations are young and growing; by 2043, 33 percent of

New Zealand children are expected to be Māori and 19 per cent to be of Pacific ethnicity (Stats NZ Tatauranga Aotearoa, 2022b). Therefore, child and youth health outcomes have heightened impact on these communities. Whilst it is generally seen that non-communicable degenerative diseases pose the greater burden of morbidity in developed countries, infectious diseases, are the leading cause of admission to New Zealand hospitals. Infants of Māori and Pacific mothers and others living in deprivation, are between two and three times as likely to be admitted with respiratory infections and around four times more likely to be admitted with skin and soft tissue infections, than those of European mothers (Hobbs et al., 2017).

In 2016 a claim under the Treaty of Waitangi Act (claim WAI2575) opened to consider Māori health inequity as a breach of the Treaty with regard to hauora (health) as a taonga (treasure). Stage one of the tribunal, which considered systemic factors and primary health care, found issues of outdated understanding of the Treaty, a lack of Māori involvement in policy and services design and decision-making, and chronic underfunding of high-needs communities. These failings were highlighted as amounting to a denial of the autonomy over their own health, promised Māori under the Treaty (Came et al., 2020). Recommendations included:

> *"...that the Crown acknowledge the overall failure of the legislative and policy framework of the New Zealand primary health system to improve Māori health outcomes since the commencement of the New Zealand Public Health and Disability Act 2000" (Waitangi Tribunal, 2019, p. 170).*

The *Three Ps* were deemed a "reductionist view of Treaty principles" (Waitangi Tribunal, 2019, p. 80), which failed to take account of legal precedent and societal practice established since the Royal Commission on Social Policy (1988). Therefore, Treaty obligations for New Zealand primary health are now expressed as five principles: *recognition and protection of tino rangatiratanga* ("… the basis of Māori political and social organization and the foundation of Māori decision-making" p.82); *active protection*; *partnership*; *options*; *and equity* (Waitangi Tribunal, 2019). With regard to the latter, rather than framing policies to *reduce* inequity the Tribunal called for unequivocal goals to *achieve* equity.

2.2.1 Health equity and determinants of health

Equity may be defined as "… the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or

geographically." (World Health Organization, n.d.). Health *inequity* occurs where differences in health outcomes are caused by societal forces acting systemically on vulnerable groups, creating *avoidable unfairness* (Whitehead, 1991). The health status of Māori is starkly inequitable, evidencing the dysfunctionality, amounting to institutional racism, of health services predicated on European cultural norms (Matthews, 2019). It is estimated that 53 per cent of deaths among Māori are potentially avoidable, for Pacific Peoples the figure is 47 per cent and in the remainder of the population it is 23 per cent. The pathologies behind these statistics include: cancers; suicide; cardio- and cerebro-vascular diseases; and diabetes (Walsh & Grey, 2019). A recently adopted bowel cancer screening programme is illustrative of how decision-making in health can disadvantage members of the non-dominant culture. The programme targets those aged 60 to 74 years. However, in Māori most bowel cancers occur before the age of 60, and a greater percentage of Māori die from bowel cancer than non-Māori. Funding and colonoscopy capacity are cited as reasons for not starting screening for all from age 50 but, given the younger population profile for Māori, continuation of the current arrangements will exacerbate inequity regarding bowel cancer diagnosis and survival, extending the lives of older non-Māori at the expense of younger Māori (McLeod et al., 2021). In such decision-making, cost-utility is typically determined on the number of quality adjusted life years likely to be gained by a particular intervention, causing efficiency to be favoured over equity; this has been termed "economic imperialism" (Klonschinski, 2014, p. 158). It is in situations like this where the practical application of Treaty of Waitangi principles to institutional processes can work to de-colonize health services by collective decision-making involving community leaders both within health and across wider society, and by recognizing *dis-ease* as a function of multiple factors, not just pathophysiology.

Those living in deprivation have shorter life expectancy and higher morbidity levels than the better-off (Ministry of Health, 2018a). Indeed, intergenerational poverty has been called the greatest negative influence on health outcomes (Health and Disability Systems Review, 2020). This reflects the health impacts of physical and social environmental factors as well as biological and lifestyle influences on health and wellbeing, including psychosocial risk arising from, for example, isolation and low self-esteem (Talbot & Verrinder, 2010). As such, racism is but one social determinant of (ill)health; there are many others which it may exacerbate, including: socioeconomic position; access to health services, housing, water, sanitation and food; early childhood development including in-utero health security; employment conditions; education; socially patterned exposure to lifestyle risks; gender (in)equity; and power of

personal and cultural expression (World Health Organization, 2017). Recent health policy in many nations including Aotearoa New Zealand, has been informed by attempts to address these determinants of health by taking a Primary Health Care (PHC) approach. PHC involves health promoting activity across all sectors, not just within health. It requires community participation, the creation of healthy living and working environments, health education and a balance between preventive and curative health services. As such primary care is but one aspect of PHC. The PHC approach, otherwise termed the New Public Health movement gained traction through the Ottawa Charter (World Health Organization, 1986) which placed social justice at the heart of health care. In addition to inequity experienced by Māori and Pacific Peoples in Aotearoa New Zealand, it is important to consider others negatively impacted by determinants of health.

A quarter of the New Zealand population live in rural areas, where there are also relatively high numbers of Māori, children and older people (Te Whatu Ora, 2023f). There are obstacles to the provision of high quality health care in remote areas since low population densities limit resource, and distance to specialist services is a barrier (Raymont et al., 2015); due to limited economic opportunities, the population may also be relatively deprived. As such, rurality has been considered a probable factor in unfair health disparity for certain groups in Aotearoa New Zealand (Zhao et al., 2019) with recent research confirming that Māori are disproportionately impacted (Sheridan et al., 2023). Aotearoa New Zealand is part of the United Nations High Commissioner for Refugees programme, accepting up to 1000 refugees per year and prioritizing the disabled and at-risk women (New Zealand Immigration, 2022). The Public Health Service carries out health screening for refugees during an initial multi-agency reception and resettlement programme, after which mainstream health services, including general practice, are responsible for their care (Auckland Regional Public Health Service, 2022). Specific vulnerabilities among the refugee population include: sexual and mental health issues, particularly for women and girls; and infectious disease, including tuberculosis and HIV/aids. In addition, the cultural mismatch between refugees and providers and the health determining effects of the overall refugee experience promote inequity of health outcomes (Blessing et al., 2018).

Almost a quarter of New Zealanders identify as being disabled by enduring impairment of some form. They are a diverse population but as a group experience socioeconomic disadvantage and discrimination and have greater health risks than the general population. These may be

compounded by intersecting factors such as ethnicity, mental health status, gender identity, sexual orientation and age (Office for Disability Issues, 2020). Moreover, health outcomes for disabled people are poor and disability services unduly complex and difficult to navigate (Ministry of Health, 2020). In addition, as many as one in five New Zealanders over the age of 14 have a mood or anxiety diagnosis, with greatest prevalence in those aged between 15 and 24 (Wilson & Nicolson, 2020). Poor mental health is also associated with poorer physical health outcomes.

Overall, despite strategic intent to follow principles of equity, they are not applied routinely to operational and financial activity throughout Aotearoa New Zealand's health system (Sheridan et al., 2011). Notwithstanding empowerment under the Treaty of Waitangi, the growing involvement of Māori service providers in primary care (Goodyear-Smith & Ashton, 2019) and attempts to target preventive services on the most disadvantaged, through primary health care, inequity persists, negatively impacting Māori and Pacific Peoples. In addition to the high incidence of disease arising from exposure to risk through deprivation, including the effects of colonization, these high mortality rates result from poor access to treatment and inappropriate levels of care (Reid & Robson, 2007). Barriers to access and effective care include, low numbers of Māori and Pacific health workers, difficulty getting appointments and cost; 15 per cent of adult New Zealanders report not visiting general practice for reasons of affordability (Ministry of Health, 2019).

2.3 The organization and funding of New Zealand general practice

General practices are community-based health services, staffed by generalist clinicians that provide primary, or first contact, care to enrolled populations. They provide planned and opportunistic preventive health services, manage acute presentations and chronic disease care and referral to secondary health services. General practices in Aotearoa New Zealand, n=988 (Sheridan et al., 2023) are typically private businesses, owned by medical general practitioners (GP) who engage other doctors under contract and directly employ nurses and administrative staff, including a practice manager (Ministry of Health, 2004a). In a small but growing number of practices, nurses and practice managers are shareholders (Cassie, 2019). In addition, some practices are community governed and not for profit, including services provided by Māori and Pacific organizations (Ministry of Health, 2004b). Still others are owned by corporate entities, Primary Health Care Organisations (PHO), DHBs, and practitioner consortia (Cassie, 2019).

The size of general practices by enrolled patient population varies considerably; those with under 2000 enrolments are considered small and those with over 5000 are considered large. The mean ratio of staff to patients is approximately one full-time-equivalent (FTE) GP per 1500 patients and one FTE practice nurse per 2000 patients (Leitch et al., 2018). Other allied health professionals, such as pharmacists, may sometimes be employed by practices; publicly funded services, such as podiatry and secondary care outpatient services, may sometimes hold clinics on practice premises. Clinically, GPs provide consulting services within a biomedical model and, relative to practice nurses, focus on more complex cases and presentations involving diagnostic uncertainty. In addition, they fulfil regulated roles regarding access to social security services. A small but growing number of nurse practitioners also fulfil these roles. Registered and enrolled nurses, have greater focus on preventive population health services. They provide immunizations, assess health status, and perform diagnostic tests such as spirometry and cardiac monitoring; they undertake infusion therapy and phlebotomy, emergency first aid, triage, wound care and cervical screening (Halcomb et al., 2015). In addition, they have a growing role in long-term condition and medication management and coordinate care, both as case managers for individual patients and by managing practice level patient communication, recall, screening and patient education programmes. Care is provided across the life-span and for both somatic and mental health presentations. While most nursing is conducted within the physical premises of general practice, some home visiting and outreach services are provided (Walker, Clendon, & Nelson, 2015). Nurse practitioners in general practice provide consulting services similar to medical general practitioners and may also perform traditional nursing tasks as appropriate to the holistic needs of patients (Adams et al., 2022).

A number of bodies provide sector and professional leadership and representation to general practice. The Royal New Zealand College of General Practitioners (RNZGP), is responsible for the vocational training of medical general practitioners (Royal New Zealand College of General Practitioners, 2023) and also leads on quality assurance standards for New Zealand general practice. The standards cover: patient rights; meeting health needs; managing medications and medical equipment; and safety and continuity of practice. The baseline standard Foundation Accreditation is required to qualify for public funding and additional quality improvement and equity modules are stipulated for practices that provide vocational training for GPs. The programmes mandate training relevant to the standards by category of

employee. For example, practice nurses specifically are required to undertake training in the use of standing orders (Royal New Zealand College of General Practitioners, 2020). The Practice Managers and Administrators Association of New Zealand (PMAANZ), advocates for and supports members, most of whom are qualified for their roles by experience rather than education, with professional development and networking opportunities, including an annual national conference (Practice Managers and Administrators Association of New Zealand, n.d.). The Hauora Taiwhenua Rural Health Network and the General Practice Owners' Association of Aotearoa, New Zealand (GenPro) are organizations active on behalf of member general practices. The former characterizes itself as the voice for rural general practices (Hauora Taiwhenua Rural Health Network, 2023) and includes a Rural Nurses Chapter. GenPro focuses on advocating for the business-sustainability of general practice (General Practice Owners' Association of Aotearoa, 2023). The College of Nursing Aotearoa (NZ), aims to:

> *"...provide a voice for the nursing profession as a whole, speaking out on issues that affect not just nurses, but the health of the whole community. We monitor and influence policies and legislation on these issues, in the same way as other powerful health industry associations. We have done this by contributing to many committees, and making submissions at all levels." (College of Nurses Aotearoa (NZ), 2023)*

However, in seeking to provide such leadership, its penetration into matters pertaining to general practice is limited in comparison with RNZCGP as it lacks the authority afforded the latter by its quality assurance role and by the ownership model which historically favours the medical profession.

In addition to the RNZCGP quality programmes, the Health Quality and Safety Commission New Zealand (HQSCNZ) conducts quarterly *adult primary care patient experience surveys* of patients presenting to practices. The findings are reviewed centrally and participating practices are able to view their own performance relative to their peers (Health Quality and Safety Commission New Zealand, 2023). Consumer rights and Health Provider obligations, are established under the Code of Health and Disability Services Consumers' Rights which addresses issues of: communication; service standards; consent; support; and fair treatment (Heath & Disability Commissioner Te Toihau Hauora Hauātanga, 2022). Otherwise there is limited public oversight of general practice fiscal or clinical performance.

2.3.1 Health expenditure and funding

Three quarters of the nine per cent of gross domestic product spent on health care in Aotearoa New Zealand is public expenditure. Per person, New Zealand health expenditure is slightly below average among OECD countries (Goodyear-Smith & Ashton, 2019). While secondary care services are available free at the point of access, government funding of general practice via population-based 'capitation' payments is supplemented by individual patient co-payments (Ministry of Health, 2017a). As a result, about 50 per cent of income to general practice is from public funds, (Downs, 2017). Medicines purchase and subsidy is managed by PHARMAC, a Crown entity, and most prescription medications are available to the public at rebated cost[2] (Goodyear-Smith & Ashton, 2019). Capitation funding has been in place since 2003. To receive subsidized health services, individuals are required to enrol with a primary care provider which then receives funding based on an expectation of demand per enrolee. Formerly a reimbursement model applied, whereby 'fees for service' were claimed for general medical services (GMS) provided by medical general practitioners. The current arrangements are intended to allow for provider-initiated health promotion and preventive services and to enable funding of services which are not physician led (Thomson, 2019). In addition to subsidizing first contact care and health promotion services, capitation funding provides payments to improve access to services for high-needs patients, defined as, Māori and Pacific Peoples and those living in deprivation. For practices where more than 50 per cent of patients are categorized as high needs Very Low-Cost Access funding is provided to allow reductions in patient co-payments. Elsewhere, fees subsidies are paid to keep point of care co-payments low for Community Service Card (CSC) and High Use Health Card (HUHC) holders and to fund free care for those under 14 years (Goodyear-Smith & Ashton, 2019). General practice also receives fee-for-service funding for maternity services, immunization and latterly assisted dying services, under s88 of the New Zealand Public Health and Disability Act 2000 . The Accident Compensation Commission, a levy-based government agency insurance programme, part-funds care necessary due to injury (Gauld, 2016). Services for injury and acute medical care are also provided outside of, sometimes alongside, general practice and hospital emergency departments, in Urgent Care Clinics. Urgent Care Clinics do not have enrolled populations but receive vote health fee for service funding for certain patient groups, for example children (Te Whatu Ora, 2022a). Like general practices Urgent Care Clinics charge co-payments and are contracted ACC providers (Accident Compensation Commission, 2017).

[2] Note: Since 1 July 2023 most standard prescription medication are free from patient co-payments.

Regionally, a range of clinical programmes are delivered by general practice under local contract. For example, secondary-care procedures such as infusion therapies and minor operations may be devolved to general practice, such as through the Primary Options for Advanced Care (POAC) Programme (East Health, 2023), and GP with Special Interest (GPWSI) schemes (Reiche et al., 2021). Long-term condition management, screening programmes, palliative care and primary mental health is also supported under local arrangements. Supplementary funding for primary care in rural locations is provided through regional Service Level Alliances, to promote equitable access to services including by the provision of financial and training incentives to aid the retention of health practitioners (Andrews et al., 2016). Some general practice care models incorporate provision of social services, addressing issues of social exclusion such as housing need, food and job security. Notably the Whānau Ora Programme, a joint enterprise implemented through the Ministry of Health, Ministry of Social Development and iwi (Māori tribes), aims to respond to individual needs in the context of family/whānau and community, using a culturally informed outcomes framework to address the social determinants of health (Boulton et al., 2018). Numerous non-government organizations (NGO) are active in the community operating as charities and under contract to the government providing social services and to which primary care may refer.

Under health reforms arising from the Health and Disability Systems Review, carried out between 2018 and 2020, on 1 July 2022 a new national health system was implemented including the creation of two new entities, Te Whatu Ora - Health New Zealand and Te Aka Whai Ora - the Māori Health Authority (Department of the Prime Minister and Cabinet, 2022). However, over the period of this study, government funding was cascaded to general practice via DHBs and PHOs, under terms agreed in the PHO Services Agreement. DHBs, of which latterly there were 20, were created under the Public Health and Disability Act 2000, and owned and ran public hospitals in addition to providing services in the community, whether directly or under contract to third parties (Te Whatu Ora, 2022b). PHOs, established from 2002, were charged with ensuring primary health care services were provided to enrolled populations (Te Whatu Ora, 2023e). Each general practice was required to belong to one of the 31 PHO, from which it received clinical and governance support and leadership and through which DHB and Ministry of Health programmes, delivered in general practice, were coordinated.

2.4 The general practice workforce

Whilst the list of health professions and associated roles in general practice is extensive, most of the workforce comprises medical doctors and registered nurses. As described in the paper "Understanding the general practice nursing workforce in New Zealand: An overview of characteristics 2015-2019", presented in Chapter One, it is estimated that there were over 4000 nurses working in general practice in New Zealand in 2019. Similarly, the Medical Council of New Zealand reported 3671 doctors were registered with the vocational scope of "general practice" in 2019 (Medical Council of New Zealand, 2019). Both cohorts were relatively older, more likely to be female and more likely to work part time than their colleagues in other areas of specialization (Hewitt et al., 2021; Medical Council of New Zealand, 2019). Around three per cent of general practitioners are Māori whereas upwards of seven per cent of nurses in general practice may be so. Doctors and nurses of Pacific Ethnicity, respectively comprise around two per cent and five per cent of their professions working in general practice (Hewitt et al., 2021; Medical Council of New Zealand, 2019). These are levels significantly below parity with the proportions of Māori and Pacific Peoples in the national population:16 per cent and eight per cent respectively (Stats NZ Tatauranga Aotearoa, 2019).

There are issues of recruitment and retention of both doctors and nurses in general practice with new entrants to each profession typically seeking careers in secondary care specializations which are perceived as higher status and are better paid. Since nursing education moved to tertiary institutions in the1970s, practical training is achieved through workplace attachments. Primary care placements are highly sought after by tertiary institutions. Moreover, it has been argued that nation-wide student nurses have relatively little exposure to the sector during initial professional education and enter practice without key primary care skills (Betony & Yarwood, 2013). However, since 2008, new nursing graduates in general practice have been supported the Nurse Entry to Practice (NETP) Programme (George et al., 2019; Hoare et al., 2013). This partially funds employment costs and provides access to post graduate study and mentoring (Te Whatu Ora Health New Zealand Te Tai Tokerau, 2022). It is funded by the Health Workforce Directorate, which also supports ongoing postgraduate training of nurses, and doctors' specialist training (Te Whatu Ora, 2023c). For the medical workforce, since 1995, the RNZCGP general practice education programme (GPEP) has provided medical vocational training for the sector. This is a three-year programme of one-to-one supervision, group

education, and patient feedback which, together with completion of a 15-point post graduate academic paper, leads to RNZCGP Fellowship (Goodyear-Smith et al., 2020).

Among the allied health professions working in general practice, pharmacists provide medication reviews, long-term condition management and medication reconciliation (Haua et al., 2019). In 2019, 29 pharmacists were reported to be working in general practice, (Pharmacy Council Te Pou Whakamana Kaimatu o Aotearoa, 2019). Clinical support tasks within general practice commonly performed by registered and enrolled nurses may also be undertaken by non-regulated health workers, such as Health Care Assistants (HCA), Medical Assistants (MA), and Physician Assistants or Physician Associates (PA). The former need have no formal training; the latter are trained medical generalists who work under the supervision of a physician. In Aotearoa New Zealand, a small number of United States trained PAs were employed in a range of settings including general practice over the period 2013 to 2015, to evaluate their potential value to the health system. The role as yet has no official footing, or training pathway in Aotearoa New Zealand. However, six United States trained PAs were working in general practice in Aotearoa New Zealand in 2019 (Maude, 2019b). The numbers of non-regulated health workers or kaiāwhina in primary care is not known but in 2016 the national figure across all sectors and designations was estimated to have been around 63,000 (Ministry of Health, 2016). In the 2019 'Wellness Budget', the Government committed $455M to primary care mental health services, creating two new categories of health worker: Health Improvement Practitioners (HIP) and Health Coaches (HC). Both are trained in the Te Tumu Wairoa - to head towards wellness Model of mental health and addiction support and provide evidence-based brief interventions to support wellbeing. HIP are any category of registered health professionals, some are nurses, HC may be health professionals or lay persons (Te Tumu Waiora - to head towards wellness, n.d.).

Doctors, nurses and allied health professionals such as pharmacists and podiatrists are regulated under the Health Practitioners Competence Assurance Act (HPCA) 2003, through responsible authorities such as the Nursing Council and the Medical Council. These bodies, maintain registers of practitioners, set scopes of practice and competency standards. For New Zealand nursing levels of registration and scopes of practice see Table 1.1. Under s41 of the HPCA, the Nursing Council of New Zealand (NCNZ), originally established in 1971 (Gage & Hornblow, 2007), is vested with responsibility for ensuring nurses' fitness and competence to practice. As such, practice certificates are required, and must be renewed annually after individual self-

certification of compliance with minimum requirements. These are: to have practised for a minimum of 60 days and to have undertaken 60 hours of professional development in the past three years; and to have met the Nursing Council Competencies for the stated nursing scope of practice. The applicant must declare any criminal and disciplinary action they may be subject to, and any health issues that may affect their fitness to practice. Where there are areas of concern, the nurse may be registered to practice within limitations, termed 'conditions on practice'. To fulfil their regulatory obligations, NCNZ review five per cent of applicants, requiring them to undertake a recertification audit. Candidates are selected at random, and the audit requires employer-certification of practice hours, a reflective summary of professional development activities, and the submission of two competence assessments (Nursing Council of New Zealand, 2019) demonstrating how each of 20 Registered Nurse Competencies, across four domains, have been met in everyday practice. Competencies cover: professional responsibility; management of nursing care; interpersonal relationships; and interprofessional health care and quality improvement (Nursing Council of New Zealand, 2012b). Employers may institute Professional Development and Recognition Programmes (PDRP), which if approved by NCNZ exempt individuals from audit. Such programmes aim to develop the expertise of nurses and typically set levels of competence within scopes of practice linked to levels of remuneration and career planning (Nursing Council of New Zealand, 2019).

Nurses working in general practice, often referred to as practice nurses are also part of the wider primary health care nurse workforce. Such Primary Health Care Nurses (PHCN) perform a range of roles in the community, as summarized in Table 2.2. Practice nurses may to a greater or lesser extent, depending on specific setting, work with their community nursing colleagues to coordinate patient care. In some circumstances, notably in rural locations, they perform some of the functions of these normally discrete roles. In contrast to nurses working within general practice, many community-based nursing services are provided free at the point of delivery. The New Zealand College of Primary Health Care Nurses (NZCPHCN), a group within NZNO formed in 2010, (New Zealand College of Primary Health Care Nurses NZNO, 2021) has developed the Aotearoa New Zealand Primary Health Care Nursing Standards of Practice. The standard's purpose is "articulating what is expected in the speciality and outlining a career pathway in primary health care nursing" (New Zealand Nurses Organisation, 2019, p. 4). To this end, it defines four standards: promoting health; building capability; improving access and equity; and working together better and smarter. It references knowledge and skills frameworks for specialty areas within primary health care nursing, including child health and

diabetes nursing and reinforces Te Ao Māori (Māori world view) values to provide culturally safe nursing practice. Regarding career progression, it acknowledges that nurses may progress through what are referred to as levels of practice, competent, proficient and expert, and links levels of practice to levels of academic qualification. However, the guidance it gives is generic and there remains no formally adopted national competency standards for nurses in general practice beyond those mandated for all nurses by the Nursing Council of New Zealand (Nursing Council of New Zealand, 2012b).

Table 2.2 Groups of primary health care nurses other than practice nurses working in community settings

Designation	Role
Public Health Nurse (PHN)	Around 900 PHNs are employed by Regional District Health Boards (Health New Zealand) and focus on children, providing free services including: school-based immunization programmes; well child checks; healthy home assessments and referrals; continence support; communicable disease contact tracing; and community follow-up following non-attendance at other services (Te Whatu Ora Health New Zealand Te Pae Hauora o Tararua Mid Central, 2017).
Youth Health Nurse (YHN)	Around 220 YHNs are employed by Regional District Health Boards (Health New Zealand Te Whatu Ora) Youth Health Services; they provide free assessment and treatment to those aged 12-24 with complex health needs, as part of a multidisciplinary team (Te Whatu Ora Health New Zealand Counties Manukau, 2019).
Mental Health & Addictions (MHN)	There are around 2500 Community MHNs, mostly employed by Regional District Health Boards (Health New Zealand) Mental Health Services; they provide free care to adults, children and infants with complex mental health needs, as part of a multidisciplinary team (Te-Upoko-me-Te-Karu-o-Te-Ika Mental Health and Intellectual Disability Service, 2022) (Te Whatu Ora Health New Zealand Counties Manukau, 2022).
Family Planning Nurse (FPN)	There are around 230 FPNs, mostly employed by Family Planning New Zealand, a charitable organization, providing mostly free sexual and reproductive health services across 33 clinics and in schools (Family Planning New Zealand, 2023).
Aged Care Nurse (AGN)	Registered and enrolled nurses in the Aged Residential Care Sector provide 24 hour care for patients 65 years and older, meeting complex clinical, social, spiritual and palliative care needs across approximately 670 facilities providing rest home, hospital, dementia and psychogeriatric care (Hughes et al., 2021). There are around 6000 AGNs.
Plunket Nurse (Well Child -Tamariki Ora Nurse)	Plunket is a charity providing Well Child Tamariki Ora Health assessments and family advocacy for families with children under-five (Carryer et al., 2018). Their services are free to users.
District Nurse (DN) (Adult and Paediatric)	Around 1600 DNs employed by District Health Boards (Health New Zealand Te Whatu Ora) provide free palliative care, intravenous therapy, ostomy and wound care, wound management, rehabilitation care coordination, discharge planning, continence support, enteral feeding and equipment supply, and rheumatic fever prophylaxis. In addition, home nursing services are provided under contract to non-government organizations, funded by the Accident Compensation Commission.
Rural Nurse Specialists (RNS)	RNSs are registered nurses with advanced skills practicing autonomously in rural areas. Specific roles, responsibilities, education requirements and settings vary geographically (Bell et al., 2018). There are round 740 nurses working in rural areas, not all of whom are formally designated rural nurse specialists. RNSs may be Primary Response in Medical Emergency (PRIME) Practitioners, trained and resourced to assist the ambulance service (Te Whatu Ora, 2023a).
Palliative Care Nurse (PCN)	PCNs provide symptom palliation, practical and spiritual support for those whose illnesses have reached the terminal phase. There are 33 hospices nation-wide, mostly funded by central government and supported by charitable donations to provide care free of charge (Te Kahu Pairui 0 Aotearoa Hospice New Zealand, 2022).
Urgent Care Nurse (UCN)	UCNs work in privately owned Urgent Care Clinics which operate extended hours providing care on a fee-paying walk-in basis for acute illness and injury (Royal New Zealand College of Urgent Care, 2015). There are around 500 urgent care clinics in New Zealand (Healthpoint, 2022).
School Nurse (SN)	There are around 300 SNs. A number are publicly funded in low decile secondary schools, Teen Parent Units and Alternative Education Sites. Others are employed directly by schools. They provide free clinical care, referral to other services and health promotion (Te Whatu Ora, 2023g).

Notes:

1. Numbers of nurses are taken from Nursing Council of New Zealand Workforce Statistics(Nursing Council of New Zealand, 2020b)

2. Registered Nurses also work in organizations such as the Health Foundation of New Zealand, (Heart Foundation, 2023) and the Cancer Society(Cancer Society Te Kahui Matepukupuku o Aotearoa, 2022) providing free advice and support for patients and their families.

3. Nurses also work privately in the community

2.5 Contemporary discourse about nursing roles

Figure 2.1 is a positional map representing perspectives relevant to nursing roles in New Zealand general practice based on contemporary nursing discourse, by which I mean the ways in which nurses talk and write about their profession and how the profession is talked and written about by others. Foucault highlighted the need to question the assumptions which underpin professional bodies of knowledge and behaviours, which become normalized through such discourse (Springer & Clinton, 2015). His work led to the methodology of Foucauldian discourse analysis which includes critical examination of how power operates in social interaction and is promoted through discourse (Kneipp et al., 2022). The following is not a formal discourse analysis but includes discussion of issues, which as highlighted by O'Connor (2012), commenting on nurses' autonomy and access to primary health care funding in Aotearoa New Zealand, include:

> *"Issues of power and control based on profession, funding streams, gender and philosophy of care [which] have, seemingly, been an integral part of PHC since Labour Prime Minister Peter Fraser's 1938 attempt to establish free GP (and hospital, pharmaceutical and maternity) services was thwarted by doctors' opposition." p. 26*

I identified relevant topics from personal experience and by engagement with opinion-pieces, letters, editorials and position statements encountered in the literature. A range of perspectives typifying attitudes towards traditional nursing roles and philosophies and advanced nursing practice were apparent. Nursing autonomy was a common theme.

2.5.1 Nursing autonomy

Nursing autonomy is described in terms of 'independence in decision-making and ability to utilize nurses' own competence', (Pursio et al., 2021, p. 1573). As such it reflects the degree of power and agency afforded to, or claimed by, nurses in particular situations. In nursing discourse there are a variety of views on autonomy and its associated themes. Traditionally, nurses were employed in general practice as doctors' assistants, typically carrying out delegated treatments or preventive episodes of care. In addition, they often undertook receptionist and cleaning duties (Docherty et al., 2008). In the mid to late twentieth century, as stated by Gage and Hornblow, "In primary care, the role of nurses was to support a fee-for-service general practitioner" (2007, p. 331). Such employment reflected the societal attitudes

and systems of the time. In Figure 2.1 the range of vocabulary used to describe nursing in this historical context is grouped in Box A. Conversely, Box B represents a contemporary context where nurses have greater autonomy to make and implement clinical decisions and to direct nursing practice (Pursio et al., 2021). Individuals and groups occupy various positions along continua, from the ideas of Box A to those of Box B, the limits of which are described by the terms paired 1 to 10 and discussed below.

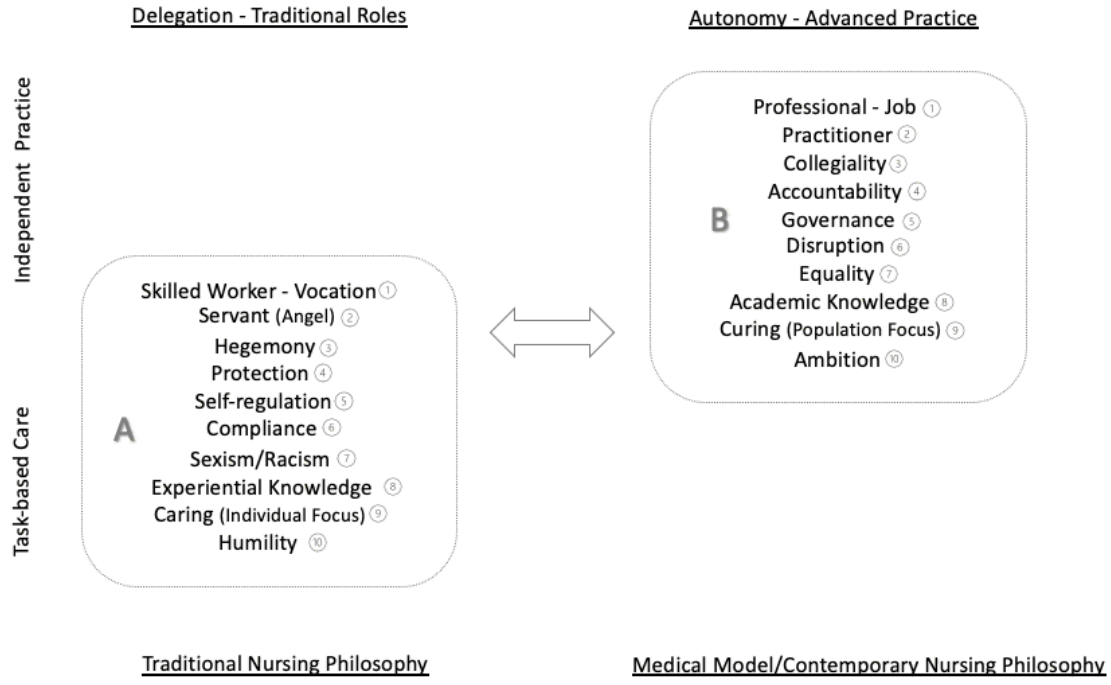


Figure 2.1 Positional map of perspectives on traditional nursing roles and advanced nursing practice evident in the contemporary nursing discourse relevant to the New Zealand general practice negotiating environment

Historically, nursing was seen as a vocation, an extension of the care and emotional work expected of women within the home. Hence, nurses were positioned as servants of society and subordinated to a medical hegemony (Yam, 2004). This positioning protected nurses from legal accountability to patients for the care they provided, rather they were answerable to doctors for delivering prescribed treatment and medical accountability was a matter of professional self-regulation (Tineke Water et al., 2017). Nursing behaviours were characterized by humble obedience to an established order. Over time nursing has become professionalized. The gender disparity between nursing and medicine has become less stark as more men have become nurses and many more women have become doctors (Medical Council of New Zealand, 2019). There is greater collegiality among health professionals as clinical and social complexity of patient need requires a team-based approach. However, a legacy of gender bias is apparent in

the extant power imbalance between nursing and medicine and in the pay inequity experienced by nurses, particularly in the primary care sector and among predominately Māori provider organization nurses (Awatere & Komene, 2018).

Professional governance is a set of structural parameters which influence individual and group behaviours. Strong professional governance is associated with "ownership of professional practice, role development, engagement and decision making" (Porter-O'Grady & Clavelle, 2020, p. 181). In Aotearoa New Zealand several developments in professional governance have driven the professionalization of nursing. I have discussed the purpose of the Health Practitioners Competence Assurance Act 2003 and of NCNZ. Advising on expanding nursing practice, NCNZ states that regulation of nursing practice is as matter of shared accountability among individual nurses, the Nursing Council, professional organizations and employers, but that ultimately, "registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards" (Nursing Council of New Zealand, 2016, p. 5). Standards are defined variously, drawing on legislation, codes of conduct, clinical guidelines, scopes of practice and competencies. Notably the Code of Health and Disability Services Consumers' Rights Regulations 1996 (the Code) bestows duties upon health care providers regarding the ethical and clinical treatment of consumers, focusing on informed choice, culturally safe care and advocacy.

Cultural safety is a concept which developed from concerns expressed by Māori nurses in the 1980s in response to their experiences of institutional racism in nursing education (Richardson, 2004). It underpins understanding of the effects of culture on health outcomes and definitions of safe nursing practice. Cultural safety, or Kawa Whakaruruhau, obliges nurses to recognize and respect individual difference, including power differentials between the provider of care and the consumer. Although founded in the context of ethnicity, the concept includes all cultural differences such as arise due to socialization, age group and sex (Papps & Ramsden, 1996). It is the recipient of care who determines whether a service in culturally safe (Richardson, 2004), challenging the historic primacy of the medical profession as arbitrator of nursing competence. Nurses' responsibilities to practice in culturally safe ways and to observe the principles of the Treaty of Waitangi are stipulated by NCNZ and embedded in scopes of practice, under the domain of professional responsibility (Nursing Council of New Zealand, 2011, 2022a). Such responsibilities also include advocating for the rights of consumers both

culturally and in clinical situations (Tineke Water et al., 2017), thereby replacing the expectation of compliance within the system, with that of challenge or disruption. In addition to changed behavioural requirements, today, nurses have an extensive and expanding range of complex procedural tasks and technologies to master, increasing the need extensive post-graduate training and education.

In Aotearoa New Zealand, hospital-based nurse training, an apprenticeship model, was phased out and replaced with nurse education within polytechnics and universities from the 1970s (Gage & Hornblow, 2007). This move bolstered nursing's professional aspirations but created concern that the caring component of nursing would be undermined. Today, the relative importance of skills and knowledge over attitudinal and behavioural characteristics such as emotional intelligence, conscientiousness, and demeanour, in defining professionalism is still debated (Walker, Clendon, & Walton, 2015). Commentators highlight that in the caring – curing discourse, nurses are disadvantaged in the health economy when seeking to define their profession's unique character in terms of "virtues", rather than "knowledge and concrete [*health*] outcomes" (Nelson & Gordon, 2006, p. 3). This makes them vulnerable to task substitution by the unregulated health workforce.

The New Zealand Primary Health Care Strategy (King, 2001) highlighted that nursing attributes of holism, self-reliance, relational and cultural competence, and care (Keller et al., 2011) were congruent with, and enablers of, the population-health approach, deemed necessary to address what, globally, has been called the "chronic disease epidemic" (Holman, 2020, p. 167). However, nursing attributes are many and various. Nursing has been described as an art and a science and distinctions are drawn between traditional nursing models and nursing theory informed practice (Younas & Quennell, 2019). Contemporary characterizations of nursing include reliance on a distinct nursing knowledgebase which informs clinical decision-making through the nursing process of assessment, diagnosis, implementation evaluation. Nursing diagnoses may be used to formulate care plans for specific actual or potential needs at the individual, family and community level and address both physiological and emotional states. Though not used widely in Aotearoa New Zealand, nursing diagnoses include states such as *powerlessness*, *spiritual distress* and *sorrow* (Jones, 2009), reflecting the philosophy of nursing wherein health need is identified from an experiential as well as a pathophysiological perspective. As such, it comprises hands on basic nursing tasks, which attend to the physical needs of those experiencing acute illness, and responses to the psychosocial needs of patients,

which arise from or exacerbate chronic conditions (Gordon & Nelson, 2006). In primary care, this may involve work at a group or community level, or in management roles and can be seen to reduce "patient proximity", a concept upon which the articulation of the uniqueness of nursing as *caring* has traditionally depended (Miller & Kontos, 2013, p. 1798).

In general practice, relational continuity of care is vested in GPs; largely, nurses and support staff provide managerial and informational continuity (Jeffers & Baker, 2016), effected through recalling, screening, medication monitoring, care coordination activities and records management. This reflects and drives the collective nature of nursing work and how nurses are perceived by colleagues and patients. This may be seen in how the professions are depicted symbolically in practice and on websites. For example, commonly GPs and NPs have an assigned consultation room, bearing their name and title, they do not wear uniforms or name badges and appear in individual photographs above professional biographies on organization websites. In contrast, nurses usually wear uniforms and name badges, often bearing first name only, and they work out of shared spaces. They may not appear on websites or may be represented in a group photograph, sometimes not distinguished from administrative staff or HCAs. Nurses' individual professional skills and education are rarely highlighted to service users or well understood by GPs (Wilmott, 2023). Where nurses adopt advanced practice roles, which draw on a more biomedical model emphasizing diagnosis and *cure*, rather than treatment and *care*, and practice with greater independence, they are more likely to be recognized for their individual skills and knowledge. Work among nurse leaders and academics to define and implement such roles and the efforts of individual nurses inhabiting them, is indicative of the move from humility and silence to ambition and voice (Carryer, 2021; Rook & Coombs, 2016). This is a global phenomenon, exemplified by the Nursing Now Campaign. Launched in 2018, this movement promotes nurses as policymakers, health leaders and agents of change for the social and economic empowerment of women (Crisp & Iro, 2018).

2.5.2 Advanced nursing practice

Advanced nursing practice is defined as an advanced, expert clinical practice, suited to the national context and supported by master's degree level education (International Council of Nurses, 2020) . In Aotearoa New Zealand, based on the performance of nurses across a range of indicators of advanced practice including leadership, educational achievement, research involvement, promoting functionality within nursing services and direct care, it is argued that

the role of clinical nurse specialist (CNS) marks the beginning level of advanced nursing practice (Carryer et al., 2018). This is recognized within employment conditions and pay scales and the term CNS is used to refer to nurses with expertise in a particular specialism. However, there is no formal definition of the term or standard educational pathway at the national level (O'Connor, 2016); there is no nationally recognised CNS designation for nurses working in general practice. Although, subject to inter and intra-professional jurisdictional disagreement, advocacy for advanced nursing practice in Aotearoa New Zealand has drawn on international experience, notably on developments in the United States, and has been supported by those who see nursing as having the ability to address population health and primary health care shortfalls, by offering greater patient choice and improving access for high-needs groups (Hughes & Carryer, 2002). One aspect of advanced practice is nurse prescribing.

Historically, non-medical prescribing in Aotearoa New Zealand was limited to dentists and midwives (Raghunandan et al., 2017). However, in 1999, prescribing rights for nurse practitioners were made possible by amendment to the Medicines Act 1981 (Lim et al., 2017). Further amendment in 2011, allowed for prescribing of diabetes-relevant medications by nurse specialists, and in 2013, nurse practitioners gained prescribing authority equivalent to that of doctors, dentists and midwives, including the ability to issue standing orders (Lim et al., 2014). Standing orders enable the supply of medications usually by registered nurses, without a prescription. Since the adoption of the Medicines (designated prescriber: registered nurses) Regulations in 2016 (Raghunandan et al., 2017), there are two categories of registered nurse prescribing: Designated Prescribing in Primary Health and Specialist Teams; and Registered Nurse Prescribing in Community Health (RNPCH). Both require nurses to work in collaboration with authorized prescribers, medical doctors or nurse practitioners, within protocols for presentations with a high degree of diagnostic certainty, and from a limited schedule of medications. However, unlike the more limited RNPCH role, which is a work-based training scheme, the former, which has subsumed the earlier cohort of diabetes nurse prescribers, requires the completion of academic post-graduate education. All types of nurse prescribing require a period of practical pre-authorization clinical supervision and mentorship.

The rationale for non-medical prescribing was to provide greater access to care by reducing cost and time barriers; current prescribing scopes allow for registered nurse diagnosis and/or continuation of treatment for numerous presentations, including: respiratory diseases, diabetes, hypertension, heart failure and gout, as well as sexual health, skin conditions, palliative care,

certain mental health presentations and common infections, such as sore throat and ear infections (Nursing Council of New Zealand, n.d.-c). Pharmacists and dieticians, like registered nurses, may also become designated prescribers, working collaboratively and from a set list of medications, and optometrists, may become authorized prescribers, working independently with access to the full formulary (Raghunandan et al., 2017).

Aotearoa New Zealand's first nurse practitioner was accredited by Nursing Council in December 2001 (Jacobs & Boddy, 2008). The Health Practitioners (Statutory References to Medical Practitioners) Bill, 2016, removed barriers to health practitioners, other than medical doctors, providing a number of essential services. Therefore, suitably qualified nurses may provide death and off-work certificates; coordinate accident rehabilitation under ACC contracts; prescribe controlled drugs; and act as a primary health care providers in relation to care under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health, 2022). Nurse practitioners in primary care can access capitation, GMS subsidies, and aged residential care payments, in the same way as medical practitioners (Ministry of Health, 2023a). Around half of Aotearoa New Zealand's nurse practitioners work in primary care (Cassie, 2021).

Whilst the International Council of Nurses definition of advanced practice characterizes it as reliant on master's degree level educational achievement, given the broad scope of practice, training and experience of registered nurses without higher level degrees, there is potential for innovation in nursing models of care outside the banner of advanced practice. This is often under the term 'nurse-led care'. Although again this has no universal definition, in general practice it ranges from nurses performing discrete protocol-based tasks or procedures, such as infusion therapy, to the performance of general clinical assessment, such as first contact care (Cullum et al., 2005). Nurses have always had roles that would fit either of these categories; the term nurse-led care is used today where nurses are providing services traditionally considered to be the work of medical doctors. However, nurses, other than nurse practitioners, have little direct access to general practice funding including public subsidies, from the Ministry of Health and ACC, and private medical insurance (Wilkinson, 2008). This not only limits their clinical autonomy within general practices owned by doctors but undermines their ability to demonstrate income potential to support any business case proposing independent nursing services (Ministry of Health, 2009; National Nursing Organisations Leaders Group, 2018; New Zealand Nurses Organisation, 2014).

2.6 Issues affecting general practice during the period of study

Primary care has become increasingly complex as a result of ageing populations, increased incidence of multimorbidity and long-term conditions (Laurant et al., 2018), and the transfer of care from hospitals (Murray-Parahi et al., 2016). Over the period of study, influences on general practice included: developments in business and care models; nurses' pay bargaining; and the COVID 19 pandemic.

2.6.1 Business and care models

As described above, most New Zealand general practices are privately owned by GPs, some are community governed not for profit entities, others are owned by PHOs and (former) DHBs, and others by corporate entities. Recent developments in the model of provision of general practice services in Aotearoa New Zealand include increased corporate ownership (Thomas, 2018) and the introduction of the patient centred medical home, (Health Care Home Collaborative, n.d.). The latter systemizes the goals of patient-centred care, population health and cost-efficiency through articulation of clear roles for members of the interdisciplinary team, collocation of services and optimum use of information technology. Patient centred care includes concepts of patient and practitioner empowerment, to deliver care that respects the individual and offers choice and shared decision-making (Byrne et al., 2020). Nurses lead in proactive coordinating roles and preventive health, quality improvement and communication, as well as providing direct acute care (Conrad & Alfredson, 2016). Each model attracts public funding in the usual way. To manage the risks of high demand, and in the face of the GP shortage, there is a trend towards amalgamation creating larger general practices (Greatbanks et al., 2017). Increasingly, practices are entering corporate ownership. Corporately owned practices are those belonging to a single business entity, running a group of practices for profit and in which staff working in the practice may or may not have a financial interest. Between 2014 and 2020, the number of practices owned by such entities is estimated to have risen from 106 to 179 (Cassie, 2020). There has also been an increase is the use of telephone and video consultations, supported by electronic means of prescribing and lab test ordering. In addition to the use of such 'virtual consults' by general practices serving their own enrolled populations, there are a growing number of providers who do not enrol patients but offer services to the general population, sometimes through mobile technology apps (Health Informatics New Zealand, 2020).

In response to uncertainty about which models of primary care are most effective, research – "Evidence to guide investment in a model of primary care for all" – was commissioned in 2018 to consider the comparative merits of traditional general practice, corporate general practice and the health care home (Health Research Council New Zealand, 2018). The research focused on health equity and outcomes for Māori and Pacific populations. It was an observational, cross-sectional study drawing on the largest-ever collection of primary care data in Aotearoa New Zealand, as at 30 September 2018. Project data, covered 924 practices, within which 91% of the New Zealand population were enrolled. Using evidence derived from datasets, routinely collected within the health system, quantitative analysis, using regression models, described associations between general practice characteristics and patient outcomes with regard to: polypharmacy; diabetes testing; childhood immunization; hospitalisations; and attendance at emergency departments. Qualitative thematic analysis of case study focus group and interview data from 24 general practices, involving 103 staff and 47 patients and more than 20 health sector experts, provided evidence of structural, procedural and attitudinal characteristics. Qualitive data collection occurred in 2019 and 2020; supplementary data was collected by survey in 2019 (N. Sheridan, pers. comm.). The study found that much of nurses' work in general practice was invisible because it was not attributed to them in practice records and highlighted the need for better quality data to quantify and understand their work. Regarding practice performance, more variety was found within than between models and performance for each type varied across indicators, concluding that patient need rather than type of practice determined primary care health outcomes (Sheridan et al., 2023). The impact of health need on the business of general practice was demonstrated during the COVID 19 pandemic.

2.6.2 The COVID 19 pandemic

Aotearoa New Zealand confirmed its first COVID 19 case on 28 February 2020, approximately one month before the World Health Organization designated the outbreak a pandemic. Between March 2020 and February 2022, a suite of public health measures implemented under a four-tier alert system, helped limit spread of the disease within Aotearoa New Zealand. From time-to-time, measures included: lockdown orders; restricting public gatherings; closure of public and commercial premises; strict border controls, including the use of managed isolation facilities for incoming travellers; and mandates regarding mask wearing, social-distancing and, in due course, vaccination for certain essential workers, including members of the health workforce. A COVID 19 vaccine programme was rolled out from February 2021, initially via

centralized vaccination facilities and later, from May 2021 in general practices and then pharmacies (New Zealand Doctor: Rata Aotearoa, 2023).

Government rules and advice from the RNZCGP guided the response in primary care and a number of diversions from business as usual occurred. Firstly, the protection of vulnerable members of the health workforce was addressed, with elderly and immune compromised staff members being removed from direct patient facing roles. To screen for COVID risk, telephone triage was instituted for those seeking appointments during periods of heightened alert. Those with symptoms suggestive of COVID 19 or with recent exposure to the disease were directed to Red Channel clinics to be seen by clinicians wearing full personal protective clothing including gowns, masks, gloves and eye protection. Red Channels were used for both clinical assessments and COVID testing, initially with polymerase chain reaction swabs and later with rapid antigen tests. Often such clinics were makeshift, using tents to provide drive-through facilities in car parks adjacent to usual premises to achieve the recommended levels of ventilation and separation of potential COVID and non-COVID patients. To run both Red Channels and business as usual, or Green Channels, with existing numbers of staff, practice opening hours were reduced and to avoid simultaneous infection of whole workforces, personnel were placed into discrete teams. Video and telephone consultations were used when appropriate, supported by the use of electronic prescribing and lab ordering platforms. Such 'virtual' technologies were in use in some settings prior but gained wider acceptance under pandemic restrictions on face-to-face consultations (Al-Busaidi & Martin, 2020).

Vaccination is a core nursing role in New Zealand general practice, with most nurses gaining authorized vaccinator status allowing them to administer National Schedule immunizations without a prescription. However, during the COVID 19 pandemic several other groups of registered health professionals became provisional vaccinators able to give COVID 19, influenza and measles, mumps and rubella vaccines. For example, physiotherapists, optometrists and podiatrists were eligible; in addition, third-year health science undergraduates, including student nurses, and fourth-year medical students were able to become provisional vaccinators and non-regulated health workers working under supervision could be approved to give COVID 19 vaccinations. A new IT platform, the COVID Immunisation Register was used for immunization documentation and managing vaccine logistics. As with testing, drive through clinics were used in some instances to achieve high vaccination uptake while adhering to infection control guidelines. During periods of lockdown,

drive through clinics were also used for high-volume flu vaccination. With the Omicron outbreak from March 2022, staff in general practice were also involved in the provision of care to COVID positive patients being managed at home under the COVID Care in the Community Programme. This was primarily with the use of telephone contact by nurses. Government funding of COVID care and vaccination greatly increased income to participating general practices during the Pandemic with one PHO reporting COVID income of $71.9M, across its 95 practices in 2021/22. The funding has been seen as buffering underfunding within the capitation model (Johnston, 2023).

2.6.3 Nurses' pay negotiations

During the period of this study, PHC Nurses' pay negotiations focused on achieving parity with nurses in other sectors. The Primary Health Care Multi Employer Collective Agreement (PHCMECA), sets out terms and conditions of employment and rates of pay based on years in practice, level of responsibility and competence including higher rates for those with skillsets which contribute to income generation (New Zealand Nurses Organisation and New Zealand Medical Association, 2021). Over half of New Zealand general practices are signatories to the PHCMECA, which is negotiated annually between employer representatives, latterly the New Zealand Medical Association (NZMA), now defunct, and the New Zealand Nurses Organization (NZNO). NZNO provides union representation and is the professional body for over 90% of New Zealand nurses (New Zealand Nurses Organisation, 2021). In November 2020, NZNO took strike action and thereafter the government funded a 'pay parity step' for senior primary care nurses within PHCMECA-signatory practices (New Zealand Nurses Organisation, 2020b).

2.7 Summary

Figure 2.2 shows the nexus of the multiple actors, elements, discourses, and issues which define the situation of inquiry of this study, within which nursing roles are negotiated. Spokes One to Six of Figure 2.2 show, "…the collective actors and the arena(s) of commitment within which

they are engaged in ongoing discourses and negotiations." (Clarke et al., 2016, p. 14).

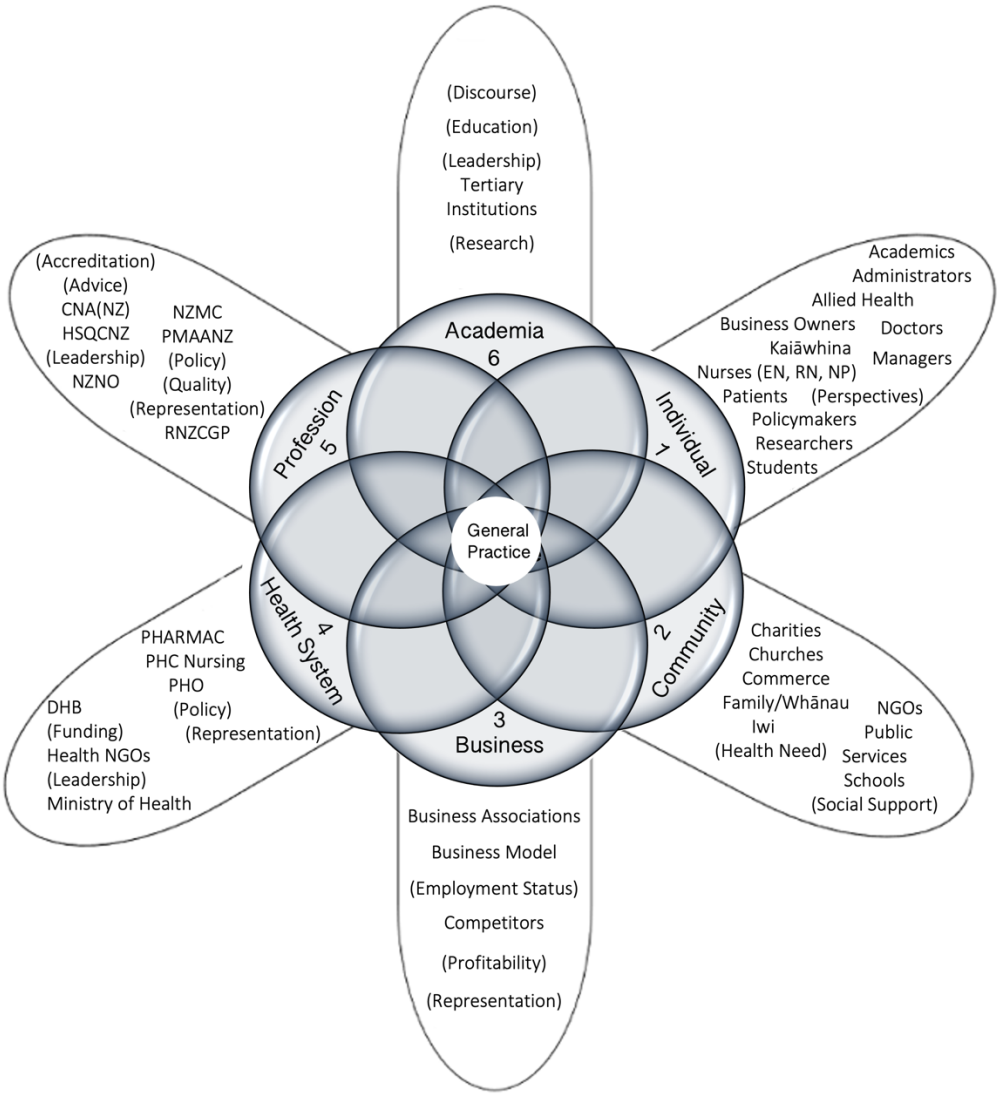


Figure 2.2 Social worlds map of interplay and roles of actors and actants (and their functions) impacting the New Zealand general practice negotiating environment

The individual actors at Spoke One represent the "varied perspectives present in the situation" (Clarke et al., 2016, p. 16). They are presented without hierarchy but have differing levels of power in the situation and differing levels of awareness of and participation in the collective social arenas, Spokes Two to Six. As demonstrated in the preceding discussion the situation of inquiry is complex. There is pressing need for general practice to play its part in addressing issues of health inequity, since not all populations' social and health needs are met, whether by primary care, other public services, or community groups. The private for-profit business model of general practice is juxtaposed with the knowledge that cost is an established barrier to accessing care for disadvantaged groups and that primary care nurses are paid less than their counterparts in (former) DHB employ. Organizationally, the health system and its funding

arrangements are difficult to navigate and in primary care, access to funding by registered nurses is largely mediated through their medical employers. Similarly, professional regulation of the sector, being vested in the RNZCGP has a medical focus, with nursing standards rather being applied at a 'whole of nursing' level. The academic sector supports general practice through education and training and research roles with post graduate study being the pathway to advanced and specialist nursing practice. The innate complexity of general practice is exacerbated by the multiple actors with similar and overlapping functionality, particularly in the areas of leadership and sector representation. Negotiation has been described as a "ubiquitous social activity" (Thompson et al., 2010, p. 492), engaged in whenever cooperation is required to achieve goals. This analysis of the situation of inquiry shows, the complexity of New Zealand general practice creates just such a negotiating imperative.

2.8 Conclusion

In this chapter, by asking the questions, 'Who and what are the actors in this situation?'; 'What is meaningful to the actors in this situation and why?'; and 'How do actors' individual lines of action interact in this situation over time?', and by using situational analysis, I have identified the major elements of the situation of inquiry. In the following chapter, I provide analysis of research relevant to nursing activity within this situation. That discussion will provide further contextual material; identify the knowledge gap addressed by this study; and discuss the development of *theoretical sensitivity*, one of the core aspects of GT method. Further discussion of nursing philosophy is in Chapter 4.

Chapter 3 Using Literature to Develop Theoretical Sensitivity about the Roles of Nurses in New Zealand General Practice

"To be 'open minded' but not 'empty headed'." (McGhee et al., 2007, p. 336)

3.1 Introduction

As introduced in Chapter One, GT is an inductive-abductive methodology used to conceptualize empirical data to create explanatory substantive theory. Unlike in hypothetico-deductive methodologies, where prior knowledge determines principles and concepts to be tested (Toledo et al., 2011), in GT the researcher uses past experience to provide context and to raise awareness of possibilities within the situation of inquiry (Birks et al., 2019; McCann & Polacsek, 2018). This is not unique to the method, Albert Einstein, for example, argued the importance to scientific creativity of "sympathetic understanding of experience", (as cited in Miller, 1992, p. 408). However, here it is termed *theoretical sensitivity* and may be developed through reflexive consideration of personal experience, immersion in the situation of enquiry and by engagement with relevant literature (McGhee et al., 2007). Reflexivity involves considering the validity of knowledge statements and the means of their derivation (Cutcliffe, 2000). This critical approach is called for in GT so that insight and creativity are retained, whilst unwarranted preconceptions are highlighted and their intrusion on the data, its collection and analysis, is militated against.

In this chapter, I present a review of research literature relevant to the roles of nurses in New Zealand general practice. The review is a preliminary exploration of broad themes. As described by Lo (2016), and in keeping with GT method, I returned to the literature throughout the study for the purposes of saturating and situating theoretical elements. As well as providing further contextual information to that described in Chapter Two, building on personal nursing experience, and participation in Health Research Council Project, 'Evidence to Guide Investment in a Model of Primary Care for All', the literature seeded insights into the perspectives of others involved in nursing research in primary care. Reflecting on these matters helped heighten my *theoretical sensitivity* and I identified several conceptual and theoretical possibilities, or "sensitizing concepts" (Blumer, 1954, p. 7), which I also discuss here.

3.2 Scoping review

Scoping reviews map the breadth of literature in a particular field and are exploratory and descriptive in nature (Peters et al., 2020). They may be used to identify gaps in knowledge, and are suitable in the initial stages of GT studies when contextual, rather than theoretical information is required (Birks et al., 2019). Using the five steps of the Arksey and O'Malley Framework (2005), I conducted literature searches to address the review question '*What is known from the research literature about the negotiation of nursing roles in New Zealand general practice*?'. After identifying this research question, I followed the remaining four steps: identifying relevant studies; study selection; charting the data; and collating, summarizing and reporting the results (Arksey & O'Malley, 2005).

3.2.1 Identifying relevant studies and study selection

Due to the breadth of the review question, searches were carried out in three phases. Firstly, to provide international context, I sought global review literature about nursing roles in primary care. Then, to understand the research landscape regarding nursing in New Zealand general practice and to locate any knowledge gap in the substantive area, I reviewed research literature pertaining specifically to Aotearoa New Zealand. Finally, I carried out searches to locate research relevant to the negotiation of nursing roles. A search strategy was developed in discussion with a health sciences librarian. Beginning with a broad search using the terms "nurs*" and "primary care", a marked increase in documents was observed beginning the 1980s; when limiting results to Aotearoa New Zealand, the number of relevant articles rose significantly from the year 2002. The timing of increased research activity followed major events in the primary health care movement. Firstly, the Ottawa Charter (World Health Organization, 1986), which sparked global interest in primary health care and secondly the New Zealand Primary Health Care Strategy (King, 2001), which introduced primary health care objectives into the national health agenda, and impacted nurses in New Zealand general practice. Therefore, subsequent searches were limited to material published from 2000, with searches taking place between October 2019 and March 2020.

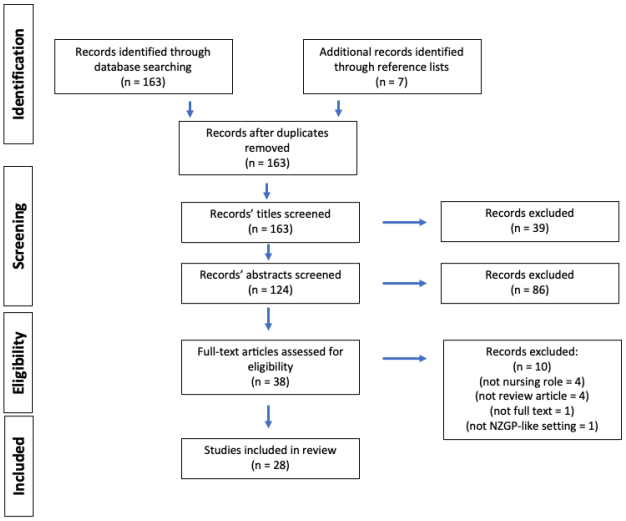
The Population, Concept, Context (PCC) framework (Peters et al., 2020) was used to create search strategies for each phase of the review. PCC and relevant MESH terms and inclusion and exclusion criteria for each phase are shown in Table 3.1. The broadest MESH terms were applied, for example the term 'nursing' was favoured over 'primary care nursing', since

Table 3.1 Population, concept, context framework, MESH terms and inclusion and exclusion criteria

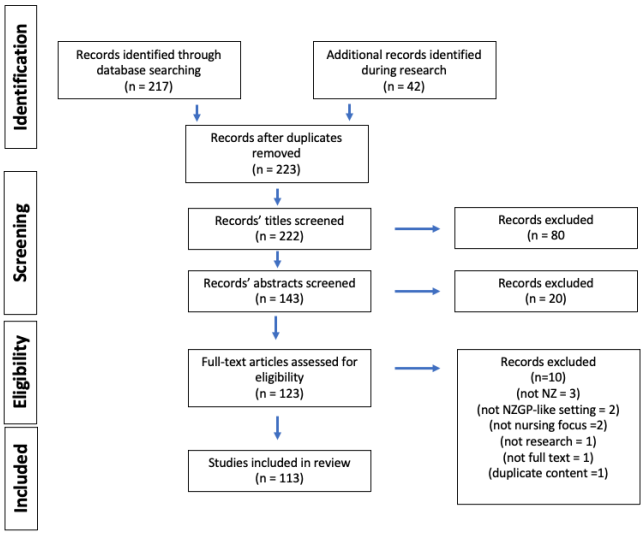
	a. Global Review Literature	b. NZ Research Literature	c. Negotiation Literature
Population	Nursing ["Nurses"] ["Nursing"]	Nursing ["Nurses"] ["Nursing"]	Nursing ["Nurses"] ["Nursing"]
Concept	Role ["Role"]	Research ["Research"]	Role Negotiation["Role"] ["Negotiating"]
Context	Primary Care ["Primary Health Care"] Global	General Practice ["General Practice"; "Family Practice"] NZ ["New Zealand"]; Aotearoa	Primary Care ["Primary Health Care"] Global
Inclusion Criteria	Available in English Published 2000 to 2020 Peer reviewed review article Primary care nursing context Full text available	Available in English Published 2000 to 2020 Peer reviewed research article NZ primary care nursing context Full text available	Available in English Published 2000 to 2020 Peer reviewed article Health care context Full text available
Exclusion Criteria	Not nursing role focus Not peer reviewed review article Editorial, commentary, book review Full text not available	Not nursing focus Not peer reviewed research article Editorial, commentary, book review Full text not available Methodology only Duplicate content Does not include Aotearoa/NZ	Editorial, or book review Does not extend knowledge beyond that gained from global and A/NZ reviews Full text not available

preliminary searches revealed more restrictive terms did not return relevant literature. These and synonyms were used to conduct keyword searches in Scopus and CINHAL electronic databases; wildcard symbols were used to extend word stems. Results of searches were exported, duplicates removed, and remaining articles were reviewed for inclusion by title and abstract. Thereafter, details of those of putative relevance to each phase were collected tabulated including citation, country affiliation of lead author, country of study, whether there was a nurse on the research team, research topic, method, nurse-population, sample size, reason for study and principal findings. The full texts of these articles were then assessed for inclusion. For all phases of the review, literature pertaining to all levels of New Zealand nursing registration, NP, RN and EN, was included. Literature reporting on settings other than primary care was excluded from phases one and two but included in phase three, where processes rather than contexts of negotiation were the focus. The process of paper selection is shown in Figure 3.1 and in all, 162 articles were included in the review. They are tabulated in Appendix 1 by phase of review showing study characteristics.

a. Global review literature



b. New Zealand research literature



c. Negotiation literature

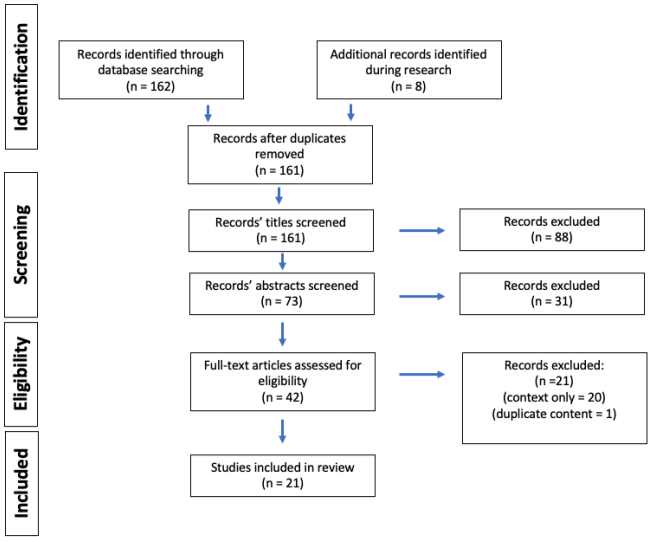


Figure 3.1 Process of paper selection Prisma (Page et al., 2021) flow diagrams a-c.

3.2.2 Global literature

Twenty-eight articles were included in the review of global review literature. By affiliation of lead authors, the research originated in nine countries (Australia, Netherlands, UK, USA, Canada, Finland, Germany, Aotearoa New Zealand, Switzerland) and reported findings from 28 countries as shown in Table 3.2.

Table 3.2 Countries reported on in included global review studies

Country	Number of times included in a study
USA	23
Australia	20
UK	18
Canada	15
Netherlands	14
Aotearoa/New Zealand	12
Sweden	6
Ireland, Finland, South Africa	3
Belgium, Cyprus, France, Germany, Norway, Spain, Switzerland	2
Brazil, Denmark, Guam, Hong Kong, Hungary, Iceland, Italy, Lithuania, Saudi Arabia, Slovenia, Thailand	1
Total number of countries included	28

Twelve of the articles were systematic reviews, one with meta-analysis; and six were integrative reviews. There were three scoping reviews, two narrative reviews, one each of adapted realist review and rapid review and three literature reviews not further differentiated. Most included studies were conducted to inform systemic change, citing increased primary care complexity as the major driver of research priorities. Authors attributed this complexity to a combination of factors impacting both demand for services and the ability of services to meet demand. Three *complexity* themes were identified: *increased demand; changes to health systems;* and *capacity to meet demand*. Firstly, increased demand for services was found to arise from demographic factors including: *ageing populations* (Coster et al., 2018; Keleher et al., 2009; Laurant et al., 2018; Matthys et al., 2017; Murray-Parahi et al., 2016; Norful et al., 2017; Stephen et al., 2018); *increased multimorbidity* (Brown & Psarou, 2008; Laurant et al., 2018; Stephen et al., 2018); *the rise of long-term conditions* (Halcomb et al., 2004; James et al., 2019; Keleher et al., 2009; Laurant et al., 2018; Martinez-Gonzalez et al., 2015; Matthys et al., 2017; McInnes et al., 2015; Norful et al., 2017; Parker et al., 2016; Parker et al., 2009; Parker & Fuller, 2016) and *mental health issues* (Halcomb, McInnes, et al., 2018). Secondly,

it was reported that changes to health systems, including the *transfer of care out of hospitals* (Ladden et al., 2013; Laurant et al., 2018; Lemetti et al., 2015; Maier & Aiken, 2016; McKittrick & McKenzie, 2018; Murray-Parahi et al., 2016), the *adoption of a primary health care approach*, including increased preventive care (Banner et al., 2010; Halcomb et al., 2016; Senior et al., 2019), and efforts to *improve outcomes and address health inequity* (Hoare et al., 2012; Laurant et al., 2018; McKittrick & McKenzie, 2018; Poghosyan & Carthon, 2017), have further increased demand. Thirdly, capacity to meet rising demand, was observed to be compromised by workforce challenges, particularly the shortage of medical professionals and by practitioner burnout (Grant et al., 2017; Jakimowicz et al., 2017; Keleher et al., 2009; Ladden et al., 2013; Maier & Aiken, 2016; Martinez-Gonzalez et al., 2015; McInnes et al., 2015; Norful et al., 2017; Rashid, 2010; Stephen et al., 2018; Van Dillen & Hiddink, 2014).

Against this background, the concept of nurses' role was explored as diversification of models of care away from the previous overriding reliance on GPs or family physicians. An overview of RN roles and responsibilities in primary care, in Australia, Canada, South Africa, Spain, UK, USA, and Aotearoa New Zealand was provided in a systematic review, conducted by Norful et al. (2017). This review highlighted the breadth of responsibilities undertaken, and the transition from mainly task-based delegated activities to more autonomous roles. Hence, primary care nurses were reported to undertake not only clinical tasks such as medication administration, first aid, triage and wound care, and clinical administrative tasks such as patient recall, but to manage long-term conditions and medication regimes. Nurses' broad scopes of practice were cited as aids to flexibility and community responsiveness, and it was proposed that in future medical practitioners would focus on the most diagnostically challenging and multimorbid cases (Norful et al., 2017). Each of the review articles focused on one of two major themes: *nursing effectiveness and efficiency*; and *task-shifting*, including interprofessional collaboration.

Discussion of the *effectiveness and efficiency* of primary care nurses, focused on performance when undertaking non-traditional roles. A Cochrane Review (Laurant et al., 2018), reported that in advanced roles, including nurse practitioner, registered nurse prescribing and chronic disease management, nurses were probably as effective as doctors, in terms of clinical outcomes, with higher levels of patient satisfaction. Other authors highlighted greater patient-adherence to treatment in nurse-led care (Coster et al., 2018; Keleher et al., 2009). These overall findings reflected condition-focused evaluations which reported positive outcomes of nursing

care in managing obesity (Brown & Psarou, 2008; Van Dillen & Hiddink, 2014), diabetes (Parker et al., 2016), and lifestyle risks, such as alcohol and tobacco use (James et al., 2019; Stephen et al., 2018). Much of this discussion was framed in terms of chronic disease care coordination (Parker & Fuller, 2016). Outside roles deemed to be advanced practice, there was less evidence to inform the performance of novel tasks by nurses operating within standard scopes of practice. Such tasks, for example the insertion and removal of long-acting reversible contraceptive devices (Coster et al., 2018), require education and training but not formal amendment to the level of practice by a regulatory body. Therefore, further research at the registered nurse level was advocated (Halcomb et al., 2004; Rashid, 2010). In a review of 18 randomized control trials, Martinez-Gonzalez et al., (2015) reported that nurses were cheaper to employ than doctors. However, they found if nurses spent more time on tasks or had high rates of referral, prescribing or test-use, cost savings were offset by increased resource use.

The transfer of tasks traditionally undertaken by doctors to other health professionals to ameliorate shortfalls in the medical workforce has been termed *task-shifting* (McInnes et al., 2015). Extensive *task-shifting* to nurses was reported in Australia, Canada, Finland, Ireland, UK, US and Aotearoa New Zealand (Maier & Aiken, 2016). This was discussed in the context of collaboration among health professionals. The collaborative practice reported covered a range of situations from close-delegation of tasks to nurses, to autonomous nursing practice (Matthys et al., 2017). It also covered collaboration among nurses in primary and secondary care (Lemetti et al., 2015); the latter necessitated by the transfer of complex cases to community care. Citing general practice nurses' competency at working in multidisciplinary teams and with the frail and chronically unwell, Senior et al., (2019) suggested they have a role to play in team-based palliative care. Again, much of the discussion on *task-shifting* and collaboration centred on advanced practice roles. Nurse practitioners in primary health care were commonly found to focus on the needs of specific cohorts of patients, defined either by disease-state or demographics (Grant et al., 2017). Often, advanced nursing roles, nurse practitioner and other, had been instituted to address social determinants of health, yet such role development in primary care was reported to be *ad hoc*, requiring professional legitimacy and clinical autonomy to be negotiated at the individual level (Jakimowicz et al., 2017; Poghosyan & Carthon, 2017). This in the face of limited understanding of nursing roles among clinical colleagues and the general public (Halcomb et al., 2016). Such lack of role clarity was found to be exacerbated by poor articulation of nursing skills and competencies, and limited education and career pathways at the national level (Parker et al., 2009). Moreover, concerns were raised

about a lack of primary health care content in undergraduate nursing curricula (Murray-Parahi et al., 2016). Banner et al., (2010) considered changes to nurses ways of practicing in the context of primary health care innovation and responsiveness to population health need through the development of existing, or the creation of new, roles. New roles were discussed in the context sf specific models of care. As such, McKittrick and McKenzie (2018) highlighted the relevance of nurses' patient advocacy skills to enhancing primary care capacity within the health care home model and called for barriers to optimum use of nursing scope to be addressed through health workforce reform. They stressed the role of government in encouraging local services to match their workforce skills to the needs of the local population. Similarly, the role of government in setting robust clinical governance parameters was discussed as an enabler of nurse role development (Hoare et al., 2012).

3.2.3 New Zealand literature

One hundred and thirteen articles were included in the review of the New Zealand literature. Again, the rationale for study was increased complexity of primary care. Forty-six per cent of articles used a qualitative methodology, 37 per cent were quantitative and 16 per cent used mixed methods. Most were descriptive and used stakeholder experience, collected as survey and/or interview data. Most often the research (78%) concerned practice nurses at the registered nurse level of practice. Seven per cent discussed nurse practitioners in primary care and five per cent referenced practice nurses in the broader context of primary health care nursing. Much of the research was conducted in the larger population centres as illustrated in Table 3.3. and nine major research topics were apparent, as illustrated in Figure 3.2.

Table 3.3 Regions reported on in included New Zealand studies

NZ Region[1]	Number of times included in a study
Auckland (*South Auckland (6), West Auckland (1), North Auckland (1)*)	16
Waikato	4
Wellington	4
Bay of Plenty, Gisborne, Hawke's Bay, Manawatu-Wanganui, Northland	2
Taranaki	1
North Island Other	5
North Island Total	40
Canterbury	7
Otago	3
Southland, West Coast	1
South Island Total	12
Total number of regions included	13

1. A further 63 articles were pan-Aotearoa/New Zealand.

Around a quarter of included articles focused on *models of care*, with studies describing and evaluating nurse-led care (Coppell et al., 2017), population health initiatives (Tipene-Leach et al., 2013) and *task-shifting* from doctors. As in the global literature, *task-shifting* to nurses was found generally effective clinically, with caveats being applied regarding financial efficiency, due to reported longer nurse consult times and the perceived need for medical supervision (Hefford et al., 2011). Challenges faced in implementing new models of care were reported to include the fixed orientation of practice workflows to the support of GP consults (Kenealy et al., 2010),

Figure 3.2 The nine major research topics apparent in the New Zealand literature

funding and regulatory complexity and the need for better nursing leadership and access to training (Nelson et al., 2009). Indeed, nine studies reported *education and training* issues, including calls for inter-professional development programmes (Bidwell & Copeland, 2017; Pullon & Fry, 2005) and for condition-specific upskilling, for example for mental health practice (Prince & Nelson, 2011). As in the global context, the lack of primary health care content in undergraduate programmes, was discussed (Betony & Yarwood, 2013). This was found to be a factor in influencing preferences for areas of practice among new graduates (Wilkinson et al., 2016). Consideration of the *impact of policy* settings highlighted how clinical governance regimes linked to outcomes criteria could promote nurse-led care (Hoare et al., 2012). However, using funding mechanisms alone to drive behaviour toward policy goals was found to be less successful (Finlayson et al., 2012).

Under the theme of *workforce characteristics*, researchers analysed the association of nurses' professional knowledge with outcomes (Daly, Arroll, et al., 2013; Desmond et al., 2011). Others explored the challenges of meeting increased demand for primary health care practitioners (Daly et al., 2018) in the face of shortages of doctors, nurses and pharmacists (Goodyear-Smith & Janes, 2008). In particular, the need to improve the ethnic diversity of the workforce in the context of culturally safe care was reported (Ape-Esera et al., 2009). This linked to concerns about patient satisfaction where there was a cultural mismatch between patient and nurse (Halcomb et al., 2015). However, like the international literature (Laurant et al., 2018), New Zealand articles reporting *patient experience*, found consumers generally satisfied with the nursing care they received (Halcomb et al., 2015), notwithstanding reports of over-reliance on patient education rather than collaborative goal setting (Macdonald et al., 2013). Nurses' *professional attitudes and behaviours* were explored in papers examining attitudes towards the performance of sexual health checks (McKernon & Azariah, 2013) and diabetes care (Kenealy et al., 2004). Ways of interacting with patients (Plumridge et al., 2009) and the use of care plans (Doolan-Noble et al., 2015), best practice evidence (Prior et al., 2010) and standing orders (Taylor et al., 2017) were also considered. Behaviours regarding self-care featured, addressing issues such as tobacco use among primary care health professionals (Christie et al., 2017). *Practice characteristics*, that is how individual general practices were organized, like workforce characteristics, were reported in relation to outcomes (Humphrey et al., 2016; Keenan et al., 2013; Warren et al., 2017). Descriptive studies of practice characteristics with large sample sizes found a high degree of organizational similarity across practices (Leitch et al., 2018). However, smaller case studies of providers in rural settings

(Raymont et al., 2015) and with differing ownership models (Walker, Clendon, & Nelson, 2015) emphasized differences in nurses' roles and responsibilities.

The discussion of *nurses' role development* by and large described experiences of those who had become nurse practitioners, nurse prescribers and clinical nurse specialists. Here, nursing practice alignment with the social dimension of health was emphasized and a tension between that and the medical model identified (Kirkman et al., 2018). Often this was related to funding constraints (Carryer & Adams, 2017; Carryer et al., 2011). These tended to promote the doctor provider model and in the absence of clear national nursing frameworks and support networks, it was reported that those in advanced nursing roles had to work hard to practice within a nursing paradigm (Adams & Carryer, 2019; Carryer et al., 2011; Gagan et al., 2014; Officer et al., 2019). At the same time, advanced roles such as nurse prescribing, were found helpful in forging broader interprofessional collaboration between doctors and nurses (Lim et al., 2015; Lim et al., 2017). In studies of *teamwork* in New Zealand general practice, communication was found to be key and necessary to bridge understanding among members of the multidisciplinary team. Misunderstanding was attributed to stove-piped training and education pathways and an absence of specific teamwork training (Pullon et al., 2009). Therefore, organizational practices such as dedicated meeting time and the articulation of shared goals were deemed important facilitators of collaboration (Finlayson & Raymont, 2012; Pullon et al., 2016; Young et al., 2017).

3.2.4 Summary of global and New Zealand literature

In both the global and New Zealand research literature the focus was on *collaborative practice* and *task-shifting* as a response to the complexity of primary care due demand, changes to the health system and the exacerbating effects of shortages of health professionals, particularly doctors and nurses. The effects of context, including political climate, cultural organizational, and educational factors, were repeatedly explored and barriers and facilitators of teamwork identified.

Although nursing is the largest health profession and, working at the top of scope, is widely considered to be key to the future of primary health care, the literature reports several factors affecting its ability to fulfil expectations. As with medical general practitioners, the primary care nursing workforce in many countries is ageing and nurse training programmes were

reported to focus on secondary care nursing at the expense of primary health care skills and knowledge. Moreover, in many countries a nursing career in primary health was seen as offering fewer opportunities for advancement and fair remuneration than in other sectors (Murray-Parahi et al., 2016). Therefore, commentators highlighted the need to provide *ab initio* and ongoing training for practice nurses during degree programmes and beyond (Banner et al., 2010; Ladden et al., 2013). Career frameworks for primary health care nurses, including those in general practice are in various stages of development globally but their application is hindered by the individual business model active in many places (Parker et al., 2009). Medically-focused ownership, business and funding models (Keleher, 2001) wherein the medical general practitioner is service provider and the employer of nurses were discussed as limiting nurses' autonomy, denying them the ability to access funding and excluding them from decision-making forums. In the face of competition from new categories of health workers, such as PAs at the higher level of practice and HCAs at the lower, some cited sector hesitancy to employ registered nurses due to cost (Norful et al., 2017). There was a high degree of commonality in findings across jurisdictions and over time. The major barrier to optimizing skill-mix across the professions was the vesting of fee-for-service, task-orientated funding in medical practitioners. The principal facilitator of teamwork was open communication in the context of shared goals.

3.2.4.1 Knowledge gap

Several authors stated explicitly that team members needed to be able to negotiate roles at the practice level (Gucciardi et al., 2016; McKittrick & McKenzie, 2018). In other articles this was implicit from discussion of the effects of local contexts (Banner et al., 2010; Nelson et al., 2009). However, the processes of such negotiation were not reported, representing a knowledge gap. Therefore, the review of global and New Zealand literature highlighted the pertinence of the question addressed in this thesis, '*How are the roles of nurses in New Zealand general practice negotiated*?'. Moreover, engagement with the global and New Zealand literature prompted the following questions: 'What aspects of role were negotiable?', "What was the effect of context on negotiation?' and 'Who were the actors in any negotiation?'. I used these three questions to guide review of the negotiation literature.

3.2.5 Negotiation literature

Twenty-one papers were included in the review of negotiation literature using the search strategy outlined in Table 3.1. Studies reported findings from 29 countries as shown in Table 3.4. Reflecting the themes encountered in the global and New Zealand literature, the negotiation literature discussed *collaboration* among health professionals and *negotiating the professional-boundary* between medicine and nursing in the context of *task-shifting*. Accordingly, most *things negotiated* related to division of labour, including task allocation between doctors and advanced practice nurses (Choi & De Gagne, 2016; Cody et al., 2020; Gysin et al., 2019), and between doctors and registered nurses, or equivalent. The discussion covered scenarios in which tasks were delegated but supervised and others in which tasks were devolved, giving the nurse greater professional autonomy (Aerts et al., 2020; Solimeo et al., 2015). Where full autonomy was not achieved, nurses were seen to negotiate for influence over clinical decision-making by advocating on behalf of patients (Merrick et al., 2015).

Table 3.4 Countries reported on in included negotiation studies

Country Name	Number of times included in a study
Australia	6
Canada, UK, USA	5
Italy, Netherlands, Switzerland	2
Belgium, Columbia, Congo, Finland, Germany, Haiti, Hong Kong, Lesotho, Malawi, Malta, Mauritius, Aotearoa/New Zealand, Norway, Saudi Arabia, Slovenia, South Africa, Spain, Sweden, Tajikistan, Uganda, Yemen, Zimbabwe	1
Total number of countries included	29

Consideration of the appropriateness of task delegation or devolvement included discussion of attitudes towards nursing scopes of practice. It was recognized that scopes of practice are stated in broad terms and subject to underpinning legislation, are intended to be enabling of role development. Therefore, they must be negotiated in the context of the level of nursing registration and individual nurses' educational and experiential preparedness within particular areas of practice (Schluter et al., 2011). Negotiation to establish individual scopes and the autonomy and resources necessary to enact them, often involved establishing credibility or status and respect for nursing roles. For advanced practice roles, this involved forming an identity encompassing both medical and nursing paradigms, whilst striving not to compromise the later (Côté et al., 2019). This and discussion about the moral dilemma of meeting the

normative expectations of particular roles, where they differ from one's own (Cribb, 2011), introduced the concept of negotiating with self. This included managing "feelings of inadequacy" (Schluter et al., 2011, p. 1215).

The concept of "patient-proximity" recurred in the literature (Merrick et al., 2015; Miller & Kontos, 2013; Schluter et al., 2011, p. 1214). Nurses reportedly conceive their professional identity and knowledgebase to be legitimized by the closeness of the nurse-patient relationship and so, prioritize negotiation for time, space and materiel to provide patient-centred care (Gucciardi et al., 2016; Josi et al., 2020). Their ability to negotiate control over such resources was found to be highly *context* dependent (Côté et al., 2019). However, the success of teams was found to rely on individuals' commitment to active negotiation (Liberati, 2017; Schadewaldt et al., 2016; Solimeo et al., 2015). Clarity of purpose at the organizational level was a major enabler of individual proactivity (Aerts et al., 2020; Sangaleti et al., 2017).

The imperative to negotiate roles was reportedly heightened in environments with high patient acuity (Liberati, 2017; Schluter et al., 2011), complexity of demand and other drivers of high workload (McInnes et al., 2017b; Schluter et al., 2011). Here, the necessity for all team members, clinical staff and others to contribute at the top of their scope meant that *actors* in the negotiation included not only nurses at all levels of registration and doctors (French, 2005), but managers (Schadewaldt et al., 2016), educators (Gucciardi et al., 2016) and policymakers (Chapple et al., 2000). A systematic review of experiences of collaboration in primary care, (Sangaleti et al., 2017) summarized the challenges to effective collaboration as having ideological, organizational and interpersonal dimensions which are experienced as a process. This process itself was not explored but was recommended as a focus for further research, underscoring the relevance of this study.

3.2.5.1 Theoretical comments

A number of articles in the negotiation literature approached the discussion from a particular theoretical standpoint. Bosque (2011), defined collaboration as a process of working together towards common goals in the absence of formal hierarchy. She used collaboration theory to explore the relationship between nurse practitioners and doctors in a neonatal setting and outlined five principles of collaboration: collaboration is an imperative; collaboration is multi-dimensional, recursive and personal; and collaboration develops in stages. Negotiated order

theory was used by a number of authors who discussed the medical nursing boundary in terms of *structural determinants* and *processes of social interaction* (Chapple et al., 2000; Liberati, 2017). Gidden's structuration theory was used by Cote et al., (2019) to explicate the interplay between actors actions and structural boundaries to study nurse practitioner roles, regarding ideas of motivation and meaning of work. Finally, Cribb (2011) discussing the moral stress engendered by occupying a professional role, used aspects of role theory to explore his topic. A theme of responding to fixed and changing normative expectations was apparent in each of these discussions. However, in keeping with GT methodology I did not explore the detail of the underpinning theories during this literature review (Ramalho et al., 2015). The information gathered was treated as data and the various theories were noted for consideration during the later methodological step of *theoretical integration*. Therefore, further discussion of these matters is in Chapters Six and Seven.

3.2.6 Sensitizing concepts

As further discussed in Chapter Four, a concept is an agreed naming convention for a phenomenon which defines parameters by which empirical instances may be recognized (Hewitt et al., 2022). Concepts will always be to some degree provisional. However, the term "sensitizing concept" refers specifically to a loose framing of ideas which does not classify objects, but which can point out that which is relevant, problematic, and explanatory and suggest ways of engaging with phenomena (Blumer, 1954, p. 7). The identification of *sensitizing concepts* is a tangible indicator of the development of *theoretical sensitivity*. From the questions prompted by the global and New Zealand literature review I developed sensitizing concepts in the domains of *context, actors*, and *things negotiated,* as shown in Table 3.5. In addition, from the negotiation literature, several *processual* concepts - short of theoretical codes - of potential significance were identified.

Table 3.5 Sensitizing concepts

Context	Actors
Complexity of demand	'All of team'
Nursing – medicine boundary	Educators
Goals organizational and individual	Managers
Workforce constraints and opportunities	Nurses at all levels of registration
	Policymakers
Things negotiated	**Process**
Autonomy	Contextual imperatives
Patient proximity	Interplay between structural and individual elements
Resource – social and materiel	Normative expectations
Scope of practice	Self-negotiation
Status/ identity	Goals organizational and individual
Task allocation	

Across the 162 articles reviewed there was much commonality of experience and evidence of strong normative expectations of what nurses roles should be. Authors described systemic constraints on the development of nursing roles arising from issues of funding and employment models, educational opportunities and sector leadership (Pullon et al., 2009) but there was little focus on how these challenges are dealt with within practices. Additionally, few studies were definitive regarding the effect on health outcomes of nursing activity. This reflects the difficulty of identifying robust primary care outcome measures across the range of interconnected health issues with which people present to primary care (Murphy et al., 2014).

3.2.7 Effect of literature review on personal positionality

As stated in the introduction to this chapter the development of *theoretical sensitivity* requires a reflexive approach, in which researchers consider their own and participants' past experiences, attitudes and beliefs and critically reflect on how they combine during research (Cutcliffe, 2000). By engagement with the literature as described, I hoped to development greater understanding of the issues important to those in the field and to situate my own positionality within this community. My own belief in the potential for transformation of health services to address unmet health need was a key proposition in many of the studies reviewed. With two-thirds of included articles having at least one nurse author, this included arguments for the better use of nursing scopes of practice. However, the tension between profit and care outcomes in general practice and the unproven financial efficiency of nurse-led care over medical care were also highlighted, (Hefford et al., 2011). Here I note that there is limited knowledge about the effectiveness, financial or otherwise of New Zealand general practice in

the round (Downs, 2017) and it is health systems framed in a medical model which are in crisis. Therefore, I contend, since the identified drivers of primary care complexity are at the population level, they are amenable to the application of nursing knowledge in established areas of nursing expertise including health promotion, care coordination, secondary prevention and patient advocacy (Ortiz, 2019).

3.3 Conclusion

In this Chapter, building on the personal and situational context explored in Chapter One and Two, I have analysed research relevant to the putative research problem and located a knowledge gap regarding the negotiation of nursing roles in general practice. In the following chapter, I address the philosophical and methodological assumptions and decisions that led to the selection of my particular research approach.

Paper 2. Statement of contribution doctorate with publications/manuscripts

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

GRADUATE RESEARCH SCHOOL

STATEMENT OF CONTRIBUTION DOCTORATE WITH PUBLICATIONS/MANUSCRIPTS

We, the student and the student's main supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the student's contribution as indicated below in the Statement of Originality.

Student name:	Sarah Louise Hewitt
Name and title of main supervisor:	Professor Nicolette Sheridan
In which chapter is the manuscript/published work?	Four

Describe the contribution that the student and members of the supervisory team have made to the manuscript/published work:[1]

Sarah Hewitt Formulated the philosophical insights, conceived the arguments and wrote the paper

Jane Mills - Reviewed it critically for important intellectual content and methodological coherence
Karen Hoare - Reviewed it critically for important intellectual content and to highlight the novelty of the content
Nicolette Sheridan - Reviewed it critically for logic, readability and important intellectual content

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Chapter 4 Belief, Reality and the Nature of Knowledge

"The ideological construction of nursing has changed over time, with the relative power of the underpinning philosophies changing in response to societal and professional demands … away from a focus on the positivist approach to care (which saw the need for scientific 'proof' as an underlying feature), to a more postmodern interpretation which identifies a range of possible realities and interpretations of the 'truth' of any given situation." (Richardson, 2004, p. 36)

4.1 Introduction

In Chapter One, I introduced my worldview and the philosophical basis of this study. I identified myself as a pragmatic pluralist, educated in the positivist paradigm, but with an appreciation of the socially constructed nature of knowledge. Considering ontology and epistemology, I outlined why constructivist GT methods informed by the SI paradigm were used as a methodology to answer the question: 'How are the roles of nurses in New Zealand general practice negotiated?'. In this Chapter, I expand on that methodology, principally in the published paper, "Grounded theory method and symbolic interactionism: Freedom of conceptualization and the importance of context in research". However, having considered my own worldview and positionality in Chapter One and Three, I first consider issues of positionality and philosophy in *nursing* and how they relate to research methodologies. As suggested by Richardson, in the opening quote, these issues are multivariant and dynamic and as introduced in Chapter Two, impact the situation of inquiry. In a reflexivity statement, considering such perspectives and my own and the Alvesson and Sköldberg model of reflexivity, I acknowledge the potential impact of positionality on my research decisions and conclusions; in keeping with constructivist methodology, this is not to discount my viewpoint but to locate it.

4.2 Nursing philosophy in practice and research

Like any discipline, nursing has a body of knowledge, comprising and created in the context of normalized practices, extant theories and conceptualizations, and particular research methodologies (Smith, 2019). Together these components amount to the *philosophy of nursing*. It is important to understand such nursing *ways of knowing*, since they are the precursors of *ways of doing* and predispose behaviours (Reybold, 2002) in the researcher and research participants.

Following developments in nursing education and practice over the twentieth century, numerous new nursing theories emerged in the 1980s. Therefore, this period has been said to mark nursing's transition from a pre-paradigm to a paradigm era (Alligood, 2018). In 1984, Fawcett contextualized the extant range of nursing paradigms, theories and perspectives, proposing a nursing *meta-paradigm* comprising the concepts of *person*, *environment*, *health* and *nursing*. Thereby, she aimed to define a distinct *domain of nursing knowledg*e, separate from its historical construct within biomedical knowledge (Smith, 2019). Whereas medicine is "…crisis oriented and illness focused." (Carryer et al., 1999, p. 8), nursing is about enabling health.

Like any concept, *health* is a construct with a range of meanings. Rather than a commodity to be supplied, it is the product of the lived experience of individuals and communities and is mediated by culture. The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease" (World Health Organization, 2023a). This definition goes beyond the biomedical model and begins to allow for biological, cultural and social diversity among peoples including Indigenous perspectives, which "emphasize[s] the interconnectedness of physical, spiritual, mental and emotional health" (Bautista-Valarezo et al., 2020). In Aotearoa New Zealand, an approach to health capable of strengthening "self-determination, identity and connection to the environment" is seen as key to the success of initiatives to improve Māori health outcomes (Reweti et al., 2023, p. 11). The Māori health model Te Whare Tapa Whā and the Pacific framework Fonofale, use the metaphor of a meeting house to integrate concepts of spiritual, mental, social and physical wellbeing within a cultural and environmental context. They emphasize collective wellbeing and connection to land and extended family and have been used successfully to engage populations in health programmes (F'asisila et al., 2022).

Fawcett's nursing *meta-paradigm* has been subject to much re-examination and criticized as offering little that is actionable in nursing practice or research. To re-conceptualize, Bender (2018) asked why notions of *person*, *environment*, *health* and *nursing* are important to nurses, finding that it is an understanding of the relationships among the domains that begins to characterize the profession:

> *"What exists for the nursing discipline is not already demarcated domains of nursing, person, health, and environment, but rather interdependent relations that constitute people, including nurses, in their health/environment circumstance, which comprises nursing's unique, fundamental point of access in the world." (Bender, 2018, p. 6).*

The relevance of each domain is determined and redetermined from time to time, place to place and person to person, according to patients' lived experiences. As such, and when this is understood and enacted by its practitioners, nursing practice can embrace multiple health perspectives including Indigenous worldviews. Moreover, a practical understanding of nursing ethics, beyond bioethics and including social ethics and advocacy, can equip nurses to address health inequity. Benner et al., (2008), reporting the experiences of student nurses in the USA reported six themes of everyday ethical concern to nursing practice: meeting the patient as a person, rather than a *case*; preserving patients' dignity; responding to poor practice; advocacy; being with patients in suffering; and *doing good*. These ethical or axiological (Brown & Dueñas, 2020) themes highlight that nursing and nurses are not value-neutral and so neither is their practise nor their research endeavours.

Whilst nurse philosophers attempt to define a paradigm to unify nurse scholarship, it is recognized that nursing incorporates a range of ways of understanding. Consequently, a range of paradigms are used in nursing research (Weaver & Olson, 2006) from positivism, which underpins the traditional medical model and the establishment of facts relating to physiology and disease, to interpretive worldviews which stress the importance of context and the lived experience when seeking to provide an evidence-base for the interpersonal act of nursing (Will, 2016). On a continuum from positivism to critical social theory, research paradigms vary as to ontology and epistemology (Durham et al., 2015), as illustrated in Table 4.1.

Table 4.1 Research paradigms used in nursing their ontology and epistemology

Positivist (Corry et al., 2019)	Post-positivist (Corry et al., 2019)	Critical realist (Peng & Shiyu, 2019)	Constructivist-Interpretivist (Brown & Dueñas, 2020)	Critical Social Theory (Weaver & Olson, 2006)
Single, objective observable reality	Single objective reality, only partially knowable through observation	Multiple objective realities, context dependent and unknowable through observation	Multiple subjective truths, each constructed by human social interaction	Multiple subjective realities, negotiated and experienced in the context of differential powerbases among groups within society
Pragmatic (Scheffler, 2012)				
No objective truth, means of knowledge derivation are appropriate where they produce useful outcomes				

Positivism is a way of thinking, that accepts that there is an underlying truth in any situation which may be revealed by careful observation, and which may be used to understand, predict or control future events. Epistemologically, it relies on experimental verification within hypothetico-deductive methodologies. Post-positivism modifies positivism to accept that human observation is imperfect and variable and will produce differing results under differing circumstances; methods of enquiry may nevertheless be experimental (Corry et al., 2019). Critical realism, a philosophical perspective founded by Roy Bhaskar, share with positivism a belief in a reality independent of human understanding (Peng & Shiyu, 2019). Positivists regard that reality as singular and governed by immutable and predictive laws: critical-realists recognize the real world outside the laboratory as an open system of mechanisms and structures, which combine in context-dependent ways and underpin observed events (Corry et al., 2019; Gorski, 2013; Peng & Shiyu, 2019). Epistemologically, critical-realists see knowledge as socially produced, experiential and therefore value-laden, incomplete and provisional; they allow a plurality of methodological paths to knowledge, while requiring their underlying assumptions to be made explicit (Lipscomb, 2008). The constructivist-interpretivist paradigm sees truth as a negotiated or constructed outcome of human interaction which is contextually situated and experience-based (Ward et al., 2015). The term interpretivist refers to the creation of meaning from perception by each individual and the consequent existence of multiple interpretations of reality (Morgan, 2007). This experiential dependence is shared by critical social theory which includes feminist and emancipatory standpoints and the wish to liberate the disempowered and achieve social justice (Weaver & Olson, 2006). Nursing axiology including ideas of duty and service, whereby the nurse acts on behalf of others to achieve pre-determined goals, is consistent with the 'research as activism' connotations of critical social theory. Pragmatism, often considered an approach rather than a true paradigm (Brown & Dueñas, 2020), emphasizes the importance of practical problem-solving in real

world situations. As such, theoretical research outputs help give meaning to human endeavour and can inform future action. Such outputs may appeal to those "interested in theory to the extent that it can help them do their work better" and can take the form of grand, middle range or substantive theory (Davidoff et al., 2015, p. 228). Grand theory is highly abstract and applicable across a broad range of situations and disciplines. Positivism, with its absolute ontology and epistemology is concerned which such broad assertions. Middle range theory has narrower reach and applicability (Davidoff et al., 2015), and substantive theory is that which provides explanation of particular phenomena within defined situations, with limited power beyond that area of study (Chun Tie et al., 2019). They are nevertheless of practical value in addressing specific phenomena in particular contexts. For example, *programme theory* is a substantive type of theory used in change management to articulate bespoke processes and outcomes (Davidoff et al., 2015).

Recognizing the relevance of different paradigms to different research questions, Weaver and Olsen (2006) advocate a pragmatic approach to nursing inquiry, whereby relevant traditions may be used singly, be integrated or be used in parallel, to explore issues fully. The paradigms illustrated in Box 4.1 are derived in the Western research tradition, pragmatically other worldviews should be considered.

According to Reweti et al., (2023, p. 13), Mātauranga Māori (Māori worldview) is

> *"…founded upon kinship relationships between people and the natural world and the interrelationship of all living things as dependent on each other. Mātauranga is constantly evolving as each new generation learns and adds to the body of knowledge."*

The interconnectedness of all things across time, is highlighted by Mika (2021) as the core tenet of Māori philosophy and he points out the essential disconnect between the Mātauranga Māori focus on the existential and the narrow focus on research questions within Western science. In this context, he highlights the importance of "responsive thinking" (Mika & Southey, 2018, p. 795) as a research strategy he terms Whakaaro. In this, the researcher is open to metaphysical uncertainty and focusing instead on the relationship between the self, participants and researcher, and the "unknowable autonomy" (Mika & Southey, 2018, p. 796) of the external world, seeks to advance knowledge, collectively and always provisionally, through creative cognition. This may be predicated as much on deviation from stipulated lines

of enquiry as on strictly formulaic methods (Smith, 1999). Non-Māori Pacific philosophies are similarly based in holism and connectivity. The Fa'afaletui Framework, one of many Pacific research methodologies (Anae, 2019), references the collective creation of new knowledge by the weaving together of differing perspectives to achieve consensus. Although the Framework shares ontological and epistemological positions with Western paradigms, including critical realism, constructivism and pragmatism (Goodyear-Smith & 'Ofanoa, 2022), the specific importance of kinship and relational accountability within ethnic-specific approaches is highlighted (Anae, 2019).

Although authors seek to delimit nursing practice and research within certain philosophical boundaries, the ubiquity of nursing and its necessary predication on human relationships means it cannot easily be so encapsulated. Therefore, as described numerous approaches within and beyond the scientific tradition may be taken and it may be unnecessary to approach inquiry as 'nursing-research' at all, rather letting the phenomenon of interest and the community of participants steer the research design. Nevertheless, GT is often used within nursing research since as an interpretive methodology it offers a variety of approaches and may be used with any type of data (Singh & Estefan, 2018). In the following section, I discuss the three main GT approaches and their philosophical assumptions.

4.3 Grounded theory

The founders of GT, Barney Glaser and Anselm Strauss, envisaged that the method should develop in response to changing conditions (Glaser & Strauss, 1967) and argued that its users need not adopt a particular philosophy or disciplinary orientation (Corbin & Strauss, 1990). Later, Corbin and Strauss described pragmatism and symbolic interactionism (SI), an interactional perspective from behavioural sociology, as the foundations of constructivist GT (2008) and this aetiology is often ascribed to GT in general (Handberg et al., 2015). GT, as originally described, was ambiguous about the nature of reality (Lomborg & Kirkevold, 2003). However, Glaser and Strauss (1967, p. 239) talked of producing grounded theories that were "faithful to the everyday realities of a substantive area". By recognising that social phenomena are not static, that human experience is a valid path to knowledge and by characterizing theories grounded in specific data as *useful* (Glaser & Strauss, 1967), GT, as first articulated, showed the influence of pragmatism. Where it recognized that human actors behave in accordance with their perception of pertaining conditions, and that their responses are not inevitably pre-

determined by fixed sociological and psychological factors, it touched on aspects of SI (Corbin & Strauss, 1990). Current GT approaches reflect "contemporaneous interpretation" in the context of changing societal forces (Ralph et al., 2015) and mirror adherents' theoretical and conceptual perspectives (Chun Tie et al., 2019). There are three main divisions of GT: classic, evolved and constructivist.

4.3.1 Classic GT

Classic GT is associated with Glaser, to whom it was simply a method, independent of extant theory or epistemological considerations (Salvini, 2019) by which theory can *emerge* through the constant comparative method (Glaser & Holton, 2004), suggesting belief in objective truth discoverable through careful data collection and analysis (Tolhurst, 2012). This is in keeping with his positivist background in quantitative survey analysis and concept-indicator construction (Birks et al., 2019; Glaser & Holton, 2005). However, he also stated, "GT is not findings, not accurate facts and not description. It is just straightforward conceptualization integrated into theory - a set of plausible, grounded hypotheses" (Glaser & Holton, 2004, para. 7). Such assertions, suggest a critical-realist ontology within the post-positivist paradigm (Annells, 1996). Epistemologically, classic GT places the researcher as detached observer (Singh & Estefan, 2018).

4.3.2 Evolved and constructivist GT

In Strauss and Corbin's evolved GT, the possibility of fundamental truth is recognized, as in the statement "grounding concepts in the reality of data" (1990, p. 7), but its discernibility is considered doubtful. Adherents acknowledge that the complexity of the world cannot be captured fully, and that knowledge is always understood from a perspective (Corbin & Strauss, 2008), implying a post-positivist, critical-realist position (Singh & Estefan, 2018) but allowing for a reflexive, rather than objective positioning of the researcher (Timonen et al., 2018). As a student of George Herbert Mead, a leading figure in American pragmatism, Strauss' approach was explicitly pragmatic and interactionist (Corbin & Strauss, 1990; Strauss, 1993) and both he and Corbin believed in the *construction* of theory through interpretation of data (Mills et al., 2006). Corbin, in particular, takes a constructivist viewpoint (Corbin & Strauss, 2008). Constructivism recognizes that the reality experienced by humans is a subjective interpretation or conceptualization of the external world (Berger & Luckmann, 1971) and is, therefore, not fixed, unchanging or "observer-neutral" (Kratochwil, 2008, p. 88). The term also applies to

philosopher and biologist Jean Piaget's theory, in which cognitive development in childhood is seen as dependent upon individuals' experiences of and responses to their environments. The similar term *constructionism* describes the perspective of psychologist Lev Vygotsky, who highlighted the importance of human interaction on the development of understanding (Claiborne & Drewery, 2010). Kathy Charmaz interpreted the method as constructivist GT, using the terms *constructivist* and *constructionist* interchangeably. She (2016) takes a relativist view that truth is not absolute but exists within changing social contexts, varies according to individuals' viewpoints and emphasizes the interactive basis through which knowledge is constructed. Arguably the term constructionism more fully reflects the belief in the interactive and social nature of the construction of meaning underpinning CGT and its view of the CGT-researcher as co-constructor of knowledge (Aburn et al., 2016; Ward et al., 2015).

As explained in Chapter One, GT guided by SI, was selected as an appropriate research design for this study. Specifically, constructivist GT was selected to accommodate the researcher's knowledge as a clinician in the field and in recognition that negotiation and role are interactional in nature.

4.4 Context and conceptualization - Paper 2

The following paper, "Grounded theory method and symbolic interactionism: Freedom of conceptualization and the importance of context in research", published in Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, includes discussion of the tenets of GT and SI and their origins in the Chicago School of Sociology and the philosophy of pragmatism. It considers the importance of processes of conceptualization in knowledge generation and the usefulness of an SI perspective in this regard and describes how and with what outcomes the method and paradigm were combined in this study.

Grounded Theory Method and Symbolic Interactionism: Freedom of Conceptualization and the Importance of Context in Research

Abstract: Symbolic interactionism (SI), a perspective used to understand human conduct, is commonly said to underpin grounded theory methodology (GTM). However, the purpose of GTM is to produce substantive explanatory social theory from data without reliance on prior assumptions. Therefore, some argue that SI is an unnecessary theoretical constraint on the principal aim of GTM—the free conceptualization of data. In this article we use examples from an ongoing constructionist grounded theory study into the negotiation of nurses' roles in general practice in New Zealand, to demonstrate how SI can inform GTM regarding conceptual development and context. We argue that by asking three questions from a symbolic interactionist perspective, at each stage of the research process, freedom of conceptualization may be enhanced, and awareness of contextual matters promoted to better bridge world views.

Section One - Introduction

Individual beliefs and collective knowledge are developed over time in the light of experience. In everyday life, the conversion of belief to knowledge occurs subliminally but in science highly formalized systems of inquiry are used to justify the transition (Douglas & Wykowski, 2011), giving rise to the argument that scientific knowledge is superior to other ways of knowing on epistemological grounds (Wray, 2012). This has implications for the status of qualitative social research which is necessarily situated in the realm of everyday human experience, such that quantitative inquiry in the more reified fields of the natural sciences has traditionally been regarded more highly (Tolhurst, 2012). Against this background, grounded theory methodology (GTM) was first developed in the 1960s by Barney Glaser and Anselm Strauss (1967) who combined their expertise in qualitative and quantitative sociology, to articulate a new system of inquiry. Motivated by the wish to promote and legitimize empirical theory generation in sociology, they presented a method by which data could be "systematically obtained and analyzed" (p.1). Their introduction of GTM marked a break from the hypothetico-deductive method (Haig, 1995) and provided greater rigour and structure in the field of qualitative social research at a time when quantitative methodologies were considered superior (Bryant & Charmaz, 2007). The term grounded theory refers not only to the method of inquiry but to the novel explanatory theories that are its intended products (Birks & Mills, 2015). Importantly, such theories are developed directly from the data and not from preconceived

theoretical frameworks (Butler et al., 2018) with free conceptualization of data at the heart of the method (Glaser & Holton, 2004).

Over time, despite extensive philosophical debate and methodological variation within GT, free conceptualization has remained central to its appeal (Tolhurst, 2012). However, two difficulties arise. Firstly, conceptualization is a skill (Glaser, 2002) which some researchers struggle to master despite immersion in the methodology (Birks et al., 2019; Glaser, 2011), and abstraction, one of the key tenets of GTM (Reichertz, 2007), is often missing. This has given rise to outputs which are merely descriptive, rather than explanatory (Glaser, 2019). Secondly, as conceptualizations are linguistic constructs, used to convey meaning for human purposes (Schmitter, 2008), their formation is unavoidably influenced by context, including differing beliefs about the nature of reality and how it may be understood (Bang et al., 2018). Therefore, it is difficult to eliminate preconception and in analyzing data, concerns may arise about data contamination (Birks et al., 2019).

Symbolic interactionism (SI) is a leading perspective and method within behavioural sociology, in which interaction is seen as the key to human behaviour and the construction of meaning (Carter & Montes Alvarado, 2018), and which has the potential to explicate the process of conceptualization and the place of context in knowledge generation. It has long been associated with GTM (Aldiabat & Le Navenec, 2011; Chamberlain-Salaun et al., 2013), and is almost invariably said to underpin GTM (Glaser & Holton, 2004). However, some regard SI as a preconceived theoretical constraint (Newman, 2008), and at odds with the stipulation that GT researchers should "take the elevator from the ground floor of raw substantive data and description to the penthouse of conceptualization and general theory. And do this without paying homage to the legacy of extant theory" (Gummesson, 2002, p. 586).

In this article, we discuss how the understanding and practice of conceptualization in GTM may be aided by framing the study with an SI perspective. We consider the general implications of conceptualization for knowledge generation in the social sciences (Section 2). Recognizing the importance of perspective in this regard, we then address the origins of GT and SI in the Chicago School of Sociology and explain their links to the philosophy of pragmatism (Section 3), before describing the tenets of SI and GTM (Sections 4 and 5). Using examples from an ongoing constructionist GTM study into the negotiation of nurses' roles in general practice in New Zealand, we go on to illustrate how, by asking three questions based on the principles of

SI, insight into the process of conceptualization upon which GTM relies may be gained and matters of contextual importance in the situations they study may be identified (Sections 6 and 7).

Section Two - General Implications of Conceptualization for Knowledge Generation in the Social Sciences

Specific language or imagery is required to define, retain and communicate knowledge. As such, knowledge statements are conceptualizations: language assigned to reality, rather than the voice of reality itself (Schmitter, 2008). In psychological terms, concepts are created through cognitive activity, prompted by perception of phenomena, and acquire shared meaning through interaction between individuals (Sharifian, 2003). Therefore, knowledge is experiential, and among those with shared experience, similar interpretations of reality develop (Kastanakis & Voyer, 2014; Smith, 1999). Such interpretations are subjective (Berger & Luckmann, 1971) and neither fixed nor "observer-neutral" (Kratochwil, 2008, p. 88); rather, they are culturally situated. For example, within established fields of study the definition of concepts and how they should be used to engage with the world is moderated by communities of academics through peer review (Kratochwil, 2008). This creates schools of thought, paradigms (Hall et al., 2013) or traditions, within which specific theoretical and conceptual frameworks provide criteria against which research assumptions are tested (Lynch et al., 2020).

In sociological research, confidence in research findings is undermined where assumptions are tested narrowly against institutional values and research practices which privilege particular traditions. Discussing research agendas of Indigenous communities in the context of colonialism, Smith observed, "research is not an innocent or distant academic exercise but an activity that has something at stake and that occurs in a set of political and social conditions" (2021, p. 5). Therefore, it is important to be clear about how the chosen system of inquiry is used to generate knowledge (Bryant & Charmaz, 2007) specific to the phenomenon of interest and the philosophical positions of both researchers and participants. Within the institutions of research, outputs are held to be reliable where the system of inquiry, philosophical frameworks and lenses interconnect meaningfully to support the aims of any study and methodological congruence is said to be demonstrated (Tracy, 2010). To be truly meaningful in the world, to promote the public understanding of science and facilitate implementation of research findings, broad context relevant to participants and their communities must be included (Canfield et al., 2020).

In the first half of the twentieth century, the Chicago School of Sociology developed under the influence of American Pragmatist Philosophy at Chicago University (Cortese, 1995). The Chicago School of Sociology is a school of thought based on pragmatist philosophy. Members of the Chicago School developed concepts and research practices which challenged the hypothetico-deductive, or experimental, research paradigm previously dominant within sociology (Haig, 1995; Kennedy & Lingard, 2006). Recognizing the importance of context, they advocated for researchers to go out and study social phenomena in the real world and aimed to generate knowledge through abductive "practical reasoning" (Brinkmann, 2017, p. 11).

Section Three - The Chicago School and the Shared History of Pragmatism in SI and GTM

Drawing on Charles Pierce's late nineteenth century writing, pragmatism gained traction with the work of William James, who characterized its effect thus: "It means the open air and possibilities of nature, as against dogma, artificiality, and the pretence of finality in truth" (1907, p. 51). In pragmatism, knowledge and theory are viewed as devised tools for living, rather than revealed truths, allowing for change in meaning over time and in the light of experience. Pragmatists focus on human action and the creation of useful knowledge through interaction with the environment and admit ways of knowing beyond science. They acknowledge, for example, the place of values, custom, the arts, and religion and make no categorical distinction between scientific and lay knowledge (Scheffler, 2012).

The works of Chicago's American pragmatist philosophers and psychologists, George Herbert Mead and John Dewey in the fields of symbolism and intelligence, concern the nature of interaction and the intimacy between individuals and the circumstances of their existence (Handberg et al., 2015; Scheffler, 2012). Although GTM was presented as a break from traditional thinking (Bryant, 2009), these works inform SI and GT, both of which focus on meaning to be found in interactive experience. Thus, a shared foundation in pragmatism links SI and GTM methodologically (Chamberlain-Salaun et al., 2013). The term symbolic interactionism was coined by Herbert Blumer at Chicago, in his interpretation of the work of Mead and other pragmatists during the 1950s and 1960s (Charon, 2010). Strauss trained in the Chicago School (Gerhardt, 2000), focusing on qualitative research (Bryant & Charmaz, 2007). Prior to his collaboration with Strauss at the University of California in San Francisco, Glaser's experience was in positivist quantitative survey analysis and concept-indicator construction at

Columbia University (Birks et al., 2019; Glaser, 2005). In keeping with Glaser's background and the then dominant scientific paradigm, several assertions in "The Discovery of Grounded Theory" (Glaser & Strauss, 1967) reflect positivist ontology; for example, the idea that theory emerges from the data before a detached observer suggests belief in objective discoverable truths (Tolhurst, 2012). However, in recognizing that social phenomena are not static, that human experience is a valid path to knowledge, and by characterizing theories grounded in specific data as useful, in the first articulation of GTM, Glaser and Strauss (1967) reflected the influence of pragmatism. Aspects of SI, including the acceptance that human actors behave in accordance with their perception of pertaining conditions, and that their responses are not inevitably pre-determined by fixed sociological and psychological factors, are also apparent in the original version of GTM (Corbin & Strauss, 1990).

Section Four - The Tenets of Symbolic Interaction

Blumer characterized SI as the formative social process, a distinctive “analytical scheme of human society and human conduct” (1969, p. 6), which provides an empirical basis for understanding the social world. He refuted ideas of behaviour being pre-determined by culture or social organization in a fixed and fatalistic way and saw SI as a set of principles to be applied when "attempting to come to grips with the obdurate character of the empirical world under study" (p.26). From a symbolic interactionist perspective, meaning is constructed through human group life wherein individuals continuously act, and understand, in the moment, in interaction with themselves, their environment and other human actors. Objects in the environment, which may take any form—physical, human, linguistic, spiritual, indeed anything which may be perceived—acquire meaning for individuals through experience, and interaction occurs within situational contexts that also have acquired meanings (Blumer, 1969). Meanings associated with objects and situational contexts are constructed and reconstructed over time through human interaction, and objects, especially words, symbolize and communicate meaning (Burbank & Martins, 2010). Although their symbology may be interpreted differently by others, for whom they have acquired different meanings through different past interactions, it is nevertheless their meaning in the present, the individuals' current thought processes and their understanding of the perspective of others in the situation, that is the direct cause of behavioural acts (Blumer, 1969). In this way, collective or group actions are seen as the combination of individual "lines of action" (p.82). As a method, SI is used to provide explanations of social phenomena which, due to their complexity and contextuality, are difficult to explicate by hypothetico-deductive means. It provides a set of

principles to apply when "attempting to come to grips with the obdurate character of the empirical world under study" (p.26), a way to:

> *"gather necessary data through careful and disciplined examination of that world; to unearth relations between categories of such data; to formulate propositions with regard to such relations; to weave such propositions into a theoretical scheme; and to test the problems, the data, the relations, the propositions, and the theory by renewed examination of the empirical world" (p.48).*

Section Five - Grounded Theory Methods

As in SI, in GTM knowledge about social phenomena is generated by systematically conceptualizing data (Birks & Mills, 2015), rather than by the hypothetico-deductive method (Haig, 1995). GTM is used with all types of data and epistemologies (Holton, 2007) in many fields including construction (Shojaei & Haeri, 2019), business (Gligor et al., 2016), medical education (Kennedy & Lingard, 2006), and nursing (McCann & Polacsek, 2018). Over time, three methodological approaches have developed (ibid.), reflecting "contemporaneous interpretation" in the context of changing societal forces (Ralph et al., 2015, p. 3) and mirroring adherents' theoretical and conceptual perspectives (Chun Tie et al., 2019). As such, GTM can sit within, across and between paradigms: positivist/realist; constructivist/relativist (Bryant & Charmaz, 2007; Clarke et al., 2018; Hall et al., 2013) (Rieger, 2019); and post-modernist/reflectivist (Denzin, 2007). Consequently, the approaches differ regarding the positionality of the researcher, which varies on a continuum from detached observer to co-constructor of knowledge (Rieger, 2019).

Classic GTM is associated with Glaser; evolved grounded theory (EGT) with Strauss, Corbin and Clarke; and constructivist grounded theory (CGT) with Charmaz (Chamberlain-Salaun et al., 2013). Regardless of specific approach, there are common GT methods (Birks & Mills, 2015; Charmaz, 2012; McCann & Polacsek, 2018) and in all cases, the researcher strives to remain grounded in data by recursively comparing empirical instances and research-insights, each with one other. Preconception is militated against through self-reflexivity and the method-specific use of literature (Birks et al., 2019; Birks & Mills, 2015). The common methods are: theoretical sensitivity; memo-writing; concurrent data generation; coding and categorizing of data, including the constant comparative method; theoretical sampling; theoretical saturation; and theoretical integration (Birks & Mills, 2015).

Section Six - The SI Perspective as an Aid to Conceptualization within Grounded Theory Methods

Within this section we describe the techniques used within each of the common grounded theory methods and outline examples from our own research where the tenets of SI were connected methodologically to GT as an aid to conceptualization and the accommodation of context. This was achieved by asking, throughout the research, three questions framed from the tenets of SI: Who and what are the actors in this situation? What is meaningful to the actors in this situation and why? and How do actors' individual lines of action interact in this situation over time? Together, these questions allow researchers to point out to themselves, "the things that have meaning" (Blumer, 1969, p. 5) in the situation of inquiry, the interpretation of which guides action.

Section Six-point-one - Theoretical sensitivity and memo-writing

GT studies begin with the acceptance that researchers, while bringing personal perspectives to the endeavour, claim no concrete knowledge of the case-specific drivers and processes at work. Glaser and Strauss stated:

> *"To be sure one goes out and studies an area with a particular sociological perspective, and with a focus, a general question, or a problem in mind. But he [sic] can (and we believe should) also study an area without any preconceived theory that dictates, prior to the research, 'relevancies' in concepts and hypotheses" (1967, p. 33)*

However, to be able to assess the relevance of data and their context, GTM researchers seek, throughout the research process, to develop sensitivity to conceptual possibilities for the exploration and explanation of the phenomena under study (McCann & Polacsek, 2018). In SI, the importance of the starting perspective is recognized, and researchers are encouraged to set out and explicate the "initiating picture of the empirical world" (Blumer, 1969, p.25), from which they engage with the topic and develop the principles to be followed in the research design. From an SI perspective, the researcher's development of theoretical sensitivity is an ongoing process of finding meaning in the situation through interaction with "things that he [sic] encounters" (p.2), including the self. GTM researchers document insights contemporaneously, in memos, allowing the genesis of ideas to be tracked, interrogated, and finessed (Chamberlain-Salaun et al., 2013). In SI terms, memo-writing facilitates self-

interaction whereby researchers point out to themselves, "the things that have meaning" (Blumer, 1969, p.5), the interpretation of which guides action. In her version of grounded theory, Clarke systemized the identification of such meaningful things employing a combination of memos and mapping in a technique called situational analysis (Clarke et al., 2016). Three types of maps are constructed: situational, social worlds/arenas and positional; insights arising from them are captured in memos (Clarke et al., 2018). Schatzman's technique of dimensional analysis (DA), based in SI thinking, is a further technique sometimes incorporated within GTM (Sbaraini et al., 2011). In DA situational factors are identified and classified by their theoretical function: process, condition, consequence or context (Kools et al., 1996).

In our study, the impetus for research was the perception, indeed the conceptualization, in the mind of the first author, SH, that nurses' role development in general practice was limited by systemic constraints. This positionality was influenced by the first author's personal experience as a nurse in general practice and familiarity with discipline-specific published research literature. However, in GTM extant information, including literature, is subordinate to data from the field under study (Ramalho et al., 2015) and SI reinforces this by calling for problems to be defined through "ongoing, flexible, shifting examination of the empirical field, itself" (Blumer, 1973, p. 798). Therefore, when framing the research question, we used the experience of interviewing nurses in general practice for a separate study, to consider other experientially-grounded perspectives and explored them using our three questions. We noted that the concerns of interviewees were expressed in terms of practice-level interpersonal relationships and that differing outcomes were observed under similar macro-level systemic conditions which we identified by looking for non-human actors and their interconnections. Having done so, we decided to begin the research by exploring the negotiation of nursing roles within general practices. Consideration of the several human actors in the situation, what might be meaningful to them and how their "individual lines of action" (Blumer, 1969, p. 82) may interact guided our selection of participants. Consequently, we included those with a range of experience in general practice in our initial sample, including not only nurses, but medical general practitioners, business owners and managers. Using situational analysis to set this issue against the big-picture, our mapping brought together multiple elements including: human actors, individual and collective; non-human actors; culture; symbolic elements and the range of actors' contested viewpoints (Clarke et al., 2018). By identifying nexus of interaction among these elements, the unit of analysis, which might otherwise have been conceptualized simply

as the general practice, as a physical and organizational entity, was conceived more broadly and characterized as the general practice negotiating environment. This expanded our pool of participants to include actors such as regional nursing leaders, with whom general practice staff interact. It also guided data generation by sensitizing SH to recognize and follow potentially significant participant narratives during semi-structured interviews. For example, awareness of symbolic elements, identified as potentially significant through mapping, facilitated exploration of examples given by participants regarding the use of name badges, website content and noticeboards.

Section Six-point-two - Concurrent data generation

In GTM, initial data are collected purposefully from sources representative of the phenomena under study and capable of providing meaningful data; participants may have experiential or observational knowledge (Morse & Clark, 2019; Palinkas et al., 2015). Incrementally, over successive phases of data generation, separated and informed by periods of analysis, grounded theorists seek to identify and explain the main concerns and behaviours of participants regarding the phenomena of interest (Glaser, 2002). However, it is not the aim merely to characterize the concerns of the participants as they describe them; rather the researcher conceptualizes patterns of concern and behaviour across multiple data. The first principle of SI reminds us that humans "act towards things on the basis of the meanings that the things have for them" (Blumer, 1969, p.2). Behaviours are therefore dynamic and responsive to the meaning found in particular situations, at particular times, in interaction with self and others (Blumer, 1969). In GTM, data can take many forms but to ensure quality, should encompass the variation in the situation of inquiry and be of sufficient depth and detail. It is also important when conceptualizing data and developing categories to be able to determine the relative value to the research aims of discrete empirical instances (Birks & Mills, 2015). We used semi-structured individual interviews to generate participant data and asking ourselves: What is meaningful to the actors in this situation and why?, created a list of questions to be used to probe further into meaning, after first asking participants to describe their experiences of nurses' roles in general practice. These questions included: What are the tasks that have meaning? What does professional autonomy mean to you? and Who supports you to do the things you love? This elicited data regarding values and meaning, and helped to identify additional actors in the situation, bringing into focus, for example, the importance of professional and personal support networks outside of workplaces. Recognizing such meaning as a labile precursor to and driver of action, the GT researcher is able to see behind the empirical

instances finding conceptual linkages that transcend the specific behaviours. In our data, for example, one participant strove to provide nurse outreach services to patients, and another to deliver nurse-led preventive care. The recognition that these behaviours arose from the specific meanings attributed to nursing care by individual participants in interaction with actors in their environments facilitated the conceptualization of a variety of such concerns as providing needs-responsive nursing practice. Applying the three SI questions to the analysis of those interactions, the needs responded to were found to include: societal need; professional need; the needs of individual patients and staff members; and the business imperative, which arises from the private business model and funding arrangements in place for New Zealand general practice.

Section Six-point-three - Coding and categorizing of data and constant comparative analysis

Whilst conceptualization is facilitated by all the common grounded theory methods, it is in coding and categorization that the concepts from which theory will be constructed are formed and theoretically linked (Holton, 2007). Both code and category are synonyms of concept but here represent the differing levels of abstraction achieved through phases of analysis. These phases vary with specific approach but address: the coding of empirical data; the development of categories by grouping related codes; and the connecting of categories to explain the data, including the creation of a core category (Birks & Mills, 2015; Glaser, 2011). In a reversal of the concept-indicator model, used in hypothetico-deductive reasoning, whereby a concept is specified, and indicators sought to test it (Glaser & Holton, 2005), the logic of discovery in GTM is largely inductive and abductive. That is, there are no predetermined explanations for observed indicators, or empirical instances found in the data; new explanations are created by intellectual effort (Reichertz, 2007). The plausibility of all possible hypotheses is considered, and reconsidered, in the light of the data and their analysis to the point of best explanation; other explanations remain possible, and the process is iterative (Von Glasersfeld, 2001; Warburton, 2013).

When coding, the researcher first identifies words, or non-textual evidence appropriate to the type of data, which describe the empirical instances, or indicators, and gives them labels (Elliott, 2018). This is usefully understood from the SI perspective that meaning arises in the moment out of interaction. The labels that the researcher assigns symbolize the meaning they construct in their interaction with the data, with participants and with other objects in the

situation, human and non-human. The labels, at this stage codes, mark instances for retrieval and further analysis by focused consideration of groups of similar instances or "interchangeable indicators" (Glaser, 2011, p. 1). Over time, groups of indicators are aggregated to form categories, and categories, rather than data, become the principal objects with which the researcher interacts, re-interpreting their meaning and defining them conceptually with properties and dimensions. As concepts then, rather than descriptions, categories become abstracted from time, place and person and can be related one to another hypothetically to explain the data and the grounded theory begins to take shape. It is at this stage that abductive reasoning is used to test the plausibility of the hypotheses by theoretical sampling, as described below. Plausibility-testing may be aided by storyline. A storyline is a narrative description of the categories and how they relate to one another (Birks et al., 2009). The process of constructing the storyline is analytical and, again in SI terms, facilitates interaction with the data at a conceptual level. A stilted narrative indicates the need for further analysis. Eventually after sequential testing, reframing and retesting of possible hypotheses, a core category is identified which conceptualizes and embodies the best explanation: the grounded theory. Constant comparative analysis is practiced throughout, considering empirical instances, codes and categories in juxtaposition within and across levels of abstraction (Birks & Mills, 2015). Throughout coding and categorization, questioning from SI tenets reminds the researcher not only to look for the actors' meaning and lines of action among the data but also to recognize herself as an actor in the situation and to take account of her own sense of meaning and action. Depending upon the positionality of the researcher, this may be to decontaminate the data, if taking a classicist view, or to fulfil the role of co-constructor of knowledge as in later GTM variants.

SI can also be informative when considering the naming of categories, as it highlights that the interpretation of specific language, like that of any other object, may differ between individuals or groups (Blumer, 1969). Sometimes, a category may be named using an in vivo form of words, taken directly from the data (Birks & Mills, 2015). In our study the term levelling up was used by a participant and was constructed as a potential core category, connoting the upskilling of nurses within the practice team. However, this term is in popular use elsewhere symbolizing a range of concepts, including topical political and economic ideas sometimes applied in health settings (Jennings et al., 2021). Due to the potential for this to disrupt the effective communication of our research, and after further analysis, we renamed the category operationalizing intent and subsequently creating place.

Section Six-point-four - Theoretical sampling and theoretical saturation

In GTM, data collection occurs episodically and is guided by the products of ongoing analysis. This is termed theoretical sampling and takes various forms, according to the stage of conceptual development (Butler et al., 2018). To begin, sources that are broadly representative of the phenomenon of interest are used to gain an initial understanding of the topic. Later, as new facets of the phenomenon are identified, sampling is focused on answering questions relevant to theory development. This may involve seeking new data or re-examining existing data (Morse & Clark, 2019) to test linking hypotheses using abductive reasoning. From an SI perspective, it allows the empirical world to "talk-back" (Blumer, 1969, p.22), through those who have experience with the research topic. The SI perspective also aids understanding of quality assurance criteria in GTM, which include, explanatory power, data-fit, relevance and generalizability (Charmaz & Thornberg, 2020). The measure of each of these is in the data and their representation of the empirical world (Blumer, 1969) and theoretical sampling is key to data sufficiency in this respect (Morse & Clark, 2019). Where analysis ceases to produce new insights, and when categories are fully described, dimensionalized and supported by a suitable number of empirical instances, the category may be considered saturated, and sampling is complete (Birks & Mills, 2015).

Early in our analysis, a provisional hypothesis of the process of negotiating nurses' roles included the sub-category norms of practice, which conceptualized patterns of behaviours seen in the data salient to particular situations and thus subject to contextual variation. Therefore, we identified the need to sample for greater variation of experience of the general practice negotiating environment, our world under study, and subsequently recruited participants from targeted cohorts including new graduates, male nurses, nurse prescribers and those with experience in general practices with a range of ownership, governance, business and care models. One group of participants were Māori nurses with experience of working in Māori Health Service Providers (MHSP), several of whom spoke passionately about their roles in terms of serving their community and giving back, and we coded these instances as meaning of work. Māori are the indigenous peoples of New Zealand and MHSP delivery models focus on reducing health inequity by grounding services in Māori values and practices (Gifford et al., 2018). Māori nurses who integrate kaupapa (first principles) within their clinical practice promote culturally safe care to Māori patients and families (whānau) (Sheridan et al., 2011). Sampling within this cultural context highlighted the importance of *meaning of work* as a driver of nursing behaviour and, following the constant comparative method, we reviewed earlier data

for other empirical instances relevant to this code. We found references to *meaning of work* in other settings, there expressed in terms of *being part of a team* and *feeling competent or useful*. This allowed us to further develop the code, to test its relevance with further sampling, and to consider its theoretical usefulness as a category to explicate behaviour across the data set.

Section Six-point-five - Theoretical integration

Most grounded theories are substantive in that they explain phenomena within specified conditions (Birks & Mills, 2015). However, their explanatory power may be increased by comparison with compatible theoretical codes from existing knowledge (McCann & Polacsek, 2018). To avoid the imposition of concepts not grounded in the substantive area, it is recommended that such extant codes are considered late in the analysis (Birks et al., 2009). Some researchers consider the adoption of an SI perspective at the outset of a GT study to be premature and prescriptive (Glaser, 2005; Glaser & Holton, 2005; Newman, 2008). We contend that SI sensitizes researchers to possibilities within situations being studied without jeopardizing groundedness.

Section Seven - Outcomes of Connecting Symbolic Interactionism and Grounded Theory to Aid Conceptualization and Accommodate Context

As discussed in Section 2, the derivation of all knowledge statements, lay or scientific, relies on the everyday subliminal cognitive process of conceptualization. In explaining the interactional nature of knowledge-construction and SI, Blumer (1969) explained conceptualization as being an everyday cognitive process invoked to deal with the limits of perception; where experience of a phenomenon is found incomplete or perplexing, explanations are constructed, to render it understandable, or meaningful. GTM is used to look for meaning in the empirical world using inductive and abductive reasoning to provide explanations of social phenomena which, due to their complexity and contextuality, are difficult to explicate by hypothetico-deductive means. In simple terms, when using GTM, the cognitive process of conceptualization is harnessed and operationalized to create scientific meaning, distinguishable from everyday "natural analysis" (Kools et al., 1996, p.315) by the purposefulness of the process, the depth of the analysis and the consciousness of the acts of conceptualization. Understanding the everyday process through the application of SI mitigates the difficulty many researchers find in grasping the process of conceptualization once it is raised to the level of a formal analytical technique.

We have described why it is important in sociological research to understand the relevance of context from the point of view of participants. However, sometimes, context is limited to description of the environment within which questions are set or findings presented (Rogers et al., 2020). Conversely, in GTM, it is the intent to look for the "everyday realities" (Glaser & Strauss, 1967, p.239) in the situation of inquiry and close attention is paid to the diverse contexts within which data are situated (Bainbridge et al., 2013). From an SI perspective, contextual factors are objects with which individuals interact to construct meaning, and the real world outside the laboratory is recognised as complex and context dependent (Blumer, 1969). Accordingly, SI techniques and theories such as Strauss' theory of action (1993) and situational analysis (Clarke et al., 2018), highlight the importance of context in the understanding of human behaviour and conceptualization. The former includes as a central theme the idea of trajectory and the effect of temporal influences on actors' interpretations of situations (Mills, 2009). The maps used in situational analysis promote understanding of the contextual complexities and stress that rather than comprising external circumstances, context is intrinsic and combines with the individual to create the situation of interest (Clarke et al., 2018). Both draw on the basic tenets of SI which present human behaviour (Blumer 1969) as arising from the diversity meanings to be found in situations and demonstrate how acceptance of SI tenets opens opportunities for conceptualization by increasing receptiveness to the range of perspectives present in the empirical field. However, they represent a further layer of methodological complexity with which researchers must grapple. More simply, by combining SI and GT methodologically, by asking at each decision point in the research process: Who and what are the actors in this situation? What is meaningful to the actors in this situation and why? and How do actors' individual lines of action interact in this situation over time? the researcher is better able to interact with the self, with the data and with the situational context to locate meaning in the situation of inquiry, with or without the application of more prescriptive techniques.

Glaser and Holton (2004) cautioned that the relevance of context must be determined through course of analysis not to be considered a preconception. However, the diligent use of constant comparative analysis in conjunction with the three questions ensures that the putative significance of all objects in the situation, contextual or other, are tested for empirical grounding. Moreover, in SI, although the meaning attached to concepts, including that associated with theoretical and conceptual frameworks, may have been constructed from past interactions, it is the meaning of the concept in the present, the individuals' current thought

processes and understandings of the perspectives of others in the situation, that drives action (Blumer, 1969). Therefore, where that act is the conduct of research, an SI perspective supports free conceptualization and need not preclude the use of other perspectives or theoretical codes, the salience of which becomes apparent during analysis. "Symbolic interactionism tells us that things could always be otherwise" (Clarke et al., 2016, p. 14) and prompts us to look for contextual variation in the data. As evidenced by examples in Section 6, attending to context and seeking to understand the various perspectives of those experiencing the phenomenon of interest, enables GT researchers "to correct and adjust the emerging [sic] theory to diverse conditions" (Charmaz & Thornberg, 2020, p.314), potentially enhancing its explanatory power and reach.

Section Eight - Conclusion

The distinction between scientific and lay knowledge, whereby the former is privileged on epistemological grounds, belies the fact that all knowledge relies on human cognition and mental processes of conceptualization, which operate, usually sub-consciously, in response to observed phenomena. In GTM the means of observation and analysis are formalized to facilitate conscious conceptualization within a substantive situation, for the purpose of understanding social phenomena therein, and to militate against concrete pre-conception. The SI perspective aids the understanding and practice of conceptualization by framing it as a continual process, whereby individuals create and re-create meaning in interaction with themselves, with others and with objects in their environment; it explains behaviour as an interpretive response to meaning. As such, an understanding of SI means sensitizing to biases and possibilities within the individual and the situations they study, promoting an open attitude to discovery and empowering the researcher to "claim the autonomy given to him [sic] by the method" (Glaser, 2011, p.12) in order to freely conceptualize the data.

In our GT study, the recursive use of three questions based on the tenets of SI effectively raised our research autonomy, guiding decisions regarding research design, including: defining and scoping the situation of inquiry, and selecting research participants and means of data generation. It informed engagement with research participants and interaction with data during the analysis. It improved reflexivity and aided the selection of terminology to convey research findings.

In keeping with their ontological and epistemological origins in pragmatism, GT and SI do not privilege positivist scientific ideas above other philosophical perspectives, practical ways of knowing or cultural interests (Scheffler, 2012); they are said to be "contextually responsive" (Bainbridge et al., 2013, p.277). Their use in combination, as described, has the potential to bridge world views and cultural differences and to remove the otherness of disparate perspectives (Ali et al., 2021). By finding the meaning in situations studied, exchange of ideas across social divisions is facilitated and knowledge is rendered truly useful.

4.5 Reflexivity statement

In Chapter One I included remarks about my motivation towards this research, and my wish to understand aspects of my own professional experience to be able to practice with greater autonomy. Throughout the analysis reported in Chapter Two and the literature review in Chapter Three, I reflected on my starting axiology and on the values and motives of other actors in the situation and recorded my thoughts in section 3.2.7. Prompted by the tone of the discussion around *task-shifting,* I found myself questioning the implicit assumption that nursing is valuable merely as a *medical substitute* and that medical care is invariably effective and value for money. As such, I entered the active phase of research desirous of understanding how to improve the utilization of nursing knowledge to address shortcomings in primary care services. My intent in this section, following the recommendations of Sirris (2022), is to acknowledge such positionality and reflexively to consider its effect on my role as researcher.

Reflexivity is the process of consciously examining and re-examining one's axiology and I chose GT methodology for this study partly because it positions the researcher as a co-constructor of knowledge. This was important to me for several reasons. Firstly, because the question of nursing voice was important to me, and I wished to bring not only my own experience to the table but to be able to represent the vicarious and vocalized experiences of those with whom I work outside of the research process. Secondly, because epistemologically I believe knowledge to be socially constructed, and thirdly because it facilitated my free interaction with research participants, to hear their voice. These facets of motivation on my part are mirrored in a variety of ways in which I have thought and felt about myself in relation to the research and the ways in which I have perceived others to have thought and felt about me as a researcher.

Regarding the question of nursing voice, prior to doctoral candidature, numerous practical professional experiences and conversations led me to understand that my own frustrations with the limits of nurse autonomy were shared by many others. For example, when discussing proposed research, colleagues supported me with comments such as "thank you for doing this for nursing". Similarly, nurse participants expressed their support for the aims of the study and hoped findings would be of practical use to them; some used our interaction to explore their aspirations for academic study, seeing me perhaps as a role model. Non-nurse participants,

with a less *sisterly* connection, nevertheless appeared to see me and my research as a means of influencing primary care policy. My perception of these expectations heightened my sense of needing to advocate for nursing and for primary care. *Constructively*, the sum of my interactions over the period of the study has been influential on its conduct and outcomes; the attitudes of all those around me including family members, colleagues, academic peers, and supervisors have inevitably had impact, not least in ensuring through force of expectation that I complete the study. Inhabiting the role of student and apprentice researcher, I have been concerned with meeting the challenges of doctoral study: the need to contribute *new knowledge*, to be *scholarly* and ultimately to be successful. These factors indeed mean the process has been anything but value neutral.

Alvesson and Sköldberg (2018) highlight the need for reflexivity in four areas. Firstly, in consideration of data generation and analysis. Secondly, regarding the nature of the interpretive act. Thirdly, in respect of the nature of the relationship between the researcher and the researched, including aspects of reporting and use of results. Finally, in examination of the language used and authority claimed in such reporting and application. Matters of preconception have been discussed in "Grounded theory method and symbolic interactionism: Freedom of conceptualization and the importance of context in research". Other issues pertinent to the model of reflexivity are addressed throughout this thesis, primarily in Chapter Five which describes the reasoning behind key decisions and discusses aspects of research quality using Tracey's "Big Tent' Model.

4.6 Conclusion

In this chapter I have discussed the nature of reality or what there is that can be known, also termed metaphysics; epistemology, or how we gain knowledge and understanding (Berryman, 2019); and axiology, or what is valued or valuable (Brown & Dueñas, 2020). These considerations contributed to the design of this study; specifically how, and with what outcomes are discussed in Chapter Five.

Chapter 5 Methods and Analyses – Elaborating the Abstraction

"The purpose of grounded theory is to elaborate the abstraction level of its theoretical results to the amount needed to solve the problems defined by the respective research purpose… this involves the formulation of plausible propositions that must be accessible to scrutiny." (Strübing, 2007, p. 7).

5.1 Introduction

In Chapter Four, I discussed GT and SI and in keeping with my pragmatic approach highlighted the philosophical equivalence of everyday problem solving and the research process. The two acts may be differentiated by the deliberate nature of the latter and the need to explicate processes of knowledge generation when offering research findings for use by the wider community (Hewitt et al., 2022). In this study the research question was '*How are the roles of nurses in New Zealand general practice negotiated?*' Here, in keeping with the aim of non-preconception, the term *negotiation* encompasses any processes used to gain consensus on actions moving forward. It is because process, action and interaction lie at the heart of this study that GT, guided by SI, was selected as an appropriate research design. In this chapter, I elaborate on my research process, focusing on key decision points in respect of: data generation, including participant selection; the identification of the participants' main concern and prime mover: the derivation of categories; and the construction of the grounded theory. My intent is to demonstrate the derivation of the findings and to facilitate the necessary scrutiny referred to by Strübing in the above quote.

Since GT is an iterative methodology, I present a chronological description of my research: a timeline of data collection and analyses. In this way, I aim to describe the ebb and flow of ideas and document their genesis. I describe six phases of study broadly defined by successive rounds of interviewing and highlight within each the application of certain GT methods. However, within the *constant comparative method* those methods were used throughout. I also discuss the quality of the research using the eight criteria of Tracy's 'Big Tent' Model (2010), meaningful coherence, rigour, sincerity, credibility, resonance, worth, relevance and ethics.

5.2 The constant comparative method

GT research is non-linear (Chun Tie et al., 2019), rather there is constant comparison across data and codes, revisiting of prior impressions and testing of developing concepts for validity and grounding. Therefore, the core GT processes - developing theoretical sensitivity, memo-

writing, concurrent data generation, coding and categorizing of data, including theoretical sampling, determining theoretical saturation and theoretical integration (Birks & Mills, 2023) - were executed recursively as shown in Figure 5.1 and elaborated on in the published paper, "Grounded Theory Method and Symbolic Interactionism: Freedom of Conceptualization and the Importance of Context in Research", included in Chapter Four. Potentially significant data segments connoting not only contextual factors but social and psychological processes, rather than themes, were identified, labelled, and developed through rounds of analysis with increasing levels of abstraction and finally integrated into a substantive explanatory theory (Chun Tie et al., 2019).

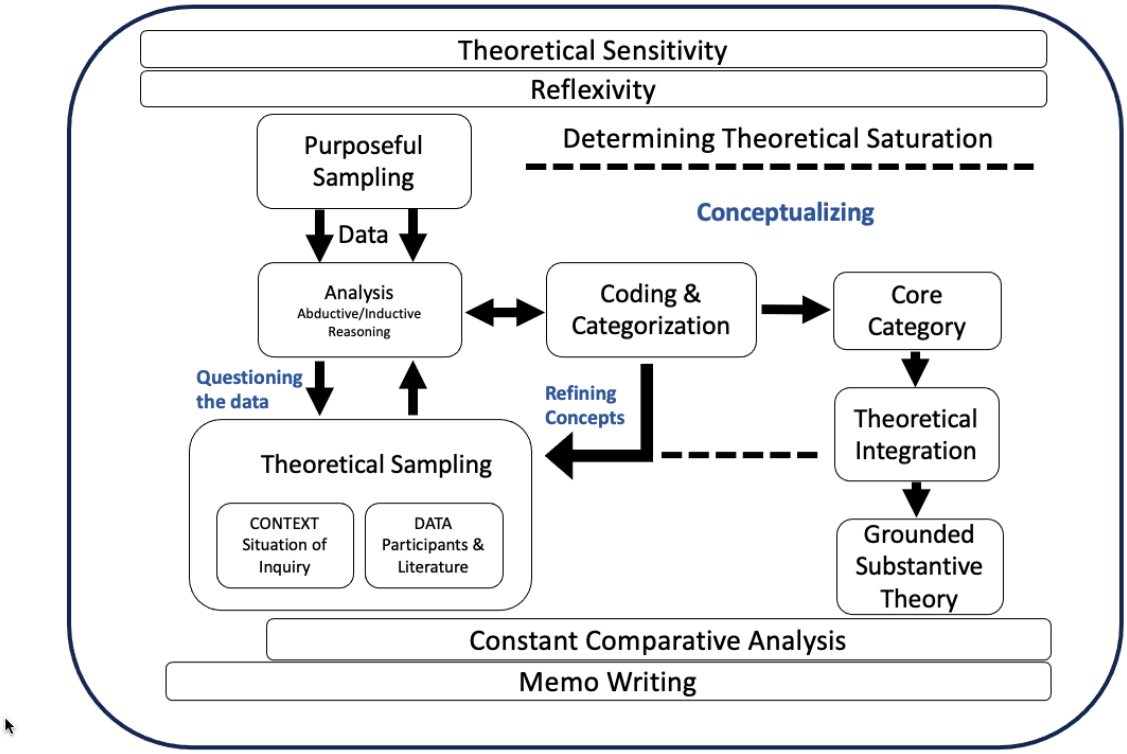

Figure 5.1 Grounded theory process

5.3 Selection of sampling method

Unlike hypothetico-deductive methods, which emphasize theory testing, and methodologies that focus on detailed description of phenomena, GT methods are designed to conceptualize empirical data to generate theory. Therefore, suitable data must first be obtained. It is important to note that the data required is that which explores the breadth of the phenomenon under consideration, rather than the diversity of the population in the situation of inquiry (Morse & Clark, 2019). Famously, Glaser (1978, p. 8) stated that in GT "all is data". Therefore, although

interview data generation is common in the method, it is not obligatory. I chose to use one-to-one semi-structured interviews for the reasons outlined below. Both face-to-face and video conference interviews were included to facilitate participation from across the country and in anticipation of COVID 19 pandemic restrictions.

Interviews are well-suited to generating detailed information about beliefs, behaviours and processes. Compared to survey instruments or their equivalent structured interviews, semi-structured interviews broaden the scope of interaction between participant and researcher. A few questions and prompts are used to begin and maintain a conversation about the matter at hand and the interviewee is free to elaborate on issues as they have experienced them, allowing the discussion to expand beyond the inevitable preconceptions of the interviewer (Alshenqeeti, 2014). Individual interviews were chosen over group interviews to promote deeper exploration of the variety of individual experience than the latter would permit (Morse & Clark, 2019). Interviews also allow for elements of observation. Where they are conducted within the situation of inquiry, there is the opportunity to observe subjects' behaviours and interactions with other actors and situational elements (Birks & Mills, 2023). In both face-to-face and videoconference interviews, participants and interviewer have non-verbalized cognitive responses to the conversation. As discussed in Chapter Four and asserted by Glaser and Holton (2004, para 43), such reactions on the part of the interviewer represent "preconscious processing" and must subsequently be reflected upon actively. Since, neither will be captured in transcribed data, they are noted at the time in field notes or shortly after the conclusion of the interaction in memos and revisited throughout the analysis.

5.4 Phase One – including discussion of data generation

While non-preconception is key to effective data generation, some assumptions must be allowed in order to begin (Strübing, 2007). Here, cognisance of the potential relevance of the sensitizing concepts identified in Chapter Three, covering the domains of *context*, *actors*, *things negotiated,* and *process,* informed the data generation strategy. These concepts contributed to the framing of the interview protocol and suggested appropriate questions and prompts as shown in Box 5.1. In accordance with the aim of identifying sources capable of providing meaningful data, a purposeful sampling approach was used. Purposeful sampling involves the identification of sources with specific knowledge and experience of the phenomena of interest and the ability and willingness to participate (Palinkas et al., 2015). In

a few instances participants were suggested by those already interviewed in a manner termed snowball sampling (Morse & Clark, 2019). Data generation was also guided by the needs of theoretical sampling. This included using targeted literature searches to elicit additional pertinent data and theoretical codes, modifying interview prompts and sourcing participants with specific traits and experience (Butler et al., 2018). Again, the four sensitizing concepts were useful: context highlighted the need to seek variation in the sampling; and actors, things negotiated, and process helped with recognition of behaviours, outcomes and sequential activity, elements necessary for theory construction.

Box 5.1 Interview protocol and associated sensitizing concepts

1. For nurses in general practice settings:
- Please describe your current roles
- How did you come to undertake these roles

2. For nurses in general practice leadership roles, or for non-nursing participants.
- Please describe the roles of nurses in your practice(s)
- How did they come to undertake these roles?

Prompts suggested by sensitizing concepts: Context, Actors, Things negotiated, Process

A. How was your (their) role decided when you (they) were first employed, in current role? **Process**
- Have there been significant changes to your (their) role since then? **Context**
- How did changes come about? **Process**
- Compare experience with previous employment/ career stages **Context**

B. Can you (they) negotiate a change in your (their)role?
- New services **Things Negotiated**
- Collective or individual negotiation **Process**
- With whom do you (they) negotiate? **Actors**

C. What are the '*tasks that matter*' to you (them) and why? **Things Negotiated/Process**

D. Who supports you (them) to do the things you (they) love? **Actors**
- Training
- Mentoring
- Professional supervision

E. What does professional autonomy mean to you (them)? **Things Negotiated**
- How do you describe your personal scope of practice?
- What influences this?

F. For each question ask: *Can you give me an example*? **Context**

After ethics approval on 10 November 2020, recruitment flyers were circulated by e-mail to contacts in general practice networks. In keeping with theoretical sensitivity to potential actors in the negotiation, participants sought included nurses, at all levels of registration, managers, employers of nurses and GPs. I contacted those who responded, by telephone to discuss their involvement and suitable candidates were sent participant information sheets by e-mail and invited to complete a written consent to participate. On receipt of confirmation of their

willingness to participate, interviews were arranged at mutually convenient times and places, the offer of videoconferencing being made to all participants. The first interviews were conducted in December 2020. Thereafter, participants were recruited to meet the needs of theoretical sampling with the final interviews taking place in January 2022. Twenty-two interviews, each of around 60 minutes duration were conducted; 11 were via ZOOM™. Table 5.1 lists interviews chronologically and details participant characteristics.

Following the principle of concurrent data generation and analysis, following each interview, I recorded my immediate impressions in memos. Initially, I did so manually; later I used Evernote™ software, to better log, retrieve and link memos. I transcribed the interviews and uploaded the transcripts into NVIVO12™. I recorded ideas arising during the transcribing process in memos and began line-by-line coding of each interview as soon as possible after transcription. Memos included comment on the effectiveness of interview questions and technique, as well as insights into the phenomenon. For example, I noted after the first two interviews to ask, 'Why not?', questions as a means of more fully exploring the drivers of participants' behaviour towards negotiation.

5.5 Phase Two – including discussion of theoretical sampling and participants' main concern

Participants in the first five interviews were nurses with at least five years' experience in general practice; all were currently in senior roles, leading or coordinating nursing teams, or in advanced practice roles. During interview, they were readily able to describe their experiences of role negotiation, both in their current practice and at earlier career stages including in their current place of employment and in other general practice settings. As such, they fulfilled the needs of purposeful sampling and provided rich data regarding experiences of negotiation and effects of contextual variation thereon. Moreover, they endorsed the relevance of the research aim to their lived experience and professional concerns.

5.5.1 Theoretical sampling – amending interview protocol

Participant Six, a GP and practice owner, was the first non-nurse participant. I found this interview to be less successful as a conversation requiring more explanation and prompting on my part. I reflected on the reasons for this, hypothesizing that it was due to differences in our professional perspectives. Nevertheless, new empirical instances of relevance were captured

from the interaction. Overall, the data from interviews one to six evidenced the relevance of managers, owners, and GPs as actors in the negotiation. For example:

> "… you've got to take responsibility for what you want to do, but the biggest support system was very supportive doctors, owners, and they wanted this to succeed and that was the big one." **Participant 1**

Therefore, I determined to seek their participation in the next round of sampling. To refine the interview protocol, I asked myself, "What do I want to ask doctors, owners and practice managers?".

Table 5.1 Participant interviews, chronology, characteristics, coding, main concerns

Number	Profession	Current Role	Years in NZGP	Sex	Age	Ethnicity	Initial Codes	Main Concern	Prime Mover
1	RN	Manager[1]/ Clinician[2]	11-15	F	35-44	Pacific	62	Matching nurse capability to the organizational vision	Population health need
2	NP	Clinician	6-10	F	35-44	European	46	Integrating NP into general practice	Desire to "do everything"
3	RN	Lead[3]/ Clinician	1-5	F	≤34	European	3	Supporting patient need with nursing	Desire to be your best
4	RN	Lead/Clinician	1-5	F	35-44	European	7	Making use of nursing difference c.f. medicine	Work-life balance.
5	RN	Clinician	6-10	F	35-44	European	8	Freedom of practice	Supporting owner's vision
6	GP	Owner[4]/Clinician	21-25	F	45-54	European	4	Freedom of practice	Maintaining independence
7	Manager	Manager	1-5	M	35-44	Asian	24	Optimizing clinical scope, income and job satisfaction	Efficiency
8	RN	Clinician	1-5	F	≤34	Asian	10	Learning skills to meet patient needs	Developing own strengths and interests
9	RN	Executive[5]	21-25	F	55-64	European	18	Integrating nursing into model of care	Providing support for nursing leadership
10	RN	Owner/ Clinician	16-20	F	55-64	European	18	Using full RN scope of practice	Taking ownership of professional domain
11	RN	Executive	21-25	F	55-64	European	8	The place of nursing in primary care	Creating a primary care nursing structure
12	RN	Lead/Clinician	21-25	F	45-54	Pacific	0	Having nurses work at top of scope	Supporting the Team
13	GP	Clinician	6-10	F	35-44	European	0	Operationalizing nurses working at top of scope	Helping with GP workload
14	RN	Clinician	11-15	F	45-54	Māori	6	Serving Community	Expressing personal values
15	NP	Clinician	1-5	F	≤34	European	3	Providing autonomous patient care	Fulfilling personal goals
16	RN	Clinician	1-5	F	45-54	Pacific	6	Serving Community	Bringing skills to bear on health need
17	EN	Clinician	11-15	F	65+	Pacific	7	Patient care	Seeking trustworthy employer
18	RN	Lead/Clinician	16-20	F	55-64	Māori	5	Creating a safe place	Relationships with colleagues and patients
19	RN	Executive	1-5	F	65+	Māori	2	Safe nursing practice	Supporting nurses
20	RN	Lead/ Clinician	11-15	M	55-64	European	1	Appropriate care	Autonomy
21	GP	Owner/Manager/Clinician	26-30	M	55-64	European	3	Team working	Pragmatism
22	RN	Clinician	6-10	F	55-64	European	1	Systemizing care	Being safe and having pride

1. Manager - Undertakes operational management role at organizational level
2. Clinician- Provides direct patient care.
3. Lead - Has formal leadership role within the practice other than as business owner
4. Owner - owns the business within which they work
5. Executive - has primary care role outside individual general practice

Drawing on memos written after individual interviews, and initial coding of interviews one to five, a memo written on 10 February 21 and produced in Box 5.2, brought together thoughts around concepts of *space*, *uncertainty, vision, need* and *autonomy.*

Box 5.2 Memo written on 10 February 21

Impression from initial coding is of a **space** for the negotiation of nursing roles in general practice arising from **uncertainty** of how to achieve or operationalize the **vision** of the organization within systemic parameters (funding, contracts, training) and constraints of work-force characteristics/aspirations/self-perception and enrolled population **need**. The degree to which individual nurses, or groups thereof, are able to negotiate, is influenced by the hierarchy and the attitudes of those within it towards nurses' **autonomy** and tolerance for different ways of working. Examples of areas of uncertainty leading to negotiation: long-term conditions; nurse leadership; lack of awareness of nurses' capabilities; NP integration; on-the-day issues; outreach; COVID; virtual consults; mental health; nurse specialization. Participants describe matters resolved in-house with limited external nurse-input other than post-graduate education.

Considering these concepts, I added four prompts to the original interview protocol for the purpose of theoretical sampling, to "chase important leads" (Morse & Clark, 2019, p. 12) when interviewing GPs, owners and practice managers in subsequent phases of data generation. The additional prompts were: firstly, relating to *uncertainty*, 'What is the biggest risk to your business/practice?'; secondly, regarding *organizational vision*, 'How do nurses support the vision of your business/practice?'; thirdly, addressing *need*, 'Who is your customer?' and 'What drives change?'; and finally, considering nurse *autonomy* 'What role do you take in directing nursing tasks?'. I also reviewed questions and prompts for future nurse interviews. Here, I incorporated phrases used by previous participants that had led to the sharing of pertinent narratives. These included asking about of *ways of working* as well as role and, to facilitate discussion of drivers of behaviour, I determined to ask, 'How do you reflect on your practise?'. To continue to scope the range of actors, I added prompts about who and what had influence over what nurses did, and about professional support networks. I noted the need to enquire about assessing *need* and, as for GPs and practice managers, added prompts about managing *uncertainty*.

5.5.2 Beginning to conceptualize the participants' main concern

At this stage I felt I was gaining an understanding of the participants' experiences and what was important to them and beginning to see patterns in their experiences. The identification of what is important to participants is essential for the 'grounding' of the grounded theory and allows any problem statement preconceived in the mind of the researcher to be challenged.

Holton (2007, p. 5) stated, "The conceptualization of this main concern and the multivariate responses to its continual resolution emerge as a latent pattern of social behaviour that forms the basis for the articulation of a grounded theory." Therefore, I started recording my impressions of participants' main concerns and the drivers of their behaviour, the "prime movers", towards resolution of those concerns (Glaser & Holton, 2004, p. para 44). My interpretation of the main concern and prime mover for each participant is recorded in Table 5.1.

5.5.3 Sampling for contextual variation

Considering theoretical sampling needs, in addition to seeking participation from non-nursing actors to understand process, I looked to sample for contextual variation (Morse & Clark, 2019). Reviewing the main concerns and prime movers conceptualized from the data generated so far, it seemed that these varied according to personal factors, such as career stage and perceptions of population health needs and personal aspirations. Therefore, I now sought participants with differing backgrounds and at various career stages and those with experience of working in practices with differing organizational structures. As discussed in Chapter Two, New Zealand general practices vary in business and care models, by size of enrolled population and by the health needs of the populations they serve. Moreover, health inequity for Māori and Pacific Peoples is a major driver of health need. Therefore, it was important to the topic and ultimately for the practical application of the resultant grounded theory, to explore actors' experiences serving these populations and to include experiences of Māori and Pacific actors.

5.6 Phase Three – including discussion of the use of literature as data, the technique of storyline and the identification of a core category

I identified participants who fulfilled the needs of theoretical sampling by referral from participants and other professional contacts, including those made through participation in Project "Evidence to guide investment in a model of primary care for all" (Health Research Council New Zealand, 2018). Again recruitment information was forwarded by e-mail and respondents were sent participant information sheets to complete a written consent to participate. Kennedy et al., (2022) highlight how serendipitous events can stimulate creativity when researching complex issues. At this stage of the research, I had the opportunity to interview informants in PHO and corporate roles. Although not then prime targets for theoretical sampling, revisiting the situational analysis reported in Chapter Two, I hypothesized

they would be of potential value and indeed, 26 new line-by-line codes arose from the subsequent interviews (Participants 9 and 11). In addition to the capturing of relevant data regarding the influence of PHO and corporate roles from these participants, they were able to contribute information from their prior experience within general practice itself and to comment on that experience with the benefit of distance. Moreover, these interviews were rich in shadowed data. Shadowed data is generated where participants highlight the presence of others in the interactions we are interested in, describe their behaviours and comment critically on their observations (Morse, 2001). Such remarks both alert us to other actors we may wish to sample and provide an outside perspective on participants' accounts. This can add depth to the data and offer alternative interpretations. For example:

> "Yeah, and I see nurse practitioners struggle with this. They want to be paid as much as doctors, but they don't want to be doctors, but then they actually… they just contribute so much to our practice, but I see them struggle as much as everyone else around them about where their role sits and how that feels and how do you explain that to people." **Participant 9**

Other participants in this phase of data generation, during March and April 2021, were a male practice manager, an early career stage RN with less than five years' experience in general practice and an RN practice owner. The data generated helped add dimensions to concepts arising from the initial coding of earlier transcripts. From the memo in Box 5.2, I sought to explore the idea that role negotiation occurred in response to *uncertainty* and this round of interviews provided additional examples of *uncertainty* arising from workforce complexity. The plethora of ancillary staff that could be employed in general practice including health coaches, health improvement practitioners, health care assistants and kaiāwhina were referenced by participants as contributing to complexity. In addition, the range of specialized or advanced roles which nurses could aspire to was cited as an operational challenge. Explanation of the terms applied to ancillary staff and of the range of specialized and advanced nursing roles is given in Chapter Two.

5.6.1 Developing the concept of need-responsive nursing practice

The inclusion of non-nurse participants highlighted the influence of the business imperative on attitudes towards nursing role development. This was relevant to the creation of a more abstract expression of the main concern across the dataset and as I included more perspectives,

interacted with the data, and discussed explanatory arguments with colleagues and supervisors, two of my analytical questions, 'What is meaningful to the actors in this situation and why?', and 'How do actors' individual lines of action interact in this situation over time?', were pertinent. I first thought of the overarching main concern as providing *appropriate nursing practice,* where what was considered appropriate varied between individuals influenced by organizational *norms* expressed in the situation. The situation being general practice, ideas of appropriateness it seemed could be defined by the purpose of general practice. Therefore, to situate my impressions in "a broader foundation of knowledge in order to further modify, clarify, and elaborate emerging concepts" (Lo, 2016, p. 182), I returned to the literature to theoretically sample existing knowledge on this topic.

In his influential paper, "What is good general practice?", Toon (1994), identified four properties of good general practice: excellence in the diagnosis and treatment of disease; the quality of the doctor[sic] – patient relationship; reduced disease incidence, through population health measures; and business efficiency and customer satisfaction. He suggested individuals' willingness to enact roles commensurate with each of these properties was dependent upon their own philosophical standpoint. Toon's analysis remains relevant today, both as a comment on general practice (Gillam, 2019), and as an interpretation of what motivates individuals in their professional lives. This perspective helped me identify data relating to the main concerns and prime movers of participants, examples of which are shown in Box 5.3.

Box 5.3 Data excerpts illustrating participants' main concerns and prime movers

Example 1. An **RN** cited the opportunity to promote health equity as important: "*I have a very strong interest in how we work with equity…*". Consequently, they considered outreach to be central to appropriate nursing practice: *"…most of us are European middle-class and commonly female. So, the, hardest population for me to access is the middle-aged Māori, Pacific Island male population … and they … least commonly accesses healthcare. Yeah, So … it appealed to me significantly … something I want to work on reducing…*". **Participant 3**

Example 2. A **GP and owner**, professional and business independence was key to their mode of practice and offered choice to patients: *"…a really good thing about general practice in New Zealand is that it is private businesses, so we can choose to do things the way we choose to do …".* Consequently, for them appropriate nursing practice was any care that supported their chosen ways of doing: *"…whatever she's (the nurse) has got an interest in it's generally something that's going to be of value to the business.".* **Participant 6**

Example 3. To a **practice manager**, customers, resourcing and workforce moral were prioritized: *"…it's about people, that's why I'm in this job, I'm about my customer, my supplies and my team"*. Consequently, they considered appropriate nursing practice to be that which met customer demand, was financially viable and was acceptable to the nurses: *"I was actually gob-smacked that I had like female nurses weren't doing [contraceptive implants] and there's a male doctor doing it … I know my female customers want to go to the nurses … I can devolve activity, so I can go and chase the bigger fruit and that top of scope stuff… I can actually devolve, nice, engaging work to a nurse"*. **Participant 7**

Example 4. For an **RN (clinician and business owner)** the idea of professional legacy was motivating: *"So, for me it's about wanting to retire and leave nursing as an RN who has pushed the boat out on what that looks like, and how registered nurses can practice…".* Consequently, they created a model of care within which appropriate nursing practice was defined in the broadest terms: *"a model where my patient appointment list … and a doctors list, would, would, be about 75 to 80% identical."*. In addition, they distinguished between diagnostic and nursing care roles, valuing the latter in the context of population need: *"And I think, my community, ultimately … my patient community doesn't need a nurse practitioner. They don't need access to more diagnostic expertise, they need nursing. We don't have 24-hour palliative care nurses doing physical mouth care in a house. That worries me more than whether someone else gets to refer for CT colonography…"*. **Participant 10**

Each example in Box 5.3 referenced some kind of *need*, including *health equity*, *business independence, workforce morale* and *legacy*. Wishing to understand perception and quantification of health need, I again consulted the literature. Bradshaw (1972), identified four types of social needs normative, felt, expressed and comparative. Normative need is that which is defined by a standard determined through expertise, and applicable in specific situations. Felt need is that perceived by the affected population and is distinct from expressed need, which is manifested by people presenting for existing services or taking action to secure new services. Comparative need is identified by measuring gaps in resourcing between populations or localities. This approach to need classification highlighted the transactional nature of recognizing and meeting social needs, including health needs. I recognized that largely, participants identified patient need through observation of patient behaviour –

expressed need – or by normative and comparative reasoning. Discussing the patient perspective, one participant reflected:

> "Occasionally, you do hear the one-off ones who are, you know, upset about the fact that they've been booked for a nurse, and they'd just rather see a doctor. Even when you do explain it to them, they still would rather see a doctor and that's fine, that's their choice. A lot of patients actually welcome that, because it's easier to come to see a nurse. A nurse can give them that time … to give patients health education. You know, what their condition is, why they need to take the medication, you know ... after that consultation, we just run it by a doctor make sure that everything's OK. Get the doctors to do the prescriptions, if we think, hey Mr. Jones' blood pressure isn't great, we should probably review his medication, and the doctors are very receptive to that. They're like, oh yeah, we can have a look, make a plan to come back two weeks for a blood pressure check. Yes, I think in general patients actually are quite receptive to seeing a nurse, because they get to be seen sooner as well." **Participant 8**

As such, the data lacked first-hand accounts of felt need from patients. From earlier engagement with the international primary care literature, I was aware of a body of work regarding the patient experience of primary care nursing. Therefore, I made a focused literature search to *theoretically sample* the New Zealand literature regarding patients felt primary care needs. The New Zealand Health Survey provides a national dataset recording self-reported health need including diagnostic information, primary care usage and barriers to access. In an analysis of the 2018-2019 data, based on a survey of 13572 respondents aged 15 years or older, high and unmet need was found to be greatest amongst Māori and Pacific Peoples, and those living in deprivation (Hau et al., 2022). Other authors who had conducted qualitative research with NZ patients or their carers highlighted felt needs regarding mental health (Shrestha-Ranjit et al., 2017), long-term conditions (Carryer et al., 2016), access to care by older people (Waterworth et al., 2018) and palliative care (Landers et al., 2018). Similar needs were indeed referenced by participants.

Using Bradshaw's Taxonomy of Need (1972) as an analytical tool and informed over time by data from all transcripts, I reconceptualized the main concern of the participants as *need-responsive nursing practice.* The properties and dimensions of this construct including *individual patient need* are shown in Table 5.2.

Table 5.2 Properties and dimensions of the concept of *need-responsive nursing practice* – the main concern of the participants

Properties	Dimensions
Societal need	Social justice (Health Equity) Affordability of care to state and individual Safe Practice: clinical and cultural competence of service and practitioner
Professional need	Professional purpose: status, reputation, (Legacy) Workforce structure and sustainability
Individual patient need	Choice: health status, accessibility Care: preventive, acute, chronic, rehabilitative, palliative Standard of care
Individual staff need	Job-satisfaction: income security, work-life balance, self-perception Supported autonomy for safe practice: resource, staffing, workload, training, team skill-mix
Business imperative	Profit, non-profit (Independence) Risk appetite Resource: material and human (Workforce Moral)

5.6.2 Exploring the question of agency through use of literature

Reflecting on, 'What empowered participants to act on their main concerns?', the question of *agency* arose. In a memo dated 28 April 2021 (Box 5.4) noted that this appeared to involve external enabling factors and internal self-reflective processes.

Box 5.4 Memo written on 28 April 21

(Negotiation Spaces) Arise(or not) from circumstance which create opportunities for the work of nurses in general practice to be actively and specifically considered through interaction among actors who are **enabled to apply** the outcomes of such considerations to practice. Spaces may arise at any level of the system, where matters likely to affect nurses/ing in general practice are at issue. There is also an intra-personal space, where individuals consider the work of nurses in general practice, through **self-interaction**. In this space, matters that are not formally aired in inter-personal spaces, nevertheless influence the formation of beliefs and values, expectations and intentions, and hence the behaviour of the actors.

From the literature, theoretical codes with potential relevance to this question were identified. Among them, from self-determination theory, relatedness, beneficence, autonomy and competence, were referenced as psychological mediators of workplace behaviours. (Martela & Riekki, 2018), and appeared explanatory. Respectively, these factors enable individuals to feel connected to others, to feel useful, to feel in control and to feel capable. Re-analyzing transcripts in the light of this theoretical perspective, highlighted how participants' *agency* could be influenced by these mediators. Table 5.3 gives examples of the expression of these codes in the data, together with questions that hypothesize aspects of participants' internal

dialogue when considering action. Competence may otherwise be termed efficacy. Self-efficacy is a belief in one's ability to exercise control and is said to mediate the translation of belief into action (Plaza et al., 2002). As such it was considered as a potential intervening condition mediating participation in role negotiation.

Table 5.3 Theoretical codes from self-determination theory, corresponding data excerpts and suggested self-reflective questions

Theoretical Code	Data excerpt	Self-negotiation questions
Relatedness	"I will do it of it's something that's important to the practice and I'll do it for [owner] because it's important to me to support her and what she's doing." **Participant 5**	Who is my team?
Beneficence	"… how do we give the most vaccinations in a safe way, whilst having no concerns about these people having COVID symptoms. And that's how we started the car park flu vaccines. And I felt the nurses were quite instrumental with that rolling out." **Participant 8**	Can I make a positive difference? Do I believe there is a possibility of positive change?
Autonomy (Volition)	"…I was always raised with the view that you know nurses can do everything, nurses should do everything." **Participant 2**	Is this my problem?
	"…because this concept was new sometimes, unfortunately, if your own nursing colleagues don't understand, there can be there can be roadblocks." **Participant 1**	Do my team want me to act? Can I make and implement decisions?
	"…you have a nursing team, but the shot-caller is the doctor … you're not going to then start thinking for your team and the entire scope that gets missed …" **Participant 7**	What are the consequences of acting
	"… they get so sick of fighting it that they get very defensive, and I've had to work. I've had to personally work on that big time. You turn up as a defensive nurse, you know, forget it …" **Participant 9**	
Competence	"I put my hand up that I want to do diabetes management, I need to take the professional responsibility to learn, to gain competency." **Participant 1**	Am I capable to act?

5.6.3 Testing developing findings

In June 2021, I presented the state of my analysis to fellow nursing doctoral candidates and their supervisors. Figure 5.2 shows a slide from that presentation. It depicts codes derived from participant data and those suggested from targeted literature searches. The process portrayed is an initial outline based around broad negotiating behaviours and is positioned centrally to reflect its being influenced by the situational context and by both the motivational state of the individual and the structural characteristics of the organization. References to retrenchment and engagement are intended to convey that when high individual motivation meets clear organizational vision there is high engagement in negotiation and *vice versa.*

Feedback suggested that the research topic and developing findings resonated with the audience members experience.

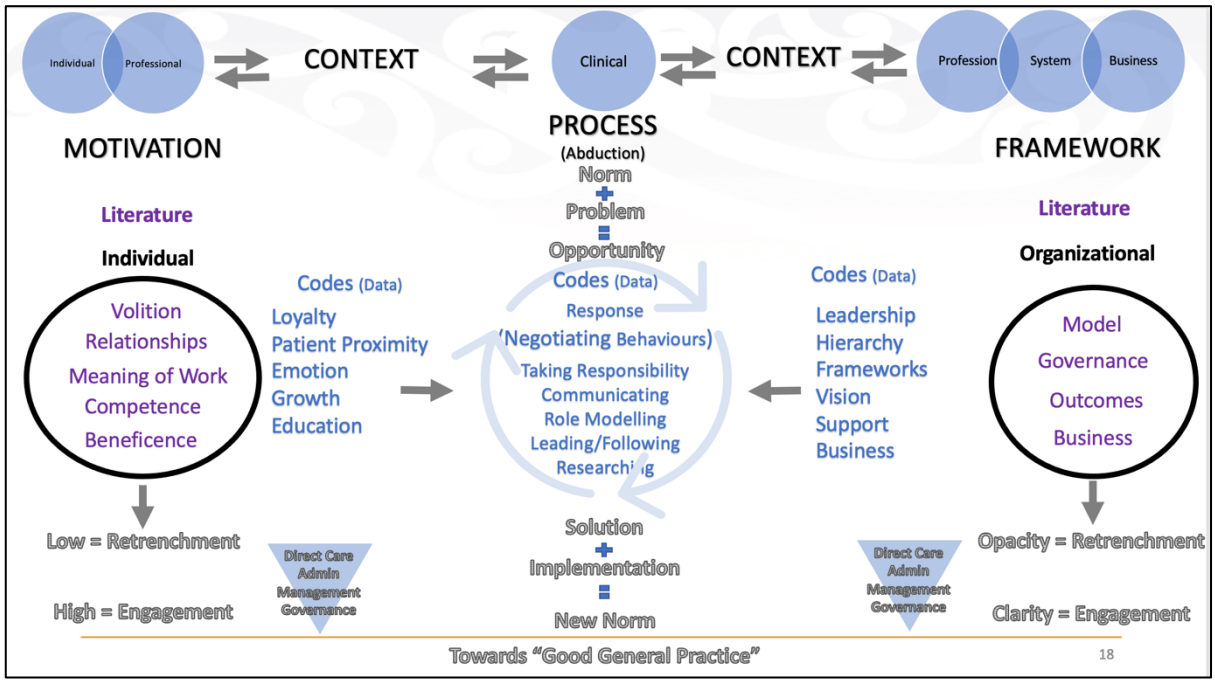

Figure 5.2 Diagrammatical memo dated June 2021

5.6.4 Theoretical sampling for process

Two further interviews were conducted during July 2021 to theoretically sample for contextual variation. The participants, a deputy lead nurse and an experienced associate GP provided further dimensions to concepts identified from previous rounds, but no new codes arose. For example, their experiences during a health care home implementation provided examples of the effects of *uncertainty* in the face of change and they cited the positive effects of clear organizational goals on willingness to accept and participate in such change. I had previously noted the potential significance of *organizational vision* to the research question. During exploration of this question in these interviews, the need for a *fit* between person and organization was cited, including a *fit* within the team and a *fit* with the population served:

> "So having a staff that understands that core value of here because the majority of patients here are Pacific Island and Māori, so we want someone who is culturally aware of those two and a down to earth kind of person, work hard, try to learn more and that's the kind of person we want." **Participant 12**

This was in keeping with the main concerns of other participants as being needs driven. Previous participants had referenced *fit* (Table 5.4). However, in response to this interview, I

recognized the processual importance to the negotiation of the act of *fitting-in* or conversely not fitting-in. Therefore, I determined to explore this issue through further theoretical sampling and to focus on distinguishing *context*, the analysis of which had established the main concern and driver of behaviour, from *process*. Hypothesizing that contexts in which individuals were strongly motivated to negotiate would provide rich processual data, I sought participants from organizations serving high-needs populations. This would also address the previously identified imperative to include Māori and Pacific actors. Recruitment information was again forwarded to contacts in target organizations.

5.6.5 Using storyline

Prior to further interviews, thinking about *uncertainty* from a processual perspective, I conjectured that it was a state arising from *disruption* to previously established ways of working. In a memo I defined it as, "*An event which challenges established ways of working and creates an opportunity for change*.". At this point, I was thinking of *space* as, "*A place where the effects of the disruption are considered and the response to it is decided*." I used storyline, an analytical technique which hypothesizes process in narrative form (Birks et al., 2009), to explore potential mechanistic links among developing concepts. An early attempt is in Box 5.5.

Box 5.5 Memo written on 24 August 2021

Negotiating Role Storyline

Negotiating role starts when a ***disrupting event***[1] (Category 1) which challenges established ways of working[2] is experienced by individuals who perceive the challenge in terms of its potential impact on their work, according to the meaning their work has for them, including their responsibility for the work and welfare of others[3]. They recognise the event may have other meanings for other members of the group and make assessments as to how their point of view may be viewed by others. Where the individual is motivated ***to engage***[4] ***with disruption*** (Category 2), where they feel they have **agency**, permission to become involved they seek access[5] to the ***negotiation space*** (Category 3) which may be formal or informal and at a floor or organisational level, rarely outside GP, and they ***strive to influence decisions***[6] (Category 4) in line with their own needs, by seeking solutions, using strategies[7] resulting in ***locally-optimised outcomes (ways of working)*** (Category 5) which are acceptable more or less to the group.

Reflecting on this storyline the following observations and questions arose:

- A *disrupting event*[1] may occur, but it is the response to that event that is the behaviour capable of driving a process of negotiation.

- How do individuals know what the *established ways of working*[2] are?
- *Responsibility for the work and welfare of others*[3] is understood through the concept of need responsive nursing practice?
- How do motivated individuals *engage*[4]?
- How do they *seek access*[5] and *strive to influence decisions*[6]?
- What *strategies*[7] are used?

However, I felt the general trajectory of firstly, a reason to negotiate, secondly, a decision to negotiate, thirdly , active negotiation, and finally, an outcome of negotiation, was plausible.

To attempt to answer the above questions, I revisited the codes mapped to data excerpts within NVIVO12™. Seeking process, I focused on gerund codes. The gerund verb form or present participle, is indicative of action and is used when coding to help find process (Charmaz, 2012). Whilst I had already looked for gerunds during initial coding, by comparing data with data, data with codes and codes with codes, I reconceptualized a number of 'noun codes' as gerunds. For example as described above *fit* became *fitting-in* and subsumed a number of similar initial codes including *space* and *place.* The properties of *fitting-in* were physical, attitudinal, relational, and systemic as shown in Table 5.4. The data across these properties was indicative of an accommodation between the goals of organization and individual, and included descriptions of behaviour towards that end.

Table 5.4 Participants 1-13 data excerpts initially coded *space, place* and *fit,* later *fitting-in*.

Properties	Data excerpts
Physical	
The effect of physical space on autonomy	"… so yeah, I think we are definitely more autonomous than you would be in a hospital because you work behind closed doors …"**Participant 4**
Attitudinal	
Acceptability of ways of working and doing to the individual	"… that doesn't *fit* with my ethics, it doesn't fit with my morals, it doesn't fit with me." **Participant 2**
Acceptability of ways of working and doing to the organization	"…that doesn't sort of *fit* with the belief system of the practice" **Participant 3**
	"how do I work with the nurse, how do I *fit* into a culture of an organization**" Participant 7**
	"… You know we've done a whole lot of work about how we can *fit* nurses in there and make sure that there's a knowledge and skills framework for it ..." **Participant 9**
	"A good *fit* is someone that is, because this is like a family … and we want someone to … *fit* with what we already have here work together with the girls." **Participant 12**
Individual mind-sets	"… some of them struggle because they're, … just not in that *space*, … you know, you're not going to get leaders in every practice." **Participant 1**
Philosophy of care	"But they came from a patient perspective. It didn't come from how do we work together to make our day better? No, it was how can we work together to make it better for the patients. A completely different *place* to come from, so someone said, 'oh that model doesn't work', but she's made it work because of that." **Participant 9**
Relational	
Support for nurse role development	"… no, no roadblock in terms of from my employers no, no, nothing unfortunately. Very lucky *space*, isn't it?" **Participant 1**
The effect of being new in a decision-making space	"Because actually she's in a *space* where she's feeling really uncomfortable … give her time" **Participant 9**
Developing new ways of working	An informal way is we do talk about oh, I wonder if we should put this in *place*, or should this be a policy? So, there is a lot of good open dialogue I feel. **Participant 8**
Systemic	
The practice space created by the Nurse Prescriber in Community Health Initiative	"I feel like there's a lot of those *spaces* and I'm not even a clinical guy. Like, I feel like this opportunity you guys are here and watch things, to go like, 'why isn't a nurse doing this?', or 'why is there a lesser perception given to a nurse?'" **Participant P7**
Use of nurse specialist designation to self-define role	"My colleague and I, decided to scope the role in and call ourselves that, because it's a little bit about claiming that role in that *space* and naming it." **Participant 10**

5.6.6 Identifying a core category

During the review of codes an *in-vivo* code was suggestive of an overarching process and was identified as having potential for developing a core category. A core category is one which embodies the best explanation of the phenomenon under study and *in-vivo* codes are data labels taken verbatim from the data (Birks & Mills, 2023). The term *levelling up* was used by a participant to encapsulate their vision of moving all members of the practice team to work at the top of their scope. As they described it, this included recognition of and allowance for differing skills and appetites for taking on particular tasks and responsibilities, different ways of *fitting-in*. While, as discussed in the published paper "Grounded theory method and symbolic interactionism: Freedom of conceptualization and the importance of context in research" in

Chapter Four, *levelling up* was discarded as a core category, this particular narrative was helpful to the conceptualization of *process*.

Whilst I found NVIVO12^{TM} useful for storing and mapping codes and for searching transcripts, I felt I needed more creative means of interaction with the data to spark cognitive insight. It is recognized that "digital tools support a more sequential form of cognition whereas manual methods and tools support the relational" (Maher et al., 2018, p. 4). Therefore, in this stage of analysis, I returned to reading printed transcripts, to listening to interview recordings and used multiple whiteboards to visualise codes and their interconnections. Bearing in mind the observation and questions arising from the *Negotiating Roles Storyline* in Box 5.5, I experimented using index cards for each code, and by positioning them on a large table was able to review them as a whole, and better consider their possible processual sequencing, whether they were germane to the main concern and where similar codes could be grouped to create pertinent categories. From this process, I conceived the *Levelling up Storyline* shown in Box 5.6. This positions the *disrupting event*[1] within a *norm* or *established way of working*[2] which individuals have come to understand by *mastering skills* and *establishing relationships*. In this storyline, motivated individuals *engage*[4] in negotiation by first asking what their role could look like and trying out ideas. They use the relationships they have built to *access*[5] and *influence decision-makers*[6], deploying information and demonstrating worth as a *strategy*[7] to galvanize support.

Box 5.6 Memo written 28 August 2021

Levelling up Storyline

Individuals begin by ***occupying their place*** in the general practice team. Over time they come to *understand their own personal scope* of practice, in the context of the existing norms within that team. Initial focus is on *mastering skills and establishing relationships* within the team.

Once they understand their place in the norm and in accordance with their perceived personal scope of practice, they ***position themselves to do more*** by: asking "*what their role could look like".* This includes looking for personal role models and systemic supports or frameworks, for particular roles, eg specialization, leadership. They *test* their own *limits;* those of their team and of the system by trying out ideas as they arise. They *acquire knowledge,* through experience and training, learning about the health system and patient need*;* and reflect on the experience to *develop personal goals.*

When confident to do so, they ***leverage opportunities to achieve goals*** by: *responding to uncertainty,* by accepting challenges arising from disruptors; *engaging in collective decision-making,* by active participation within the hierarchy*; and demonstrating worth,* which includes bargaining for reward*;* to galvanize support (gain power), by deploying knowledge.

Finally, they ***create a new place*** for and within the team *demonstrating new skills*, improving inter-professional collaboration, through *matured relationships* and thereby realising a developed *team scope of practice.*

5.7 Phase Four – including discussion of the prime mover of participants' behaviour

Four interviews were conducted during October 2021 using the existing interview structure. Also where appropriate, after the other open questions were discussed, I referenced the developing *Levelling up Storyline* to test its plausibility. As planned, Māori and Pacific participants were included in this round, including participants with experience of working in organizations delivering integrated health and social services within communities following kaupapa Māori principles, including under the Whānau Ora Programme (p.33). "Kaupapa Māori provides an avenue for Māori to enact health care within a Māori worldview,…" (Rolleston et al., 2020, p. 2). Data from these interviews built on the postulated importance of *organizational governance* as an intervening condition, as recorded in Figure 5.2. The code *culture* was used for data in which participants discussed their own specific *need* to practise in ways that were true to the traditions of the cultural group to which they felt belonging and willing filial duty. It appeared that within kaupapa Māori organizations participants found governance parameters enabled them to better contextualize personal goals and envision their realization within the organization than in other contexts they had experienced. Therefore, data from this round contributed further ideas about finding somewhere to practice as one would wish, by *fitting-in* to a *norm* and by influencing that *norm* to better *fit* oneself.

Participants in this round highlighted the importance of feeling ethically and materially comfortable, to perform a role in the manner required of them by their employing organization, and demonstrated clear motivation to provide culturally safe care. This built on the dimensions of *individual staff need* within the concept of *need-responsive nursing practice* as shown in Table 5.2 and positioned *safety* as a key intervening condition. In addition to the concept of cultural safety mentioned above and discussed in Chapter Two (pp.41-42), here, *safety* means the avoidance of harm to nurse, patient or team member, whether physical, emotional or reputational and participants' sense of safety is enhanced by access to training and education; by access to leaders and mentors; and through collegial support.

I noted that *fitting-in* could not be assumed on the basis of *prima facie* cultural concordance. Rather it is multidimensional and is affected by personal and professional ethos. One participant recalled finding her place within a Kaupapa Māori organization:

> "I was a junior nurse at that time … I did placement for 12 months at one medical, GP practice, mainstream … but of course the whole reason for knocking on the door was because I felt this organization may have possibly aligned with what was dear to my heart and that is strongly around the cultural needs of whānau … and I hounded and hounded … my current employer to let me in, let me in." **Participant 14**

She cited ongoing community engagement as a practical expression of the organization's commitment to providing culturally safe care. However, another at interview shared her disillusionment when the Māori Provider for whom she worked developed a model of care which conflicted with her professional needs:

> "I said to the clinical lead then, this is not the growth of nurses, this is putting nurses back 20-30 years … you are putting them behind a desk on the phone, they are making phone calls. You know the HCA was going to have more contact with the … patients, than the nurse was." **Participant 18**

Although an apparent *fit*, with changes the participant found she was unable to influence the *norm* to meet her professional ethos and she sought employment elsewhere.

Additionally in this phase, as discussed in, "Grounded theory method and symbolic interactionism: Freedom of conceptualization and the importance of context in research", included in Chapter Four, instances describing connection to and serving community led to the code *meaning of work*. This concept then informed analysis across the dataset to elucidate factors material to participants' motivation towards negotiating behaviour. Thereby, and through comparison with the individual prime movers, identified in Table 5.1, *meaning of work* was identified as the main contextual influence on *need-responsive nursing practice* and the prime mover of negotiating behaviour. As such, each example in Box 5.2 could be contextualized by the personal and professional circumstances of the participant, allowing for change of meaning over time and with position in the organization as illustrated in Table 5.5

Table 5.5 Properties and dimensions of the concept of meaning of work

Time	Properties (Context)	Dimensions
variable over time and change of context	***Personal meaning*** (Life stage)	Work-life balance Personal ethics, worldview
	Professional meaning (Career stage)	Professional ethics Professional ethos
	Meaning within the Organization (Position in the organization) Owner, employer, employee, contractor Clinician, Manager, Administrator, Leader, Specialist	Profit Efficiency Clinical Outcomes Relationships Status

Reflecting on the idea of *fitting-in*, I created the code *accessing the market*. This arose from discussions that I had labelled, *changing goal posts, investing in nursing* and *I didn't ask for this.* The data relating to these labels described experiences of nurses who had taken opportunities that promised goal-fulfilment through advance practice roles but had encountered unsurmountable obstacles. For example, organizational support whether moral or financial had been withdrawn or having been approached to take on a particular role, participants found themselves without clear pathways or guarantees of employment. Ultimately for some, the high personal financial and emotional costs of such pioneering became unsustainable and they sought alternative *access to market* in established registered nursing roles working then to expand their autonomy within their existing scope, incrementally. Again data excerpts relevant

to theses specific observations are excluded as having potential for breach of participant confidentiality. However, they highlighted behaviours by which nurses sought changes to their role parameters, leading to codes such as *acting through proxies*, *growing ourselves,* and *specializing*. Such codes later formed part of a category *demonstrating worth*, later *demonstrating value*.

5.8 Phase Five – further sampling for process

As well as high-needs environments potentially offering rich processual data, from my experience as a prescriber, I believed others with experience of implementing this role would be valuable sources of data. Therefore, I sent recruitment fliers to this cohort. In interviews with responding participants, and two others identified through snowball sampling, in December 2021 and January 2022, I added questions about the effect on registered nurse autonomy of using newly acquired prescribing skills. I also continued to review the developing storyline with informants. Few new codes were created but the data contributed depth to existing codes. Predominate narratives led to codes including *feeling useful,* by virtue of their new skills*, normalizing* new skills within the team and *owning one's practice.*

5.9 Phase Six – including discussion of the derivation of categories, theoretical integration and saturation

Again, using whiteboards, index cards and storyline to review new codes and data with one another and with concepts from previous analysis, I reviewed the *Levelling up Storyline* shown in Box 5.6. to create and integrate pertinent categories. I separated contextual codes from processual codes, again looking for gerunds, and asked how the concepts of *need-responsive nursing practice* and *meaning of work* drove process.

5.9.1 Derivation of categories

Reflecting on data codes *space* and *place*, I reconceptualized them as expressions of distinct role conditions. Space became a role into which one must fit and place a role which, at least in part, one creates. The properties and dimensions I recognized in these concepts, so expressed and as shown in Table 5.6, led me to visualize the negotiating process as one of moving from *occupying* a *space* within an established norm to *defining* a *place* within a new norm.

Table 5.6 Properties and dimensions of key concepts/categories

Concept/ (Categories)	Properties	Dimensions		
		From Space		To Place
Concept:Role	*Skills*	Tasks		Responsibilities
Category 1. Occupying Space 4. Defining Place	*Relationships*	Transactional		Collegial
	Practice	Delegation		Autonomy
2. Positioning to do Differently	*Role possibilities*	Un-envisaged		Apparent
	Limits	Constrained		Expansive
	Goals	Short-term		Long-term
3. Leveraging Opportunity	*Responding to Uncertainty*	Avoidance		Engagement
	Engaging in Collective Decision-making	Dialogue	Problem-solving	Just doing it
	Demonstrating Value	Explaining role		Pioneering new roles

At this stage, earlier conceptualizations were reviewed for coherence with the whole and accepted, adapted or rejected. For example, the category label *doing differently* was ultimately preferred to *doing more*, since the trajectory of role changes was not always expansive. This realization introduced a further intervening condition, that of *satisfaction with area of autonomous practice,* as a mediator in the decision to seek role change. In this way the processual categories *positioning to do differently* and *leveraging opportunity* were developed from the *Levelling up Storyline*, and further defined and integrated into the putative grounded theory of *creating place*. Bringing together the concepts discussed in the foregoing paragraphs, Appendix 2 provides an overview with examples of the abstraction of categories from initial codes.

5.9.2 Theoretical saturation

As shown in Figure 5.1 part of the constant comparative method is determining theoretical saturation. In GT, theoretical saturation refers to the point where the properties and dimensions of categories are fully defined and when new data does not contribute materially to better conceptualization of the phenomenon under study (Birks & Mills, 2023). Arguably, new data could always add to the research. Therefore, the decision to stop sampling must be pragmatic. As referenced in Chapter Four, (Clarke et al., 2016, p. 14) "Symbolic interactionism tells us that things could always be otherwise" and within a constructive methodology, the interaction

of other researchers and other participants would produce other outcomes. Therefore, in addition to assessing saturation by considering the richness of the description of categories and their contributing codes, other hallmarks of sufficiency are the credibility and resonance of the proposed theory (Charmaz & Thornberg, 2020).

In September 2022, I presented the draft theory of *creating place* to fellow nursing doctoral candidates and their supervisors. In discussion, it was observed that the process, based on data from a range of actors, could be applied to all members of the general practice team not just nurses. This was influential when considering the position of the proposed theory within extant knowledge as discussed in Chapter Seven. Moreover, the storyline and supporting data excerpts were considered credible by the audience. The final storyline is presented below and illustrated in Figure 5.3. It is more fully described in the manuscript, "The process of nurses' role negotiation in general practice: A grounded theory study", included in Chapter Six

5.10 Creating place storyline

In New Zealand, nurses in general practice strive to provide what they consider to be *need-responsive nursing practice* and the process they use to negotiate the provision of this standard of practice is one of *creating place.* To create place, nurses first occupy space within the pre-existing norms of a specific organization. They do so by consolidating their extant skills, building relationships with colleagues and establishing an area of autonomous practice. As their confidence grows and relationships deepen, they begin to position themselves to do differently. Seeking engagement with the wider general practice team, they begin to explore what their role could look like in the future and test the limits of identified possibilities against the parameters of the norm-defined space they have come to occupy. As a result they set goals for their career development. Becoming more embedded in the general practice team, they start to leverage opportunities to pursue these goals. Such opportunities present where change in the operating environment creates uncertainty as to how to proceed. Nurses recognize and respond to uncertainty in accordance with the skills and knowledge gained whilst occupying space and positioning to do differently. Capitalizing on the relationships they have built, they engage in collective decision-making, demonstrating their value to the organization as skilled clinicians and leaders in health care, to define a place for themselves within a developed organizational norm: the outcome of creating space. By changing from *occupying space* to *defining place*, nurses redefine their assigned roles, optimizing the relationships they have

fostered in the team and the skills and knowledge they have actively developed, to expand the boundaries of their professional autonomy. They are thereby better able to determine and deliver need-responsive nursing practice. Hence, the grounded theory of creating place explains how the provision of *need-responsive nursing practice* and therefore, nurses' roles in general practice are negotiated, as individuals progress from occupying workspaces wholly defined by the care-philosophies of others to defining workplaces that incorporate their own professional beliefs, values and expectations. In the course of the negotiation, views of what constitutes *need-responsive nursing practice* are themselves developed. Concepts of need-responsive nursing practice vary among nurses, and other members of the general practice team, and from time-to-time, according to the contemporary meaning they attach to their work, commensurate with their personal and professional circumstances, and position in the organization.

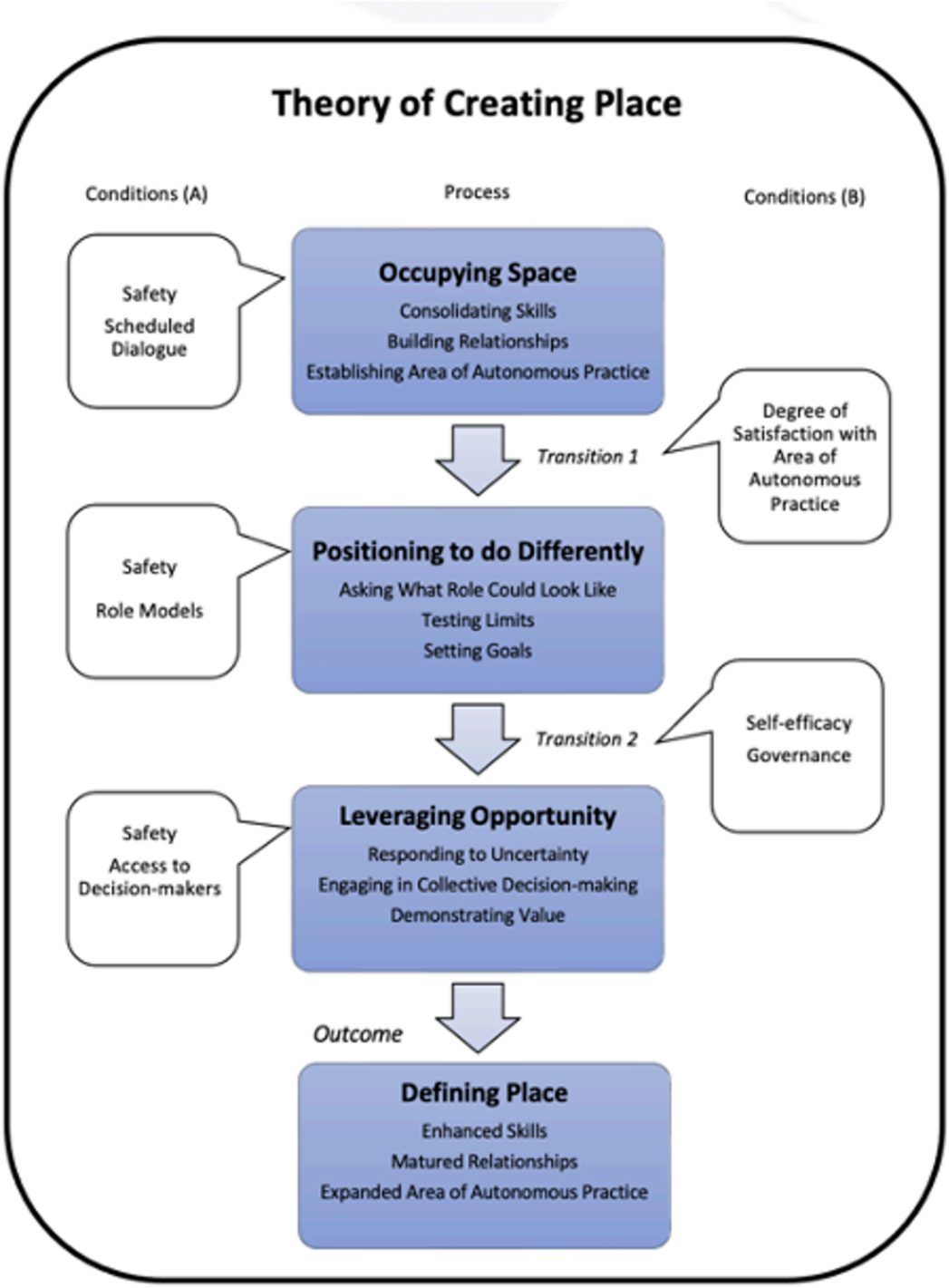

Figure 5.3 Model illustrating the theory of creating place

5.11 Research Quality

The 'Big-Tent' Model is a set of eight criteria used for assessing quality in qualitative research. It is intended to accommodate a broad range of philosophical and methodological approaches and to be flexible as to exact means and positionality. As such it espouses the following markers of quality, meaningful coherence, rigour, sincerity, credibility, resonance, worth, relevance and ethics (Tracy, 2010). The remaining paragraphs of this chapter discuss how these criteria were met in this study.

5.11.1 Meaningful coherence

The Big-Tent model's principal criterion is that the design and associated methods should be congruent, or meaningfully coherent, with the research aims and that their application should answer the research question and any sub-questions. As discussed in Chapter Four, constructivist GT informed by SI was selected as an appropriate approach for this study as it was congruent with my philosophical position, allowed for researcher co-construction of knowledge and was well-suited to conceptualizing lived experience to elicit process. The recursive use of literature and the identification of theoretical codes in this study, in keeping with GT methods, also evidences the required synthesis of extant and new knowledge and perspectives throughout the research process and in the articulation of the products of research (Tracy, 2010), further bolstering meaningful coherence.

5.11.2 Rigour and credibility

The tenets of GT which make up the constant comparative method were applied consistently throughout this study and the SI perspective was operationalized using three questions, 'Who and what are the actors in this situation?', 'What is meaningful to the actors in this situation and why?' and 'How do actors' individual lines of action interact in this situation over time?'. By use of situational analysis and theoretical sampling the data constructed were highly pertinent to the research question and richly contextualized. This allowed theoretical constructs used as analytical tools and those conceptualized from the data to be tested empirically at each stage of analysis. All findings are linked to the empirical instances in the data and key methodological aspects of the research and its findings have been submitted for publication and subjected to peer review eliciting the review comment, "The research methods were clearly described and appeared appropriate. The findings were explained, linked to participant quotations and the resultant theory appeared justified from the analysis."

5.11.3 Sincerity

The account of my research process is presented chronologically in this Chapter, in acknowledgement that research of this nature "does not follow the straight lines of positivism, and any suggestion that it does overlooks the relationship among the iterative elements of the design and that research can deviate along unexpected paths" (Piper & Stokes, 2020). Time spent considering the main concern and prime mover of participants reflected the importance I placed on grounding the research in the lived experiences of the participants. This was an imperative arising from the knowledge gap regarding nurses' work in New Zealand general practice and to challenge my own assumptions and biases about what was important in that regard. Moreover, as a doctoral candidate, I took pains always to base research decisions on sound methodological principles rather than on the exigencies of completing a programme of study.

5.11.4 Resonance

Resonance refers to the degree to which audiences are engaged by the research. Academic and clinical colleagues with whom I discussed my analyses and findings appeared interested in the developing concepts and able to identify their potential relevance within their own experience. Through formal consideration of comparable theoretical codes as described in Chapters Six and Seven, the theory of *creating space* has been situated within extant theoretical codes, enhancing its practical application within New Zealand General Practice and its transferability to other fields.

5.11.5 Worth and significance

The worth of this research, including consideration of its relevance, timeliness and significance is discussed in Chapter Seven.

5.11.6 Ethics

Research ethics approval was obtained from Massey University Human Ethics Committee NOR 20/46 dated 10 November 2020, Appendix 3. All participation was voluntary and informed via the use of participant information sheets and written consent forms, as at Appendices 4 and 5. Protocols were used to protect confidentiality and address the possibility of participant distress during interviews. Whilst data collection was directed by theoretical

sampling, and involved the general population, recognizing obligations to Aotearoa New Zealand's Indigenous Māori population under the Treaty of Waitangi (February 6,1840), participants were sought to reflect the diversity not only of the specific research context but of the New Zealand population at large. The research findings have been submitted for publication and will be shared with participants and the wider primary health care community.

5.12 Conclusion

In this Chapter, I have endeavoured to give a detailed account of the processes of data construction and analysis in this study. However, due to the nature of the topic and that of abductive reasoning, which involves preconscious processing, this cannot be a perfect description of all cognitive insights over the three years of study. Where detail described in the published paper, "Grounded theory method and symbolic interactionism: Freedom of conceptualization and the importance of context in research", included in Chapter Four does not precisely align with that described here, it reflects the stage of analysis pertaining at the time of the preparation of that manuscript. Rather than undermine the quality of the research, this underscores the iterative, recursive and open conceptualization of the processes at work within the situation of interest. The manuscript, "The process of nurses' role negotiation in general practice: A grounded theory study", currently under review for the Journal of Advance Nursing, presented in the next chapter includes a full description of the theory of *creating place*, and begins a discussion of its practical implications, which are further elaborated in Chapter Seven.

Paper 3. Statement of contribution doctorate with publications/manuscripts

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

GRADUATE RESEARCH SCHOOL

STATEMENT OF CONTRIBUTION DOCTORATE WITH PUBLICATIONS/MANUSCRIPTS

We, the student and the student's main supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the student's contribution as indicated below in the Statement of Originality.

Student name:	Sarah Louise Hewitt
Name and title of main supervisor:	Professor Nicolette Sheridan
In which chapter is the manuscript/published work?	Six

Describe the contribution that the student and members of the supervisory team have made to the manuscript/published work:[1]

Sarah Hewitt Carried out the research, conceived the arguments and wrote the paper

Nicolette Sheridan - Oversight and leadership responsibility for the research activity, planning, execution and reporting
Karen Hoare - Supervised the research, development of methodology, assistance with manuscript revision
Jane Mills - Supervised the research, development of methodology, assistance with manuscript revision

Please select one of the following three options:

○ The manuscript/published work is published or in press
Please provide the full reference of the research output:

◉ The manuscript is currently under review for publication
Please provide the name of the journal:
Journal of Advanced Nursing

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Student's signature:	Sarah Hewitt Digitally signed by Sarah Hewitt Date: 2023.07.28 12:30:27 +12'00'	Main supervisor's signature:	Professor Nicolette F Sheridan Digitally signed by Professor Nicolette F Sheridan Date: 2023.08.23 16:17:55 +12'00'

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[1] Refer to the Massey University Publishing and Authorship guidelines (OneMassey for staff, Stream for students) and/ or Contributor Roles Taxonomy (CRediT) guidelines for guidance.

Chapter 6 The Grounded Theory - Creating Place

"What begins as undifferentiated space becomes place as we get to know it better and endow it with value" (Tuan, 2001, p. 6)

6.1 Introduction

As previewed in Chapter Five, the theory of *creating place* explains the negotiation of nursing roles within New Zealand general practice as a three-stage process involving *occupying space*, *positioning to do differently* and *leveraging opportunity.* The process is driven by individual conceptualizations of *need-responsive nursing practice*, towards the outcome *defining place*. This represents an accommodation between the values, beliefs and expectations of individuals and pre-existing organizational norms. Throughout the process, individual and group-normative concepts of *need-responsive nursing practice* are themselves developed. As such, *creating place* is about the development of meaning and understanding through experience, which, as alluded to by human geographer Yi-Fu Tuan in the opening quote, mediates human interaction with the environment.

In this chapter, the theory of *creating place* is explained in the manuscript, "The process of nurses' role negotiation in general practice: A grounded theory study", introduced in paragraph 6.2. Thereafter, in paragraph 6.3 the transition from *occupying space* to *defining place* is illustrated with an example from the data.

6.2 Findings manuscript – Paper 3

The following manuscript (Hewitt et al., 2023) is a review copy currently under consideration for publication in the Journal of Advanced Nursing. It incorporates changes made in response to reviewers' comments since first submission in February 2023. Due to the limitations of word count and reviewers' recommendations, the discussion section focuses on integration of findings with the nursing literature only. Further discussion is included in Chapter Seven.

The process of nurses' role negotiation in general practice: A grounded theory study

Abstract

Aim: To explain the process by which nurses' roles are negotiated in general practice.

Background: Primary care nurses do important work within a social model of health to meet the needs of the populations they serve. Latterly, in the face of increased demand and workforce shortages, they are also taking on more medical responsibilities through task-shifting. Despite the increased complexity of their professional role, little is known about the processes by which it is negotiated.

Design: Constructivist grounded theory.

Methods: Semi-structured interviews were conducted with 22 participants from 17 New Zealand general practices between December 2020 and January 2022. Due to COVID19, 11 interviews were via Zoom™. Concurrent data generation and analysis, using the constant comparative method and common grounded theory methods, identified the participants' main concern and led to the construction of a substantive explanatory theory around a core category.

Results: The substantive explanatory theory of *creating place* proposes that the negotiation of nurse roles within New Zealand general practice is a three-stage process involving *occupying space*, *positioning to do differently* and *leveraging opportunity.* Nurses and others act and interact in these stages, in accordance with their conceptualizations of *need-responsive nursing practice*, towards the outcome *defining place*. *Defining place* conceptualizes an accommodation between the values beliefs and expectations of individuals and pre-existing organizational norms, in which individual and group-normative concepts of *need-responsive nursing practice* are themselves developed.

Conclusion: The theory of *creating place*, provides new insights into the process of nurses' role negotiation in general practice. Findings support strategies to enable nurses, employers and health system managers to better negotiate professional roles to meet the needs of the populations they serve, while making optimum use of nursing skills and competencies.

Implications for the profession and/or patient care?

Findings can inform nurses better negotiation of the complexities of the primary care environment, balancing systemic exigencies with the health needs of populations.

Impact:

- **What problem did the study address?**

  In the face of health inequity, general practice nurses in New Zealand, as elsewhere, are key to meeting complex primary health needs. However, there is an evidence gap regarding the processes by which nurses' roles are negotiated within provider organizations. A deeper understanding of such processes may enable better use of nursing skills to address unmet health need.

- **What were the main findings?**

  Nurses' roles in New Zealand general practice are determined through goal-driven negotiation in accordance with individual concepts of *need-responsive nursing practice*. Individuals progress from occupying workspaces defined by the care-philosophies of others to defining workplaces that incorporate their own professional beliefs, values and expectations. Negotiation is conditional upon access to role models, scheduled dialogue with mentors and decision-makers, and support for safe practice. Strong clinical and organizational governance and individuals' own positive personal self-efficacy are enablers of effective negotiation.

- **Where and on whom will the research have impact?**

  The theory of *creating space* can inform organizational and individual efforts to advance the roles of general practice nurses to meet the health needs of their communities. General practice organizations can provide safe supported environments for effective negotiation; primary care leaders can promote strong governance and develop individuals' sense of self-efficacy by involving them in key decisions. Nurses themselves can use the theory as a framework for engaging in active negotiation of their professional roles.

Key words: ['nurses', 'nursing', 'general practice', 'primary care', 'primary health care', 'role', 'negotiation', 'grounded theory']

Reporting Method The authors adhered to relevant EQUATOR guidelines using the COREQ reporting method.

Patient or public contribution

Researchers and participants currently working in general practice were involved in the development of this study. By the process of theoretical sampling and constant comparison participants comments helped to shape the study design.

What does this paper contribute to the wider global clinical community?

An understanding of the processes by which health professionals negotiate their roles is important to support them to meet the challenges of increased complexity across all health sectors globally.

Introduction

Internationally, primary care demand is exacerbated by the high incidence of chronic disease, ageing populations (Norful et al., 2017), by the resurgence of vaccine preventable disease (Fraser-bell, 2019) and latterly by the COVID 19 pandemic (Lim et al., 2021). With a concurrent shortage of primary care physicians, nurses are taking on a range of clinical tasks formerly vested in doctors, a trend termed task-shifting (Leong et al., 2021). While research shows that nurses are effective in these medicalized roles (Laurant et al., 2018), community nurses' work as advocates for the needs of individuals and communities is also key to improving health outcomes (McCarthy & Jones, 2019). Understanding the processes by which nurses' roles are determined in general practice may help achieve balance between these competing imperatives. This study addresses the question of how the roles of nurses in New Zealand general practice (NZGP) are negotiated using a constructivist grounded theory design.

Background

Globally, increasing numbers of nurses work in community settings (Halcomb, Smyth, et al., 2018). In NZ, 15% of nurses work in primary health care (PHC) (Nursing Council of New Zealand, 2020b), including over 4000 in general practice. Most (97%) are bachelor's degree educated registered nurses (RN), but the number includes diploma-holding enrolled nurses (EN) (Hewitt et al., 2021). As in Australia, Netherlands and UK, they are termed practice nurses (Barrett et al., 2021) and traditionally have focused on vaccination, wound care, medication administration and clinical administration. Since the adoption of a primary health care policy (King, 2001), they also lead in population-based preventative health initiatives, including screening and health education (Finlayson et al., 2012). This is prioritized under NZ's founding document, the Treaty of Waitangi (February 6, 1840) which underpins the drive

towards equitable outcomes for Māori, NZ's indigenous people. Following legislative changes (Key & Hoare, 2020), RNs have few absolute barriers to role development and practice nurses may undertake advanced assessment and prescribing, emergency first response and long-term condition care. By completing a clinical master's degree and practicum, experienced RNs may become nurse practitioners (NP), gaining rights of diagnosis and treatment equivalent to doctors. Increasing numbers of NPs work NZGP (Hewitt et al., 2021).

Most NZGP are small businesses within which nurses are employees and doctors are business owners or contractors. Others in corporate ownership, employ both doctors and nurses across several locations with centralized business support. A number are publicly owned or are otherwise not-for-profit and, according to ethos and populations served, some identify as either Māori or Pacific entities. Although largely publicly funded, most practices have considerable freedom to decide how services are delivered (Sheridan et al., 2023). Hence, there is opportunity to tailor models of care and use the full scope of nursing practice to meet local health needs. However, the ephemeral nature of general practice funding for nurse-led care, the tension between profit and care delivery and the predominance of the medical model, militate against this (Greatbanks et al., 2017).

The main themes of the literature relevant to the negotiation of nurses' roles in primary care are interprofessional collaboration and the contextual facilitators and barriers of such. The medical-nursing boundary is greatly researched, and the negotiation of nurses' role parameters is reported to be negatively impacted by: the greater ability of doctors to command fees; the politics of labour relations when nurses are employed by doctors; and role confusion about professional designations (McInnes et al., 2015). Discussing competition for traditional and emerging roles from non-regulated health workers, Norful et al., (2017) emphasize the need for nurse participation in decision-making about their roles but observe that, globally, such participation is rare. Umbrella and systematic reviews of the literature on interprofessional collaboration in healthcare teams (Rawlinson et al., 2021; Sangaleti et al., 2017) highlight philosophical, structural, fiscal and interpersonal challenges faced by primary health care providers. The rational for this research was to address a knowledge gap about how in the context of these challenges, nursing roles are negotiated within NZGPs.

The Study

Aim

The aim of this study was to construct a substantive theory of the processes used to negotiate the professional roles of nurses in NZGP, grounded in the experiences of those involved. The implications of findings on the development of nursing roles were also explored.

Methodology

Design

To accommodate the authors' primary care clinical and research experience, we used a constructivist grounded theory design in which researchers are positioned as co-constructors of knowledge. Reflecting the abductive logic (Reichertz, 2007) of grounded theory, we defined our research terms loosely allowing the *de facto* processes of negotiation and pertinent facets of role to be determined through engagement with the data. Data was collected and analysed using constant comparative analysis and the common grounded theory methods: theoretical sensitivity; memo-writing; concurrent data generation; coding and categorizing of data, including theoretical sampling; theoretical saturation; and theoretical integration (Birks & Mills, 2023).

Sample and Participants

Participants capable of contributing meaningful data representative of the phenomena of interest were recruited by purposeful sampling (Morse & Clark, 2019). Initially, flyers were sent by e-mail to general practice networks, introducing the research and researchers. The first author contacted those who responded by telephone, e-mailed them participant information sheets and invited them to complete consent forms. To identify those with characteristics and experience relevant to developing categories further flyers were circulated to contacts in selected organizations. Thereby, the sample expanded beyond nurses, managers, general practitioners (GP), employers and nurse leaders within NZGPs, to include regional nurse leaders and academics. In addition, men Māori and Pacific participants, and those at differing career stages were theoretically sampled using similar recruitment methods.

Data collection

Semi-structured one-to-one interviews each of around 60-minutes were conducted by the first author, using the protocol in Box 6.1. Where possible these were face-to-face in the

participants' workplace. However, data collection occurred over the period December 2020 to January 2022 and, due to restrictions imposed during the COVID19 pandemic 11 of 22 interviews were conducted via Zoom™. All were audio recorded and transcribed by the first author, who also wrote reflective memos soon after each interview. Sampling stopped when categories were fully saturated, and properties and dimensions defined.

Box 6.1 Participant interview protocol

Prior to recording:

- Answer any questions arising from Participant Information Sheet
- Confirm written consent
- Document contextual data
- Reminder: The purpose of the interview, is to explore your experiences of nursing roles in general practice, how they are developed, and to understand what is important to you in that regard.

1. For nurses in general practice settings:

- Please describe your current roles
- How did you come to undertake these roles

2. For nurses in general practice leadership roles, or for non-nursing participants[1]:

- Please describe the roles of nurses in your practice(s)
- How did they come to undertake these roles?

Prompts:

G. How was your (their) role decided when you (they) were first employed, in current role?

- Have there been significant changes to your (their) role since then?
- How did changes come about?
- Compare experience with previous employment/ career stages

H. Can you (they) negotiate a change in your (their)role?

- New services
- Collective or individual negotiation
- With whom do you (they) negotiate?

I. What are the '*tasks that matter*' to you (them) and why?

J. Who supports you (them) to do the things you (they) love?

- Training
- Mentoring
- Professional supervision

K. What does professional autonomy mean to you (them)?

- How do you describe your personal scope of practice?
- What influences this?

L. For each question ask: *Can you give me an example*?

Note:

1. The intent of asking non-nurse participants to describe nurse roles and their derivation, was to establish the range of perspectives and interactions present in the situation of enquiry.

Data analysis

The first author coded transcripts, identifying data of apparent significance to the research question. Iteratively, and in discussion with co-authors, initial or open codes were developed and collapsed to form abstract categories. Situational analysis was used to highlight the range of actors, cultural and symbolic elements, and contested viewpoints in the situation (Clarke et al., 2018). NVIVO12™ Software was used to manage the coding process and memos written to track analytic insights were recorded in Evernote™.

The potential significance of *space* was recognized during initial analysis as recorded by memo (Box 5.2). Space and similar terms occurred often in the data, relating to the interplay of physical, attitudinal, relational, temporal, and systemic factors. *Uncertainty, vision* and *need* were considered contextually significant, and *autonomy* was considered the principal object of negotiation. We began to conceptualize the negotiation as a transition from a pre-existing *space* to a re-constructed *place*. Finessed by comparison with other empirical instances and with other codes over successive phases of data collection and analysis, pertinent codes were grouped into categories. At each stage the validity of conceptual choices was tested against extant data and through theoretical sampling. Abductive reasoning was used to hypothesize and test processual links between categories, including the use of storyline (Birks et al., 2009), leading to the construction of the core category and consequent theory of *creating place*.

Ethical considerations

University Research Human Ethics Committee approval was obtained (NOR 20/46 dated 10 November 2020). Participation was voluntary and identifying participant information was anonymized from the point of transcription. The Manchester Metropolitan University Distress Protocol for qualitative data collection was adopted in case of participants becoming distressed during interview (Haigh & Witham, 2013).

Rigour and reflexivity

Quality criteria for constructivist grounded theory include originality, credibility, resonance, and usefulness (Charmaz & Thornberg, 2020). Developing categories were discussed with participants and experienced researchers throughout the analysis and the final-draft theory was presented to academic and clinical colleagues. Feedback demonstrated that the theory of *creating place* resonated with and had explanatory power regarding third-party experiences. For example, a non-participant EN endorsed the theory regarding her experience of developing

a nurse-led palliative care role. The use of memos to record matters of procedural logic enhanced procedural precision (Birks et al., 2008).

Findings

Participants were drawn from 17 NZGP organizations, with a variety of business and care models and in both urban and rural locations. The characteristics and order of recruitment of the 22 participants are presented in Table 5.1.

The data evidenced differing norms of practice across general practices. However, participants' main concerns across the dataset were conceptualized as the provision of *need-responsive nursing practice (NRNP)*. Nurses, and other members of the general practice team, understand *NRNP* according to the meaning they attach to their work, commensurate with their personal and professional circumstances, and position in the organization. Such context influences the interpretation of the range of needs arising from societal professional, individual and business imperatives. Properties and dimensions of the concept of *NRNP* in the context of meaning of work are shown in Table 6.1 with examples from the data.

The grounded theory

The grounded theory of *creating place* proposes that general practice nursing roles are negotiated as individuals progress from *occupying* work*spaces* delimited by pre-existing norms of specific organizations, to *defining* work*places* that incorporate their own values, beliefs and expectations. The theory comprises the categories of *occupying space*, *positioning to do differently*, *leveraging opportunity,* and *defining place*, see Figure 5.3. During the negotiation, individual and group-normative concepts of *NRNP* which drive the process are themselves developed.

The first two categories conceptualize phases where internal or self-negotiation predominates, the third category comprises mainly group-negotiation and the fourth represents outcomes of negotiation. Progression between phases occurs after the completion of subordinate activities. The conditions referred to in Figure 5.3 are contextual factors which influence the completion of steps within each phase (A) and the transition between phases (B).

Table 6.1 Properties and dimensions of the concept of need-responsive nursing practice in the context of meaning of work, with examples

Meaning of Work (Context)	Properties	Need-responsive nursing practice Dimensions
Personal Circumstances	***Societal Need***	Social Justice
Work-life Balance		Affordability
Personal Ethics/ Worldview		Safe Practice – Competence: clinical and cultural
Life-stage	***Professional Need***	Professional Purpose/Status/Reputation/Legacy
Professional Circumstances		Workforce Structure
Professional Ethics	***Individual Patient Need***	Choice: Health Status /Access/ Accessibility
Professional Ethos		Care: Preventive /Acute /Chronic/Rehabilitative/Palliative
Career Stage		Standard of Care
Position in the Organization	***Individual Staff Need***	Job-satisfaction:
Owner/Employer/Employee/Contractor		Income Security/Work-life Balance/Self-perception
Clinician		Supported Autonomy for safe practice:
Manager		Resource/Staffing /Workload/Training/Team Skill-mix
Administrator		
Leader	***Business Imperative***	Profit/Non-profit
Specialist		Risk Appetite
		Resource: Material and Human

Example 1. An RN cited promoting health equity as giving her work meaning: "*I have a very strong interest in how we work with equity …*". Consequently, she considered outreach to be central to need-responsive nursing practice: *"…most of us are European middle-class and commonly female. So, so, the, the, hardest population for me to access is the middle-aged Māori, Pacific Island male population … and they're well known to be the group that least commonly accesses healthcare … that's something I want to look into and work on …*". **Participant 3**

Example 2. An RN in a lead role, found meaning in professional autonomy and patient contact: *"… we have been encouraged to think for ourselves, to ask questions, to um broaden our scope of practice, to enlighten and lighten a patient's load around their own journey around their health…."*. Consequently, she rejected a new model of care as inappropriate on grounds of felt professional need: *"….and yet now, we were being asked to be in a room, make phone calls, ask them to go and get a blood test and book an appointment and then that's it!"*. **Participant 18**

Example 3. For an RN-clinician and business owner, the idea of professional legacy was meaningful: *"So, for me it's about wanting to retire and leave nursing as an RN who has pushed the boat out on what that looks like, and how RNs can practice…"*. Consequently, she created a model of care within which need-responsive nursing practice was defined in the broadest terms: *"a model where my patient appointment list … and a doctors list, would, would, be about 75 to 80% identical."*. She distinguished between diagnostic and nursing care roles, valuing the latter in the context of population need: *"ultimately … my patient community doesn't need a nurse practitioner. They don't need access to more diagnostic expertise, they need nursing. We don't have 24-hour palliative care nurses doing physical mouth care in a house. That worries me more than whether someone else gets to refer for CT colonography…"*. **Participant 10**

Example 4. For a GP and owner, independence was key to their mode of practice which they felt was meaningful and offered choice to patients: *"…a really good thing about general practice in New Zealand is that it is private businesses, so we can choose to do things the way we choose to do …".* Consequently, for them need-responsive nursing practice was any care that supported their chosen ways of doing: *"…whatever she's (the nurse) has got an interest in it's generally something that's going to be of value to the business.".* **Participant 6**

Example 5. To a practice manager, customers, resourcing and staff moral were meaningful: *"…it's about people, that's why I'm in this job, I'm about my customer, my supplies and my team"*. Consequently, he considered need-responsive nursing practice to be that which met customer demand, was financially viable and was acceptable to the nurses: *"I was actually gob-smacked that I had like female nurses weren't doing [contraceptive implants] and there's a male doctor doing it … I know my female customers want to go to the nurses … I can devolve activity, so I can go and chase the bigger fruit and that top of scope stuff… I can actually devolve, nice, engaging work to a nurse"*. **Participant 7**

The categories and conditions within the grounded theory are abstracted from person, place and time. Behaviours attributed to actors, are conceptualizations from the data and are not intended to have universal validity outside the substantive area. For brevity, the theory is

described from the perspective of nurses as the principal enactors of the role being studied. However, all general practice team members act towards the process in accordance with personal concepts of *NRNP*.

Category 1. Occupying Space

When new to the team, nurses react to the norms they encounter in the light of past experiences. Aspects of *norms* may challenge individual beliefs but initially they strive to fit in.

> **Participant 18**: "I needed to learn their way before I could start thinking about any improvements ..."

This involves the process of *occupying space* in which individuals transition through *consolidating skills* and *building relationships,* to *establishing an area of autonomous practice*. Individuals work to *consolidate their skills* and knowledge and become orientated to local ways of working. In this period of self-reflection, nurses critically compare their own performance with that of colleagues and take time to settle-in, fearing damage to reputation if they fall short of expectations.

> **Participant 12**: "There was always a fear that you might make a mistake and it's going to be your fault …"

Therefore, only when they feel both technically adept and supported are they confident to perform tasks autonomously. Nurses recognize the interdependence of members of the wider team and carefully *build* mutually supportive interpersonal *relationships*.

> **Participant 9**: "You can do anything if you have a good working relationship, and you have respect for the professions ... It's just so important …"

They strive to understand hierarchical and peer-to-peer norms and rules about the division of work; workloads are negotiated day-to-day to make use of differing skills and knowledge within the team and to adapt one-to-another as team composition changes. Describing the experience of a new staff member unused to group-working one participant recalled:

> **Participant 9**, "And so, she felt all the work that came in was her work … and now she had to rely on others. She found that really hard … she said it was like going to a completely different job."

However, where outcomes are not compromised, and individuals respond constructively to feedback, variation in practice is tolerated.

> **Participant 21**: "…every practitioner has strengths and weaknesses, and it can't be oh you're a nurse and this is what you are going to do. It's more like, this is what they are good at and … are motivated to do, and we are all fairly flexible. And then we back each other up if things change or there's a problem."

Throughout, intensity of feeling engendered by the demands of primary care nursing, and self-imposed expectations of coping are challenging. These and other issues not solvable in the course of daily work are discussed informally with peers and during *scheduled dialogue*, including one-to-one sessions with supervisors, group meetings, clinical peer review sessions and working groups.

> **Participant 20**: "… we always share ideas, nurses meeting every day, you present your case. OK this is what I struggle with, this is what came up the other day … we take it to the peers ..."

In this context, reflective self-confidence, openness and reliability are valued and rewarded by colleagues' supportive behaviour.

> **Participant 1**: "…we had a nurse who did not realize she wasn't good at taking feedback. She became defensive and we have worked with her, and she's changed it around. She's become amazing …"

Once accepted as team members, and when competent in core skills, nurses can practice with increased autonomy. Thus, with experience and after reflecting on the *skills* they have *consolidated* and the *relationships* they have *built*, nurses *establish an area of autonomous practice.* This is bounded by organizational norms and individual constructs of *NRNP* and represents what they feel they can safely do day-to-day to *occupy a space* in the organization.

> **Participant 2**: "I have very firm beliefs in my own boundaries of competence, which I think is probably quite a good thing ... It is me negotiating my own role with myself a little bit as well …"

The *area of autonomous practice* is a baseline. Where it does not satisfy expectations regarding *NRNP*, individuals seek opportunities to vary their practice and prepare to realize them by *positioning to do differently*. Conversely, where the *area of autonomous practice* is fulfilling, variation is not sought.

Category 2. Positioning to Do Differently

When experienced in the operating environment and so motivated, nurses begin to consider ways of practising which better fit their concepts of *NRNP*. This may involve broadening the area of practice or focusing on key activities. They consider possibilities, within the organization or beyond, and look for the *next step*. They ask, "*What could my role look like*?". They *test the limits* of the norm and *set personal goals*.

To identify opportunities, nurses look for role models and to available post-graduate education.

> **Participant 2:** "…being able to stand up and say, 'Yep!', that's what I want to do, how do I do that? I can see other people are doing it. I want to do it as well."

Within the profession, those in advanced nursing roles provide inspiration. Community leaders, equity champions and health advocates are also influential. Locally, supervisors and employers may support post-graduate education or otherwise encourage potential.

> **Participant 1**: "… she said there's no growth here … so she actually started looking for [opportunities], so that's a sign of a very good nurse manager isn't it, like recognizing that I had aspirations wanting to go further and she could see that I could not achieve it there in my current job … I really respect her for that, yeah."

After exploring possibilities, the feasibility of realizing change is considered in the next phase, *testing limits*. This establishes the art of the possible within the situational constraints, systemic, organizational or personal, of the norm-defined space individuals have come to occupy. As nurses try things out, beliefs, values and expectations inherent in the local norm become clearer.

> **Participant 3**: "… If I wanted to start doing, I don't know – casting. You know, if I could come up with an appropriate kind of business model, as well as the safety confines …, then they might look at doing it but if I wanted to start doing … Botox! That doesn't sort of fit with the belief system of the practice …"

For individuals, considerable effort is needed to effect change and challenging the norm may compromise existing relationships. Therefore, they first consider the consequences of acting. This is an emotional and self-reflective process: professional values are weighed against personal needs and obligations, issues of work-life balance, career-stage, and job security.

> **Participant 10**: "I decided that I either just have to … suck it up, and say it is what it is … I'm just going to carry on. It's really easy, I come to work, I go home. I'm six minutes from my job, I'm in the community that I live in, I'll just get on with it! But then there's always this bit of me that's like, you can do better, you can, you're settling."

Over time, individuals determine the potential costs and benefits of challenging the norm and *set personal goals*. *Goal setting* is the outcome of self-negotiation and provides an agenda for group engagement.

> **Participant 12**: "Women's health is my thing. I like smear, STI, contraceptive, all those stuffs, so why not add on. So, I put up my hand and they paid for the training and that's how I come to be doing it now."

When confident to do so, and using their goal-agenda, nurses engage with the group in the next phase, *leveraging opportunity.*

Category 3. Leveraging Opportunity

Opportunities to achieve goals arise when norms of practice are disrupted, creating uncertainty. External *disruptors* include changes to service contracts, new training opportunities, legislative change, and changing patient need. Internally, staff turn-over, proposed new ways of working or the acquisition of new knowledge create disruption.

> **Participant 4**: "So. when I came on, I was the first new staff in 10 years, so, it was quite a process, and I don't think they knew how to take on new staff …

Critical insight and self-reflection are required to recognize opportunity. Humility on the part of those being asked to change and audacity from those challenging the *status quo* is called for.

> **Participant 7** "…to show that humility and say there's a different way to work … and sometimes you need to be provocative and bold."

Leveraging opportunity involves two steps: *responding to uncertainty*; *and engaging in collective decision-making* which includes *demonstrating worth.*

Nurses respond positively to uncertainty where they see opportunity to work towards their personal goals and *vice versa*.

> **Participant 1**: "… Dr … says, "I have to do IV antibiotics for this patient". [He is] basically requesting me to help him prepare for the IV antibiotics, and I'm like very confused … I can do it! I can do it! And he was like, "What? You can do it?". And I said, "Yes, I have got certification, I have done this, many times.". So, what had happened, the other nurse who had been working there, never let the doctors know that she can do that. So, she decided, she chose her scope of practice …"

Similarly, in response to uncertainties arising from the COVID 19 differing attitudes were observed in response to the delegation of vaccination administration from nurses to non-regulated health workers. Moreover, the influence of pre-existing norms was apparent. In practices with a history of clinical delegation, such innovation was more readily accepted:

> **Participant 21**: "…we [had] started getting the receptionists doing blood tests … we started them doing ECGs and spirometry ages before … and now they are doing all the vaccinations and they are doing the nasal swabs."

Having broadened their knowledge and reflected on their goals, nurses use evidence to scope gaps in service and develop potential solutions. Following individual responses to disruption, the utility and acceptability of embedding nascent change into new team norms is considered.

> **Participant 10**: "We put together a programme … the "winterizing warrant of fitness" and we linked it to flu vaccinations … when they came for flu vaccinations, we made sure they had had spirometry in living memory, that their inhalers were

> fine, we checked their technique, gave them new spacers, looked at the exacerbation plan, arranged repeat scripts and exacerbation backups and with the education around when to use those, and we noticed that winter rates of late presentations plummeted … and that's something now that's carried on."

Individuals capitalize on the relationships they have built to promote change. They identify key team members and seek to engage them in *collective decision-making*. Nurse input to decision- may be limited in forums such as owners' meetings. To overcome this lack of representation nurses may act through proxies, often practice managers.

> **Participant 14**: "But [practice manager] is really driving the move towards nurse-led clinics which we are absolutely feeding her around … so she has driven that business model with upper management."

Some take on management and ownership roles to gain influence. Others decide their own clinical practice using personal professional judgement.

> **Participant 10**: "…it's a not asking for permission model effectively. So, if we decide that something new is something that we need to do … we just sort of announce it at a clinical meeting, we don't ask, unless it materially impacts the business, in which case those discussions we have as a group …"

Where process efficiencies, team cohesion and/or improved care outcomes are seen to stem from any changes, *worth is demonstrated*.

> **Participant 1**: "I think what it happened with my other nurses was because I was already doing diabetes … they could see the success of it. Yes! … that's how they got interested ... in other nurse-led clinics."

Category 4. Defining Place

Having established their worth, nurses become highly trusted members of the general practice team. By optimizing the relationships they have fostered, and the skills and knowledge they have actively developed, they are able to reshape the boundaries of their professional autonomy, *defining a place* for themselves within the organization and creating new norms of practice.

> **Participant 10**: "Which is why we … decided to scope the role in … it's a little bit about claiming that role in that space and naming it."

Completion of each phase of *creating place* and transition between phases are mediated by the six intervening conditions illustrated in Figure 5.3. Where participants successfully completed the process, there was evidence that personal *self-efficacy* had been encouraged through strong organizational *governance* in which conditions of *safety*, *scheduled dialogue*, and *access to role models* and *decision-makers* were operationalized. Under these conditions, individuals felt able to proactively seek change as evidenced in areas including but not limited to, travel medicine; laboratory testing; outreach; and nurse-led long-term condition care.

Discussion

The theoretical model *creating place* fills a knowledge-gap about how nursing roles are negotiated in NZGP. Our finding that the negotiation is heavily influenced by local norms is consistent with international primary care literature. This shows that norms of practice vary between organizations according to local funding models, team composition, population health needs and with individual nurses' professional competency (Barrett et al., 2021). Experience in Australia, where business models are similar to NZ, suggests that practice nurses must "navigate the preferences of individual employers" (Halcomb & Ashley, 2019, p. 523). We found that the preferences of individual nurses and managers, expressed through the concept of *NRNP*, are also central to the negotiation of roles. As expected, participants were motivated by the meaning found in their work. Previous nursing research has identified meaning in work as an essential motivator, promoting physical, emotional and cognitive engagement in the workplace (Gómez-Salgado et al., 2019; Lee, 2015). Whilst all our participants gave examples of their proactive and subjectively successful negotiation of role, they also reported experiences which were demotivating, and which led them to disengage. Since we specifically sought participants with experience of negotiation, it is likely that disengagement from processes of negotiation is higher among the practice nursing population than within the sample. Certainly, in Halcomb and Ashley's 2019 study, which included 950 Australian practice nurses, only around 50% of primary care nurses had engaged their employers in discussion about role development, despite feeling they could use their skills more fully. Hence the intervening conditions we identified have relevance when seeking to promote proactivity.

We found that high personal *self-efficacy* encouraged by strong organizational *governance* enabled the process of *creating place*. Positive self-efficacy is a belief in one's ability to exert control over self and the environment. It is engendered by experiencing success and mediates the desire to act on conviction. However, it is situation dependent. "Under forcible disincentives or imposed social and physical constraints" even those who perceive themselves highly capable may chose inaction (Bandura, 2012, p. 10). The relevance of self-efficacy as a predictor of performance in general nursing practice has been previously established (Caruso et al., 2016). In primary care, we know that nurses' freedom to act is constrained by systemic factors including, legislative and funding barriers, role confusion and inter-professional power struggles (Busca et al., 2021). However, the literature also indicates this may be mitigated by creating an inclusive organizational culture and positive attitude towards innovation (Rawlinson et al., 2021). An organization's governance regime sets out how and by whom decisions will be made and implemented in pursuit of defined objectives *(International Standards Organization, 2010)*. We propose that organizational governance settings can enable transition from *positioning to do differently* to *leveraging opportunity* when they provide clear rules of engagement and expectation of participation.

We conceptualized this negotiation as an accommodation between the values beliefs and expectations of individuals and those inherent in organizational norms. In addition to the personal positionality that underpins these attitudinal factors, professional identity based on discipline-specific values (Godfrey & Young, 2020) is also influential. NZ nursing practice competencies are informed by the Treaty of Waitangi (1840), all nurses are charged with advocating for patients, and NPs have the specific remit to improve population health outcomes (Ministry of Health, 2023a). Moreover, cultural safety, originating in the institutional racism experienced by Māori in nursing education (Richardson, 2004), is considered a core component of safe NZ nursing practice facilitating understanding of how culture mediates health outcomes. The importance nurse participants attached to improving health outcomes for disadvantaged populations showed internalization of these national professional values.

The study findings are untested beyond their situational context. Nevertheless, aspects of *creating place* are consistent with established role theory. Role theory, hypothesizes how behaviours arise in response to normative expectations with perspectives that see roles as more or less fixed or negotiable (Anglin et al., 2022). It has been used in nursing to explore interaction between individuals and organizations (Brookes et al., 2007). Addressing the

phenomenon of role transition, Duchscher's Transition Shock (2009) and Benner's Novice to Expert (1984) Models are well-known. Focusing on adaptation to normative role expectations, these theories include concepts, like those in our category *occupying space*. Hence, insofar as it represents a resolution of the conflict between personal and organizational expectations, the establishment of an *area of autonomous practice* may be likened to the outcome of Duchsher's stages of "doing, being and knowing" (Duchscher & Windey, 2018, p. 229). Whilst transition shock relates to the new graduate experience, Benner's Model highlights that when transitioning between settings and roles, even experienced nurses take time to recover prior levels of felt competency (Benner, 1984). Primary care role theory includes reference to "shaping roles" (Holt, 2008, p. 123). This involves role holders developing roles and the theory of *creating space* builds on this premise. It highlights that the accommodation represented by completing the process of role transition is provisional and through the further processes of *positioning to do differently* and *leveraging opportunity* new role parameters may be established.

Strengths and Limitations

The integration of our findings with extant role theory increases their generalizability, which is otherwise untested outside the substantive area. The use of videoconferencing for some interviews precluded observation of participants in their work environments. However, participants speaking to us from their homes were relaxed and candid and provided rich data. This is in keeping with other researchers' experiences (Oliffe et al., 2021). Due to the inductive natures of the method, other researchers may have derived different constructions from the data.

Recommendations for further research

There would be benefit in future research to investigate the applicability of the theory of *creating place*, in other general practice settings in NZ and elsewhere. Our data showed that participants considered patient attitudes to be influential in the negotiation and, consistent with ground theory method, we included extant literature as data in our exploration of this issue. However, there would be merit in further research specifically exploring the patient perspective.

Conclusion

Our concept of *need-responsive nursing practice* includes recognition that matters of personal gain, convenience and status are influential. Therefore, no moral assumption that individuals are necessarily and invariably working towards a greater good is inherent in our findings. However, reflecting NZ nursing values, our participants demonstrated a patient-centred approach and successfully negotiated changes to their roles to include an expanded range of biomedical and social-model tasks and responsibilities. Therefore, the theory of creating place demonstrates that despite constraining systemic factors, local action can be taken to address unmet health need using nurses' broad scopes of practice. Whilst task-shifting may be implemented in a top-down fashion, through regulatory change, how it is implemented within practices is key. Here, it is important that policy settings and organizational governance, the principal intervening condition in our model, are such that nurses are empowered to own and develop their roles and to retain and express their nursing ethos to meet health needs.

6.3 Example of transition from occupying space to defining place

The reference to autonomy as the "principal object of negotiation" in the above manuscript (p.135) relates to the transition between the area of autonomous practice achieved when *occupying space* and that achieved after *defining place*. The definition and significance of nursing autonomy was discussed in section 2.5.1. It is to do not only with freedom of clinical decision-making but also with accountability and volition, as illustrated in Figure 2.1. As such, nursing autonomy, was important to participants, for whom enhanced autonomy could include better supported, safer, autonomy within an existing area of practice as well as freedom to enact a greater breadth of autonomy. Several instances in this study's data, were illustrative of nurses *leveraging opportunity* to enhance their autonomy. One instance is outlined below.

The example concerns a triumvirate of participants, a GP, a practice manager and an RN in one practice, who had experienced transition to a new care and business model. Prior to the transition, nurses were seeing patients primarily as an adjunct to GP appointments, taking simple observations and providing episodic task-based care such as dressing changes and medication administration. Afterwards, nursing roles were expanded to include for example, diabetes and gout management and sexual health consultations, including insertion of long-acting reversible contraception devices. Regarding *meaning of work* and *need responsive nursing practice*, these developments satisfied the goals of all three participants. The GP was able to devote more time to complex cases, satisfying the biomedical imperative to diagnose; from the manager's perspective the devolution of management of stable patients to nurses was financially efficient; and the RN found greater engagement in her work through increased autonomy. In the new model, patient-centred care, population health and cost-efficiency were prioritized, and members were assigned clear roles. Nurses were expected to coordinate acute and preventive health care and to lead continuous quality improvement, as well as to provide direct care using their full scope of practice. As such, the model provided strong organizational *governance*. Staff were challenged by the required changes but negotiated the resources and time to adapt so they felt *safe*. GPs and managers felt *safe* to give nurse more *autonomy* and nurses felt *safe* to accept more *autonomy*. *Scheduled dialogue* was provided through team huddles and nurses working in similar models in other practices provided *role models*. A nurse leader was appointed facilitating communication and *joint decision-making* across the team. The changes caused individuals to evaluate and consider the *degree to which they were satisfied* with their current roles and in the new working environment proactivity was encouraged,

boosting their sense of *self-efficacy*. Significantly, the changes in practice were achieved with little change in personnel demonstrating the restraining effect of contextual factors on expression of personal proactivity. In this instance the externally imposed change of care model was the *disrupting* influence, to which individuals *responded*.

As illustrated in the above example, there is support for expanded nursing autonomy among the wider general practice team where it promotes greater efficiency and frees up GP time. Among our participants, managers and general practitioners, as well as nurses were enthusiastic about developing nursing roles but observed that nurses did not always 'step up'. The intervening conditions of the theory of *creating place* address issues of role clarity within organizations and explain the motivation of individuals towards tasks. Where participants had expanded their roles their 'stepping up' was supported by conditions of *safety*, *scheduled dialogue*, and *access to role models* and *decision-makers*. Strong *organizational governance* which normalized these conditions allowed the personal conditions of *degree of satisfaction with current area of autonomous practice* and *self-efficacy* to be brought to bear on the situation. Notably, there was evidence that participants were enabled to step up organizations operating within a kaupapa Māori framework where nurses felt themselves to have *culturally safe employment* and empowered to provide *culturally safe care* through, *inter alia*, the active engagement of the community in service design.

6.4 Conclusion

In this chapter I have explained the theory of *creating place* including examples from the data. In the manuscript "The process of nurses' role negotiation in general practice: A grounded theory study", I discussed *creating place* as building on existing knowledge about nurses' role transition demonstrating that despite constraints, nurses' broad scopes of practice can be brought to bear on the health needs encountered in daily practice. In the context of *task-shifting,* I noted the importance of retaining a strong nursing ethos. In the following chapter, I extend the discussion of how the theory of *creating place* fits with what is already known and what its practical implications may be.

Chapter 7 Situating the Grounded Theory of Creating Place within Existing Knowledge

"... the job is not done until we have integrated our theory into existing ones in the field." (Urquhart, 2013, p. 130)

7.1 Introduction

It is the job of all researchers to demonstrate the place of their findings among knowledge that has prior acceptance in relevant fields. In GT methodology, prior knowledge may be used as data and may be used to help hypothesize links between concepts in the creation of theory. Therefore, through researchers' development of *theoretical sensitivity* and by the *theoretical sampling* of literature during the research process, the first relationship between extant knowledge and new grounded theories is a formative one. However, once the theory is fully conceptualized, its explanatory power may be enhanced through consideration of where, as a new collection of propositions, it might fit with what is already known (Birks et al., 2019). Therefore, in this chapter I first review how the use of literature in the analysis contributed to the theory of *creating place* and associated concepts and further relate those concepts to the literature. Thereafter, I consider how extant theoretical knowledge may be used to enhance the understanding and application of the study findings.

7.2 The use of literature in the analysis

Through personal experience (Chapter One), situational analysis (Chapter Two) and initial literature review (Chapter Three), I entered the active phase of research with a particular awareness of and attitude towards possibilities within the situation of inquiry. Philosophical considerations (Chapter Four), led to the selection of a research design based on constructivist GT and SI, and throughout the study, where demonstrably salient to concepts derived from the data, previously reviewed and *theoretically sampled* literature was used to support insight and abductive reasoning. Therefore, contextual information regarding the complexity of primary care and the nature of primary care nursing practice, and extant theoretical knowledge in the fields of nursing and behavioural sociology, were contributory.

7.2.1 Contextual material

The literature review reported in Chapter Three, highlighted primary care complexity as a global phenomenon, predicated on *increased demand, changes to health systems,* and the

limited *capacity* of health workforces to *meet demand*. In response, through a process termed *task-shifting*, a range of clinical responsibilities, formerly the purview of physicians has been vested in nurses and, in turn certain traditional nursing tasks have been delegated to non-registered health workers. This aspect of complexity, also of great relevance in Aotearoa New Zealand, informed the concept of *responding to uncertainty* within the *creating place* category of *leveraging opportunity*. Uncertainty engendered by role expansion and the introduction of new categories of worker has previously been identified as a stimulus to role negotiation. For example, Lim et al., (2017, p. 6) describes the negotiation of new role parameters among nurses, pharmacists and doctors as "boundary work", in the context of non-medical prescribing.

In this study, detailed narratives obtained through in-depth qualitative interviews, showed that participants experienced significant differences in *norms* of practice between organizations. Conversely, and despite the complexity of the sector, previous research using relatively large sample sizes and quantitative approaches have found a high degree of similarity in organizational characteristics and services across New Zealand general practices (Leitch et al., 2018). Such findings may overlook variation in nursing practice, since nurses' work is poorly recorded in practice data (Sheridan et al., 2023), and larger sample sizes can deemphasize variation at the limits of the distribution. However, experientially and at the interpersonal level as explored here, a greater degree of variation may be apparent. The juxtaposition of my data with previous research pointed out that, despite systemic commonalities, each participant occupied a different starting position in the organization, and in any process of negotiation, and influenced the conceptualization of the category of *occupying space* as a phase of *self-negotiation* with an emphasis on relationship building. Such conceptualization was also informed by SI in which, as discussed in Chapter Four (Hewitt et al., 2022), social processes are seen as the product of individual "lines of action" (Blumer, 1969, p. 82).

References to the needs of enrolled populations occurred often in the data and formed part of the conceptualization of the participants' main concern as *need-responsive nursing practice.* As discussed in Chapter Four, Bradshaw's Taxonomy of Need (1972) was used as an analytical tool in this conceptualization and the New Zealand Health Survey (Hau et al., 2022) was used as a data source. Recent in-depth research into equity of patient health outcomes in New Zealand general practice found patient characteristics explained most variation in patient outcomes, although distinct differences in practice characteristics were attributed to different models of care (Sheridan et al., 2023). The study sought to determine the sum of work

undertaken by professional grouping – RN, NP and GP to enable comparisons by profession and clinical activity. As such, locally negotiated variation in nursing roles was not reported. However, small differences arising from the pursuit of *need-responsive nursing practice* by individuals, as reported by participants in this study could affect local patient health outcomes and if effected systemically could have national impact. Therefore, it is important not to discount initiatives taken in response to local circumstances because they do not immediately appear to have universal utility.

Meaning of work, a code identified following interviews with participants working in organizations following kaupapa Māori principles, was found to be the main contextual influence on *need-responsive nursing practice* and the prime mover of negotiating behaviour. The manuscript "The process of nurses' role negotiation in general practice: A grounded theory study" (Hewitt et al., 2023), in Chapter Six, included discussion of how participants embraced the patient advocacy role required of them under the New Zealand Code of Conduct for Nurses (Nursing Council of New Zealand, 2012a) and articulated meeting patient need as a source of meaning in work. This is in keeping with the known tendency, reported in the literature review, of nurses to conceive their professional identity in terms of the nurse-patient relationship, a concept named "patient-proximity" (Schluter et al., 2011, p. 1214). In an Australian study (Merrick et al., 2015), practice nurses were reported to use insights into patients' needs obtained through physical and relational proximity to them, to legitimize their own clinical decisions and to inform those of general practitioners. This was seen as a negotiating strategy used to establish trust among clinicians and patients.

As described in Chapter Five, the concept of *need responsive nursing practice* was also informed by Toon's discussion of the purpose of general practice (1994). This included consideration of how individuals constructed different meanings of good general practice according to their personal and professional philosophies. As such, three groups of factors were deemed to influence constructions of meaning of work among participants': personal circumstances; professional circumstances; and position in the organization. The finding that work can have differing meanings for different people and that such meanings shape work behaviours is unsurprising. Rosso et al., writing in the field of organizational behaviour summarized a range of previously proposed social processes by which work activities acquire meaning. Such "mechanisms of meaning" (2010, p. 108) include the attribution of specific purposes to work behaviours and the derivation of a sense of belonging from their performance.

In the context of complexity, the roles of nurses in New Zealand general practice are perceived to be constrained by disempowering systemic factors which subordinate them to general practitioners (McInnes et al., 2015). Ownership, business and funding models based on a biomedical approach (Keleher, 2001) are cited as limiting nurses' access to funding and decision-making forums such that their ability to practice autonomously is severely constrained. However, this study's findings show that motivated by the meaning they found in their professional lives, nurses use formal and informal processes to negotiate changes to nursing roles, tasks, responsibilities, and relationships, their own or others', daily and over time, towards goals defined in terms of their beliefs about *need responsive nursing practice*. The intervening conditions identified in *creating place* contribute to the understanding of how such barriers act on the process of negotiation and may provide a focus for overcoming them. The relationships between *self-efficacy* and *governance*, the principal intervening conditions and their known mediating influence on nursing role development and performance have been discussed in Chapters Five and Six. To further explore the application of findings to practice, in the following section I discuss how the theory of *creating place* fits within extant theoretical knowledge.

7.2.2 Integration with extant theoretical knowledge

The manuscript, "The process of nurses' role negotiation in general practice: A grounded theory study", includes discussion of how the theory of *creating place* builds on two established nursing theories: Duchscher's Transition Shock (2009) and Benner's Novice to Expert (1984) Models, and on previous work on role transition in primary care nursing (Holt, 2008). The term Transition Shock™ was coined to describe the disconnect between expectation and reality experienced by new graduate nurses on entering practice (Duchscher, 2009). Where individuals are unable to come to terms with the disconnect, they experience disillusionment which can lead to their leaving the profession. Ellis and Chater (2012) likened the experience of transitioning to community nursing roles from other areas of practice to that of the new graduate nurse. Quoting Disch, they saw this as a role adjustment from "expert to novice" (2002, p. 301), an inversion of the general skill acquisition model postulated by Dreyfus and Dreyfus as a journey through stages of, beginner, advanced beginner, competent and proficient (Dreyfus, 2004), and applied to nursing career development by Benner (1984). The model highlights the situatedness of the state of expertise, in which the individual has not only an

advanced skillset but a contextual awareness of how to apply those skills in the particular environment (Dreyfus, 2004). The process of *fitting-in* experienced by participants in this study, may be seen as their progression or re-progression through such phases of skill acquisition on joining new organizations, whatever their career stage or experience. As it is for new graduates entering practice, this is a challenging transition typified by emotional intensity. Negative experiences may cause the individual to seek employment elsewhere or dissuade them from moving beyond the phase of *occupying space*. These extant models explore the interaction between organizations and individuals and normative expectations of what it is to be a nurse and may be seen to sit within role theory. This is a broad field, encompassing perspectives that see role and associated behaviours as relatively fixed or relatively negotiable (Anglin et al., 2022).

In Chapter Three, I noted that the discussion of nurses' role negotiation in the extant literature included reference to collaboration theory (Bosque, 2011), negotiated order theory (Liberati, 2017), role identity theory (Cribb, 2011) and Gidden's structuration theory (Côté et al., 2019). Like Duchscher's Transition Shock™ and Benner's Novice to Expert, these too concern the interplay of organizational and individual factors as antecedents of individuals' work behaviours (Allen, 1997; Lamsal, 2012; van der Meer, 2023) and highlight that organizational conditions and individual agency may constrain or enable individuals to be proactive in developing work roles. The identification of contextual factors capable of exerting such constraining or enabling effects expressed as *intervening conditions* on the process of *creating place* is consistent with these previous propositions. The intervening conditions of *governance*, *safety, role models, access to decision-makers and scheduled dialogue* conceptualize organizational or contextual mediators arising in the situation of inquiry. Those of *satisfaction with area of autonomous practice* and *self-efficacy* conceptualize issues related to personal agency or volition.

Further exploration of role theory from an organizational perspective (Sluss et al., 2011) led me to consider role making as a potential theoretical code through which to expand the explanatory power of *creating place.* Role making is a process whereby "desired roles" (Sluss et al., 2011, p. 22) are reinforced by reciprocal behaviour between two individuals, subordinate and superior (Graen & Scandura, 1987). Looking for a broader conceptualization of like processes, I identified job crafting theory as a vehicle to enhance understanding of the social

processes at work in *creating place* and to offer practical means of using the study findings to inform nurses' role development.

7.3 Job crafting

Job crafting theory was first proposed in 2001 and has been applied in a range of employment settings, including catering, engineering and health. Job crafting is a process of jobholder-initiated change to work roles and may include: altering the number or type of tasks undertaken (task crafting); varying the nature of workplace interpersonal interaction (relational crafting); and reconceptualizing the meaning of work (cognitive crafting) (Wrzesniewski & Dutton, 2001). It is a three-stage process involving: motivation to craft; crafting techniques; and outcomes (Berg et al., 2008). As in *creating place*, job holders' intrinsic proactivity may be conditional upon organizational settings, including team and managerial feedback and support, safety climate and participative decision-making (Gruman & Saks, 2011). The several parallels between job crafting and creating place are mapped in Table 7.1.

Table 7.1 Mapping job crafting to creating place

Job Crafting (Wrzesniewski & Dutton, 2001, p. 182)	**Creating place categories and concepts**
Motivation for job crafting	**Meaning of work**
Need for control over job and work meaning	Meaning of work Table 5.5
Need for positive self-image	Individual staff need Table 5.2
Need for human connection with others	Supported autonomy Table 5.2
Moderating variables	**Intervening conditions**
Perceived opportunity to job craft	Role models – safety – scheduled dialogue – access to decision-makers
Job features	Norms of practice – organizational governance
Individual orientation towards work	Need-responsive nursing practice Table 5.3
Motivational orientation	Self-efficacy – degree of satisfaction with area of autonomous practice
Job crafting practices[1]	**Positioning to do differently & Leveraging Opportunity[1]**
Changing task boundaries	Asking what role could look like
Changing cognitive task boundaries	Testing limits
Changing relational boundaries	Setting goals
	Responding to uncertainty
	Engaging in collective decision-making
	Demonstrating Value
Specific effects	**Defining Place**
Changes the design of the job	Enhanced skills
Changes the social environment at work	Matured Relationships
General effects	
Changes the meaning of the work	Developing meaning of need-responsive nursing practice
Changes one's work identity	Expanded area of autonomous practice

1. The categories of positioning to do differently and leveraging opportunity include conceptualization of behaviours which explain how task, cognitive and relational boundaries are developed

Job crafting behaviours may be seen to promote fit between person and job (Bakker, 2018) by changing job demands and job resources, expressed as the job demands-resources (JD-R) framework (Tims et al., 2013). As described in Chapter Five, the conceptualization of the processes of negotiation as *creating place* developed *inter alia* from codes highlighting the significance of *fit* between the ethos of the organization and that of the individual. This is supported by the concept of person-organization (P-O) fit described in the organizational culture literature (Ahmad, 2022). Good P-O fit occurs when an individual feels ethically and materially comfortable, or *safe*, to perform a role in the manner required of them by their employing organization, or in other words where there is "value-congruence" (Kristof, 1996,

p. 10). This study's finding regarding the significance of congruence between values inherent in *norms* of practice within general practices on the one hand and those of individual team members on the other, is in keeping with the concept P-O fit. Participants in this study, strove to achieve good P-O fit through negotiating changes within current employment as in job crafting, or by seeking roles in other organizations which they perceived could offer greater P-O fit.

In job crafting, individuals seek to reduce hindering demands and acquire resources to "balance their job demands and job resources with their personal abilities and needs." (Tims et al., 2012, p. 174). Within the job demands-resources (JD-R) framework (Tims et al., 2013), demands are either hindering or challenging. Hindering demands cut across progress towards goals, whereas challenging demands galvanize individuals to personal growth and skill-development. Resources are contextual or personal elements that help meet demands whilst reducing the cognitive and emotional burden on the job holder (Jose et al., 2022). Job holder behaviour in the JD-R model includes seeking challenges, seeking resources and reducing demands (Gordon et al., 2018). When personal and organizational goals are integrated, job crafting can both increase job-holder satisfaction and benefit organizations by promoting innovation.

Like the process *creating place*, job crafting is needs driven, and jobholders seek to achieve goals, consistent with the meaning and meaningfulness they find in their work. Meaning and meaningfulness in the context of work are discussed by Rosso et al., (2010) who argue that the former refers to the perceived purpose of the work and the latter to the worth of that purpose. That is to say, meaning can be significant or insignificant. Job crafting is an ongoing relational and improvisational process through which individuals proactively change the parameters of their assigned roles to create more desirable or meaningful work roles and identities (Sluss et al., 2011). The focus on the jobholder as the principal actor differentiates the theory from similar perspectives including role innovation (Schein, 1972) and from the previously mentioned role making (Graen & Scandura, 1987). Despite the focus on the individual, there are contextual factors which encourage job crafting behaviours and others which necessitate them.

Job crafting is particularly helpful in environments characterized by high levels of *uncertainty* and interdependence among roles, where it is "not possible to anticipate all contingencies" in formal and time bound episodes of job design (Griffin et al., 2007, p. 329). In this context,

individual and team adaptability, through job crafting, may be advantageous by allowing employees agency to respond creatively to demand. As discussed throughout this thesis, healthcare is such an environment, and health professionals' proactive shaping of future roles through job crafting, has previously been proposed to improve both the responsiveness of services and the occupational health of the workforce (Bakker, 2018; Gordon et al., 2015). It is recognized that organizational agility is particularly relevant in the public sector which is characterized by scarcity of resource, demanding "citizen-clients", and rapidity of change arising from political imperatives, (Luu et al., 2022, p. 1124).

7.3.1 How can job crafting theory enhance the application of study findings?

The JD-R framework proposes a mechanism by which job conditions affect job holders' behaviour towards job crafting through the effects of hindering and challenging demands and differential access to resources. By identifying such factors within New Zealand general practice, it may be possible to act on them to promote proactivity towards role development. For example, under the framework, standard ways of working unsuited to the local situation may represent hindering challenges.

Implicit in the findings of this study is the fact that each organization has its own *norms* of practice. Others have highlighted that among New Zealand general practices, each has "its own history of adapting to their enrolled patient population and region, and changes in policy and funding context" (Sheridan et al., 2023, p. 17). Such adaptation from the standard is necessary. As Timmerman and Epstein (2010) observe, standards have a particular cultural history and may have unintended consequences when applied in other contexts. Therefore, the question of whose interests standards serve is crucial in the context of institutional racism and inequity in health. For example, discussing the work of Māori health provider nurses Eggleton et al., (2022, p. 113) refer to "white normative pressures" cutting across Indigenous oral and holistic traditions through the imposed use of standard documentation practices which devalue aspects of the lived experience, othering them as subjective. More broadly, in this study, clinicians and managers express frustration that the funding and care models they work under sometimes hinder their ability to respond effectively to patient need.

Since they have limited opportunity to command patient fees for services (Pullon et al., 2009), much of nurses' work in general practice is carried out in fulfilment of programmes delivered

under contract to Te Whatu Ora Health New Zealand (formerly DHBs) or the Ministry of Health (Docherty et al., 2008; McKinlay et al., 2012). Some argue that generic programmes can reward activity rather than outcomes (Daly, Kenealy, et al., 2013), that they are too episodic to reap long-term improvements (Nelson et al., 2009) and that there is too little input from the nurses who are tasked with their implementation (McKinlay et al., 2012). Consequently, nurses may experience greater hindrance to autonomy than their medical counterparts. Moreover, as highlighted in Chapter Two, the effects of economic cost-utility calculations at the national level may disadvantage sections of the community through "economic imperialism" (Klonschinski, 2014, p. 158). Additionally, forces of standardization are not limited to the effects of central and regional contracts. Ernst observes that evidence-based practice (EBP) and new public management (NPM) are forces of standardization which limit "practitioner's space for manoeuvre" (2020, p. 1729).

NPM is an approach which, in part, applies private sector management practices to public service organizations (Funck & Karlsson, 2020) and which has been criticized as applied to health, for prioritizing financial management over patient care and limiting the autonomy of health professionals (McCabe & Sambrook, 2019). EBP is about using best available evidence to guide treatment. Its use has been criticized where evidence of relevance at the population level is applied to individuals without regard to their personal context, beliefs and right to choose (McCormack & Elwyn, 2018) and where the needs of minority populations are overlooked due to a focus on clinical science and quantitative evidence within the Western research paradigm (Hewitt et al., 2022; Morales & Norcross, 2010). NPM and EBP guide policy within the New Zealand Ministry of Health, through directorates such as Te Pou Mahi Pūnaha (System Performance and Monitoring) and Te Pou Whakamārama (Evidence Research and Innovation), are seen as key to quality improvement (Ministry of Health, 2023b) and shape the formal contracting of services through DHBs and PHOs to general practices (Tenbensel et al., 2017). Experience delivering packages of care under contract to the public health system may constrain action to meet need and cause practitioners to view the development of new models of care as the responsibility of others. In this study's data these others appeared as the '*they'* and included external agencies such as: the Nursing Council and the New Zealand Nurses Organization; (former) DHBs; PHOs; and gatekeepers within organizations, including managers and business owners. Often such bodies, less so individuals, were perceived by participants as having limited appreciation of the issues faced by nurses in daily primary care practice.

Viewed from a *job crafting* perspective, a lack of input from those delivering contracted services, risks perpetuating gaps in provision by the non-anticipation of local contingencies (Griffin et al., 2007). However, when autonomy to apply programmes flexibly is permitted, contracts can be used to *leverage opportunity* for lasting change. Prior research corroborates the finding that primary health care nurses in Aotearoa New Zealand respond to opportunities to develop roles and services which address unmet health need (Nelson et al., 2009; Water et al., 2016). Provider instituted programmes with community input have been reported as providing service improvements for patients, for example through the provision of local spirometry testing (Epton et al., 2015) and preventive diabetes care (Tipene-Leach et al., 2013). In this study, such proactivity was particularly apparent among Māori health provider nurses, but was seen in other general practice settings, for example where nurses created outreach services and facilitated better access to diagnostic tests.

The experience of several participants in this study with the At Risk Individuals Model of Care (Middleton & Cumming, 2016), provides an example of how, when autonomy to apply programmes flexibly is permitted, contracts can be used to *leverage opportunity* for lasting change. Between 2014 and 2019 (Maude, 2019a), this model supported nurse-led care for those with long-term conditions in the (former) Counties Manukau DHB. After its demise some practices went on to establish their own models of nurse-led long-term condition care. From a JD-R point of view, the contract provided three job resources, namely: experiential knowledge; a framework and proof of concept; and an aspirational demand, that is the challenge to deliver nurse-led care. While extant, the contract also imposed hindering demands such as external feedback reporting, invoicing and mandated patient eligibility criteria. However, after the funding ended, participants were able to tailor the framework to meet local needs, apply it to a broader range of conditions and populations than was permitted under contractual terms and measure its success against locally agreed goals. Hence, in effect they crafted their roles to minimize hindrances in fulfilment of personal and organizational goals. The data showed that this was well facilitated in organizations with governance regimes that signaled the expectation that staff would participate in shaping their own roles, where leaders acknowledged their limitations and where business models and attitudes could accommodate the loss of funding.

Studies have shown job crafting behaviour can be encouraged by conducive management practices, such as the inclusion of job crafting as a topic for regular discussion at staff meetings,

and by training staff in job analysis, goal-setting and planning (van Wingerden et al., 2017). Participative management, for example by frequent and effective performance appraisal, allows employees to discuss desired changes and receive support to make changes. Together with information-sharing, it promotes knowledge of organizational goals and resources, fostering understanding of how personal goals may fit and be fitted into the greater scheme. It can enhance job holders' sense of purpose and reinforce trust (Hu et al., 2022).

A study of hospital nurses in Saudi Arabia (Baghdadi et al., 2021) found a high incidence of job crafting behaviours and engagement in an environment characterized by robust human resource management (HRM), participative management and prioritization of professional development. Working with Dutch doctors and nurses Gordon et al. (2018, p. 102), trialled an intervention whereby participants were introduced to the JD-R model of job crafting and attended a workshop in which they developed a "…personal crafting plan…" (PCP). They found that participant well-being and performance were enhanced by the intervention. Given the congruence of *creating place* and job crafting theory, such strategies may have application in the effective negotiation of nurses' roles in New Zealand general practice. From job crafting it is known that HRM is a job resource which mediates the expression of personal resources, including motivation to influence the work environment (Jose et al., 2022). This is like the mediation of personal *self-efficacy* by organizational governance in the *creating place* model. Therefore, in considering the implications of my findings for the development of the practice nurse role in Aotearoa New Zealand it is useful to consider the state of HRM in the nation's general practices.

A key element of HRM is performance appraisal, the functions of which are: linking organizational and personal goals; skills development; and incentivizing performance improvement (Madlabana et al., 2020). There is limited research on the impact of performance appraisal on nurses and associated patient outcomes in primary care. However, Brinkman et al. reported that whilst "Performance appraisals may be a time where educational plans are discussed, and management support is negotiated." (2008, p. 25), in a survey of NZNO members (n=720), they found only 21% had annual performance appraisals. It appears that formal performance appraisal may not be prioritized by employers or nurses, leading to missed opportunities for development. Among our participants most were appraised by non-nurse managers or employers. Similarly, Halcomb et al. (2021) reported in a cross-sectional survey of Australian practice nurses, over 57% had not recently had a formal performance appraisal,

that most appraisals of practice nurses were undertaken by a doctor or manager, rather than a nurse, and that among those who had had an appraisal, few regarded it as satisfactory. Unlike in other jurisdictions such as UK (Hoare et al., 2008), anecdotally many general practices in Aotearoa New Zealand do not have a formally designated nurse leader. This may have the effect of isolating individual nurses from the collegiality and collective voice on nursing matters that is known to support nurse role development in the general practice environment. If appraisals are a time to negotiate management support (Brinkman et al., 2008), 'non-nurse' appraisal may mean that support must be negotiated piecemeal without a central focus to develop a local and distinct nursing vision within organizations. In addition, if the non-nurse appraiser is an owner of the practice, there may be less incentive to enter a negotiation that has fiscal implications. In this study, participants in this situation reported restricting their focus of development to personal practice they could implement within individual consultations. From a job crafting perspective, personal practice is relatively non-interdependent on the work of others with more degrees of freedom to effect change (Wrzesniewski & Dutton, 2001).

The use of PDRP which document nurses' compliance with competence requirements and are intended to encourage and reward good performance, as discussed in Chapter Two, has been suggested as a measure of organizations' "commitment to nurses' professional development" (Heath et al., 2020, p. 51). However, they are reported to be used by only 25% of all New Zealand Nurses and mainly in secondary care settings (Nursing Council of New Zealand, 2020a). In this study, participants reported differing attitudes and experiences of PDRP implementation. Those in favour of PDRP saw them as an aid to reflective practice and professional growth; those against, saw them as an administrative burden favouring those who could tell a good story over those with practical strengths. Research suggests the value of PDRP for continuous professional development is overshadowed by its competency assurance purpose and there are calls to redesign programmes with a focus on developing nursing expertise aligned to patient health outcomes (Heath et al., 2020). The JD-R framework may offer an approach to HRM in general practice which could allow such alignment to occur.

Two premisses are inherent in the JD-R model (Bakker & Demerouti, 2007). Firstly, that excessive demands placed on workers produce negative outcomes and burnout. Secondly, that positive outcomes may be promoted through the provision of appropriate job resources. Katou et.al., (2021, p. 2705) term the first premise the "stress process" and the latter the "motivational process", and propose that it is the job of leaders to maintain the health and productivity of

their workforce by balancing demands and resources. Therefore, leadership is an important resource in job crafting. As small and medium enterprise (SME) businesses, staff-employer relationships in most New Zealand general practices may "operate on trust, rather than on systems and contracts" (New Zealand Small Business Council, 2019, p. 2). As discussed, in-house HRM functionality is typically not robust, and few resources are allocated to nursing leadership. Within the complex operating environment, good leadership is as desirable as it is difficult to achieve. However, job crafting theory and particularly the JD-R framework has the potential to support those interested in transformational leadership within the sector. For nurses, it has been demonstrated that it can help nurse managers identify strengths within their teams that can be leveraged to improved performance and reduced turnover (Chu et al., 2022). Also, from an advocacy and outcomes perspective and in keeping with the findings in this study job crafting has been shown to enable nurses to find greater meaningfulness at work through the provision of better service to patients. Importantly, from an advocacy and outcomes perspective, better patient care may be valued more highly by nurses than better compliance with organizational norms (Harbridge et al., 2022).

Job crafting is impacting contemporary HRM practices globally and increasingly, information is available to support its practice. For example, crafting toolkits which include resources to facilitate strengths identification, role visualization and communication about job crafting are available online (Department of Employment and Workplace Relations, 2023; Future of Work Institute, n.d.). Therefore, the adoption of job crafting techniques in New Zealand general practice may be a practical and timely means of linking personal and organizational goals to promote positive responses not only to contractual changes but to the other potential *disruptors*, legislative change, new knowledge and varying demands for service. Moreover, beyond the benefits for individual and organization the application of job crafting techniques may have significance at the systems level. As previously noted, there is growing recognition that healthcare professionals' proactivity towards role development is necessary to improve health services (Gordon et al., 2018).

7.3.2 The potential impact of job crafting on primary care sector responsiveness

Under the health reforms arising from the Health and Disability Systems Review (Health and Disability Systems Review, 2020), there is a policy intent to improve primary health care services in Aotearoa New Zealand through the establishment of 'localities'.

> *"Localities is place-based planning for health and wellbeing services which will focus on helping whānau stay well; give iwi and communities a strong voice in deciding what's needed in their local area; and get different health and wellbeing organisations [sic] working together better to improve people's healthcare experience." (Te Whatu Ora, 2023d)*

This approach will require collaboration and adaptability among service providers, and it may be anticipated that individuals' task repertoires and interprofessional relationships will be challenged in the establishment of new ways of working within the localities model. Collaboration among independent organizations some of whom, due to the business model of general practice, may consider themselves commercial competitors is likely also to require changes to ways in which they think about the work that they do. As such the job crafting domains of task crafting, relationship crafting and cognitive crafting are applicable (Wrzesniewski & Dutton, 2001).

Job crafting may have impact at the individual and team level. At the organizational and systems level, it is important that higher aims are not sacrificed to personal ambitions. Job crafting at the team level as explored by Tims et al., (2013) involves collaboration among members in to increase job resources and reduce hindering demands at the level of organizational *norms* and has similar benefits to organizations as to individuals, including better work engagement and performance. As previously discussed, the JD-R model provides mechanisms for job crafting within nursing teams in the context of transformational leadership. Transformational leadership, focusing on supporting individuals to remain healthy and productive, has also been found to increase workforce engagement, reduce burnout and improve performance at higher levels of organization (Katou et al., 2021).

In a recent speech to general practitioners, the New Zealand Health Minister acknowledged the importance to effective health reform of the knowledge and skills of the primary care workforce. She stated her intention to engage with the sector in problem-solving and

referencing localities, said they would offer "a better balance of national and consistent standards and local tailoring" (Dougan, 2023). As in individual general practices a job crafting, JD-R approach would appear to offer practical means of effecting such engagement. The Minister referred to tailoring standards to local needs. This study has shown that the primary concern of participants was to achieve *norms* of nursing practice informed by such needs and that nurses, in particular were motivated in this regard to advocate for patients towards the eradication of health inequity (Hewitt et al., 2023). This positioning of nurses as well-placed to understand health need is a recurrent theme in contemporary nursing discourse. Responding to United Nations Development Goal 3.8 - Universal Health Coverage (Ghebreyesus, 2017), and advocating for investment in nursing, the UK All-Party Parliamentary Group on Global Health observed, "… [nurses] are also part of their local community – sharing its culture, strengths and vulnerabilities – and can shape and deliver effective interventions to meet the needs of patients, families and communities." (2016, p. 3). Therefore, it is important that their voices contribute to health reform.

7.4 Worth and significance

The relevance, timeliness and significance of this research is demonstrated in its applicability to contemporary health issues and aspirations as discussed in section 7.3.

7.5 Conclusion

This study has shown members of general practice teams in New Zealand experience the negotiation of nursing roles in the context of local *norms*. This is in line with established role theory, whereby role behaviour is moderated by established social standards (Anglin et al., 2022). Sociologist Erving Goffman described roles as, "…the basic unit[s] of socialization", and, linking the idea of role incumbency with self-identity stated, "A self, then, virtually awaits the individual entering a position; he [sic] need only conform to the pressures on him[sic] and he [sic] will find a me ready-made for him[sic]." (Goffman, 1961, p. 77). Norms of nursing in general practice are limited by disempowering systemic factors and subordination to GPs (McInnes et al., 2015). This subordinate role could be seen as the normative *ready-made me*, and in the discussion of role theory earlier in this chapter, I noted perspectives that see role behaviours as relatively fixed or relatively negotiable (Anglin et al., 2022). The theory of *creating place* provides insight into the ways in which members of general practice teams, despite seemingly fixed role parameters, negotiate changes to normative expectations to

achieve personal and organizational goals. The explanatory power of the theory of *creating place* is enhanced through its consistence with the theory of *job crafting*. Hence the *job crafting* JD-R model, may be an aid to promoting effective negotiation of nurses' roles and by extension the continuous improvement of health services. These parallels support the recommendations for action included in the following chapter.

Chapter 8 Conclusion and Recommendations

"…agency matters in social life and, therefore, agents are not simple throughputs of structures – material or ideal – working behind their backs." (Kratochwil, 2008, p. 86)

8.1 Introduction

In this chapter, I review and reflect on the research process and the study findings to articulate the key themes of this thesis. I discuss how the findings contribute new knowledge and make recommendations for their practical application. In addition, I consider avenues for future research and identify strengths and weakness of the study. I began the thesis with a quote which calls for us to challenge the assumptions that underpin our habits of daily practice and to consider whether they embody our true values and intent (Toon, 1994). This reference, found during theoretical sampling, helped me articulate the purpose of this study as seeking to understand how habits could be made "consistent with current societal and professional imperatives … to realize high-quality *nursing* care" (p.2). As discussed in Chapter Four, philosophically, my research approach was guided by pragmatism and constructivism. The above quote from Kratochwil, discussing the nature of constructivism, highlights human *agency* as key to the construction of social reality: a reality defined in part by assumptions and habits. As I shall explain further below, the theme of *agency*, is of first importance when considering the question 'How are the roles of nurses in New Zealand general practice negotiated?'.

8.2 The situation

In Chapter Two, through situational mapping, I explored in detail myriad factors active in the New Zealand general practice environment, each capable of impacting the work of nurses therein in multiple and context-specific ways. The issue of health inequity was a key concern. As such, the complexity of the situation of inquiry and the necessity for negotiating a *place* within it was demonstrated. Through consideration of actors' positionality, the power of nurses to exert influence in this arena was discussed in terms of safety, autonomy and professional governance; it was established that nurses' power of influence was militated against by a lack of strong nursing leadership and representation in the sector. Considering, 'What is known from the research literature about the negotiation of nursing roles in New Zealand general practice?', Chapter Three identified similar findings in both the global and New Zealand

research literature. The ubiquity of *complexity* as a defining feature of primary care was the principal theme. This was considered a consequence of high demand, the adoption primary health care policies, and workforce shortages, and occasioned two further common themes, those of *collaborative practice* and *task-shifting*. The latter, predicated largely on nurses, the greater part of the health workforce, operating at the top of their broad and enabling scopes of practice, often in advanced roles, was presented as key to the future ability of health systems to service currently unmet health need. Contextual effects were repeatedly explored as barriers and facilitators of effective collaboration. The vesting of fee-for-service, task-orientated funding in medical practitioners was frequently cited as a major barrier to optimizing skill-mix in health teams. Conversely, open communication in the context of shared goals was considered the principal facilitator of teamwork.

8.3 The knowledge gap and study aim

By reviewing the literature, it was established that systemic and organizational factors are widely reported as mediating the realization of enhanced nursing practice in primary care. However, the question of how, that is by what processes, general practice nursing roles are negotiated in the context of such factors had not been substantively reported. Moreover, much of the research considering contextual factors had been conducted from a systems perspective, not focusing specifically on daily nursing practice. Therefore, the aim of this study was to develop a theory to explain staff experiences of negotiating nursing roles in general practice in Aotearoa New Zealand and to identify implications of findings for the development of primary care nursing practice.

8.4 Embarking on the research

As reflected in Chapter Four, in response to the literature on *task-shifting*, couched as it often is, in terms of medical substitution rather than nursing practice or health need, I began the research process with an interest in how nursing philosophy was represented in the negotiation of role. Constructivist GT methods guided by the SI perspective were selected as an appropriate research design because they offered the ability to explore the research question from a range of perspectives and for others' ideas to challenge my own preconceptions. Prior to beginning the active phase of research, I spent time considering the underlying philosophy of GT and SI and some of my conclusions are discussed in the paper "Grounded theory method and symbolic

interactionism: Freedom of conceptualization and the importance of context in research" (pp.78-93).

8.5 Philosophical considerations

In the aforementioned paper (Hewitt et al., 2022), taking a pragmatic approach, I argued that both everyday problem solving and research processes are necessarily dependent upon human cognition and are distinct from one another only insofar as the latter is systemized and highly deliberate. GT methods provide such systemization and the SI perspective, representing as it does the articulation of the essential ways in which human cognition works, enables the researcher to proceed deliberately. During the genesis of the paper, including consideration of peer review feedback, I framed three questions from the tenets of SI to be used throughout the study to identify meaning of relevance to the research question: 'Who and what are the actors in this situation?'; 'What is meaningful to the actors in this situation and why?'; and 'How do actors' individual lines of action interact in this situation over time?'. Their application kept the research focus on the participants and helped ground the findings in their lived experience.

Throughout the thesis, I also considered epistemological perspectives from medicine, nursing, Indigenous and other cultures, representing a range of worldviews which influence concepts of health and illness and attitudes to research. This is important, since concepts are culturally situated human constructions and research is not value-neutral but reflective of the meaning any set of circumstances invokes (Hewitt et al., 2022). Therefore, and given the interpersonal nature of nursing and considering the imperative to be *culturally safe*, I endeavoured to be open to all ways of knowing and to let "the phenomenon of interest and the community of participants" (p.75) guide me.

8.6 Reflection on the data generation and analyses

Following the intent to ground the study in the experiences of participants, in the initial phases of data generation and analysis I focused on context and the main concern of the participant and the prime mover of their behaviour towards the resolution of that concern. As described in Chapter Five, that led to the development of the concept of *need-responsive nursing practice,* the provision of which, was the participants' main concern, and that of *meaning of work* as the prime mover. The properties and dimensions of these concepts are broad and speak to the diversity of perspectives pertaining among general practice team members. As referenced in

the paper "The process of nurses' role negotiation in general practice: A grounded theory study" (pp.129-147) meaning and need may include non-altruistic matters and do not necessarily drive behaviour towards the greater good. However, as shown in Box 5.4 participants' viewed patient-centred outcomes as important. The establishment of the main concern of the participants effectively led to the re-phrasing the research question as 'How do members of the general practice team behave in order to provide *need-responsive nursing practice*?'. From the point of formulating the construct of *need-responsive nursing practice*, and whilst it was always subject to amendment, it guided lines of inquiry, including through *theoretical sampling*, the selection of subsequent participants, literature searches and interview questions. Hence, the findings are grounded in the experience and values of participants working in New Zealand general practice.

Later data generation focused on identifying processes. Here, the experiences of those working in high-needs contexts were helpful and nurses with experience working in Māori Health Service Providers provided perspectives that 'opened up' the entire dataset to broader interpretation. Working within clearly defined cultural frameworks appeared to promote reflective practice and proactivity to achieve personal and organizational goals. This may have been what enabled participants to articulate insights about processes of negotiation and demonstrated the importance of *contextual variation*, not only for purposes of representation but to achieve research aims.

Regarding the research design, in Chapter Four, I discussed a range of research paradigms, their ontology and epistemology and noted critical social theory as offering a suitable approach for the 'nurse as advocate' researcher. As I have conducted this study and as discussed in section 4.5, I have felt a sense of obligation to advocate for my profession and considered whether an alternative approach would have afforded greater opportunity in that regard. However, my chosen methodology has allowed me to explore the values, motivations and goals of those in the situation and the contextual factors that mediate their *agency*. Moreover, as described below, the findings have potential to be of practical use within the community represented.

8.7 Findings

The theory of *creating place* is described in the findings manuscript "The process of nurses' role negotiation in general practice: A grounded theory study" (pp. 129-147). As summarized above, it is a substantive theory, grounded in the experience of those working in general practice. Therefore, it provides a *situated* explanation of how nurses engage in processes of negotiation to better incorporate their own beliefs, values and expectations into their daily practice, motivated by their understanding of a range of personal, patient and organizational needs and the meaning their work has for them. Opportunities for negotiation present where there is *uncertainty* as to how to proceed and, within the contexts studied, nurses' responses to uncertainty reflected their skills, knowledge and experience within the operating environment. Therefore, interplay among normative expectations arising from organizational factors and personal factors, mediated individuals' *agency* to engage successfully in the process. These are represented in creating place by the seven intervening conditions: safety; scheduled dialogue; role models; access to decision-makers; governance; self-efficacy and satisfaction with the level of autonomy. Since the participants in this study espoused strong intent to address health inequity through their work, increasing nurses' *agency* to negotiate enhancements to their role parameters has positive implications for the future of primary health care services.

The explanatory power and practical use of the theory of *creating place* is increased and informed by its congruence with the extant theory of job crafting (Table 7.1). Both theories reflect that organizational settings mediate job holders' intrinsic proactivity and that concepts of *meaning* guide their behaviour causing them to seek to alter aspects of their work role. As such, they vary the tasks they perform, alter the interpersonal relationships they have with co-workers, and find different meaning in what they do. Job crafting theorists recognize the need for job crafting in environments with high levels of *uncertainty*, where all factors cannot be anticipated in job design. As described in Chapter Seven, healthcare is an environment, characterized by *complexity* and *uncertainty*, and the proactive shaping of future roles by members of the health workforce through job crafting, has been shown to have beneficial outcomes at organizational and individual levels, including reduced stress and improved performance. This is through the balancing of job demands and resources which has the effect of increasing personal *agency*. Practical tools have been developed to promote job crafting which have may have application also in promoting effective negotiation of nurses' roles.

8.8 Recommendations

My recommendations are intended to encourage creativity and participation in sector decision-making among nurses. As such they involve action at individual, organizational, professional and sector levels.

8.8.1 Individual action

Nurses in general practice should:

a. Reflect on their practice to better understand their personal nursing ethos and career goals.

b. Seek opportunities to participate in collective decision-making about how primary care services are delivered.

c. Participate in Professional Development and Recognition Programmes.

d. Engage with employers to promote effective performance appraisal.

e. Advocate for the full use of nursing scope to address unmet health need.

8.8.2 Organizational action

Practice owners/managers should:

a. Engage with their staff to articulate a clear organizational vision and governance frameworks in which proactivity towards role development is normalized.

b. Include all team-members in collective decision-making about how practice services are delivered.

c. Institute effective Professional Development and Recognition Programmes.

d. Ensure effective performance appraisal.

e. Advocate for the full use of nursing scope to address unmet health need.

f. Appoint nurses to leadership positions.

Nurse leaders within organizations should:

a. Challenge nurses to develop their roles and facilitate their access to the resources they need.

b. Role model behaviours recommended in paragraph 8.8.1

8.8.3 Professional action

The following recommendations are in keeping with the aims of the Nursing Now Campaign, discussed in Chapter Two (p.43).

The Nursing Council of New Zealand should:

a. Emphasize the need for nurses to participate in role development in nursing codes, competency standards and scopes of practice and in their application.

b. Rephrase the reference to regulation of nursing practice as cited in Chapter Two, (p.41) to reflect nurses' *responsibility* for their own practice, rather than their *accountability* for such, thereby suggesting expectations of *agency* rather than *conformity*.

The College of Primary Health Care Nurses should:

a. Continue to seek participation in collective decision-making about primary care services at all levels.

b. Promote the Aotearoa New Zealand Primary Health Care Nursing Standards of Practice, as discussed in Chapter Two (pp.36-37) among nurses in New Zealand general practice.

Nursing academics should continue to promote participation of primary care nurses in research to expand the evidence-base for nursing practice and continue to seek participation in collective decision-making about primary care services at all levels.

8.8.4 Sector action

Primary care leaders should:

a. Proactively solicit the views and participation of primary care nursing leaders, organizations and academics in collective decision-making about how primary care services are delivered.

b. Proactively solicit the views and direct participation of nurses working in general practice in collective decision-making about how primary care services are delivered.

8.8.5 Summary

General practice owners, managers and nurse leaders, supported by the nursing profession and primary care leaders, can provide safe supported environments for effective negotiation of nursing roles within general practice by promoting strong governance, and can develop individuals' sense of self-efficacy by involving them in key decisions. Nurses and others can use the theory of *creating space* as a framework for engaging in active negotiation of professional roles. Through the application of the above recommendations, nurses may be encouraged to engage in constructive disruption rather than obedient conformity and claim *agency* to determine and direct the future of primary care nursing based on patient-centred care.

Resources based on the job-demands-resources model and job crafting can offer practical tools to support individuals, practice owners and managers, nurses' organizations and sector leaders, to harness the nursing knowledge and ethos embodied by the general practice nursing workforce to develop services that are responsive to the health needs of the population of Aotearoa New Zealand. As such, the understanding of the processes by which nursing roles are negotiated presented in this thesis may support meeting the challenges of increased complexity within primary health care and achieving health equity.

8.9 New knowledge

As evidenced in the literature review and noted during the review process for the paper "Understanding the general practice nursing workforce in New Zealand: An overview of characteristics 2015-2019", there is limited peer reviewed research published on the New

Zealand general practice nursing workforce. Written as background to the situation of inquiry, that paper involved secondary statistical analysis of published workforce statistics and integrated preliminary insights from research project research "Evidence to guide investment in a model of primary care for all". As such it highlighted that falling numbers of nurses in general practice in Aotearoa New Zealand identified as practice nurses and greater numbers identified as primary health care nurses.

Reviewers of the manuscript, "The process of nurses' role negotiation in general practice: A grounded theory study", acknowledged that the theory of *creating place*, adds to the primary care nursing literature by providing new insights into the process of nurses' role negotiation in general practice. Previous research had focused on contextual influences on the development of nurse roles. Through the identified intervening conditions, this study has linked such contextual factors to behavioural mechanisms of negotiation. By integration with established role theory and job crafting theory it has extended previous work on role transition and offered practical recommendations to encourage nurses' role development. Themes from this research findings have been shared with health leaders at conference (Brightstar, 2023)

In the methodological paper "Grounded theory and symbolic interactionism: Freedom of conceptualization and the importance of context in research", extensive interaction with the peer reviewers led to the identification of three questions which may be used to enhance engagement with the situation of inquiry. Acceptance for publication demonstrated that this approach and remarks about conceptualization provided new perspectives of potential use to grounded theorists.

8.10 Further research

In the manuscript "The process of nurses' role negotiation in general practice: A grounded theory study" (Hewitt et al., 2023), I recommended that future research should consider the negotiation of nurses' roles in general practice from the patient perspective and explore the applicability of findings in other practice settings. In addition, there would be value in conducting an intervention study on the use of job crafting techniques in New Zealand general practice.

8.11 Strengths and Limitations

The strengths of this study are discussed in sections 5.11 and 7.4. As a substantive grounded theory the findings, prior to further testing, are necessarily limited to the contexts studies. This was a small study conducted by a novice researcher and, as the product of a constructivist methodology, circumstances other than those which pertained to this project would have produced different results.

8.12 Summary

Against previously identified contextual challenges - philosophical, structural and interpersonal - the theory of *creating place* provides new insight into the negotiation of nursing roles in New Zealand general practice. Organizational governance regimes mediate individuals' sense of *self-efficacy* and willingness to negotiate role-change in keeping with their *degree of satisfaction* with their current role and beliefs regarding *need responsive nursing practice*. As such, training general practice teams in job crafting techniques and creating expectation of individual proactivity towards role development through robust organizational governance, may be practical strategies to empower nurses not only to provide care but to tailor their skills and models of care to better match the needs of the populations they serve.

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Appendix 1 Articles included in literature review

Global Review Articles

Serial	Citation	Country Affiliation of Lead Author	Country of Study	Nurse Author?	Research Topic(s)	Method	Population	Sample Size	Rationale for Study	Principal Findings
1	Banner, D., MacLeod, M. L. P., & Johnston, S. (2010). Role transition in rural and remote primary health care nursing: A scoping literature review. *Canadian Journal of Nursing Research, 42* (4), 40-57.	Canada	Canada	Yes	Role: Task-shifting	Scoping Review	Primary Health Care Nurses	65 Articles	Complexity: Changes to Health System	Need for: community consultation, planning and professional development to support nurse role transition
2	Brown, I., & Psarou, A. (2008). Literature review of nursing practice in managing obesity in primary care: Developments in the UK. Journal of Clinical Nursing, 17(1), 17-28.	UK	UK	Yes	Role: Effectiveness & Efficiency	Integrative Literature Review	Primary Care Nurses	11 Studies	Complexity: Increased Demand	Primary care nurses may help patients with obesity
3	Coster, S., Watkins, M., & Norman, I. J. (2018). What is the impact of professional nursing on patients' outcomes globally? An overview of research evidence. *International Journal of Nursing Studies, 78* , 76-83	UK	Global not further defined	Yes	Role: Effectiveness & Efficiency	Research Review	All nurses	61 Reviews	Complexity: Increased Demand	Some evidence that nurses in high income countries can reduce patient mortality
4	Grant, J., Lines, L., Darbyshire, P., & Parry, Y. (2017). How do nurse practitioners work in primary health care settings? A scoping review. *International Journal of Nursing Studies, 75* , 51-	Australia	Canada, NZ, UK, Australia, USA, Guam, Slovenia, NL	Yes	Role: Task-shifting	Scoping Review	Nurse Practitioners	74 Articles	Complexity: Capacity	Nurse practitioners predominantly work with specific populations targetting social determinants of
5	Halcomb, E. J., McInnes, S., Patterson, C., & Moxham, L. (2018). Nurse-delivered interventions for mental health in primary care: A systematic review of randomized controlled trials. *Family practice, 36* (1), 64-71.	Australia	UK, NL, US, Canada, Australia	Yes	Role: Effectiveness & Efficiency	Systematic Review	Primary Care Nurses	9 RCT	Complexity: Increased Demand	Limited evidence about impact of nurse-led adult mental health interventions in primary care
6	Halcomb, E., Davidson, P., Daly, J., Yallop, J., & Tofler, G. (2004). Australian nurses in general practice based heart failure management: Implications for innovative collaborative practice. *European Journal of Cardiovascular Nursing, 3* (2), 135-147.	Australia	England, Australia, US, Sweden, Scotland	Yes	Role: Effectiveness & Efficiency	Narrative Review	Practice Nurses	28 Articles	Complexity: Increased Demand	Nurse -led heart-failure intervention has potention to improve care
7	Halcomb, E., Stephens, M., Bryce, J., Foley, E., & Ashley, C. (2016). Nursing competency standards in primary health care: An integrative review. *Journal of Clinical Nursing, 25* (9-10), 1193-1205.	Australia	Australia, NZ, Brazil, Thailand, SA, Canada, UK	Yes	Role: Effectiveness & Efficiency	Integrative Review	Primary Health Care Nurses	9 Papers	Complexity: Increased Demand	Need for competency standards to be articulated to communicate the skills and knowledge required by primary health care nurses
8	Hoare, K. J., Mills, J., & Francis, K. (2012). The role of government policy in supporting nurse-led care in general practice in the United Kingdom, New Zealand and Australia: An adapted realist review. *Journal of Advanced Nursing, 68* (5), 963-980.	NZ	NZ, UK, Australia	Yes	Role: Task-shifting	Adapted Realist Review	Practice Nurses	45 Studies	Complexity: Changes to Health System	Clinical governance required for development of nurse-led care
9	Jakimowicz, M., Williams, D., & Stankiewicz, G. (2017). A systematic review of experiences of advanced practice nursing in general practice. *BMC Nursing, 16* (1), 1-12.	Australia	Australia, NZ, Canada UK, Belgium	Yes	Role: Task-shifting	Systematic Review of Qualitative Studies	Practice Nurses	20 Articles	Complexity: Capacity	GP and patient attitudes, lack of understanding about role and costs impact the experiences of nurses in advanced roles
10	James, S., Halcomb, E., Desborough, J., & McInnes, S. (2019). Lifestyle risk communication by general practice nurses: An integrative literature review. *Collegian, 26* (1), 183-193.	Australia	UK, Sweden, Finland, NL, Australia, Ireland	Yes	Role: Effectiveness & Efficiency	Integrative Literature Review	Practice Nurses	15 Articles	Complexity: Increased Demand	Better role clarity and systemic support needed by nurses managing people with long-term conditions
11	Keleher, H., Parker, R., Abdulwadud, O., & Francis, K. (2009). Systematic review of the effectiveness of primary care nursing. *International Journal of Nursing Practice, 15* (1), 16-24.	Australia	Australia, UK, USA, NL, Canada, Sweden, NZ, Hong Kong	Yes	Role: Effectiveness & Efficiency	Systematic Review	Primary Care Nurses	31 Studies	Complexity: Capacity	Primary care nurses can provide effective health care. Stronger data is required to support their role development
12	Laurant, M., van der Biezen, M., Wijers, N., Watananirun, K., Kontopantelis, E., & van Vught, A. J. A. H. (2018). Nurses as substitutes for doctors in primary care. *Cochrane Database of Systematic Reviews, 2018* (7).	Netherlands	UK,NL,US, Canada,Sweden, Spain, SA	Yes	Role: Effectiveness & Efficiency	Systematic Review	Primary Care Nurses	18 Randomized Trials	Complexity: Increased Demand	Nurse care may provide similar or better outcomes than docto care in primary health care
13	Lemetti, T., Stolt, M., Rickard, N., & Suhonen, R. (2015). Collaboration between hospital and primary care nurses: A literature review. *International Nursing Review, 62* (2), 248-266.	Finland	US, Australia, Ireland, NL, Finland. Sweden, Canada	Yes	Role: Task-shifting	Literature Review	Primary Care Nurses	22 Articles	Complexity: Changes to Health System	Effective collaboration between hospital and primary care nurses benefits patient care

14	Maier, C. B., & Aiken, L. H. (2016). Task shifting from physicians to nurses in primary care in 39 countries: A cross-country comparative study. *European Journal of Public Health, 26* (6), 927-934.	Germany	US, Australia, Ireland, NL, Finland. Canada, NZ, Cyprus, Iceland, Lithuania, Sweden, Germany, Norway, Switzerland, France, ..	No	Role: Task-shifting	Scoping Review	Primary Care Nurses	Not Reported	Complexity: Changes to Health System	Task-shifting is used to maximize capacity
15	Martinez-Gonzalez, N. A., Rosemann, T., Djalali, S., Huber-Geismann, F., & Tandjung, R. (2015). Task-shifting from physicians to nurses in primary care and its impact on resource utilization: A systematic review and meta-analysis of randomized controlled trials. *Medical Care Research and*	Switzerland	UK, US NL	nk	Role: Task-shifting	Systematic Review and Meta-analysis	Primary Care Nurses	20 RCT	Complexity: Capacity	Further research is required on resource utilization by doctors and nurses performing physician tasks in order to determine cost-effectiveness
16	Matthys, E., Remmen, R., & Van Bogaert, P. (2017). An overview of systematic reviews on the collaboration between physicians and nurses and the impact on patient outcomes: What can we learn in primary care? *BMC Family Practice, 18* (1), 1-22.	Netherlands	Australia, Canada, US, Switzerland, NL	nk	Role: Task-shifting	Overview of Systematic Reviews	Primary Care Nurses	11 Systematic Reviews	Complexity: Increased Demand	Collaboration between doctors and nurses may improve health outcomes
17	McInnes, S., Peters, K., Bonney, A., & Halcomb, E. (2015). An integrative review of facilitators and barriers influencing collaboration and teamwork between general practitioners and nurses working in general practice. *Journal of Advanced Nursing, 71* (9), 1973-1985.	Australia	Canada, Australia, Lithuania, NZ, Germany, France	Yes	Role: Task-shifting	Integrative Literature Review	Practice Nurses	11 Papers	Complexity: Capacity	More resaerch required on practice nurses roles and responsibilities and the facilitators and barriers to their collaboration with GPs
18	McKittrick, R., & McKenzie, R. (2018). A narrative review and synthesis to inform health workforce preparation for the health care homes model in primary healthcare in Australia. *Australian Journal of Primary Health, 24* (4), 317-329.	Australia	Australia	Yes	Role: Task-shifting	Narrative Review & Synthesis	Practice Nurses	53 Studies	Complexity: Changes to Health System	Health care home model may support development of the practice nurse role
19	Murray-Parahi, P., DiGiacomo, M., Jackson, D., & Davidson, P. M. (2016). New graduate registered nurse transition into primary health care roles: An integrative literature review. *Journal of Clinical Nursing, 25* (21-22), 3084-3101.	Australia	Norway, SA, UK,US, Australia, Saudi Arabia	Yes	Role: Task-shifting	Integrative Literature Review	Primary Health Care Nurses	19 Articles	Complexity: Changes to Health System	Shift from hospital to comminity based care poses a risk to transitioning novice nurses
20	Norful, A., Martsolf, G., de Jacq, K., & Poghosyan, L. (2017). Utilization of registered nurses in primary care teams: A systematic review. *International Journal of Nursing Studies, 74* ,	USA	Australia, US, Spain, Canada, NZ	Yes	Role: Task-shifting	Systematic Review	Primary Care Nurses	18 Studies	Complexity: Capacity	RNs perform important clinical and administrative roles. Work is required to integrate their capabilities into
21	Parker, D., Maresco-Pennisi, D., Clifton, K., Shams, R., & Young, J. (2016). Practice nurse involvement in the management of adults with type 2 diabetes mellitus attending a general practice: Results from a systematic review. *JBI Evidence Implementation, 14* (2), 41-52.	Australia	Australia, US, Canada, NL, Denmark	Yes	Role: Effectiveness & Efficiency	Systematic Review & Meta-analysis	Practice Nurses	7 Studies	Complexity: Increased Demand	Nurse care in type 2 diabetes may support moderately significant improvement in clinical outcomes
22	Parker, R. M., Keleher, H. M., Francis, K., & Abdulwadud, O. (2009). Practice nursing in Australia: A review of education and career pathways. *BMC Nursing, 8* , 6p-6p	Australia	Australia, Uk, NZ	Yes	Role: Task-shifting	Systematic Review & Narrative Synthesis	Practice Nurses	24 Papers	Complexity: Increased Demand	Primary care nursing frameworks are important to support nurs role development
23	Parker, S., & Fuller, J. (2016). Are nurses well placed as care co-ordinators in primary care and what is needed to develop their role: A rapid review? *Health & social care in the community, 24* (2), 113-122.	Australia	Australia, UK, NL, USA, Canada, NZ	Yes	Role: Effectiveness & Efficiency	Rapid Review	Primary Care Nurses	18 Systematic Reviews	Complexity: Increased Demand	Whole team skill mix is important when considering nurses effectiveness in chronic disease management
24	Poghosyan, L., & Carthon, J. M. B. (2017). The untapped potential of the nurse practitioner workforce in reducing health disparities. *Policy, Politics, & Nursing Practice, 18* (2), 84-94.	USA	USA	Yes	Role: Task-shifting	Literature Review	Nurse Practitioners	Not Reported	Complexity: Changes to Health System	Changes to regulatory frameworks may be needed to allow NPs to address health disparaties
25	Rashid, C. (2010). Benefits and limitations of nurses taking on aspects of the clinical role of doctors in primary care: Integrative literature review. *Journal of Advanced Nursing, 66* (8), 1658-1670.	UK	UK	Yes	Role: Effectiveness & Efficiency	Integrative Review	Primary Care Nurses	8 Studies	Complexity: Capacity	Nurses taking on additional roles does not necessarily reflect patient choice

26	Senior, H., Grant, M., Rhee, J. J., Aubin, M., McVey, P., Johnson, C., Monterosso, L., Nwachukwu, H., Fallon-Ferguson, J., & Yates, P. (2019). General practice physicians' and nurses' self-reported multidisciplinary end-of-life care: A systematic review. *BMJ supportive & palliative care* .	Australia	NZ, Belgium, NL Italy, Canada	Yes	Role: Task-shifting	Systematic Review	Practice Nurses	29 Papers	Complexity: Capacity	Practice nurses may have a role in shared palliative care
27	Stephen, C., McInnes, S., & Halcomb, E. (2018). The feasibility and acceptability of nurse-led chronic disease management interventions in primary care: An integrative review. *Journal of Advanced Nursing, 74* (2), 279-288.	Australia	UK, NL, Australia, NZ	Yes	Role: Effectiveness & Efficiency	Integrative Review	Practice Nurses	11 Papers	Complexity: Capacity	Nurse-led primary care interventions may be feasible and acceptable
28	Van Dillen, S. M., & Hiddink, G. J. (2014). To what extent do primary care practice nurses act as case managers lifestyle counselling regarding weight management? A systematic review. *BMC Family Practice, 15* (1), 1-9.	Netherlands	UK, NL, Australia, USA	No	Role: Effectiveness and Efficiency	Systematic Review	Practice Nurses	45 Studies	Complexity: Capacity	Practice nurses may play the role of case manager for lifestyle counselling

New Zealand Articles

Serial	Citation	Country Affiliation of Lead Author	Location of Study	Nurse Author?	Research Topic	Method	Population	Sample Size	Rationale for study	Principal findings
1	Adams, S., & Carryer, J. (2019). Establishing the nurse practitioner workforce in rural New Zealand: Barriers and facilitators. *Journal of Primary Health Care, 11* (2), 152-158.	Aotearoa NZ	A/NZ	Yes	Role Development	Qualitative Descriptive Interview	Nurse Practitioners	17	Complexity: Capacity	Local support, supervision, funding and job opportunities critical to success; GP shortages and chance to improve health outcomes drove
2	Ape-Esera, L., Nosa, V., & Goodyear-Smith, F. (2009). The Pacific primary health care workforce in New Zealand: What are the needs? *Journal of Primary Health Care, 1* (2), 126-13	Aotearoa NZ	Auckland Taranaki Hawke's Bay Wellington	No	Workforce Characteristics	Qualitative Descriptive Interview	Primary Health CareNurses	13	Complexity: Capacity	Mainstream and Pacific-specific primary care services have both advantages and disadvantages for Pacific populations
3	Bell, J., Crawford, R., & Holloway, K. (2018). Core components of the rural nurse specialist role in New Zealand. *Rural and Remote Health, 18* (2), Article 4260.	Aotearoa NZ	A/NZ	Yes	Role Development	Qualitative Descriptive Interview	Rural Nurses	4	Complexity: Changes to Health System	The NP role is valued for role clarity and role recognition
4	Betony, K., & Yarwood, J. (2013). What exposure do student nurses have to primary health care and community nursing during the New Zealand undergraduate Bachelor of Nursing programme? *Nurse Education Today, 33* (10), 1136-1142.	Aotearoa NZ	A/NZ	Yes	Education & Training	Mixed Method Survey & Interview	Student Nurses	14	Complexity: Changes to Health System	Governing bodies' expectations regarding student nurses' experience of PHC must be made clear
5	Bidwell, S., & Copeland, A. (2017). A model of multidisciplinary professional development for health professionals in rural Canterbury, New Zealand. Journal of Primary Health Care, 9(4), 292-296.	Aotearoa NZ	Canterbury	No	Education & Training	Qualitative Survey	Rural Nurses	12	Complexity: Changes to Health System	Peer-led multidisciplinary small group programme has improved access to professional development
6	Brown, R. C., Gray, A. R., Yong, L. C., Chisholm, A., Leong, S. L., & Tey, S. L. (2018). Current nut recommendation practices differ between health professionals in New Zealand. *Public health nutrition, 21* (6), 1065-1074.	Aotearoa NZ	A/NZ	No	Attitudes & Behaviours	Cross-sectional Survey Quantitative	Practice Nurses	318	Complexity: Changes to Health System	There are opportunities to improve the adoption of nut consumption recommendations
7	Carryer, J., & Adams, S. (2017). Nurse practitioners as a solution to transformative and sustainable health services in primary health care: A qualitative exploratory study. *Collegian, 24* (6), 525-531	Aotearoa NZ	A/NZ	Yes	Role Development	Qualitative Ethnography Interview	Nurse Practitioners	13	Complexity: Increased Demand	Nurse practitioners competently perform a range of medical tasks with a nursing approach to practice
8	Carryer, J., Boddy, J., & Budge, C. (2011). Rural nurse to nurse practitioner: An ad hoc process. *Journal of Primary Health Care, 3* (1), 23-28.	Aotearoa NZ	A/NZ	Yes	Role Development	Records Review Study Quantitative	Nurse Practitioners	21	Complexity: Changes to Health System	Nurse practitioner candidates experience: uncertainty about employment; legislative and funding barriers; support/resistance from GPs and nurses; self-doubt; mentoring; difficulties with registration and meeting competencies; and challenges in rural locations
9	Carryer, J., Claire Budge, R., & Francis, H. (2016). Measuring care alignment in general practice consultations for people with long-term conditions: An exploratory study. *Journal of Primary Health Care, 8* (3), 256-262.	Aotearoa NZ	A/NZ	Yes	Patient Expereience	Quantitative Survey	Practice Nurses	24	Complexity: Changes to Health System	Patients and practitioners percieve levels of self- management support received and provided similarly
10	Christie, C., Bidwell, S., Copeland, A., & Hudson, B. (2017). Self-care of Canterbury general practitioners, nurse practitioners, practice nurses and community pharmacists. *Journal of Primary Health Care, 9* (4), 286-291.	Aotearoa NZ	Canterbury	No	Attitudes & Behaviours	Quantitative Survey	Practice Nurses	504	Complexity: Capacity	A significant proportion of health professionals took minimal annual leave and even more worked while ill
11	Cleghorn, C. L., Wilson, N., Nair, N., Kvizhinadze, G., Nghiem, N., McLeod, M., & Blakely, T. (2020). Health benefits and costs of weight-loss dietary counselling by nurses in primary care: a cost-effectiveness analysis. *Public health nutrition, 23* (1), 83-93.	Aotearoa NZ	A/NZ	No	Models of Care	Qualitative Literature Review & Modelling	Practice Nurses	Not Reported	Complexity: Increased Demand	Brief dietary counselling for weight loss in generates small health gains at the population level
12	Coppell, K. J., Abel, S. L., Freer, T., Gray, A., Sharp, K., Norton, J. K., Spedding, T., Ward, L., & Whitehead, L. C. (2017). The effectiveness of a primary care nursing-led dietary intervention for prediabetes: A mixed methods pilot study. *BMC Family*	Aotearoa NZ	A/NZ	Yes	Models of Care	Mixed Methods Intervention	Practice Nurses	37 Qual 157 Quant	Complexity: Increased Demand	Primary care nurses can provide structured dietary advice to pre-diabetic patients in general practice

13	Cumming, J., Mays, N., & Gribben, B. (2008). Reforming primary health care: Is New Zealand's primary health care strategy achieving its early goals? *Australia and New Zealand Health*	Aotearoa NZ	A/NZ	No	Policy Impact	Quantitative Cost Analysis	Practice Nurses	na	Complexity: Changes to Health System	The Strategy lowered fees for primary health care and increased consultation rates
14	Daly, B. M., Arroll, B., & Scragg, R. K. R. (2019). Trends in cardiovascular management of people with diabetes by primary healthcare nurses in Auckland, New Zealand . *Diabetic Medicine, 36* (6), 734-741.	Aotearoa NZ	Auckland	Yes	Workforce Characteristics	Mixed Methods Survey and Interview	Practice Nurses	1091	Complexity: Increased Demand	Practice nurses are undertaking an increasing proportion of diabetes consultations
15	Daly, B. M., Arroll, B., Honey, M., & Scragg, R. K. R. (2018). Trends in the primary health care nursing workforce providing diabetes care in Auckland, New Zealand: A cross-sectional survey. *Primary Care Diabetes, 12* (6), 491-500.	Aotearoa NZ	Auckland	Yes	Workforce Characteristics	Mixed Methods Survey & nterview	Practice Nurses	1416	Complexity: Capacity	There was a significant increase in practice nurses and a large decrease in the number of diabetes specialist nurses in the Auckland region
16	Daly, B. M., Arroll, B., Kenealy, T., Sheridan, N., & Scragg, R. (2015). Management of diabetes by primary health care nurses in Auckland, New Zealan. *Journal of Primary Health Care, 7* (1), 42-49.	Aotearoa NZ	Auckland	Yes	Models of Care	Mixed Methods Survey & Interview	Practice Nurses	591	Complexity: Increased Demand	Practice and specialist nurses could access patients' weight and HbA1c levels and focused on health education to improve these
17	Daly, B. M., Arroll, B., Sheridan, N., Kenealy, T., & Scragg, R. (2013). Characteristics of nurses providing diabetes community and outpatient care in Auckland. *Journal of Primary Health Care, 5* (1), 19-27.	Aotearoa NZ	Auckland	Yes	Workforce Characteristics	Quantitative Survey	Primary Health Care Nurses	1091	Complexity: Increased Demand	More specialist and practice nurses had post-registration diabetes education compared with district nurses, more district and practice nurses nurses had worked in their current workplace for >10 years compared with specialist nurses
18	Daly, B. M., Arroll, B., Sheridan, N., Kenealy, T., & Scragg, R. (2016). Quantification of diabetes consultations by the main primary health care nurse groups in Auckland, New Zealand. *Primary Health Care Research & Development (Cambridge University Press / UK), 17* (5), 524-529.	Aotearoa NZ	Auckland Midland	Yes	Models of Care	Quantitative Survey	Practice Nurses	120	Complexity: Capacity	Practice nurses carry out the largest number of community diabetes consultations by nurse
19	Daly, B. M., Arroll, B., Sheridan, N., Kenealy, T., Stewart, A., & Scragg, R. (2014). Foot examinations of diabetes patients by primary health care nurses in Auckland, New Zealand. *Primary Care Diabetes, 8* (2), 139-146.	Aotearoa NZ	Auckland	Yes	Attitudes & Behaviours	Mixed Methods Survey & Interview	Practice Nurses	287	Complexity: Increased Demand	Diabetes foot examinations are performed differently by primary health care nurses according to patient and nurse characteristics
20	Daly, B. M., Kenealy, T., Arroll, B., Sheridan, N., & Scragg, R. (2013). Contribution by primary health nurses and general practitioners to the diabetes annual review (Get Checked) programme in Auckland, New Zealand. *New Zealand Medical*	Aotearoa NZ	Auckland	Yes	Attitudes & Behaviours	Mixed Methods Survey & Interview	Practice Nurses	276	Complexity: Capacity	There is collaboration between doctors and nurses managing diabetes in the community and a need to involve nurses in the design of
21	Desmond, N., Grant, C. C., Goodyear-Smith, F., Turner, N., & Petousis-Harris, H. (2011). Nurses make a difference in immunisation service delivery. *Australian Journal of Advanced Nursing, 28* (4), 28-35.	Aotearoa NZ	Auckland Midland	Yes	Workforce Characteristics	Quantitative Survey & Regression Analysis	Practice Nurses	124 Practices	Complexity: Increased Demand	Better immunization delivery is achieved where the nurse to child ratio is lower, where nurses are confident and perceptive of parental
22	Doolan-Noble, F., Gauld, R., & Waters, D. L. (2015). Are nurses more likely to report providing care plans for chronic disease patients than doctors? Findings from a New Zealand study. *Chronic Illness, 11* (3), 210-217.	Aotearoa NZ	Southern Region	Yes	Attitudes & Behaviours	Quantatitive Survey	Practice Nurses	198	Complexity: Changes to Health System	Nurses more likely than GPs to document they provided aspects of chronic illness care
23	Dowell, A., Stubbe, M., MacDonald, L., Tester, R., Gray, L., Vernall, S., Kenealy, T., Sheridan, N., Docherty, B., Hall, D. A., Raphael, D., & Dew, K. (2018). A longitudinal study of interactions between health professionals and people with newly diagnosed diabetes. *Annals of Family Medicine, 16* (1), 37-44.	Aotearoa NZ	Auckland Wellington	Yes	Teamwork	Mixed Methods Observational Cohort Study	Practice Nurses	32	Complexity: Changes to Health System	Health professionals have poor understanding of other disciplines' contributions to patient care
24	Edwards, R., Tu, D., Stanley, J., Martin, G., Gifford, H., & Newcombe, R. (2018). Smoking prevalence among doctors and nurses-2013 New Zealand census data. *NZ Med J, 131* (1471), 48-	Aotearoa NZ	A/NZ	nk	Workforce Characteristics	Quantatitive Survey	All Nurses	51840	Complexity: Changes to Health System	Mental health nurses are the nurses most likely to smoke
25	Eggleton, K., & Kenealy, T. (2009). What makes Care Plus effective in a provincial Primary Health Organisation? Perceptions of primary care workers. *Journal of Primary Health*	Aotearoa NZ	North Island	No	Models of Care	Qualitative Descriptive Interview & Survey	Practice Nurses	24	Complexity: Changes to Health System	GPs are under-involved with chronic care programmes

26	Epton, M. J., Stanton, J. D., McGeoch, G. R., Shand, B. I., & Swanney, M. P. (2015). The development of a community-based spirometry service in the Canterbury region of New Zealand: Observations on new service delivery. *NPJ Primary Care Respiratory Medicine, 25* (1), 1-4.	Aotearoa NZ	Canterbury	nk	Role Development	Case Study Mixed Method	Practice Nurses	10	Complexity: Capacity	Hospital and clinical support and centralised quality assurance programme supported service development
27	Finlayson, M. P., & Raymont, A. (2012). Teamwork general practitioners and practice nurses working together in New Zealand. *Journal of Primary Health Care, 4* (2), 150-155.	Aotearoa NZ	A/NZ	Yes	Teamwork	Qualitative Descriptive Interview & Survey	Practice Nurses	Not Reported	Complexity: Changes to Health System	Doctors and nurses in general practice in A/NZ see themselves as a team
28	Finlayson, M. P., Sheridan, N. F., Cumming, J. M., & Fowler, S. (2012). The impact of funding changes on the implementation of primary health care policy. *Primary Health Care Research & Development, 13* (2), 120-129.	Aotearoa NZ	A/NZ	Yes	Policy Impact	Qualitative Descriptive Interview	Practice Nurses	128	Complexity: Changes to Health System	The way funding devolves at the practice level affectes practice nurse role development
29	Fouche, C., Kenealy, T., Mace, J., & Shaw, J. (2014). Practitioner perspectives from seven health professional groups on core competencies in the context of chronic care. *Journal of*	Aotearoa NZ	Auckland	Yes	Attitudes & Behaviours	Qualitative Descriptive Interview	Practice Nurses	55	Complexity: Increased Demand	Chronic care requires:teamwork, clarity of professional roles and responsibilities, interprofessional
30	Gagan, M. J., & Maybee, P. (2011). Patient satisfaction with nurse practitioner care in primary care settings. *Australian Journal of Advanced Nursing, 28* (4), 12-19.	Aotearoa NZ	A/NZ	Yes	Patient Expereience	Quantitative Survey	Nurse Practitioners	193	Complexity: Changes to Health System	Patients are satisfied with the care they receive from nurse practitioners
31	Gagan, M. J., Boyd, M., Wysocki, K., & Williams, D. J. (2014). The first decade of nurse practitioners in New Zealand: A survey of an evolving practice . *Journal of the American Association of Nurse Practitioners, 26* (11), 612-619.	Aotearoa NZ	A/NZ	Yes	Role Development	Qualitative Survey	Nurse Practitioners	26	Complexity: Changes to Health System	Nurse practitioners are contributing to increased access to health care and improved health outcomes in A/NZ
32	Gilmour, J., Strong, A., Chan, H., Hanna, S., & Huntington, A. (2014). Primary health care nurses and heart failure education: A survey. *Journal of Primary Health Care, 6* (3), 229-237.	Aotearoa NZ	A/NZ	Yes	Attitudes & Behaviours	Quantitative Survey	Practice Nurses	630	Complexity: Changes to Health System	Practice nurses would find more education about heart failure and nurse practitioner support useful
33	Gilmour, J., Strong, A., Chan, H., Hanna, S., & Huntington, A. (2016). Primary health-care nurses and Internet health information-seeking: Access, barriers and quality checks.	Aotearoa NZ	A/NZ	Yes	Attitudes & Behaviours	Quantitative Survey	Practice Nurses	630	Complexity: Changes to Health System	Level of nursing qualification correlated with computer confidence; nurses access and evaluate Internet
34	Goodyear-Smith, F., & Janes, R. (2008). New Zealand rural primary health care workforce in 2005: More than just a doctor shortage. Australian Journal of Rural Health, 16(1), 40-46.	Aotearoa NZ	A/NZ	No	Workforce Characteristics	Quantitative Survey	Primary Care Nurses	1404	Complexity: Capacity	Health professional students need exposure to rural training and living
35	Goodyear-Smith, F., Arroll, B., Sullivan, S., Elley, C. R., Docherty, B., & Janes, R. (2004). Lifestyle screening: Development of an acceptable multi-item general practice tool. *New Zealand Medical Journal, 117* (1205).	Aotearoa NZ	Auckland Otago Hawke's Bay	Yes	Patient Expereience	Quantitative Survey	Practice Nurses	2543	Complexity: Changes to Health System	Most adult patients in a A/NZ general practice setting will complete a self-administered questionnaire on lifestyle and mental-health issues
36	Halcomb, E. J., Davies, D., & Salamonson, Y. (2015). Consumer satisfaction with practice nursing: A cross-sectional survey in New Zealand general practice. *Australian Journal of Primary Health, 21* (3), 347-353	Australia	A/NZ	Yes	Patient Expereience	Quantitative Survey	Practice Nurses	1505	Complexity: Changes to Health System	Patients are satisfied with practice nurse care
37	Halcomb, E. J., Peters, K., & Davies, D. (2013). A qualitative evaluation of New Zealand consumers perceptions of general practice nurses. *BMC Family Practice, 14* , Article 26.	Australia	A/NZ	Yes	Patient Expereience	Qualitative Descriptive Interview	Practice Nurses	18	Complexity: Changes to Health System	Patients are satisfied with practice nurse care but there are some issues with role clarity
38	Hefford, M., Love, T., Cumming, J., Finlayson, M., & Raymont, A. (2011). The financial impact of clinical task substitution between practice nurses and GPs in New Zealand primary care centres. *New Zealand Medical Journal, 124* (1342), 59-65.	Aotearoa NZ	A/NZ	Yes	Models of Care	Mixed Method Case Study	Practice Nurses	1826 Consults	Complexity: Capacity	Practice nurses provide a broad set of primary care services, increasing the proportion of nurse consults and reducing GP consults, could result in significantly improved profitability
39	Henninger, J. (2009). Human papillomavirus and papillomavirus vaccines: knowledge, attitudes and intentions of general practitioners and practice nurses in Christchurch. Journal of Primary Health Care, 1(4), 278-285.	Aotearoa NZ	Christchurch	No	Attitudes & Behaviours	Quantitative Survey	Practice Nurses	155	Complexity: Changes to Health System	Practice nurses were more likely than GPs to recommend HPV immunisation

40	Hoare, K. J. (2016). Retaining new graduate nurses in practice; under-pinning the theory of reciprocal role modelling with 'routinisation'theory and transition shock. Social Theory & Health, 14, 224-238.	Aotearoa NZ	A/NZ	Yes	Teamwork	Grounded Theory	Practice Nurses	17	Complexity: Changes to Health System	Graduate nurses can be supported to practice by experienced colleagues as 'anchor'
41	Hoare, K. J., Mills, J., & Francis, K. (2012). The role of government policy in supporting nurse-led care in general practice in the United Kingdom, New Zealand and Australia: An adapted realist review. Journal of Advanced Nursing, 68(5), 963-980.	Aotearoa NZ	UK, NZ, Aus	Yes	Policy Impact	Qualitative Adapted Realist Review	Practice Nurses	45 Studies	Complexity: Changes to Health System	A/NZ and Australia lag behind the UK in practice nurse development; differeing clinical governance regimes may account for this
42	Hoare, K. J., Mills, J., & Francis, K. (2013). New graduate nurses as knowledge brokers in general practice in New Zealand: A constructivist grounded theory. *Health and Social Care in the Community, 21* (4), 423-431	Aotearoa NZ	South Auckland	Yes	Attitudes & Behaviours	Grounded Theory	Practice Nurses	17	Complexity: Changes to Health System	Experienced practice nurses model clinical skills to new graduate nurses who in turn role model information seeking
43	Horsburgh, M. P., Bycroft, J. J., Mahony, F. M., Roy, D. E., Miller, D. J., Goodyear-Smith, F. A., & Donnell, E. C. J. (2010). The feasibility of assessing the Flinders Program™ of patient self-management in New Zealand primary care settings. Journal of Primary Health Care, 2(4), 294-302.	Aotearoa NZ	Auckland	Yes	Models of Care	Intervention Study Quantitative Analysis with Descriptive Statistics	Practice Nurses	57	Complexity: Changes to Health System	A substantive trial of the Flinders ProgramTM in primary care was not supported
44	Humphrey, C., Hulme, R., Dalbeth, N., Gow, P., Arroll, B., & Lindsay, K. (2016). A qualitative study to explore health professionals' experience of treating gout: Understanding perceived barriers to effective gout management. *Journal of Primary Health Care, 8* (2), 149-156.	Aotearoa NZ	South Auckland	No	Practice Characteristics	Qualitative Descriptive Interview	Practice Nurses	14	Complexity: Increased Demand	Practice nurses have a role to play in improving health outcomes for those with gout
45	Janes, R., Arroll, B., Buetow, S., Coster, G., McCormick, R., & Hague, I. (2005). Rural New Zealand health professionals' perceived barriers to greater use of the internet for learning. Rural Remote Health, 5(4), 436.	Aotearoa NZ	North Island	No	Education & Training	Quantitative Survey	Practice Nurses	430	Complexity: Changes to Health System	Rural health professionals experience digital inequity
46	Keenan, R., Amey, J., & Lawrenson, R. (2013). The impact of patient and practice characteristics on retention in the diabetes annual review programme. *Journal of Primary Health Care, 5* (2),	Aotearoa NZ	A/NZ	No	Practice Characteristics	Quantitative Retrospective Observational Study	Practice Nurses	6610	Complexity: Changes to Health System	The practice nurse to GP ratio may be an important factor in the retention of patients diabetes programmes
47	Kenealy, T., Arroll, B., Kenealy, H., Docherty, B., Scott, D., Scragg, R., & Simmons, D. (2004). Diabetes care: Practice nurse roles, attitudes and concerns. *Journal of Advanced Nursing (Wiley-Blackwell), 48* (1), 68-75.	Aotearoa NZ	South Auckland	Yes	Attitudes & Behaviours	Quantitative Survey	Practice Nurses	146	Complexity: Changes to Health System	Developments in A/NZ primary care may increase the role of primary health care nurses in diabetes
48	Kenealy, T., Docherty, B., Sheridan, N., & Gao, R. (2010). Seeing patients first: Creating an opportunity for practice nurse care? *Journal of Primary Health Care, 2* (2), 136-141.	Aotearoa NZ	A/NZ	Yes	Models of Care	Quantitative Survey Descriptive Statistics	Practice Nurses	225	Complexity: Changes to Health System	Nurses role in patient centred preventive care is hindered by the working environment in A/NZ general
49	Kirkman, A., Wilkinson, J., & Scahill, S. (2018). Thinking about health care differently: Nurse practitioners in primary health care as social entrepreneurs. *Journal of Primary Health Care, 10* (4),	Aotearoa NZ	A/NZ	Yes	Role Development	Qualitative Descriptive Interview	Nurse Practitioners	7	Complexity: Capacity	Nurse practitioners wish to change healthcare delivery this aligned with social entrepreneurship
50	Krothe, J. S., & Clendon, J. M. (2006). Perceptions of effectiveness of nurse-managed clinics: A cross-cultural study. Public Health Nursing, 23(3), 242-249.	USA	A/NZ	Yes	Models of Care	Qualitative Descriptive Interview	Primary Care Nurses	Not Reported	Complexity: Changes to Health System	Nurse managed care enhances perceptions of effectiveness and responsibility for personal care
51	Landers, A., Dawson, D., & Doolan-Noble, F. (2018). Evaluating a model of delivering specialist palliative care services in rural New Zealand. Journal of Primary Health Care, 10(2), 125-131.	Aotearoa NZ	West Coast	Yes	Models of Care	Quantitative Survey Descriptive Statistics	Practice Nurses	147	Complexity: Changes to Health System	Quality services needs strategic partnership and capacity building in local communities
52	Lawrenson, R., Joshy, G., Eerens, Y., & Johnstone, W. (2010). How do newly diagnosed patients with type 2 diabetes in the Waikato get their diabetes education? Journal of Primary Health Care, 2(4), 303-310.	Aotearoa NZ	Waikato	No	Patient Expereience	Quantitative Survey Descriptive Statistics	Practice Nurses	333	Complexity: Increased Demand	Perceived knowledge of type 2 diabetes lower for Māori following diabetes education

53	Leitch, S., Dovey, S. M., Samaranayaka, A., Reith, D. M., Wallis, K. A., Eggleton, K. S., McMenamin, A. W., Cunningham, W. K., Williamson, M. I., Lillis, S., & Tilyard, M. W. (2018). Characteristics of a stratified random sample of New Zealand general practices. Journal of Primary Health Care, 10(2), 114-124.	Aotearoa NZ	A/NZ	No	Practice Characteristics	Quantitative Survey Descriptive Statistics	Practice Nurses	45	Complexity: Changes to Health System	There is a high degree of homogeneity across A/NZ general practices
54	Lillis, S., Swan, J., Haar, J., & Simmons, D. (2008). Concordance and discordance between primary and secondary care health workers in perceptions of barriers to diabetes care. 100 Years Ago in the NZMJ, 121(1270), 45-52.	Aotearoa NZ	Waikato	No	Attitudes & Behaviours	Quantitative Survey Descriptive Statistics	Practice Nurses	315	Complexity: Changes to Health System	Primary care staff perceive more barriers to diabetes care than those in secondary care
55	Lim, A. G., Honey, M., North, N., & Shaw, J. (2015). Learning to become a nurse prescriber in New Zealand using a constructivist approach: A narrative case study. *Nursing Praxis in New Zealand, 31* (3), 27-36.	Aotearoa NZ	A/NZ	Yes	Role Development	Qualitative Descriptive Interview	Nurse Prescribers	10	Complexity: Changes to Health System	Nurse prescribing learning was aided by a constructivist approach drawing on prior experience
56	Lim, A. G., North, N., & Shaw, J. (2017). Navigating professional and prescribing boundaries: Implementing nurse prescribing in New Zealand. *Nurse Education in Practice, 27* , 1-6.	Aotearoa NZ	A/NZ	Yes	Role Development	Qualitative Descriptive Interview	Nurse Prescribers	43	Complexity: Changes to Health System	Traditional health professional roles and boundaries are challenged by role expansion and the introduction of new professions
57	Macdonald, L., Stubbe, M., Tester, R., Vernall, S., Dowell, T., Dew, K., Kenealy, T., Sheridan, N., Docherty, B., Gray, L., & Raphael, D. (2013). Nurse-patient communication in primary care diabetes management: An exploratory study. *BMC Nursing,*	Aotearoa NZ	A/NZ	Yes	Patient Expereience	Qualitative Ethnography Interview	Practice Nurses	28	Complexity: Increased Demand	Consultations are driven by the nurses' clinical agenda rather than by patient need
58	Martel, R., Crawford, R., & Riden, H. (2017). By the way....Hows your sex life?': A descriptive study reporting primary health care registered nurses engagement with youth about sexual health. Journal of Primary Health Care, 9(1), 22-28.	Aotearoa NZ	A/NZ	Yes	Education & Training	Mixed Method Survey & Interview	Primary Health Care Nurses	24	Complexity: Increased Demand	Clinicians lack confidence engaging with youth about sexual health
59	McGeoch, G., McGeoch, P., & Shand, B. (2015). Is healthpathways effective? An online survey of hospital clinicians, general practitioners and practice nurses. New Zealand Medical Journal, 128(1408), 36-46.	Aotearoa NZ	Canterbury	No	Models of Care	Quantitative Survey Descriptive Statistics	Practice Nurses	364	Complexity: Changes to Health System	HealthPathways has achieved a high level of acceptance and is a valuable change management tool
60	McKernon, S., & Azariah, S. (2013). Staff views of an opportunistic chlamydia testing pilot in a primary health organisation. *Journal of Primary Health Care, 5* (4), 283-289.	Aotearoa NZ	South Auckland	No	Attitudes & Behaviours	Quantitative Survey Descriptive Statistics	Practice Nurses	81	Complexity: Changes to Health System	Practice nurse–led approaches to opportunistic testing for chlamydia may be successful
61	McKillop, A., Crisp, J., & Walsh, K. (2012). Practice guidelines need to address the 'how' and the 'what' of implementation. Primary Health Care Research & Development, 13(1), 48-59.	Aotearoa NZ	A/NZ	Yes	Models of Care	Qualitative Descriptive Interview	Primary Health Care Nurses	33	Complexity: Changes to Health System	Health professionals have difficulty implementing guidelines in practice
62	McKinlay, E., & McBain, L. (2007). Evaluation of the Palliative Care Partnership: A New Zealand solution to the provision of integrated palliative care. The New Zealand Medical Journal,	Aotearoa NZ	Mid Central	Yes	Models of Care	Mixed Method Routine Data Analysis & Interview	Practice Nurses	63	Complexity: Changes to Health System	Palliative Care Partnership is an effective model of funded palliative care in primary care
63	McKinlay, E., Garrett, S., McBain, L., Dowell, T., Collings, S., & Stanley, J. (2011). New Zealand general practice nurses' roles in mental health care. International Nursing Review, 58(2), 225-233.	Aotearoa NZ	A/NZ	Yes	Models of Care	Qualitative Descriptive Interview	Practice Nurses	Not Reported	Complexity: Changes to Health System	There are specialist mental health nurses and practice nurses working in mental health in general practice.Barriers exist to the development of the new roles
64	McKinlay, E., Kljakovic, M., & McBain, L. (2009). New Zealand men's health care: are we meeting the needs of men in general practice? Journal of Primary Health Care, 1(4), 302-310.	Aotearoa NZ	A/NZ	Yes	Patient Expereience	Qualitative Descriptive Interview	Practice Nurses	43	Complexity: Changes to Health System	The importance of men's health is recognized but there is unwillingness to engage with men's health care in general practice
65	Moana, B., Crawford, R., & Isaac, D. (2017). Discussing Sexual Health with Older Clients: Are Primary Health Care Nurses Sufficiently Prepared? Whitireia Nursing & Health Journal(24),	Aotearoa NZ	A/NZ	Yes	Education & Training	Qualitative Descriptive Interview	Primary Care Nurses	16	Complexity: Increased Demand	Older people's sexual health needs are not addressed
66	Nelson, K., Wright, T., Connor, M., Buckley, S., & Cumming, J. (2009). Lessons from eleven primary health care nursing innovations in New Zealand. *International Nursing Review,*	Aotearoa NZ	A/NZ	Yes	Models of Care	Qualitative Case Study	Primary Health Care Nurses	11	Complexity: Changes to Health System	Innovations funding can provide opportunity to develop the potential of clinical nursing leadership

67	Officer, T., Cumming, J., & McBride-Henry, K. (2019). Successfully developing advanced practitioner roles: Policy and practice mechanisms. *Journal of Health Organization and Management, 33* (1), 63-77.	Aotearoa NZ	A/NZ	Yes	Role Development	Qualitative Descriptive Interview & Document Review	Nurse Practitioners	84	Complexity: Changes to Health System	Engagement in planning, well-defined career pathway and championing role uptake can promote full use of scopes of practice
68	Parry Strong, A., Lyon, J., Stern, K., Vavasour, C., & Milne, J. (2014). Five-year survey of Wellington practice nurses delivering dietary advice to people with type 2 diabetes. Nutrition and Dietetics, 71(1), 22-27.	Aotearoa NZ	Wellington	No	Education & Training	Quantatitive Survey	Practice Nurses	301	Complexity: Changes to Health System	Practice nurses provide most of the dietary advice in general practices
69	Patel, A., Schofield, G. M., Kolt, G. S., & Keogh, J. W. (2011). General practitioners' views and experiences of counselling for physical activity through the New Zealand Green Prescription program. BMC Family Practice, 12(1), 1-8.	Aotearoa NZ	A/NZ	No	Attitudes & Behaviours	Qualitative Descriptive Interview	Practice Nurses	15	Complexity: Changes to Health System	Green Prescriptions should be delgated to practice nurses and counsellors
70	Petousis-Harris, H., Goodyear-Smith, F., Turner, N., & Soe, B. (2005). Family practice nurse views on barriers to immunising children. Vaccine, 23(21), 2725-2730.	Aotearoa NZ	A/NZ	No	Attitudes & Behaviours	Qualitative Descriptive Survey	Practice Nurses	150	Complexity: Increased Demand	Practice nurses play a significant role in overcoming immunization fears
71	Plumridge, E., Goodyear-Smith, F., & Ross, J. (2009). Nurse and parent partnership during children's vaccinations: A conversation analysis. *Journal of Advanced Nursing, 65* (6), 1187-1194.	Aotearoa NZ	A/NZ	No	Attitudes & Behaviours	Observational Qualitative Descriptive	Practice Nurses	18	Complexity: Increased Demand	By cuing bravery or stoicism to children prior to immunization nurses may minimize their stress
72	Plumridge, E., Ross, J., & Goodyear-Smith, F. A. (2008). Parents and nurses during the immunization of children - Where is the power?: A conversation analysis. Family practice, 25(1), 14-19.	Aotearoa NZ	A/NZ	No	Attitudes & Behaviours	Observational Qualitative Descriptive	Practice Nurses	18	Complexity: Increased Demand	Parents treat nurses as immunization 'experts', nurses recognize patient expertise in knowledge of themselves
73	Price, R., Gilmour, J., Kellet, S., & Huntington, A. (2016). Settling in: Early career registered nurses. Nursing Praxis in New Zealand, 32(3), 31-41.	Aotearoa NZ	A/NZ	Yes	Role Development	Quantitative survey	All Nurses	138	Complexity: Capacity	Most early career nurses are employed in their preferred practice area
74	Prince, A., & Nelson, K. (2011). Educational needs of practice nurses in mental health. *Journal of Primary Health Care, 3* (2), 142-149.	Aotearoa NZ	Hawkes Bay Tairawhiti	Yes	Education & Training	Qualitative Descriptive Interview	Practice Nurses	52	Complexity: Capacity	Nurses perform a variety of mental health interventions such as counselling and advice on medication but have minimal confidence in their
75	Prior, P., Wilkinson, J., & Neville, S. (2010). Practice nurse use of evidence in clinical practice: A descriptive survey. *Nursing Praxis in New Zealand 26* (2), 14-25.	Aotearoa NZ	West Auckland	Yes	Attitudes & Behaviours	Qualitative Descriptive Survey	Practice Nurses	55	Complexity: Changes to Health System	Educational interventions are identified as an integral aspect of implementing evidence-based practice and enhancing practice nurses' knowledge and skill relevant to the use of evidence in practice
76	Pullon, S., & Fry, B. (2005). Interprofessional postgraduate education in primary health care: Is it making a difference? Journal of Interprofessional Care, 19(6), 569-578.	Aotearoa NZ	A/NZ	No	Education & Training	Quantitative Survey Destcriptive Statistics	Primary Health Care Nurses	114	Complexity: Changes to Health System	Interprofessional education is positive, contributing to an increase in collaboration
77	Pullon, S., Cornford, E., McLeod, D., De Silva, K., & Simpson, C. (2005). Workplace factors: The key to successful and sustained continuation of a general practice-based smoking cessation programme. Australian Journal of Primary Health, 11(1), 55-62.	Aotearoa NZ	Wellington	No	Models of Care	Mixed Method Routine Data Analysis & Interview	Practice Nurses	58	Complexity: Changes to Health System	There are funding, time and workload barriers to sustaining smoking cessation programmes in general practice
78	Pullon, S., McKinlay, E., & Dew, K. (2009). Primary health care in New Zealand: The impact of organisational factors on teamwork. *British Journal of General Practice, 59* (560), 191-197.	Aotearoa NZ	Wellington	Yes	Teamwork	Qualitative Descriptive Interview	Practice Nurses	18	Complexity: Changes to Health System	Barriers to teamwork can be political, organizational, educational and cultural
79	Pullon, S., Morgan, S., Macdonald, L., McKinlay, E., & Gray, B. (2016). Observation of interprofessional collaboration in primary care practice: A multiple case study. *Journal of Interprofessional Care, 30* (6), 787-794.	Aotearoa NZ	A/NZ	Yes	Teamwork	Qualitative Case Study Observational	Practice Nurses	3 Practices	Complexity: Changes to Health System	The built environment, practice demographics and location, practice business models, shared goals, team structure and climate impact collaboration
80	Raphael, D., Waterworth, S., & Gott, M. (2014). The role of practice nurses in providing palliative and end-of-life care to older patients with long-term conditions. International Journal of Palliative Nursing, 20(8), 373-379.	Aotearoa NZ	A/NZ	Yes	Education & Training	Qualitative Descriptive Interview	Practice Nurses	21	Complexity: Changes to Health System	With time and eduction, practice nurses can contribute to end of life care

81	Raymont, A., Boyd, M. A., Malloy, T., & Malloy, N. (2015). Rural health care in New Zealand: The case of coast to coast health centre, Wellsford, an early integrated family health centre. *Journal of Primary Health Care, 7*(4), 309-315.	Aotearoa NZ	Wellsford	Yes	Practice Characteristics	Qualitative Descriptive Survey	Practice Nurses	58	Complexity: Changes to Health System	Local agencies have a role to play with rural communities to provide integrated health care
82	Richard, L., Richardson, G., Jaye, C., & Stokes, T. (2019). Providing care to refugees through mainstream general practice in the southern health region of New Zealand: A qualitative study of primary healthcare professionals' perspectives. BMJ Open, 9(12), e034323.	Aotearoa NZ	Dunedin	nk	Attitudes & Behaviours	Qualitative Descriptive Interview	Practice Nurses	15	Complexity: Increased Demand	Coordination across agencies is required to meet the neeeds of refugees and the healthcare professionals providing services to them
83	Richardson, A., & Gage, J. (2010). What influences practice nurses to participate in post-registration education? Journal of Primary Health Care, 2(2), 142-149.	Aotearoa NZ	Christchurch	Yes	Models of Care	Qualitative Descriptive Interview	Practice Nurses	16	Complexity: Capacity	Motivation and vision, enablers for learning and access to education were factors in participation in post-registration education
84	Roy, D. E., Mahony, F., Horsburgh, M., & Bycroft, J. (2011). Partnering in primary care in New Zealand: Clients' and nurses' experience of the Flinders Program™ in the management of long-term conditions. Journal of Nursing & Healthcare of Chronic Illnesses, 3(2), 140-149.	Aotearoa NZ	A/NZ	Yes	Patient Expereience	Mixed Methods Survey & Interview	Practice Nurses	355	Complexity: Changes to Health System	There are benefits of the Flinders approach for clients and nurses in terms of greater understanding of self-management, collaborative care and effective strategies for behaviour
85	Scott-Jones, J., Lawrenson, R., & Maxwell, N. (2008). Sharing after hours care in a rural New Zealand community: A service utilization survey. Rural and Remote Health, 8(4), 1-17.	Aotearoa NZ	BOP	Yes	Models of Care	Quantitative Utilization Survey	Primary Health Care Nurses	204	Complexity: Changes to Health System	A model of first on-call nurse with GP back up provides a sustainable service
86	Scrymgeour, G., Forrest, R., & Marshall, B. (2013). Implementing a continuity of cancer care nursing role into a New Zealand primary health organisation: The patient's perspective. Journal of Primary Health Care, 5(4), 322-329.	Aotearoa NZ	A/NZ	Yes	Patient Expereience	Mixed Methods Survey & Interview	Practice Nurses	19	Complexity: Changes to Health System	Nurses provide informational continuity of care
87	Sheridan, N. F., Kenealy, T. W., Connolly, M. J., Mahony, F., Barber, P. A., Boyd, M. A., Carswell, P., Clinton, J., Devlin, G., Doughty, R., Dyall, L., Kerse, N., Kolbe, J., Lawrenson, R., & Moffitt, A. (2011). Health equity in the New Zealand health care system: A national survey. *International Journal for Equity in*	Aotearoa NZ	A/NZ	Yes	Models of Care	National Survey Descriptive Statistics	All Nurses	15 DHB 21 PHO 31 Experts	Complexity: Changes to Health System	Equity principles are not enacted in the A/NZ health system
88	Sheridan, N. F., Kenealy, T., Parsons, M., & Rea, H. (2009). Health reality show: Regular celebrities, high stakes, new game - A model for managing complex primary health care. New Zealand Medical Journal, 122(1301), 31-42.	NZ	South Auckland	Yes	Models of Care	Qualitative Descriptive Interview & Cohort Data	Practice Nurses	10	Complexity: Changes to Health System	Priority issues not addressed by disease-focused or chronic care management programmes
89	Sherman, S. M., Bartholomew, K., Denison, H. J., Patel, H., Moss, E. L., Douwes, J., & Bromhead, C. (2019). Knowledge, attitudes and awareness of the human papillomavirus among health professionals in New Zealand. PLoS One, 13(12), e0197648.	UK	A/NZ	Yes	Attitudes & Behaviours	Quantitative Survey	Practice Nurses	320	Complexity: Changes to Health System	There are gaps in knowledge about the role of HPV testing in the New Zealand National Cervical Screening Programme
90	Simmons, D., Lillis, S., Swan, J., & Haar, J. (2007). Discordance in perceptions of barriers to diabetes care between patients and primary care and secondary care. Diabetes Care, 30(3), 490-495.	Aotearoa NZ	Waikato	Yes	Patient Expereience	Cross-sectional Survey Quantitative	Practice Nurses	6848	Complexity: Changes to Health System	There is discordance between patients and health professionals in the perception of barriers to diabetes
91	Stokes, T., Tumilty, E., Doolan-Noble, F., & Gauld, R. (2017). Multimorbidity, clinical decision making and health care delivery in New Zealand Primary care: A qualitative study. BMC Family Practice, 18(1), Article 51.	Aotearoa NZ	Otago	Yes	Models of Care	Qualitative Descriptive Interview	Practice Nurses	16	Complexity: Changes to Health System	The co-payment funding model is a barrier to the delivery of care
92	Taylor, R., McKinlay, E., & Morris, C. (2017). Standing order use in general practice: The views of medicine, nursing and pharmacy stakeholder organisations. *Journal of Primary Health Care, 9* (1), 47-55.	Aotearoa NZ	A/NZ	Yes	Attitudes & Behaviours	Qualitative Descriptive Interview	Practice Nurses	9	Complexity: Changes to Health System	Standing orders can extend nursing practice and enable patients to get safe and timely care
93	Taylor, S., & Briggs, L. (2012). A mental health brief intervention in primary care: Does it work? The Journal of family practice, 61(2), E1-E5.	Aotearoa NZ	A/NZ	No	Models of Care	Qualitative Survey & Interview	Practice Nurses	46	Complexity: Changes to Health System	Brief intervention can improve outcomes by facilitating treatment for patients with depression

94	Tipene-Leach, D. C., Coppell, K. J., Abel, S., Pāhau, H. L. R., Ehau, T., & Mann, J. I. (2013). Ngāti and healthy: Translating diabetes prevention evidence into community action. *Ethnicity & Health, 18* (4), 402-414.	Aotearoa NZ	Te Puia Springs	No	Models of Care	Qualitative Longitudinal Survey	Primary Health Care Nurses	Not Reported	Complexity: Changes to Health System	Community lifestyle interventions have the potential to reduce rates of type 2 diabetes as in high-risk communities, need commitment from the health sector and buy-in from the
95	Titchener, J. (2014). A patient-centred clinical approach to diabetes care assists long-term reduction in HbA1c. Journal of Primary Health Care, 6(3), 195-202.	Aotearoa NZ	A/NZ	No	Models of Care	Mixed Methods Test Results Analysis & Survey	Practice Nurses	183	Complexity: Changes to Health System	A patient-centred clinical approach to diabetes can contribute to sustained reductions in HbA1c
96	Tracey, J., & Bramley, D. (2003). The acceptability of chronic disease management programmes to patients, general practitioners and practice nurses. The New Zealand Medical Journal (Online), 116(1169).	Aotearoa NZ	South Auckland	No	Patient Expereience	Quantitative Survey	Practice Nurses	170	Complexity: Changes to Health System	Chronic disease management programmes are valuable and acceptable to patients and providers
97	Turner, N. M., Charania, N. A., Chong, A., Stewart, J., & Taylor, L. (2017). The challenges and opportunities of translating best practice immunisation strategies among low performing general practices to reduce equity gaps in childhood immunisation coverage in New Zealand. BMC Nursing, 16(1), 31.	Aotearoa NZ	A/NZ	No	Models of Care	Mixed Methods Intervention Study Quantitative Descriptive Interview	Practice Nurses	10 Practices	Complexity: Changes to Health System	Customised plans and support to providers are helpful in improving childhood immunization rates
98	Turner, N., Rouse, P., Airey, S., & Petousis-Harris, H. (2009). The cost of immunising at the general practice level. Journal of Primary Health Care, 1(4), 286-296.	Aotearoa NZ	A/NZ	Yes	Models of Care	Quantitative Survey	Practice Nurses	24	Complexity: Capacity	Level of immunization subsidy is lower than the cost of a standard vaccination event
99	Turner, N., Taylor, L., Chong, A., & Horrell, B. (2017). Identifying factors behind the general practice use of the term 'decline' for the childhood immunisation programme in New Zealand. Journal of Primary Health Care, 9(1), 69-77.	Aotearoa NZ	A/NZ	Yes	Attitudes & Behaviours	Qualitative Descriptive Interview	Practice Nurses	35	Complexity: Changes to Health System	The reasons for coding individuals as 'decliners' are a complex mixture of individual, community, practitioner and practice systems
100	Waldron, S., & Horsburgh, M. (2009). Cardiovascular risk assessment: Audit findings from a nurse clinic - a quality improvement initiative. Journal of Primary Health Care, 1(3), 226-	Aotearoa NZ	Northland	Yes	Models of Care	Quantitative Audit	Practice Nurses	621	Complexity: Changes to Health System	Nurse care can reduce CVD risk factors
101	Walker, L., Clendon, J., & Nelson, K. (2015). Nursing roles and responsibilities in general practice: Three case studies. *Journal of Primary Health Care, 7* (3), 236-243.	Aotearoa NZ	A/NZ	Yes	Practice Characteristics	Qualitative Case Study	Practice Nurses	6	Complexity: Capacity	Enabling nurses to work to the full extent of their scope, with adjustments to the models of care, could mitigate future workforce
102	Walker, R., Marshall, M. R., & Polaschek, N. (2013). Improving self-management in chronic kidney disease: A pilot study. Renal Society of Australasia Journal, 9(3), 116-125.	Aotearoa NZ	Hawkes Bay	Yes	Patient Expereience	Intervention Study Quantitative Analysis with Descriptive	Practice Nurses	52	Complexity: Changes to Health System	Targeted self-management support programmes can improve patient-centred outcomes
103	Warren, B., Marugeesh, C., & Greaves, K. (2017). The management of immunisation decliners in Waikato general practices. *Kai Tiaki Nursing Research, 8* (1), 37-42.	Aotearoa NZ	Midlands	Yes	Practice Characteristics	Data Analysis & Qualitative Descriptive Interview	Practice Nurses	16	Complexity: Changes to Health System	The allocation of sufficient time for immunisation activities and a culture of quality improvement improve management of immunization
104	Waterworth, S., & Gott, M. (2012). Involvement of the practice nurse in supporting older people with heart failure: GP perspectives. Progress in Palliative Care, 20(1), 7-12.	Aotearoa NZ	Urban NZ	Yes	Attitudes & Behaviours	Qualitative Descriptive Interview	Practice Nurses	30	Complexity: Changes to Health System	GPs continue to determine the role and boundaries of nurses in their practices
105	Waterworth, S., Arroll, B., Raphael, D., Parsons, J., & Gott, M. (2015). A qualitative study of nurses' clinical experience in recognising low mood and depression in older patients with multiple long-term conditions. Journal of Clinical Nursing (John Wiley & Sons, Inc.), 24(17-18), 2562-2570.	Aotearoa NZ	A/NZ	Yes	Attitudes & Behaviours	Grounded Theory	Practice Nurses	40	Complexity: Increased Demand	Ongoing monitoring for depression and support pathways are necessary to prevent decline in the older person's quality of life; nurses have a role in this
106	Waterworth, S., Gott, M., Raphael, D., Parsons, J., & Arroll, B. (2015). Working with older people with multiple long-term conditions: A qualitative exploration of nurses' experiences. Journal of Advanced Nursing (John Wiley & Sons, Inc.), 71(1), 90-	Aotearoa NZ	A/NZ	Yes	Attitudes & Behaviours	Qualitative Descriptive Interview	Practice Nurses	42	Complexity: Increased Demand	Key patterns of nursing work are: system work, relationship work and patient work
107	Waterworth, S., Raphael, D., Parsons, J., Arroll, B., & Gott, M. (2018). Older people's experiences of nurse–patient telephone communication in the primary healthcare setting. Journal of Advanced Nursing, 74(2), 373-382.	Aotearoa NZ	A/NZ	Yes	Patient Expereience	Qualitative Descriptive Interview	Practice Nurses	21	Complexity: Increased Demand	Increasing awareness of nurse roles in general practice is key to meeting the needs of a growing older population

108	Weir, R., Brunton, C., Jennings, L., Smith, L., & Litt, J. (2004, June). Knowledge and attitudes about influenza vaccination: a New Zealand study of primary care practitioners and elderly people. In International Congress Series (Vol. 1263, pp. 276-280).	Aotearoa NZ	Northland Waikato Bay of Plenty Christchurch	No	Attitudes & Behaviours	Quantitative Survey	Practice Nurses	550	Complexity: Increased Demand	There are high levels of awareness about influenza and the role of vaccination in its control
109	Wilkinson, J. (2015). Proposals for registered nurse prescribing: Perceptions and intentions of nurses working in primary health care settings. Journal of Primary Health Care, 7(4), 299-308.	Aotearoa NZ	A/NZ	Yes	Attitudes & Behaviours	Mixed Methods Survey	Primary Health Care Nurses	305	Complexity: Changes to Health System	Nurses are positive about the prescribing role and see in it potential to address unmet health need
110	Wilkinson, J., Neville, S., Huntington, A., & Watson, P. (2016). Factors that influence new graduates' preferences for speciality areas. *Nursing Praxis in New Zealand, 32* (1), 8-19.	Aotearoa NZ	A/NZ	Yes	Attitudes & Behaviours	Quantitative Survey	All nurses	287	Complexity: Capacity	Supported first year practice programmes influence where nurses choose to work
111	Wong, G., Glover, M., McPherson, M., Garrett, N., & McLeod, S. (2018). Boosting efficacy of nurse-led stop smoking interventions with a quit and win contest: Pilot study results. Contemporary Nurse, 54(4-5), 395-408.	Aotearoa NZ	A/NZ	nk	Models of Care	Mixed MethodsIntervention Study	Practice Nurses	10	Complexity: Changes to Health System	Incentives may be useful in stop smoking programmes
112	Wright, K. R. (2010). An audit of two methods of anticoagulation monitoring in a general practice. Journal of Primary Health Care, 2(4), 318-322.	Aotearoa NZ	A/NZ	No	Models of Care	Quantitative Retrospective Audit	Practice Nurses	32	Complexity: Changes to Health System	Moving from doctor-intensive ad hoc system to the nurse-led system improved practice efficiency
113	Young, J., Egan, T., Jaye, C., Williamson, M., Askerud, A., Radue, P., & Penese, M. (2017). Shared care requires a shared vision: Communities of clinical practice in a primary care setting. *Journal of Clinical Nursing, 26* (17-18), 2689-2702.	Aotearoa NZ	Dunedin		Teamwork	Qualitative Descriptive Interview Observation	Practice Nurses	24	Complexity: Changes to Health System	Nurses are important in communities of clinical practice as they share the patient's vision of care with other participants

Negotiation Articles

Serial	Citation	Country Affiliation of Lead Author	Location of Study	Nurse Author?	Research Topic	Method	Population	Sample Size	Rationale for study	Principal findings
1	Aerts, N., Van Bogaert, P., Bastiaens, H., & Peremans, L. (2020). Integration of nurses in general practice: A thematic synthesis of the perspectives of general practitioners, practice nurses and patients living with chronic illness. *Journal of Clinical Nursing, 29* (1-2), 251-264.	Belgium	Belgium	Yes	Collaboration	Qualitative Descriptive Interview	Practice Nurses	47	Complexity: Increased Demand	Practice nurse autonomy can be facilitated by clear vision, team communications and trust-based professional relationships
2	Bosque, E. (2011). A model of collaboration and efficiency between neonatal nurse practitioner and neonatologist: Application of collaboration theory. *Advances in Neonatal Care, 11* (2), 108-113.	USA	USA	Yes	Collaboration	Vignette	Nurse Practitioners	na	Complexity: Changes to Health System	Approriate education, licensure, certification, and institutional support is required to support nurse practitioner practice
3	Chapple, A., Rogers, A., Macdonald, W., & Sercason, M. (2000). Patients' perceptions of changing professional boundaries and the future of 'nurse-led' services. *Primary Health Care Research and Development, 1* (1), 51-59.	UK	UK	Yes	Negotiating Professional Boundaries	Case Study	Nurse Practitioners	42	Complexity: Capacity	Nurse-led services provide social supports and continuity of care that patients value,other aspects of care are more important than whether or not the service is nurse or doctor led
4	Choi, M., & De Gagne, J. C. (2016). Autonomy of nurse practitioners in primary care: An integrative review. *Journal of the American Association of Nurse Practitioners, 28* (3), 170-174.	USA	USA	Yes	Collaboration	Integrative Review	Nurse Practitioners	12 articles	Complexity: Capacity	Nurse practitioner autonomy is associated with: job satisfaction, patient satisfaction, and collaboration with physicians
5	Cody, R., Gysin, S., Merlo, C., Gemperli, A., & Essig, S. (2020). Complexity as a factor for task allocation among general practitioners and nurse practitioners: A narrative review. *BMC Family Practice, 21* (1), 1-17.	Switzerland	Australia, Canada, Finland, Netherlands, Norway, UK, USA,	nk	Negotiating Professional Boundaries	Narrative Review	Nurse Practitioners	37 studies	Complexity: Capacity	Generally, nurse practitioners treat socially complex patients and GPs focus on medically complex cases
6	Côté, N., Freeman, A., Jean, E., & Denis, J.-L. (2019). New understanding of primary health care nurse practitioner role optimisation: The dynamic relationship between the context and work meaning. *BMC Health Services Research, 19* (1), 1-10.	Canada	Canada	Yes	Negotiating Professional Boundaries	Qualitative Descriptive Interview	Nurse Practitioners	41	Complexity: Capacity	Role optimization must include work engagement, effective collaboration and opportunities to exercise agency
7	Cribb, A. (2011). Integrity at work: Managing routine moral stress in professional roles. *Nursing Philosophy, 12* (2), 119-127.	UK	UK	No	Negotiating Professional Boundaries	Vignette	Cancer Nurses	na	Complexity: Capacity	Role occupation has moral costs for health professionals with ethical views at odds of those expressed through managerialism
8	French, B. (2005). Contextual factors influencing research use in nursing. Worldviews on Evidence-Based Nursing, 2(4), 172-183.	UK	UK	Yes	Negotiating Professional Boundaries	Qualitative Descriptive Interview	Specialist Nurses	58	Complexity: Capacity	To implement research findings, practitioners weigh-up alternative scenarios, contexts, and contingencies, seeking strategies to adapt care, to influence others, and to affect organizational decision-making
9	Gualano, M. R., Bert, F., Adige, V., Thomas, R., Scozzari, G., & Siliquini, R. (2018). Attitudes of medical doctors and nurses towards the role of the nurses in the primary care unit in Italy. Primary Health Care Research & Development, 19(4), 407-415.	Italy	Italy	Yes	Negotiating Professional Boundaries	Cross-sectional Survey Questionnaire	Primary Health Care Nurses	105	Complexity: Changes to Health System	Young nurses and GPs positive attitudes promise a more collaborative future model of primary care
10	Gucciardi, E., Espin, S., Morganti, A., & Dorado, L. (2016). Exploring interprofessional collaboration during the integration of diabetes teams into primary care. *BMC Family Practice, 17* (1), 1-14.	Canada	Canada	Yes	Collaboration	Qualitative Descriptive Interview	Specialist Nurses	57	Complexity: Increased Demand	New ways of working require negotiating space and place to practice, role clarification, and frequent and effective communication

11	Gysin, S., Sottas, B., Odermatt, M., & Essig, S. (2019). Advanced practice nurses' and general practitioners' first experiences with introducing the advanced practice nurse role to Swiss primary care: A qualitative study. *BMC Family Practice, 20*, 1-11.	Switzerland	Switzerland	No	Negotiating Professional Boundaries	Qualitative Descriptive Interview	Advanced Practice Nurses	15	Complexity: Increased Demand	Introducing advanced practice roles in primary care involves pioneering by those involved and recognition of the added value and limits of advanced practice nurses
12	Josi, R., Bianchi, M., & Brandt, S. K. (2020). Advanced practice nurses in primary care in Switzerland: An analysis of interprofessional collaboration. BMC Nursing, 19, 1-12.	Switzerland	Switzerland	Yes	Collaboration	Ethnography Interview	Advanced Practice Nurses	16	Complexity: Increased Demand	Role clarification is crucial for effective interprofessional collaboration
13	Karimi-Shahanjarini, A., Shakibazadeh, E., Rashidian, A., Hajimiri, K., Glenton, C., Noyes, J., Lewin, S., Laurant, M., & Colvin, C. J. (2019). Barriers and facilitators to the implementation of doctor-nurse substitution strategies in primary care: A qualitative evidence synthesis. Cochrane Database of Systematic Reviews(4).	Iran	Australia, Canada, Colombia, Congo, Germany, Haiti, Hong Kong, Lesotho, Malawi, Malta, Mauritius, Mozambique, Netherlands, New Zealand, Saudi Arabia, Slovenia, Spain, Swaziland, Sweden, Tajikistan,Uganda, UK, USA, Yemen, Zimbabwe	Yes	Negotiating Professional Boundaries	Systematic Review	Prrimary Care Nurses	66 studies	Complexity: Capacity	Nurses taking on extra tasks need collegial support from doctors; proper resources; good referral systems; experienced leaders; clear roles; and adequate incentives, training and supervision
14	Liberati, E. G. (2017). Separating, replacing, intersecting: The influence of context on the construction of the medical-nursing boundary. *Social Science & Medicine, 172*, 135-143.	UK	Italy	No	Negotiating Professional Boundaries	Ethnography Interview	Secondary Care Nurses	73	Complexity: Changes to Health System	The medical-nursing boundary is affected by: patients' awareness, the type of clinical approach adopted and the acuity level
15	McInnes, S., Peters, K., Bonney, A., & Halcomb, E. (2017). A qualitative study of collaboration in general practice: Understanding the general practice nurse's role. Journal of Clinical Nursing, 26(13-14), 1960-1968.	Australia	Australia	Yes	Collaboration	Qualitative Descriptive Interview	Practice Nurses	24	Capacity: Increased Demand	Nurses' role clarity promotes collaboration and supports nurses to work to the full extent of their scope
16	Merrick, E. T., Fry, M., Duffield, C., & Stasa, H. (2015). Trust and decision-making: How nurses in Australian general practice negotiate role limitations. *Collegian, 22* (2), 225-232.	Australia	Australia	Yes	Collaboration	Mixed Method	Practice Nurses	160	Capacity: Changes to Health System	Nurses gain influence in clinical decision-making by building relationships with patients and medical colleagues
17	Miller, K. L., & Kontos, P. C. (2013). The intraprofessional and interprofessional relations of neurorehabilitation nurses: A negotiated order perspective. *Journal of Advanced Nursing, 69* (8), 1797-1807.	Canada	Canada	No	Negotiating Professional Boundaries	Qualitative Descriptive Observational Secondary Analysis	Secondary Care Nurses	35	Capacity: Changes to Health System	Intraprofessional negotiation is highly influenced by context producing a variety of strategies and tactics by nurses
18	Sangaleti, C., Schveitzer, M. C., Peduzzi, M., Zoboli, E. L. C. P., & Soares, C. B. (2017). Experiences and shared meaning of teamwork and interprofessional collaboration among health care professionals in primary health care settings: A systematic review. *JBI database of systematic reviews and implementation reports, 15* (11), 2723-2788.	Brazil	International	Yes	Collaboration	Systematic Review	Primary Health Care Nurses	21 studies	Capacity: Changes to Health System	Teamwork and interprofessional collaboration is a process which is not fully understood
19	Schadewaldt, V., McInnes, E., Hiller, J. E., & Gardner, A. (2016). Experiences of nurse practitioners and medical practitioners working in collaborative practice models in primary healthcare in Australia: A multiple case study using mixed methods. *BMC Family Practice, 17*, 1-16.	Australia	Australia	Yes	Collaboration	Mixed Method Case Study	Nurse Practitioners	22	Capacity: Changes to Health System	Practitioners' individual relationships can partially overcame systemic restrictions on collaboration
20	Schluter, J., Seaton, P., & Chaboyer, W. (2011). Understanding nursing scope of practice: A qualitative study. *International Journal of Nursing Studies, 48* (10), 1211-1222.	Australia	Australia	Yes	Negotiating Professional Boundaries	Qualitative Descriptive Interview	Secondary Care Nurses	20	Capacity: Changes to Health System	Negotiation is a fundamental aspect of nursing practice and has allowed nurses to find innovative ways of working in teams

21	Solimeo, S. L., Ono, S. S., Lampman, M. A., Paez, M. B., & Stewart, G. L. (2015). The empowerment paradox as a central challenge to patient centered medical home implementation in the veteran's health administration. *Journal of Interprofessional Care, 29*(1), 26-33.	USA	USA	No	Collaboration	Mixed Method Survey & Interview	Primary Care Nurses	99	Capacity: Changes to Health System	Team members find it difficult to share tasks that are counter to traditional roles

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Appendix 2 Examples of the abstraction of categories from initial codes

Example Initial Codes Total n-242	Key Intermediate Codes	Categories
• Ways of working • Here versus there • Hierarchies • Populations	Norms Norms	"Owning One's Practice" "Normalizing New Skills"
• Place • Space • Fit	Fitting-in (Accessing the Market)	Occupying Space → Defining Place
		Occupying Space
• Gaining competency • Finding my feet • Training • Education	Learning Ways of Working	(Mastering) Consolidating Skills
• Reflecting • Being New • Tolerating • Respecting	Trusting Supporting	(Establishing) Building Relationships
• Comfortable doing (Safety) • My work • Patient Proximity • Choosing/imposing scope	Autonomy	(Beginning Personal Scope) Establishing Area of Autonomous Practice
	Entering the Space	**Positioning to Do Differently**
• Exploring • **Role models** • Outside opportunities • Seeing the big picture	Awareness of Possibilities	Asking what Role Could Look Like
• Pushing back • Just doing it • Testing myself • Trial and error	Testing Boundaries	Testing Limits
• Having an interest (**Self-efficacy**) • Having a vision (**Governance**) • Having Plan B • Self-negotiation	Sticking or Twisting (**Satisfaction**)	Setting Goals
	Creating Opportunities	**Leveraging Opportunity**
• Uncertainty • COVID • Risk (Safety) • Changing goalposts	Uncertainty Meeting Roadblocks	Responding to Uncertainty
• Specializing • Meetings • Warm handovers • Cooperating • Acting through proxies (**Access to decision-makers**) • Growing ourselves	Involving the Whole Team Dialogue (**Access to decision-makers**)	Engaging in Collective Decision-making
• Novel roles pioneering • Being perceived differently		

Note: Not all codes are included. A hand writing font is used to reference the creative and personal, though interactive, nature of the process of conceptualization. In the Table, concepts are colour coded to indicate their theoretical purpose - contextual, conditional, processual and consequential (outcomes). Parentheses indicate terms used as labels at an earlier stages of analysis.

Appendix 3 Ethics notification NOR 10/46 10 November 2020

Date: 10 November 2020

Dear Sarah Hewitt

Re: Ethics Notification - **NOR 20/46 - Negotiating the roles of practice nurses in New Zealand: A grounded theory study**

Thank you for the above application that was considered by the Massey University Human Ethics Committee: **Human Ethics Northern Committee** at their meeting held on **Tuesday, 10 November.**

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand **T** 06 350 5573; 06 350 5575 **F** 06 355 7973
E humanethics@massey.ac.nz **W** http://humanethics.massey.ac.nz

Appendix 4 Participant information sheet

Negotiating the role of practice nurses in New Zealand general practice: A grounded theory study

PARTICIPANT INFORMATION SHEET – INDIVIDUAL INTERVIEW

RESEARCHERS' INTRODUCTION

My name is Sarah Hewitt, I am undertaking research into how the role of practice nurses is negotiated in New Zealand general practice, for a PhD qualification at Massey University, School of Nursing at Albany. I am also a registered nurse working in general practice in the Auckland Region.

My studies are being supervised by the following:

Professor Nicolette Sheridan RN PhD, Head of School Nursing, Director of the Centre for Nursing & Health Research, Massey University

Associate Professor Karen Hoare, NP PhD, Nurse Practitioner for Children and Young People, Post Graduate Director, Massey University

Professor Jane Mills RN PhD, Dean and Head, La Trobe Rural Health School

PROJECT DESCRIPTION AND INVITATION

The primary care environment is complex, its nursing workforce is diverse, and the services provided by nurses in New Zealand general practice varies from place to place. This research seeks to understand that variation by asking how the role of practice nurses is determined **within individual organisations.** It aims to derive a theoretical model of the processes used to negotiate the role and to identify implications for the development of practice nursing in New Zealand. You are invited to be interviewed as part of this research.

PARTICIPANT IDENTIFICATION AND RECRUITMENT

We are inviting practice nurses, and those who employ and manage practice nurses, to share their knowledge. You have been identified as a potential participant by virtue of your role as a Practice Nurse (RN/EN)/ Nurse Practitioner/ Manager/ Medical General Practitioner / Nurse-Leader/ Other* _____

The number of participants involved in this research is not pre-determined. Additional interviewees will be sought until each concept suggested by previous participants has been explored fully, within the time constraints of the study, which will be completed by June 2022.

There are no anticipated discomforts or risks in participating in this research and it is anticipated that the research will benefit the wider primary care sector.

PROJECT PROCEDURES

You are invited to take part in a face-to-face or video conferencing (Zoom) interview which will take approximately 60 minutes. The purpose of the interview, which will be audio recorded, is to explore your experiences of nursing roles in general practice and how they are developed, and to understand what is important to you in that regard. The interview will be semi-structured with open ended questions and will be at a time and location of your choice. The researcher may take notes during the interview and, to provide context for your remarks, you will be asked for the following specific information:

- *Personal Information*: age; gender; ethnicity; job title; level of practice; time in practice; time in general practice
- *Organisation Information*: location of practice; number of nurses; number of doctors; number/type of other health professional staff eg pharmacists; number of clinical assistants eg

health care assistants; number of administrative staff; number of enrolled patients; organisational model

The information gained during this interview will be used only for the purpose of this study. You may be invited to take part in a further group-interview. Participation in such interviews would be subject to separate consent, involve between 2 and 4 persons and last approximately 60 minutes. Participation in the initial individual interview does not oblige participation in any further group interviews.

DATA MANAGEMENT

The interview recording will be transcribed by the researcher into written form and its content will be analysed, alongside that from other interviews and from literature sources. Electronic interview data will be stored securely, with password protection, on Massey University IT systems. Working paper copies of transcripts will be held securely by the researcher and destroyed securely at Massey University when no longer required. One copy each of the interview recording and the transcript will be held for 10 years within the University, before being securely destroyed. Your privacy will be protected by not using your name or practice location in any report, presentation or discussion. Any personal information you provide will be used only for contextual purposes and will be anonymised.

PARTICIPANTS' RIGHTS

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study by 31 March 22;
- ask any questions about the study at any time;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded; please provide an e-mail contact for this purpose;
- ask for the recorder to be turned off at any time during the interview

PROJECT CONTACTS

Please contact one of the following if you have any questions about this research:

Sarah Hewitt sarah.hewitt.6@uni.massey.ac.nz [redacted]

Professor Nicolette Sheridan N.Sheridan@massey.ac.nz [redacted]

Associate Professor Karen Hoare K.J.Hoare@massey.ac.nz [redacted]

MASSEY UNIVERSITY HUMAN ETHICS COMMITTEE APPROVAL STATEMENT

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 20/46. If you have any concerns about the conduct of this research, please contact Dr Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz

School of Nursing
Private Bag 102904, North Shore, Auckland 0745, New Zealand, T +64 9 4419166 www.massey.ac.nz

Appendix 5 Participant consent form

Negotiating the role of practice nurses in New Zealand general practice: A grounded theory study

PARTICIPANT CONSENT FORM – INDIVIDUAL This form will be held for 10 years

- I have read, or have had read to me in my first language, and I understand, the Information Sheet attached as Appendix I
- I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time.
- I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study by 31 March 2022.
- I understand that my responses will be recorded and transcribed. I also understand that recording can be stopped at any time.
- I understand that my confidentiality with respect to identity cannot be guaranteed but that we will not be identified in any report or publication resulting from this research.
- I understand that I am able to request the findings of the study.
- I understand that study data will be kept for ten years, after which time it will be destroyed.

Declaration by Participant:

Please state full name

I _____ hereby agree to take part in this study

Signature: _____ Date: _____

To receive a copy of the report, please write your email address or home address below:

_____

_____

Researcher:
Sarah Hewitt
Doctoral Candidate
Massey University
sarah.hewitt.6@uni.massey.ac.nz

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