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A Critical Reflection on Advanced Practice Nursing

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A CRITICAL REFLECTION ON ADVANCED PRACTICE NURSING

By

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A Critical Reflection on Advanced Practice Nursing

Abstract

Legitimation of the Nurse Practitioner and Advanced Practice Nursing is explored using

the framework of Critical Theory and the Case Study Methodology of Yin. Three

different cases are analyzed using classic themes of critical theory - oppression,

alienation and ideology. Three publishable articles comprise this portfolio. First is

"Looking for love (legitimation) in all the wrong places - A Critique of Nurse Practitioner

effectiveness literature". This article reviews the literature of Nurse Practitioner

effectiveness and offers an analysis of the failures and problems of these positivistic

studies. Article two is "At least some of us are still alive – whatever happened to history?

The historical context." The history of nursing and the genesis of the Nurse Practitioner

role are explored using the themes of oppression and alienated labor and their dialectic

relationship to praxis. The third is "Just a nurse - A critical reflection on a nurse's tale."

An interview with a Nurse Practitioner educated in an early program reveals the inherent

ideology and false consciousness which underpins the role of the Nurse Practitioner and

continues to subvert and derail legitimation of Nurse Practitioners.

DEDICATION

To my husband, Robert Greaves,

And my father James Quinn

ACKNOWLEDGEMENTS

At the heart of my dissertation, and my journey through the world of the Nurse Practitioner, in all its permutations, is my wonderful colleague and professor, Patricia Roth. Trish's integrity, intelligence and love, I hope, shine through every word I wrote. Without her, and this is not a cliché, there would be nothing.

To Drs. Georges, Instone, & Hunter, all of you exemplified grace under pressure as I am sure I tested your limits and I found that all of you more than rose to the occasion and gave me an example to emulate.

To Nancy, I don't think I would have finished this without all these years of your unfailing encouragement and support.

To Cheryl, your words say it all, you were the catalyst and the exemplar.

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Introduction

Background and Significance

Almost everyone in the United States has contact with nurses. Moreover, as this contact often occurs in a context of vulnerability, need, and crisis, it possesses an intimacy and impact transcending many social and professional relationships. Nurses are present at our birth and often at our death. Nurses, as few do, know our fears, weaknesses, courage, and dreams. They see us, literally touch us, at our most vulnerable and heroic moments. Not surprisingly, nurses are highly respected by the general population. This is revealed by the consistent ranking of nursing as one of the most respected professions in European and North American polls (Gordon, 2005).

In 1965, a time of intense cultural transition throughout the larger U.S. society, the nursing profession extended the unique nursing approach to healing by expanding the scope of nursing practice in the creation of the Nurse Practitioner (NP) (McLeod, 1995). An important hope in the establishment of the NP clinician was and is the expansion of primary care services to underserved populations. In addition, the early pioneers of NP education believed the traditional nursing approach to the whole person, combined with advanced clinical training, would make a significant and positive contribution to the health care delivery system. Given the pervasive respect accorded nursing and the ever-increasing need for primary care providers, it was reasonable to imagine the nascent NP movement would soon find acceptance.

However, despite almost 50 years of impressive practice, the NP movement is haunted by a glaring contradiction. Numerous studies over two decades consistently reveal NPs provide a quality of care equal to and often exceeding that of physicians.

Despite this empirical fact, however, NPs remain significantly underutilized. And related to this, NPs remain poorly understood by many in nursing, medicine, hospital administration, and the general population.

This contradiction represents, to borrow a term from sociology, a legitimation crisis. That is, NPs have the professional training and legal authority to practice, but they remain underutilized. More importantly, the opportunity for the NP profession to demonstrate the practical functioning to which it is entitled by education and law is severely circumscribed. In other words, the impact of the NP movement on the health care delivery system is far less than it can and should be. This is to the detriment of NPs, the larger nursing profession, and health care consumers. NPs, as a highly educated collective of professional healers, have much more to offer than they have been allowed to give.

Most studies of NPs have focused on the quantitative and qualitative analysis of the effectiveness and clinical outcomes of NPs from a rationalist post-Enlightenment philosophical stance. However, despite overwhelming empirical evidence documenting the effectiveness of NPs, the legitimation crisis continues unimpeded. This suggests this crisis is beyond the rational; that the inability of healthcare system to fully utilize NPs is perhaps related to unknown or hidden social forces. An exploration of such forces is the concern of the present research.

Purpose of the Study

The purpose of this case study was to examine the perception of legitimacy in nurse practitioners using literature review, historical critique, and an exemplar interview of an NP with 40 years of experience in the role. Data from these sources were analyzed

utilizing the classic themes of critical theory: oppression, alienation, ideology and false

consciousness. By examining multiple sources, results from this study provide important

information at a critical juncture in nursing history. Potentially, data from this study can

form the basis for the future study of intra- and inter-disciplinary power relations and can

be used to shape curricula in DNP programs.

Methodology

Case Study Methodology is a method of empirical inquiry that investigates a

contemporary phenomenon within its real life context. Case studies can be done using

qualitative or quantitative evidence. One of the key characteristics of case study research

is that it allows researchers to focus on complex situations while taking the context of the

situation into account (Keen and Packwood 1995), thus capturing the holistic and

meaningful characteristics of events (Yin 1994; 1999; 2003). The inclusion of context,

such as socio-historical factors, adds richness and meaning to the study. The use of

multiple data collection methods and multiple sources provides a more convincing and

accurate case study (Yin 1994).

The methodology of case study was especially appropriate for the focus of this

study. Noor (2008) discusses the ability of the case study method to provide a round

picture of events, and a more holistic view because of the many sources of evidence.

Anderson (1993) sees case studies as being concerned with the how and why things

happen, "allowing the investigation of contextual realities and the differences between

what was planned and what actually occurred" (p.155). The case study can provide a

credible, original and creative approach that provides a useful way to develop the theories

and hypotheses required to generate evidence for change (McGloin, 2008)

Yin (1994) describes the strategic triangulation of the data that is possible with case study methodology. With triangulation, multiple sources of data are used, thus enhancing the credibility of the strategy (Yin, 1994). Such sources of data may include survey instruments, archival documents, observations, interviews and quantitative measurements. By using such a variety of methods, the trustworthiness of the case study should be enhanced (Tellis, 1997).

In this research the use of case study methodology allowed for the generation of new hypotheses and perspectives that will perhaps help engender a different approach to an old problem – the legitimation of NPs. The use of multiple pieces of evidence for the study and the collection of what Yin (1994, p.116) calls "deep data" add particular strength to any outcomes.

Data were obtained in this study from three sources; a critical review of the NP effectiveness literature, an analysis the origins of nursing and the genesis of the NP role and, finally, an exemplar case study interview/dialogue with an NP with 40 years experience in the role. This case study was of the exploratory type and extracted derivations, explanations and possibly solutions for the NPs legitimization crisis. These three sources of data were analyzed and critiqued using the perspectives of critical theory as a starting point.

Philosophical perspective

Yin (1994) and McGloin (2008) both suggest that to undertake a case study effectively it is essential to develop a conceptual framework to guide the collection and analysis of data. I have chosen to use a philosophical perspective, critical theory, as a sensitizing starting point. Critical theory offers a different and needed perspective.

Perhaps the origins of the legitimation crisis lie not in lack of knowledge or measures, but rather within the historical roots of nursing and the evolution of the NP. Nurses have historically lacked power, and communication problems with dominant interests in the health system, both nursing and medicine, have been distorted by issues of power, gender, and money (Robert, 1996)

The paradigm of critical theory uses oppositional thinking to perform a critique of the social situation under study in a historical, cultural and political context. Implicit rules and assumptions are examined, conditions are identified that would facilitate uncoerced knowledge, and a theoretical framework is tested against individual cases These three pieces of data, the literature review, the historical critique and the exemplar interview, were analyzed utilizing the classic themes of critical theory; oppression, alienation, ideology and false consciousness.

Alienation is the transformation of people's own labor into a power which rules them as if by a kind of natural or supra-human law. Alienated workers are those who have lost control over their lives and destinies because they have been deprived of control over their actions. Alienated laborers may be alienated not only from the product of their labor, but also the process of production. NPs have struggled to achieve control over the production of their labor and that has formed a large core of the legitimation crisis. The working dialogues of NPs may be characterized as those of alienated labor, but the source of their alienation remains murky.

Alienation is directly related to the phenomena of ideology. Abercrombie et al(1984) defines ideology as beliefs, attitudes and opinions that are bound together either loosely or very tightly. Though there are some who consider ideology as being mostly

neutral (Thompson, 1966), the majority of writers present ideology in a critical sense

(Taylor, 1997). Street (1992) describes ideological critique as "the process by which

these patterns of shared social meaning are subject to scrutiny with an explicit aim of

demonstrating the internal contradiction and false understanding inherent in them (p.78)."

Thompson (1966) writes that "to study ideology is to study the ways in which meaning

serves to establish and sustain relations of domination" (p.56). Marx , though he did not

coin the term, was the first to elucidate the concept of ideology as false consciousness,

belief in one's own subordination (Lichtman, 1975). Conditions of inequality create

ideologies which confuse people about their true aspirations, loyalties and purposes.

Through analysis of the effectiveness literature, history and the NP interview, the aim of

this study was to uncover the ideological assumptions the might contribute to a false

consciousness.

Freire (1970) defined oppression as the imposition of one person's (or group's)

choice upon another in order to transform an individual's consciousness to bring it in line

with the oppressor's. Because the characteristics and values of the oppressed group are

devalued, the oppressed group seeks to become more like the dominant culture and

begins to reject its own characteristics. Threads of oppression of both women and nursing

run throughout much of the story of nurses, and were examined in this case study.

A complication of empirical investigation and the positivistic orientation in

general is that its values and categories of research are grounded in the existing social

system. McIntyre (1995) notes that our research questions are often constructed to

support rather than challenge existing knowledge. While such an orientation does not

inherently prohibit valuable work, it does tend to accept and reproduce the status quo.

The possibility that the social system has fundamental flaws is beyond the vision of positivism. Likewise, the need and possibility of structural transformation is also outside the discourse of most traditional research.

The nature of the legitimation crisis, however, suggests fundamental problems in the social relations between NPs and other players in the health care delivery system. The fact that no amount of empirical evidence supportive of NPs has convinced the prevailing structures of the health system to utilize NPs to their full potential is a clear example of the present irrational social relations in health care. Traditional research, however, continues to adhere to the belief that more empirical studies will somehow be helpful and continues to replicate earlier findings. Implicit in this, is the assumption that the problem is rational, and can be solved by additional rational knowledge.

As the contradictions of NPs are both determined by and reflect contradictions in the larger nursing profession, a journey into the modern history of the nursing labor force and its social contexts is mandatory. Questions regarding the effectiveness and professionalism of NPs have long been resolved and are of little relevance to continuing research surrounding the legitimation crisis of the NP movement. It was the goal of this research to uncover primary etiological determinants of this crisis, and more importantly, possible solutions.

Looking for Love (Legitimation) in all the Wrong Places - A Critique of the Nurse

Practitioner Effectiveness Literature

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Running Head: CRITICAL REFLECTIONS

Abstract

This article reviews the literature of Nurse Practitioner (NP) effectiveness and offers an

analysis of the failures and problems of these positivistic studies. Numerous quantitative

and qualitative studies over three decades have consistently documented the provision by

NPs of a quality of care equal to and often exceeding that of physicians, and these studies

demonstrate that NPs should have a crucial and effective role to play in health care

delivery. Despite this often replicated empirical fact, NPs continue to encounter

significant barriers to practice and remain profoundly underutilized. A review of the

literature and a critique framed by the critical theoretical concepts of alienation and

ideology reveal the false consciousness that has been mistakenly held by nurses and NPs.

The literature on NP effectiveness and barriers to practice is constrained and limited by

its paradigm of definition. NPs are striving to legitimate themselves, but are using a

construct which only reinforces their marginalization, and the ineffectiveness of such

research is preordained.

Looking for Love (Legitimation) in all the Wrong Places - A Critique of the Nurse

Practitioner Effectiveness Literature

In 1965, at time of intense cultural transformation throughout the larger society,

the character of nursing practice was significantly altered through the creation of the

Nurse Practitioner (NP). During this period the civil rights and anti-poverty movements

were ascendant, and the demand for greater access to health care for the disenfranchised

was an important component of change. It was during this time that the slogan, "Health

care is a right, not a privilege," first entered popular culture. NPs, as often argued by the

nursing leadership of the time, could make a significant contribution to the delivery of

primary health care to underserved populations. This was one of the main justifications

for the establishment of the NP category of Advanced Practice Nurse (APN).

In addition, the early pioneers of the NP movement believed that the traditional

holistic nursing approach to healing, which included the praxis of medical, behavioral,

and social science expertise, would make NPs uniquely qualified to provide primary

health care services (Baer, 1981; Mundinger, 1994). Given the pervasive respect

accorded nurses, as evidenced by the consistently high ranking of nursing as one of the

most respected professions in European and North American polls, it was reasonable to

assume the nascent NP movement would soon find acceptance.

Numerous quantitative and qualitative studies over three decades have

consistently documented the provision by NPs of a quality of care equal to and often

exceeding that of physicians and these studies demonstrate that NPs should have a crucial

and effective role to play in health care delivery. Despite this often replicated empirical

fact, NPs continue to encounter significant barriers to practice and remain profoundly

underutilized. Related to this, the role of NPs continues to be poorly comprehended by

many in nursing and the larger health care community (Fairman, 2008). From this

beginning, effectiveness literature has abounded. A chronologic review follows.

Review of Effectiveness Studies

Soon after the initiation of NP education at the University of Colorado in 1965,

research was initiated to produce the evidence to support the claims of advocates of the

NP movement (Freund, 1986). Early research primarily addressed NP's impact in four

areas: (1) access and availability of services; (2) consumer and employee acceptance; (3)

productivity, profitability and cost of care, and (4) quality of care. In general, this

research yielded positive findings in all four areas. In regards to access to care, the

majority of NPs worked in underserved areas (Sultz, Henry & Carroll, 1977). The NPs

increased the availability of primary care services (Morris & Smith, 1977; Mendenhall &

Neville, 1980) and patients and physicians were satisfied with NP care (Schiff, Fraser &

Walter, 1969). The care provide by NPs was found to cost less than the same care

provided by physicians (Freund, 1981; Schneider & Foley, 1977). The quality of care

provided by NPs equaled, and in some instances, exceeded that provided by physicians

(Freund, 1986; Lewis, Resnick, Schmidt & Waxman, 1969).

These conclusions were drawn with some qualifications. Many of these studies

were merely case examples, with small samples of NPs, physicians and patients.

Randomization was rarely used. There were no controls over variables such as patient

acuity, practice type, provider training and experience. The policy initiatives of that

decade, the 1970s, had been to provide increased quality of primary care services, and to

promote access; NPs had contributed to that end (Freund, 1986).

The same factors which motivated research on NP practice in the 1970s (access,

acceptance, productivity, cost and quality) continued into the 1980s. But social and

political conditions were changing. The physician shortage of the 1970s became a

physician glut (Morris & Smith, 1987), and lack of physician primary care services in

rural areas was no longer a problem. If NPs were identified as being an answer to

physician shortage by substitutive services, there was no further need for NPs.

The growing influence of business and industry on health policy and delivery

began in the 1980s. Health care costs began dramatically spiraling upward, and the

underwriters of these costs (business) began to develop policies to contain costs. At the

heart of many of these cost containment policies were attempts to limit access to services.

Many viewed NPs as an addition to the quantity of services provided and thus

representative of an increase in overall cost. Legal barriers and restrictive reimbursement

policies were established (Stanford, 1987). As patients' access to NP services was

limited, this provided a disincentive for employers of NPs, and in some cases actually

prohibited NPs from practicing. Restrictive policies designated the physicians as the

gatekeeper, assuming the physician would limit the volume and therefore the cost. These

policies then put the NP at the mercy of the physician (OTA, 1986).

Until this time, NPs had cast themselves in the mode of physician substitutes,

offering comparable services of equal quality as a means to improve access to care. But

as barriers to this model came into place the profession's tenor underwent a change. NPs

envisioned themselves as changing the nature of primary care services. With their focus

on the traditional nursing values of health promotion and prevention, teaching and counseling, NPs felt they could improve both the quality of services provided and patient outcomes. Towards the end of the 1970s, research initiatives began to address broader questions related to NP practice and this expanded focus has continued to the present.

Research of the 1980s continued to strive to prove the effectiveness of the NP within the broader nursing definition of primary care. The studies have slowly increased in numbers and rigor, and have had overwhelmingly positive findings (Diers & Molde, 1979; Sullivan, Dachelet, Sultz, Henry & Carroll, 1979). I will comment on some of the major research of the 1980s and 1990s, and place them within the broader scope of health care expectations of the times, corresponding to the attempt of NPs to position themselves in the larger schema.

Several comprehensive review articles by Edmunds (1978), Prescott & Driscoll (1979, 1980), Goodwin (1981), Abdellah (1982), Yankhauer & Sullivan (1982), Shamansky (1984), Molde & Diers (1985), Crosby, Ventura & Feldman (1987), Feldman, Ventura & Crosby (1987), and Stanford (1987) have provided extensive meta analyses of studies of access, availability, acceptance, satisfaction, cost and clinical outcomes. All have concluded that NPs are successful and effective.

Among the most comprehensive of the effectiveness studies was a case study released in 1986 by the Office of Technology Assessment (OTA). The OTA summarized 10 studies which concluded that the quality of care provided by the NP and physician was equivalent. The OTA also reviewed 14 studies which demonstrated that the quality of care rendered by NPs was better than physicians. The OTA found consistent results in increased patient satisfaction with NPs over physicians. The authors freely

acknowledged the difficulty of their study. Direct measurement of quality of care as provided by NPs was not possible because the standard of quality is set by medicine. They could not examine the possible differences in NP care provision.

Studies of patient acceptance of NPs conducted in the mid 1980s confirmed the findings of previous studies. Patients were found to be accepting of NP services and satisfied with the care received. Prior experience with NPs was repeatedly found to be the most important predictor of acceptance (Shamansky, 1984).

Research into cost effectiveness and economic impact has been closely tied to issues of reimbursement. With prohibitive reimbursement practices and restrictions, cost savings have been difficult to demonstrate (Sirles, Leeper, Northrup & O'Rrear, 1986). Studies conducted in settings not dependent on third party reimbursement demonstrated actual cost savings associated with NP services (Dellinger, Zettner, Dowell, & Annas, 1986). Yeater (1985) noted that a 1980 evaluation found that reimbursed expenses to NPs were 30% less than physicians. These studies have been limited because they measured cost effectiveness on a per visit episode of illness basis without considering costs incurred in other health care sectors. In one study, however, costs of care for congestive heart failure patients at a Veterans' Administration center were compared before and after the institution of a NP clinic, demonstrating significant savings in decreased time of hospitalization (Garrard, Kane, Radosesvich, Skay, Arnold & Kepferele, 1990) and the hospitalization rates of geriatric patients (Wieland, Rubenstein, Ouslander & Martin, 1986).

Quality of care has continued to be studied extensively. Yankauer and Sullivan (1982) commented that research into quality of care of these new health professionals has

received far more attention that quality of services delivered by physicians (a presumption that physician centric care is without fault seems to pre exist). Most studies have continued to use physician care as the standard for quality (Hal, 1990; Hickman, Sox & Sox, 1985; Watkins & Wagner, 1982). If NP care, in terms of process or outcomes or both, was equivalent to physician care, it is considered safe, competent quality care (Prescott & Driscoll, 1979). In comparison studies of the 1980s, subtle differences between NPs and physicians were noted. NPs had fewer missed appointments and higher return rates for follow up visits (Bibb, 1982; Becker, Fournier & Garner, 1983). NPs prescribed fewer medications (Rosenauer, Stanford, Morgan, & Curtin, 1984). In a study comparing NP and physician care for hypertension and obesity, NPs had more success on all measures (Ramsay, McKenzie & Fish, 1982).

Recent research has tended to move away from proof of effectiveness and quality to focus on demonstration of better care and outcomes than physicians (perhaps another measure of effectiveness and quality). NPs have long asserted that their style and pattern of practice is different from that of physicians, and that they are more than a physician substitute or a cheaper brand of provider. Explication of this assumption is fraught with difficulties, and the paradox of proving the superiority of one paradigm of care by using the standards of another might seem to be insurmountable.

A case in point is a recent project whose chief architect is Mary Mundinger, Dean of the Columbia University School of Nursing. The Columbia Presbyterian Advanced Practice Nurse Associates is a group of 20 NP faculty of Columbia University who have reached an agreement with a large health maintenance organization (HMO). Oxford Health Plans, Inc. has agreed that members may choose a Columbia NP as their primary

care provider rather than a physician. The managed care company will pay the same

reimbursement rates to NPs and physicians (Stanley, 1997). Mundinger (1996) has

asserted NPs will bring a value added component of nursing skills to patient encounters,

and that the care the NPs provide will be more comprehensive. Dr. Mundinger admits

though, that accruing lower costs for services is the drawing card for the HMO. The

outcome measurements of the study, released in 1998, revealed that NPs compared

favorably to physicians or exceeded physician outcomes in all points of comparison.

In addition, the move by Oxford to impanel NPs has drawn extensive physician

protest (Grandinette, 1997). The New York State Medical Society voted to seek

legislative prohibition of the substitution of licensed primary physicians with NPs.

Support from any physicians outside the Columbia Presbyterian Hospital has been

nonexistent (Brenna, 1997).

Common themes have emerged from the multitude of studies and research on

NPs. The directions and tone of the studies have slightly altered and realigned, but the

basic empirical proofs are still being attempted.

The research has, in large part, mirrored the development and nature of prior

research in nursing. Education and the raising of educational requirements and the

placement of programs in academic settings have long been equated, in nursing, with

increased professional status and acceptance (Sultz, Henry & Carroll, 1977). Some of the

earliest research on NPs focused on the best mode of education, and the

recommendations to locate that education at the Masters level (Sultz, 1986). The

advanced level of education was presumed to equate with increased professional

acceptance by medicine and patients. Though first postulated over 100 years ago, these

thoughts are still being replicated with the institution of the Doctorate of Nursing

Practice.

Buppert's (1995) call for hard facts and figures has been repeatedly accomplished

as evidenced by all the studies. Cost saving, efficiency of care, cost conscious practice,

and excellent outcomes have all been repeatedly demonstrated. Large statistical studies

are problematic and will remain so because of the shadow provider status of

reimbursement mechanisms (Andrews, 1996). However, the statistical studies that have

been done are impressive and sound enough that their results can be generalized and

validated when applied to a larger populace.

Studies which have looked at quality of care measures (Avron, 1991; Hall, 1990;

Salkever, 1992) have compared NP and physician care in several types of primary care

and found the NP's care as good or superior to that of physicians. Quality of NP care,

especially when demonstrated against that of physicians, has been proven again and again

to be effective in all indices.

More recent attempts to explain the underutilization phenomenon have centered

around the concept of barriers to practice. The most influential work in this area was

published by Barbara Safriet (1992), Associate Dean and Lecturer of Law at Yale Law

School. Safriet offers a large volume of evidence as to the competency, care, and quality

of advance practice nurses, and concluded that full potential has not been realized

because of barriers to practice. She identifies these barriers primarily as legislative and

legal, involving limitations and ambiguities of scope of practice, lack of consistent

prescriptive authority, and hindrances to reimbursement. Andrews (1996) also proposes

alternatives in licensing and regulation at the federal level to "assure that such statutes do

not privilege doctors at the expense of the patient" (p. 1417). The well written and

researched policy documents have been embraced by NPs as a plan of action and a

solution to insure full utilization, and hence, justification. NP leaders such as Loretta

Ford, Karen Knutson, and Bonnie Bullough, have all identified these barriers to practice

as the greatest impediment to NP utilization, and have actively encouraged all NPs to

direct their energies at the removal of these barriers (Pearson, 1990).

A substantial body of research supports and justifies the full utilization of the

NPs in the health care delivery system of the United States. Current studies, such as

Mundinger's Oxford Plan, tend to replicate and verify the existing literature. The fact

remains, however, that NPs and other non-physician providers continue to be seriously

underutilized (Andrews, 1996; Brown, Grimes, 1993; McGrath, 1990; Safriet, 1992).

This underutilization has profound consequences not only for NPs, but for multiple levels

of society. It results in fewer heath care services being delivered, and at higher prices

than necessary.

To explore this phenomenon of underutilization it is necessary to introduce the

concept of legitimation.

Legitimation

In Weberian sociology legitimacy refers to a process through which

institutionalized power is accorded moral grounding, and hence, acceptance (Marshall,

1998). Weber (1978) contends that legitimation is based on the ground of rationality,

tradition and charisma. Biddle (1979) describes legitimacy as a form of authority. When

role expectations and performances are legitimated, authority becomes prescribed and

inherent. Legitimacy is the extent to which an expectation is viewed as right and proper

by members of a social system. In the NP context, this social system includes consumers

of care, other providers, hospital and clinic administrators, and reimbursement

institutions, such as insurance companies and Medicare.

In nursing, the most influential model of legitimation is that delineated by Benner

(1984). She posits that increased proficiency and expertise, when coupled with

competence, will lead to legitimation of role. While this model has been widely accepted

by researchers studying NPs and nursing in general, it does not always reflect the social

reality health care is delivery and receipt. Numerous quantitative and qualitative studies

over three decades consistently document NPs provision of a quality of care equal to and

often exceeding that of physicians. It is logical to assume that NPs should have a crucial

and effective role to play in health care delivery. Despite this often replicated empirical

fact, NPs continue to encounter significant barriers to practice and remain profoundly

underutilized. Related to this, the role of NPs continues to be poorly comprehended by

many in nursing and also the larger health care community (Fairman, 2008).

The depth of the confusion emanating from the legitimation crisis is revealed by the

fact that NPs themselves have trouble clearly defining what they do, questioning whether

they belong to medicine or nursing. Such confusion promotes a perception by many NPs

that they are in conflict with both medicine and nursing, and essentially, in terms of

professional identity, they are homeless. Not surprisingly, NP practice seems to be

shaped at a micro, almost individualistic level of definition, rather than by a macro

perspective of ownership and unity. Related to this, nursing and NPs have been unable to

claim any domain in the health care delivery system that only NPs, by virtue of their

authority and expertise, inhabit as the recognized expert provider of that service.

Legitimation continues to be elusive for NPs. Hence, it is crucial that the legitimacy crisis be elucidated and transcended. Current events make this task even more urgent. Loretta Ford, co-creator of the first NP program, observed that "in times of chaos lies the opportunity for change." We are presently immersed in such "times of chaos." There is almost universal agreement that the U.S. health care delivery system is in chaos and that change is not only likely, but mandatory. NPs, along with a myriad of physician, non-physician and alternative providers, are currently positioning themselves for impending profound changes in the health care delivery system. Given that NPs are sympathetically received by the Obama administration and by many in the general public they have served so well, NPs are in a position to claim a valuable and useful expertise in the evolving health care system. However, for this potential to be realized, NPs must throw-off the confusing veil of legitimation which continues to obscure their formidable accomplishments as healers.

The present article is part of an analysis of the social origins and functions of the NP legitimation crisis, and hopes to offer a new paradigm or "lens" for viewing the NP role. The purpose of this analysis is to contribute to the emancipation of NPs from the disruptive constraints imposed on their professional and private lives by their lack of authority and public definition.

Critical Theory

As Chin (1998), Leininger (1985), and many others engaged in both positivist and qualitative research have observed, the selection of conceptual and methodological paradigms from which to approach the phenomenon being studied is crucial. Critical theory is grounded in the union of social theory with individual psychological theory.

Such an orientation allows the researcher to examine the dialectical relationships between social, historical and individual psychological factors in the causation of social phenomenon. This is crucial if the seemingly irrational discongruency between empirical evidence and lack of legitimation for NPs is to be understood. Moreover, critical theory is informed by a commitment not just to understanding, but to social change and emancipation. NPs have much to gain from such an exploration. This paradigm of social inquiry evolved in Germany during the 1920s, and in many ways is antithetical to the positivist orientation which dominates much nursing research (Jay, 1973; Leininger, 1985). In marked contrast to positivism, critical theory asserts that knowledge does not originate in a vacuum, but is produced and defined by specific social-historical contexts. Moreover, critical theory epistemology holds that knowledge is not neutral, but can be used in ways that serve forces and social structures of oppression or human emancipation (Lichtman,1982; Marcuse,1977). Directly related to this, critical theory research is united by the fundamental assumption that knowledge should be used to elucidate and transcend all forms of domination (Allen, 1987; Chin, 1998; Held, 1981). In accordance with this assumption, the purpose of the present study is to contribute to the emancipation of NPs from the disruptive constraints imposed on their professional and private lives by the legitimation crisis.

Critical theory is a paradigm of understanding social phenomena that was developed by German intellectuals during the late 1920's and 1930's (Horkheimer, 1972; Jay, 1973). Important pioneers of this school of thought include Max Horkheimer, Theodore Adorno, Leo Lowenthal, Frans Neumarm, Herbert Marcuse, and Eric Fromm. Their diverse intellectual backgrounds in sociology, psychology, political science,

history, literature, economics and philosophy, were unified in a general orientation to non-positivistic radical social theory, most notably, Marxism.

These underscore two important values of critical theory; the belief in a multidisciplinary approach to the study of social problems, and a commitment to radical social transformation. Implicit here is the assumption of critical theory that knowledge is not neutral; it is a partisan tool that can be used for or against life. For critical theorists, the goal of research and knowledge is praxis — theoretically guided action, aimed at human emancipation (Arato & Gebhardt, 1982).

The institutional home of critical theory was the Institute of Social Research, established in Frankfurt in 1924. The Institute was loosely associated with the University of Frankfurt, and hence, critical theory is also known as the Frankfurt School (Lichtman, 1982). The institute was fortunate to have independent financing. Felix J. Weil, a radical young political scientist, secured an endowment of $30,000 per year for the institute from his father, a wealthy grain merchant. This fiscal independence allowed for autonomy of intellectual pursuits that was not commonplace in traditional German higher education.

Controversial areas of study, such as the history of the labor movement, and the origins of anti-Semitism, were freely pursued by scholars at the Institute. Critical theory arose in a social context of great turmoil. In the 1920's, Europe was reeling from the effects of World War I, the Russian Revolution, the great depression, the ascendancy of capitalism, and somewhat later, the rise of fascism. It was a time of great social, economic, and political unrest. Traditional social structures were collapsing, and no one knew what was going to replace them. It is in such turmoil that new ideas are often born.

The groups of intellectuals at the Institute were not satisfied with the prevailing modes of understanding what was happening in society. They believed that both positivism and orthodox Marxism were unable to grasp the complexity of social reality. The former was focused almost exclusively on the actions of individuals, ignoring economic determinants of society. This approach also implied an acceptance of the status quo. The dogmatic Marxists had essentially reduced all social reality to the economic sphere, ignoring the individual and subjective realm. Such important questions as why individuals would willingly accept inherently destructive social systems, such as fascism, beyond the understanding of both approaches.

In response to this absence of adequate theoretical frameworks for the study of society, critical theory was developed. Crucial to this approach is the emphasis on understanding both social and individual factors. In short, the individual and society, including the political and economic spheres, are not separate identities, but are dialectically related; part of the same whole. Each of us is influenced by social, political, and economic forces, and these same forces are influenced by the actions of individuals. One cannot understand the individual without understanding the social context in which they live, and society cannot be understood without knowing the individual. In order to facilitate such a dialectical understanding, the critical theorists turned to Marx for social theory and to Freud for individual psychological theory (Jay, 1973).

The Institute for Social Research had a short life. On January 30, 1933, the Nazi Party, assumed power in Germany. On April 13, 1933, Max Horkheimer, Director of the Institute, was relieved of his position at Frankfurt by the Nazis. Horkheimer and others at the Institute, most of Jewish descent, were among the first academics to be fired by

Hitler. Their radical scholarship had placed their lives in danger, and most soon fled

Germany for France, Switzerland, England, and the United States. During the war years,

several former Institute members worked for the Office of Strategic Services, the

American intelligence service that was the forerunner of the Central Intelligence Agency.

(Jay, 1973).

The Institute may have been short lived, but its' influence was not. During the

postwar years, critical theory played an influential role in shaping western European

communism. It was especially powerful in its critique of Stalinism (Marcuse, 1960). In

the United States during the late 1960's, the works of Marcuse became very popular

among university students, and had an important influence on the American New Left

(Marcuse, 1960; Poster, 1978). Strands of critical theory can be discerned in the grounded

theory of Strauss and Glaser, and in a myriad of feminist writings. In the late 1980's,

Critical Theory first began to be used as a paradigm of inquiry in nursing research,

starting with D. Allen at the University of Washington (Allen, 1985).

Examining Legitimation Using the Methods of Critical Theory

A complication of empirical investigation and the positivistic orientation in general, is

that its values and categories of research are grounded in the existing social system.

McIntyre (1995) notes that our research questions are often constructed to support rather

than challenge existing knowledge. While such an orientation does not inherently prohibit

valuable work, it does tend to accept and reproduce the status quo. The possibility that

the social system has fundamental flaws is beyond the vision of positivism. Likewise, the

need and possibility of structural transformation is also outside the discourse of most

traditional research.

The nature of the legitimation crisis, however, suggests fundamental problems in the social relations between NPs and other players in the health care delivery system. The fact that no amount of empirical evidence supportive of NPs has convinced the prevailing structures of the health system to utilize NPs to their full potential is a clear example of the present irrational social relations in health care. Traditional research, however, continues to adhere to the belief that more empirical studies will somehow be helpful and continues to replicate earlier findings. Implicit in this, is the assumption that the problem is rational, and can be solved by additional rational knowledge. If the powers only knew, they would correct the present injustices. This assumption, however, has not been validated in the social world. In fact, it has been repeatedly denied.

Critical theory offers a different and needed perspective. Perhaps the origins of the legitimation crisis lie not in lack of knowledge or measures, but rather within the historical roots of nursing and the evolution of the NP. Nurses have historically lacked power, and communication problems with dominant interests in the health system, both nursing and medicine, have been distorted by issues of power, gender, religion and money. Alienated workers are those who have lost control over their lives and destinies because they have been deprived of control over their actions. The working dialogues of NPs may be characterized as those of alienated labor, but who they are alienated from is unclear. Part of the discourse of NPs is that the movement emerged because of the need nurses had for autonomy and patient interaction. But despite moving closer to these ideals, the NP is underutilized, exploited economically and undervalued – legitimation has remained elusive

In the paradigm of critical theory, the first step in addressing this situation is to

understand how the objective conditions of alienation developed among the NPs. The

starting point would be a critical examination of the work of the NP or APN. This would

include looking at such important areas as the role of women in nursing, class issues, the

history of nursing and the APN's place and significance within the nursing profession –

the ideology of the profession.

Ideology

Abercrombie et al. (1984) defines ideology as beliefs, attitudes and opinions that

are bound together either loosely or very tightly. Though there are some consider

ideology as being mostly neutral (Thompson, 1986) the majority of writers present

ideology in a critical sense (Taylor, 1997). Street (1992) describes ideological critique as

"the process by which these patterns of shared social meaning are subject to scrutiny with

an explicit aim of demonstrating the internal contradiction and false understanding

inherent in them" (p.78). Thompson (1990) writes that to study ideology is to study the

ways in which meaning serves to establish and sustain relations of domination" (p.56).

Marx, though he did not coin the term, was the first to elucidate the concept of ideology

as false consciousness, belief in one's own subordination. Conditions of inequality create

ideologies which confuse people about their true aspirations, loyalties and purposes.

Gavin (1997) states that the most important feature of ideology is not whether it is true or

not, but whether it is successful.

The problems of legitimation surrounding the NP suggest that the ideology of

the role and its place within health care services is false, because it has not been

successful on several levels. NPs are underutilized and economically exploited. The

early founders who hoped to raise the credibility and prestige of nursing have not seen

fruition of these goals. This false consciousness inhibits NPs from understanding and

appropriating the power and respect inherent in their role as valuable providers of health

care. An important implication of this consciousness is the continued inability of NPs to

claim their own area of importance and service in the health system of the United States.

Critique of the Effectiveness Literature

The extensive body of literature surrounding proof of the effectiveness of NPs is

limited and constrained by the medicine-centric nature of its construction. Heavily

reliant on a rationalistic, scientific, quantitative process, the studies do not lack power or

rigor. Nor are the contradictions as simplistic as the apparent foible of using a medical

paradigm to define nursing outcomes. Historically, there has been a singular lack of

ability by nurses to define what those nursing outcomes might be for NPs, and how those

outcomes might be different than those of medicine, or the greater body of nursing. The

problem is significant and more pervasive than that.

Nursing has a long history of difficulty in defining what precisely constitutes

nursing care and how best to support the value of that care with scientific research. In its

early years, nursing enjoyed an autonomy and independence from medicine. This eroded

over the years as economic forces intervened and social changes abounded. The earlier

professional distinction between nursing and medicine allowed nurses to contribute to

health care in a unique way, but was criticized because it perpetuated traditional views on

the role and domestication of women (Wall, 2008).

Nurses, the quintessential "pink collar workers", semi-professionals (according

to many) in a position overwhelmingly populated by women, sought to establish their

credibility, in the tsunami of 1960's feminism, by distancing themselves from the

"feminine" aspects of their work. Just as the private duty nurses sought legitimation by affiliating with medical modes of thought (moving into the hospitals) , nurses in the 1960's tried to validate the power of nursing practice by moving into medicine (Wall, 2008). Interestingly, NPs continue to employ these old ways of dealing with this historical legitimation crisis. Leaving behind the tradition of primary care, which has also undervalued primary care physicians, NPs are moving into hospital settings, practicing in acute care settings in ever increasing numbers. The emergence of the Doctorate of Nursing Practice (DNP), a "PhD lite", as the entry level degree for NPs, is another attempt to seek legitimation within the nomenclature of medicine. (Though the MD is also a clinical doctorate, presuming that it will carry the same social acceptance is egregious (Meleis, 2005).

The literature on NP effectiveness and barriers to practice is constrained and limited by its paradigm of definition. NPs are striving to legitimate themselves, but are using a construct which only reinforces their marginalization, and the ineffectiveness of such research is preordained.

Conclusion

Having argued for a legitimation crisis among NPs and the existence of the conditions of an alienated work force, there is a need to critically examine the ideological presumptions, beliefs and attitudes of the NP. The review of the effectiveness and barriers to practice literature clearly reveals that there is nothing further to be gained by continuing to do research in a positivistic, scientific manner. The embrace of technological, mechanistic medicine has been unrelenting, and the vogue for evidence based practice as the new Holy Grail clearly demonstrates this (Wall, 2008).

NPs have sought to define themselves as different from all those nurses who are "just a nurse." NPs are smarter, more educated, and more talented than the masses of RNs. The kernel of truth lying within the lack of legitimation for NPs is that the attempts to establish credibility and authenticity have been built upon a foundation of disenfranchisement from nursing. The NP has defined what they are and what they do in terms of what nursing is not capable of, what nurses cannot do. The NP claims to be a different type of health care provider, "we do not practice medicine, we are about caring, not curing, we are nurses" (Mundinger,1996). But there is an inherent contradiction, a fundamental false consciousness that betrays this ideological assumption. By attempting to leave nursing behind, the NPs have ensured their problematic placement in a larger arena. Nursing, by embracing the APN, for a multitude of reasons, has devalued itself.

Instead of framing Nurse Practitioner practice in the very old definition of medical care provision, perhaps the role needs to be framed in the ideology of current health care needs for the populace. Chin (2010) states "The interests of the people have not been well served for many years. I believe that nurses, who represent a large grassroots group of people of ordinary background and standing in society, can become the leaders, movers and shakers of the future. Unlike medical science which grew towards a more mechanistic view of the human body and health, nursing from its inception maintained a totally different perspective on health care" (p.1).

The solution to this crisis should be based on the health care needs of the people rather than on the political struggles of competing power groups. Burnham (2007) states, "The question one must ask is, what is the state of health care needs in modern industrial societies? Given the present status of health in these societies, there is little demonstrable

benefit to be gained from further expansion of the mechanistic paradigm. It is time for advanced practice nursing to embrace a uniquely nursing contribution to health care". A reconceptualized core of advanced practice nursing that focuses on health promotion and disease prevention is vital.

Berman (1998) states "The health care needs of the vast majority are primarily of such a nature that they require services defined by a new paradigm. In this new paradigm, there must be a reuniting of the body and the mind, but 'mind' must be expanded to encompass social, economic and cultural aspects" (p.30).

The power of NPs lies within nursing. If nurses are enabled and can articulate the significance of what they do as an essential thread of contemporary healthcare provision, all will benefit.(Lichtfield & Jondottir ,2008)   As Newman (2008) articulated so profoundly, "What is missing in healthcare is what nursing can provide"(p.26). The time is now.

A Critical Reflection on Advanced Practice Nursing

"At least some of us are still alive – what ever
happened to history?" Loretta Ford in 1994

The Historical Context: An Overview of U.S. Nursing History

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Abstract

The history of nursing and the genesis of the Nurse Practitioner (NP) role are explored using the themes of oppression and alienated labor and their dialectic relationship to praxis. In its early history, nursing enjoyed a distinctive role and autonomy and independence from medicine. (Boutilier, 1994). The tracing of nursing history has continued to be intertwined with debates about the distinction between the two: what is nursing, what is medicine and who justly (or unjustly) has control? The development of the NP role and the shifting boundaries of legitimacy are enmeshed in these fundamental questions. These questions are explored using the critical theoretical assumptions of alienation, oppression and ideology and reveal the historical foundations and subsequent false consciousness which has led NPs to disenfranchise themselves from nursing while setting in motion the very forces that prevent their legitimation.

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The Historical Context: an Overview of U.S. Nursing History

Foucault (1980) suggests that, in understanding how power, knowledge, and

subjects are viewed, it is useful to develop a genealogy, which is a tracing of a historical

context, a return to the past to understand the present. In its early history, nursing enjoyed

a distinctive role and autonomy and independence from medicine. (Boutilier, 1994). The

tracing of nursing history has continued to be intertwined with debates about the

distinction between the two: what is nursing, what is medicine and who justly (or

unjustly) has control? The development of the Nurse Practitioner (NP) role and the

shifting boundaries of legitimacy are enmeshed in these fundamental questions.

Early Nursing

Nursing as a secular profession is a relatively recent phenomena, having its

origins in the latter part of the nineteenth century. Until that time, no organized nursing

labor force existed in the United States. Nursing care was provided by relatives or

community members, usually in the home. In some of the larger Eastern cities such as

Boston, New York, and Philadelphia, hospitals did employ women as nurses. These early

hospitals evolved from almshouses and until the late nineteenth century, primarily served

charity and welfare functions, as opposed to medical care (Vogel, 1980).

The women who were employed as nurses in these institutions were recruited

from prisons and asylums and were loaned from other hospital-almshouses. Poor

women, especially immigrants, were an additional labor pool from which the hospitals recruited. Another source of nursing labor utilized by these early institutions was that of patients. Ambulatory patient-inmates were expected to help in the care of those more severely stricken. These early institutional nursing workers did not enjoy a good reputation. Hospital nursing was considered a vocation for women of low character and morals. Ehrenreich and English (1973) noted "Hospital nurses, history has it, were a disreputable lot, prone to drunkenness, prostitution and thievery" (p. 35).

The nursing pioneer, Florence Nightingale, was well aware of the poor image hospital nurses held with the general public. The training school established by Nightingale, in 1860 at St. Thomas Hospital, London, stressed the character and moral development of the nurses over academic education (Nightingale, 1908, 1914). The nursing students, or probationers as they were called, were expected to live in a nurses' home under careful supervision of the matron. The students were allowed to leave the home only in pairs and with the prior permission of the matron. Discipline was strict and flirtation resulted in immediate dismissal from the school. Nightingale justified this strict discipline and emphasis on morality as being part of her effort to raise "nursing from the sink" (cited in Bullough & Bullough, 1978, p. 95).

The majority of the early nursing workers were from the working class. A few upper-and middle-class women, however, worked in the hospitals as head nurses and supervisors. As class position was the key factor in becoming a head nurse, the vast majority of nurses had no hope of advancement. Susan Reverby (1975) noted "from the very beginning there was a class division in nursing and a lack of upward mobility for poor women: middle-class status being a requirement for supervisory positions" (p. 9).

Nightingale differentiated between two classes of nursing students: lady

probationers and nurse probationers. The latter, recruited from the working class, were

often literate servants and did most of the actual nursing labor. The lady probationers

were upper-and middle-class women who paid for their training and were given more

academic lectures than the nurse probationers. It was the hope of Nightingale that these

"educated gentlewomen" (Nutting & Dock, 1907, p. 92) would work as matrons or

superintendents of hospitals and other nursing schools following their training. As

George Deveraux (1950) has pointed out, the fact that most patient care was performed

by working-class nurses from the beginning of organized nursing has influenced the

social status and function of nursing. It is of interest to note that American nursing

pioneers, such as Dorothea Dix and Louisa Schuyler, were aristocratic women. In an

effort to attract upper-class women into nursing, training schools such as Johns Hopkins

and Bellevue presented nursing as a socially useful alternative to reproduction

(Ehrenreich & English, 1973).

The Beginnings of Organized Nursing

During the latter part of the nineteenth and early twentieth centuries, hospitals

underwent a rapid period of growth. In 1848, Bellevue Hospital in New York City

became the first institution in the United States devoted entirely to medical care, in

contrast to welfare and charitable functions, and it is considered the first hospital in the

United States (Shryock, 1959, p. 288). By 1873, 178 hospitals with 34,453 beds were in

operation. By 1909, the number of hospitals had grown to 4,349 with 421,065 beds

(Cannings & Lazonick, 1975, p. 193). In 1923, 6,830 hospitals were in existence, an increase of 3,700% from 1873 (Reverby, 1979, p. 208).

Corresponding with the growth of hospitals was the beginning of organized nursing education. In 1860, the New England Female (medical) College established the first nursing school in the United States. During the next few decades the number of schools grew rapidly. In 1880, 15 schools were training 323 nurses. By 1900, 432 schools were in operation training 11,000 students (Reverby, 1972, p. 18). In 1910, the number of schools had grown to 1,129 with 32,636 students (Ashley, 1976, p. 21). This tremendous growth of nursing schools is closely connected with the rapid expansion of hospitals noted above. Secular nursing emerged as a profession between 1860 and 1930 largely in response to the increased labor needs of the growing hospital industry. Most nursing schools since the 1880's were established or controlled by hospitals. Some of the earlier schools that attempted to function independently of hospitals faced financial difficulties that eventually forced most of them to merge with hospitals (Cannings & Lazonick, 1975). In exchange for financing the training schools, hospitals utilized nursing students to meet their nursing labor needs. Soon nursing students began to replace untrained attendants as the primary source of nursing care in the hospitals. The expanding hospital industry was in constant need of a disciplined, cheap labor source, and the labor of nursing students met this need.

The student nurses were remunerated for their labor with room and board and some spending money. This was very profitable for the hospitals. L.L. Dock, the assistant superintendent of nurses at Johns Hopkins Hospital and a leading nurse educator, estimated that in 1893 each student nurse cost the hospital $12.00 a month. The market

value of nursing labor for that time was $15.00 a week (Dock, 1949, p. 15). In addition to hospital work, the students were sent out into the homes of hospital patrons and others for private duty nursing. The hospital charged for these services, often at graduate nurse rates, but students were not compensated for this additional labor. Hospital administrators justified this practice by arguing that the experience was important for the education of the student. This practice was an important source of revenue for many small hospitals.

The control of the training schools by hospital administrators effectively removed most nursing education from nurse educators, to the detriment of the students' education. The economic asset of free student labor was the reason most hospitals financed nursing schools; quality education of nurses was at best a secondary priority. Nightingale, fearing this would happen, insisted that the administration of the training school be separate from the hospital administration. This component of the Nightingale Plan did not meet with much success in the United States.

Students in the hospital training schools received minimal formal training and were often placed immediately on the wards, working 12-to 16-hour days. Little supervision was provided for the students; until the 1930's, most head nurses in charge of wards were senior students. During the 3 years that most training programs usually required, most nurses received only 4-to 6-months of academic-course work (Wagner, 1980).

The students were subjected to a strict discipline, not limited to the workplace, but extending to their private lives as well. Most hospitals required students to live in a nurses' home, consistent with the views of Nightingale. Questioning physician's orders or hospital rules usually led to dismissal. Some schools required pupils to sign an agreement

showing: "their willingness to obey all rules, to subordinate to authorities and to conduct themselves as members of a noble profession" (cited in Ashley, 1976, pp. 20-21).

As the exploitation of student labor was an important factor in the ability of many hospitals to survive, training schools continued to be established at a rapid pace. By 1924, 1 out of every 4 of the nation's 6,830 hospitals had a nursing school (Reverby, 1979, p. 211). Between 1920 and 1930, the number of nurses grew from 149,128 to 294,263, an increase of 90%. The U.S. Population had only increased 16% during this period (Wagner, 1980, p. 274). It was estimated by nursing educators that there were 10 times as many schools in existence as were necessary. In some cities, 1 out of every 10 women workers was nurse during the 1920's (Wagner, 1980, p. 274). As early as the 1890's, nurses complained of overcrowding in the profession in some urban areas. By 1928, the surplus of nurses had created serious unemployment in the nursing field.

The Era of Private-Duty Nursing - 1880-1930

As hospitals were utilizing student labor almost exclusively to meet their nursing labor needs, very few graduate Registered Nurses (RNs) were employed in hospitals during the early years of organized nursing. In 1927, 73% of the nation's hospitals associated with a training school did not employ any RNs. Out of approximately 214,300 active nurses in 1929, only about 4,000 were employed in hospitals (Bullough & Bullough, 1978, p. 167). The vast majority of RNs (70% in 1930) were self-employed in private-duty nursing (Wagner, 1980, p. 272). The era of private-duty nursing, 1880-1930, is an important and often neglected period of modern nursing history.

The nature of the health care services also provided an impetus for private duty nursing during the late nineteenth and early twentieth centuries. Hospitals during this

period were largely philanthropic institutions in the almshouse tradition: in short, a place

where the urban poor could die. They served primarily social as opposed to medical

functions characteristic of modern hospitals. Care was funded by philanthropists and

provided by student nurses and volunteer physicians. Hospital populations during this

period were composed almost exclusively of the destitute and working classes. The

historian Maurice Vogel (1979) has observed of the hospital population during this period

"Dependence as much as disease still distinguished hospital patients from the public-at-

large" (p. 105).

The middle-and upper-classes were resistant to entering hospitals, preferring to

be cared for in their homes or private hotels during illnesses. One factor that explains this

was the stigma attached to hospitals as being primarily paternalistic institutions for the

poor. The most important factor, however, was the fact that hospitalization could be quite

unhealthy and not very effective. During this period knowledge of epidemiology and

asepsis was in its infancy and not universally applied; infection posed a substantial risk to

hospital patients. This is illustrated dramatically by the practice during the late nineteenth

century of referring to infection as hospitalism (Vogel, 1979, p. 106). Until the turn of the

century, intervention by "regular medicine" was at best ineffective and often harmful.

Hospital care could offer little that one could not receive at home in a safer environment.

Those who could afford to do so hired private-duty nurses who tended to them in their

homes.

This two-class health delivery pattern, the poor in hospitals and the upper-and

middle-classes cared for in their homes, remained a dominant aspect of the health care

system until the late 1920's and created a demand for private-duty nurses. Until the

1930's, private-duty nursing was the dominant type of labor performed by most RNs, and the private-duty nurse became an important figure in the health care system. By providing aseptic conditions, postoperative and rehabilitative care, and nutritional counseling, these nurses played a significant role in the recovery of the patients (Wagner, 1980).

Private-duty nurses were self-employed and were usually paid directly by their clients. Referrals for patients came from physicians and registries. The latter were established by nursing schools, alumnae groups, medical societies, and hospitals. During the 1920's, for profit employment agencies also became active in the private-duty market. The field was extremely competitive; not only was there a surplus of graduate nurses, but large numbers of untrained women also competed for these positions. The surplus of nurses and others seeking private-duty positions allowed registries during the 1920's to exploit the nurses by charging large fees for referrals and refusing service to rebellious nurses. Some nurses were forced out of the profession after being blackballed by registries. With the exception of mass medical crises (such as the 1918 flu pandemic) there was little employment security, and often nurses had to wait long periods between cases.

Private-duty nursing was on a one-to-one basis between the nurse and her client and frequently was very demanding work. The nurse lived in the home of the patient and was expected to be available 24 hours a day, seven days a week. Time off and time to sleep depended on the medical condition of the patient and on the family who employed the nurse. Pay was poor and, as the nurse was subject to the whims of the patient and his or her family, working conditions could be quite difficult.

A tension existed between the role of a professional, crucial in the care of the sick, and that of a domestic servant. In discussing the ambiguous role of the private-duty nurse, Wagner (1980) has observed:

> One the one hand, she was a professional, indispensable in the recovery of patients. On the other hand, the personalistic relationship of employment in the home led to her use by patrons as servant, maid, cook, and housemother. The contradictory status of private nursing remains a central problem in the history of nursing. As with other female occupations, nursing's attempt to achieve professional status has been weakened by the traditional association of women with household work. Rather than being paid wages, private duty nurses were greatly compensated in room and board, historically depressing their wage levels relative to other professional workers. Moreover, because of the association of nursing with household work, a wide variety of women workers, untrained by the definitions of the nascent nursing profession, grew up simultaneously providing cheap competition for those nurses who had trained at a nursing school (p. 272).

Private-duty nursing, as the name implies, was a very privatized type of work. The nurse, though in close contact with the client and family, was isolated from other nursing workers. The competition for private-duty positions, which increased in the 1920's, did not foster solidarity among nurses. Largely due to the character of nursing labor during this period, nurses' opposition to unfair working conditions was usually of an individual nature, refusing referrals or leaving the profession (Reverby, 1979).

Private-duty nursing could also be quite dangerous. These nurses, in a time before the clinical use of antibiotics, were constantly exposed to infectious diseases. A

relief fund established by the American Nurses Association (ANA) during the Depression for unemployed nurses was rapidly exhausted by payments to nurses who had contracted tuberculosis while working. During the 1918 influenza pandemic, many nurses working in the homes of flu victims became ill themselves.

Despite the competition, job insecurity, danger, and work conditions (which were at times demanding and degrading), here were many positive aspects associated with private-duty nursing. These nurses enjoyed an independence and control over their labor not equaled in modern hospital nursing. Typically, the physician would make the diagnosis, prescribe the treatment, and make short visits to see the patient. The nurse was responsible for almost all of the actual care the patient received, often living with the patient for several months. The responsibility for continuity of care clearly belonged to the nurse. Many nurses developed great skill in dealing with the emotional and physical problems of their patients and the patients' families.

The personal nature of private-duty nursing could be exploitative, yet it also allowed for much personal satisfaction. Nursing someone for 24 hours a day was no doubt a trying experience, but it could also be a very intimate and rewarding one as well. The nurse could see the results of her labor in the progress and recovery of the patient. Sometimes the nurse was present when death occurred, and she would mourn with the family. Few situations in modern hospital nursing, characterized by as a rigid hierarchy and division of labor, are as rewarding and as human as private-duty nursing had the potential to be.

The Rise of Hospital Nursing - 1930 to the Present Day

During the 1930's a dramatic change began in nursing with a shift away from private-duty work toward hospital employment. As previously noted, in 1930 about 70% of all RNs worked as private-duty nurses. By 1946, approximately three quarters of all RNs were employed in hospital positions as staff nurses (Wagner, 1980). This shift from private duty, toward staff nurse positions in hospitals and wage labor has been called the proletarianization of the nursing labor force (Navarro, 1982) and is one of the most crucial events in the history of modern nursing. A brief discussion of the historical conditions responsible for this shift will be the concern of the following section.

By the 1930's, the paradigm of scientific, technological medicine was dominant in the United States health. Medical care was becoming increasingly sophisticated, technical, and capital intensive, requiring greater rationalization. E. Richard Brown has noted (1980) "Medical technology's demands for heavy capital investment also encourage rationalization of medical resources --centralization and coordination of capital, facilities, expenditures, income and personnel"(p. 8). In large part due to these needs of scientific medicine, the focus of the health care delivery system shifted from the home to the hospital during the 1920's and 1930's. The hospital provided a central location to house medical care. By this time hospitals were utilized by all classes, and their focus was on medical care, as opposed to welfare functions.

It is important to note that the two-class health delivery pattern continued in the hospital: the poor and working class cared for primarily in public institutions and the middle-and upper-classes in the private sector (Rosner, 1979). The increasing use of hospital services by all classes and the changing character of medical care were factors

that played a role in the shift of nurses away from private duty and into hospital labor. As

diagnosis and treatment procedures became more technical and sophisticated, the need

for skilled labor became necessary. No longer could hospitals depend almost entirely

upon the untrained attendants and nursing students to meet their labor needs. The most

crucial factor, however, in the proletarianization of the nursing labor force was the Great

Depression of 1929. During the Depression, a national unemployment rate between 20

and 25% and the falling incomes among large segments of the population made it

difficult (if not impossible) for many people to afford either home or hospital care.

One nursing journal estimated that 75% of those medically ill could not afford medical

care during this period (The Biennial, 1934, p. 612). By 1932, just as the hospital was

becoming entrenched as the center of health care, hospital admission rates had dropped

50% (Wagner, 1980).

The health care sector was facing its first major fiscal crisis. As Woodward

(1979) has pointed out, it was a crisis of realization, in contrast to a crisis of production;

hospitals, physicians, and private-duty nurses were unable to sell their services. The

development of hospital insurance during the Depression years was to provide economic

restabilization for hospitals and physicians but not private-duty nurses. As early as 1900,

small segments of the population had health insurance, most notably some lumberjacks

and miners but the vast majority of the population had no health insurance until the

1930's. During this period, in response to the crisis of funding in the health care sector,

hospital insurance plans were endorsed by private foundations, hospital superintendents

and trustees, physicians, and business people (Woodward, 1978). Hospital insurance

controlled by the private sector was much more attractive to the elite who controlled

health services than the alternative of a government-run national health insurance plan.

The latter had been advocated by reformers since the early 1900's. The result of this

support was the rapid growth of hospital insurance utilized by large segments of the

population.

In 1934, hospital insurance was subscribed to by 100,000 people in 40 cities. By

1936, 450,000 people had hospital insurance of some kind. In the latter years the Julius

Rosenwald Foundation awarded a grant to the American Hospital Association to establish

the Hospital Service Plan (Bullough & Bullough, 1978). This commission advised

institutions and communities on the creation of nonprofit insurance plans, greatly

facilitating the growth of hospital insurance. It should be noted that the American

Hospital Association represented the business-educated and more capitalistic hospital

administrators that would dominate the field by the 1940's. Their outlook was very

different from the philanthropists who managed the nation's hospitals until the turn of the

century. Plans that were approved by this commission became known as Blue Cross

plans. By 1938, 1.5 million people subscribed to Blue Cross plans, and by 1941,

6,049,222 people subscribed (Cannings & Lazonick, 1975). By 1947, Blue Cross

enrollment had grown to 27 million, 19% of the population (Brown, 1980,).

The growth of hospital insurance provided hospitals, and most physicians, with a

stable source of income. The fiscal crisis was short lived; hospitals emerged from the

Depression years not only financially stable, but continuing to increase in importance in

the health care delivery system. The secure income generated from hospital insurance

plans was to provide the financing necessary for the hospital industry to greatly expand

its services in the coming decades.

Not only was private-duty nursing being rendered increasingly obsolete by the rise of hospital-centered care, but fewer and fewer people could afford to retain the services of these nurses. This was compounded by the surplus of nurses and the large numbers of retired nurses and untrained women who were forced to join the competition for the scarce private-duty cases as the Depression worsened. The result was a high unemployment rate, estimated by one source to be 60% in 1932 (Wagner, 1980). By 1933, thousands of nurses were leaving the profession.

To address this critical situation, the nursing leadership represented by the American Nurses' Association (ANA), joined by some hospital administrators, mounted a campaign to convince hospitals to employ graduate nurses and end the practice of student labor. In 1932, the ANA established the Committee on the Distribution of Nurses. This committee sent a letter to every hospital in the country encouraging them to replace students with graduate nurses. The nursing leaders noted:

> The nurses' problem is due not chiefly to the economic depression but to the
>
> weakness of a system of accepting students primarily as workers in the hospital
>
> instead of selecting them as potential graduates for service in their community in
>
> the various types of nursing (National Nursing Groups Appeal, 1932, p. 108).

The nursing leaders also noted that graduate nurses were available and willing to work at low salaries. Studies began to appear in nursing and hospital administration literature on the advantages of graduate verses student labor. Reverby (1979) noted:

> The studies were attempts to convince hospitals and reluctant nursing
>
> superintendents that graduate nurses were more efficient workers, cheaper
>
> because of low wage demands, and easier to discipline both because of their

professionalism and because they would be the hospital's, not the patient's,

employee. (p. 216)

The nurses' labor was indeed inexpensive; during the worst part of the

Depression, many nurses worked for only room and board. Many of the nurses who were

fortunate enough to obtain private-duty assignments had to be supplied with shoes by

registries.

Initially, many hospital administrators were reluctant to hire graduate nurses.

They feared that graduate nurses who were used to working independently would be

difficult to discipline. The exploitation of student labor was a tradition that hospitals

would not let go of easily. A 1928 nursing report noted: "It is an extraordinary thing, but

it seems to be a fact that hospitals regard the suggestion that they pay for their own

nursing service as unreasonable the student nurse is seen as an inalienable right"

(Reverby, 1975 p. 220).

The resistance of hospital administrators to employing graduate nurses was short-

lived. They soon saw the advantages of replacing student labor with graduates. The

surplus of nurses and the high unemployment rate made it financially advantageous to

close down the hospital schools of nursing and employ graduates at low pay. The

replacement of students with RNs also held the promise of fewer turnovers and a more

stable work force. As medical care continued to become more sophisticated, the objective

need for skilled labor was also a factor in lowering the earlier resistance, as was the fact

that RNs could supervise auxiliary personnel (Reverby, 1975). The latter became very

important, since hospitals began to employ thousands of subsidiary workers during the

1930's. By 1934, hospitals looked upon the employment of graduate nurses in a positive way.

The most significant resistance to the staffing of hospitals with RNs came not from the hospital administrators but from the private-duty nurses who formed the bulk of the rank and file of nursing. Even when unemployment and the Depression were at their worst, many hospital staff positions remained vacant. With the general upturn of the economy in 1936, it became almost impossible to recruit nurses for hospital positions (Geister, 1941). Hospital labor was widely viewed by nurses as being degrading and exploitative.

There were sound reasons for this resistance to staff positions in hospitals by rank-and-file nurses. Traditionally, hospital nurses worked 12 to 16 hours a day for minimum pay. Most nurses were required to work 7 days a week with 2 half-days off. Hospitals also required nurses to live in nurses' homes and take their meals there, a practice referred to as maintenance. As late as 1941, 80% of hospital nurses were required to live in hospital nurses' homes (Wagner, 1980). These residences were often authoritarian, maintaining strict curfews and forbidding males from entering rooms. Until the 1940's, most nurses had no sick pay, pension plan, or overtime pay. As supervisory positions were reserved for middle-and upper-class women, the majority of nurses of working-class background had little hope of advancement. Hospital nurses were also subject to sudden lay-offs and dismissals. A 1936 study by the American Journal of Nursing (AJN), showed that 56 out of 75 hospitals surveyed employed nurses for indefinite periods, "depending upon hospital needs" (1932, National Nursing Groups Appeal, p.108). During times of low patient census, nurses were laid off or fired.

The character of hospital labor was also an important factor in the resistance of nurses to staff positions. The one-to-one nurse/patient relationship characteristic of private-duty work allowed the nurse to observe the progress of her patient and see the results of her labor. The intimate relationships with patients were a source of much satisfaction for the private-duty nurse. The advent of staff nursing in the hospital fundamentally transformed the nurse/patient relationship; the nurse acquired a patient load of sometimes as many as 30 patients. The over-crowding of patients and the understaffing of nurses have remained chronic problems in hospital nursing. Nurses were also frequently rotated between different hospital services, further inhibiting the nurse/patient relationship.

An important historical factor contributing to the alienating work conditions in the hospitals and the resistance of nurses to staff positions was the increasingly capitalistic organization of these institutions during the 1930's. An aspect of this was the effort by management, supported by the nursing leadership, to rationalize the labor force for greater productivity. This was done, to a large extent, by the introduction of scientific management techniques or Taylorism into the hospital workplace. Braverman (1974) in the following quote notes the importance of scientific management for capitalism in general.

> Scientific management, so-called, is an attempt to apply the methods of science to the increasingly complex problems of the control of labor in rapidly growing capitalist enterprises. It lacks the characteristics of a true science because its assumptions reflect nothing more than the outlook of the capitalist with regard to the conditions of production. It is impossible to overestimate the importance of

the scientific management movement in the shaping of the modern corporation

and indeed all institutions of capitalist society which carryon labor processes (p.

86).

The introduction of scientific management techniques in the hospital was very

influential, greatly affecting the character of nursing labor. Two important ramifications

for nursing labor resulting from the application of Taylorism to the hospital were the

development of a nursing hierarchy and a division of labor. During the 1930's, hospitals

began to hire large numbers of subsidiary nursing workers. The use of subsidiary nursing

workers had been recommended earlier by the Rockefeller sponsored 1923 Goldmark

report on nursing education(Committee for the Study of Nursing Education, 1923). The

nursing category of licensed practical nurse (LPN) was created during the 1930's,

requiring 1 year of training in a technical program. The use of LPNs provided hospitals

with a cheaper nursing source and helped fill positions left vacant as RNs continued to

resist hospital employment. Many rank and file nurses were opposed to the creation of

auxiliary nursing workers, fearing increased competition from this cheaper grade of

nurse. By 1937, many hospitals were employing subsidiary workers and by the end of

World War II their use was widespread.

A third category of nursing worker, the nursing aide entered the hospital

workplace during the 1940's. Included in this category were attendants and orderlies. The

development of this occupational classification was helped by the American Red Cross

who initiated a 10-week training program for aides in 1938. By 1945, 212,000 aides were

employed in hospitals or nursing homes (Cannings & Lazonick, 1975, p. 200).

Licensed Practical Nurses (LPNs) and aides began to replace nurse RNs as the

main providers of direct patient care. The former, however, were supervised by RNs.

This was consistent with a policy advocated by Eli Ginzberg, chairman of the 1948

Committee on the Functions of Nursing to never use high-priced personnel for low-priced

work. One influential physician, Charles Mayo of the Mayo Clinic, believed that

professional nurses could be eliminated and "100,000 country girls could be trained as

sub-nurses" (cited in Reverby, 1975, p. 12). Concurrent with the development of a

nursing hierarchy was the division of labor in hospitals. Functional nursing was

introduced during this period, the dividing up of nursing tasks, similar to detail work in

industrial labor. Individual nurses were assigned specific tasks, such as medications,

dressing changes, and starting intravenous lines, which they would perform for an entire

ward. This was in great contrast to private-duty nursing where the nurse cared for the

total patient.

The trend began in the 1930's to remove nurses from bedside care with the

employment of subsidiary workers, and the development of a division of labor

contributed further estrangement of the nurse/patient relationship, which had been a

source of much satisfaction for nurses. Isabel Menzies (1974) in her influential study of a

hospital nursing service, referred to the division of labor in nursing as a "splitting-up of

the nurse/patient relationship"(p.361). She noted the following of nurses and students she

observed in the course of her study:

It is hardly too much to say that the nurse does not nurse patients. The total

work-load of a ward or department is broken down into lists of tasks, each of

which is allocated to a particular nurse. She performs her patient-centered task

for a large number of patients, perhaps as many as all the patients in the ward,

often 30 or more in number. As a corollary, she performs only a few tasks for, and

has restricted contact with, anyone patient. p. 361)

Nurses, as individuals and professional healers, have always had to struggle for

their identity as a health care professional and for the rights of their patients. Beginning

in the mid-1960s, the nursing tradition of struggle and patient advocacy entered a new

realm with the emergence of the Advanced Practice Nurse (APN) and the NP. The

development and evolution of the NP had its genesis in the professional struggles of the

RN and its aspirations were formed in the autonomy of the private duty nurse.

Medicine in the Sixties

During the 1960s, a wave of ideologies centered on the problems of the poor,

ethnic minorities, and women swept the nation. Among them was the realization that

among the many inequities in society, disparities in access to health care were painfully

apparent. Social programs were proposed and directed toward improvements in health,

education, civil rights, and employment. Issues in health care were clearly front and

center in domestic policy. As a period characterized by major social movements, the

1960s also saw the war in Viet Nam escalate and eventually divide a nation.

An additional factor in the climate of change was the Johnson Administration's

War on Poverty which brought public attention to the substandard conditions and

deprivation of some people within the borders of the richest country on earth. The nation

felt optimistic about finding solutions for chronic social ills.

The Origins of the NP and Physician's Assistant (PA)

The establishment of the NP profession in American nursing was a remarkable occurrence in several respects. It was part of many rapidly evolving changes in health care and society, and the boundaries for many health care professions changed and flexed in the era.

The following will take a closer look some of the forces surrounding medicine, nursing, and the health system. Also examined will be the various and sometimes competing rationales put forth for the creation of the NP and PA.

What were the preconditions that existed to set the stage for the introduction of the NP? Most historical accountings note that there was a shortage, or at least the perception of a shortage, of physicians (McCleod,1996). Was that perception correct? Some believe that it was only partially the case and that there were other more profound considerations at play. In health workforce policy circles, it is often argued that it is inherently impossible to know what the "right" number of physicians is, that this is a perception of so-called experts, and that in many instances this largely subjective judgment is based on considerations of self interest (Fairman,2008).

Innovations of the 1960s and 1970s in the health care sector included the passage of the Medicare and Medicaid laws, the development of health maintenance organizations, neighborhood health centers, community mental health centers, free clinics, rural primary care clinics, the emergence of family practice as a medical specialty, and the development of new health professions. Ironically the general practitioner, once the foundation of the medical workforce, was becoming obsolete just as funding and the demand for primary care services increased. In the turbulent 1960s, a

decade of change in many areas of American society, a fundamental restructuring of the division of medical practice came about. The concept of the NP and PA were developed with a medical and societal expectation that focused on extending the capabilities of physicians in the delivery of primary care, particularly to medically underserved populations or rural areas. Stead (1979) asserted that there was a short supply of primary care physicians in America at that time, as physicians were becoming more specialized. This laid the foundation for his proposal to establish a new category of personnel to augment physician capacity to deliver needed generalist/primary care services (Carter 1982). Carter, Ferrell, Germino & Scott (2005) believe that the PA movement emerged in the 1960s in America as the product of a nationwide demand for clinical support personnel who could extend the role of the physician in the management of patient problems whether in hospital or office-based practice settings.

The original suggestion to train PAs came in 1961. Motivated by the concern of the shortage of physicians, Charles Hudson (1961), a physician on the faculty of the Cleveland Clinic suggested providing assistants for physicians; he called them externs. He felt these externs could be recruited from the ranks of nurses. Hudson's concept of new types of health personnel to extend physician services in the United States was suggested based on changing medical labor/hospital staffing personnel demands and advancing technology. At the time, Hudson was President of the National Board of Medical Examiners (NBMEs). In a speech to the House of Delegates of the American Medical Association (AMA) he was among the first to suggest the role. He proposed that these workers could assume the tasks of routine medical care, such as taking patient histories and performing physical examinations. He made it clear that the assistant would

be directly responsible to the physician. Hudson realized that proposing the creation of

externs based on a nursing model ran the risk of upsetting the nursing profession. He

noted theoretically that the goals for nursing could be redefined as part-nursing and part-

medicine, thus allowing nursing manpower to fill the role of the extern but believed that

nurse leaders would frown on the proposal of medicine nursing hybrid.

The AMA proposed the profession as an opportunity for nurses to leave their field

in order to gain more responsibility and pay. Referencing the fact that most physician

assistants were male and earned salaries equal to or higher than more formally educated

nurses, the ANA retorted by characterizing the new role as a bit of government supported

male chauvinism (Fairman, 2008) What leaders at the respective organizations did not

know was that the physician assistant concept was the end result of nearly a decade's

work by Stead and others surrounding the notion of training health-care professionals -

nurses among them - for advanced clinical care.

It was Dr. Eugene A. Stead, Jr. at Duke University who transformed Hudson's

prophecy into reality by developing the first physician assistant training program. Stead

was Chairman of Medicine at Duke University in the 1960s and recognized the changing

medical service and personnel needs in and around Duke University Medical Center.

Stead was an impressive figure in academic internal medicine and had long been

interested in breaking down barriers in medical education. Stead accepted the common

wisdom of the time that there was a shortage of physicians. At Duke in the early 1960s,

he began experimenting with programs for new health care personnel and began efforts to

incorporate medical training with nursing. Knowing what could be accomplished with

focused training, he envisioned a new type of mid-level generalist (between the level of a

doctor and a nurse), a medical clinician who could be trained in a relatively short time period to assist physicians in a broad range of practice settings. Stead (1979) believed that such providers should work closely with the physician and established the role in a configuration that would not directly threaten physicians.

Stead's initial efforts to reform medical education began with an attempt to train nurses with previous experience to function as PAs. He sought to build such a provider upon a nursing background and first approached a nurse, Thelma Ingles, to undergo advanced medical training. Ingles were a nursing leader at Duke who was interested in an advanced nursing/medical role. Stead and Ingles began to experiment with training approaches to expand the nursing role in generalist medical care delivery. Stead had great respect for nursing experience in patient care. After creating a prototype advanced medical training program for nurses at Duke Stead concluded that nurses "… were very intelligent and they learned quickly, and at the end of a year we had produced a superb product, capable of doing more than any nurse I had ever met"(p. 44). This program could have initiated the NP movement, but was refused accreditation by the National League of Nursing (NLN); it was denied on the basis that delegating medical tasks to nurses was inappropriate (Holt, 1998). Nursing organizations were reluctant to accredit this program because it taught nurses to perform medical tasks rather than nursing tasks. Ingles left Duke for the Rockefeller Foundation, and Stead was left with a conviction that people with varied backgrounds can deliver high quality patient care.

Estes (1986) stated that if the master's program Thelma Ingles attempted to start had succeeded, the PA profession would have been dominated and shaped by nurses.

After his failed attempt to start his PA program with nurses, Stead realized that there might be benefits to the utilization of corpsmen as the basis for the PA. Holt (1998) recounted, "He (Stead) hoped a physician assistant with a powerful presence would convince skeptics – of which there were many among medical and nursing ranks alike – of the viability of the physician assistant concept" (p.266).

The Genesis of the NP Movement

Dr. Loretta Ford came to academic nursing and the University of Colorado with an extensive background in public health nursing. She worked a as public health nurse in Boulder, Colorado and became involved with the University of Colorado as a field teacher. She eventually received her Ed.D with a focus in Public Health Nursing Administration. It is interesting to note that Dr. Loretta Ford who was instrumental in establishing the advanced practice role for nurses had a military background and had served in World War II.

Prior to developing the Pediatric Nurse Practitioner (PNP) model, Dr. Ford was involved with the Western Interstate Commission for Higher Education (WICHEN)a group which was working to identify advanced clinical content in various nursing specialties. (Wells, 1993). Dr. Ford was part of the community health group and developed a model of specialization in that area that she described as natural outgrowth of her years of independent decision making in public health nursing. She wanted to increase the breadth and depth of knowledge required for independent decisions in public health arenas while retaining the public health nurses' basic orientation (Wells, 1993).

Dr. Silver, a pediatrician who taught at the University of Colorado, had developed three medical training programs, each representative of a new category of health care provider. Dr. Ford initially met Dr. Silver through colleagues who knew of their mutual interests. Dr. Silver had been unable to interest the maternal child nursing faculty in what he saw as an expansion of nursing skills, the nurse centered conference. Dr. Ford collaboratively developed the role of the PNP with Dr. Silver and was able to actualize it within the Community Health department of the School of Nursing. They originally called the role the Public Health Pediatric Nurse Practitioner (PHPNP), later changing the title to PNP as it was less cumbersome.

Silver, Ford & Lewis (1968) identified a pressing need at almost all levels of the populations of the United States for the health care for an increasing population of children. They stated that the need could only be met by drastically altering and improving the pattern of health service delivery and by better use of health professionals. Analysis of their early published writings reveal that Dr.Silver and Dr.Ford had very differing visions of this new role, its application and scope. Though most articles will state the NP role was developed jointly by Drs. Ford and Silver, a reading of the original articles reveals little congruency in their goals or directions.

Dr. Silver also promoted the institution of two more levels of health care providers for children. The Child Health Associate (CHA) would graduate from a three year course and could care for 90% of patients in a pediatric office. CHAs would make diagnoses, institute therapy and write prescriptions. They would be employees of

physicians but enjoy a great deal of independence. Dr. Silver (1968) felt it desirable that the physician retain control over the CHAs.

Another program Dr. Silver developed was the Primary Care Medical Practitioner. This program was designed to produce an individual who would provide independent autonomous primary care limited to the care of ambulatory patients. Physicians would not supervise them, but would function as consultants and advisers. The time to train such a practitioner would be one half that of a physician. Dr. Silver saw their training as occurring within medical schools alongside medical students.

The PNP was instituted first and was initially offered as a four month program. Baccalaureate RNs were educated in history taking, complete physical examination, interpretation of labs and the skill set of preventive pediatrics. Under a physician's standing orders they could provide care to ill or injured children. Dr. Silver felt that such trained PNPs could care for 75% of children seen in an ambulatory pediatric practice. Silver (1968) felt this four month course would be a rapid and inexpensive way to train needed health professionals.

The curriculum Ford & Silver developed for the PNP was centered in nursing; it retained nursing's' focus on health and wellness by emphasizing and refining the work of nurses, not replacing nor mimicking physicians work (as did the PAs). It is ironic that the NP role has evolved more in line with Dr. Silver's envisioning of the CHA rather than Dr. Ford's PHPNP. Just a few years after the initiation of the first program Dr. Ford (1975) expressed concern that some NPs did not understand the role. She felt that NPs should practice in an educative behavioral model and should not place themselves in

systems that would have them function as physician extenders or PAs. Ford (1975)

stated "the nurse practitioner movement was not created to meet a deficit of physician

services. Compensating for medical deficiencies is the physician's responsibility, not the

nurses. It wasn't in my frame to help medicine out" (p.10).

Nursing Responds

Leaders in nursing were vehemently opposed to combining elements of the

physician's education and clinical training with a nurse's education. Hauser and Player

(2007), describe Ford's struggle with the nursing faculty. The faculty believed that

Loretta, and thus nursing, were selling out to medicine. Loretta struggled to convince her

nurse colleagues that the use of stethoscope, otoscopes, ophthalmoscopes, and critical

thinking did not erase the nursing perspective. The American Nurses Association (ANA)

was suspicious from the beginning about the PA role (Fairman2008).

When Ernest B. Howard, executive director of the American Medical Association

(AMA) proposed recruiting 100,000 nurses to be trained as PAs, the ANA saw it as

another attempt of medicine to control nursing. "It is not the prerogative of one

profession to speak for another"(Fairman, 2008, p188).

The AMA developed a position statement about NPs well before the ANA even

attempted to craft such a document. (Medicine and Nursing, a position statement, 1973).

Dorothy Meneres (1970), Dean of the School of Nursing at the University of

Pennsylvania cautioned "the members of organized nursing may be relegated to the role

of observer and lose the opportunity to shape their profession" (p.31). Hildregard Peplau

(1971) called it a fundamental issue of control.

In 1973, the National Board of Medical Examiners (NBME) invited NPs to

participate in the PA certification exam, an invitation warmly received by NPs as there

was no other certification exam available for the NPs. The ANA, horrified at this

professional intrusion, reminded nurses that certification is not a legal sanction to

practice, and therefore was not necessary. The ANA argued that nurses who passed the

PA exam and then practiced, lost their authority to practice as a nurse. These positions

did nothing to bring NPs into the nursing fold.

The American Academy of Pediatrics (AAP), in 1970 developed and published

guidelines for training NPs, without any nursing participation and long before organized

nursing moved to control curricula or training. The ANA was reluctantly pulled in,

realizing they had lost control.

Ironically a NP certification exam was finally developed, not by a nursing entity,

but under the aegis of a medical organization, the AAP. In addition, the AAP, with the

National Association of Pediatric Nurse Associates/Practitioners (NAPNAP) (note the

use of Silvers' associate terminology) was the entity that finally accredited nurse

practitioner programs.

NP programs, despite opposition from nursing, succeeded in part because of the

changing landscape of American medical care and the actual support of the medical

establishment. This is contrary to the notion that medicine had always opposed NPs and

has been threatened by them. In reality, it was nursing that was threatened and posed the most significant opposition to the development of the role. The AMA's response was timelier and nursing's delay led to increased medicalization of the role.

Ironically, certification battles still take center stage. In 2008 Mundinger proposed a separate certification exam for NP graduates of DNP programs. This exam would, once again, be administered by the NBME and would essentially be identical to the Step II exams taken by all medical students. Even more surprisingly, this proposal was made despite the fact that there is absolutely nothing in the curricula of any DNP program that would support a DNP's ability to take this test versus a masters educated NP. The scope or role of the NP does not change because of attainment of a DNP.

A Conundrum

The mythology surrounding the origins of the role of the NP and its conflict with medicine are embedded in the current under-utilization and problematic self conceptualization of the NP. The ideological mirror that NPs have used to structure their role is no truer than the assumption that NPs practice nursing not medicine. The truth is perhaps somewhere in between.

Through their early training and experience as nurses, and continuing in their didactic and experiential advanced clinical education, NPs make a unique and profound contribution to the art and science of healing. This contribution includes a nursing orientation to patient advocacy, which in practice far exceeds the advocacy of many physicians. In addition, nurses and NPs are taught from the beginning to have an

orientation toward treating the whole person and the context in which they reside. Hence, far less than physicians, NPs do not shy away from considering social causation in the etiology of pathology. NPs are not only trained in scientific technological medicine, but they also consider modes of healing involving self-care and preventative medicine. These are perhaps some of the reasons why NPs often compare more favorably than physicians in patient outcome studies.

Nurse have traditionally gravitated towards and tried to strengthen the best parts of their practice, the connection to the patient, the control of their care. These same things are the strength of the NP, not the rational technical side, which is not what is needed in the country, but the primary care side which has long been a foundation of nursing, not medicine.

Unfortunately NPs were pushed away by nursing in the early days and the early support of medicine led them to embrace the medical model to a degree that wasn't needed. Legitmation has been elusive as NPs have drifted in between the two worlds.

Nurses' holistic orientation, and the warmth by which it is often embraced by patients, embodies that core of nursing values that nurses have always sought to protect and cherish. It represents a different vision than the individualistic, mechanistic health care promoted by the existing system.

But nursing was afraid to rightfully formalize their power and claim their traditional scope of practice. Branded as a female profession (less worthy) the nurses were caught in the polemic of the era and were unsure, so made a choice to legitimate themselves by claiming 'advanced skills' from another profession – medicine. But therein lays a self destructive contradiction.

The early opposers, like Thelma Ingles and Hildegard Peplau, were astute. If you create a new professional entity (NP or APN) within an already established identity (RN), and that new group is not just more expert (in Benner's terms) in the skills of nursing, but is deemed advanced because it possesses skills from another profession (medicine), you have devalued all other nurses. Legitimation has proved elusive because at a profound level, the role of the NP is built upon the unspoken assumption that nursing is not adequate.

Given the resources this country has, we could develop a remarkable health care system: one in which both the productive process and product are humanized. While truly providing for people's need in health care, health workers could realize the potential of how rewarding and how human the activity can be. But such a system, however rational and needed, cannot be realized within the present health care structures. Nevertheless, the establishment of such a health care system is not merely a utopian ideal, but a historical possibility -- one that can only be realized in the struggle for a more just and healing society.

Nursing must enter such a struggle, and President Obama's quest for a new health care system offers a way to begin. Nurses are in position to assume an important role in this new health care system, which is surely coming. This requires that first, nursing recognize and embrace their power and acknowledge they have had the 'sorcerer's spellbook" all along, they did not have to steal it from medicine. The sorcerer's spell book is a metaphoric tool encompassing not only the skills and knowledge to care for a particularly defined population group but also the language, rhetoric, and image needed to gain legitimacy in the medical system (Fairman, 2008).

The PAs had to embrace medicine's spell book, they had no legitimacy of their own. But

nurses have their own spellbook, and that is all they ever needed.

All nurses are APNs, and always have been.

Just a Nurse

A Critical Reflection on an NP's tale

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Abstract

An interview with a Nurse Practitioner educated in an early program highlights her University of California, San Francisco BSN education and her first years in nursing. She discusses her work in the communes of Northern California and the Haight district of San Francisco and the fulfillment she found there. Her subsequent career as a NP and university professor is tempered with the realities and difficulties of advanced practice, working as a nurse but not really supported by nursing. Analyzing the data using the critical theoretical constructs of oppression and alienation reveal the inherent ideology and false consciousness which underpin the role of the Nurse Practitioner and continue to subvert and derail legitimation of Nurse Practitioners.

Just a Nurse

A Critical Reflection on an NP's tale

At the heart of everything, you find not doctrines or philosophical
propositions, but stories, just stories that get to the heart of things
(Hellinga, 1998).

In 2010, on the cusp of momentous changes in the health care system of the

United States, multiple players are jockeying and pushing for position and power.

"Naturopaths, chiropractors, nurses, we're in, but those family practice doctors, they are

out" (Jan Towers at American Academy of NPs region 9 meeting, March 13,2010)).

Nurse Practitioners (NPs) have been performing this dance of seeking credibility,

validity and preeminence for the 40 plus years of their existence and to date, show neither

signs of slowing down, nor recognizable success. Recent innovations include a mandate

for NPs to obtain, as a minimum requirement for entry into practice, a clinical doctorate,

the Doctorate of Nursing Practice (DNP), commencing in 2015. "It (the degree) will

allow us to sit at the table with the big boys"(Marion, Viens, O'Sullivan, Crabtree,

Fontana, & Price, 2003).

Credibility, validation, remuneration; there is no sure path. The best laid plans and

the most well intentioned of schemes do not necessarily guarantee a positive outcome.

Typically, unseen consequences ensue and complications are always waiting.

As NPs, once again, try to reinvent and re-brand themselves, it is probably of

value to look into the history of the development of the NP and attempt to glean any

persistent threads that might help to validate and strengthen the legitimacy of the NP

(Roberts, 1996), and possibly highlight clues as to current unfolding dilemmas .

Despite almost 50 years of impressive clinical practice, all copiously documented, the NP is haunted by a nonsensical contradiction. NPs possess the professional training and legal authority to practice, but this authority is not considered valid or legitimate by many physicians, health care employers, insurance companies or patients. This contradiction has created, to borrow a term from social theory, a legitimation crisis for NPs, both personally and professionally.

It is crucial that the legitimacy crisis be elucidated and transcended. Current events make this task even more urgent. Loretta Ford (1975), co-creator of the first NP program, observed that "in times of chaos lie the opportunity for change" (p,10). We are presently immersed in such "times of chaos." Given that NPs are sympathetically received by the Obama administration and by many in the general public they have served so well, NPs are in an advantageous position to carve out a valuable and useful niche in an evolving health care system. However, for this potential to be realized, NPs must first clearly delineate and claim their unique and valuable position and abilities.

Legitimation

In Weberian sociology, legitimacy refers to a process through which institutionalized power is accorded moral grounding, and hence, acceptance (Marshall, 1998). Biddle (1979) describes legitimacy as a form of authority. When role expectations and performances are legitimated, authority becomes prescribed and inherent. Legitimacy is the extent to which an expectation is viewed as right and proper by members of a social system. In the NP context, this social system includes consumers of care, other providers, hospital and clinic administrators, and reimbursement institutions, such as insurance companies and Medicare.

In nursing, the most influential model of legitimation is that delineated by Benner (1984). She posited that increased proficiency and expertise, when coupled with competence, would lead to legitimation of role. While this model has been widely accepted by researchers studying NPs and nursing in general, it does not accurately reflect the social reality of health care delivery. Numerous quantitative and qualitative studies over four decades consistently document that NPs provide a quality of care equal to and often exceeding that of physicians, and accordingly, NPs should have a crucial and effective role to play in health care delivery. Despite this often replicated empirical fact, NPs continue to encounter significant barriers to practice and remain profoundly underutilized. Related to this, the role of NPs continues to be poorly comprehended by many in nursing and also those in the larger health care community (Fairman, 2008).

The depth of the confusion emanating from the legitimation crisis is revealed by the fact that NPs themselves have trouble clearly defining what they do, questioning whether they belong to medicine or nursing. Such confusion promotes a perception by many NPs that they are in conflict with both medicine and nursing, and essentially, in terms of professional identity, they are homeless. Not surprisingly, NP practice seems to be shaped at a micro, almost individualistic level of definition, rather than by a macro perspective of ownership, need and unity. Related to this, nursing and NPs have been unable to claim any domain in the health care delivery system where only NPs, by virtue of their authority and expertise, are recognized as the expert provider of a service.

This interview is one part of a series of investigations that will explore the social origins and functions of this problematic legitimation. In regard to method, as Chin (1998), Leininger (1985), and many others engaged in both positivist and qualitative

research have observed, the selection of conceptual and methodological paradigms from which to approach the phenomenon being studied is crucial. Habermas (1971) stated that while technical problems are best studied using empirical/analytical research models, practical problems are best approached through historical/hermeneutical modes of investigation (McLain, 1988). In accordance with Habermas, to address this non-technical problem, case study methodology will be utilized, and the analysis will be framed in the perspectives of critical theory with exemplars exploring the concepts of oppression and ideology.

Case Study Methodology

Case study methodology is a method of empirical inquiry that investigates a contemporary phenomenon within its real life context. Case studies can be done using qualitative or quantitative evidence. One of the key characteristics of case study research is that it allows researchers to focus on complex situations while taking the context of the situation into account (Keen & Packwood 1995), thus capturing the holistic and meaningful characteristics of events (Yin 1994, 1999, 2003). The inclusion of context, such as socio-historical factors, adds richness and meaning to the study. The use of multiple data collection methods and multiple sources provides a more 'convincing and accurate' case study (Yin 1994).

Corcoran (2004) argues that the case study can be used as a mechanism to transform and improve practice. This improvement occurs when, through case study research, practitioners are faced with confronting their theories and are stimulated to engage in the building of further theory to bring about a change in practice (Corcoran et al., 2004).

Case study methodology is not to be confused with the case study method of teaching that is often used in nursing and medicine involving the "story" of a particular patient or problem that might illustrate several important points or concepts (Bryar, 2000). Corcoran (2004) argues that case study research is a study of practice, with practitioners' actions and the theories that underpin such actions being studied. Case study methodology is a study of phenomena with multiple implications.

The history of case study research is marked by periods of intense use and disuse. The earliest use of this form of research can be traced to Europe, predominantly to France. The methodology in the United States was most closely associated with The University of Chicago Department of Sociology. From the early 1900's until 1935, The Chicago School was preeminent in the field and their studies on immigration, poverty and unemployment were seminal (Tellis, 1997).

The field of sociology has been long associated with case study research, and during the period leading up to 1935, several problems with cases study method were raised by researchers in other fields. This coincided with a movement within sociology, and other academic fields, to become more scientific. This resulted in the denigration of case study as a methodology. In 1935, there was a public dispute between Columbia University professors, who were championing the scientific method, and The Chicago School and its supporters. The outcome was a victory for Columbia University and the consequent decline in the use of case study as a research methodology. In the 1960s, researchers were again becoming concerned about the limitations of quantitative methods. Yin, with his extensive writings and research has been instrumental in reestablishing the rigor of the method and its credibility.

Yin (2002) proposed three types of case study that can form the philosophical

perspective:

Exploratory – debates the value of further research, suggesting various

hypotheses.

Explanatory – explains aspects and causal arguments identified by the

descriptive research.

Descriptive – describes the phenomenon.

A further strategy described by Yin (1994) is triangulation of the data. With

triangulation, multiple sources of data are used, thus enhancing the credibility of the

strategy. Such sources of data may include survey instruments, archival documents,

observations, interviews and quantitative measurements. By using such a variety of

methods, the trustworthiness of the case study is enhanced (Tellis 1997).

Yin (2002) argues that the methodology is designed to expand and generalize

theories. Researchers from many disciplines utilize the case study method to build upon

theory, to produce new theory, to dispute or challenge theory, to explain a situation, to

provide a basis to apply solutions to situations, to explore, or to describe an object or

phenomenon. Illustrative case studies primarily serve to make the unfamiliar familiar and

to give readers a common language about the topic in question.

Most empirical studies lead from theory to data. Yet, the accumulation of

knowledge involves a continual cycling between theory and data. Perhaps this

approach will stimulate some researchers to complete the cycle by conducting

research that goes in the less common direction from data to theory....

(Eisenhardt, 1989, p.540)

This case study will be of the exploratory type and potentially will extract

derivations, explanations and possibly solutions for the NPs legitimization crisis.

Critical Theory

A complication of empirical investigation and the positivistic orientation in

general is that its' values and categories of research are grounded in the existing social

system. (McIntyre, 1995) notes that our research questions are often constructed to

support rather than challenge existing knowledge. While such an orientation does not

inherently prohibit valuable work, it does tend to accept and reproduce the status quo.

The possibility that the social system has fundamental flaws is beyond the vision of

positivism. Likewise, the need and possibility of structural transformation is also outside

the discourse of most traditional research.

In marked contrast to positivism, critical theory asserts that knowledge does not

originate in a vacuum, but is produced and defined by specific social-historical contexts.

Moreover, critical theory epistemology holds that knowledge is not neutral, but can be

used in ways that serve forces and social structures of oppression or conversely,

emancipation (Lichtman, 1982; Marcuse, 1977). Directly related to this, critical

theoretical research methods are united by the fundamental assumption that knowledge

should be used to elucidate and transcend all forms of domination (Allen, 1987; Chin,

1998; Held, 1981).

Critical theory is grounded in the union of social theory with individual

psychological theory. Such an orientation allows the researcher to examine the dialectical

relationships between social historical and individual psychological factors in the causation of social phenomenon. This is a crucial perspective if the seemingly irrational incongruence between empirical evidence and lack of legitimation for NPs is to be understood. Moreover, critical theory is informed by a commitment not just to understanding, but to social change and emancipation. NPs have much to gain from such an exploration.

The Roots of Critical Theory

Critical theory was developed by a group of German intellectuals during the late 1920's and 1930's (Horkheimer, 1972, Jay, 1973). Important pioneers of this school of thought include Max Horkheimer, Theodore Adorno, Leo Lowenthal, Frans Neumarm, Herbert Marcuse, and Eric Fromm. Their diverse intellectual backgrounds in sociology, psychology, political science, history, literature, economics and philosophy, were unified in a general orientation to non-positivistic radical social theory, most notably, Marxism.

Their varied backgrounds illuminate two important values of critical theory; the belief in a multidisciplinary approach to the study of social problems, and a commitment to radical social transformation. Implicit here is an assumption of critical theory that knowledge is not neutral; it is a partisan tool that can be used for or against freedom. For critical theorists, the goal of research and knowledge is praxis — theoretically guided action, aimed at emancipation (Arato &Gebhardt, 1982).

The institutional home of critical theory was the Institute of Social Research, established in Frankfurt in 1924. The Institute was loosely associated with the University of Frankfurt, and so critical theory is also known as the Frankfurt School (Lichtman, 1982). The institute was fortunate to have independent financing. Felix J. Weil, a radical

young political scientist, secured an endowment of $30,000 per year for the institute from

his father, a wealthy grain merchant. This fiscal independence allowed for autonomy of

intellectual pursuits that was not commonplace in traditional German higher education.

Critical theory arose in a social context of great turmoil. In the 1920's, Europe was

reeling from the effects of World War I, the Russian Revolution, the great depression, the

ascendancy of capitalism, and somewhat later, the rise of fascism. It was a time of great

social, economic, and political unrest. Traditional social structures were collapsing, and

no one knew what was going to replace them. Controversial areas of study, such as the

history of the labor movement, and the origins of anti-Semitism, were freely pursued by

scholars at the Institute.

The intellectuals at the Institute were not satisfied with the prevailing modes of

understanding that were predominant. They believed that both positivism and orthodox

Marxism could not grasp the complexity of social reality. The former was focused almost

exclusively on the actions of individuals, ignoring economic determinants of society and

they felt this implied an acceptance of the status quo. On the other hand, the dogmatic

Marxists had essentially reduced all social reality to the economic sphere, ignoring the

individual and subjective realm. Such important questions as to why individuals would

willingly accept inherently destructive social systems, such as fascism, were beyond the

understanding of both approaches.

In response to this absence of adequate theoretical frameworks for the study of

society, critical theory was developed. Crucial to its approach was the emphasis on

understanding both social and individual factors. The individual and society, including

the political and economic spheres, were perceived to be not separate, but are

dialectically related; part of the same whole. They theorized that each of us is influenced by social, political, and economic forces, and these same forces are influenced by the actions of the individual. One cannot understand the individual without understanding the social context in which they live, and society cannot be understood without knowing the individual. In order to facilitate such a dialectical understanding the critical theorists turned to Marx for social theory and to Freud for individual psychological theory (Jay, 1973).

The Institute for Social Research had a short life. On January 30, 1933, the Nazi Party assumed power in Germany. On April 13, 1933, Max Horkheimer, Director of the Institute, was relieved, by the Nazis, of his position. Horkheimer and others at the Institute, all mostly of Jewish descent, were among the first academics to be fired by Hitler. Their radical scholarship had placed their lives in danger, and most soon fled Germany for France, Switzerland, England, and the United States. During the war years, several former Institute members worked for the Office of Strategic Services (OSS), the American intelligence service that was the forerunner of the Central Intelligence Agency (Jay, 1973).

The Institute may have been short lived, but its' influence was not. During the postwar years, Critical Theory played an influential role in shaping western European communism. It was especially powerful in its' critique of Stalinism (Marcuse, 1960). Strands of critical theory can be discerned in the grounded theory of Strauss and Glaser, and in a myriad of feminist writings. In the late 1980's, critical theory first began to be used as a paradigm of inquiry in nursing research, starting with David Allen at the University of Washington (Allen, 1985).

The Research Process of Critical Theory.

Critical theory offers a different and needed perspective. A critical theoretical analysis will be utilized here to contribute to the emancipation of the constraints imposed on NPs professional and private lives by their lack of authority and public definition. The origins of the legitimation crisis lie not in the lack of will to succeed, but rather within the subjective and objective conditions of the organization of nursing. NPs and nurses have historically lacked power, and communication problems with dominant interests in the health system, both nursing and medicine, have been distorted by issues of power.

The paradigm of critical theory uses oppositional thinking to perform a critique of the social situation under study in a historical, cultural and political context. Implicit rules and assumptions are examined, conditions are identified that would facilitate uncoerced knowledge and a theoretical framework is tested against individual cases. Finally dialogue should lead to collective consciousness raising and action against oppressive forces (Burns & Grove,1993). Case study methodology offers a path to explore legitimation in a real life context from multiple perspectives.

The Interview as Method

Interviews are an essential component of case study investigations (Yin, 2007). Themes relevant to understanding the legitimation crisis, that is, the human experience of this crisis as it is lived, were obtained through an oral interview with a NP educated in the early 1970's. A dialogic retrospection style of interview was employed. In dialogic retrospection, as delineated by McLain (1988), both researcher and subject are active

participants in the research process, including jointly determining the direction of the interview.

In addition, this approach, which essentially allows both subject and researcher to tell and reflect on the story, is directed at the personal growth and empowerment of all involved. Chin (1998) observed "In essence the telling of the story enables the research participants to 'name their reality' and to examine strategies for changing that reality. The researcher in this context is not a passive listener but is actively engaged with the research participants in a dialogic exchange. Thus, the emphasis is on personal change, growth and empowerment" (p. 8).

The subject is a female NP who was trained in one of the earlier NP certification programs. She was selected to be interviewed as her four decades of experience essentially cover the entire history of the NP. She is a unique and valuable source of phenomenological and historical information. Both the researcher and subject are NPs with extensive clinical and academic experience; the researcher is masters prepared and a doctoral candidate, and the subject's terminal degree is a PhD. Both have taught at the University level for over 20 years. Their shared professional experiences and backgrounds inhibit the traditional unequal power relationship between researcher and subject, and hence, facilitate the fluid telling of stories.

A Nurse's Tale

"I became a NP because of the University of California at San Francisco (UCSF). I didn't go to the NP program there, but everything about the school prepared me for the role."

Nancy grew up in Bakersfield, California (CA) where her father was an optometrist. She describes her childhood as tumultuous, especially after her father's religious visions drove him to the seminary at Berkeley and her family moved to San Rafael, California. She attended high school there, very close to the streets famously cruised by Harrison Ford in the movie American Graffiti. Frequent forays into the "city" (San Francisco) afforded not only shopping excitement, but a look into another, more diverse, side of life. Working as an aide at a nursing home led to the decision to pursue a nursing career back at Bakersfield junior college. A faculty member in the nursing department there urged her to set her sights higher and set her goal for the BSN program at UCSF. "It was the best advice I ever received. It changed my life!" After 2 years at Bakersfield junior college she was accepted into the BSN program at UCSF.

The BSN program at UCSF then was in community health nursing – very different from most diploma bedside programs, (it was) academically rigorous but had a social perspective.

There were new, exciting currents emerging in nursing education. The changing social climate was leading to innovation everywhere (Fairman,2008) .

By then early 1960s nurse educators who were aware of the clinical realities in hospitals and the lack of care in rural and urban clinics began to conceptualize new clinical practice models and innovative academic clinical education programs. Their goal was to provide nurses with an intellectual foundation based on a liberal arts education in universities and colleges that supported broader clinical practice roles for nurses (p.44).

> Nancy recalls the feeling of the era, how different and exciting it was.
>
> It was the 1960's, free love, free clinics, free everything, and I was a small town
> girl with a limited Christian type background and everything was exploding. The
> School of Nursing was in the middle of everything – We did our bedside nursing
> and were very good at it, but we were also out in the Haight at the free clinics and
> down in South San Francisco and in the Mission. And our faculty was there too.
> They drove us so hard; we wrote paper after paper after paper. Our education was
> truly holistic in the very best sense; our clients were (not only) the patients, but
> the community and society too. The sense of excitement was palpable; we felt we
> were on the cutting edge of nursing and social change.

After graduating from UCSF Nancy continued to work for the University on a grant funded project that provided nursing services and care to commune members in Northern California.

> We drove a Volkswagen bus with a flying nurse logo on the side.....I drove down
> back roads and looked for tie dyed curtains and hippies. I never acknowledged
> we were attached to a grant. I just said we were working with UCSF on a project
> to support communes. People were very suspicious then if you were with a
> government agency. We realized there probably was an ulterior motive for the
> grant; it was obviously a way to keep track of all those hippies.

After being inculcated in community health nursing at UCSF and writing so many papers on theoretical aspects, Nancy was still taken aback by the terrible need for the most basic of nursing care and intervention.

The communes were pathetically poor. There were kids with dysentery, scabies, and malnutrition. The women were pregnant all the time, losing their teeth because they lost so much calcium. I got to know the midwives who weren't really midwives at all and really didn't know what they were doing. I bought them books on obstetrics and tried to teach them about sterile technique and basic nursing. There was so much to be done.

She took justifiable pride in her abilities to implement effective interventions and still hold true to some of the most basic tenets of holistic nursing care.

I'd try to convince the women to take oral contraceptives, telling them that they were organic, made from South American yams, which they aren't, but it was a good argument and almost true. And they needed a way out.

The pride and delight in her accomplishments still radiates.

How lucky could I be, I worked with the brightest women in nursing, Virginia Olesen for one, in the most beautiful place on earth, from Mendocino to Monterey, and I was doing important needed work.

After funding for the position ran out, Nancy returned to UCSF and obtained a masters degree in Psychiatric Community Health Nursing. Her training grounds were once again the community health clinics of San Francisco, "I was in an expanded role and didn't even know it, and I just loved what I was doing and what we could accomplish with nursing. There was such desperate need I always felt I needed to do more, know more."

In a few years, Nancy moved back east to teach community health nursing at Boston University (drawn by Dean Irene Palmer) and went on from there to be a nursing supervisor at the Harvard Community Health Center, an early HMO type organization. Several physicians in the organization wanted to extend the role of the nurses in the clinic and Nancy was among four nurses that entered an 18 month NP certificate program. "We were there to work collaboratively with the physicians, but they (the administration) wanted us to provide something the doctors couldn't, the nursing care. Over time we became quite powerful partners with the MDs."

Nancy eventually moved to New Haven to teach at Yale School of Nursing and worked in an outlying community clinic 3 ½ days a week, where she was the only provider in a poor, blighted area. "The reason I was there was because nobody else wanted to be, not because of my nursing skills or expertise, it was just a place physicians didn't want to be. I think we (NPs) fill in the blanks in places of practice where physicians are thin or unavailable or doctors need to expand their practice."

This echoes a statement issued by the American Academy of Pediatricians (AAP) in the early 1970's, "I feel the only role these people can play is in Appalachia and in large cities where physicians are overwhelmed "(cited in Fairman,2008, p.84).

The excitement and enthusiasm that were at the heart of her early nursing career diminished as she became more aware of the realities of expanded practice.

> In the early days we couldn't prescribe at all so I carried signed prescriptions
>
> which weren't legal at all. I never filled it out in front of the patient, I'd go
>
> outside the room and pretend that I consulted with a physician and then come

back in with the prescription. So I was pretty much on my own even though I had

to pretend I wasn't.

There is apparent a growing sense of discontent, the feeling of being the outlier

who is doing important work but is also, at a profound level, not supported.

Like most things in life, there is the good with the bad. Expanded practice is

more fun... its more intellectually engaging, you can really get to know patients

and intervene in a profound way. The expectations are higher but so are the

rewards......and the risks.

Nancy still questions what she is doing as an advanced practice nurse. She was

clear in what her nursing role encompassed back in the communes and what intervention

were needed, but as her practice strayed always from nursing and into the realm of

medicine the questions multiplied.

NPs are now trying to compete head to head with physicians. I am not a doctor

and never will be and I like that, but we (NPs) need to be clear about what we do

and what we don't do. If we practice medicine just as well as physicians and then

add nursing on top of that that's just pointless. Nursing has never been really

supportive of the NP, nursing hasn't bought in and it hasn't bought out.

Analysis

Oppression

In 1996 Roberts argued persuasively that NPs and nurses manifested oppressed

group behaviors. She based her model of NP oppression on the writings of Fanon and

Fr(2000) and their observations in colonial Africa and Brazil. Oppressed group

behaviors include low self esteem, self hatred, and hiding evidence of belonging to their

own culture, taking on the characteristics of the dominant group, passive-aggressive behavior and horizontal violence (Roberts, 1996, p.210). She also discussed NP's signs of marginality; rejection of nursing identity, feeling superior to other nurses, looking to medicine for support and supporting medicine over other nurses.

In Robert's (1996) model, oppression is maintained by the behavior patterns of the oppressed group. These behavior patterns, although necessary for survival, lead to a cycle of further oppression. Jobs or privileges are given to those in the oppressed group who proclaim the dominant values are correct. "Many NPs found that aligning with nursing weakened their power and potential..........others viewed nursing as inferior, and (saw) NPs as a superior group of nurses (p211)." Many NPs prided themselves on being "not just a nurse", even saying that traditional nurses were jealous of their abilities (Roberts, 1996).

Certainly many of these themes of oppression are present in Nancy's recounting. "I think we (NPs) fill in the blanks in places of practice where physicians are thin or unavailable or doctors need to expand their practice." The reason I was there was because nobody else wanted to be." Nancy personifies the low self esteem of NPs doing what nobody else wanted to do and trying to feel grateful for the opportunity. NPs had no identifiable home, nursing had cast them aside and they had no choice but to put their lot with medicine. "Nursing has never been really supportive of the NP, nursing hasn't bought in and it hasn't bought out." This could be thought to exemplify a rejection of nursing identity but in a profound way is true Accountability to patients was supplanted by accountability to physicians and the system. Nancy found the hiring practices of hospitals and clinics tended to be unpredictable and subject to rapid change. At times

clinics and hospitals would adopt policies favorable to retaining NPs, at other times such

policies were abandoned. "You can be sure that once your pay starts to go up, there goes

the job. Nobody wants an expensive NP." Despite this, Nancy feels that her four-

decade career as a NP was personally and professionally challenging. She also possesses

an experienced confidence that the product of her labor, caring for patients as an

advanced practice clinician, has a value which is self-evident.

If Nancy's career as a NP is expressed in the language of oppressed group

behavior, it is self evident that the dominant powers created behaviors in nurses and NPs

which have blocked their legitimation. As her world changed and education and role

played out in wider arenas, that excitement and enthusiasm of nursing is muted and

dissipated. Her role became more physician centric and the sense of empowerment fades

"as we filled in the blanks." Employment opportunities and practice definitions were and

are often dictated by what the physicians did not want to do, most typically in the areas of

pediatrics, women's health, and primary care for the unfunded. The fulfilling,

redemptive aspects of her NP career are muted by a sense of isolation, or what critical

theory would call alienation. Nancy felt her labor was realized in a murky, borderless

realm somewhere between nursing and medicine. And she felt like she never really

belonged to either nursing or medicine. "I belong to a lot of NP organizations, but not the

American Nurses Association, (ANA), they don't get us and certainly don't support us."

At the time, the ANA was so worried about incursions from medicine into nursing that

they saw only another paternalistic manipulation by medicine. They were very slow to

acknowledge the changes that had occurred in nursing (Fairman, 2008).

Running Head: CRITICAL REFLECTIONS

For Nancy, each new employer required that she define again what her scope of practice would be, and figure out the role expectations for the NP in that specific context. "First I would need to see what they didn't want to do, then make those the things I would do." Physicians in each new setting typically had no experience with NPs, and so had to learn how to relate to her, including whether to accept her, and in what role. The question if she was a nurse, a physician extender, or a junior doctor needed to be constantly addressed.

Ideology

At first sight ideology simply appears to be neutral, no more than a shared system of beliefs and values that is for the most part natural. The ideology implicit in Robert's (1996) article, that medicine is the dominant oppressing force, is never questioned or argued. The reader of Roberts "knows" that the oppressor is medicine, or more specifically physicians. This "knowing" is so pervasive among nurses and NPs, that even the educated academics the article was surely aimed at, need not identify the oppressor or dominant group, as it is part of our shared ideology. The oppression of nursing by medicine is a predictive assumption that can be found in the underpinnings all of our research, social relations, reimbursement, wages and care of patients.

Classic reasons for domination and oppression lie within the spheres of gender, political and economic relations. It is assumed that physicians, insurance companies, and hospital administrators have power; nurses and nurse practitioners do not. And as the history of nursing and the larger society clearly reveal, the empowered elite are not interested in sharing power, but in retaining and even expanding their privileged position.

These are all long held nursing beliefs that serve to maintain the status quo. (Navarro,

1975, Reverby, 1972, Bullough & Bullough, 1978).

Ideology though, is neither necessarily factual nor neutral. When ideology

supports a belief in one's own subordination it can be considered to be a false

consciousness (Habermas, 1978). Taylor (1997) writes that conditions of inequality,

while true, may create ideologies which confuse people about their true aspirations,

loyalties and purposes. She warns that a false consciousness can prevent a critique of

circumstance and without reflective critique inequality may persist. Critical ideology can

provide insight and, therefore, strength and coherence for nursing. Ideological

perspectives mystify and legitimate oppressive power relations (Held, 1981, Lichtman,

1993). The distortion inherent in ideology inhibits individuals and larger social

groupings from grasping the reality of their situation (Habermas 1978, Jay, 1973).

Hence, ideological accounts of a given reality produce both a false consciousness and a

barrier to consciousness.

Back to Nursing

What shines through Nancy's narrative is the excitement and wonder of her early

days as a nursing student at UCSF. Her enthusiasm and engagement are palpable. There

is nothing to compete with her "out on the road" delight, and her sense of fulfillment in

the provision of nursing care. Noticeably lacking is the imprimatur of physician

involvement, both in the educational setting and in the service arena. A very nurse-

centric world predominated and is reflected in the empowerment of Nancy and her

colleagues.

The classic definition of alienated labor holds that the alienated worker is distanced from the product of their labor. This is certainly not true of nurses or NPs who, with a great deal of immediacy, truly possess and own the product of their labor. But estrangement or alienation can also manifest itself within the activity of production itself.

NPs have become estranged from their foundation and their core of labor, the nursing profession. Oppression has not been at the heart of the NPs legitimation problem, rather its roots lie within the NPs alienation from nursing, abetted by the initial attempts to build the NP role on the alleged deficiencies of nursing. The perception of oppression comes not from medicine but from the self defeating agendas and scripts written for women many years ago. If oppression is not the driving force, the bogeyman hiding under the bed, the sought solutions need to be crafted in a radically different fashion. Self defeating agendas and scripts are what drove nurses to try to advance their practice with medical provenance; nurses never truly believed they possessed the sorcerers spell book.

To a large degree, the NP legitimation crisis has been created and sustained by the ideology, or false consciousness of both the medical and nursing models. The relevant component of this model for the dilemma at hand is the assertion that physicians are the most valued, skilled, and useful providers of health care and that nurses practice "just' nursing, which is a derivative skill with a limited knowledge base. It only follows that NPs, nurses and other non-physician providers are second-class citizens at best, and useful only in their ability to assist physicians in the provision of health care services. As Nancy said "we fill in the gaps." This perspective is presented as a fact of life, as if it was a truth of nature, and enjoys almost ubiquitous acceptance throughout the health

sector. The depth of its acceptance is revealed by the fact that many, including NPs and nurses, internalize this belief and willingly contribute to its continuation (Roberts, 1996).

However, the physician-as-superior-healer concept is not a natural fact, but a socially generated ideological construct useful in maintaining the status quo. Also false is the belief that nurses do not have a complete set of skills or the knowledge base to fully take care of patients. It can be argued that nurse practitioners existed decades ago as exemplified by the private duty nurse. Medicine has taken over areas that traditionally belonged to nursing such as well child care, health promotion, and obstetrics. Nursing had to reclaim those areas by labeling them as part of an advanced practice nursing scope. Until this ideology is subverted, NPs will continue to be haunted by barriers to practice, underutilization, and other pathologic manifestations of the legitimation crisis.

The fatal flaws in the effectiveness and barriers to practice research are preordained. Their false premises have been made evident as the volume of effectiveness studies increase and barriers to practice fall; still legitimation remains elusive.

Just Do It

Perhaps most crucially, NPs need to leave the place they now occupy between nursing and medicine and come home to nursing. Advanced practice nursing skills and abilities have always been within the scope of nursing. A very long and complicated legacy has made nurses cautious and afraid to truly own the breadth and extent of their practice. Very good arguments can be made about the values of survival and "flying under the radar". However, nurses in the 1960's did not need to borrow skills from medicine to legitimate nurses' performance, nor do we now. We need to just do it, just be nurses. The history of professional nursing, and before that, lay nursing, is a stunning

legacy of courage, intelligence, compassion, and healing. Nancy's foundational

education at UCSF and her tales of patient care delivered via a Volkswagen bus

underscore the vitality, cohesion and beauty of nursing. Together, NPs and other nurses

need to stand as one, and demand, not ask, for recognition of their value as individuals

and healers.

The power of nursing has always been immense, and it has been too long

unrealized. And now, with a sympathetic administration in Washington, the time has

come for this to change. Nurses can play a valuable role in the coming struggle for

liberation.

Dissertation Conclusion

I believe the heart of NP's elusive legitimation lies in their troubled relationship with the nursing profession. The problems that have persisted for so many decades do not come from external oppression, but rather from what sometimes seems insurmountable, the ideology and the false consciousness that has been embraced by almost all nurses, and held as a firm belief. An ideological perspective of shared acceptance of the superiority of medicine is what led to the genesis of the NP role, and the persistence of that false consciousness has driven much of the research and writing around the role of the NP. True evolution of the NP has been hampered by the subversive subjugation of the NPs true nature. Emancipation from the constraints of this false consciousness is the goal of my present case study. Nurses, and NPs as specialists within the profession, posses a holistic orientation that represents a different vision than the individualistic, mechanistic view held by much of the existing health care system. This is an orientation that is craved by patients and desperately needed to provide effective health care for everyone in the United States

Given the resources this country has, we could develop a remarkable health care system: one in which both the productive process and product are humanized. The landscapes and structures of health care are radically changing. No longer are the driving forces those of business, profit and power. Instead, the patient and the needs of the patient are moving to the center of the fray and will be crucial in redefining the boundaries for us all. Nurse Practitioners are part of a very long tradition of superb health

care, delivered by nurses. And as nurses, just nurses we possess all that is needed to change the country.

Implications for Nursing Practice, Education, and Research

A shared ideology of false consciousness is a powerful tool in maintaining the status quo and inhibiting change. It has profound social consequences. It is very hard to argue against something which seems so true, such a fact. False consciousness can prevent a critique of circumstance and lead to unforeseen problems. To paraphrase Gavin (1997), our shared ideology is not working particularly well.

Nursing Practice

Imagine a nursing world not divided by hierarchies of skill and educational degree, rankings that none of us can reliably qualify or describe. In such a world, each educational degree is not built upon a foundation of previously inadequate degrees. In this reality, the title RN describes someone who has had didactic and clinical experience that represents a shared level of what we now call advanced practice.

All registered nurses are able, and should have legal and social permission, to perform complete physical exams, do complete histories and apply diagnostic reasoning to the development of an assessment and plan. All nurses, not just those with advanced training in the "skills of medicine". Those supposed advanced abilities are not borrowed, nor do they belong, to medicine, they already exist within a nursing scope of practice and always have. All nurses should be able to diagnose, order tests, interpret them and prescribe medications and treatments. The reason it has been so hard to delineate precisely what encompasses nursing versus what is medicine is that the distinction is artificial, and not something that needs to be more finely drawn, but actually eliminated.

This imaginary line in the sand is a true barrier to practice, and it has not been imposed

from without but supported by our own shared ideology of nursing.

The RN should be the highest professional degree obtained and it should allow a

full scope of practice that includes what we now term advanced practice. This could

perhaps be attained a masters or doctorate level, but would be possessed by a highly

educated nurse who has a full set of skills at the beginning practice level. Specialization

would be the next level; a specialist in primary care, in acute care, intensive care, public

health, administration – there are scores of areas of specializations possible but all

specialties would be built on that core of a basic skill set we now call advanced practice

nursing. Those tasks that we have appropriated from medicine and call advanced – such

the writing of a prescription or the interpretation of lab tests are just that – tasks – and

should be pursued in legal and legislative venues, not educationally. And they should be

pursued for all nurses, not just NPs or APNs.

Imagine how different hospital bedside care would be if provided by a RN who

had the legal authority, paired with education and experience so as to be able to diagnose

illnesses, order tests, treatments and medications. Imagine the care provided by the nurse

and physician who are truly collaborative. As you can now choose to see a family

practice physician, or a physician specialist, a chiropractor or an osteopath, another

choice might the nurse specialist in primary care, the acute care nursing specialist or the

nurse specialist in women's health care, no one will be 'just a nurse'.

Nursing Education: Liberation Pedagogy

Freire (1970) proposed that in order to be liberated from oppression, an unveiling

of the world of oppression and the expulsion of the myths created and enforced by the old

order must be done. This is done through conscientization, which is the process in which human beings, not as recipients, but as knowing subjects, perceive and understand the socio-cultural and political reality that shapes their lives and are then able to take action against the oppressive elements of reality. Liberation pedagogy is the recognition that the individual may also be the oppressor. Oppression does not always emerge from without. This realization must involve knowing the history of the oppression-where it began, how it evolved, who benefits from the oppression and the part that the individual (self) continues to play in the oppression. Freire (1970) states, "liberation is a praxis-action and reflection upon the world to transform it" (p. 79). Authentic liberation is the process of humanization and as we gain insight into our role and its larger place and consequence, we become better nurses in the very best way imaginable.

The application of liberation pedagogy in the design of DNP curricula has the potential to promote the conscientization of future NPs. As developing NPs begin to embrace a new paradigm of definition, both for themselves and nursing, old hierarchical relationships and battles will fade. Proof of NP effectiveness will not need to use medicine as a standard but will be redefined in new ways on their own terms.

Liberation pedagogy within the nursing educational system provides an opportunity for nurses and NPs to share a re-envisioning and reconstruction of ideologies, to value historical and lived experiences, and encourage respect and 'a home' for all of us. These are the elements that are fundamental to empowerment and emancipation.

Nursing Research

Based upon the results of this study, future research efforts in this area need to focus on a deeper exploration of the legitamation crisis. A major finding of this study was

the central role of legitimation in shaping NP practice. Future studies in which legitimation is explored using strategies such as grounded theory methodology could provide the basis for the creation of mid-range theories regarding legitimation, with subsequent opportunities for theory testing. Using a systems approach, the real costs-both human and economic- of the lack of NP legitimation could be analyzed, with the development of subsequent "real world" interventions. A pilot project in which a truly legitimized NP role is developed, realized, and analyzed within a system of health care delivery could provide the basis for its more widespread adoption.

This study sought to examine the perception of legitimacy in nurse practitioners using multiple sources analyzed through the lens of the classic themes of critical theory: oppression, alienation, ideology and false consciousness. By establishing the centrality of legitimation, results from this study provide important information at a critical juncture in nursing history.

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APPENDIX